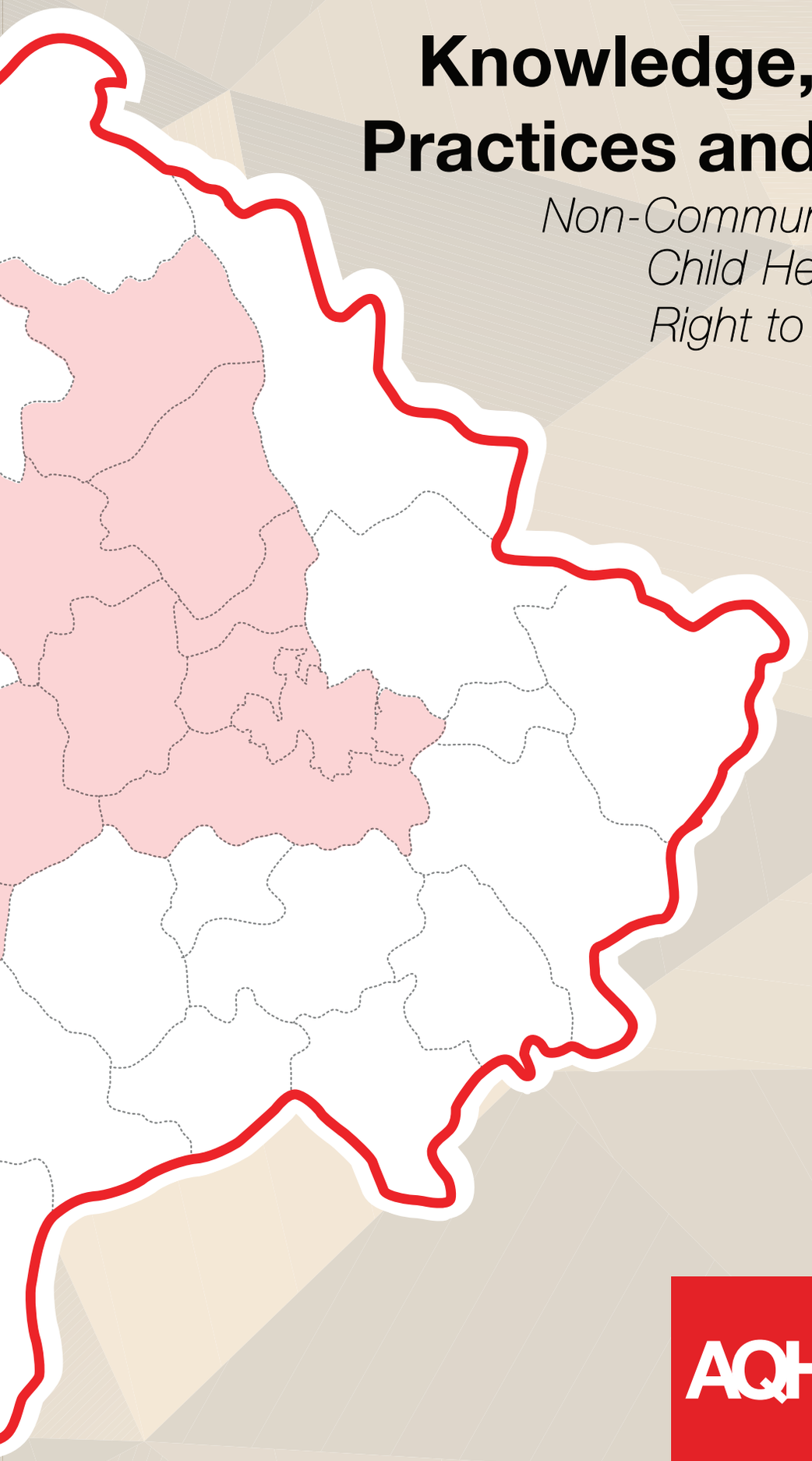

Knowledge, Attitudes, Practices and Behavior:

Non-Communicable Diseases, Child Health and Citizens' Right to Health in Kosovo

December 2016

KANTAR TNS

AQH

Accessible Quality Healthcare

Kujdesi Shëndetësor i Qasshëm dhe Cilësor
Kvalitetna i Dostupna Zdravstvena Zaštita

SDC project implemented by Swiss TPH and Save the Children

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Executive summary

Introduction

The health sector in Kosovo faces many challenges in delivering quality health services that meets the needs of the population. This is especially important for the health of particular vulnerable groups such as the rural poor, the elderly, the very young, the disabled, the chronically ill, and the Roma, Ashkali and Egyptian (RAE) community). Health indicators for the most marginalized are worse than those of the general population, indicating deep inequities to which the system is currently not responsive.

The Accessible Quality Healthcare (AQH) project, funded by the Swiss Agency for Development and Cooperation (SDC), supports the implementation of the national health sector reform agenda and complements other donor-supported programmes with a focus on the primary health care level. The project aims to strengthen the quality of health care and to stimulate access and use of quality primary health care services by all Kosovo citizens, with particular attention to the needs and inclusion of socially vulnerable populations.

The project commissioned this study to assess the Knowledge, Attitude, Practice and Behaviour (KAPB) of the general population regarding selected non-communicable diseases (NCDs) and selected aspects of child health (child diarrhoea and acute respiratory infections) with a particular focus on vulnerable groups (i.e. rural women and RAE communities). In addition, the study provides information about the population's knowledge, attitude and behaviour regarding citizens' right to health.

Methodology

The KAPB Study used two approaches for data collection, quantitative survey and qualitative research. In order to collect baseline information from the target population, the quantitative survey was conducted in the first stage with 1,200 adult respondents to determine the level of knowledge amongst the target population in the 12 target municipalities (Fushë Kosovë, Gjakovë, Gllogovc, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skenderaj and Vushtrri). Afterwards, issues emerging from the quantitative survey that were of strategic importance for the AQH project were further explored in the qualitative research (12 mini-group discussions) to better understand the factors contributing to certain attitudes and practices.

Conclusions

One of the most important findings of this study was that, generally, there is a high level of knowledge about NCDs but a very low level of knowledge about risk factors, early signs and preventive measures. In addition, a very small portion of respondents have declared that they feel being informed about the selected NCDs and associated problems. The majority of un-informed respondents were willing to acquire greater knowledge about NCDs and associated problems NCDs.

There is a general lack of understanding about smoking as a risk factor for NCDs and the majority of smokers smoke inside their houses, some of them with children in the households. Also, the intake of fruits and vegetables among the population of the 12 target municipalities is highly insufficient for being healthy and avoiding health risks. In addition, a significant portion of the population lacks the recommended physical activity for being healthy and avoiding health risks.

Although the majority of respondents believe that they should seek medical treatment if they or their family member or friend has an NCD, a significant proportion still does not believe that this should be the case.

The study shows that whilst there is a clear preference for people to use public healthcare services rather than private services, the satisfaction levels with PHC services are shown to be considerably lower than previously reported by other studies in Kosovo.

The RAE community, being potentially the most vulnerable group in Kosovo in terms of health, shows considerably lower levels of knowledge about NCDs, risk factors, early signs and preventive measures, compared to the Albanian community. In addition, the RAE community shows far riskier health behaviours especially towards smoking. This community is also reported to face discrimination in the provision of health services.

Women are more knowledgeable than men, especially when it comes to risk factors, early signs and preventive measures against NCDs. Also, women are less prone to high risk behaviours, since they smoke less than men, drink less alcohol and eat a little more fruits and vegetables than men do. Still, women lag behind men in terms of physical activity.

Recommendations

1. Increase the awareness of the adult population, particularly of the RAE community, on risk factors associated with NCDs, the early signs of NCDs and preventive measures that can be taken in order to avoid or minimise the impact of NCDs.
2. Healthcare professionals should better inform the adult population on the associated problems with NCDs.
3. Increase understanding that smoking is a risk factor related to NCDs.
4. Inform the adult population about the importance of a healthy diet and physical activity for a healthy lifestyle and avoiding health risks.
5. Increase the awareness of the adult population about the importance of seeking medical treatment in cases where people have NCDs.
6. Provide support to public primary healthcare centres to increase the quality of their services, increase the level of customer care and better respect patient rights.

1 Background

1.1 The Accessible Quality Healthcare Project

The health sector in Kosovo faces challenges in meeting the health needs of its citizens and in delivering quality health services, particularly for vulnerable groups, such as the rural poor, the elderly, the very young, the disabled, the chronically ill, and Roma, Ashkali and Egyptian communities (RAE). Health indicators for the most marginalized are worse than those of the general population, indicating deep inequities to which the system is currently not responsive.

The Accessible Quality Healthcare (AQH) project, funded by the Swiss Agency for Development and Cooperation (SDC), supports the implementation of the national health sector reform agenda and complements other donor-supported programmes with a focus on the primary health care level. The project is implemented by the Swiss Tropical and Public Health Institute (Swiss TPH) and Save the Children (SC).

With its three long-term outcomes, the project aims to strengthen the quality of health care and to stimulate access and use of quality primary health care services by all Kosovo citizens, with particular attention to the needs and inclusion of socially vulnerable populations.

The project has the following expected outcomes:

- Outcome 1 - Primary Health Care (PHC) providers in project municipalities deliver quality services that respond better to communities' needs, including those of vulnerable groups. This component of the AQH project is oriented towards providers and aims at improving the quality of service provision, reducing access barriers and making services more responsive to patients' needs.

- Outcome 2 - Health managers in project municipalities improve their performance in guiding service delivery towards continuous quality improvement that responds to communities' needs. This component aims at strengthening service integration at municipality level through improved management, stronger inter-sectoral collaboration, increased effectiveness and accessibility of health services and by addressing contextual determinants and risks factors for ill-health.

- Outcome 3 - Health awareness and care seeking behaviour of the population in project municipalities improves (in particular of vulnerable groups) and communities are empowered to demand the right to quality services and better access to care. This component is oriented toward the population by promoting an active patient role for the delivery of PHC services, positively influencing health seeking behaviour - particularly for the poor and current non-users or low-users - and promoting healthy lifestyles at population levels.

In order to be better informed about Outcome 3, AQH contracted a local research company, Kantar TNS (Index Kosova), to conduct a Knowledge, Attitudes, Practices and Behaviour (KAPB) Study on Non-Communicable Diseases (NCDs), Child Health and Citizens' Right to Health in Kosovo.

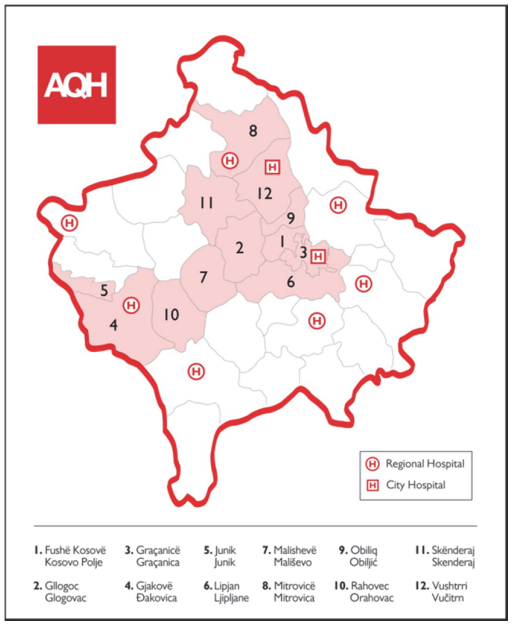
1.2 Purpose and Objectives of the KAPB Study

The purpose of the study was to assess the knowledge, attitude, practice and behaviour of general population, particularly focusing on vulnerable groups (e.g. rural women, RAE communities, etc.), regarding selected non-communicable diseases (NCDs) and child health

(child diarrhoea and acute respiratory infections). In addition, the study provides information about the population's knowledge, attitude and behaviour regarding citizens' right to health.[1]

The objective of the study was to collect primary data from 12 project municipalities. The KAPB study will serve as a baseline against which the impact of the project activities will be measured upon completion of the project in 2019. In addition, data from this study will inform the project's Behavioural Change and Communication (BCC) activities and enable the project to develop a comprehensive awareness raising strategy.

The KAPB Study was implemented in the following 12 Municipalities which are the focus for the AQH project: Fushë Kosovë, Gjakovë, Gllogovc, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skenderaj and Vushtrri.



1.3 Review of Related Research

There have been numerous and different studies conducted in Kosovo in the health sector in the 1999 post-war period. However, these studies rarely dealt with NCDs and child health issues. One of those studies was conducted by the Kosovo National Diabetes Association – a survey with diabetes patients in Kosovo in 2013 and, based on the results from this survey, the Association produced 6 policy briefs with the following topics[2]:

1. "Availability of Basic Services and Medication",
2. "Insulin Usage in Kosovo",
3. "Service Preferences and Utilisation Profile of Diabetes Patients",
4. "Health Costs and Affordability Among Diabetic Patients",
5. "Access to a Specialized Healthcare Workforce",
6. "Diagnosis and Gravity of Diabetes in Kosovo".

Some of the findings from this survey, i.e. information about the utilisation of public and private health services and satisfaction with these services, are relevant to our study and will be discussed and compared in the results section of this report.

Another study was conducted in 2014 by the Friedrich-Ebert-Stiftung, which was a comparative qualitative study on the performance of the public health care systems in South-East Europe. Kosovo was one of the countries included and the study focused on the needs of patients in relation to five major health care problems that represent the major causes of death in the region and require diverse types of health care response, namely: myocardial infarction, strokes, cancer, injuries and diabetes (type 2).[3] The findings from this study that are discussed in this report due to their relevance are: related health-seeking behaviours; satisfaction with health services, namely the main obstacles in access to public healthcare; and quality of treatment.

The Kosovo Agency of Statistics in collaboration with UNICEF has conducted the Multiple Indicator Cluster Survey in 2013-2014[4]. This survey aims at generating data on key indicators on

[1] Request for Quotation, AQH, March 2016

[2] http://solidar-suisse-kos.org/?id=8

[3] The Performance of Public Health-care Systems in South-East Europe – A Comparative Qualitative Study, Friedrich-Ebert-Stiftung, 2014

[4] http://ask.rks-gov.net/en/kosovo-agency-of-statistics/add-news/multiple-indicator-cluster-survey-known-as-mics-key-indicators

the well-being of children and women, as well as helping shape policies for the improvement of their lives.[5] Although this survey focused also on the RAE community in Kosovo, the published findings are not directly relevant to our study.

The AQH Project conducted a Survey of Healthcare Management in Kosovo in early 2016, where the objective was to collect data on current management practices in Primary Health Care services in the 12 project Municipalities, on the profile of current managers and on their eventual needs for training or support.[6] Some of the findings from this study, more specifically findings related to corruption and patient complaints, will be discussed in this report.

The AQH Project conducted another relevant study in 2015 on Barriers in Accessing Primary Healthcare in Kosovo. The objective of this qualitative study was to investigate what other significant factors influence access to primary health care services and information, (in addition to or excluding direct costs of treatment), that determine health care seeking behaviour, particularly among specific vulnerable sub-groups, in order to generate evidence on which to develop project indicators and activities for increased utilisation among these groups.[7] Findings on health seeking behaviours and perceptions on the quality of services from this study will be discussed in the results section of this report.

In addition, a Baseline Assessment of Quality of Care in Kosovo that was conducted by the AQH Project in spring 2016 and completed in June 2016, among other approaches, included an exit survey with patients of Primary Health Care centres. The exit survey contained a limited number of questions on the knowledge, attitude, practice and behaviour (KAPB) regarding acute respiratory infections (ARI), diarrhoea and NCDs, specifically diabetes and hypertension.[8] This study will take into account the findings from the Baseline Assessment of Quality of Care and specifically discuss the relevant findings with regard to the quality of services, diarrhoea and diabetes.

There were also several Knowledge, Attitude and Practices (KAP) studies conducted in Kosovo by different local and international organizations, such as UNICEF, Kosovo Institute of Public Health, Population Services International (PSI), UNDP and CARE International. However, all the KAP studies were related to HIV/AIDS, reproductive health and antenatal care, hence they do not represent a direct relevance to the findings of our current KAPB study.

[5] http://mics.unicef.org/about

[6] Report on the Healthcare Management Survey in Kosovo, AQH, June 2016

[7] Barriers in Accessing Primary Health Care, AQH, September 2015

[8] Report on the Baseline Assessment of Quality of Care in Kosovo, AQH, June 2016

1.4 Overview and Description of Report Structure

This report will be organised in two main chapters in terms of presentation and analysis of key findings: the quantitative survey and the qualitative research.

The **chapter on quantitative findings** will be presented in three main sections. The first section will describe and analyse the findings on risk factors, key practices and behaviours with regard to tobacco, alcohol, diet, physical activity and lifestyle advices.

The second section will focus on the specific diseases that were this focus of this KAPB study. This section will present and analyse knowledge, attitudes, practices and behaviours on diabetes, cardiovascular diseases, hypertension, chronic respiratory diseases and child diarrhoea.

The third section will introduce and analyse the findings related to quality of healthcare, namely health-seeking behaviour and attitudes, patient rights and communication.

A further chapter is focused on qualitative findings and will be presented in three main sections. The first section will discuss the experience in public healthcare facilities in terms of perceptions, reasons and habits, satisfaction, as well as perceptions about private clinics.

The second section will analyse risk factors, more specifically attitudes and practices about tobacco usage and prevention, alcohol and physical activity.

The third section will focus on the diet, especially on eating habits and perceptions about healthy diet.

2 Methodology

2.1 Study Design

The KAPB Study used two approaches for data collection, quantitative survey and qualitative research. In order to collect baseline information from the target population, the quantitative survey was conducted in the first stage to determine the level of knowledge amongst the target population. Afterwards, issues that came out from the quantitative survey that were of strategic importance for the AQH project, were further explored in the qualitative research in the second stage to identify underlying factors leading to certain attitudes and practices.

2.2 Stage 1: Quantitative Survey

2.2.1 Study design

The KAPB quantitative survey was designed as a baseline study, which had to assess the knowledge, attitude, practice and behaviour of general population regarding selected NCDs and child health, and regarding citizens' right to health. The quantitative survey employed face-to-face interviews, through the Tablet Aided Personal Interview method[9], and the interview was conducted "in-home" of the respondent.

2.2.2 Study area and target population

The KAPB quantitative survey was conducted in the 12 target municipalities for the AQH project in Kosovo: Fushë Kosovë, Gjakovë, Gllogovc, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skenderaj and Vushtrri.

The target universe for the survey was Kosovar residents of age 18+ years from the above-mentioned municipalities, from both urban and rural areas. Specific information on child health was collected from the designated respondent, if the respondent was knowledgeable about the health of the children in their household. If the designated respondent did not have the (complete) information about child health, then the interviewer collected this information from the person who was the most knowledgeable about child health issues in the household, either mother or any other caregivers of children in the household.

2.2.3 Sample size and method

The sample frame included the adult (18+ years) population of the 12 above-mentioned target municipalities. The survey is representative of the adult (18+) population as specified in the sampling frame. Exclusions included people in hospitals, prisons, military facilities and similar. The breakdown of the population by municipalities was based on the latest census[10] from 2011, broken down by municipality and type of residence (urban and rural). The total sample size was 1,200 effective interviews. There were two conditions that were taken into account for the calculation of the sample size. One was that the total sample size should allow an acceptable confidence interval when the data analysis is performed for all municipalities altogether (±2.83%). The other one was to have on average 100 respondents per municipality and at least 30-50 respondents in the small municipalities, in order to provide better representation of small municipalities for comparative analysis across municipalities.

The health sector in Kosovo faces challenges in meeting health needs of its citizens and in delivering quality health services, particularly for vulnerable groups, such as the rural poor, the elderly the very young, the disabled, the chronically ill, and RAE communities.[11] Considering that

[9] Tablet-aided personal interviewing (TAPI) is an interviewing technique in which the interviewer uses a tablet to answer the questions

[10] Statistical Agency of Kosova

[11] Request for Quotation, Save the Children International, March 2016

the study was designed to assess the knowledge, attitude, practice and behaviour of the general population, particularly focusing on the above mentioned vulnerable groups, the sample design took into account the representation of all these groups in the sample.

Due to the very low proportion of the RAE population (2.8%)[12] in total in the 12 target municipalities, an oversampling of this population was required to allow better representation of this portion of the population in the total sample. A higher oversampling was proposed for the RAE sub-population due to the focus of the study on this sub-population identified as a vulnerable group. In addition, due to more effective field management, the sample was divided into two main sub-samples:

1. Albanian sub-sample: 950 effective interviews
2. RAE sub-sample: 250 effective interviews

The representation of other vulnerable groups was ensured by employing multi-staged random probability sampling, which is explained in detail in the next section "Survey Method". Considering that the sample distribution was conducted by taking into account the population data, the rural population is represented in the sample with 56% of the sample. In addition, random selection of respondents within households had to ensure approximately an equal representation of women and men – the final sample resulted in 48% males and 52% females. Other vulnerable groups, such as children and the chronically ill were represented in the sample by designing specific sections of the instruments that collected data on these groups from the randomly selected respondent within the household.

The following tables show the population numbers (sample frame) and the sampling plan.

Table 1: Population figures (Sample frame)

Population							
	Total	**Albanian**	**Urban**	**Rural**	**RAE**	**Urban**	**Rural**
Fushë Kosova	**37447**	**33499**	**17856**	**15643**	**3948**	**N/A**	**N/A**
Gllogovc	**56820**	**56820**	**5963**	**50858**	**0**	**N/A**	**N/A**
Obiliq	**21918**	**20652**	**6664**	**13988**	**1266**	**N/A**	**N/A**
Gracanica	**4217**	**3365**	**0**	**3365**	**852**	**N/A**	**N/A**
Lipjan	**57583**	**55425**	**6231**	**49195**	**2158**	**N/A**	**N/A**
Gjakova	**98247**	**91779**	**39622**	**52158**	**6468**	**N/A**	**N/A**
Rahoveci	**55224**	**54437**	**15346**	**39091**	**787**	**N/A**	**N/A**
Malisheva	**53050**	**53019**	**3296**	**49723**	**31**	**N/A**	**N/A**
Junik	**5906**	**5906**	**0**	**5906**	**0**	**N/A**	**N/A**
Mitrovica	**70977**	**69796**	**44772**	**25024**	**1181**	**N/A**	**N/A**
Vushtrri	**67669**	**67457**	**26472**	**40985**	**212**	**N/A**	**N/A**
Skenderaj	**49336**	**49325**	**6419**	**42906**	**11**	**N/A**	**N/A**
TOTAL	**578395**	**561481**	**172638**	**388842**	**16914**	**N/A**	**N/A**

[12] Statistical Agency of Kosova

Table 2: Sampling plan

Sample							
	Total	Albanian	Urban	Rural	RAE	Urban	Rural
Fushë Kosova	110	50	30	20	60	60	0
Gllogovc	90	90	10	80	0	0	0
Obiliq	50	30	10	20	20	0	20
Gracanica	30	0	0	0	30	30	0
Lipjan	120	90	10	80	30	20	10
Gjakova	240	160	70	90	80	60	20
Rahoveci	110	100	30	70	10	10	0
Malisheva	90	90	10	80	0	0	0
Junik	30	30	30	0	0	0	0
Mitrovica	140	120	80	40	20	20	0
Vushtrri	110	110	40	70	0	0	0
Skenderaj	80	80	10	70	0	0	0
TOTAL	1200	950	330	620	250	200	50

2.3 Survey Method

The survey method was multi-staged random probability sampling. The following steps explain in detail the survey method in terms of distribution and selection of sampling points, selection of starting points, household and respondent selection, as well as procedures for call-backs, refusals and non-contacted respondents.

Step One: Distribution of sampling points by region and urban/rural strata

The sample was stratified per municipalities and residential profile (urban and rural) of each municipality. Municipalities were defined by geographic borders.

Step Two: Selection of sampling points and replacement of sampling points

Each sampling point in the Albanian sub-sample was designed to have 10 households irrespective of the type of residence (urban or rural), with 95 sampling points in total. The residential split is 35% urban vs. 65% rural. For the RAE minority population, each sampling point is designed to have 10 households irrespective of the type of residence (urban or rural), with 25 sampling points in the RAE sub-sample. The residential split in the RAE sub-sample is 80% urban vs. 20% rural.

Within each region the sampling points were selected executing a step over the list of settlements ordered per their size of population, the one with the highest number of dwellers being on top of the list.

The settlements were listed from the most populous at the top to the one with lowest number of population at the bottom. The step was defined by the population – for instance 580,000 (Albanian universe) was divided by 110 (number of sampling points) equals to approx. 5,273. This number was rotated over this list and each time it falls on a settlement a sampling point was allocated to this place. For settlements that were larger and the selection yields more than one sampling point in that settlement, the process of placement of these sampling points within that settlement was the same as the overall selection of sampling points, using the estimated number of population for each neighbourhood within that settlement.

Step Three: Selection of starting points within each sampling point

Each sampling point was given a starting point. There are several possible locations available to be selected as starting points in each sampling point. The starting point was selected in the field by rotating different starting points within the sampling point to start, using a map of the settlement, e.g. picking a starting point along the north edge of the first sampling point, north-west edge for the second, west edge for the third, etc. The available starting points within each sampling point are usually some recognizable social sites or buildings, like mosque, school, post office, medical centre, coffee shop, etc.

Step Four: Household Selection

Selection of household was based on the 'random route' method.

In urban areas the first contacted household was the third house/address number from the starting point on the left-hand side of the street/route, and each third one from that household onward. In a block-of-flats the selected household was every third apartment, counting from the top floor of each entrance.

In rural areas, the selected household was every third inhabitable house/dwelling on both sides of the interviewer's route/track. Where the houses were aligned or scattered over larger territory, the interviewers applied wave-wise approach selecting the third house, counting from the first house on the left. In compounds of several houses behind a common fence, the procedure was to select the third one from the left (counting from the gate), or if there were less than three houses behind a common fence to count the houses as if they were separate dwellings along the street. In compact and well-structured villages the selection procedure followed the instruction for urban areas.

In case of refusal or non-contact (non-residential building, no one at home or long term absence, respondent never available for appointment) after two call-backs, the instruction was to select first next house/flat and then continue in the regular manner, with every third after the last

selected household, or continue with same manner where the interviewer had left of before attempting the call-back.

Step Five: Respondent Selection

Selection of a respondent was carried out using the 'next birthday' method. The interviewer created a list of all members of the household aged 18+ years, with their details on gender and birthday. Then, using the next birthday method, the interviewer selected one person from that household.

Step Six: Call-backs, Refusals and Non-contacted Respondents

A household/respondent was recorded as a non-contact after three failed attempts to accomplish the interview (first visit and two call-backs). The further selection was governed by the rules for selecting a household, followed by the 'next birthday' principle. If a selected respondent refused to be interviewed, the next household selected was the neighbouring address, followed by the 'next birthday' principle.

2.3.1 Questionnaire development

During the questionnaire design process, Key Performance Indicators (KPI) were consulted and taken into account from the Log Frame Approach (LFA) provided by the AQH Project Implementation Unit (PIU). In addition, the questionnaire was designed by also taking into account the objectives of the Terms of Reference for this particular study, the indicators already measured in the Baseline Assessment of Quality of Care in Kosovo, as well as details provided by the AQH PIU in meetings during the preparation stage of this study.

The questionnaire for the quantitative stage had the following sections and sub-sections:

1. Survey Information
2. Demographic Information
3. Knowledge, Attitudes, Practices and Behaviour
    a. Tobacco Use
    b. Alcohol Consumption
    c. Diet
    d. Salt and Sugar
    e. Physical Activity
    f. Lifestyle Advice
    g. Diabetes
    h. Cardiovascular Diseases
    i. Raised Blood Pressure
    j. Chronic Respiratory Diseases
    k. Child Diarrhoea
    l. Healthcare Seeking
    m. Patient Rights
    n. Communication
4. Ending Section

2.3.2 Pre-testing of the questionnaire

In order to test the wording of the questions, the flow of the questionnaire, as well as how questions are being understood by respondents, a pre-test of the questionnaire was organized prior to launching the fieldwork. The sample size of the pre-test was 10 effective interviews that were conducted by 5 different interviewers, with a variety of different respondents.

The brief report from the pre-test included a short summary of problems identified on specific issues, as well as recommendations for revising problematic questions.

2.3.3 Interviewers and training

The training for the Albanian and RAE sub-samples was held in the offices of Kantar TNS (Index Kosova). The briefing was conducted by the project manager for this project, senior researcher, assisted by the field manager and was attended by regional supervisors. The field manager along

with the regional supervisors conducted the briefings for regional teams on the same day or early next morning.

The agenda of the training was as follows:

I. Sampling procedures

1. Selection of the respondent
2. Problems with refusals and non-contacted respondents
3. Other Problems

II. The Questionnaire

1. Review of the questionnaire question by question

III. Role play - mock interviews

1. Discussion of results of mock interviews

All interviewers are recruited through an application process, where interested individuals first undergo an interview with the field manager and fill-in a simple application form. Potential interviewers are short-listed based on the following criteria: to have a minimum completed secondary education, to be communicative and have good reading skills, be willing to work in the field in different areas. Those that are short-listed from the application procedure are recommended for one-day training on sampling procedures and administration of questionnaires, which is conducted by the field manager. Interviewers' first experience in the field is accompanied by the respective regional supervisor, whereas the supervisor shows the interviewer how an interview is conducted, as well as closely observes the performance of the newcomer and gives recommendations for his/her work.

2.3.4 Quality measures

A little over 15% of completed interviews were back-checked by the supervisors and the management team continuously during data collection, and all completed surveys were subject to quality control for proper administration.

The back checking procedure included a secondary interview with the selected sample (secondary interview consisted of several questions from the first interview – mainly demographic indicators) and a comparison of the first and the second responses of the sample.

The vast majority of interviews were back-checked in person, in the rest of the cases back-check was carried out by phone and direct supervision during the interview.

When completed interviews are back-checked in person, field supervisors go back in the field with completed interviews and field documents submitted to them by the interviewer and they check interviewer's performance in terms of: random walk from the starting point, selection of household, selection of respondent, questionnaire administration and general conduct.

In cases when interviews are directly observed, regional supervisors accompany the interviewers throughout the whole process and give recommendations to the interviewers on the spot. If needed, the supervisors also conduct an interview in front of newcomer interviewers, in order to show them how to properly administer the whole process.

The field manager accompanies several supervisors during their work in the field, and in a number of cases back-checks the supervisors' performance individually, after they had submitted their field documents.

All quality control indicators related to sampling procedures and respondent verification are a part of an instrument (questionnaire) that is administered by regional supervisors during quality control. They complete this questionnaire with tablets, upload the data to the company server and the field manager, together with the project manager check the validity of the data and they compare them against the interview with the respondent. If any inconsistencies are found, they are reported back to the supervisors, who send back the interviewers to the field for correcting the inconsistencies or for making additional interviews.

2.3.5 Data processing and analysis

Data was processed during the interview, since the interview was conducted using tablets and "iziSurvey" software program. After a sampling point was completed, the interviewer uploaded the data via an Internet connection to the company server.

The data, as they got uploaded during the fieldwork, were checked daily by the data processing manager, the field manager and the project manager.

The final data set was validated in SPSS for Windows version 22 software, in Kantar TNS (Index Kosova) offices by the data processing manager and the project manager assigned for this project.

The data set was weighted using the latest data from the Census conducted in 2011, as well as the most reliable and updated estimates the Statistical Agency of Kosova. The weighting factor includes the following indicators: ethnicity, municipality, age and gender.

Data analysis was performed in SPSS for Windows 22 software program, where tabular reports were produced, which are easily used for further analysis and interpretation. Apart from SPSS, Microsoft Excel 2013 was also used for performing specific analysis, as well as for creating charts and tables.

The data analysis will focus on the following factors:

1. Scores for the level of overall knowledge, as well as the level of knowledge for each disease,
2. Scores for attitudes for each of the research topics and each disease,
3. Analysis of scores for practices and behaviours for each of the research topics and each disease.
4. WHO Global Physical Activity Questionnaire Analysis
5. Demographic profile of users and non-users of healthcare services
6. Data analysis according to the LFA indicators

The data[13] will be disaggregated by the following indicators:

1. Users and non-users of services (the threshold for non-users is 5 years of more without visiting a health facility)
2. Users of public and private practice
3. Ethnicity
4. Gender
5. Age
6. Monthly household income
7. Education
8. Size of the household
9. Type of residence (urban/rural)

2.4 Stage 2: Qualitative Research

2.4.1 Study design

The KAPB qualitative research was designed to further explore issues that arise from the quantitative survey that are of strategic importance for the AQH project. Considering that the issues that were to be discussed in the qualitative research may be of sensitive nature, the qualitative research used mini-group discussions, with smaller number of participants per group than in normal focus group discussions.

[13] The data is the property of the contractor, i.e. is the AQH project consortium. At the completion of the study, the final data set will be handed over to the AQH project.

2.4.2 Study area and target population

The KAPB qualitative research was conducted in the 12 municipalities of the AQH project in Kosovo.

The target universe for the survey was Kosovar residents of age 18+ years from the above-mentioned municipalities, from both urban and rural areas. More specifically, the criteria that were used to select focus group participants were the following:

1. Age: Each participant will be an adult, 18 years old or older.
2. Gender: Four out of eleven mini-group discussions will consist of men whereas other seven will consist of women.
3. Minorities: Two out of eleven mini-groups will be held with RAE community.
4. History of disease: At least two participants in each group will be with chronic disease or caregivers of a family member with the chronic disease.
5. Parents: At least two participants in the group will be parents of children younger than 5 years old.

2.4.3 Sample and method

There were a total of 12 mini group discussions conducted. Each group consisted of 4-5 participants and the duration of a single discussion group was around 120 minutes on average.

Selection and recruitment of participants for mini groups was random, within the criteria of the target population. The selection ensured a variety of different age groups and social statuses in every group discussion.

The selection was performed in three stages.

Stage 1: At least two sampling points were allocated in order to recruit participants for one group discussion within the designated municipality. Each sampling point produced at least 3 effective participants who fulfil the criteria of the target universe and are willing to participate in the group discussion, as well as are estimated by the recruiter that they are communicative enough so to contribute to the discussion. For each group 6 participants were recruited, in order to have at least 4 of them showing up at the location for discussion, since about 20 percent may fail to participate for different personal reasons.

Stage 2: Selection of a household using random-route technique. Each sampling point was assigned starting point and given direction. In urban areas the selected household was each third house/address on the left-hand side of the street. In block-of-flats the selected household was every third apartment, counting from the top floor in each entrance. In rural areas, the selected household was every third inhabitable dwelling on both sides of the interviewer's route, counting them wave-wise. In rural settlements with dense and compact pattern, the selection procedure resembled the one for urban areas.

Stage 3: Selection of 1 respondent per household based on the target group criteria set in the sample design.

2.4.4 Sample design

Out of the total 12 group discussions, 9 (6 with women and 3 with men) of them were conducted with the Albanian community and 3 (1 with women and 2 with men) with the RAE community. Also, out of the total number 5 were in urban areas and 7 in rural areas.

Table 3: Group Discussion Sample

	Group Discussion Sample[14]									
	Total	Albanian+	Urban	Rural	RAE	Urban	Rural	Serb	Urban	Rural
Fushë Kosova	1	0	0	0	1	1M	0	0	0	0
Gllogovc	1	1	0	1M	0	0	0	0	0	0
Obiliq	1	1	0	1M	0	0	0	0	0	0
Gracanica	1	0	0	0	1	1M	0	0	0	0
Lipjan	1	0	0	0	1	0	1F	0	0	0
Gjakova	1	1	1F	0	0	0	0	0	0	0
Rahoveci	1	1	0	1F	0	0	0	0	0	0
Malisheva	1	1	0	1F	0	0	0	0	0	0
Junik	1	1	1F	0	0	0	0	0	0	0
Mitrovica	1	1	1M	0	0	0	0	0	0	0
Vushtrri	1	1	0	1F	0	0	0	0	0	0
Skenderaj	1	1	0	1F	0	0	0	0	0	0
TOTAL	12	9	3	6	3	2	1	0	0	0

2.4.5 Development of the discussion guide

The discussion guide was developed based on the preliminary analysis of the data from the quantitative survey. This preliminary analysis revealed which research topics the study needs to focus on further. These research topics were discussed with the client and together it was decided to about the main topics to be reflected in the discussion guide. In addition, other existing reports were also used to identify and design key research topics.

2.4.6 Quality measures

Quality measures in the qualitative research included quality control of participants that were recruited for the group discussions, i.e. making sure that they are being selected based on the sample design and that they represent a variety of different age groups and social groups.

Another issue that was a focus of quality measures is making sure that all the relevant topics are being covered in the research instrument, as well as having two researchers work in the data analysis, in order to ensure that all aspects and perspectives of the collected data are being reflected in the analysis.

2.4.7 Moderation, note taking and analysis

Qualified moderators moderated the group discussions, based on the previously designed discussion guide. The moderators took notes during the group discussion, and with the help of audio recordings, the moderators provide detailed notes for each research topic and question, including specific and important quotes for further analysis.

The group moderator(s) analysed the notes and the recordings and produces key findings from each group discussion.

[14] Beside each number a symbol for female (F) and male (M) is placed to identify the gender of the group

2.5 Ethical Considerations and Key Challenges

Participation in the study was voluntary. Before the interviews, participants were asked for their verbal consent. To obtain consent, participants were informed that a) their participation in voluntary, b) they can withdraw from participation at any time, c) non-participation will not have any negative effects. Participants were also informed how the data will be used and that confidentiality is ensured as no names or identifying personal information will be linked to the answers they provide.

Considering that the KAPB survey was conducted "in-home" of respondents with the adult population and the surveying procedure did not entail any invasive techniques or procedures, there was no ethical clearance needed from the relevant national bodies.

2.5.1 Limitations and challenges faced by Data Collection Teams

One of the key challenges in the study was collecting information among the RAE population and the rural population in general. Education levels among these portions of the population are rather low, hence it was more difficult for them to understand the questions, especially in the quantitative survey, as well as give relevant answers to the specific questions.

There were a total of 1,801 contacts made in order to reach a sample of 1,200 effective respondents. The number of non-contacts was 494, out of which 287 cases were un-inhabited buildings or dwellings, 89 cases of designated respondents not being available during the fieldwork period, 47 cases when it was impossible to enter the building or dwelling, 33 cases of no one answering after 3 attempts, as well as other cases of non-contacts.

The total number of refusals was 307, whereas the majority (300 cases) refused to take part in the study during the first stage (first contact and introduction) and only 7 cases refused to take part during the stage of respondent selection. There were no cases of refusals at later stages of the survey (questions and completion of the survey).

Another general challenge of the study was to adhere to the tight study timelines, particularly the period between the quantitative survey and the qualitative research. All parties involved in the study needed to be highly responsive in order to use the time in the most efficient way possible to review the preliminary analysis of the quantitative data, decide on the research topics for the qualitative research and take part in the design of the instrument for the qualitative research.

2.6 Key Personnel and Field Teams

Table 4: Table of Key Staff

Name of Staff	Area of Expertise Relevant	Designation for this Assignment	Assigned Tasks
Visar Berisha	Master of Science in Public Policy and Management	Project Manager	Overall management of the project, including methodology, designing the instruments, moderation, data analysis and reporting.
Vlora Basha	Master of Research in Educational and Social Research – Candidate	Senior Researcher	Takes part in methodology, sample design, design of instruments and moderation.
Shemsi Krasniqi	PhD in Social Anthropology	Research Consultant	Takes part in methodology, sample design and reporting.
Granita Basha	Master of Cultural Heritage and Tourism Management	Researcher	Focus group moderation, takes part in data analysis and reporting
Mimoza Zhubi	PhD in Medical Sciences	Expert Consultant	Takes part in design of instruments, data analysis and reporting

Field team:

- 1 field manager
- 4 regional supervisors
- 30 field interviewers (on average 40 interviews per interviewer, daily strike rate 8-10 interviews)

3 Chapter 1: Results – Quantitative Survey

3.1 Section 1: Risk Factors of Non-Communicable Diseases

The World Health Organisation (WHO) recognizes that common, preventable risk factors underlie most NCDs.[15] Most NCDs are the result of four particular behaviours: (tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol) that lead to four key metabolic/physiological changes (raised blood pressure, overweight/obesity, raised blood glucose and raised cholesterol).[16] This study focuses, among other diseases, on diabetes, cardiovascular diseases and hypertension. Hence, the questionnaire for the quantitative survey contained a specific section on risk factors related to these diseases. This section of the report will reveal results on tobacco use, alcohol consumption, diet and physical activity of the Kosovo population in the 12 target municipalities of the AQH project. In addition, it will also analyse the profile of both users and non-users of healthcare services.

3.1.1 Tobacco use

The quantitative survey reveals that 21% of the adult (18+ years old) population of the 12 target municipalities smoke tobacco products, such as cigarettes, cigars or pipes.

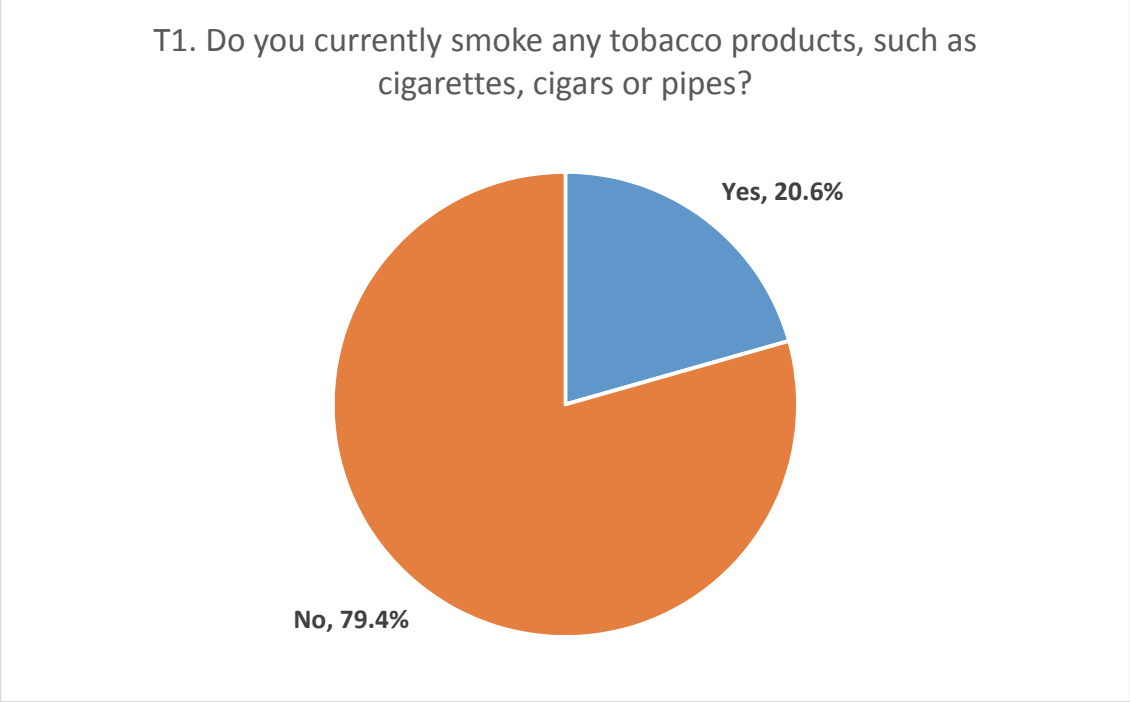


Figure 1: Proportion of smokers

Tobacco use is significantly higher among the RAE community (43%) than among the Albanian community (20%). While only 8% of the Albanian community belongs to the lowest monthly household income bracket (0-199 EUR), this percentage is as high as 44% among the RAE

[15] http://www.who.int/gho/ncd/risk_factors/en/

[16] Ibid.

community. Also, 63% of RAE respondents are educated only to primary level. These factors could explain the higher levels of smoking within the RAE community as several studies from different parts of the world have shown that smoking and other forms of tobacco use are much higher among the poor.[17]

Males have declared that they use tobacco products much more (30%) than females (12%), with rural females (9%) not much different from females in general. Also, tobacco use is slightly higher in urban areas than in rural areas. Similarly, the use of tobacco products is slightly higher among users of private healthcare services than among users of public healthcare services. Although the number of non-users of healthcare services (people that have not visited a healthcare facility for 5 years of more) is relatively low (4% of the total sample) and the result is not statistically significant, tobacco use is reportedly higher among non-users than among users of healthcare services.

There is a direct correlation between age and tobacco use: tobacco use increases with age (from 11% among 18-24 year olds to 29% among 45-54 year olds). Nevertheless, the increase of tobacco use among age groups stops among the 55+ year olds, where it drops to 23%. A similar, but indirect correlation is noticed between tobacco use and household income, where tobacco use decreases with the increase of household income. For instance, tobacco use is at 28% among the lowest household income (0-199 EUR) and it drops to 8% among the highest household income (600+ EUR). The same indirect correlation is revealed with regard to level of education and number of members in the household, where tobacco use drops with the increase of education levels and the increase of household members.

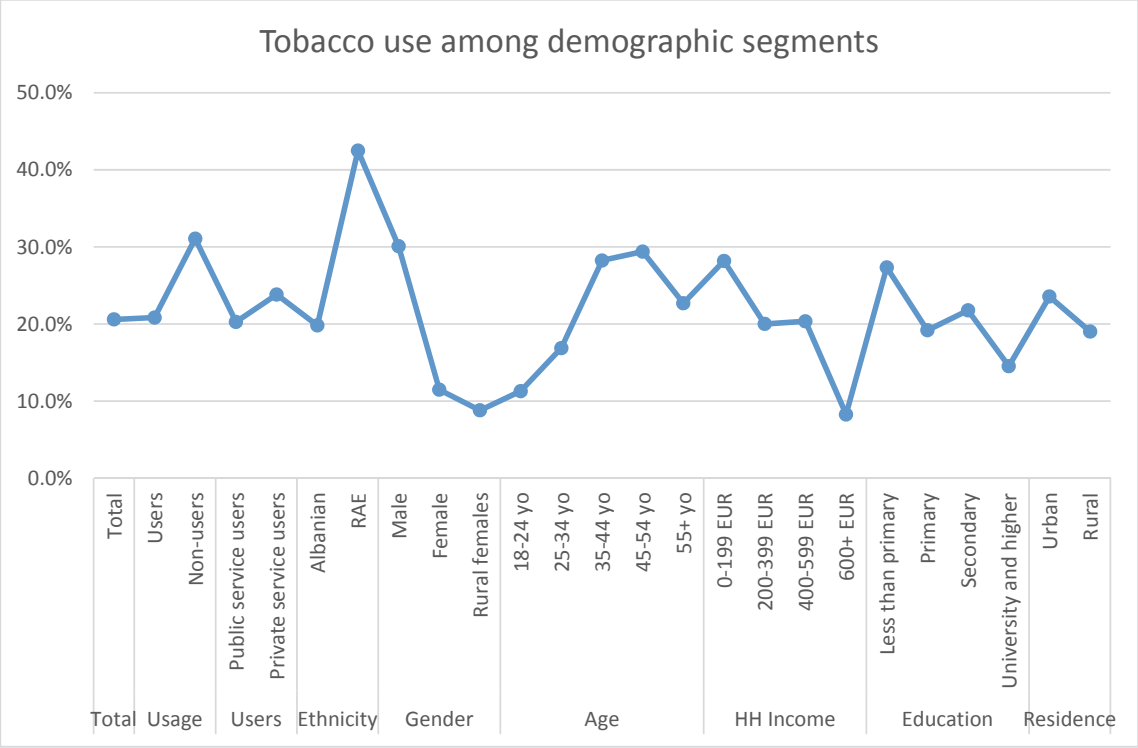


Figure 2: Tobacco use among demographic segments

The average age when people started using tobacco products is 22 years old. The most significant differences in the average age when people started smoking are marked between ethnic groups, gender and age. Respondents from the Albanian community have started to smoke much later (age 22), compared to their RAE fellow compatriots (age 18). Also, males have declared to have started smoking earlier (age 21) than females (age 24).

[17] http://www.who.int/tobacco/research/economics/rationale/poverty/en/

There is a direct correlation between age of respondents and the age when they first started smoking. What is interesting here is the fact that younger people have started earlier - the lowest age group (18-24 year olds) have first started smoking at the age of 19, whereas the highest age group (55+ year olds) have first started smoking at the age of 25.

A few other differences are noticed among other demographic segments - some of them that are worth mentioning are the differences between education levels. Those with less than primary and with primary education have started smoking a little later (age 23 and 23 respectively) than those with secondary and higher education (age 21 each). Similarly, respondents that come from households with 1-3 members and 4-5 members have started smoking a little later (age 23 and 22 respectively) than those that come from households with 6+ members (age 20).

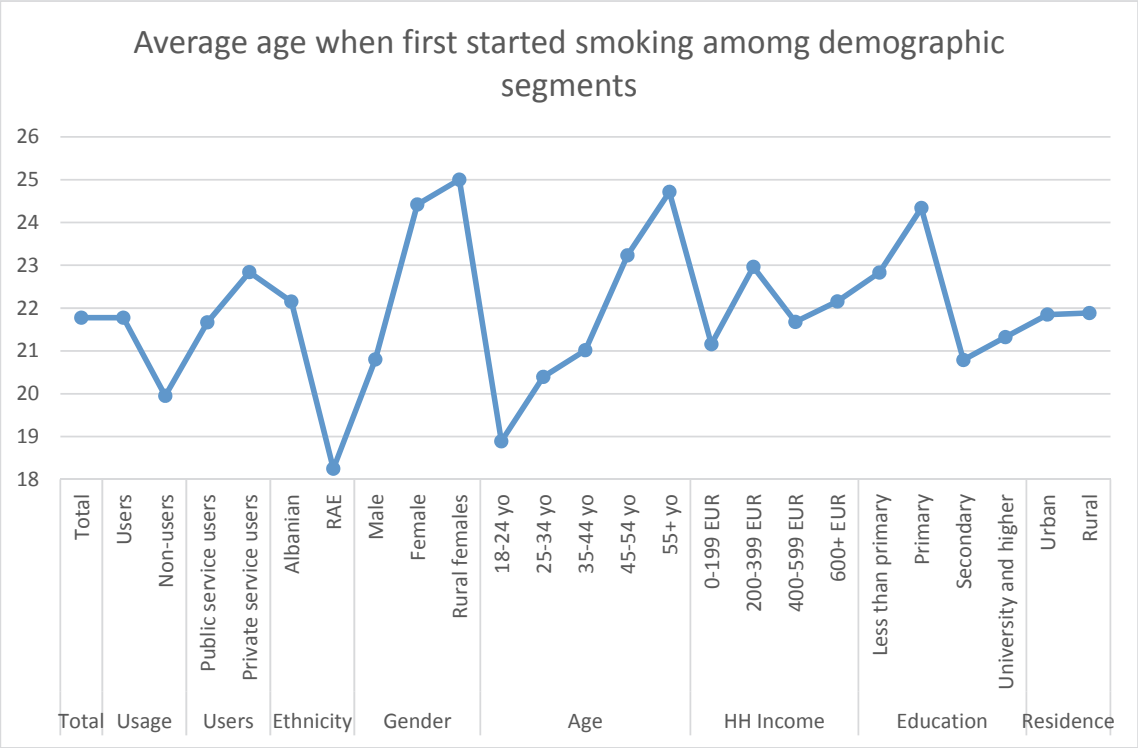


Figure 3: Average age when first started smoking among demographic segments

On average, respondents have declared that they smoke around 13 tobacco products each day, including cigarettes, hand-rolled cigarettes, pipes, cigars, and similar. The number of smoked tobacco products per day is significantly higher among the RAE community (19) than among the Albanian community (13). In addition, males smoke much more tobacco products daily (14) than females do (9). There is a direct correlation between the number of smoked tobacco products and age – the higher the age the higher is the number of smoked products per day. Respondents coming from households with the lowest monthly income (0-199 EUR) and the highest monthly income (600+ EUR) smoke more tobacco products daily (17 and 20 respectively) than those from households with medium (200-399 EUR and 400-499 EUR) range income (9 and 13 tobacco products respectively). Further, respondents from larger households with 6+ members smoke more tobacco products (16 daily on average) than respondents from smaller households (11-13 daily on average).

The survey data reveals that people have smoked tobacco products on average on 28 days during the last one month. There are no significant differences among most of the demographic segments in this respect. Differences are evident among a few segments, such as the younger age group of 18-24 years old (25 days a month) and respondents with monthly household income of 600+ EUR (21 days a month).

It is striking to learn that 70% of smokers declared that they smoke inside their houses and these numbers are significantly higher among non-users (98%)[18], among the RAE community (91%) and among those with less than primary education (86%). It is also important to emphasize that 21% of smokers that declared to be smoking inside their houses have children under 18 years old in their household.

3.1.2 Alcohol consumption

Alcohol consumption, including regular usage of alcohol, is far less prevalent among the population of the 12 target municipalities as compared to the regular use of tobacco products, according to the survey results. Close to 16% of the sample has declared that they have consumed alcohol such as beer, wine or spirits and half of them (49%) have said that they have consumed alcohol in the past 30 days.

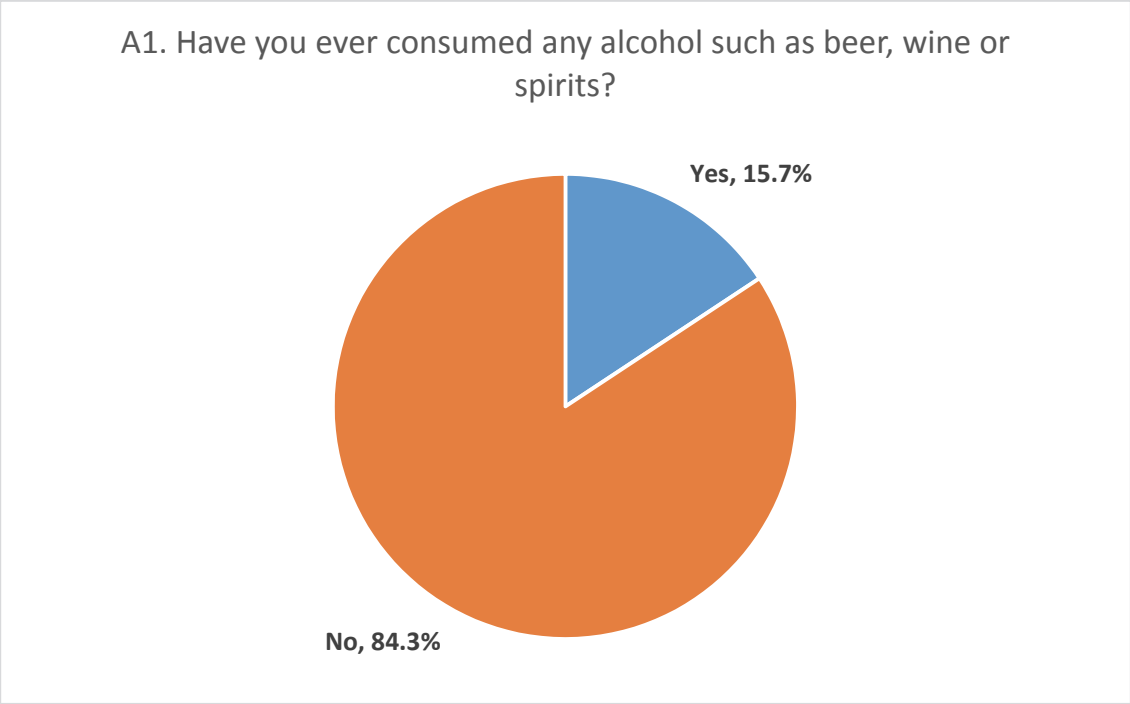


Figure 4: Consumption of alcohol

In terms of demographic segments, it turns out that alcohol consumption is much more prevalent among males (29%) than among females (3%).

[18] Statistically insignificant due to low sample

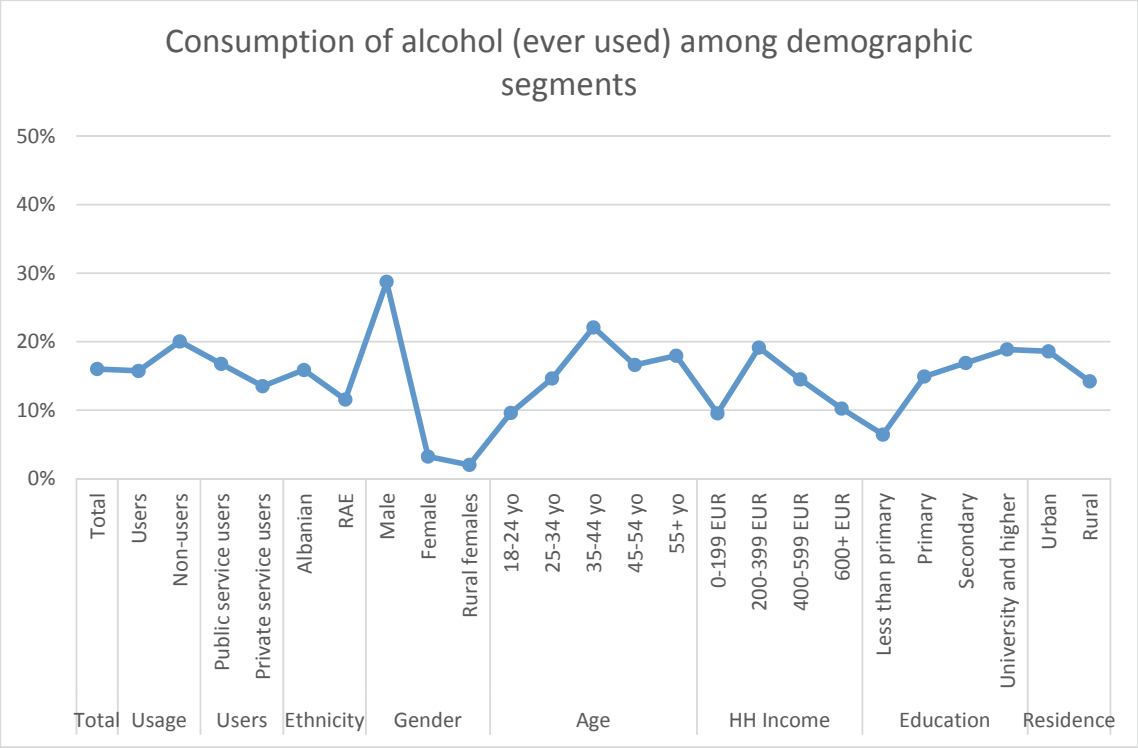


Figure 5: Consumption of alcohol among demographic segments

Smaller, but significant differences are marked among other demographic segments. For instance, alcohol consumption is a little higher than the total average among the age group of 35-44 year olds (22%), among those with household monthly income of 200-399 EUR (19%), among those with higher level of education (19%), among respondents from households with 1-3 members (20%) and among respondents from urban areas (19%). On the other hand, alcohol consumption is a little lower among the RAE community (12%), among the youngest age group of 18-24 year olds (10%), among the lowest and highest monthly household income (10% each), among respondents from households with 6+ members (12%) and among respondents with less than primary education (6%).

Regular consumers of alcohol (respondents that have consumed alcohol within the past 30 days) have had at least one alcoholic drink on average 10 days during the past 30 days. And, on the days that they drank alcohol, they usually had on average 2 drinks per day.

3.1.3 Diet

The WHO emphasizes the importance of fruits and vegetables consumption for keeping a healthy diet and avoiding health risks. For instance, approximately 1.7 million (2.8%) of deaths worldwide are attributable to low fruit and vegetable consumption.[19] In addition, according to WHO, low fruit and vegetable intake is among the top 10 selected risk factors for global mortality.[20] Further, worldwide, insufficient intake of fruit and vegetables is estimated to cause around 14% of gastrointestinal cancer deaths, about 11% of ischaemic heart disease deaths and about 9% of stroke deaths.[21]

[19] http://www.who.int/dietphysicalactivity/fruit/en/index2.html

[20] Ibid.

[21] Ibid.

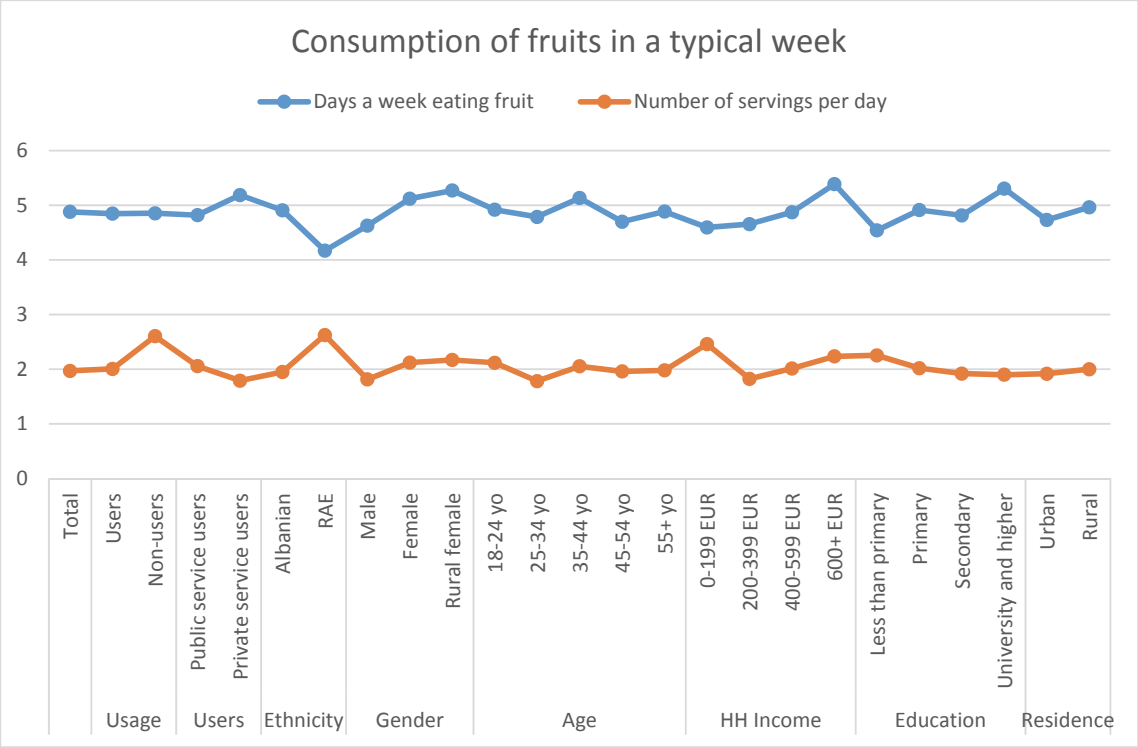


Figure 6: Consumption of fruits in a typical week among demographic segments

The survey included questions for measurement of fruit and vegetables consumption among the adult population of the 12 target municipalities. Survey data reveal that people eat fruits and vegetables on average 5 days in a typical week. In addition, respondents have declared that they eat on average 2 servings of fruits and 2 servings of vegetables on those days where they do eat fruits and vegetables. The WHO recommends at least 400 grams of vegetables and fruits per day — or five servings each day[22]. This is not achieved by the study population.

Although there are slight differences between the demographic segments, all of them move closely around the average of 5 days a week and 2 servings per day for both fruits and vegetables consumption.

[22] http://www.fao.org/english/newsroom/focus/2003/fruitveg2.htm

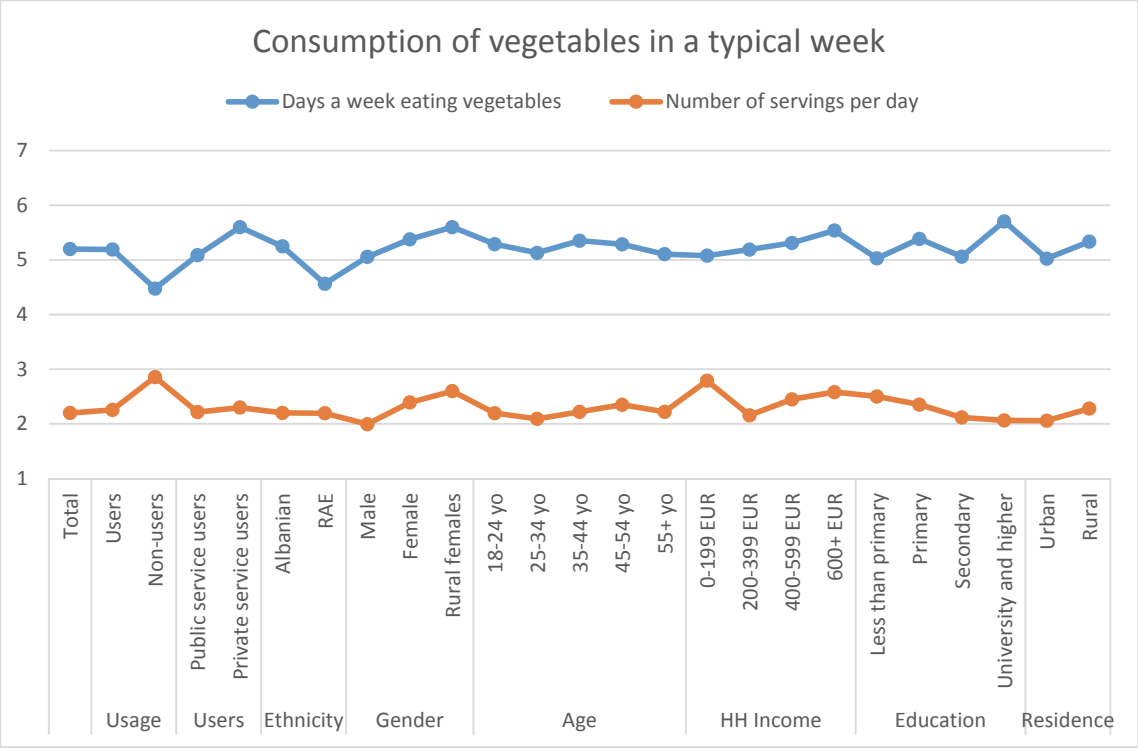


Figure 7: Consumption of vegetables in a typical week among demographic segments

It is known that limiting intake of salt and sugar contributes to a healthy diet. More specifically, controlling the intake of salt and sugar helps prevent hypertension and reduces the risk of heart disease and stroke in the adult population.[23] Hence, several questions were posed to the respondents about different ways of salt and sugar intake, as well as consumption of fat.

Less than half of respondents (43%) have added salt or a salty sauce to their food before they eat it or as they were eating it, several times a day or at least once a day. In addition, more than half of them (56%) used salt, salty seasoning or a salty sauce during cooking or preparing foods in their household, several times a day or at least once a day. More than one third (38%) said that they consume soft drinks, such as Coca Cola, Fanta, energy drinks and similar several times a day or at least once a day. Two thirds of respondents (65%) use sugar in their tea or coffee several times a day, and around one third (35%) consume fried food several times a day or at least once a day.

Compared to the above mentioned intake of salt and sugar, it first seems that the population does not use other high risk foods so often. Nevertheless, 40% have declared that they use commercially baked good and packaged snack foods several times a week. Furthermore, 35% uses cakes, sweets, chocolate or biscuits several times a week and another 30% uses solid fats several times a week.

[23] http://www.who.int/mediacentre/factsheets/fs394/en/

Table 5: Frequency of usage of food in diet

Usage of food in diet	Several times a day	Once a day	Several times a week	Less often	Never
Salt or a salty sauce to your food right before you eat it or as you are eating it	21%	22%	29%	18%	7%
Salt, salty seasoning or a salty sauce used in cooking or preparing foods in your household	32%	24%	28%	12%	3%
Cakes, sweets, chocolate or biscuits	5%	18%	35%	25%	12%
Soft drinks, such as Coca Cola, Fanta, energy drinks and similar	16%	22%	28%	21%	8%
Sugar in your tea or coffee	65%	15%	9%	5%	3%
Commercially baked goods	2%	8%	40%	33%	14%
Packaged snack foods	3%	11%	40%	26%	13%
Solid fats	2%	18%	30%	15%	5%
Fried food	12%	23%	32%	17%	13%

3.1.4 Physical activity

In order to measure the levels of physical activity among the population, this study used the WHO Global Physical Activity Questionnaire (GPAQ). The questionnaire was developed by WHO for physical activity surveillance in countries. It collects information on physical activity participation in three settings (or domains) as well as sedentary behaviour, comprising 16 questions (P1-P16)[24]. The domains are:

1. Activity at work
2. Travel to and from places
3. Recreational activities

The WHO has certain recommendations on physical activity for health. For the calculation of a categorical indicator, the total time spent in physical activity during a typical week and the intensity of the physical activity are taken into account.

According to the WHO, throughout a week, including activity for work, during transport and leisure time, adults should do at least:

- 150 minutes of moderate-intensity physical activity OR
- 75 minutes of vigorous-intensity physical activity OR
- An equivalent combination of moderate- and vigorous-intensity physical activity achieving at least 600 Metabolic Equivalents (MET)[25]-minutes.

According to the survey data and the GPAQ data analysis, almost half of the Kosovo population in the 12 target municipalities (46%) does not meet the WHO recommendations on physical activity for health.

In addition, the difference between genders is significant and high. While 39% of men do not meet the WHO recommendation on physical activity for health, for women this percentage is considerably higher (52%).

[24] Global Physical Activity Questionnaire (GPAQ) – Analysis Guide, WHO

[25] METs (Metabolic Equivalents) are commonly used to express the intensity of physical activities, and are also used for the analysis of GPAQ data. MET is the ratio of a person's working metabolic rate relative to the resting metabolic rate. One MET is defined as the energy cost of sitting quietly, and is equivalent to a caloric consumption of 1 kcal/kg/hour.

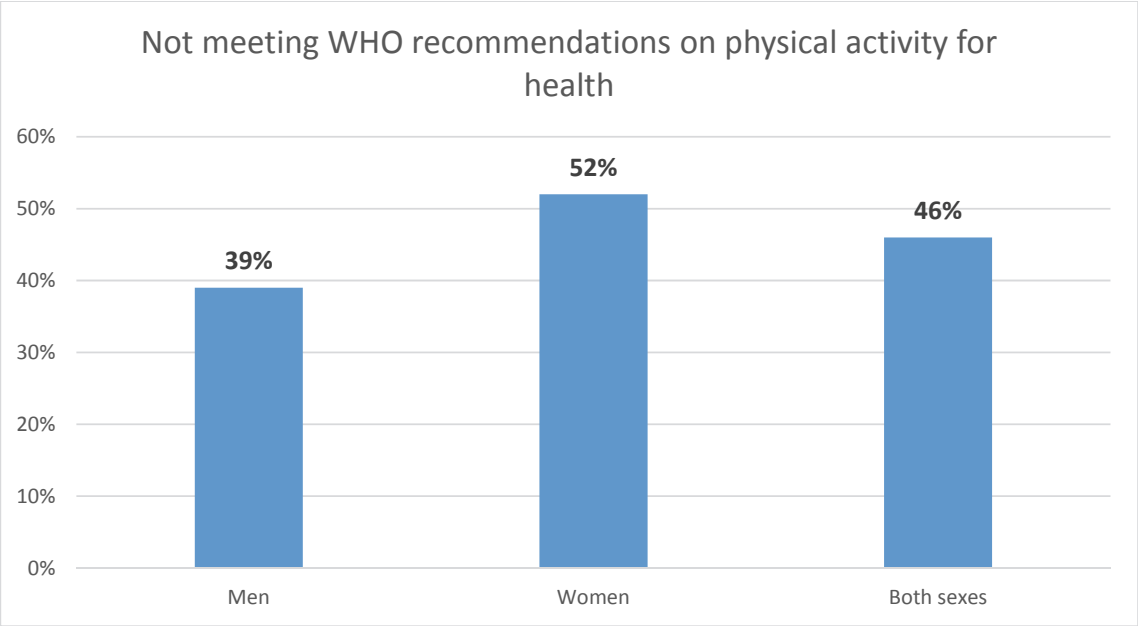


Figure 8: Proportion of respondents not meeting WHO recommendations on physical activity

In terms of mean minutes of physical activity required on average per day for health, figures are very high when looking at the average means of the total population in the 12 target municipalities.

With regard to moderate-intensity activity, where the requirement is to have 150 minutes of physical activity per week, men score 630 minutes and women score 427 minutes. In terms of vigorous-intensity activity, where the requirement is to have 75 minutes of physical activity per week, men score 371 minutes and women score 49 minutes.

Table 6: Average time spent on physical activity

Mean minutes of physical activity on average per day	Total vigorous	Men	Women	Total moderate	Men	Women
Work related	26	48	6	57	69	46
Transport related	-	-	-	16	17	15
Recreation related	3	5	1	2	4	-
TOTAL PER DAY	**29**	**53**	**7**	**75**	**90**	**61**
TOTAL PER WEEK	**203**	**371**	**49**	**525**	**630**	**427**

The differences between males and females can be explained by the following detailed results. The proportion of working men in the survey is much higher (50%) than the proportion of working women (13%). In addition, 25% of males have declared that their work involves vigorous-intensity activity, whereas only 7% of females have declared the same. Also, the percentage of males who perform vigorous-intensity sports, fitness or recreational activities is much higher (25%) than the percentage of females who perform such activities (4%). Similar results are noticed for moderate-intensity sports, fitness or recreational activities, where 20% of males and 3% of females perform these activities.

3.1.5 Lifestyle advice

Sometimes the lack of information, lack of knowledge or awareness about certain lifestyle issues can lead people to risky behaviours for their health. Hence, we sometimes need to rely on

healthcare workers to remind us and warn us of such risks and explain us what we need to do in order to have a healthy lifestyle. In this respect, the questionnaire for the quantitative survey contained a set of questions, where respondents were asked if a doctor or other health worker advised them for certain lifestyle issues.

The survey data reveal that the most frequent recommendation health workers give to their patients is reducing fat in their diet (24%), followed by reducing salt (20%), maintaining a healthy body weight or losing weight (19%) and start or do more physical activity (19%). Less frequent advices are given about eating at least five servings of fruits and/or vegetables each day (16%) and quit using or not start using tobacco (14%).

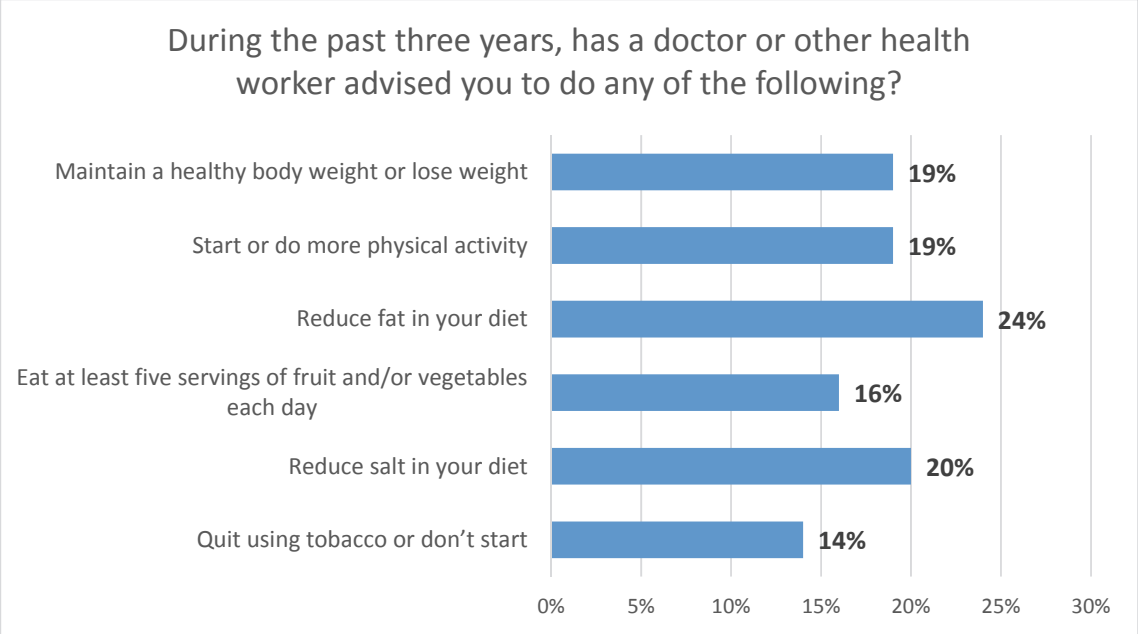


Figure 9: Proportion of respondents advised about lifestyle by health workers

In relation to the advice given by health workers about quitting or not starting to use tobacco, it is worth mentioning that 21% of smoker respondents have already tried to quit smoking during the past 12 months. The worrying fact is that not only the advice by health workers to quit using or not start using tobacco is low among all respondents (14%), but it is not considerably higher among smokers (18%), as well as among those who have been trying to quit smoking (24%).

3.1.6 Profile of users and non-users of healthcare services

Users of healthcare services have been defined as respondents that have declared to have visited a doctor or a nurse in a public or private healthcare facility at least once in the last 5 years. Non-users have been defined as respondents that have visited a doctor or a nurse only 5+ years ago.

The study reveals that 87% of respondents are classified as users, 4% as non-users and 10% were not able to answer these questions. The sample size of non-users is very low and the confidence interval is too high, hence the results on the profile of non-users are not statistically significant.

Users of services are both males and females equally, without any statistical significant difference. Users of services also come proportionally from both main ethnic groups that were a part of this study, Albanian community and RAE community. There is also no significant difference among other demographic indicators of users of services, such as age, level of education, household income, size of household and type of residence. This means that users of services are equally spread among the population as a whole.

On the other hand, males (63%) are identified as non-users of services more than females (37%). Also, non-users of healthcare services come much more from rural areas (83%) than from urban areas (17%).

3.2 Section 2: Knowledge, Attitudes, Practices and Behaviours on Non-Communicable Diseases and Child Health

This section of the report will talk about knowledge, attitudes, practices and behaviours of the Kosovo population from the 12 target municipalities on the following diseases: diabetes, cardiovascular diseases, hypertension, chronic respiratory diseases and diarrhoea. Most of these diseases that are covered in this study have been already identified among the major causes of death in the region of South-East Europe.[26]

3.2.1 Diabetes

In order to be able to show the results about knowledge, attitudes, practices and behaviours in a consistent and comparable manner, some data have been combined together. In cases where these is only one indicator, such as knowledge on diabetes, the result is a reflection of one single question (positive answer in percent). In cases where there is a number of indicators for one question, such as risk factors, the score is a result of average (in percent) of all indicators.

Survey data shows that the level of knowledge about the disease in general (diabetes or "sugar disease") is very high (93%). Nevertheless, knowledge about associated risk factors, early signs and preventive measures is rather low.

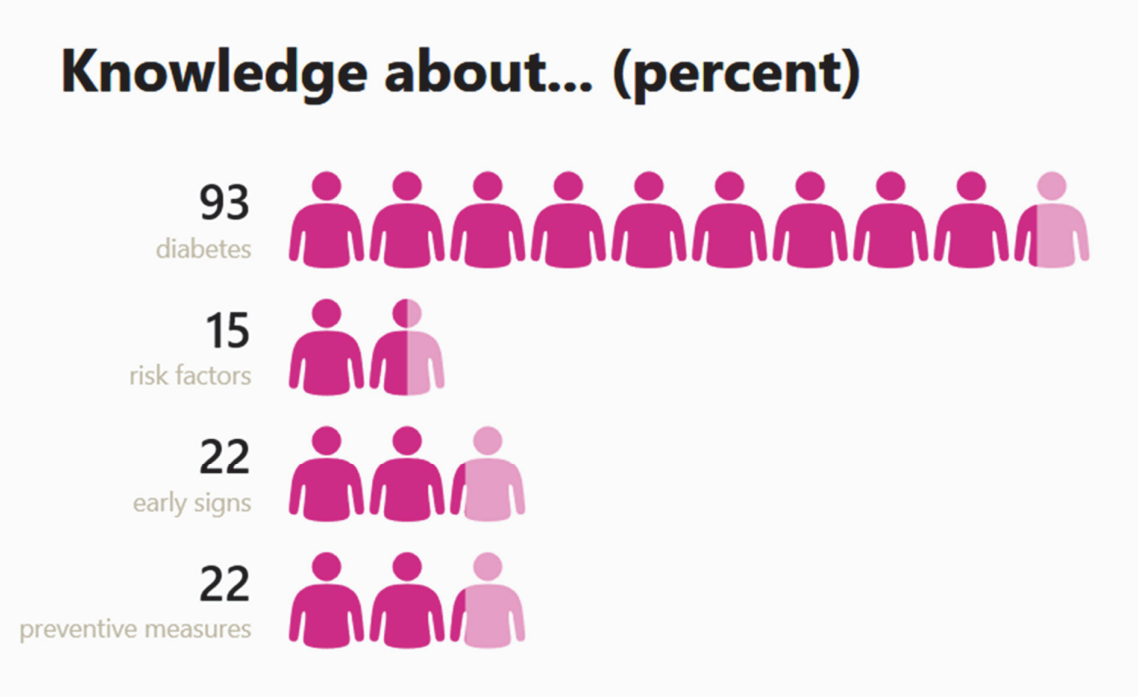


Figure 10: Level of knowledge related to diabetes

The detailed results show that knowledge about diabetes is a little higher among user of healthcare services compared to non-users. Also, there is a significant difference between the

[26] The Performance of Public Health-care Systems in South-East Europe – A Comparative Qualitative Study, Friedrich-Ebert-Stiftung, 2014

Albanian and RAE community, whereas 93% of Albanians and 81% of RAE have heard about diabetes. There is a direct correlation between knowledge about diabetes and age of respondents. Although the differences are not great, results show that knowledge about diabetes increases with the increase of age. There is a similar correlation with household income and level of education, where knowledge about diabetes also increases with the increase of household income and the increase of level of education. There are no significant differences in the knowledge about diabetes between public and private facility users, gender, household size and type of residence.

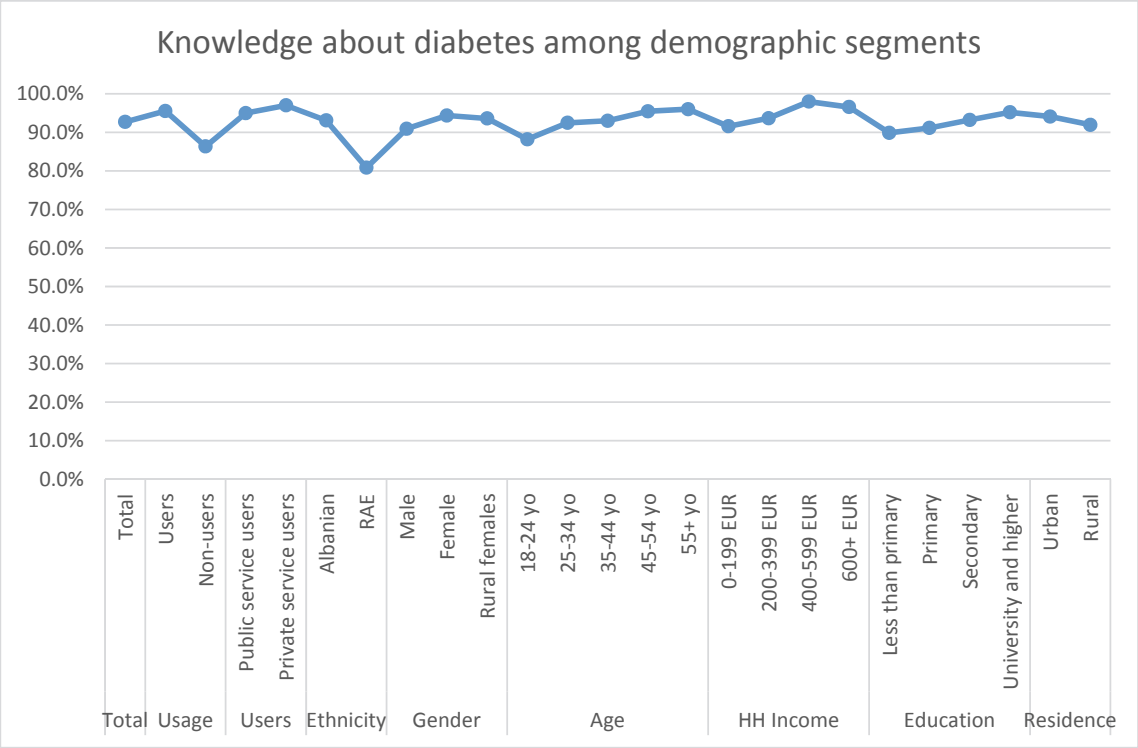


Figure 11: Level of knowledge about diabetes among demographic segments

As mentioned earlier, the knowledge about risk factors among the Kosovo population in the 12 target municipalities is relatively low. Respondents were asked to name some of the things that may lead to a person developing diabetes. The most mentioned risk factors are family history of diabetes, eating too much sugar, followed by stress and being overweight. It is important to emphasize that risk factors such as smoking, lack of exercise and alcohol are each mentioned in less than 4% of cases. It is also important to note that a total of 25% of respondents were not able to name even one risk factor and they responded with 'Do not know'.

Detailed results in the table below show that the level of knowledge is relatively higher among the Albanian community compared to the RAE community, and slightly higher among females compared to males.

Table 7: Knowledge about risk factors associated with diabetes

Risk factors	Total	Albanian	RAE	Male	Female
Family history of diabetes	35.2%	35.6%	24.3%	32.3%	38.0%
Eating too much sugar	32.6%	33.0%	17.7%	29.1%	35.8%
Stress	27.4%	27.7%	18.3%	26.6%	28.1%
Overweight	24.5%	24.8%	15.5%	20.7%	28.0%
Overeating	18.4%	18.8%	4.8%	17.3%	19.4%
Eating too much fat	18.2%	18.5%	7.0%	14.0%	22.0%
Age over 40	11.9%	11.9%	10.5%	11.1%	12.5%
Old age	10.1%	10.1%	9.4%	7.3%	12.6%
Smoking	3.5%	3.5%	3.4%	3.9%	3.1%
Lack of exercise	3.0%	3.1%	0.4%	3.3%	2.8%
Alcohol	2.7%	2.8%	2.3%	2.9%	2.6%
Ethnic origin	0.8%	0.8%	-	0.2%	1.3%
Other	1.4%	1.4%	0.7%	2.1%	0.7%
Do not know	25.0%	24.7%	33.4%	31.6%	18.8%

Similarly to the knowledge of the population on risk factors, the knowledge about early signs of diabetes is also low (22%), although a little higher than for risk factors (15%). The most frequent signs that respondents have mentioned to be associated with having diabetes are excess thirst and tiredness/lethargy, followed by vision problems, passing lots of urine, loss of appetite, etc. Just over one quarter of the sample (28%) could not mentioned any sign they know of that is associated with having diabetes.

As shown in the table below, the level of knowledge about early signs of diabetes is higher among the Albanian community than among the RAE community. There is also a slight difference between genders, where females are a little more knowledgeable about early signs of diabetes than men.

Table 8: Knowledge about early signs of diabetes

Early signs of diabetes	Total	Albanian	RAE	Male	Female
Excess thirst	54.2%	54.4%	46.2%	52.0%	56.1%
Tiredness/lethargy	37.4%	37.9%	20.5%	36.4%	38.3%
Vision problems	19.4%	19.8%	6.2%	17.8%	20.9%
Weight loss	17.3%	17.3%	18.3%	14.1%	20.3%
Passing lots of urine	16.2%	16.6%	5.0%	15.3%	17.1%
Loss of appetite	14.2%	14.5%	5.2%	12.7%	15.6%
Skin and genital infections	4.8%	4.8%	4.4%	4.4%	5.2%
Other	2.9%	2.9%	1.5%	2.7%	3.0%
Do not know	27.8%	27.4%	40.4%	32.0%	23.9%

The level of knowledge about what actions can people take to make it less likely to develop diabetes in the future is also relatively low (22%). Only around one third of respondents believes that preventive measures against developing diabetes are limiting sugar, health checks or screenings, or adopting a healthy diet and eating habits. The differences between ethnic

communities are significant and high – again the RAE community are less knowledgeable about preventive measure against developing diabetes than the Albanian study population. Similar to previous cases, females are more knowledgeable than males about preventive measures against diabetes.

Table 9: Knowledge about preventive measures against diabetes

Preventive measures against diabetes	Total	Albanian	RAE	Male	Female
Limit sugar	34.6%	34.9%	25.2%	31.5%	37.6%
Health checks/ screening	33.0%	33.2%	26.3%	32.9%	33.1%
Healthy diet/ eating habits	28.0%	28.3%	18.4%	24.9%	30.9%
Exercise	21.7%	22.3%	4.6%	21.3%	22.1%
Weight control	20.8%	20.8%	18.1%	20.2%	21.3%
Limit fatty foods	18.7%	19.0%	6.6%	14.8%	22.2%
Avoid stress	17.5%	17.9%	6.6%	16.1%	18.9%
Weight loss	13.6%	13.8%	5.9%	13.9%	13.3%
No action	2.2%	2.2%	3.5%	1.7%	2.7%
Other	1.2%	1.2%	0.5%	1.8%	0.7%

Respondents were asked several questions about their attitudes related to different issues on diabetes. Overall, survey results tell that attitudes about these matters are relatively positive. With regard to attitudes about seeking medical treatment if the respondent or family member or friend has diabetes, the absolute majority of the sample (84%) believes that they should seek treatment. Nevertheless, it is worrisome that the rest of the sample (16%) does not believe it is necessary to seek medical treatment in case they have diabetes.

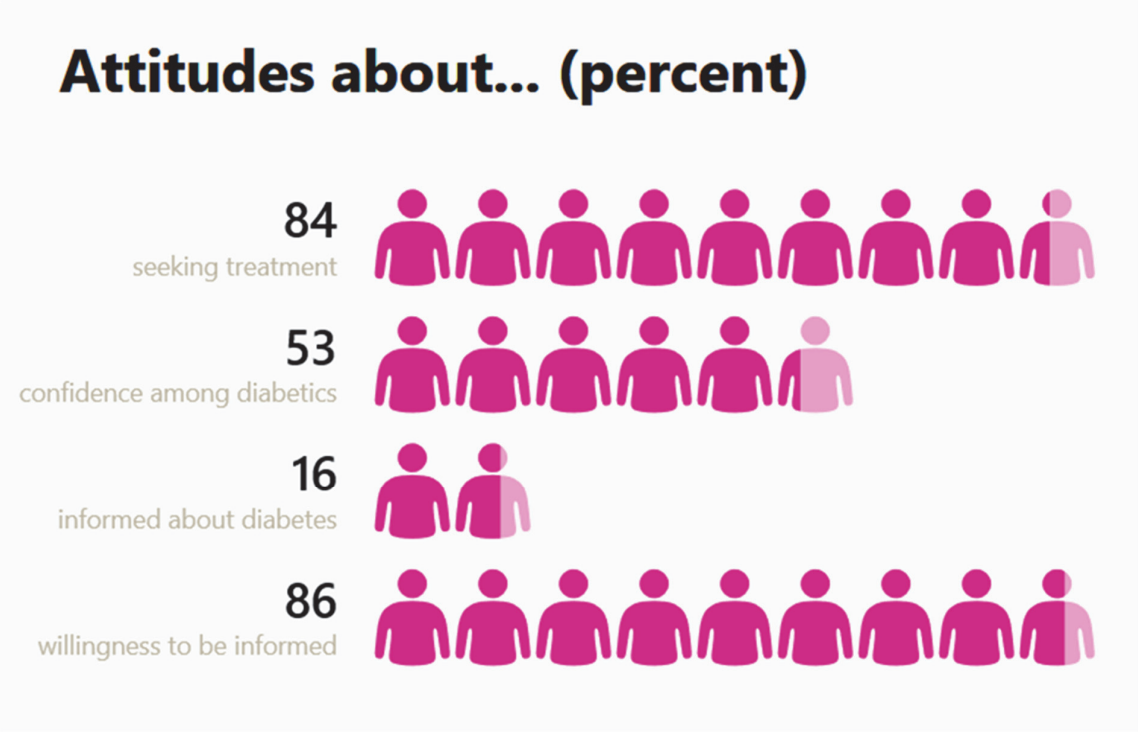


Figure 12: Attitudes related to diabetes

The level of confidence among diabetics included in the survey about what to do when their blood sugar level goes higher or lower than it should be is slightly above the average (53%), which is actually related to the low levels of knowledge about specifics of the diabetes disease. This also tells us a lot about the needs of the population in general, and diabetics in particular, to be more informed and hence become more confident about how to deal with diabetes and its symptoms.

The low level of knowledge about diabetes specifics is reflected in the level of information about problems associated with diabetes (16%). This means that the absolute majority of respondents admits that they do not have enough information about problems associated with diabetes. Nevertheless, the positive aspect in this respect is that they also admit at the same time that they would like to have more information about these problems (86%). It is worth mentioning that a study conducted by Solidar Suisse in 2012 with diabetes patients in Kosovo showed that the patients themselves are a little more informed than the general population from the KAPB survey. In the 2012 study, 37% of patients reported that they possessed sufficient knowledge about diabetes and diet received from health professionals.[27]

It is interesting to note that there are no significant differences among different demographic segments with regard to their attitudes about diabetes issues registered in this survey.

The survey questionnaire had several questions about practices and behaviours of the population with regard to diabetes. The scores vary depending on the practices: they are relatively high when it comes to taking diabetes medication, but a little lower when speaking of glucose measurement and taking insulin.

Figure 13: Practices and behaviours related to diabetes

More specifically, 35% of respondents that know about diabetes have declared that they had their blood sugar measured by a doctor or other health worker. There are significant differences between demographic segments in this respect. It is well expected that users of healthcare services have had their blood sugar measured twice more than non-users. Non-users of private healthcare services report a more frequent measurement of blood sugar than users of public services. In addition, the RAE community and females also report a more frequent blood sugar

[27] Service Preferences and Utilization Profile of Diabetes Patients – Policy Brief, Kosana, Solidar Suisse, 2012

measurement than the Albanian community and males. There is a direct and expected correlation between reported measurement of blood sugar and age – frequency of blood sugar measurement increases with the increase of age. On the other hand, there is an indirect correlation with household income and level of education, whereas frequency of blood sugar measurement decreases with the increase monthly household income and with the increase of education level. The frequency of blood sugar measurement is higher among respondents from urban areas than those from rural areas. Blood sugar measurement is also reported a little more by females than by males, most likely due to potential blood sugar measurements during pregnancies among females.

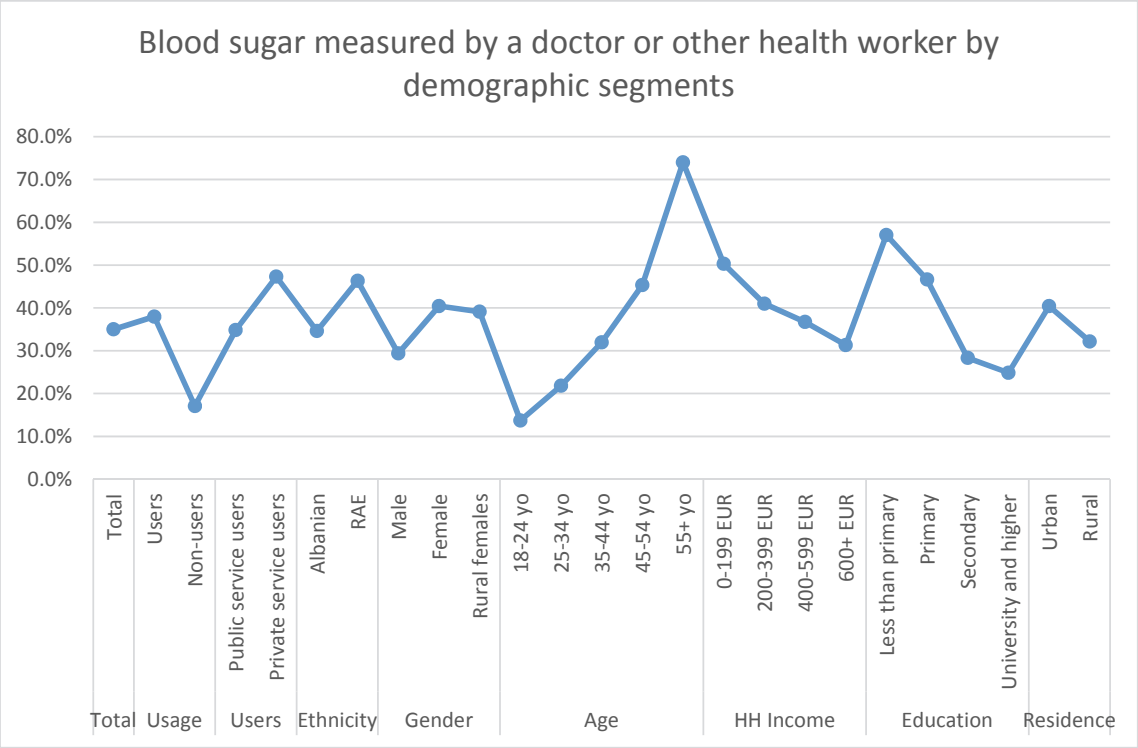


Figure 14: Blood sugar measurement practices by demographic segments

According to the survey data, the prevalence of diabetes among the adult population of the 12 target municipalities is 5.4%. Diabetics from these municipalities have discovered they had diabetes in various ways: 28% during routine check-ups, 24% during check-ups for other reasons, 20% after first symptoms have appeared and 10% after advanced complications. Two thirds of diabetics (67%) have reported that they have taken drugs (medication) for diabetes prescribed by a doctor in the past two weeks, and 29% declared that they are taking insulin prescribed by a doctor.

Apart from asking respondents if they were told that they have diabetes, the survey also asked them if they had any other member of the household with diabetes – 13% of respondents that know about diabetes said that they had a diabetic in their household. These diabetics have in most of the cases discovered their disease during routine check-ups (42%), as well as after first symptoms have appeared (22%) and during check-ups for other reasons (13%). 11% discovered they had diabetes after developing advanced complications. An overwhelming majority of diabetics in the household (90%) are reported to have taken diabetes medication prescribed by a doctor in the past two weeks, and 44% are taking insulin prescribed by a doctor.

3.2.2 Cardiovascular Diseases

Knowledge level for cardiovascular diseases (CVDs) is a little lower than the knowledge level for diabetes. Still, the overall level of knowledge for CVDs as a whole is relatively high (84%). But, similar to the case for diabetes, knowledge about associated risk factors, early signs and preventive measures for CVDs is very low.

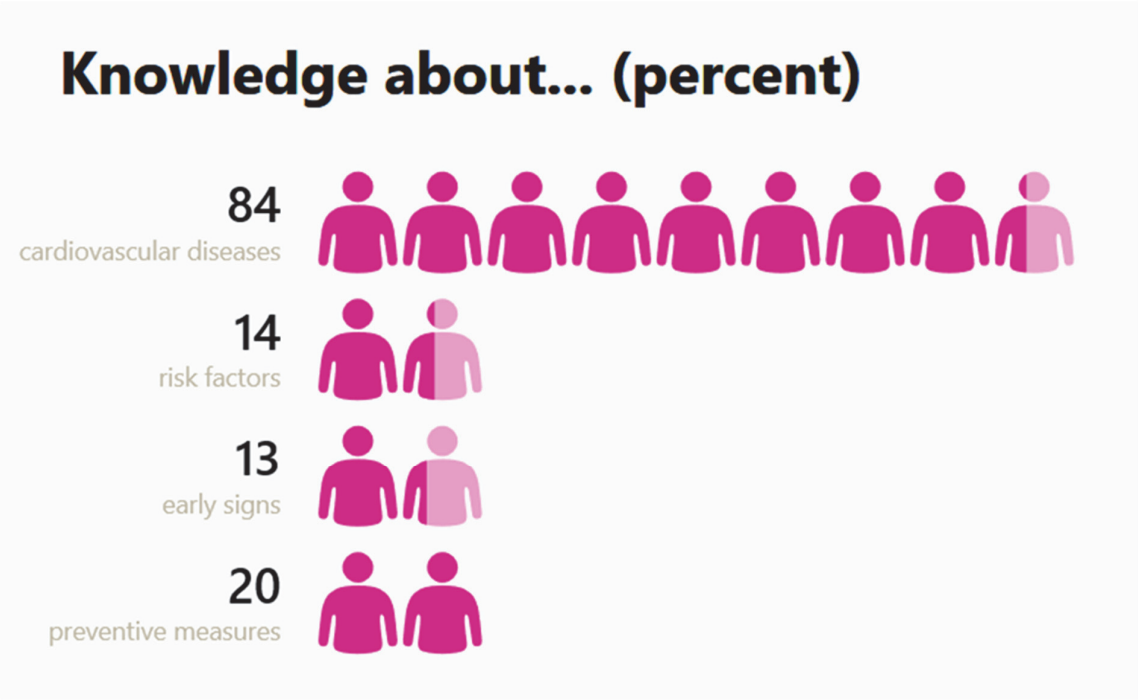


Figure 15: Level of knowledge related to CVDs

In terms of exact figures, 84% of respondents have declared that they have heard of CVDs. However, there are not so many significant differences between different demographic segments with regard to overall knowledge about CVDs. The only difference is between the ethnic communities, in that the Albanian community is a little more knowledgeable than the RAE community.

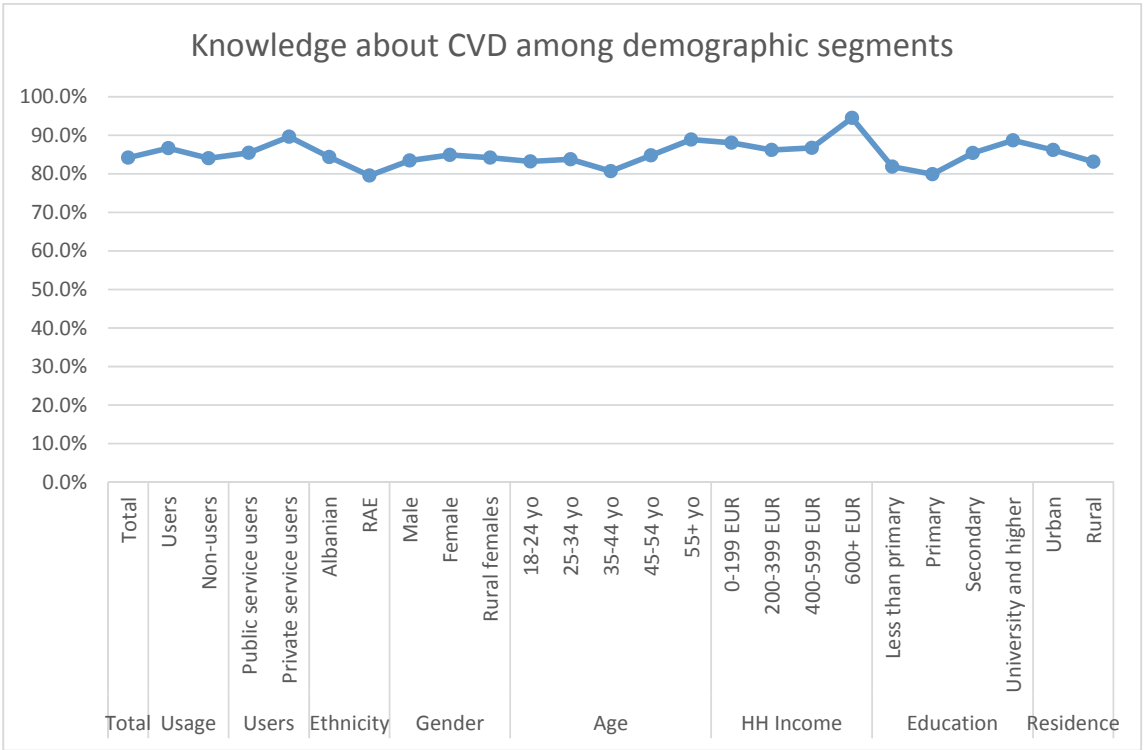


Figure 15: Level of knowledge about CVDs among demographic segments

Beyond asking respondents about their knowledge of CVDs in general, the survey also asked them to name specific cardiovascular diseases they know of. The most frequently mentioned disease is cardiac arrest (34% - cumulative percent of three mentions), followed by blood vessels narrowing (cumulative 6%), blood vessels expansion (cumulative 4%) and angina (cumulative 4%).

With regard to the risk factors associated to cardiovascular diseases, where the knowledge score is very low among the population of the 12 target municipalities, respondents mentioned specific factors that may lead to a person developing CVDs. The most mentioned risk factors are stress, family history of CVDs, followed by being overweight, eating too much fat, and smoking. The percentage of respondents that could not name even one factor is as high as 27%.

Demographic comparisons show that differences between males and females are almost non-existent. However, the level of knowledge about risk factors associated with CVDs is relatively higher among the Albanian community compared to the RAE community.

Table 10: Knowledge about risk factors associated with CVD

Risk factors	Total	Albanian	RAE	Male	Female
Stress	34.3%	34.7%	21.0%	31.6%	36.8%
Family history of CVD	27.1%	27.5%	16.5%	26.6%	27.6%
Overweight	22.4%	22.6%	15.1%	20.9%	23.8%
Eating too much fat	19.8%	19.9%	15.6%	18.4%	21.1%
Smoking	16.7%	16.9%	11.2%	19.3%	14.3%
Overeating	14.2%	14.6%	3.2%	13.5%	14.9%
Alcohol	14.2%	14.5%	5.8%	16.7%	11.9%
Salty food	13.8%	14.0%	6.6%	14.3%	13.4%
Age over 40	12.3%	12.5%	5.5%	11.2%	13.3%
Old age	12.0%	11.8%	16.5%	11.5%	12.4%
Lack of exercise	5.7%	5.9%	0.6%	4.7%	6.7%
Ethnic origin	0.7%	0.7%	0.7%	0.4%	1.1%
Other	2.5%	2.6%	0.3%	1.9%	3.1%
Do not know	26.7%	26.2%	39.8%	29.3%	24.2%

Knowledge level about early signs of CVDs is very low (13%). The most frequent symptom mentioned by respondents for CVDs is chest discomfort (52%). Other early signs mentioned less frequently are: getting exhausted easily, feeling dizzy and lightheaded; lack of breath during physical exercise; irregular heart beat; and pain that spreads to the arm. Again, a quarter of the sample (25%) were not able to mention any early sign of CVDs and they responded with "Do not know".

Similarly to the knowledge about risk factors, differences in the knowledge about early signs are almost inexistent between males and females. The level of knowledge about is higher among the Albanian community than among the RAE community with regard to knowledge about early signs of CVDs.

Table 11: Knowledge about early signs of CVD

Early signs of CVD	Total	Albanian	RAE	Male	Female
Chest Discomfort	51.8%	52.4%	32.8%	48.5%	54.9%
You Get Exhausted Easily	28.0%	28.5%	13.8%	27.4%	28.6%
You Feel Dizzy or Lightheaded	21.0%	21.5%	6.7%	18.6%	23.3%
Lack of breath during physical exercise	19.5%	19.6%	15.7%	18.0%	20.8%
Irregular heart beat	17.1%	17.4%	5.8%	15.5%	18.6%
Pain that Spreads to the Arm	16.2%	16.5%	7.4%	17.6%	14.9%
Sweating	9.9%	10.1%	2.6%	10.3%	9.5%
Legs, feet and ankles are swollen	6.6%	6.6%	4.1%	5.9%	7.2%
Throat or Jaw Pain	5.7%	5.8%	2.3%	5.9%	5.5%
Snoring	4.8%	4.8%	2.7%	4.7%	4.8%
A cough that won't quit	4.5%	4.5%	3.4%	4.3%	4.7%
Nausea, Indigestion, Heartburn, or Stomach Pain	3.3%	3.3%	0.7%	3.5%	3.0%
Other	1.5%	1.6%	0.3%	1.7%	1.4%
Do not know	24.6%	24.2%	36.3%	28.9%	20.6%

The level of knowledge about what actions can people take to prevent developing CVDs in the future is relatively low (20%). The most mentioned preventive measure against developing CVDs is health checks or screenings, followed by health diet or eating habits, no smoking and exercise. The differences between ethnic communities are significant and very high with the Albanian community being twice as knowledgeable about preventive measures as the RAE community. Again, there is no significant difference in these results between genders.

Table 12: Knowledge about preventive measures against CVD

Preventive measures against CVD	Total	Albanian	RAE	Male	Female
Health checks/ screening	41.4%	41.5%	38.3%	43.4%	39.5%
Healthy diet/ eating habits	28.0%	28.3%	19.7%	23.1%	32.6%
No smoking	25.0%	25.4%	12.1%	24.8%	25.2%
Exercise	22.2%	22.8%	3.0%	21.4%	22.9%
No alcohol	20.9%	21.3%	9.2%	19.9%	21.9%
Weight control	19.9%	20.4%	5.6%	19.6%	20.2%
Limit fatty foods	16.1%	16.3%	12.2%	14.0%	18.1%
Weight loss	13.1%	13.3%	6.9%	12.5%	13.6%
No action	2.6%	2.4%	9.0%	3.1%	2.2%
Other	1.2%	1.2%	0.4%	1.3%	1.2%
Do not know	21.1%	20.8%	31.1%	23.0%	19.3%

Respondents were asked the same questions as in the diabetes section about their attitudes related to CVDs. Compared to the case of diabetes, attitude scores about CVDs are lower. With respect to attitudes about seeking medical treatment if the respondent or family member or friend

has CVD, the majority of the sample (77%) believes that they should seek treatment. Nevertheless, the rest of the sample (23%) does not believe it is necessary to seek medical treatment in case they have CVDs.

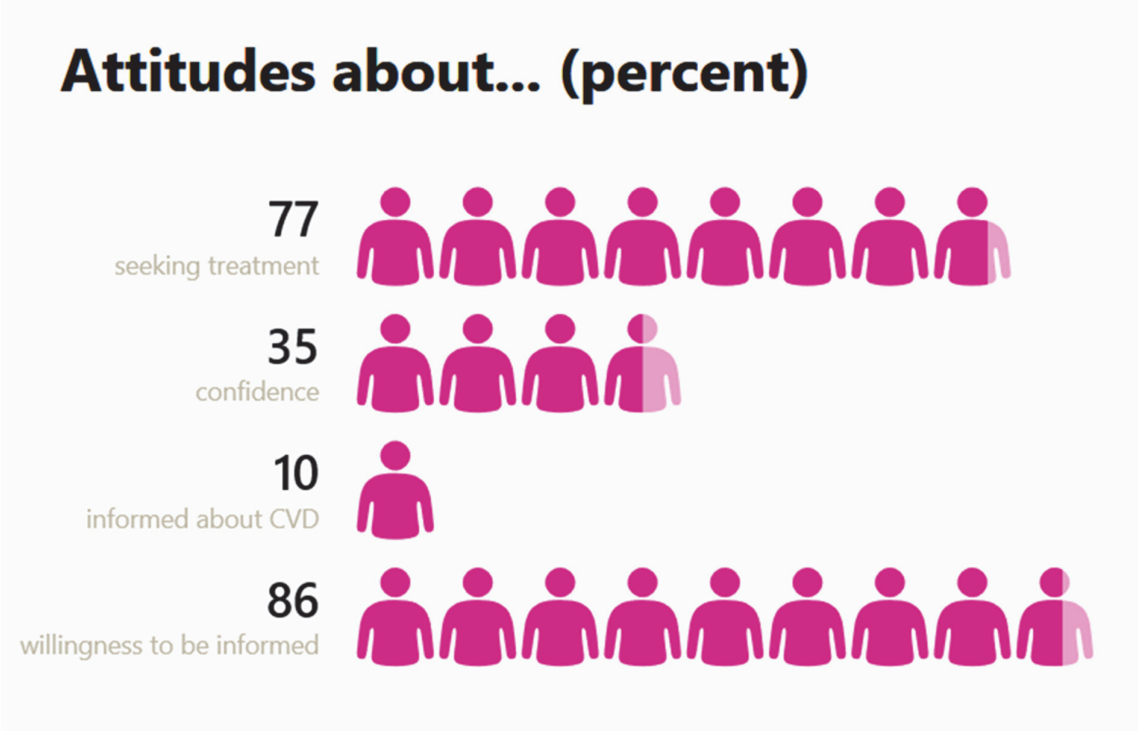


Figure 16: Attitudes related to CVDs

The level of confidence about what to do if they have symptoms of a cardiovascular diseases is below the average (35%). The level of information about problems associated with CVDs is very low (10%), meaning that the absolute majority of respondents admits that they do not have enough information about problems associated with CVDs. Similar to the case of diabetes, the vast majority of those that do not feel informed report that they would like to have more information about problems associated to CVDs (86%).

When respondents were asked if they ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident), 4.5% responded positively. The number of such reported cases is much higher among the RAE community (12.6%) than among the Albanian community (4.3%). Also, these cases are reported more from urban areas (7.1%) than from rural areas (3.3%).

Regardless if respondents had any problems with CVDs, they were asked if they are using preventive or treatment medication against such diseases. Exactly 8% of respondents declared that they are currently taking aspirin or other medication regularly to prevent or treat heart disease. Demographic differences show that these rates are much higher twice as high among the RAE community (17%) than among the Albanian community (8%). In addition, respondents from urban areas report a higher usage of such medication (13%) compared to those from rural areas (5%). There is a direct correlation between such medication and age, whereas the usage of these drugs increases sharply with the increase of age (from 1% among 18-24 year olds to 27% among the 55+ year olds).

A higher number of respondents (9%) declared that they have a member in their household that has had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident). Further, 14% of them are currently taking aspirin or other medication regularly to prevent or treat heart disease.

3.2.3 Hypertension

Knowledge level about raised blood pressure or hypertension is very high (95%), however the knowledge level about complications associated with hypertension is very low (20%).

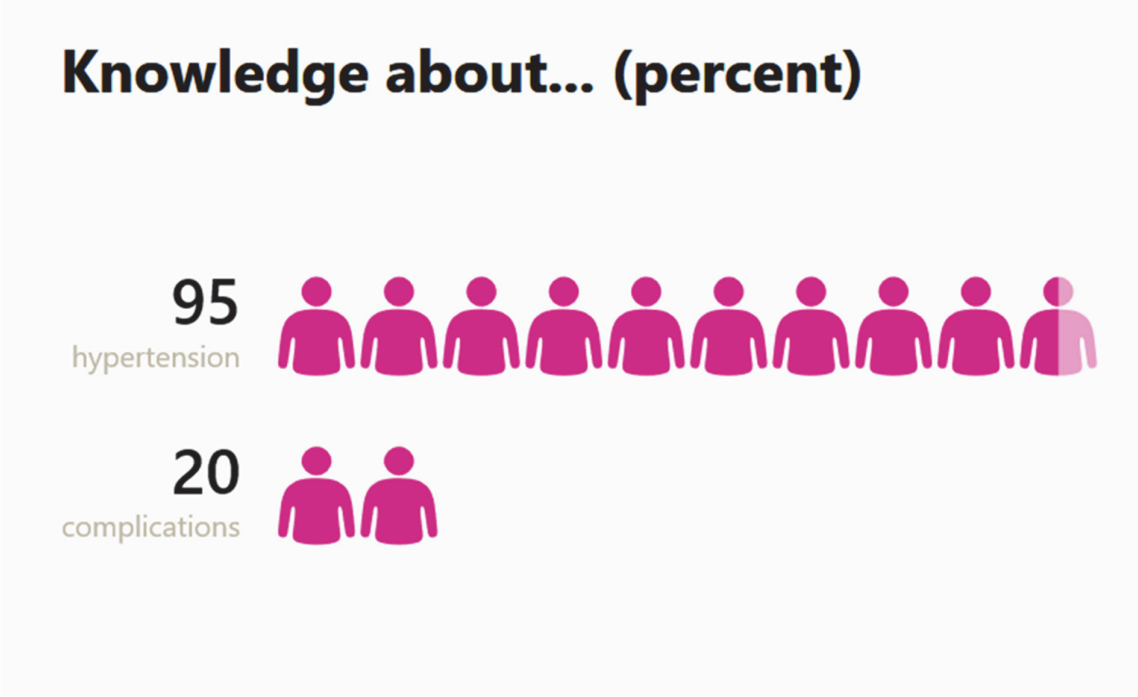


Figure 17: Level of knowledge related to hypertension

Among the 95% of respondents that have declared that they have heard about raised blood pressure or hypertension, there are no significant demographic differences of note.

In terms of complications, although the average knowledge level is very low, half of the sample was able to mention two of the complications of hypertension: heart attack or stroke and heart failure. Other complications that were mentioned are pain that spreads to the arm (15%), weakened and narrowed blood vessels in kidneys (11%), trouble with memory or understanding (10%) and thickened, narrowed or torn blood vessels in the eyes (10%).

The vast majority of respondents (73%) that are aware of hypertension declared that they had their blood pressure measured by a doctor or other health worker. There are no significant differences between most of the demographic segments, however it is worth mentioning that blood pressure measurement is mentioned a little more among females (83%) than among males (62%). Also, blood pressure measurement is more frequent among the elderly than among the younger age groups, that is the higher the age the more frequent is blood pressure measurement reported.

Among respondents that had their blood pressure measured by a doctor or other health worker, 24% said that they have been told they have raised blood pressure or hypertension. There are significant differences between most of the demographic segments in this respect. Respondents that have been told they have hypertension are found a little more among users of private practice (38%) than among users of public services (22%). Also, hypertension is twice as present among the RAE community (42%), compared to the Albanian community (23%). Due to the nature of the disease, the presence of hypertension is expected to increase with the increase in age of respondents (from 6% among 18-24 year olds to 51% among the 55+ year olds). It is also interesting to see that the presence of hypertension drops with the increase of monthly household income, as well as with the increase in the level of education, with the exception of those with higher education.

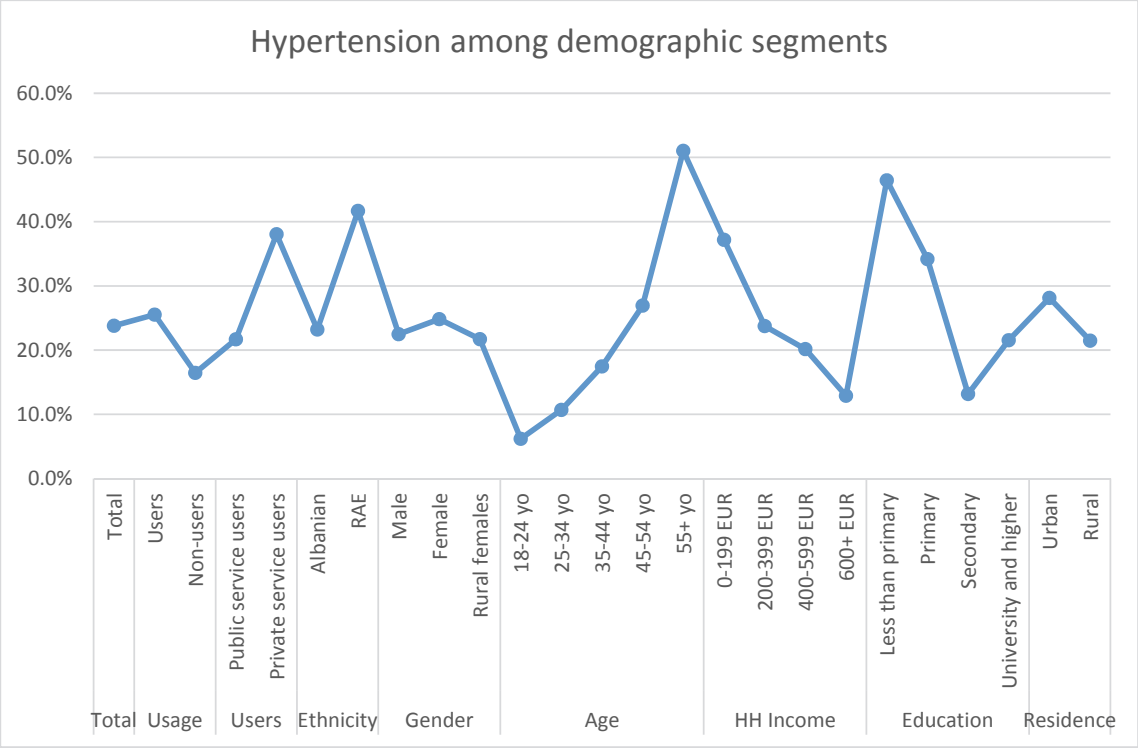


Figure 18: Percentage of respondents told they have hypertension among demographic segments

Attitudes related to hypertension are similar to the ones about diabetes. The level of confidence about what to do if they have very high blood pressure is above the average (60%). The level of information about problems associated with hypertension is low (22%), which means that the absolute majority of respondents declare that they do not have enough information about problems associated with hypertension. However, the vast majority of those that do not feel informed report that they would like to have more information about these problems (90%).

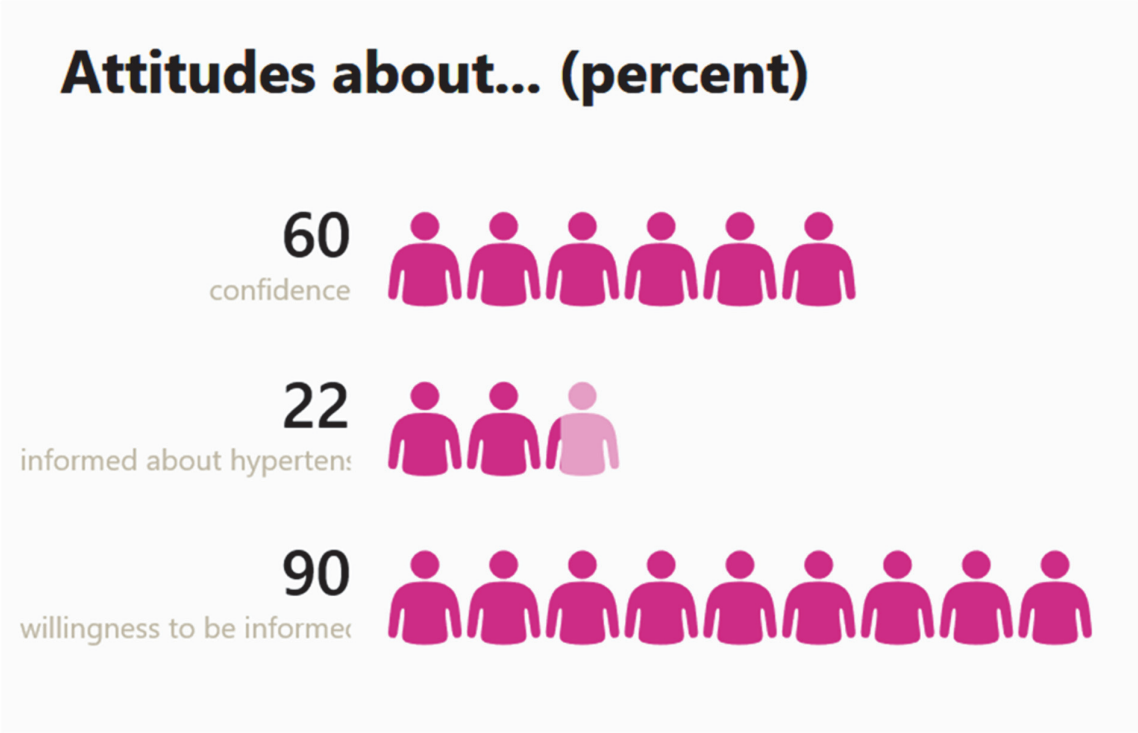


Figure 19: Attitudes related to hypertension

When respondents feel that their blood pressure has increased, around 56% take medicine against hypertension, 22% go to the doctor and 12% restrict their diet (these are all cumulative percent of three mentions). In addition, 28% of respondents report that they do not know what action to take when they feel their blood pressure has increased. In most of the cases (55%) respondents go for routine blood pressure checks when they are not feeling well, 17% go as advised by the doctor and 23% go in both cases. Besides turning to a primary healthcare centre, in most of the cases respondents measure their blood pressure on their own (53%), but also with the help of neighbour or family member (40%) and in 27% of cases they go to their regional hospital.

In addition, it is worth mentioning that in 87% of cases, respondents with hypertension have been told by a doctor or nurse to control their blood pressure. Also, another 71% of those with hypertension admit that they have been informed by the doctor or nurses or someone at the health centre about the complications of hypertension.

3.2.4 Chronic Respiratory Diseases

Respondents seem to have a slightly lower level of knowledge about chronic respiratory diseases (CRDs), compared to other diseases analysed so far in this report. The overall knowledge level for CRDs as a whole is 76%. Still, similarly to the case of other diseases, knowledge about associated risk factors, early signs and preventive measures for CRDs is low, although in this case it is slightly higher than for the other diseases.

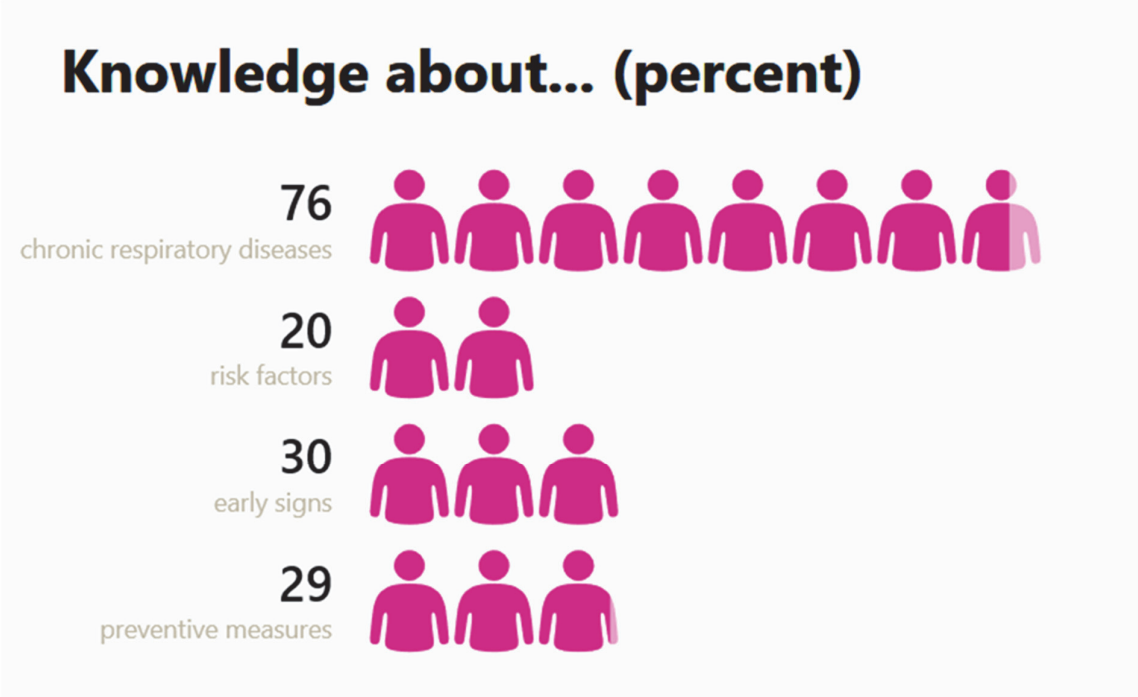


Figure 20: Level of knowledge related to CRDs

76% of respondents have said that they have heard of CRDs however there are some significant differences between different demographic segments with regard to overall knowledge about CRDs. For instance, users of healthcare services are more knowledgeable about CRDs than non-users of these services. Also, males are less knowledgeable than females about CRDs and the RAE community is less knowledgeable than the Albanian community. In addition, respondents from households with the lowest and the highest monthly income, as well as respondents with higher education know about these diseases more than other groups.

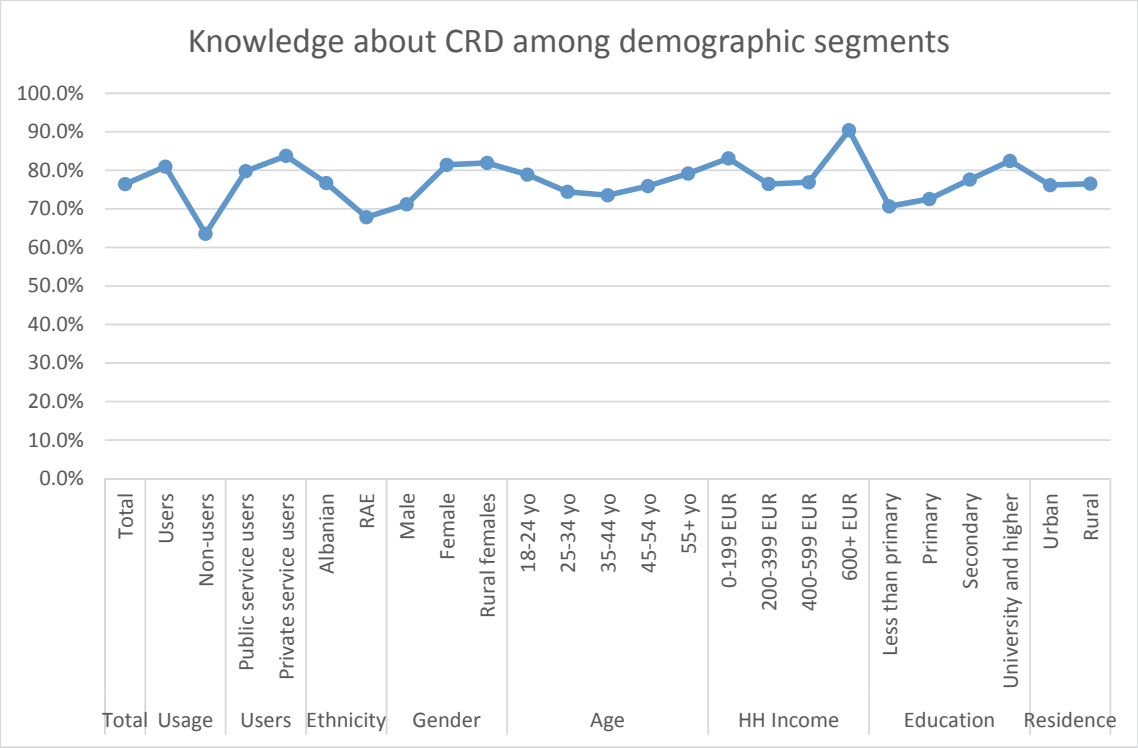


Figure 21: Knowledge about CRDs among demographic segments

When speaking of risk factors associated with chronic respiratory diseases, where the knowledge score is very low among the population of the 12 target municipalities (20%), respondents mentioned specific factors that may lead to a person developing CRDs. The most mentioned risk factor is tobacco smoke, followed by second hand tobacco smoke, outdoor air pollutants, allergens and indoor air pollutants.

Demographic comparisons show that on average there are significant differences between males and females about their knowledge of risk factors associated with CRDs, although the difference is not that high. Females are more knowledgeable than males. Also, the level of knowledge about these risk factors is much higher among the Albanian community than among the RAE community.

Table 13: Knowledge about risk factors associated with CRD

Risk factors	Total	Albanian	RAE	Male	Female
Tobacco smoke	61.4%	61.2%	69.1%	57.2%	64.9%
Second hand tobacco smoke	35.0%	35.7%	10.4%	32.4%	37.1%
Outdoor air pollutants	27.3%	27.9%	6.4%	25.2%	29.0%
Allergens	25.3%	26.0%	2.3%	21.2%	28.7%
Other indoor air pollutants	22.3%	22.9%	3.7%	19.3%	24.9%
Respiratory infections	16.6%	16.7%	12.8%	15.2%	17.8%
Occupational agents	15.1%	15.2%	9.4%	13.7%	16.2%
Diet and nutrition	7.2%	7.0%	11.5%	7.7%	6.7%
Do not know	18.3%	18.1%	26.4%	22.2%	15.1%

Knowledge level about early signs of CRDs is low (30%), although this is slightly higher than when compared to other diseases discussed so far. The most frequent symptoms for CRDs mentioned by respondents are shortness of breath or difficulty breathing, wheezing and noisy

breathing, and a cough lasting for a month or longer. Similar to other diseases, a little over a quarter of the sample (28%) were not able to mention any early sign of CRDs and they responded with "do not know".

Differences in the knowledge about early signs of CRDs show that the level of knowledge is much higher among the Albanian community than among the RAE community, whereas females are a little more knowledgeable than males with regard to early signs of CRDs.

Table 14: Knowledge about early signs of CRD

Early signs of CRD	Total	Albanian	RAE	Male	Female
Shortness of breath or difficult breathing	46.1%	46.3%	40.6%	41.6%	49.9%
Wheezing, noisy breathing	42.6%	43.3%	21.7%	40.3%	44.6%
A cough lasting for a month or longer	42.2%	42.2%	42.7%	42.0%	42.4%
Chronic mucus production	26.6%	27.0%	12.0%	22.9%	29.6%
Other	1.5%	1.6%		1.7%	1.3%
Do not know	27.6%	27.6%	30.2%	30.7%	25.0%

The level of knowledge about what actions can people take to prevent developing CRDs in the future is low (29%). The preventive measures that were mentioned most frequently by respondents against developing CRDs are spending time in mountains, quitting smoking, followed by avoiding passive smoking and avoiding lung irritants at work. The differences between ethnic communities are significant and very high – the Albanian community is almost twice as knowledgeable about preventive measures as the RAE community. Females are a little more knowledgeable than males in this case too.

Table 14: Knowledge about preventive measures against CRD

Preventive measures against CRD	Total	Albanian	RAE	Male	Female
Spend time in mountains	49.7%	50.8%	16.3%	46.0%	52.9%
Quit smoking	48.5%	48.2%	57.5%	45.5%	51.0%
Avoid passive smoking	28.6%	29.2%	9.9%	22.0%	34.1%
Avoid lung irritants at work	25.5%	26.3%	1.3%	26.5%	24.7%
Do not know	27.8%	27.6%	34.1%	32.1%	24.2%

Respondents were asked the same questions as other sections about their attitudes related to CRDs. Attitudes for CRDs are very similar to the attitudes for CVDs. In this respect, only two thirds of the sample (67%) believes that they should seek treatment. The rest of the sample (33%) does not believe it is necessary to seek medical treatment in case they have CRDs.

The level of confidence about what to do if they have symptoms of chronic respiratory diseases is a little below average (40%). The level of information about problems associated with CRDs is very low (12%), meaning that the absolute majority of respondents do not have enough information about problems associated with CRDs. Nevertheless, the vast majority of those that do not feel informed said that they would like to have more information about problems associated to CRDs (87%).

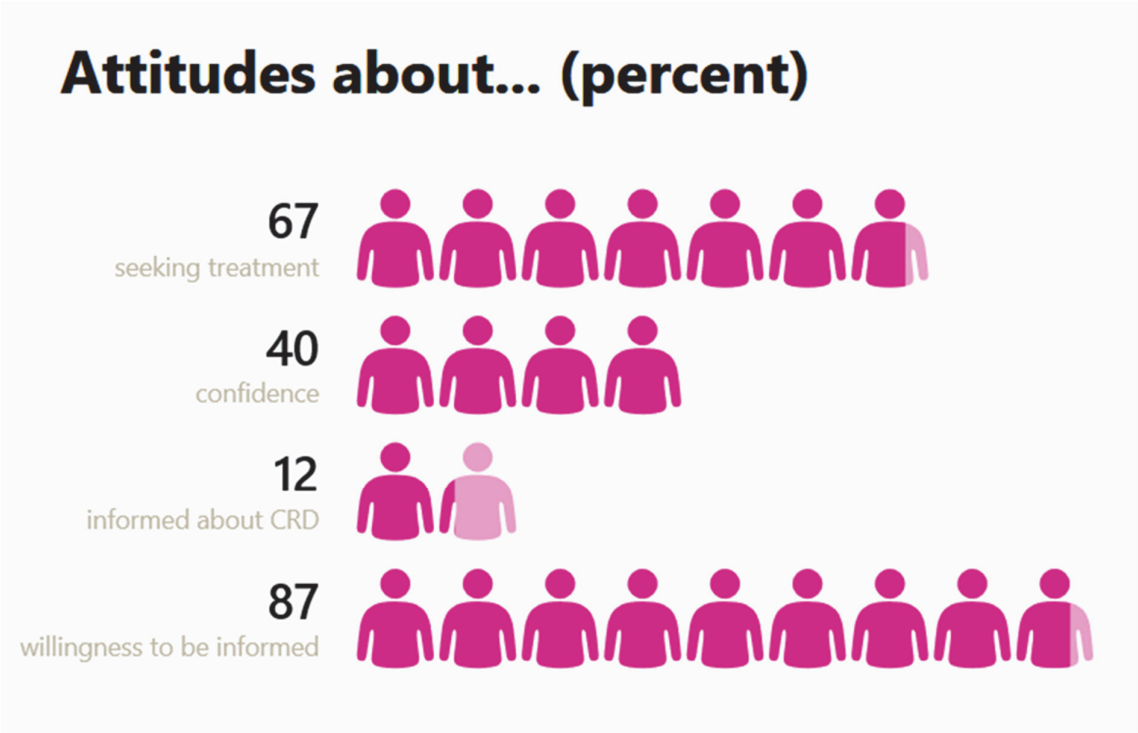


Figure 22: Attitudes related to CRDs

The survey took the opportunity to ask respondents that know about CRDs if they had ever suffered from any chronic respiratory disease in the past. The most common chronic respiratory disease to be reported among respondents is asthma - 3.3% of respondents said that they have suffered from or are currently suffering from this condition. The difference between ethnic communities is enormous – while only 2.8% of Albanian respondents report suffering from asthma, the proportion of the RAE community suffering from asthma is reported to be as high as 19.6%. Other CRDs reported by respondents are chronic obstructive pulmonary disease (2%), occupational lung disease (1.5%), lung cancer (1.3%), cystic fibrosis (0.6%) and sleep apnoea (0.6%). In addition, 8.2% of respondents declared that they have a member of their household that has had a chronic respiratory disease.

3.2.5 Child diarrhoea

The survey data reveals that level of knowledge for diarrhoea in general is very high - 91% of respondents from households that have children under 18 know about this condition. However, similarly to the case of other diseases, knowledge about associated risk factors, early signs and preventive measures for diarrhoea is very low. There are no significant differences between demographic sub-groups in this respect.

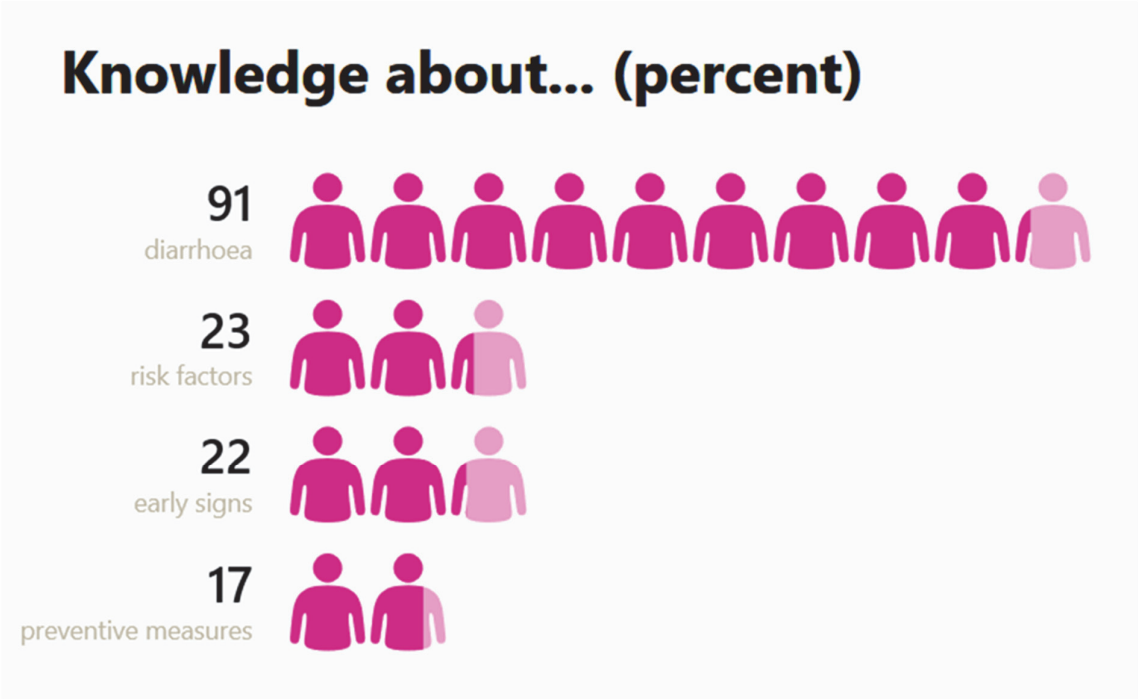


Figure 23: Level of knowledge related to diarrhoea

The level of knowledge about the risk factors associated to diarrhoea is as low as in the case of other diseases discussed in this report so far (23%). The two most mentioned risk factors that respondents believe that can cause a diarrhoea could be due to food poisoning and infection. Other factors less frequently mentioned are food allergies, medications and lack of clean water. Only 11% of respondents mentioned poor hygiene and only 8% mentioned poor sanitation among risk factors associated with diarrhoea.

Demographic comparisons show that the level of knowledge about risk factors associated with diarrhoea is relatively higher among the Albanian community compared to the RAE community. The differences between males and females on average are not that high, however females are a little more knowledgeable about these risk factors than males.

Table 15: Knowledge about risk factors associated with diarrhoea

Risk factors	Total	Albanian	RAE	Male	Female
Food poisoning	60.1%	61.3%	43.2%	58.0%	61.9%
Infection	48.7%	50.2%	25.3%	44.5%	52.2%
Food allergies	19.0%	19.7%	7.8%	17.8%	20.0%
Medications	17.9%	18.1%	14.9%	11.5%	23.3%
Lack of clean water	12.4%	12.3%	13.9%	10.9%	13.7%
Poor hygiene	10.9%	11.2%	6.2%	9.0%	12.5%
Irritable bowel disease	9.0%	9.6%	0.9%	6.9%	10.8%
Poor sanitation	7.6%	7.7%	5.4%	6.1%	8.9%
Other	6.5%	6.7%	3.3%	6.1%	6.9%
Do not know	12.2%	12.2%	12.8%	17.0%	8.2%

The knowledge level about early signs of dehydration is relatively low (22%). The most frequent symptoms of dehydration that are mentioned by respondents are dizziness and light headedness,

dry and sticky mouth and lack of energy. Other early signs mentioned less frequently are: cool and dry skin, dark yellow urine, very little or no urine; and few or no tears when crying.

Detailed data show that the Albanian community is much more informed about early signs of dehydration than the RAE community. Also, females are again significantly more informed than males about early signs of dehydration in children.

Table 16: Knowledge about early sings of dehydration

Early signs of dehydration	Total	Albanian	RAE	Male	Female
Dizziness and light headedness	35.7%	36.8%	19.6%	30.6%	40.0%
Dry, sticky mouth	30.0%	30.7%	19.9%	23.8%	35.2%
Lack of energy	27.2%	28.1%	13.3%	23.5%	30.3%
Cool, dry skin	15.1%	15.7%	6.5%	13.2%	16.7%
Dark yellow urine, or very little or no urine	14.7%	15.5%	3.3%	10.0%	18.6%
Few or no tears when crying	7.2%	7.6%	1.6%	7.1%	7.2%
Other	4.6%	4.7%	2.9%	6.1%	3.3%

As with the other diseases mentioned, the level of knowledge about preventive measures against developing diarrhoea in the future is relatively low (17%). The preventive measures mentioned most by respondents in the case of diarrhoea are: watching what you eat and drink; washing hands frequently; and asking your doctor about using antibiotics. However, it is worrying that almost one third of the sample said that they do not know about any preventive measure to make it less likely that a child will develop diarrhoea.

Again, as in other similar questions, and females are almost as twice as knowledgeable as males and the Albanian community are almost as twice as knowledgeable as the RAE community.

Table 17: Knowledge about preventive measures against diarrhoea

Preventive measures against diarrhoea	Total	Albanian	RAE	Male	Female
Watch what you eat and drink	32.6%	33.1%	25.0%	24.8%	39.1%
Wash hands frequently	30.2%	29.9%	35.1%	21.9%	37.2%
Ask your doctor about using antibiotics	23.4%	24.8%	3.6%	19.8%	26.5%
Wash work surfaces frequently	15.3%	16.2%	2.1%	13.5%	16.9%
Lather with soap for at least 20 seconds	11.8%	12.1%	6.9%	10.0%	13.2%
Serve food right away or refrigerate it after it has been co	9.3%	9.6%	4.8%	5.5%	12.5%
Use hand sanitizer when washing isn't possible	7.8%	8.1%	4.8%	3.2%	11.7%
Use the refrigerator to thaw frozen items	3.9%	3.8%	4.3%	4.4%	3.4%
Other	1.7%	1.7%	1.6%	2.5%	1.0%
Do not know	31.2%	30.8%	36.7%	39.2%	24.5%

Survey data show that the level of confidence about what to do when a child has diarrhoea is around the average (53%). The level of information about problems associated with child

diarrhoea is very low (20%), meaning that the absolute majority of respondents said that they do not have enough information about problems associated with diarrhoea. The vast majority of those that do not feel informed report that they would like to have more information about problems associated with diarrhoea (89%).

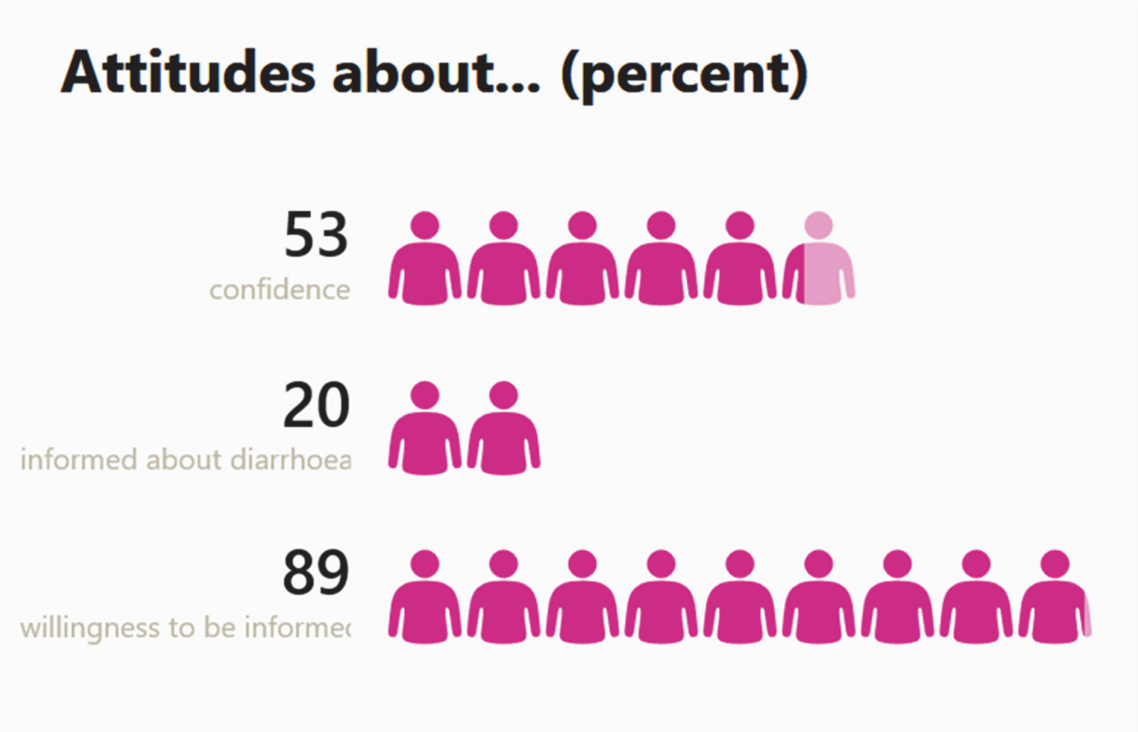


Figure 24: Attitudes related to diarrhoea

34% of respondents give liquids and 75% give food to the child when they have diarrhoea. Less than half of these respondents (45%) are aware of Oral Rehydration Salts (ORS) solutions, and 73% of those aware of ORS's have used these solutions to treat diarrhoea.

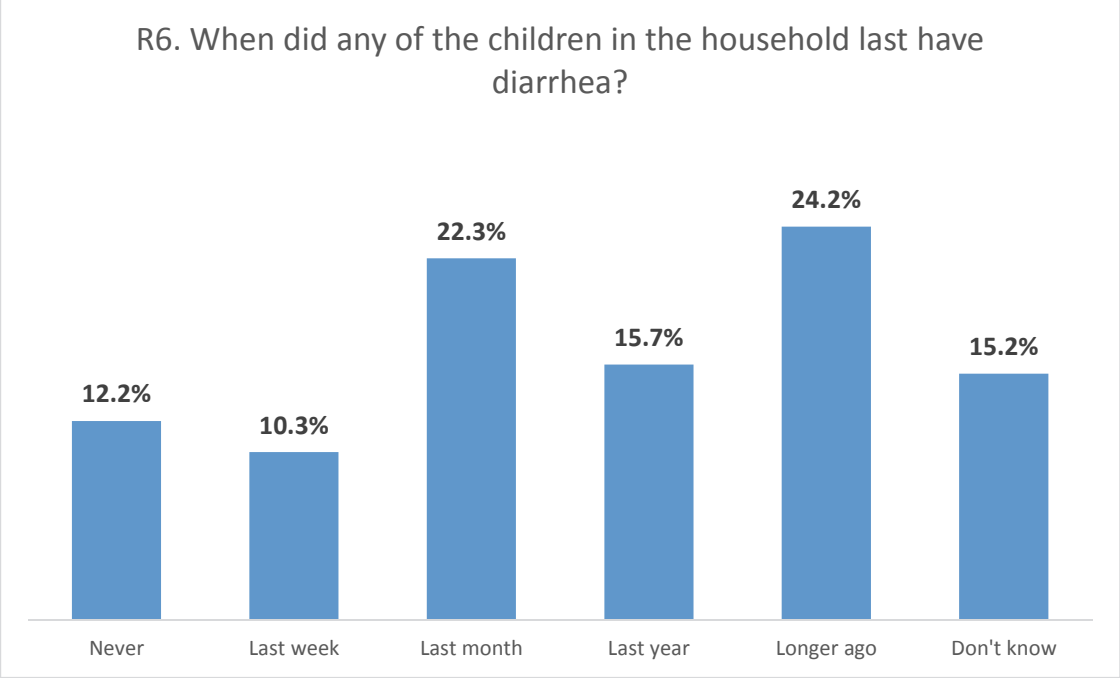


Figure 25: Frequency of occurrence of diarrhoea in children

Although respondents have declared that they are not so much informed about problems associated with diarrhoea, 10% have said that children in their household have had diarrhoea last week and 22% last month. Of those respondents with children in their household that have had diarrhoea in the past, 58% take their child immediately to the doctor and the rest (42%) first try to treat it at home on their own.

3.3 Section 3: Quality of Healthcare, Patient Rights and Communication

This section of the report will introduce and analyse the findings related to quality of healthcare, namely health-seeking behaviour and attitudes, the types of services patients use, satisfaction with these services, as well as knowledge and attitudes about patients' rights, and current and preferred channels of communication about health services.

3.3.1 Healthcare seeking behaviour

Healthcare in Kosovo receives less funding than in other developing countries, for example in 2014 Kosovo spent only 7.91%[28] of its government budget on healthcare, whereas Albania spent 9.37%, Serbia 13.86%, France 15.69% and Switzerland 22.70%[29]. The lack of funding of the public health sector is thought to be one of the reasons why the private healthcare sector has developed swiftly in Kosovo since 1999, and there has been much discussion in the post-war period about whether patients prefer public or private healthcare services, but also about what they can afford.

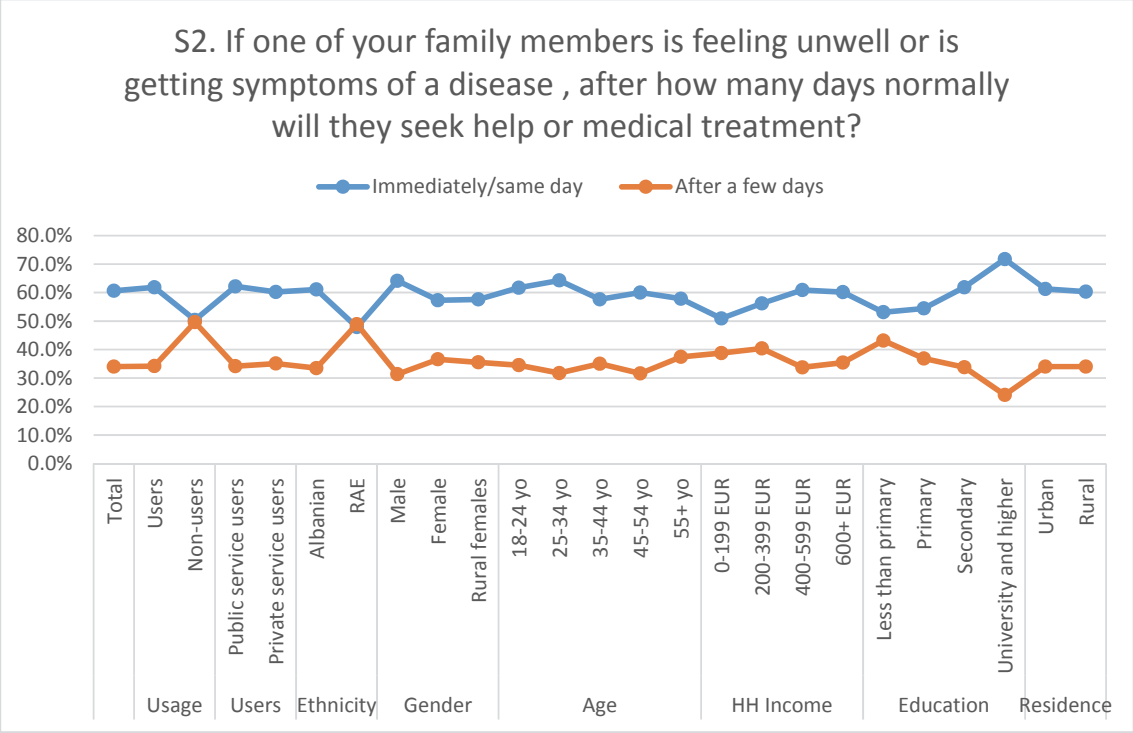


Figure 30: Treatment seeking behaviour among demographic segments

If one of the family members is feeling unwell or is getting symptoms of a disease (for example, coughing, headache, or chest pain), people usually prefer seeking help or medical treatment immediately or the same day as the symptoms begin (61%), whereas 34% wait for a few days until seeking help or medical treatment. Demographic differences show that the Albanian community is a little keener than the RAE community to seek help immediately as opposed to waiting for a few days. There is a direct correlation between seeking help immediately and monthly household income – the higher is the income more urgent is the help seeking behaviour among respondents with ill family members. This issue becomes even more urgent for with respondents that have a higher level of education.

[28] http://www.institutigap.org/spendings/

[29] http://apps.who.int/gho/data/node.main.75

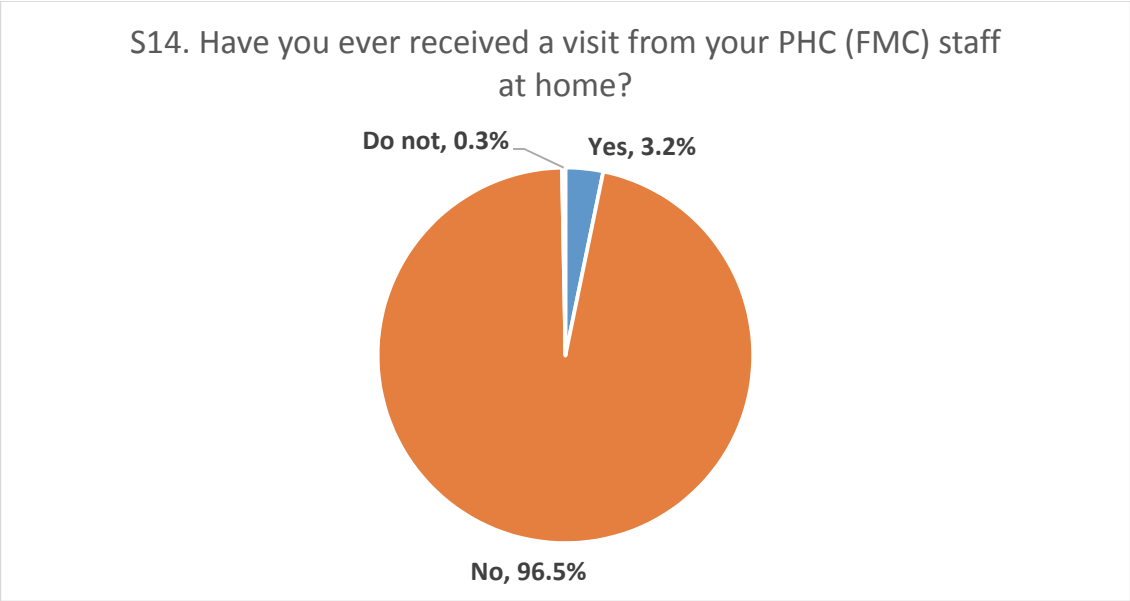


Figure 31: Reported visits from FMC staff at home

There is a very low number of reported home-visits by PHC staff, whereas only 3.2% declared that they have received a visit from their Family Medicine Centre (FMC) staff at home.

3.3.2 Types of services used

The quantitative survey asked respondents who would they normally approach in a case of any sickness, and the cumulative answers of all mentions by respondents reveal that doctor or nurse at FMC is the first point of contact in 82% of cases. Further, regional hospital comes second (61%), followed by a local private clinic (56%) and the Kosovo Clinical University Centre (KCUC) in Prishtina (45%). Disaggregated data shows that the RAE community prefers regional hospitals and the KCUC a little more than the Albanians community.

However, the expectation that better-off households prefer private practice does not hold true. When looking at preferences for FMC's, it is true that the lower is the household income the higher is the preference for FMC's. However, private clinics are mostly preferred (76%) by respondents from the second household monthly income bracket (200-399 EUR) and the least preferred (57%) by the last income bracket (600+ EUR). On the other hand, there is a direct correlation between household income and the preference for the KCUC, where the higher the income the greater the preference (28% among income bracket 0-199 EUR and 48% among income bracket 600+ EUR).

Table 18: Frequency of visits in public and private facilities

Last time visited the…	FMC	Private Facility
5+ years ago	7.4%	12.9%
3-4 years ago	5.2%	8.5%
1-3 years ago	16.9%	12.9%
6-12 months ago	16.6%	7.9%
1-6 months ago	25.1%	14.6%
Less than a month ago	18.3%	10.1%
Do not know	10.5%	33.0%

The above table also shows that in general, people have been visiting the public primary healthcare facilities more often than the private healthcare facility. The data shows that visits have been more frequent in FMC's in the last 3 years, whereas the situation was a little different 3 and more years ago, when respondents declared that they have been going to private facilities more often. Respondents have declared that they have visited the doctor on average 3 times in the past 12 months. However, the differences between demographic segments are large and significant. For instance, the RAE community has been visiting the doctor much more frequently (7 times) than the Albanian community (3 times) in the past 12 months. It is interesting to note that females and users of private services and respondents from urban areas have visited the doctor a little more often than males and users of public services and respondents from rural areas.

There is a direct correlation between age and frequency of visiting the doctor. The frequency of visits to the doctor increases with the increase of age, especially for the most elderly (5 times in the past 12 months), whereas there is an indirect correlation between monthly household income and frequency of visits to the doctor, where the lower is the income the higher is the frequency of visits to the doctor. The indirect correlation between level of education and frequency of visits stops with the higher education, where the frequency of visits suddenly increases.

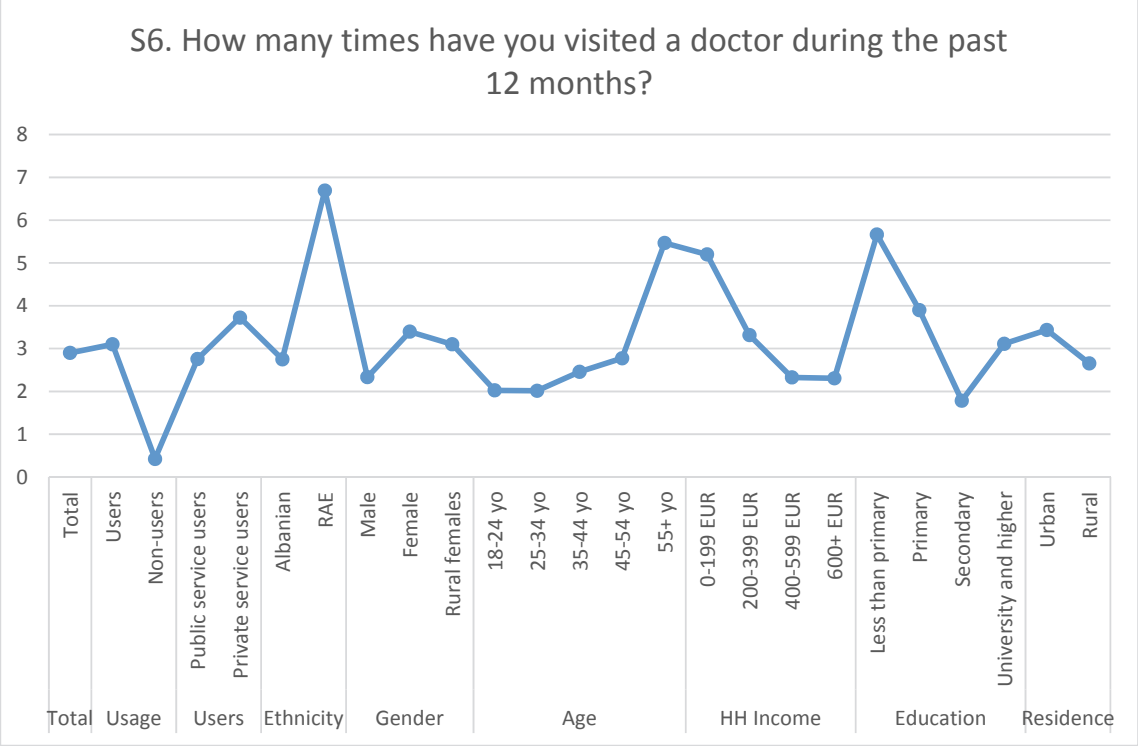


Figure 26: Frequency of visits to the doctor among demographic segments

When asked about the last time that respondents visited a primary health clinic, there is a clear preference for the public healthcare service. The main reason for this visit was check-up (58%) and the second reason was illness (30%).

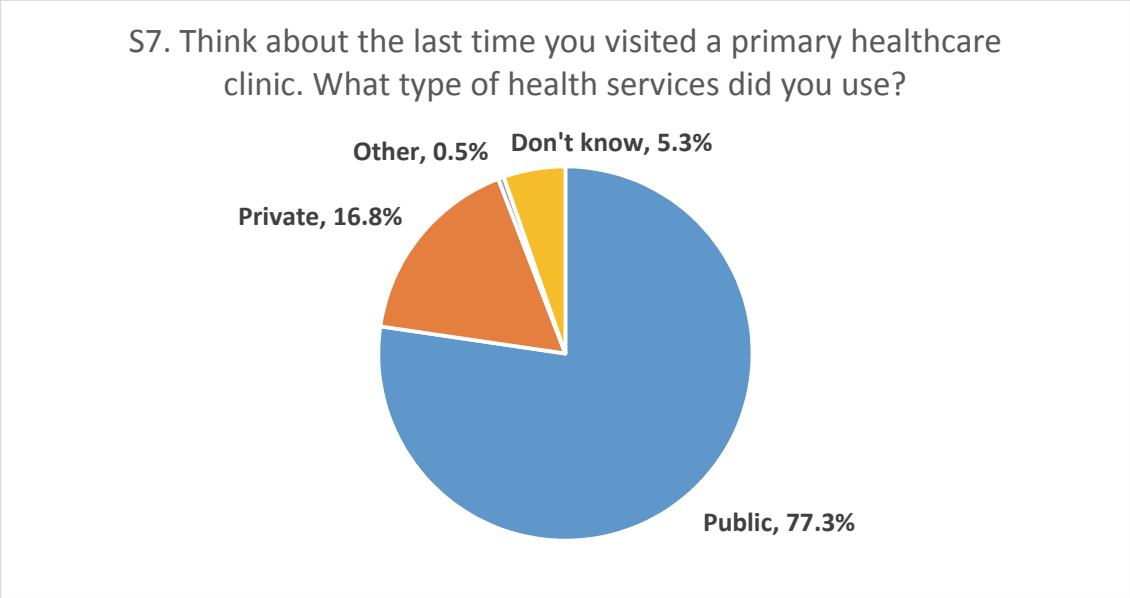


Figure 27: Share of visits between public and private healthcare clinics

When respondents visited the healthcare facilities, in 76% of cases the doctor prescribed medication and the absolute majority of them (97%) said that they took the medicine.

3.3.3 Patient satisfaction

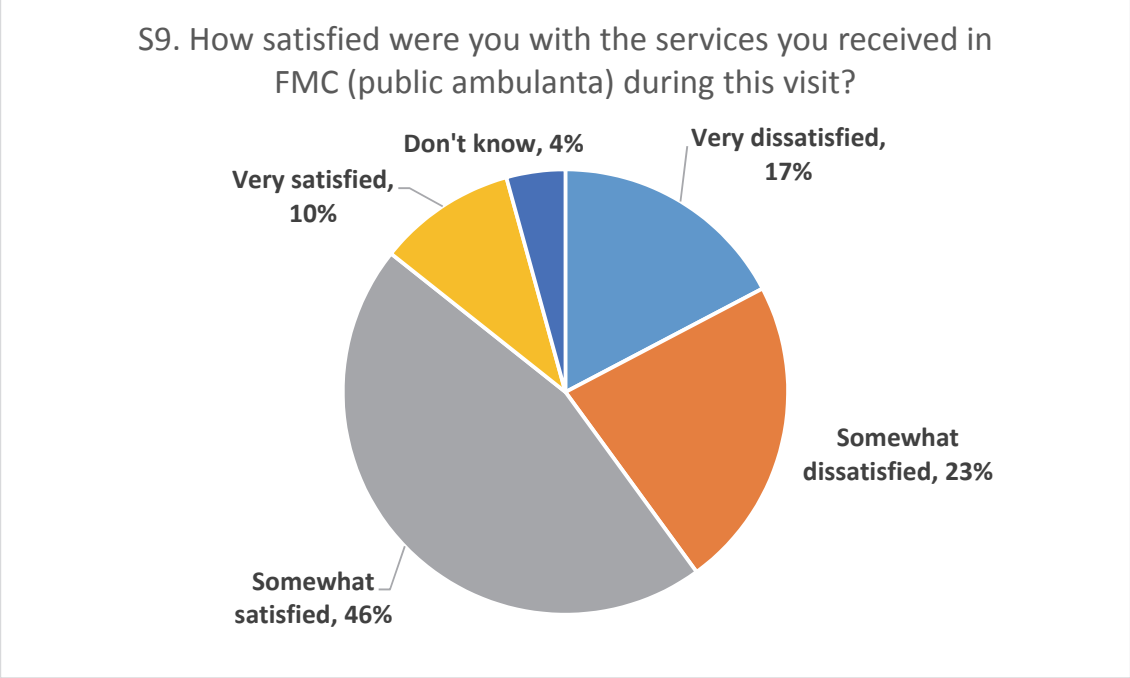


Figure 28: Satisfaction with services received in FMC's

The majority of respondents (56%) were satisfied with the services they received in FMC during this visit (10% very satisfied and 46% somewhat satisfied), whereas 40% of respondents were not satisfied with this visit (17% very dissatisfied and 23% somewhat dissatisfied). The satisfaction levels recorded in this KAPB survey are considerably lower than previously reported by other studies. For instance, the Baseline Assessment of Quality of Care in Kosovo conducted in June 2016 reported that 93% of patients were satisfied (53% satisfied and 39% very satisfied) with services received at the public primary healthcare facilities in the 12 target AQH municipalities.[30] Another study conducted by UNDP in 2013 revealed that 75% of patients were satisfied (31% very satisfied and 44% satisfied) with services of primary healthcare facilities in Kosovo.[31]

The most frequent problem respondents have encountered during visits at the FMC facilities is the lack of medicine. The Ministry of Health is responsible for providing essential medicine to all public healthcare facilities in Kosovo, based on the list of essential medicine that is designed by a team of experts.[32] Nevertheless, often patients complain that they are not provided with such medicine in public healthcare facilities, mainly because there are delays in the provision of medicine from this list or not all of them are provided from the Ministry. Other problems include absence of the staff, lack of other supplies (syringes, bandages, alcohol, etc.), impolite staff, unhygienic equipment, lack of attention from the staff and premises were unhygienic or in poor repair.

Although discriminative behaviour was mentioned by only 4% of respondents (4% of Albanians and 6% of RAE), some RAE respondents commented during the survey that they are often discriminated by the healthcare staff. They complained that they have no financial means to go to private clinics and when they go to public facilities, their impression is that apart from the discrimination, they are overlooked by the staff just because they are RAE.

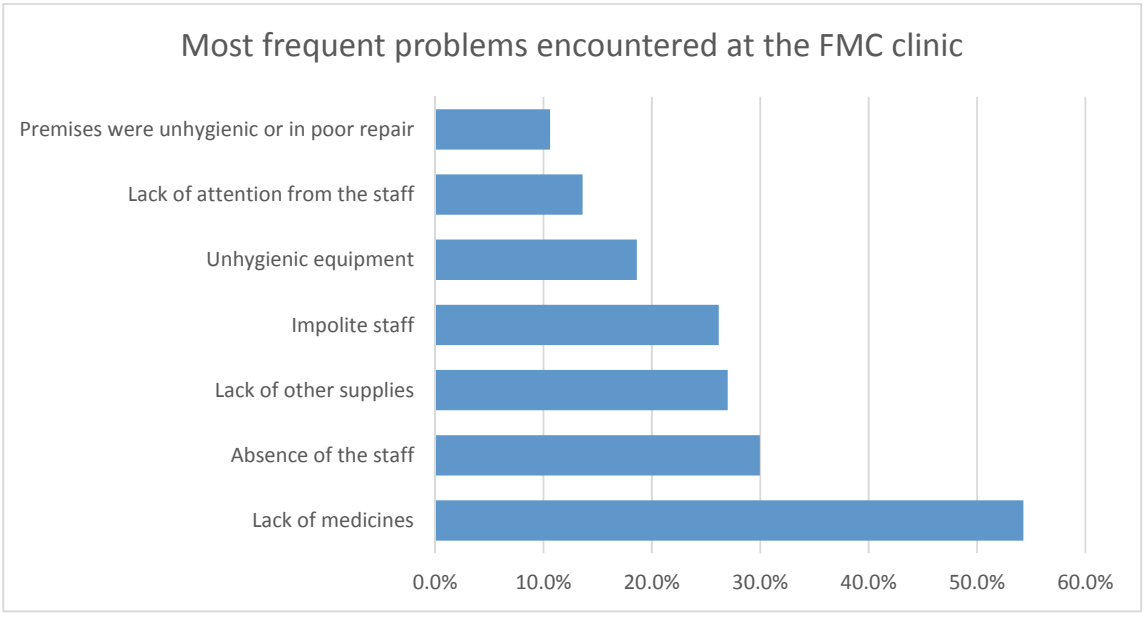


Figure 29: Most frequent problems encountered at FMC's

[30] Report on the Baseline Assessment of Quality of Care in Kosovo, AQH, June 2016

[31] Action Paper on Healthcare in Kosovo, UNDP, 2013

[32] http://msh-ks.org/wp-content/uploads/2013/11/Lista-Esenciale-sipas-VEN-dhe-ABC-Indikatoreve.pdf

3.3.4 Patient rights

Respondents were asked if they have ever heard of patient rights in Kosovo and 44% answered they had heard about such rights.

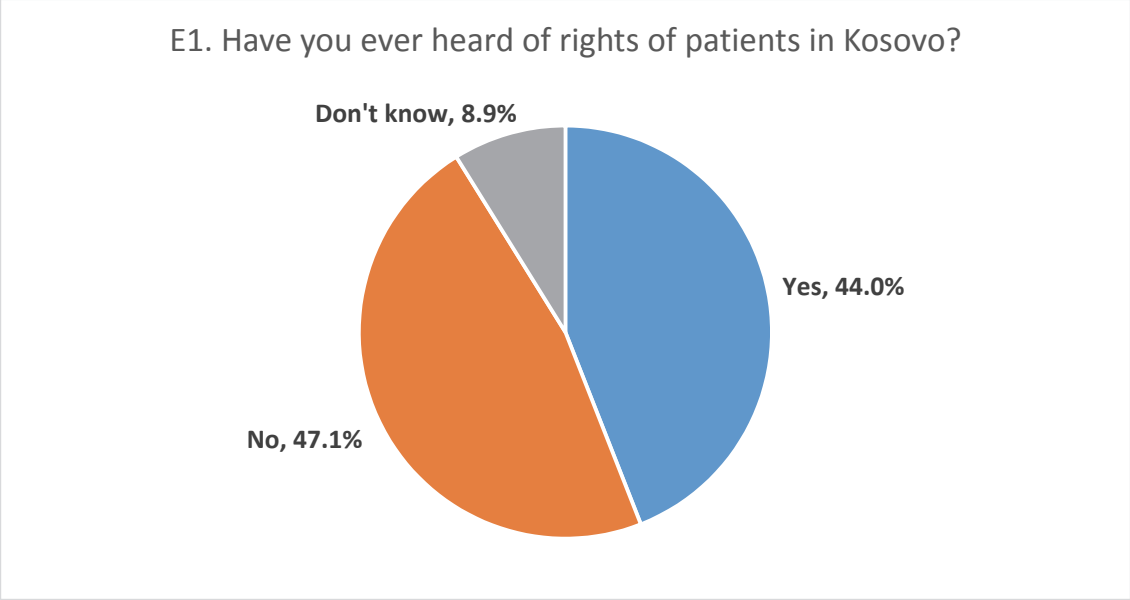


Figure 32: Level of awareness about patient rights

There are no significant differences among most of the demographic segments, however the difference can be noticed only with regard to ethnicity. The Albanian community is much more aware (45%) than the RAE community (23%) about the existence of patient rights in Kosovo.

In terms of which of the patient rights people believe they are entitled to in Kosovo, the two most mentioned rights are right of access to healthcare services (56%) and right to information (50%). With regard to the rest of the entitled rights for patients in Kosovo less than 40%, and in some cases even less than 20%, of respondents know that they are entitled to these rights.

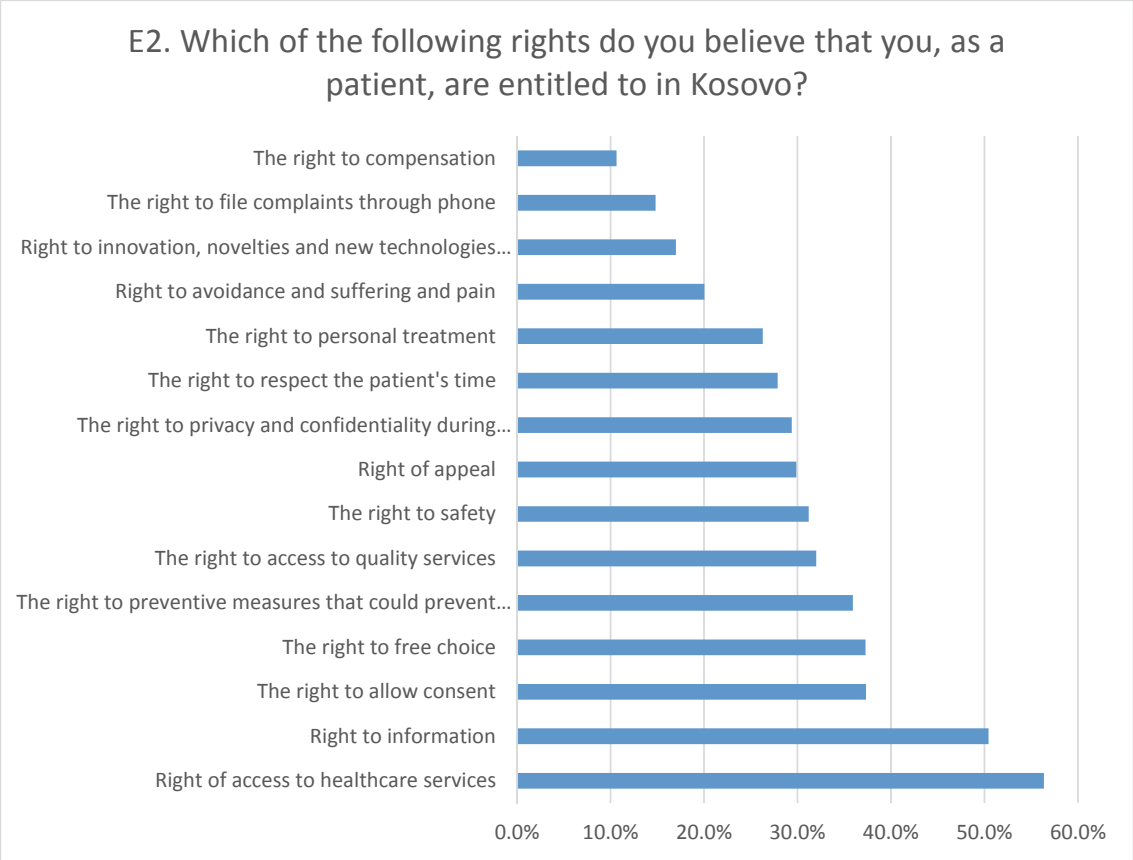


Figure 33: Awareness about rights patients are entitled to in Kosovo

Only 26% of respondents declared to have seen a list of patient right exposed in the FMCs they have visited in Kosovo, and this declaration is much more frequent among Albanians than among RAE, among those with higher education and among respondents from rural areas.

It is striking to learn that only 2% of respondents believe that patient rights are fully enforced in Kosovo. 49% believe that these rights are only somewhat enforced, 23% feel they are not enforced so much and 17% that they are not enforced at all. Also, only 27% of respondents have heard that there is a telephone number where they can call and complain about healthcare services.

3.3.5 Communication channels

The two most prevailing communication channels for obtaining information about healthcare in general, and about health services in their areas specifically, are people's doctors or nurses and television. Internet seems to be another important communication channel, as well as family, friends and neighbours.

Table 19: Current and preferred channels of communication about health issues

Channels of communication	Current	Preferred	Differential (current minus preferred)
Your doctor or nurse	52.7%	68.2%	-15.5%
TV	50.1%	45.9%	4.2%
Internet	31.7%	37.7%	-6.0%
Family, friends, neighbours	27.1%	19.5%	7.6%
Newspaper	16.3%	18.6%	-2.3%
Radio	13.7%	16.4%	-2.7%
Leaflets	5.6%	11.4%	-5.8%
Posters/Billboards	2.2%	3.7%	-1.5%
None	1.6%	0.1%	1.5%
SMS	0.7%	6.1%	-5.4%
Public meeting in the neighbourhood/village	-	11.0%	-11.0%
Other	0.3%	-	0.3%

Respondents feel that they should be getting information about health issues from their doctors or nurses much more than they do now, a little less from television and their family, friends and neighbours, and a little more through the Internet.

4 Chapter 2: Results – Qualitative Research

4.1 Section 1: Previous Experience in Public Healthcare Services

4.1.1 Perceptions about the public health system in Kosovo

General perception of the participants about the healthcare system in Kosovo is that it is unsatisfactory. Participants stated the public health system is worrisome for them from the moment they need healthcare services. Based on their experience regarding the public health service, they consider it to be of the lowest quality, starting from the doctor's non commitment to patients, professional irresponsibility, lack of specialists in certain fields, lack of essential drugs and other issues of mismanagement. As a result of this current situation in the healthcare system in Kosovo, many of patients are forced to seek treatment in private clinics and some of them abroad.

The main challenge seems to be healthcare service prices, since these costs are paid out of their pocket, which is posing too heavy a burden for them or their family members.

> *"My son suffers from diabetes, it has cost me 800 EUR to pay for his hospital bill and for the tests. I had to seek for help in Nish, because I did not have any more money to continue my son's treatment here. In Nish the service was cheaper and they made my son better. Here, his health situation got only worse.* ***(Group with male, Obiliq, rural)***

During the discussions, participants declared that there are often cases when they are forced to postpone their treatment for days or stop their treatment altogether because the medications are too expensive and they cannot cover all expenses. According to the participants of the RAE community, this is a bigger problem for them because their financial and social situations are limiting their access to adequate healthcare services. A participant from Fushe Kosova declared that he often has to beg for money in the streets, so he can afford to buy drugs (medication) for his family.

> *"Often in cases when my wife would get really sick I had to beg for money in the streets, so I could make little money to buy her drugs".****(Group with male, Fushe Kosove, rural, RAE)***

> *"A relative of mine, recently passed away, and it was only because he didn't have money to buy one drug for his asthma".* ***(Group with male, Fushe Kosove, rural, RAE)***

Another reported challenge for the RAE Community participants from Fushe Kosova is the discrimination that they are facing in all health institutions: denying them the right to wait in line to visit the doctor; addressing them with expressions such as "one less gipsy"; or in some cases not giving them the proper treatment that they need because of their lack of personal hygiene.

> "Immediately, when they see your darker skin colour, they won't consider to treat you*".* ***(Group with male, Fushe Kosove, rural, RAE)***

> *"In the public health clinic, the women that collects our health care cards, she says that we have to put them on her table, and she will read it without touching it."* ***(Group with male, Fushe Kosove, rural, RAE)***

'Misbehaviour', 'arrogance' and 'neglect' are the main words that the participants used to describe the performance of some staff members, based on their experiences they had when they sought help in public health clinics in Kosovo.

4.1.2 Healthcare seeking behaviour

The most common reasons why people go to the doctor, mentioned spontaneously by participants, are: diabetes, hypertension, seasonal flu and for injury cases.

Other reasons mentioned for visiting the doctor, either by them or their family members, are: heart disease, breathing problems (mentioned: asthma, bronchitis), and gynaecological examinations (mentioned: pregnant women). The RAE community groups also visit doctors for more serious health conditions, such as: tumours, skin infections, and spinal operations. Also there are some other health issues and diseases that were not specifically named because the participants did not know the name of their disease. In these cases they made statements such as 'My doctor knows it, but I cannot remember the name' – this was especially the case with the female participants group in Lipjan.

It is interesting to note that none of the participants mentioned diarrhoea. When the moderator mentioned it, they said that they do not consider it as a serious illness and 'grownups treat it with any drugs that they have at home'. They take it more seriously when their child suffers from it, while 'grownups' visit doctors for diarrhoea only in very serious cases.

> *"My father had to go to the doctor because he would get worse, he suffers from hypertension and he gets dehydrated."* – ***(Group with male, Gllogovc, rural)***
>
> *"I sent my child to the doctor when he had diarrhoea because he was really sick. The ambulance did not come, they said they were busy with some traffic accident. We had to wait for a very long time for them to come."* ***– (Group with male, Fushe Kosove, rural)***

Participants do not have the same opinion for asthma, hypertension and diabetes. They consider asthma, hypertension and diabetes as being very strong reasons to visit a doctor, because they cannot treat them by themselves at home.

Diabetes and hypertension are two main chronic diseases that send people to visit the doctor, because most people who suffer from these diseases do not pay attention to eating healthy food regularly or to proper treatment of the disease.

Asthma was considered to be a more frequent disease lately, particularly in the municipality of Obilic and Gracanica since participants consider them as very polluted. Everyone agrees that asthma is a very good reason to go to the doctor and it demands constant treatment, because the disease triggers breathing difficulties.

> *"For asthma, I send my brothers son to the doctor very often, sometimes three times during one night when his situation worsens. Very often it happens that they do not have the proper medication for inhalation so he has to suffer until the morning".* ***(Group Gllogovc, rural, male)***
>
> *Here, you can say that every second person suffers from asthma, they try to be very careful and prevent it because in the long run it can cause very big problems."* ***(Group Obiliq, rural, male)***
>
> *"Now people are more cautious about asthma, it is not like it was before. My grandmother had asthma and we never knew it. She died very young."* ***(Group Malisheve, male)***
>
> *"My grandfather never went to a doctor even if he knew he had asthma. But now, people immediately go to the doctor, when the first symptoms appear"* ***(Group Malisheve, male)***

Most participants thought that people generally do not try to prevent their diseases and visit the doctor only when their pain is unbearable, and they certainly do not do regular check-ups without having a good reason (health reason) to do so. Females that belong to older age groups tend to be more careful and they visit the doctor more frequently.

Participants claimed that there are many people who never went to the doctor, and they turned out to be among some of the participants. They said that they never felt the need to go to the doctor because they never felt too much pain (they were never too sick).

The second reason is high cost of the service. They say that the doctors would "prescribe drugs for just a simple flu and it can cost us up to 20 euros".

The majority of the participants said that it is a good idea to visit the doctor every 6 months, whereas others do not find it necessary to visit the doctor this often without having any pain or serious concerns.

> *"I never went to the doctor, I went only when I had to give birth to my four children. I do not send my children to the doctor as well, because they never get sick, I do not even vaccinate them. My younger son has difficult seeing during the night. The doctor said he has a little shade in his eye, but later he said he was born that way, so if they operate him, his situation would only get worse"* ***(Group with female Lipjan, rural)***
>
> *"I have a very bad toothache but I never go to the doctor because I am very scared of them"* ***(Group with female, Lipjan, rural,)***

4.1.3 Public PHC services

Participants expressed concerns mainly about healthcare infrastructure, emphasizing the lack of medical equipment, technology and the limited number of beds, lack of hygiene and essential medicines.

Their complaints relate in particular to the lack of medicines and medical equipment within health institutions. In almost every case they provided examples of where the participants, their family members, or their friends had to go and buy medications themselves if they wanted to get treated.

In rural areas participants mention that the main problem is the location of the healthcare institutions and the lack of staff. Also access to emergency services and after-hours care is not consistently available in FMC's – patients cannot always count on finding healthcare staff in these centres after-hours. These services are mostly available in big cities, but not in rural areas. Especially in rural areas there is a very small number of pharmacies and they lack supplies.

It is also mentioned that in these primary healthcare institutions, the patients are required in either a direct or indirect way to go to private clinics, even if they came for a routine check-up.

> *"The same doctors, when we go to their private clinks, they behave very differently (behave much better)"* ***(Group with female, Junik, urban)***

They also mentioned that the doctors tell them to buy certain drugs, even if they are not necessary, just because doctors have agreements with the companies that produce those drugs.

In many cases there are also reports of cases when doctors allegedly neglect patients. However, participants do not question doctors' professionalism and instead argue that usually the conditions are very poor in these institutions making it impossible for the doctors to provide excellent and quick care.

As an advantage it is mentioned that check-ups are not expensive, you do not have to pay for your children, pregnant women or retired people, and also people with social welfare benefits do not have to pay for their check-ups. In some cases, families with financial problems are relieved of payment too.

Regarding diseases that are the main focus of this survey, people most often visit the doctor in the public healthcare service for hypertension and diabetes. For asthma and diarrhoea, the public healthcare clinics do not have the necessary equipment to treat them.

> *"You cannot go to the public health clinic for asthma, because they do not have anything. We do not send our children there for asthma."* ***(Group with female, Junik, urban)***

Participants also mentioned that in very serious health cases staff do treat them with urgency and care.

Table 20: Reported advantages and disadvantages of public healthcare clinics

Public healthcare clinics	
Advantages	**Disadvantages**
Cheaper check-ups / do not have to pay	Lack of medical equipment
Insulin supply	Lack of paediatrician, dentist, etc.
Urgent cases, do not have to wait in line	Lack of staff
Some of the drugs (very rarely) – for free	The staff do not respect the working hours
24 hours service (only in the main clinic in the centre)	Lack of drugs
Elderly always have priority	Lack of basic equipment (patches, syringes, etc.)
Professionally qualified staff	Doctors sending patients to private clinics
Public health care clinic is very near (in urban areas)	Prescription of unnecessary drugs due to the personal interest of doctors to pharmacies.
	If they are on their lunch break, they do not care about the urgent cases.
	Their bad attitude towards patients
	Lack of communication with patients
	Racism (for the RAE community)
	The location of public health care clinic is very far (in rural areas)
	No 24 hours health service in other public health clinics besides the central one.
	Lack of hygiene

4.1.4 Private PHC services

Most of the participants have a favourable opinion of the infrastructure and the performance of the doctors. They state that they are treated with respect, that their concerns have been heard and understood, they had the opportunity to express themselves, have received the necessary information and doctors have spent sufficient amount of time to treat them. Also most of them said that they were pleased with the appointment scheduling procedures.

The main reason why they go to private clinics is because of those diseases that cannot be diagnosed in the public health institutions, or because of old medical equipment or lack of specialists. The most common reasons given are: emergency cases; because the waiting list gets too long in public health institutions; or when public healthcare doctors ask them to go to their private clinics.

> *"We go to private clinics because we cannot wait for two or three months in the public health institutions."* ***(Group with male, Obiliq, rural)***
>
> *"My sister had to wait 6 months in the public health clinic* ***(Group with female, Junik, urban)"***

Private clinics are preferred for chronic diseases, diabetes, hypertension, diarrhoea and asthma, but this is not always the case due to their higher prices. People turn to private health clinics mainly for their children and elderly when they require special treatment of the disease.

Reasons for going to private clinics include: trust and easy communication with the doctor; the quality of medical treatment; and availability of new medical equipment, however private clinics are lacking in the rural areas, as they are mainly located in the centre of the city.

As a disadvantage, besides the higher prices for services, participants report their fear that in the private sector doctors sometimes offer services in medical fields where they are not specialized.

> *"My child suffered a lot from diarrhoea. I sent him to a private clinic but the doctor prescribed him the wrong medication because it was not his field, but they admit you as a patient anyway in order to take money for the visit."**(Group with female, Junik, urban)***

Table 21: Reported advantages and disadvantages of private healthcare clinics

Private healthcare clinics	
Advantages	**Disadvantages**
Fast service	Expensive
Good service	They perform medical services in fields where they are not qualified
Hospitality	In case of complication, they do not hold themselves accountable in front of state.
They have essential equipment	
Modern equipment	
Advice from doctor	
Safer feeling	
Good hygiene	

4.2 Section 2: Risk Factors

4.2.1 Attitudes and practices about smoking

Participants perceive that the proportion of smokers in Kosovo is very high. Almost every one of the participants knows that smoking is harmful to human health, even fatal, but those who smoke continue to do so because it helps them to relieve anxiety, stress and anger, by giving them the feeling of relaxation.

All of them agree that young people are the biggest smokers, with a perception that young males smoke more than young females do. They attribute this to the fact that the majority of young people are unemployed and lack different activities, so they do not have much to do, they spend a lot of time in pubs (cafes).

> *"I was physically active, I did sports for 8 years. When I got injured, I stopped. I had nothing to do, so I spend most of my time on the streets and pubs (cafeteria). So I started smoking, I joined my group of friends that smoked frequently"* ***(Group with male, Obiliq, rural)***

> *"In order for a smoker to quit, he/she should be active elsewhere. The state has to find different alternatives, to make the youth more active and not just say: Stop smoking"* ***(Group with male, Obiliq, rural)***

Low cigarette prices and the ability to smoke in many public places are other reasons for higher number of smokers in Kosovo. Smoking among minors is a very worrying issue – all the participants agreed on this. Participants consider that the minors see the adults constantly smoking, so they think that it is ok if they smoke too. Most to blame are the parents that do not

pay much attention to their children and also minors can go and buy cigarettes anywhere, they also can smoke inside their houses.

> *"Parents do not spend much time with their children, they do not talk to them. They give money to their children and have no idea what they do with that money."* ***(Group with male, Mitrovice, urban)***

Smoking within enclosed spaces according to participants affects the health of other family members. They also believe that it is more harmful to passive smokers than among active smokers. This was confirmed by participants who were smokers, declaring that they smoke in their home environment. They smoke while watching TV, drinking tea or coffee and they often ignore frequent family members complaints about smoking inside the house.

> *"I can't imagine what would it would be like, if I couldn't smoke inside. It has never occurred to me to stop smoking inside the house, I am used to this."* ***(Group with female, Gjakove, urban)***
>
> *"Albanians watch too much TV, so they cannot go outside for a smoke and miss something on TV"* ***(Group with male, Mitrovice, urban)***
>
> *"If I tell my father to smoke outside, he will get mad and say how can you say that!"* ***(Group with male, Fushe Kosove, rural)***
>
> *"If I go outside to smoke my parents would say, why are you going outside to smoke!"* ***(Group with male, Fushe Kosove, rural)***
>
> *6 members of my family smoke, excluding me, so you can constantly feel the smoke in the room. They do not even consider the option to go outside to smoke. Even in those houses where none of the family members smoke, they have guests who smoke inside when they come to visit."* ***(Group with female, Gjakove, urban)***

They would only stop smoking inside the house, when they have guests that do not smoke, otherwise they will not stop.

> *"It is very difficult to tell our guest that he cannot smoke inside, he may not want to come for a visit again"* ***(group with female, Junik, urban)***
>
> *If we do not let our guests to smoke inside our house, it means that we are not respecting them, so they won't come again, or they will say, I do not want to go there, I can't smoke there."****(Group with female, Malisheve, rural)***

These smokers, who smoke inside their homes, know that this is a bad habit but it is still not clear to them how harmful it is, and how badly it can affect other family members.

Nevertheless, all of them agree that by strengthening the law banning indoor smoking, more specifically banning smoking inside pubs, restaurants, public institutions and the banning of cigarette packages exposure in shops, can lead to a public awareness and help smoking inside home premises as well.

4.2.2 Opportunities to prevent smoking

Increasing the price of cigarettes is considered as a motive and they think it can help to reduce smoking, but not stop it completely. It cannot help people to quit smoking, especially for those who are long time smokers. According to participants, those who are addicted to smoking will find ways to continue smoking, regardless of the price. Many people complain about their low standard of living, but it does not make them stop smoking.

According to participants, strengthening the law against smoking in public places, as well as giving fines for those who do not respect the law, will significantly influence the reduction of smoking in Kosovo. A law prohibiting minors' access to tobacco products and not allowing them to buy or sell cigarettes will prevent them from trying to start smoking. By raising parents'

awareness to spend more time with their children and applying good communication methods, parents can carry clear messages to the children on the damages that is caused by smoking

They help in raising awareness on dangers of smoking inside house premises and applying no-smoking signs indoors.

> *"It is not enough if we say that they are harmful, because they have it written on the cigarette packages. People need to be 'served' the damages so they can really understand them"* ***(Group with male, Mitrovice, urban)***

Banning smoking by law in other public places, including streets, parks, places that are more crowded, would be another strategy that would somehow limit smoking.

> *"When they started banning smoking inside pubs (cafeteria), and banning of cigarette packages exposure in shops, people have started to reduce smoking inside their houses"* ***(Group with female, Malisheve, rural)***

It was clear that the participants were not aware of the content of the law against smoking in general, especially the part on prohibiting minors' access to tobacco products, as well as in collective housing buildings.

According to participants, public awareness campaigns through the media, including talk shows, commercials, and interviews with health professionals, play a major role in informing the population.

4.2.3 Attitudes and practices about physical activity

In general participants defined physical activity as being every body movement and any activity carried out during the day. According to them, physical activity is walking when going to work, walking while doing housework, gardening, working on their land, walking up the stairs, child care, physical work, etc.

> *"I paint houses and I am nonstop active. I do more exercise than people who go to the gym or do sports."* ***(Group with male, Obiliq, rural)***
>
> *"I was never healthier than when I worked in construction"* ***(Group with male, Obiliq, rural)***
>
> *"Women are more active because they are unemployed so all day they deal with housework."* ***(Group with male, Obiliq, rural)***

Also according to them, physical activity is considered to be doing different sports, running and other physical exercise.

Most participants, especially female participants, consider doing the housework during the day, working in the garden, walking to work etc. to be physical activity because there is a frequent movement of limbs and body. Less than half of the participants considered that these activities exercise the body more than the exercises done in the gym or sports centres.

The majority of the participants define a person that is physically active as a person who runs, exercises in the gym, or walks at least two or three times per week for 1 or 2 hours. Other participants define a person that is physically active as being someone who carries out daily exercise or 5 times a week for about 1 hour a day.

The majority of the participants do not consider themselves to be physically active. Women consider themselves to be more active than men, especially women in rural areas who deal with more difficult (hard) housework. All participants believe that generally people in Kosovo are not physically active because they do not know the value it brings to persons health.

Participants from rural areas stated that they have limited opportunities for physical activity, besides everyday activities around the house and taking care of the children. They see as an obstacle the mind-set that still prevails in these rural areas. Mostly the elderly (males) are more active because it is recommended by a doctor.

> *"A doctor advised me that housework is not enough, I have to walk. But where can I walk here in the village, people will start talking!"* ***(Group with female, Malisheva, rural)***
>
> *I work as a teacher and mothers of my students very rarely come to parent-teacher meetings. Women are not allowed to go outside their house, let alone to come to their children school".* ***(Group with female, Malisheva, rural)***

In urban areas (cities), the youth is more physically active because they have lots of sport centres and gyms nearby, while the elderly and mothers with children are less active because there is a lack of walking trails or parks.

In rural areas more awareness is required as well as different initiatives that will enable women to get involved in physical activities.

> *"It is very easy to organize physical activity in different areas. If one organization would organize something like that, by bringing people together, others would then go and do it by themselves "****(Group with male, Fushe Kosove, rural)***

Almost every participant agreed that you do not have to be financially stable in order to be physically active. Physical activity is mentioned to be especially crucial for people suffering from diabetes and hypertension.

4.2.4 Attitudes and practices about alcohol

Participants believe that although Kosovo has a high level of unemployment the level of alcohol consumption is less than other countries in the region and Western countries, the main reason being that Kosovo does not favour alcohol consumption because of its' culture or tradition, and that the majority respects the Muslim religion (which bans alcohol consumption). Also they consider that there is another reason - it is not cheap.

Alcohol consumption has changed among middle aged and slightly older people. Now it is consumed mainly by very young people - at parties and during weekends - and it is thought that they can sometimes exceed the normal dose, whereas middle aged and older people consume alcohol in small doses and with appetizers. According to participants, compared to men, the number of women who consume alcohol is significantly lower and is mainly in urban areas.

Participants from the female group in Lipjan were especially concerned about alcoholism within the RAE community. They stated that the majority of men in their community are alcoholics, especially younger and middle aged men.

> *"My husband often drinks while driving. It would be better if he spends that money to buy something for our children. He drinks because he says he likes how it tastes."****(Group with female, Lipjan, rural, RAE)***
>
> *"My husband says that alcohol keeps him healthy. He can skip his meals but he won't skip drinking." Lipjan* ***(Group with female, Lipjan, rural, RAE)***

Participants state that the main reason for alcohol consumption is having fun and feeling happy, but another reason is that people have a lot of financial problems and they have the wrong idea that by getting drunk they will feel better and solve their problems.

Participants believe that alcohol consumption causes many diseases. The most commonly mentioned are: addiction, depression, heart disease, liver failure and hypertension. According to them the expansion of educational programs in schools, awareness campaigns and organizing groups for alcohol addicts, could help to prevent or reduce the number of consumers in the country.

4.2.5 Raising awareness about risk factors

In the 12 target municipalities of the study there are no organizations that specifically focus on raising awareness about the risk factors and consequences of smoking, alcohol consumption, poor diet or physical passivity, although some organisations do support related activities. The RAE community in Fushe Kosove is reported to be very active in participating in events organized to raise awareness about various infectious diseases (AIDS, tuberculosis), drugs, smoking, alcohol, educating pregnant women (how to take care of themselves during pregnancies), how to maintain personal hygiene, as well as language courses. Through their engagement in these sort of activities participants feel they have a better understanding for a healthy way of living and an advantage is that participation in these sorts of activities are free. The Women's Association also organizes activities in schools to raise awareness about the damage that smoking among young people can cause.

Participants state that these sorts of activities have positive impact in our society, although in Junik some talked about there being a lack of interest from people to participate in such events because they say they need stimulating mechanism (money). In addition such activities are not available in all municipalities.

> *"I tried to organize something for the women but nobody supported me, including women from our community. In these small places nothing is being done, the main focus are always big cities." (**Group with female, Junik, urban)***

4.3 Section 3: Diet

4.3.1 Eating habits

In order to have a better understanding of their lifestyle- focusing mainly on how often they eat, exercise, smoke or drink alcohol - participants were asked to describe a typical day in their life. Most stated that they usually have two main meals per day, depending on their schedule.

From the typical three main meals, the majority of participants said that lunch and dinner are most important. They do not pay much attention to breakfast. They usually wait until 12:00 to 13:00 to have lunch and then they have dinner around 19:00.

People who eat breakfast are mainly those who usually have lunch at around 16:00 and then have dinner at around 19:00 to 21:00.

The majority of groups said that for lunch they usually eat something "heavier".

The types of foods that they consume for breakfast, lunch and dinner are almost the same for the majority of participants.

Breakfast food usually contains dairy products, fried eggs and dough products with milk content. Children consume more processed meat (salami, sausage) and also chocolate cream and butter. Eggs are usually considered to be healthy because of their protein content, but all agreed that they have to be cautious in quantity. Most people is considered butter to be healthy because of the type of fat it contains. Amongst dough products, pancakes are considered as not harmful because their main content is milk. Processed meat is considered as very unhealthy because it is processed food and they contain remains of real meat.

For lunch the participants usually eat meat products. They all said that they eat meat almost every day with the only variation being how the meat is prepared and what other dish they serve to accompany it. White meat is considered to be healthier than red meat. Besides meat, they consume meals containing some kind of dough at least two times per week (spinach pie, pie with meat, pie with cheese etc.).

At dinner they typically eat the remaining food from lunch. For dinner they prefer food with less fat content. For dinner they usually eat: pasta, pizza, bread, corn bread, etc. The most common

is white bread baked in the oven. Integral bread is used mainly by people with diabetes. Often the types of food products consumed for dinner are the same as breakfast.

Soup is considered very healthy regardless if it is homemade or bought. The food that contains water are considered healthy, the most common among them are beans and goulash. Rice and potatoes are more preferable especially when prepared in the oven. Fried peppers with cheese are also very common in their menu. Salads (tomato, onion, green salad, cabbage, cucumbers) are the most common in all focus groups. Pickled salads are consumed at almost every meal. Generally sea food is not mentioned as being a usual food by the participants, few of them mentioned oily fish such as sardines.

Most people consume water with their meals, but often they consume soft drinks or fruit drinks that they buy in the store.

Very few mention cereals and honey as food on their menu. In between meals they consume: different fruits, sweets (that contain white sugar), black tea and coffee.

To make their menu healthier participants regularly mentioned that they need to add more vegetables, fruits, dairy products, water, and rarely did they mention grains and seafood. One participant also said that types of foods should not be too limited, especially fruits and vegetables. Items that should be avoided are described as all foods prepared outside the home, industrially prepared drinks, sweet products, coffee and black tea. Less mentioned are modified ways to make healthier food. Only few mentioned the amount of fat that should be used to prepare food and ways of preparing food.

4.3.2 Perception of healthy eating

Focus group discussions were dominated by the overall concept of healthy eating habits - participants said that a way to eat healthier is by not getting too full with food, eliminating one of the three main meals and not eating at late hours. Healthy eating is considered to eliminate foods that contain fat, white flour, pasta, sweets and processed meat foods, and to instead add more dairy products, meat, fruits and vegetables.

Only two participants (females) said that eating healthy does not mean eliminating many food ingredients, but you can limit the amount and you should know how to prepare them. The male group (in Skenderaj) thinks that food should contain a variety of ingredients so that our body can get all the vitamins needed.

Healthier eating is considered as consuming foods that are boiled, and less healthy is consuming those that are fried or baked. Preparing food on the grill is considered to be the most harmful to health.

However, participants often said that that it is unnecessary to be rigorous about food content if people do not suffer from any disease. They argue that if after they consume a certain kind of food and they do not feel sick, then that type of food is not harmful for your health so you should continue eating it.

People suffering from any type of disease are the people who care more for a healthy way of eating in comparison to healthy people. They make sure to eat three times a day, reduce certain products and add those recommended by a doctor. However many participants share were of the opinion that people who suffer from any disease usually do not pay attention to a healthy diet.

The majority of participants declare that people in Kosovo do not eat healthily for two main reasons: they are not familiar with the healthy way of eating and they do not thing is in a priority. They think that trying to eat healthily is very complicated and requires a lot of discipline.

> *"When we buy meat, we let it dry, when it dries it loses all its calories".*
> ***(Group with female, Junik, urban)***

> *"We go and buy all kind of medicines and vitamins, instead of using organic tea like elderberry or sweetbrier tea. These are very healthy, especially for children diarrhoea"* ***(Group with female, Junik, urban).***
>
> *We eat meat and dough almost every day****."(Group with male, Skenderaj)***
>
> *"Almost all Albanians have problems with their teeth, it is an indicator that we consume unhealthy food"* ***(Group with male, Obiliq, rural)***
>
> *"If a guest comes for dinner and you serve cauliflower, they will say are you trying to feed us grass. People simply do not know the value of healthy eating."* ***(Group with male, Obiliq, rural)***

In urban areas, eating healthily is perceived as being very expensive, so it depends on the financial situation of the family. However people from rural areas do not see this as a problem, because they produce vegetables and fruits by themselves.

> *"Even if I was wealthier, I would eat the same way, because this is the way I am used to eating. I do not think it has anything to do with money, because you can find healthy food with lower prices."* ***(Group with female, Gjakove, urban).***

The RAE community imply something completely different in regards to eating healthily - for them eating healthily means having enough to eat three meals.

> *"For example, a person who earns 500 or 600 euro, he can make a list of all the food that he want and he can go and buy them.* ***(Group with male, Fushe Kosove, rural, RAE)***
>
> *Moderator: Let's say you have that money, what would your daily menu contain?*
>
> *"I would make potatoes with meat, with cabbage, every dish would contain meat, every day."****(Group with male, Fushe Kosove, rural, RAE)***
>
> "*Not everybody can afford to buy butter, milk and yoghurt, these are expensive."* ***(Group with male, Fushe Kosove, rural, RAE)***

Eating habits do not significantly differ by gender. Women usually are more cautious about the amount of food they consume, because women are considered to be more body-conscious by nature. Younger people consume more fast-food.

During discussions, participants often found it difficult to give an opinion on each food that is part of their everyday menu, i.e. what makes it unhealthy or healthy, how can you prepare it to make it healthy, what component must be removed or added, or how often should one eat.

5 Conclusions and Recommendations

5.1 Conclusions

The purpose of this study was to assess the knowledge, attitude, practice and behaviour of general population, particularly focusing on vulnerable groups (e.g. rural women, RAE communities, etc.), regarding selected NCDs and child health (child diarrhoea and acute respiratory infections). This section of the report will provide conclusions about respondents' knowledge on NCDs, as well as their knowledge about associated risk factors, early signs and preventive measures. The conclusions will also focus on smoking as a risk factor, as well as healthy eating and physical activity as preventive measures against NCDs.

In addition, since the study provided information about the population's knowledge, attitude and behaviour regarding citizens' right to health, there will also be conclusions about treatment seeking, satisfaction with services and patient rights in Kosovo. And since there was a special focus on vulnerable groups such as the RAE community and women in general, there will also be remarks about these two groups in particular.

Knowledge about NCDs

Generally, there is a high level of knowledge about NCDs, but a very low level of knowledge about risk factors, early signs and preventive measures. For instance, more than 90% of respondents know about diabetes, hypertension and diarrhoea, whereas 84% are knowledgeable about CVDs and 75% about CRDs. Nevertheless, only a small portion of the population in the 12 target municipalities know about risk factors associated with the above mentioned NCDs (15% for diabetes, 14% for CVDs, 20% for CRDs and 23% for diarrhoea). Although knowledge about early signs is generally low, it is a little higher than knowledge about risk factors (22% for diabetes, 13% for CVDs, 30% for CRDs and 22% for diarrhoea). A similar low level of knowledge is report for preventive measures for NCDs (22% for diabetes, 20% for CVDs, 29% for CRDs and 17% for diarrhoea).

Only a very small portion of respondents declared that they feel they are informed about these selected NCDs and associated problems – ranging from as low as 10% for CVDs to 22% for hypertension. However, the absolute majority of respondents that feel that they are not informed have expressed their willingness to acquire greater knowledge about NCDs and associated problems. In addition, they also feel that the best source of information is health professionals.

Smoking as a risk factor

There is a general lack of understanding about smoking as a risk factor for NCDs. It was striking to learn that 70% of smokers smoke inside their houses and that 21% of smokers that declared that they smoke inside their houses have children under 18 years old in their household. In addition, only around one fifth of smokers have said that they have tried to quit smoking in the past 12 months.

Healthy eating

The WHO emphasises the importance of fruits and vegetables consumption as part of a healthy diet and avoiding health risks. Based on the WHO recommendations, the intake of fruits and vegetables among the population of the survey group is highly insufficient. The survey revealed that people typically eat fruits and vegetables on average only 5 days in a typical week, with an average of 2 servings of fruits and 2 servings of vegetables on those days where they do they eat fruits and vegetables. The WHO recommends at least five servings per day.

Lack of physical activity

Apart from healthy eating, a significant portion of the population lacks the recommended physical activity for being healthy and avoiding health risks. Almost half of the Kosovo population in the 12 target municipalities (46%) does not meet the WHO recommendations on physical activity for health. On the other hand, those who do meet the recommended levels far exceed them.

Throughout a week, including activity for work, during transport and leisure time, WHO says that adults should do at least 150 minutes of moderate-intensity physical activity or at least 75 minutes of vigorous-intensity physical activity. In our survey men have reported that they do 630 minutes and women 427 minutes of moderate-intensity activity. However, in terms of vigorous-intensity activity, men score very high (371 minutes) and women score very low (49 minutes).

Health seeking behaviour

Although the majority of respondents believe that they should seek medical treatment if they or their family member or friend has an NCD, a worrying proportion still does not believe this to be the case. For instance, 16%, 23% and 33% of respondents does not believe it is necessary to seek medical treatment in case they or their family member or friend have diabetes, CVDs and CRDs respectively.

In terms of utilisation of public versus private healthcare services, it is obvious from the data that there is a clear preference for the public healthcare service – 77% of respondents said that they visited a public primary healthcare clinic in their last visit. In addition, they have also declared that they would normally first approach a doctor or nurse at a FMC, second choice would be the regional hospital, third choice a local private clinic, and the least preferred choice is the KCUC in Prishtina. It is also worth mentioning that visits have been more frequent in FMCs only during the last 3 years, whereas 3 years ago and earlier respondents state that they would go to private facilities more often.

Satisfaction with services and patient rights

Although majority of respondents (56%) were satisfied with the services they received in FMC's during their last visit, the satisfaction levels recorded in this KAPB survey are considerably lower than previously reported by other studies. For instance, the Baseline Assessment of Quality of Care in Kosovo conducted in June 2016 reported that 93% of patients were satisfied and another study conducted by UNDP in 2013 revealed that 75% of patients were satisfied with services of primary healthcare facilities in Kosovo.

A low knowledge about patient rights has been reported by this survey – only 44% answered they have heard about patient rights in Kosovo.

Vulnerable groups

The lower level of education and the higher level of poverty amongst the RAE community is reflected in their low knowledge about NCDs, risk factors, early signs and preventive measures, in comparison to the Albanian community. In addition, the RAE community shows far riskier behaviours especially towards smoking – tobacco use is significantly higher among the RAE community (43%) than among the Albanian community (20%).

In addition to these findings, the qualitative research also reveals that the RAE community faces discrimination by the staff in healthcare premises, but also from people in general. They are often treated unfairly and overlooked by the professional staff during visits to healthcare facilities.

Although women have been identified as a vulnerable group, the survey data reveal that women are more knowledgeable about NCDs than men, especially when it comes to risk factors, early signs and preventive measures. In addition, in one aspect women seem to have a less risky life-style in terms of most risk factors, since they reportedly smoke less than men, drink less alcohol and eat a little more fruits and vegetables than men do. Nevertheless, in terms of physical activity

women lag behind men - while 39% of men do not meet the WHO recommendation on physical activity for health, for women this percentage is considerably higher (52%). Rural women have been identified as a specific vulnerable group, however the survey data reveal that there are no significant differences between rural women and women in general.

5.2 Recommendations

Based on the key findings of the study, the derived recommendations are as follows:

1. Increase the awareness of the adult population, particularly of the RAE community, on risk factors associated with NCDs, early signs of NCDs and preventive measures they can take in order to avoid NCDs.

2. Inform the adult population on the associated problems with NCDs through healthcare professionals.

3. Increase understanding that smoking is a risk factor related to NCDs.

4. Inform the adult population about the importance of a healthy diet and physical activity for a healthy lifestyle and avoiding health risks.

5. Increase the awareness of the adult population about the importance of seeking medical treatment in cases people have NCDs.

6. Provide support to public primary healthcare centres to increase the quality of their services, increase the level of customer care and respect patient rights.

6 Appendix 1: Survey Questionnaire

Knowledge, Attitudes, Practices and Behaviour Survey in Kosovo

Non Communicable Diseases, Child Health and Citizens Right to Health

September 2016

Survey Information

Location and Date	Response	Code
Respondent Identification Number	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋	I1
Sampling Point Code	⌊__⌋⌊__⌋⌊__⌋⌊__⌋	I2
Interviewer ID	⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋	I3

Begin Sampling Procedure Here

1. After selecting a house or apartment using the random route technique,

2. Introduce yourself: "Good morning/afternoon/evening. My name is _____.
I am working for TNS Index Kosova. We are conducting a survey on knowledge, attitudes, behavior and practices on different health issues throughout Kosovo and would like to interview one person from your household. We will select this person at random; depending on whom in the household has the next birthday. Answers to the survey will be strictly confidential, according to international research standards."

3. Ask for the first name and birthday (date and month) of all members of the household who are 18 years of age and older.

4. The software program will randomly choose the designated respondent for that household. Attempt to complete the interview with the designated respondent now.

5. If the designated respondent is at home and refuses the interview or another family member blocks the interview, politely leave the house and continue to the next appropriate house or apartment on that route.

6. If the designated respondent is not at home, attempt to schedule an interview for later that day (in rural areas) or at any other time in the fieldwork period (in urban areas).

Demographic Information

Question	Response	Code
Sex (*Record Male / Female as observed)*	Male 1 Female 2	D1
How old are you? WRITE DOWN AGE	Years ⌊__⌋⌊__⌋	D2
What is the **highest level of education** you have completed? SINGLE ANSWER	No formal schooling 1 Less than primary school 2 Primary school completed 3 Secondary school completed 4 High school completed 5 College/University completed 6 Post graduate degree 7 Refused 8	D3
What is your **ethnic background**? SINGLE ANSWER	Albanian 1 Roma 2 Ashkali 3 Egyptian 4 Other, specify _____ 5 Refused 6	D4
What is your **marital status**? SINGLE ANSWER	Never married 1 Currently married 2 Separated 3 Divorced 4 Widowed 5 Cohabitating 6 Refused 7	D5
Which of the following best describes your **main work** status over the past 12 months? Have you been … SINGLE ANSWER	Working 1 Homemaker 2 Student or apprentice 3 Retired or disabled 4 Unemployed looking for work 5 Unemployed not looking for work 6 Refused 7	D6
How many people, including yourself, live in your household?	Number of people ⌊__⌋⌊__⌋	D7A
How many of them are children 5 years old and younger?	Number of children ⌊__⌋⌊__⌋	D7B
And how many of them are 60 years old and older?	Number of elderly ⌊__⌋⌊__⌋	D7C
Taking **the past year**, can you tell me what the average **monthly** earnings of the household have been?	per month ⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋⌊__⌋ Refused 99999	D8

Do you receive any income from any social assistance scheme? If yes, how much is this amount per month?	per month ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋ Refused 88888 Does not receive 99999	D9

Knowledge, Attitudes, Practices and Behavior

Tobacco Use

Now I am going to ask you some questions about tobacco use.

Question	Response	Code
Do you **currently** smoke any **tobacco** products, such as cigarettes, cigars or pipes?	Yes 1 No 2 *SKIP TO A1*	T1
How old were you when you **first started** smoking?	Age (years) Don't know 77 ⌊_⌋⌊_⌋	T2
On average, **how many** tobacco products do you smoke **each day**, including cigarettes, hand-rolled cigarettes, pipes, cigars, etc.? *Don't Know 7777*	Tobacco products ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋	T3
During the last one month, on how many days did you smoke tobacco products?	Days ⌊_⌋⌊_⌋	T4
Do you smoke inside your house?	Yes 1 No 2	T5
During the past 12 months, have you tried to quit smoking tobacco?	Yes 1 No 2	T6

Alcohol Consumption

The next questions ask about the consumption of alcohol.

Question	Response	Code
Have you **ever** consumed any alcohol such as beer, wine or spirits?	Yes 1 No 2 *SKIP TO F1*	A1
Have you consumed any alcohol within the **past 30 days**?	Yes 1 No 2 *SKIP TO F1*	A2
During the past 30 days, on how many **days** did you have at least one alcoholic drink?	Number Don't know 99 ⌊_⌋⌊_⌋	A3
During the past 30 days, on the days that you drank alcohol, how many **drinks** did you usually have per day?	Number Don't know 99 ⌊_⌋⌊_⌋	A4

Diet

The next questions ask about the fruits and vegetables that you usually eat. As you answer these questions please think of a typical week in the last year.

Question	Response	Code
In a typical week, on how many days do you **eat fruit**?	Number of days Don't Know 99 ⌊_⌋⌊_⌋	F1
How many servings of fruit do you eat on one of those days? INTERVIEWER: Please explain that one serving is equal to one medium size piece of banana, apple, etc.	Number of servings Don't Know 99 ⌊_⌋⌊_⌋	F2
In a typical week, on how many days do you **eat vegetables**?	Number of days Don't Know 99 ⌊_⌋⌊_⌋	F3
How many servings of vegetables do you eat on one of those days? INTERVIEWER: Please explain that one serving is equal to one cup of spinach/salad or half cup of tomatoes, carrots, cabbage, onions, etc.	Number of servings Don't Know 99 ⌊_⌋⌊_⌋	F4

Salt and sugar

With the next questions, we would like to learn more about salt and sugar in your diet.

How often do you **use salt or a salty sauce such as ketchup** to your food right before you eat it or as you are eating it? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F5
How often is **salt, salty seasoning or a salty sauce used** in cooking or preparing foods in your household? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F6
In a typical week, how often do you eat cakes, sweets, chocolate or biscuits? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F7
In a typical week, how often do you have soft drinks, such as Coca Cola, Fanta, energy drinks and similar? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F8
In a typical week, how often do you use sugar in your tea or coffee? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F9

In a typical week, how often do you eat each of the following:		
Commercially baked goods (cookies, pie crusts, pizza dough, breads like hamburger buns and pastries)? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F10
Packaged snack foods (crackers, popcorn, chips, candy, chocolate, biscuits)? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F11
Solid fats (margarine, vegetable shortening, butter, ghee and lard)? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F12
Fried foods? SINGLE ANSWER	Several times a day 1 Once a day 2 Several times a week 3 Less often 4 Never 5 Don't know 6	F13

Physical Activity

Next I am going to ask you about the time you spend doing different types of physical activity in a typical week. Please answer these questions even if you do not consider yourself to be a physically active person.

Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, study/training, household chores, harvesting food/crops, fishing or hunting for food, seeking employment. *[Insert other examples if needed].* In answering the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate.

Question	Response	Code
Work		
Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like *[carrying or lifting heavy loads, digging or construction work]* for at least 10 minutes continuously?	Yes 1 No 2 *SKIP TO P4*	P1
In a typical week, on how many days do you do vigorous-intensity activities as part of your work?	Number of days ⌊__⌋	P2
How many hours do you spend doing vigorous-intensity activities at work on a typical day?	Hours ⌊__⌋⌊__⌋ hrs	P3
Does your work involve moderate-intensity activity, that causes small increases in breathing or heart rate such as brisk walking *[or carrying light loads]* for at least 10 minutes continuously?	Yes 1 No 2 *SKIP TO P7*	P4
In a typical week, on how many days do you do moderate-intensity activities as part of your work?	Number of days ⌊__⌋	P5
How many hours do you spend doing moderate-intensity activities at work on a typical day?	Hours ⌊__⌋⌊__⌋ hrs	P6

Travel to and from places		
The next questions exclude the physical activities at work that you have already mentioned. Now I would like to ask you about the usual way you travel to and from places. For example to work, for shopping, to market, to place of worship.		
Do you walk or use a bicycle *(pedal cycle)* for at least 10 minutes continuously to get to and from places?	Yes 1 No 2 *SKIP TO P10*	P7
In a typical week, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places?	Number of days ⌊__⌋	P8
How many minutes do you spend walking or bicycling for travel on a typical day?	Minutes ⌊__⌋⌊__⌋⌊__⌋ min	P9
The next questions exclude the work and transport activities that you have already mentioned. Now I would like to ask you about sports, fitness and recreational activities (leisure).		
Do you do any vigorous-intensity sports, fitness or recreational *(leisure)* activities that cause large increases in breathing or heart rate like *[running or football]* for at least 10 minutes continuously?	Yes 1 No 2 *SKIP TO P13*	P10
In a typical week, on how many days do you do vigorous-intensity sports, fitness or recreational *(leisure)* activities?	Number of days ⌊__⌋	P11
How many minutes do you spend doing vigorous-intensity sports, fitness or recreational activities on a typical day?	Minutes ⌊__⌋⌊__⌋⌊__⌋ min	P12
Do you do any moderate-intensity sports, fitness or recreational *(leisure)* activities that cause a small increase in breathing or heart rate such as brisk walking*, [cycling, swimming, volleyball]* for at least 10 minutes continuously?	Yes 1 No 2 *SKIP TO P16*	P13
In a typical week, on how many days do you do moderate-intensity sports, fitness or recreational *(leisure)* activities?	Number of days ⌊__⌋	P14
How many minutes do you spend doing moderate-intensity sports, fitness or recreational *(leisure)* activities on a typical day?	Minutes ⌊__⌋⌊__⌋⌊__⌋ min	P15
The following question is about sitting or reclining at work, at home, getting to and from places, or with friends including time spent sitting at a desk, sitting with friends, traveling in car, bus, train, reading, playing cards or watching television, but do not include time spent sleeping.		
How many hours do you usually spend sitting or reclining on a typical day?	Hours ⌊__⌋⌊__⌋ hrs	P16

Lifestyle Advice

During the past three years, has a doctor or other health worker advised you to do any of the following?		
Quit using tobacco or don't start	Yes 1 No 2	L1
Reduce salt in your diet	Yes 1 No 2	L2
Eat at least five servings of fruit and/or vegetables each day	Yes 1 No 2	L3
Reduce fat in your diet	Yes 1 No 2	L4
Start or do more physical activity	Yes 1 No 2	L5
Maintain a healthy body weight or lose weight	Yes 1 No 2	L6

Diabetes		
Have you ever heard of diabetes?	Yes 1 No 2 *SKIP TO B6*	B1
Can you name some of the things that may lead to a person developing diabetes? (If respondent asks what type of diabetes does this refer to, say type 2 diabetes) OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Family history of diabetes 1 Age over 40 2 Overweight 3 Eating too much sugar 4 Overeating 5 Eating too much fat 6 Old age 7 Stress 8 Lack of exercise 9 Ethnic origin 10 Smoking 11 Alcohol 12 Other, specify _____ 13 Don't know 14	B2
What can be early symptoms of diabetes? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Passing lots of urine 1 Excess thirst 2 Tiredness/lethargy 3 Loss of appetite 4 Weight loss 5 Vision problems 6 Skin and genital infections 7 Other, specify _____ 8 Don't know 9	B3
What actions can you take to make it less likely that you will develop diabetes in the future? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	No action 1 Weight control 2 Weight loss 3 Exercise 4 Healthy diet/ eating habits 5 Limit sugar 6 Limit fatty foods 7 Health checks/ screening 8 Avoid stress 9 Other, specify _____ 10 Don't know 11	B4
When you or your family member or friend has diabetes, should they seek medical treatment?	Yes 1	B5

	No 2	
Have you ever had your blood sugar measured by a doctor or other health worker?	Yes 1 No 2 *SKIP TO B12*	B6
Have you ever been told by a doctor or other health worker that you have raised blood sugar or diabetes?	Yes 1 No 2 *SKIP TO B12*	B7
How did you discover you had diabetes? Was it… READ OUT. SINGLE ANSWER	During routine check-ups 1 After first symptoms appeared 2 Check-up for other reasons 3 After advanced complications 4 Other, specify _____ 5 Don't know 6	B8
How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be? Do you feel…	Very confident 1 Somewhat confident 2 Somewhat unconfident 3 Very unconfident 4 Don't know 5	B9
In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor?	Yes 1 No 2	B10
Are you currently taking insulin for diabetes prescribed by a doctor?	Yes 1 No 2	B11
Do you have any member of your household, other than yourself, that has diabetes or raised blood sugar?	Yes 1 No 2 *SKIP TO B16*	B12
How did this person discover they had diabetes? Was it… SINGLE ANSWER	During routine check-ups 1 After first symptoms appeared 2 Check-up for other reasons 3 After advanced complications 4 Other, specify _____ 5 Don't know 6	B13
In the past two weeks, did this member of the household take any drugs (medication) for diabetes prescribed by a doctor?	Yes 1 No 2	B14
Is this person currently taking insulin for diabetes prescribed by a doctor or other health worker?	Yes 1 No 2	B15
Do you think you have enough information about problems associated to diabetes?	Yes 1 SKIP TO C1 No 2 Maybe 3 Don't know 4	B16
Would you like to have more information about problems associated to diabetes?	Yes 1 No 2 Maybe 3	B17

	Don't know 4	

Cardiovascular diseases		
Have you ever heard of cardiovascular diseases?	Yes 1 No 2 *SKIP TO C7*	C1
Can you name any cardiovascular disease that you know of? OPEN ENDED, UP TO THREE ANSWERS	_____ 1 _____ 2 _____ 3 Don't know 4	C2
Can you name some of the things that may lead to a person developing cardiovascular diseases? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Family history of cardiovascular diseases 1 Age over 40 2 Overweight 3 Salty food 4 Overeating 5 Eating too much fat 6 Old age 7 Stress 8 Lack of exercise 9 Ethnic origin 10 Smoking 11 Alcohol 12 Other, specify _____ 13 Don't know 14	C3
What can be early symptoms of cardiovascular diseases? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Lack of breath during physical exercise 1 Chest Discomfort 2 Nausea, Indigestion, Heartburn, or Stomach Pain 3 Pain that Spreads to the Arm 4 You Feel Dizzy or Lightheaded 5 You Get Exhausted Easily 6 Throat or Jaw Pain 7 Snoring 8 Sweating 9 A cough that won't quit 10 Legs, feet and ankles are swollen 11 Irregular heart beat 12 Other, specify _____ 13 Don't know 14	C4

What actions can you take to prevent developing cardiovascular diseases in the future? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	No action 1 Weight control 2 Weight loss 3 Exercise 4 Healthy diet/ eating habits 5 No smoking 6 No alcohol 7 Limit fatty foods 8 Health checks/ screening 9 Other, specify _____ 10 Don't know 11	C5
When you or your family member or friend has cardiovascular diseases, should they seek medical treatment?	Yes 1 No 2	C6
Have you ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident)?	Yes 1 No 2	C7
How confident do you feel that you know what to do if you have symptoms of a cardiovascular disease? Do you feel…	Very confident 1 Somewhat confident 2 Somewhat unconfident 3 Very unconfident 4 Don't know 5	C8
Are you currently taking aspirin or any other medication regularly to prevent or treat heart disease?	Yes 1 No 2	C9
Do you have any member of your household, other than yourself, that has ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident)?	Yes 1 No 2	C10
Is any of the household members taking aspirin or any other medication regularly to prevent or treat heart disease?	Yes 1 No 2	C11
Do you think you have enough information about problems associated to cardiovascular diseases?	Yes 1 SKIP TO C14 No 2 Maybe 3 Don't know 4	C12
Would you like to have more information about problems associated to cardiovascular diseases?	Yes 1 No 2 Maybe 3 Don't know 4	C13

Raised Blood Pressure		
Have you ever heard of raised blood pressure or hypertension?	Yes 1 No 2 *SKIP TO C16*	C14
Can you name some of the complications of raised blood pressure or hypertension? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Heart attack or stroke 1 Aneurysm (vessels to weaken and bulge) 2 Heart failure 3 Pain that Spreads to the Arm 4 Weakened and narrowed blood vessels in your kidneys 5 Thickened, narrowed or torn blood vessels in the eyes 6 Metabolic syndrome 7 Trouble with memory or understanding 8 Other, specify _____ 9 Don't know 10	C15
Have you ever had your blood pressure measured by a doctor or other health worker?	Yes 1 No 2 *SKIP TO C25*	C16
Have you ever been told by a doctor or other health worker that you have raised blood pressure or hypertension?	Yes 1 No 2 *SKIP TO C25*	C17
What do you usually do, what actions you taken, when you feel your blood pressure has increased? OPEN ENDED, UP TO THREE ANSWERS	_____ 1 _____ 2 _____ 3 Don't know 4	C18
When do you go for your routine blood pressure check? SINGLE ANSWER	As advised by the doctor 1 When I do not feel well 2 Both 3 Other, specify _____ 4 Don't know 5	C19
Beside a primary health center, how else do you get your blood pressure measured (checked)? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Your regional hospital 1 KUCC (QKUK) 2 Neighbor/family member 3 Myself 4 Check in a nearby pharmacy 5 Other, specify _____ 6 Only in the primary health center 7	C20
Have you been told by a doctor or nurse to control your blood pressure?	Yes 1 No 2	C21

How confident do you feel that you know what to do when you have a very high blood pressure? Do you feel…	Very confident 1 Somewhat confident 2 Somewhat unconfident 3 Very unconfident 4 Don't know 5	C22
In the past two weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor?	Yes 1 No 2	C23
Have you been informed by the doctor or nurses or someone by the health center about the complications of hypertension?	Yes 1 No 2	C24
Do you think you have enough information about hypertension?	Yes 1 SKIP TO H1 No 2 Maybe 3 Don't know 4	C25
Would you like to have more information about problems associated to hypertension?	Yes 1 No 2 Maybe 3 Don't know 4	C26

Chronic respiratory diseases		
Have you ever heard of chronic respiratory diseases such as asthma, chronic obstructive pulmonary disease (COPD), lung cancer, cystic fibrosis, and similar?	Yes 1 No 2 *SKIP TO H9*	H1
Can you name some of the things that may lead to a person developing chronic respiratory diseases? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Tobacco smoke 1 Second hand tobacco smoke 2 Other indoor air pollutants 3 Outdoor air pollutants 4 Allergens 5 Occupational agents 6 Diet and nutrition 8 Respiratory infections 9 Other, specify _____ 10 Don't know 11	H2
What can be early symptoms of chronic respiratory diseases? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	A cough lasting for a month or longer 1 Shortness of breath or difficult breathing 2 Chronic mucus production 3 Wheezing, noisy breathing 4 Other, specify _____ 5 Don't know 6	H3

What actions can you take to make it less likely that you will develop chronic respiratory diseases in the future? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Quit smoking 1 Avoid lung irritants at work 2 Spend time in mountains 3 Avoid passive smoking 4 Other, specify _____ 5 Don't know 6		H4
When you or your family member or friend has chronic respiratory diseases, should they seek medical treatment?	Yes 1 No 2		H5
Have you ever suffered from any of the following chronic respiratory diseases? READ OUT. MULTIPLE RESPONSE	Asthma 1 Chronic obstructive pulmonary disease (COPD) 2 Lung cancer 3 Cystic fibrosis 4 Sleep apnea 5 Occupational lung disease 6 None 7 Don't know 8		H6
Do you have any member of your household, other than yourself, that has ever had a chronic respiratory disease?	Yes 1 No 2		H7
How confident do you feel that you know what to do when you suffer from a chronic respiratory disease? Do you feel…	Very confident 1 Somewhat confident 2 Somewhat unconfident 3 Very unconfident 4 Don't know 5		H8
Do you think you have enough information about problems associated to chronic respiratory diseases?	Yes 1 No 2 Maybe 3 Don't know 4	SKIP TO R1	H9
Would you like to have more information about problems associated to chronic respiratory diseases?	Yes 1 No 2 Maybe 3 Don't know 4		H10

Child diarrhoea

Now we are going to talk a little bit about child health issues.
INTERVIEWER: If the designated respondent does not have the complete information about child health, then ask to talk to the person who is most knowledgeable about child health in the household, this being the mother or another person who takes care of children in the household.

Do you have children under 18 in your household?	Yes	1		R1
	No	2	*SKIP TO S1*	
Have you ever heard of diarrhea?	Yes	1		R2
	No	2	*SKIP TO S1*	
Can you name some of the things that may cause a child to have diarrhea? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Infection	1		R3
	Medications	2		
	Food poisoning	3		
	Irritable bowel disease	4		
	Crohn's disease	5		
	Food allergies	6		
	Lack of clean water	7		
	Poor sanitation	8		
	Poor hygiene	9		
	Other, specify _____	10		
	Don't know	11		
Can you please tell me what are the signs of dehydration (loss of fluids)? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Dizziness and light headedness	1		R4
	Dry, sticky mouth	2		
	Dark yellow urine, or very little or no urine	3		
	Few or no tears when crying	4		
	Cool, dry skin	5		
	Lack of energy	6		
	Other, specify _____	8		
	Don't know	9		
What actions can you take to make it less likely that a child will develop diarrhea? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	Wash hands frequently	1		R5
	Lather with soap for at least 20 seconds	2		
	Use hand sanitizer when washing isn't possible	3		
	Serve food right away or refrigerate it after it has been cooked or reheated	4		
	Wash work surfaces frequently	5		
	Use the refrigerator to thaw frozen items	6		
	Watch what you eat and drink	7		
	Ask your doctor about using antibiotics	8		
	Other, specify _____	9		
	Don't know	10		

When did any of the children in the household last have diarrhea? SINGLE ANSWER	Never 1 SKIP TO R13 Last week 2 Last month 3 Last year 4 Longer ago 5 Don't know 6 SKIP TO R13	R6
How confident do you feel that you know what to do when a child has diarrhea? Do you feel…	Very confident 1 Somewhat confident 2 Somewhat unconfident 3 Very unconfident 4 Don't know 5	R7
When the child has diarrhea, do you try to treat it yourself first or do you take the child immediately to the doctor?	Try treatment at home 1 Immediately to the doctor 2	R8
Do you give liquids to the child when he or she has diarrhea?	Yes 1 No 2	R9
Do you give food to the child when he or she has diarrhea?	Yes 1 No 2	R10
Have you ever heard of Oral Rehydration Salts (ORS) Solutions?	Yes 1 No 2 SKIP TO R13	R11
Have you ever used Oral Rehydration Salts (ORS) Solutions for treating diarrhea?	Yes 1 No 2	R12
Do you think you have enough information about causes and problems associated to diarrhea?	Yes 1 SKIP TO S1 No 2 Maybe 3 Don't know 4	R13
Would you like to have more information about diarrhea?	Yes 1 No 2 Maybe 3 Don't know 4	R14

Healthcare seeking			
Who would you normally approach first in a case of any sickness, and who would you approach second and third and so on? RANK ANSWERS	Doctor or nurse at (FMC), a local public clinic Doctor or nurse at a local private clinic Your regional hospital The Prishtina Hospital Pharmacy staff Family members Friends Neighbors Traditional alternative healer Other, specify _____ Don't know	1 2 3 4 5 6 7 8 9 10 11	S1
If one of your family members is feeling unwell or is getting symptoms of a disease (for example, coughing, headache, or chest pain), after how many days normally will they seek help or medical treatment? DO NOT READ OUT. SINGLE ANSWER	Immediately/same day as the symptoms begin After a few days After a few weeks After a few months Never/wait until the symptoms disappear Don't know	1 2 3 4 5 6	S2
Have you ever been to a doctor or a healthcare facility?	Yes No Don't know	1 2 SKIP TO S14 3 SKIP TO S14	S3
When was the last time you have visited a doctor or a nurse at a FMC or public ambulanta? SINGLE ANSWER	5+ years ago 3-4 years ago 1-3 years ago 6-12 months ago 1-6 months ago Less than a month ago Don't know	1 2 3 4 5 6 7	S4
When was the last time you have visited a doctor or a nurse at a private facility? SINGLE ANSWER	5+ years ago 3-4 years ago 1-3 years ago 6-12 months ago 1-6 months ago Less than a month ago Don't know	1 2 3 4 5 6 7	S5

How many times have you visited a doctor during the past 12 months?	__ __ times Don't know 99	S6
Think about the last time you visited a primary healthcare clinic. What type of health services did you use? READ OUT OPTIONS. SINGLE ANSWER	Public 1 Private 2 Abroad 3 Other 4 Don't know 5 Not applicable/No answer 6	S7
What was the reason for your last visit? SINGLE ANSWER	Checkup 1 Illness 2 Emergency due to an accident 3 Screening 4 Prescription 5 Health certificate 6 Referral 7 Pregnancy or post-natal check-up 8 Other, specify _____ 9 Don't know 10	S8
How satisfied were you with the services you received in FMC (public ambulanta) during this visit? SINGLE ANSWER	Very dissatisfied 1 Somewhat dissatisfied 2 Somewhat satisfied 3 Very satisfied 4 Don't know 5	S9
Did you encounter any of the following problems at the clinic? READ OUT. MULTIPLE RESPONSE	Under the table payments 1 Absence of the staff 2 Impolite staff 3 Lack of attention from the staff 4 No service available in your language 5 Discriminative behavior from the staff 6 Discriminative behavior from other patients 7 Premises were unhygienic or in poor repair 8 Unhygienic equipment 9 Lack of medicines 10 Lack of other supplies 11 Other, specify _____ 12 Don't know 13	S10
Did the doctor prescribe you to take medicine?	Yes 1 No 2 SKIP TO S14	S11

	Don't know	3	SKIP TO S14	
Did you take the medicine?	Yes	1	SKIP TO S14	S12
	No	2		
	Don't know	3	SKIP TO S14	
What was the main reason for not taking the medicine? DO NOT READ OUT. MULTIPLE RESPONSE	Felt healthy/the problem got cured on its own	1		S13
	Could not afford	2		
	Pharmacy is too far away	3		
	Don't trust the doctors or other medical staff	4		
	Don't trust medicines	5		
	Use of alternative traditional services	6		
	I don't bother with my health	7		
	Other, specify _____	8		
	Don't know	9		
Have you ever received a visit from your PHC (FMC) staff at home?	Yes	1		S14
	No	2		
	Don't know	3		

Patient rights			
Have you ever heard of rights of patients in Kosovo?	Yes	1	E1
	No	2	
	Don't know	3	
Which of the following rights do you believe that you, as a patient, are entitled to in Kosovo? READ OUT. MULTIPLE RESPONSE	The right to preventive measures that could prevent diseases	1	E2
	Right of access to healthcare services	2	
	Right to information	3	
	The right to allow consent	4	
	The right to free choice	5	
	The right to privacy and confidentiality during treatment	6	
	The right to respect the patient's time	7	
	The right to access to quality services	8	
	The right to safety	9	
	Right to innovation, novelties and new technologies used in healthcare	10	
	Right to avoidance and suffering and pain	11	
	The right to personal treatment	12	
	Right of appeal	13	
	The right to file complaints through phone	14	
	The right to compensation	15	

Have you ever seen a list of patient right exposed in the primary healthcare facilities (FMC or public ambulanta) you have visited in Kosovo?	Yes	1	E3
	No	2	
	Don't know	3	
To what extent do you believe that these patients' rights are enforced in Kosovo? SHOW CARD. SINGLE ANSWER	Fully enforced	1	E4
	Somewhat enforced	2	
	Not enforced so much	3	
	Not enforced at all	4	
	Don't know	5	
Have you heard that there is a telephone number where you can call and complain about healthcare services?	Yes	1	E5
	No	2	
	Don't know	3	

Communication

Now I would like you to think about the information you receive about healthcare in general and health services in your area. How do you currently obtain information about health issues? Is it through… READ OUT. MULTIPLE ANSWER	Your doctor or nurse	1	E6
	TV	2	
	Radio	3	
	Newspaper	4	
	Internet	5	
	Family, friends, neighbors	6	
	Leaflets	7	
	Posters/Billboards	8	
	SMS	9	
	Other, specify _____	10	
	None	11	
And how would you prefer to obtain information about health issues? Would it be through… READ OUT. MULTIPLE ANSWER	Your doctor or nurse	1	E7
	TV	2	
	Radio	3	
	Newspaper	4	
	Internet	5	
	Family, friends, neighbors	6	
	Public meeting in the neighbourhood/village	7	
	Leaflets	8	
	Posters/Billboards	9	
	SMS	10	
	Other, specify _____	11	
	None	12	

Ending Section

Read Closing Statement to the Respondent:

"Thank you for participating in our survey. Do you have any questions? In the next few days my supervisor may contact you to evaluate the quality of my work and answer any other questions you may have about the interview. To help him do that, could I have your telephone number?"

Interviewer Certification: "I certify that I have completed this interview according to the instructions provided me by INDEX KOSOVA."

Name: _____
Signed: _____
Date: _____

I-4. Would you be willing to participate in another of our surveys later this year?

1. Yes
2. No

I-5. Interviewer: Code number of people present at the interview including yourself and the respondent:

— —

I-6. Municipality

1. Fushë Kosovë
2. Gjakovë
3. Gllogovc
4. Graçanicë
5. Junik
6. Lipjan
7. Malishevë
8. Mitrovicë
9. Obiliq
10. Rahovec
11. Skenderaj
12. Vushtrri

I-7. Settlement

1. Urban
2. Rural

To be Completed by the Supervisor:

I-8. Interview Subject to Back-check/Control

1. Yes
2. No

I-9. Method of Back-check/Control

1. Direct supervision during interview
2. Back-check in person by supervisor
3. Back-check by telephone by supervisor or Index Kosovo
4. Not Subject to back-check

7 Appendix 2: Discussion Guide

Discussion Guide

Knowledge, Attitudes, Practices and Behaviour Survey in Kosovo

Non Communicable Diseases, Child Health and Citizens Right to Health

Objectives

Explore reasons for specific perceptions, attitudes and practices about risk factors related to specific diseases

Identify the rationale behind perceptions and practices about the influence of tobacco, alcohol, diet and physical activity in people's health

Explore reasons for healthcare seeking behaviour in public vs. private primary healthcare facilities, as well as analyse drivers and barriers for public vs. private facilities

Identify reasons why non-users do not use healthcare services

Focus on the following diseases: diabetes, hypertension, asthma, diarrhoea

Below is a general guide for leading our focus groups. We may modify this guide as needed as each focus group will inform the subsequent groups.

Before the group begins, conduct the informed consent process, including time for participants to get food. Encourage people to get food after they fill out consent forms. After individuals are consented, give them a card with a number and instruct them to sit down.

Materials to bring: consent forms, blank papers for name placards, 2 digital recorders, snack foods and beverages, napkins, cups, extra batteries, plates, trash bag. Bring a large sheet of paper/flipchart and coloured dots.

I. INTRO (10 min)

Welcome

Hello. Welcome to our focus group. My name is _____ and this is _____ and we will be moderating today's session. Joining me today is _____, _____, _____, who will be taking notes and will be here to assist me if I need any help.

We want to hear from people who use health care services and your perception and experience with some of rather common diseases that you or other people around you might have faced. We want to record our discussion, so we can remember everything that you say. Everything that you say is confidential, and no one else will hear the tape besides the people who are working on this project. When the project is over, we will destroy the tapes. Your names will not be associated with anything that you say on the tape. Please take a minute to read these consent forms, and sign them on the back after you have read them.

Today's discussion

We would like everyone to participate. We would like the discussion to be informal, so there is no need for you to raise your hand before speaking. We encourage you to respond to each other's comments. We just ask that everyone speak one at a time and be respectful of the other participants.

I might interrupt at points during the discussion to assure that we have enough time to cover all topics. If you don't understand a question, please let us know. We are here to ask questions, listen, and make sure everyone has a chance to share.

Before you speak, please state your name.

Rules recap

Before we begin, a few quick ground rules/reminders;

- Everyone's opinion is important, we want this session to be a discussion.
- This meeting is confidential
- Please speak clearly so that we can transcribe the discussion later.
- Remember to turn off all pagers and cell phones

Begin TURN ON TWO DIGITAL RECORDERS!!!

Let's begin. Let's go around the room and introduce ourselves by just giving our first names. I'll start. My name is _____.

II. **Previous experiences at the public health care services (15-20 min):**

Start with an open-ended ice breaker type question. To get people talking.

Tell me some words that describe experiences with the health system here in (xxx). (Prepare flip chart - get them to write on flip chart, then probe)

Please think of the reasons people go to the doctor. What are the most common ones? What about you and your family members, for what reasons do you go to the doctor? (Moderator: list the reasons in a flip chart. Focus on KAPB priorities if they do not come out spontaneously)

Probe: What about asthma? Is that a reason to go to the doctor? Why is asthma an issue/not an issue for visiting a doctor? [Ask separately for diarrhoea, diabetes and hypertension].

Give some examples of your thoughts on primary healthcare facilities.

What do you like or don't like about the primary healthcare? (Prepare two flip charts, one that says PROS, another that says CONS. Write list on flip chart. Example: PROS - free, convenient & CONS - long waits, extra costs from medicine…)

Give some examples of your thoughts on private clinics.

What do you like or don't like about the private clinics*?* (Write list on flip chart. Example: PROS – no waits, good service & CONS - expensive…)

What are the key reasons due to which you mainly go to private clinics? (This maybe a very long list. Moderator should focus on KAPB priorities.)

Probe for each separately: What about for: Asthma, diarrhoea, hypertension, diabetes)

Our quantitative study showed that there is a percentage of people who never go to the doctor. What would you say are their reasons for never going to the doctor? Why do you think that happens? (Moderator: probe deeper on reasons depending on the outcomes).

III. Risk Factors (60 min)

Intro (5 min)

Now I would like to do a little exercise. I would like from each of you to hear about your typical day, from the moment you wake up until you go to bed. (Moderator: write down on a flip chart each characteristic mentioned by respondents for a. morning, b. afternoon and c. evening. Focus on food intake frequency, physical activity frequency, smoking, alcohol drinking).

Diet (15 min)

Let's move to another exercise. I want you to design a typical daily menu of 3 main meals. Please write down what you mainly eat for breakfast, for lunch and for dinner. This is a group exercise and we would like you to all participate in it. (Moderator: please let one person describe the 'daily menu' including beverages and then proceed with questions).

How tasty do you think this menu is? How healthy would you say this diet is? What would have to be modified in order to make it healthier? Which ingredients would need to be removed? What should we add? Why is that? What do they contain that it is harmful/beneficial? What else do you think we should add to our daily menu to make it healthier? What items do you consider as particularly harmful or that we should avoid?

In overall, do you think a healthy diet has a direct impact on our health? Why is that? Do you think people in your surrounding pay enough attention to healthy eating? Why is that? Do you think that varies on age and gender?

What should be done to encourage people eat more healthy food? (Probe for: Food price, accessibility/availability of healthy food: do you find these healthy foods in the nearest shop/market place? Are they easy to find?)

Physical Activity (15 min)

Let's continue with physical activity. How would you define a physical activity? What does it consist of? What does count as exercise? What doesn't? Why is that? How would you describe a physically active person? What does he do that defines him/her as such? (probe: runs/exercises/ walks at least XX times a week) Would you consider yourself as physically active? Why? What are your weekly activities that make you belong to this group?

In overall, do you think physical activity has a direct impact on our health? Why is that? Data from our quantitative survey show that people in Kosovo generally are not very physically active. What are the reasons why these people are not very physically active? (Probe for: no time, no interest, lack of habit). Do you think that varies on age and gender? How do they vary? Why is that? Is it costly?

What would you say would help these people be more active? (probe creatively: enough green parks/green gyms; access to sport facilities; what would be easier for women, for men? Etc.). What about mothers? What would help them get more active?

Smoking (15 min)

In overall how common would you say smoking is in our country? Do you think it is similar to countries in the region? What about compared to Western countries? Do you think more or less people smoke? Why is that? Do many people in your community smoke? What do you think is the main reason people smoke? Any other reason? (probe: habit, trendy, makes them feel better, etc.). Do reasons vary depending on age? How? Findings from our quantitative study reveal that percentage of smokers in Kosovo is very high, regardless of age. Why do you think this is happening?

Do you think smoking impacts smokers' health? How? What are the causes of smoking (probe for: respiratory diseases, cancer, etc.). Do you think smokers know that? If yes, why do they continue smoking? What are other reasons they smoke? Any other reason? What do you think are the best ways to help smokers reduce or quit smoking? Why is that? How likely are elderly to respond to this help? What about youth? Should the approach be different for men and different for women? How?

What are the reasons that people do not quit smoking? What is preventing them? Why is it difficult for people to quit smoking? (moderator: list the reasons)

Do you think smoking impacts the health of other people/family members? How? (probe: by smoking in front of them, smoking inside the house, inside restaurants, etc.). How does it impact the health of others? Do you think smokers are aware of what their smoking might cause to their family members? Why do you think they continue smoking inside houses/facilities? What could be done to help/prevent them from smoking inside?

Alcohol (10 min)

In overall how common do you think is alcohol consumption in Kosovo? Do you think it is similar to countries in the region? What about compared to Western countries? Do you think more or less people drink alcohol? Why is that? Any other reason? (probe: habit, trendy, makes them feel better, etc.). Do reasons vary depending on age? What about frequency? How?

Do you think there are differences in consumption between men and women? What are these differences? Why?

Do you think alcohol consumption impacts consumers' health? How? What are the causes of alcohol consumption (probe for diseases)? Do you think consumers know that? If yes, why do they continue drinking? What are other reasons they drink? Any other reason? What do you think are the best ways to help people who drink reduce or quit drinking? Why is that? How likely are elderly to respond to this help? What about youth? Should the approach be different for men and different for women? How?

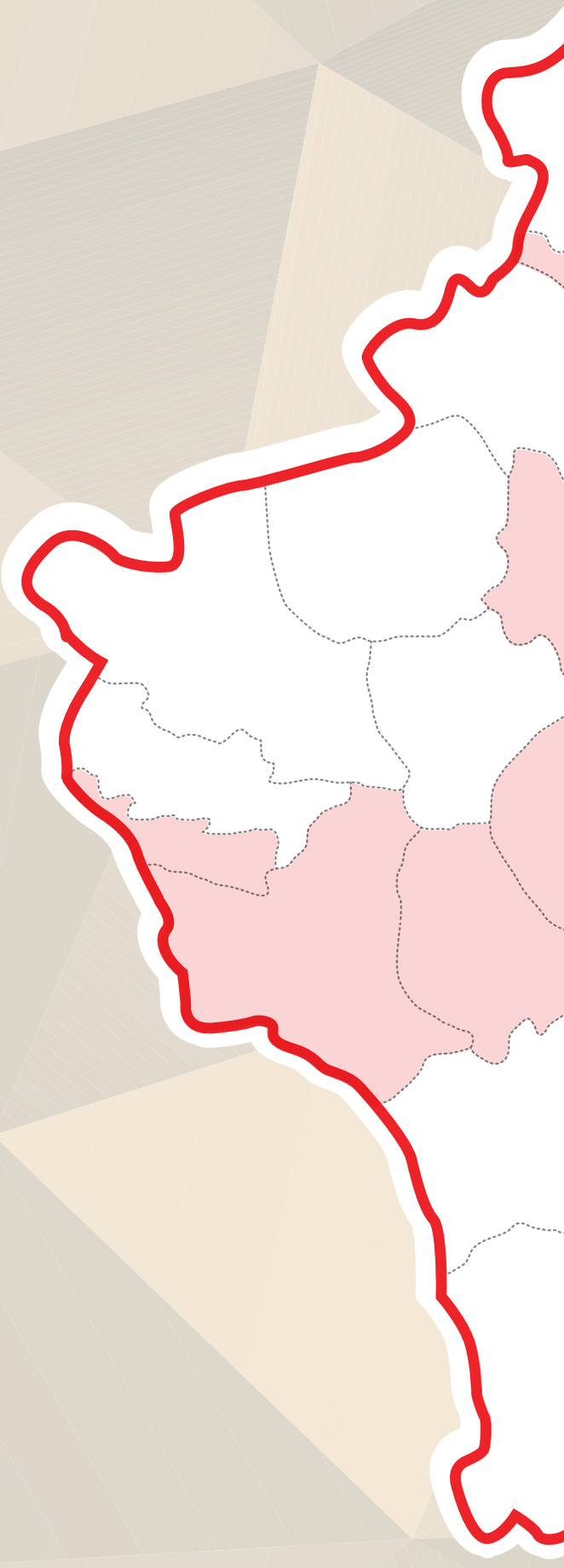
III. CLOSING (10 min)

Before we end our discussion today, does anyone have anything additional to add or does anyone think we missed something?

THANK YOU

8 Abbreviations and Acronyms

AQH	Accessible Quality Healthcare project
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
CRD	Chronic Respiratory Disease
CVD	Cardio Vascular Disease
FMC	Family Medicine Centre
GPAQ	WHO Global Physical Activity Questionnaire
KAPB	Knowledge, Attitude, Practice and Behaviour
KCUC	Kosovo Clinical University Centre
LFA	Logical Framework Approach
ORS	Oral Rehydration Salts
PIU	AQH Project Implementation Unit
RAE	Roma, Ashkali and Egyptian
SC	Save the Children
SDC	Swiss Agency for Development and Cooperation
Swiss TPH	Swiss Tropical and Public Health Institute
WHO	World Health Organisation



Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Cooperation Office Kosovo