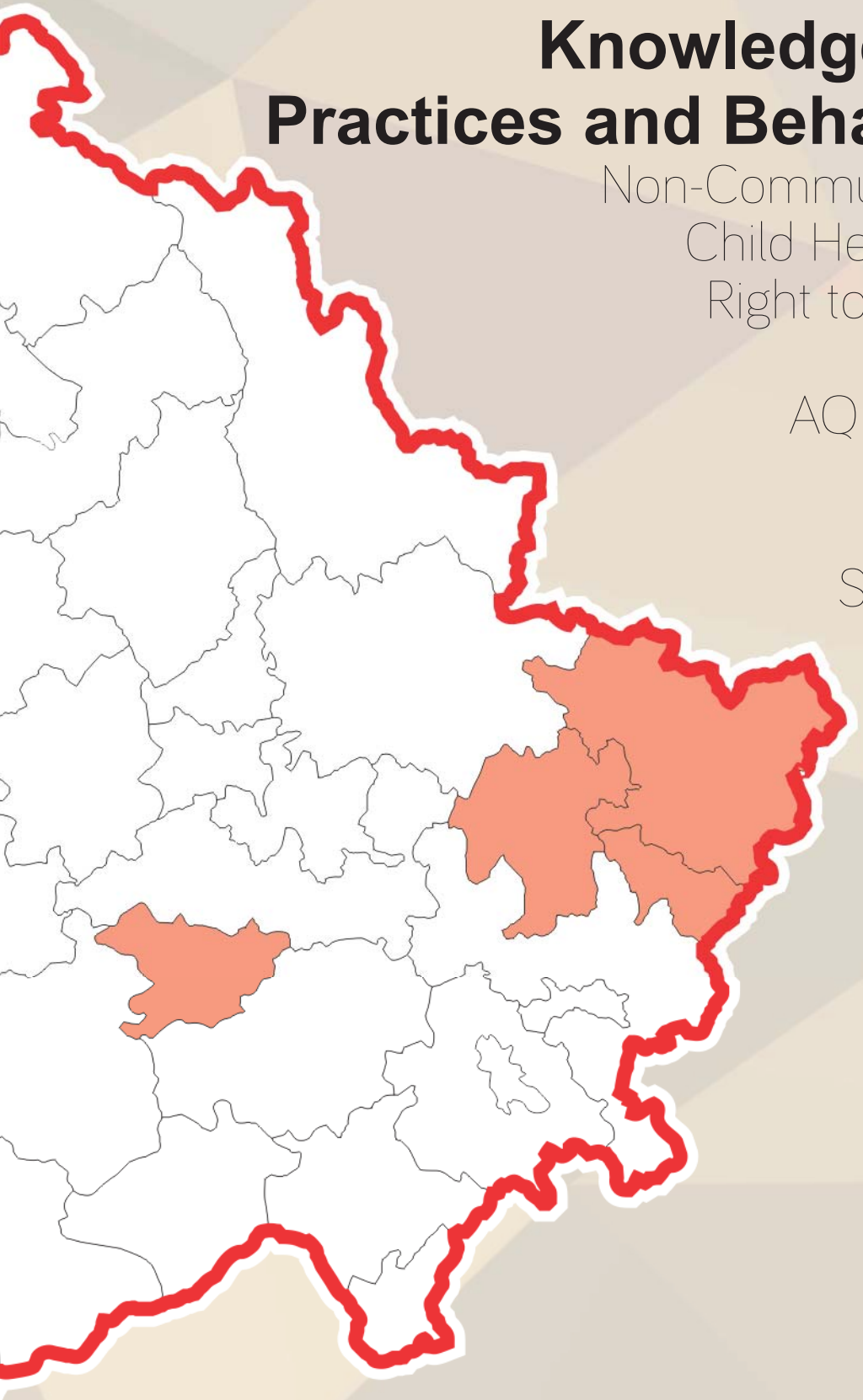
Knowledge, Attitudes, Practices and Behaviour 2020:

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

AQH II municipalities: Pejë, Istog, Deçan, Kamenicë, Klinë, Shtime, Novobërdë and Ranillugë

July 2021



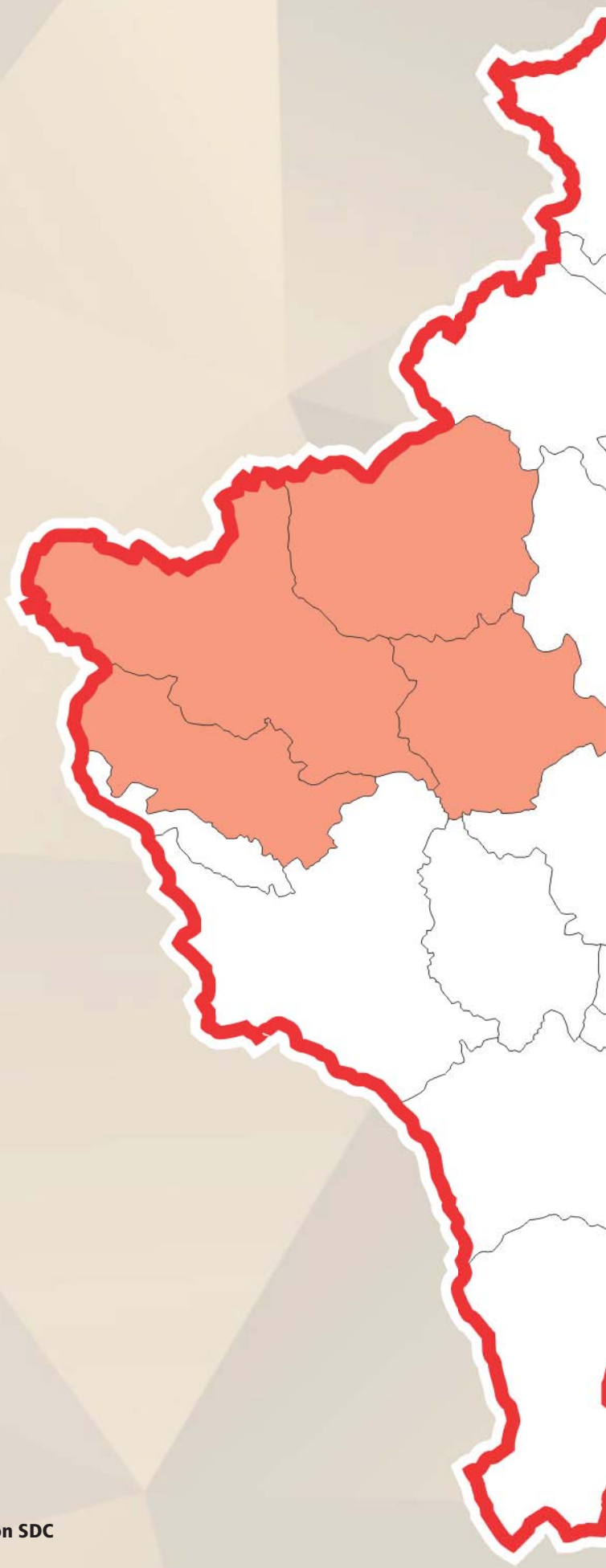
KANTAR TNS

AQH

Accessible Quality Healthcare

Kujdesi Shëndetësor i Qasshëm dhe Cilësor
Pristupačna i Kvalitetna Zdravstvena Zaštita

SDC project implemented by Swiss TPH



Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency For Development and Cooperation SDC

Knowledge, Attitudes, Practices and Behaviour 2020:

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

AQH II municipalities: Pejë, Istog, Deçan, Kamenicë, Klinë, Shtime, Novobërdë and Ranillugë

July 2021

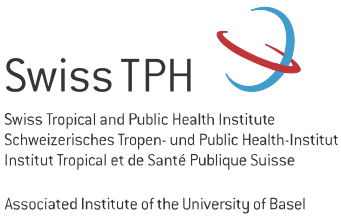
Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency For Development and Cooperation SDC

Contacts

SDC project implemented by Swiss TPH

Nicu Fota
Team Leader
Accessible Quality Healthcare (AQH) Project
Email: nicu.fota@aqhproject.org



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

Website: www.swisstph.ch

Dr. Manfred Zahorka
Senior Public Health Specialist
Head of Unit
Swiss Centre for International Health

Tel: +41 61 284 8158

manfred.zahorka@unibas.ch

Acknowledgements

We would like to express our sincere thanks to the community members who participated in our survey. We also thank Manfred Zahorka and Xuân-Mai from Swiss TPH who provided technical support.

Table of Contents

Table of Graphs

Abbreviations

AQH	Accessible Quality Healthcare project
CRD	Chronic Respiratory Disease
CVD	Cardiovascular Disease
FGD	Focus Group Discussion
FMC	Family Medicine Centre
HH	Household
KAPB	Knowledge, Attitudes, Practices and Behaviour
NCD	Non-Communicable Disease
PHC	Primary Health Care
RAE	Roma, Ashkali and Egyptian
SDC	Swiss Agency for Development and Cooperation
WHO	World Health Organisation

Executive Summary

The Accessible Quality Healthcare project, funded by the Swiss Agency for Development and Cooperation, 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 healthcare and to stimulate access and use of quality primary healthcare services by all Kosovo citizens, with particular attention to the needs and inclusion of socially vulnerable populations.
The purpose of the Knowledge, Attitude, Practice and Behaviour (KAPB) study is to collect data, regarding selected NCDs (specifically diabetes, cardiovascular disease, chronic respiratory disease and hypertension) and child health (specifically child diarrhoea). The study has a particular focus on vulnerable groups. Additionally, it provides information about the populations' knowledge, attitude and behaviour regarding patients' rights.

The objective of the KAPB Study 2020 was to provide baseline data for the 8 Municipalities included during the second phase of the AQH project, namely: Peja, Istog, Deçan, Kamenicë, Klinë, Shtime, Novobërdë and Ranillugë.

The KAPB Study 2020 has 2 parts: 1) a quantitative study comprising **800 interviews** to collect data via a questionnaire and; 2) qualitative research comprising data collection via **8 focus group discussions**.

The study findings highlight that while the overall level of knowledge about NCDs is high the the level of knowledge about risk factors, early signs and preventive measures is low. Across all studied NCDs there is a very high level of feedback (80% at a minimum) saying that respondents want to better informed, illustrating that health education is considered to be an important issue. Replicating findings form other KAPB studies, health professionals are identified as being by far the most important channel of communication in relation to all health matters, followed by television and internet.

19% of the study population currently smoke and smoking is significantly more prevalent among minority communities compared to the Albanian population. 50% of this population report that they smoke inside their houses, and whilst this figure is lower than seen in other KAPB studies, it is still a concern given that it occurs whether or not there are children present.

Alcohol consumption is stated to be highest amongst RAE and Serbian communities. Whilst the number of respondents stating that they have never consumed alcohol even once in their lifetime seems unusually high (71%), it is noted that similar findings are also presented in other KAPB reports, suggesting this finding is not necessarily an outlier.
The consumption of fruit and vegetables is low and does not meet World Health Organization (WHO) recommendations which states that consumption should be at least five servings per day. Study findings are that typically only 2 portions are consumed. Furthermore, the study highlights that almost a third of study population does not meet WHO recommendations on physical activity for health.

Lack of equipment and essential drugs, and poor infrastructure in the public health sector, are areas of concern for service users and appear to be drivers for the utilisation of private health clinics. Out-of-pocket-expenditure and the costs associated with private care are also identified as concerns. 83% of respondents state that they are either satisfied or very satisfied with their last FMC visit. This paradox is seen with other patient satisfaction surveys – where the high satisfaction scores seem to contradict participants' reports about poor quality of services – therefore these findings should therefore be treated with caution.

Only 35% of the quantitative survey population have heard of patients' rights and only 54% of the FGD participants believe that patients' rights are enforced in any way.
89% use Family Medical Centres (FMCs) as their first point of contact with health services, although this is lower amongst RAE community (79%). Even amongst those who use private facilities, 83% still go the public FMC as their first point of contact.

Patients consider that they receive better quality care in private rather than public health facilities, but cost is a major concern. However, all 2020 study findings relating to health service utilisation and patient perceptions should be viewed cautiously given the likely impact of conducting the study in the midst of the COVID-19 pandemic.

Recommendations are to*:*

1) In addition to interventions that increase knowledge, consideration should be given to interventions that promote behaviour change.
2) Continue to develop the health educator role of health professionals as a mechanism for quality improvement, focusing not only on patient education but also on facilitation of behaviour change.
3) Continue using television as a medium for health education/health promotion campaigns and explore options for development of internet campaigns as health professionals, television and internet are still the three most used channels of communication. Consider to emphasize on positive framing of campaign messages.
4) Offer education campaigns and training programmes on a recurring basis. Stand-alone activities may increase knowledge in the short-term, but repetition helps to refresh thinking and deepen knowledge. This is especially important in relation to training programmes for staff where there is frequent staff-turnover.
5) Support further activities to improve knowledge about healthy eating as feedback show that there is still somewhat limited understanding of what foods can be considered as healthy. Information should be based on WHO guidelines to avoid reinforcing any diet 'trends' that might be promoted by the television or internet.
6) Target more interventions at women given that they: usually control how families eat in the home; they do very little exercise themselves; they are able to influence the eating and exercise habits of their children; and they are often the care-givers for family members with chronic diseases that require long-term care.

1 Background

1.1 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 (RAE) communities. 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 project (AQH) is funded by the Swiss Agency for Development and Cooperation (SDC) and implemented by Swiss TPH. With its three outcomes, the project aims to strengthen the quality of healthcare and to stimulate access and use of quality Primary Health Care (PHC) 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: PHC providers deliver quality services for Non-Communicable Diseases (NCDs) to informed Citizens.
Outcome 2: Health managers ensure delivery of quality PHC services that respond to communities' needs.
Outcome 3: The population improves its health literacy and demands better access to high quality care.

1.2 Purpose and Objectives of the KAPB Study

In 2020, the AQH project conducted a 'Knowledge, Attitudes, Practices and Behaviour (KAPB) Study on Non-Communicable Diseases (NCDs), Child Health and Citizens' Right to Health in Kosovo' in the eight municipalities that were added as beneficiary municipalities at the start of the project's second phase, namely: Pejë, Istog, Deçan, Kamenicë, Klinë, Shtime, Novobërdë and Ranillugë.

The purpose of the study was to assess the knowledge, attitude, practice and behaviour of general population, particularly focusing on vulnerable groups (i.e. rural women, RAE communities, etc.), regarding selected 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.

The objective of this KAPB Study 2020 was to provide a baseline set of data for the selected eight municipalities. The process replicated the baseline KAPB Study conducted in 2016 in the 12 municipalities that were the original beneficiaries for the first phase of the AQH project during 2016 – 2019.

1.3 Study Design and Report Structure

Data collection for the KAPB Study 2020 comprised 2 stages: Stage 1) quantitative survey and; Stage 2) qualitative research. In order to collect baseline information from the target population, the quantitative survey was conducted first to determine the level of knowledge amongst the target population. Issues emerging were then explored through the qualitative research.

The report is organised in three parts:

1) **Study methodology**.

2) **Quantitative survey findings** - divided into 3 sections:
   i. risk factors, key practices and behaviours with regard to tobacco use, alcohol consumption, diet, physical activity and lifestyle factors;
   ii. specific diseases - diabetes, cardiovascular diseases, hypertension, chronic respiratory diseases and child diarrhoea;
   iii. the quality of healthcare, specifically health-seeking behaviour and attitudes, patient rights and communication.

3) **Qualitative research findings -** divided into 3 sections:
   i. participants experience of using public and private healthcare facilities;
   ii. attitudes and practices related to tobacco use and prevention, alcohol and physical activity;
   iii. eating habits and perceptions about healthy eating.

2 Methodology

2.1 Stage 1: Quantitative Survey

2.1.1 Study design

The KAPB quantitative survey was designed to assess the knowledge, attitude, practice and behaviour of general population regarding selected NCDs and child health, as well as citizens' right to health. The quantitative survey comprised a questionnaire completed via face-to-face interviews, using the Tablet Aided Personal Interview (TAPI) method.[1] The questionnaire is attached at Annex 1. Each interview was conducted in the respondents' home.

2.1.2 Study area & target population

The KAPB quantitative survey was conducted in the 8 project municipalities, targeting residents age 18+ years 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 the child's health, then the interviewer collected this information from the person in the household who was the most knowledgeable.

2.1.3 Sample size and survey method

The survey is representative of the adult (18+) population specified in the sampling frame (see Annex 2). 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 Roma, Ashkali and Egyptian (RAE) communities. Considering that 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 RAE population (2.8%) and Serbian population (3%)[2] in the 8 municipalities, oversampling was required to allow better representation of this portion of the population in the total sample. To facilitate effective field management, the sample was divided into two main sub-samples:

1. **Albanian sub-sample: 400 interviews**
2. **RAE sub-sample: 200 interviews**
3. **Serbian sub-sample: 200 interviews**

In total, 800 interviews were conducted.

The representation of other vulnerable groups was ensured by employing multi-staged random probability sampling. Considering that the sample distribution was conducted by taking into account the population data, the rural population is represented in the sample

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

2 Statistical Agency of Kosova

with 65% 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 50% males and 50% 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.

2.1.4 Questionnaire development

This study used the same questionnaire as the KAPB Study 2016 to allow for comparison of the findings against specific indicators, and therefore pre-testing was not required.

2.1.5 Interviewer training and quality control measures

All interviewers were recruited through an application process. Training was conducted online due to coronavirus precautions. Around 16% of completed interviews were back-checked by the supervisors and the management team during the data collection process, and all completed surveys were subject to quality control. Training agenda and quality control measures are presented at Annex 3.

2.1.6 Data processing and analysis

Data processing and analysis is detailed in Annex 4. The data[3] were 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)

2.2 Stage 2: Qualitative Research

2.2.1 Study design

The main purpose of the qualitative research was to provide information related to current knowledge, attitudes, practice and behaviour patterns related to health and healthcare.
In total, 8 Focus Group Discussions (FGDs) were conducted.

2.2.2 Study area & target population

The KAPB qualitative research was conducted in the 8 project municipalities, targeting residents age 18+ years of age in both urban and rural areas. Focus group participants were selected using the following criteria:

3 The data is the property of the AQH project At the completion of the study, the final data set will be handed over to the AQH project.

1. Age: Each participant in the study was adult, 18 years old or older;
2. Gender: 4 FGDs comprised men and 4 comprised women;
3. Minorities: 1 of the 8 FGDs groups comprised participants from the RAE community; and 1 comprised participants from the Serbian community;
4. History of disease: At least 2 participants in each group were with chronic disease or caregivers of a family member with the chronic disease;
5. Parents: At least 2 participants in the group were parents of children younger than 5 years old.

2.2.3 FGD sample and selection method

The study used the same sampling method used for the original KAPB study in 2016 (see Annex 5). 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 FGDs was random, within the criteria of the target population. The selection ensured participation of different age groups and social statuses in every group discussion. Due to Covid 19 restrictions the FGDs were conducted through Zoom platform.

Out of the total 8 group discussions, 6 (4 with women and 2 with men) of them were conducted with the Albanian community, 1 with RAE community (men) and 1 with Serb community (men). Five of the FGDs were in urban areas and 3 in rural areas.

2.2.4 FGD discussion guide

To enable comparability with the 2016 qualitative research no changes were made to the discussion guide for 2020. The discussion guide is presented at Annex 6.

2.2.5 Quality control

Quality measures in the qualitative research included the selection of participants that were recruited for the group discussions, i.e. making sure that they were selected based on the sample design representing a variety of different age groups and social groups, ensuring that all the relevant topics were covered in the research instrument. Two researchers worked data analysis, to ensure that all aspects and perspectives of the collected data were considered in the process.

Two moderators were enrolled, one for focus groups in Albanian language and the other for a group in Serbian language. Both moderators took part in each focus group, one serving as note taker and the other moderating the discussion. Further details of the discussion were drawn from video recordings of the focus groups. The moderators provide detailed notes for each research topic and question, including specific and important quotes for further analysis. Moderators analysed both notes and recordings to produce key findings from each group discussion.

2.3 Ethical considerations

The AQH Project obtained ethical approval for the study from the Kosovo Doctors' Chamber, as well as approval from the Ethics Committee North-West Switzerland (EKNZ), before the study was launched.

Participants signed a consent form prior to taking part in the survey informing them that a) their participation was voluntary, b) they could withdraw from participation at any time, c) non-participation would not have any negative effects. Participants were informed how

data would be used and that confidentiality was ensured as no names or identifying personal information would be linked to their answers.

2.4 Study limitations

The key challenge for the survey was the overall situation created by Covid-19 pandemic. It was dificult to focus the attention of participants on other topics besides the pandemic and many were concerned about having an unknown person visiting their home. It was not possible to conduct interviews outside given the below-zero temperatures, and maintaining social distance indoors often proved challenging, raising levels of anxiety amongst both the participants and the study teams. In 42 cases, households refused to accommodate the team because the whole households were Covid positive. These issues increased the non-response rate. A total of 1,554 contacts were made in order to reach a sample of 820 effective respondents. The number of non-contacts was 409 and the total number of refusals was 350.

Data collection was particularly challenging among the rural and RAE populations where education levels are generally lower, making it more dificult for them to understand and give relevant answers to specific questions.

FGDs were conducted online which in itself proved challenging because many of the households were living in poor conditions, whilst others lacked the equipment (smart phone, tablet or computer and internet) or were not skilled in using the equipment. Elderly people in particular needed assistance from younger household members or the data collection team to enable them to take part in the discussions. Internet connection was poor in several remote locations due to the limited network availability. In these cases, alternate households had to be selected.

2.5 Key Personnel and Field Teams

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 and analysis.
Vlora Basha	Postgraduate degree in in Educational and Social Research	Senior Researcher	Takes part in methodology, sample design and design of instruments analysis and report writting
Shemsi Krasniqi	PhD in Social Anthropology	Senior Researcher	Takes part in methodology, sample design.
Granita Limani	Master of Science in Cultural Heritage and Tourism Management	Research Manager/ Moderator	Takes part in focus group moderation and analysis

Table 4: Table of Key Staff

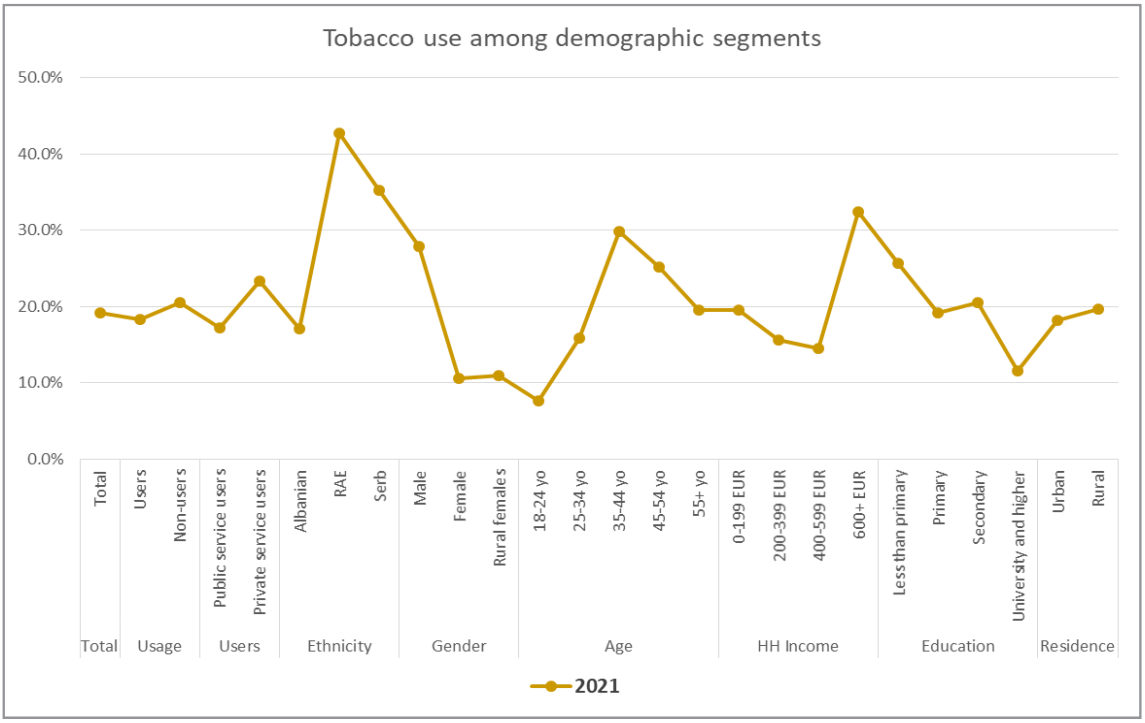
Field team:

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

3 Results – Quantitative Survey

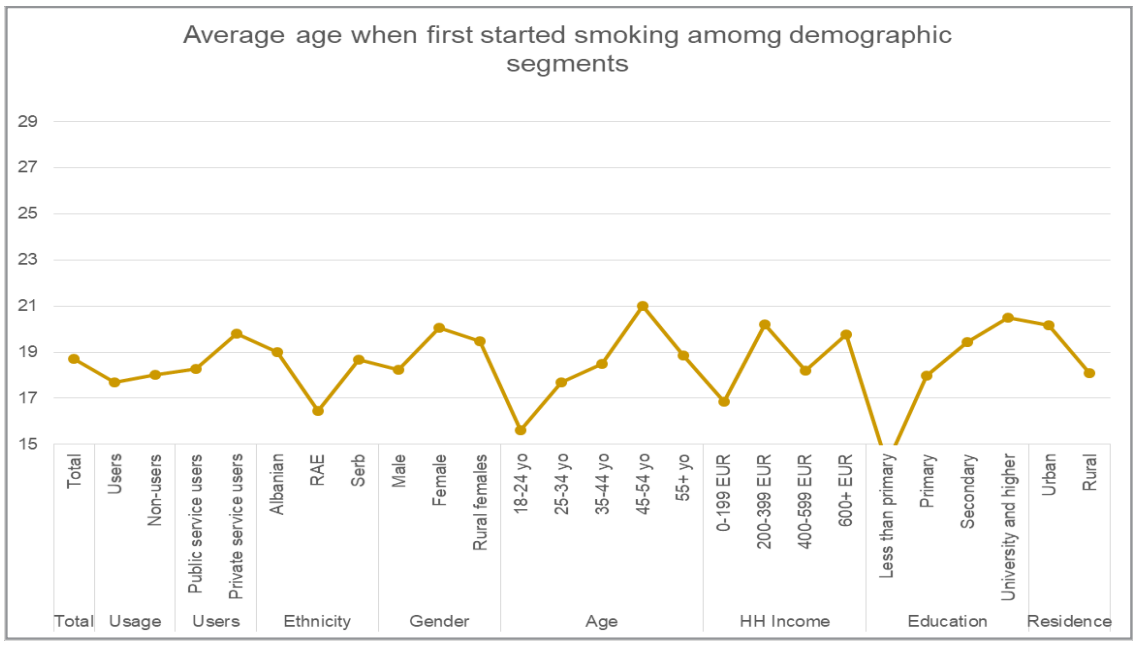
3.1 Section 1: Non-Communicable Diseases

3.1.1 Tobacco Use



Graph 1: Tobacco use among demographic segments

- 19% of the population currently smoke tobacco products such as cigarettes, cigars or pipes.
- Smoking is significantly more prevalent among minority communities compared to the Albanian population (RAE 43%; Serb 35%; Alb17%).
- It is most common among the age groups of 35-44 (30%) and 45-54 (25%).
- It is least common among the youngest age group (18-24 8%).
- There is an indication that the highest income demographic group (Household (HH) income 601+ 32%) smokes more compared to respondents coming from household with less income (HH income 0-199 20%; HH income 200-399 16%; HH income 400-599 15%)
- There is little difference in the number of smokers in urban and rural settlements (urban 18%; rural 20%).
- The largest share of smokers are from the 'less than primary school completed' group (26%), while the smallest percentage is observed among those with higher level of education. Nevertheless, the Pearson Chi-square correlation analysis, does not indicate any correlation between smoking and education variable (*p>0.067).*



Graph 2: Age when first started smoking

- RAE community started smoking significantly earlier, at the age of 16 years, compared to Serbian and Albanian populations who first started smoking, on average, when they were 19 years old.
- Smokers from the Serbian community smoke significantly more tobacco products a day (20) compared to RAE (12) and Albanian community (13).
- The population in the lowest income group (HH 0-199 Euro) started smoking whilst very young, on average at the age of 10 years, compared to smokers in HH with higher monthly incomes.

Tobacco consumption

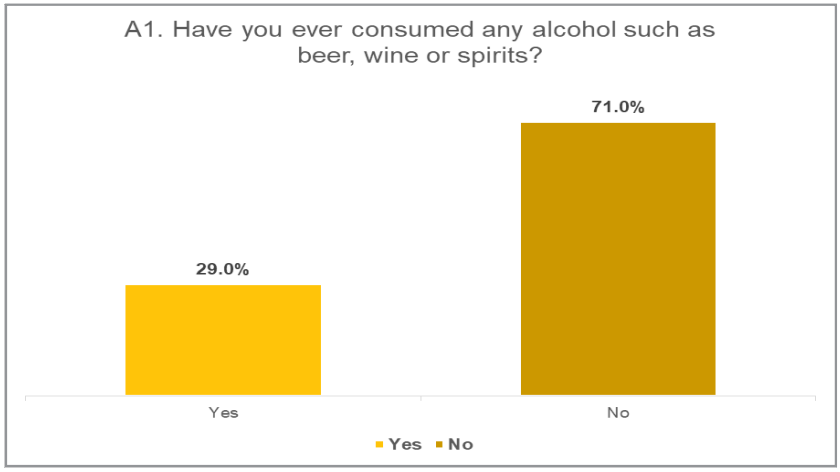
- The average number of tobacco products used per day is 13, but it varies widely across demographic segments.
- Urban population smoke more (19 tobacco products a day) compared to the rural ones (11 tobacco products a day).
- There is no significant difference between male and females regarding the number of tobacco products used per day (male 13; female 14).
- Serbian communities smoke on average 20 tobacco products per day while Albanian communities average 13 products, and RAE communities average 12 products.
- The total population smoked tobacco products on average on 29 days during the previous month.
- 24% of smokers have tried to quit smoking in the past 12 months. This was higher among rural smokers (25%) compared to those living in urban areas (19%) and significantly more female (38%) than male (18%).

Indoor smoking

This was identified as a major area of concern in previous KAPB studies. The findings of this study are:

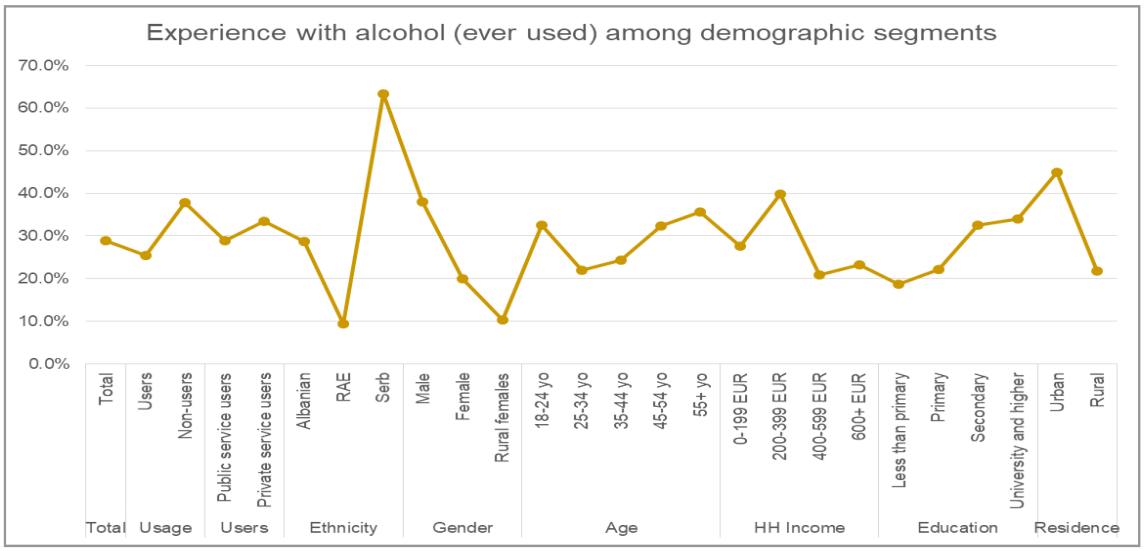
- 50% of the total population smoke inside their houses.
- In the urban areas 76% smoke inside their house compared to 39% in rural areas.
- 90% of the Serbian community smoke inside their houses, 55% in RAE communities and 45% in Albanian communities.
- Indoor smoking is more common amongst female smokers (53%) compared to males (48%).

3.1.2 Alcohol Consumption



Graph 3: Alcohol consumption

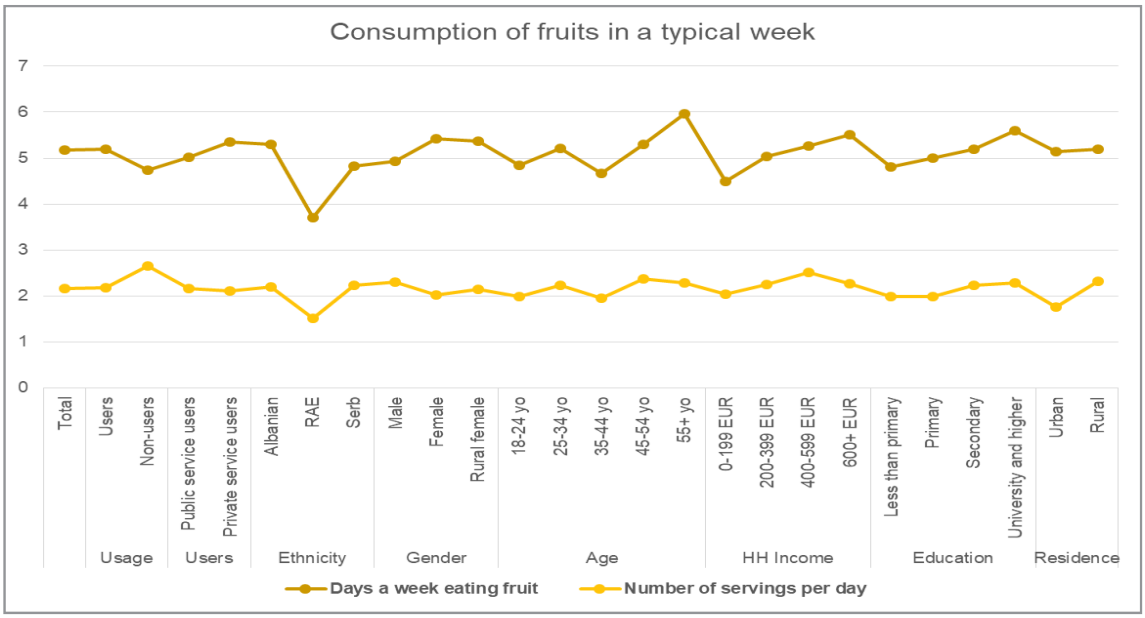
- 29% of the population had tried alcohol such as beer, wine or spirit, at least once. Of these, 42% had consumed alcohol at least once in the previous 30 days.
- On average, alcohol was consumed on 9 out of the last 30 days.



Graph 4: Alcohol consumption among demographic segments

3.1.3 Diet

Fruit consumption

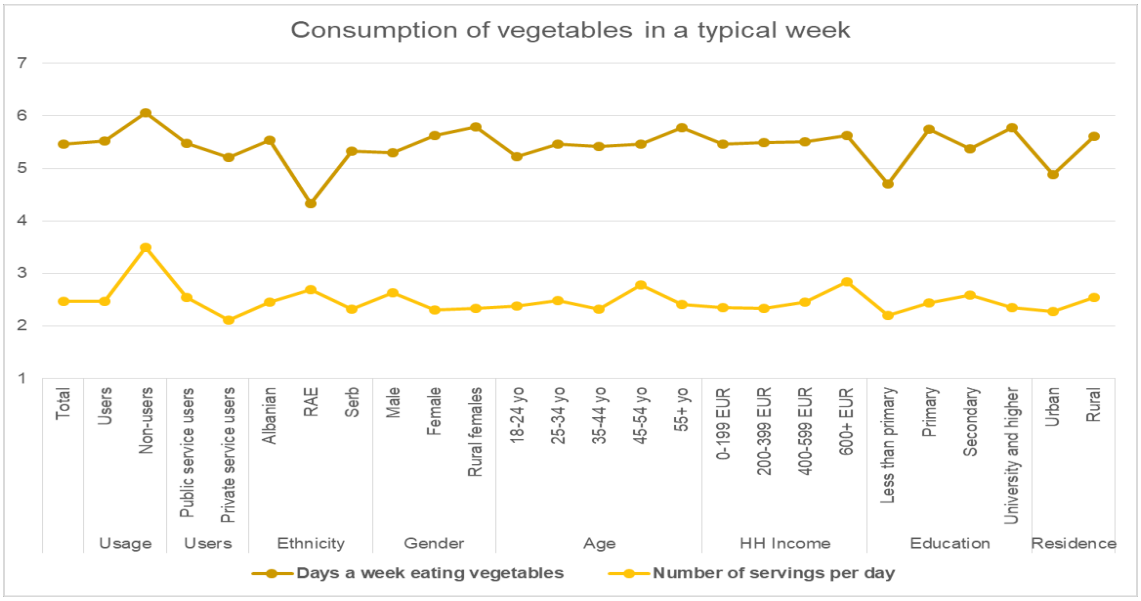


Graph 5: Consumption of fruits in a typical week

- Fruits are typically consumed on 5 days per week.
- In almost absolutely all demographic segments, 2 servings of fruits are served per day.

Vegetable consumption

- Almost all demographic segments do not meet the WHO dietary recommendations for fruit and vegetable intake[4].



Graph 6: Consumption of vegetables in a typical week

4 http://www.fao.org/english/newsroom/focus/2003/fruitveg2.htm

- On average vegetables are consumed on 5 days per week.
- Vegetables are consumed on average 6 days per week by: women; rural population; population living with more than 6 household members; and the population with primary and higher education completed.
- The average number of vegetable servings per day is 2.

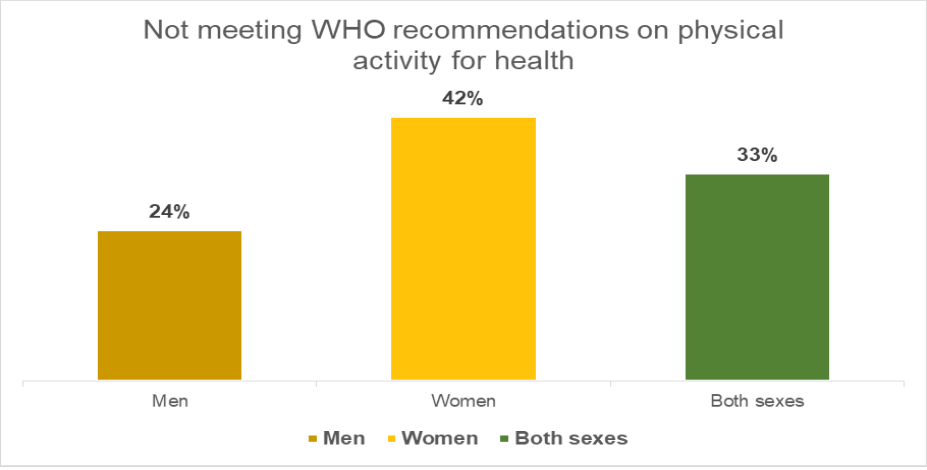
Salt and sugar consumption

- 80% of the total population consume sugar in coffee and tea, 60% do so several times per day.
- Cakes, sweets, chocolates and biscuits are consumed daily by 20% of the population and 49% consume these products several times a week.
- 27% consume soft drinks that are high in sugar on a daily basis.
- Daily sugar intake is slightly higher among urban population (urban 87%, rural 79%), but rural populations consume more sugary soft drinks on a daily basis (urban 16%, rural 33%).
- 42% of the total population put salt or salty sauces such as ketchup on food right before they eat (86% in Serbian communities, 41% in Albanian communities and 34% in RAE communities.)
- 45% consume commercially baked goods such cookies, pie crust, pizza dough, breads etc. several times a week. 8% consume these products on daily basis.

Use of salts, sugars and fats (see Annex 7)

- Consumption of packaged snack foods is more common among populations living in rural areas (18%) compared to those living in urban ones (8%).
- 19% of the population eat some form of solid fat every day.

3.1.4 Physical Activity



Graph 7: Percentage not meeting WHO recommendations on physical activity

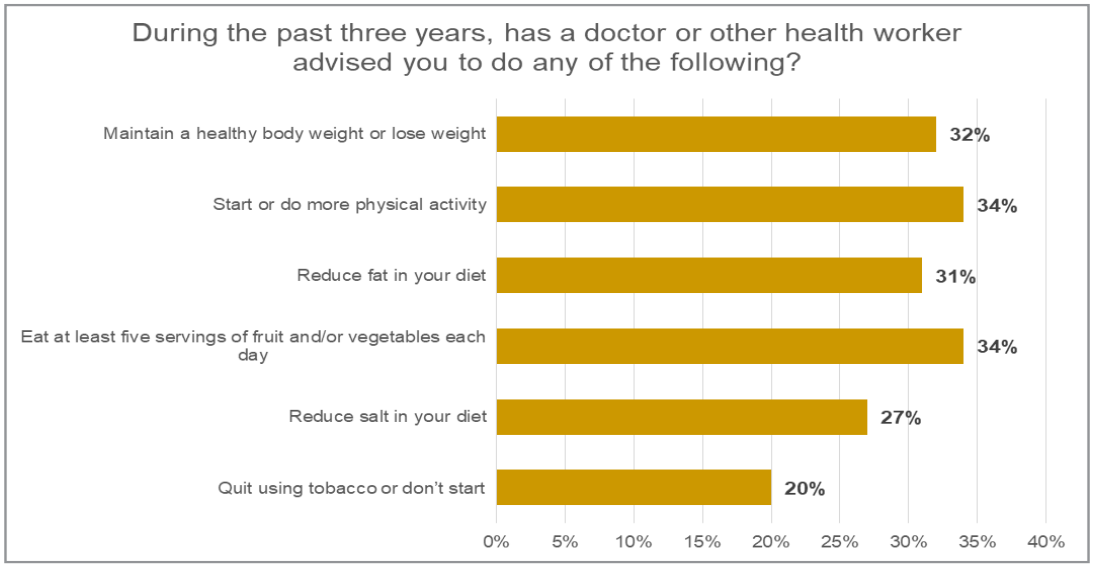
- Recommended time for vigorous physical activity is 75 minutes per week. Study findings are that the total population undertakes vigorous activity for an average of 210 minutes per week, although almost all of this is work-related, with limited activity for recreation purposes. Nevertheless, a third of this population (33%), did not meet WHO recommendations on physical activity for health.

- The least active group in undertaking vigorous activities are women of the age group 20-34 (20%), followed by those 55+ years old (18%). Among men, the most active are 55 yrs+ (16%).

Mean minutes of physical activity on average per day	Total vigorous	Men	Women	Total moderate	Men	Women
Work related	25	46	4	77	78	76
Transport related	-	-	-	23	30	15
Recreation related	5	10	1	5	6	4
TOTAL PER DAY	**30**	**56**	**5**	**104**	**114**	**95**
TOTAL PER WEEK	**210**	**392**	**35**	**728**	**798**	**665**

Table 1: Average time spent on physical activity

3.1.5 Lifestyle Advice



Graph 8: Percentage respondents advised about lifestyle by health workers

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

This section of the report focuses on the knowledge, attitudes and behaviours of the targeted population related to each of the following NCDs: diabetes, cardiovascular diseases, hypertension, chronic respiratory diseases and diarrhoea.

For analysis purposes, and in order to be able to show results in a consistent and comparable manner, some variables in this section have been combined together. In cases where these is only one indicator measuring a specific objective, such as knowledge on a specific NCD, the result reflects a single data variable (positive answer in percent of one question). In cases when a number of indicators had to be combined to understand a single objective, such as for example risk factors, the score is drawn from the average scores of all the indicators consisting and reported in percentage.

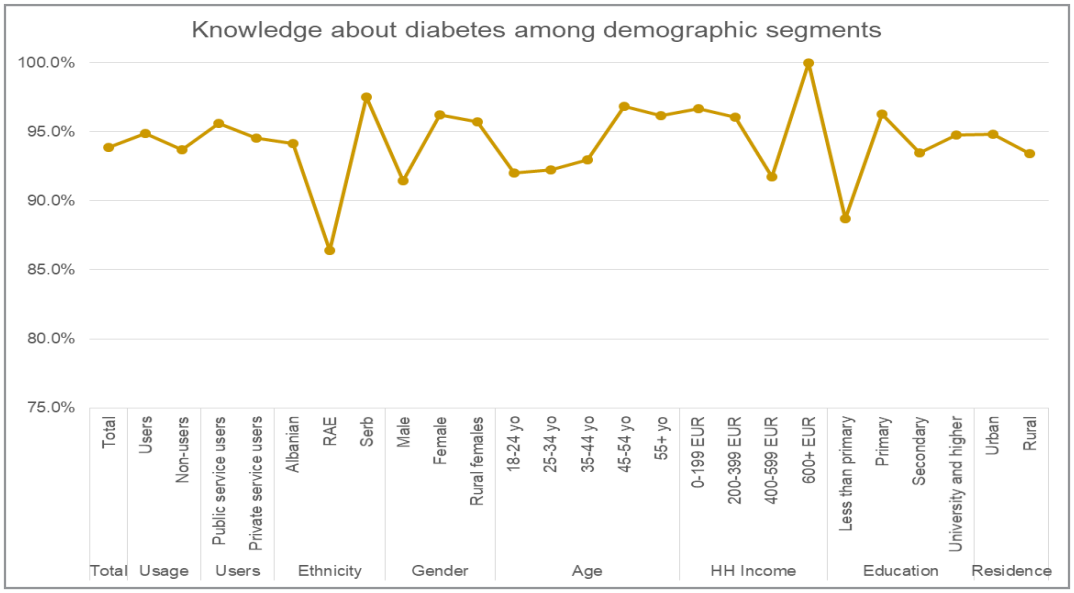
3.2.1 Diabetes

Data related to diabetes scores are presented at Annex 8.

Knowledge

Knowledge: Diabetes	
Topic	**Result**
Have heard of diabetes	**94%**
Overall knowledge of risk factors	**17%**
Knowledge of early signs	**16%**
Understanding of preventive measures	**20%**

- Awareness of diabetes is slightly lower among RAE community (86%) compared to the rest of the ethnicities included in the study (Albanian 94%; Serbian 98%), especially among the population with no formal education completed (89%).
- 92% of the population believes that if one has diabetes, then they should seek treatment. Therefore 8% does not consider that diabetes requires medical attention



Graph 9: Knowledge of diabetes

- RAE communities and women are the least informed about diabetes risk factors.
- Only 16% know any early signs. Excess thirst is a known sign of diabetes for 42%, 30% consider tiredness/lethargy, and problem with vision is considered an early sign for 13%.
- The overall knowledge about the preventive measures of diabetes is limited (overall score 20%).

- 35% consider screening to be a preventative measure.
- Knowledge about healthy diet and eating habits is highest among the Serbian

Attitudes

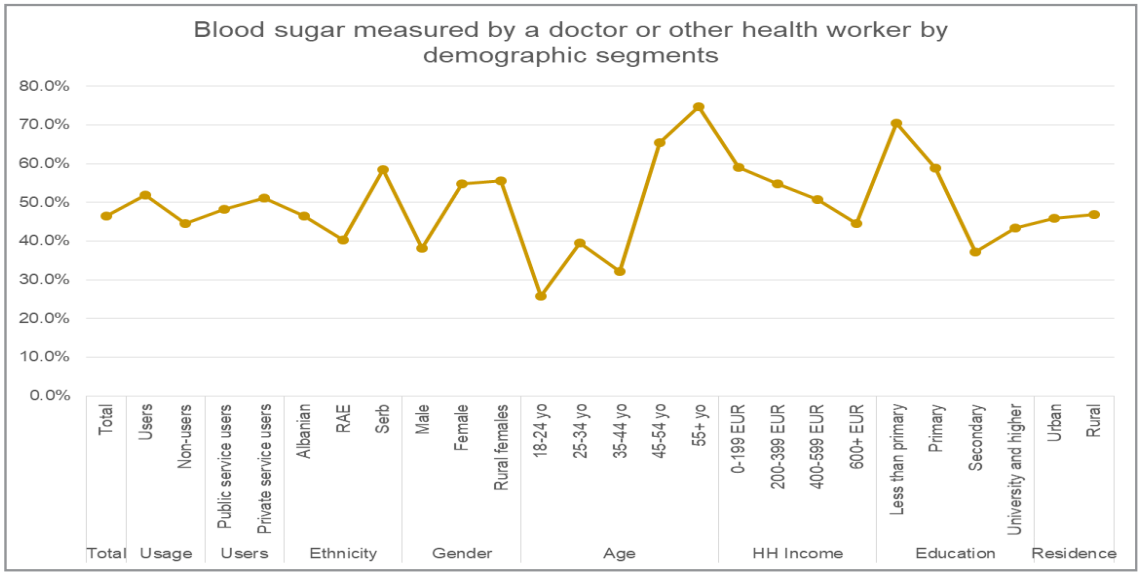
Attitudes: Diabetes

Topic	Result
Would seek treatment if they thought they had the disease	86%
Patients are confident about when to seek care	62%
Patients feel informed about their disease	22%
Patients want to be better informed about the disease	81%

Practices and behaviours

Practices & Behaviours: Diabetes

Topic	Result
Have blood tested by health professional	47%
Taken oral diabetes medication prescribed by doctor in last 2 weeks	66%
Taken insulin prescribed by doctor in last 2 weeks	11%
Household member takes oral diabetes medication	91%
Household member takes insulin	29%



Graph 10: Blood sugar measurement practices

- 47% had been tested for diabetes at some point in their life.
- Of those who had been tested, 59% were Serbian, 46% Albanian and 40% RAE.
- 17% of the population were given a positive result when they were tested, of which 25% were RAE, compared to 17% Albanian and 14% Serbian.
- 37% of those diagnosed with diabetes were diagnosed during their routine check-ups, with 24% diagnosed only after they first experiences symptoms.
- 66% were currently taking medication for diabetes and 11% were taking insulin.
- 78% were confident that know what to do when their blood sugar level goes higher or lower.
- 15% of respondents that know about diabetes said that someone else in their household was diabetic diagnosed through their routine check-ups (42%) and after first symptoms appeared (33%).
- Most family members were currently taking medication for diabetes (91%), and 29% were taking insulin.

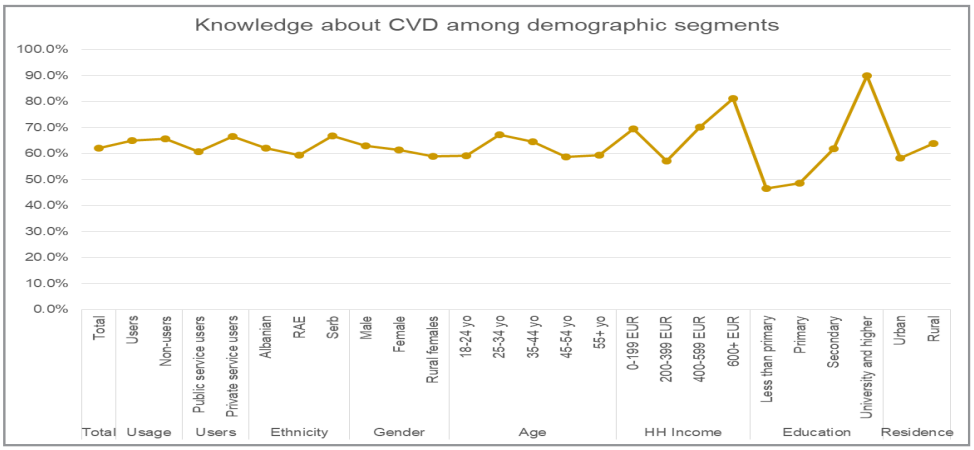
3.2.2 Cardiovascular Diseases

Data related to cardiovascular diseases are attached at Annex 9.

Knowledge

Knowledge: Cardiovascular Diseases

Topic	Result
Have heard of CVDs	62%
Overall knowledge of risk factors	11%
Knowledge of early signs	8%
Understanding of preventive measures	14%



Graph 11: Level of knowledge about CVDs

- The population from households with higher income (600+ Euro) is much more aware (81%) of the cardiovascular disease compared to the rest of the population.
- There is a correlation of knowledge about CVD and level of education – higher percentage of the population with higher degree completed (90%) knows about the disease compared to those in the 'primary school completed' (49%) or the 'no formal education' (47%) groups.
- 27% of the total population consider that the leading cause of CVD is stress. Eating too much fat is ranked second (21%) and both family history and old age are ranked as joint third (13% each).
- In groups where alcohol consumption or smoking is high, there is a very low level of knowledge that these are risk factors for NCDs, although there is a general awareness that these are unhealthy behaviours.
- Women are the least aware of risk factors of CVDs.
- Knowledge that weight loss (5%) and limiting fatty foods (9%) are preventive measures is limited.

Attitudes

Attitudes: Cardiovascular Diseases

Topic	Result
Would seek treatment if they thought they had the disease	94%
Patients are confident about when to seek care	32%
Patients feel informed about the disease	15%
Patients want to be better informed about the disease	80%

- With respect to attitudes about seeking medical treatment - if the respondent or family member or friend has CVD- absolute majority of those who have heard about CVDs (94%) believes that they should seek treatment. The rest of the sample (6%) does not believe it is necessary to seek medical treatment in case they have CVDs.
- Scores for confidence in seeking care and feeling informed about CVDs are both very low.

Practices and behaviours

Practices & Behaviours: CVDs

Topic	Result
Patient takes CVD medication	15%
Household member takes CVD medication	21%

- An average of 6% of the total population had had either a heart attack, or chest pain from heart disease (angina), or a stroke at some point in their life - higher amongst the RAE community (12.6%) than among the Albanian community (4.3%), and higher in urban areas (7.1%) than rural areas (3.3%).
- 15% of respondents were currently taking aspirin or other medication regularly to prevent or treat heart disease.
- 8 % of the total population reported that they have at least one family member who had heart attack, chest pain or stroke at least once in their life.
- 21% of family members were regularly taking aspirin or other medication to prevent or treat heart disease.

3.2.3 Hypertension

Knowledge

Knowledge: Hypertension

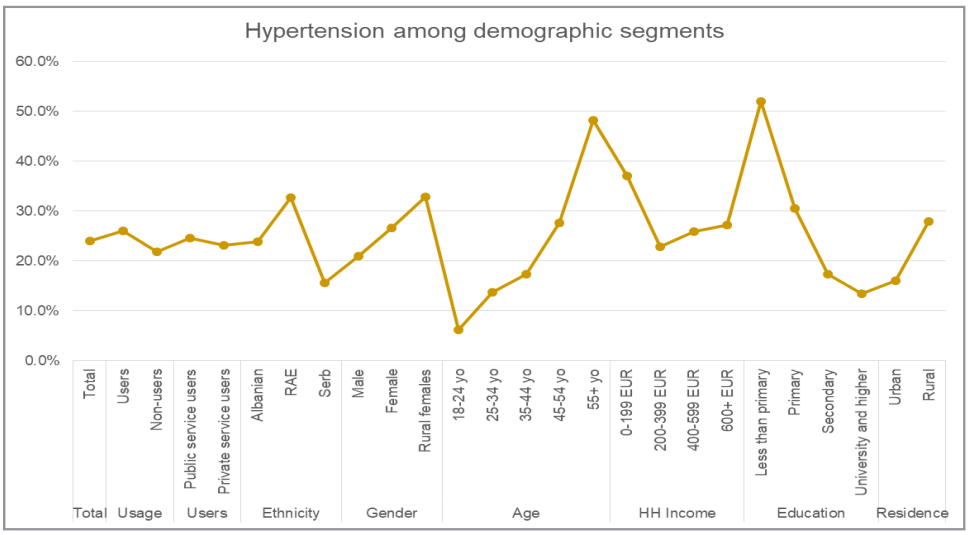
Topic	Result
Have heard of Hypertension	92%
Knowledge of complications	13%

- Although the awareness level for hypertension is high, knowledge of the complications is extremely low. 32% state they have no knowledge about complications whatsoever
- Heart attack or stroke (43%) and heart failure (35%) are the most commonly mentioned complications of hypertension.

Attitudes

Attitudes: Hypertension

Topic	Result
Patients are confident about when to seek care	54%
Patients feel informed about the disease	28%
Patients want to be better informed about the disease	89%



Graph 12: Percentage of respondents told they have hypertension

- Hypertension is slightly more prevalent among RAE community (33%), among the rural population (28%) compared to urban one (16%) and among female (27%) compared to male (21%) without any significant difference between users of different healthcare facilities.

Practices and behaviours

Practices & Behaviours: Hypertension

Topic	Result
Have blood pressure measured by health professional	81%
Told to monitor blood pressure by health professional	84%
Informed of complications by health professional	56%

- 81% had their blood pressure measured by a doctor or other health worker at some point in their life, lowest amongst RAE community.
- More women had their blood pressure measured in this way compared to men (m 74% / f 87%).
- 24% of the population who were tested were told that they have hypertension.
- 61% take medication when they feel their blood pressure has increased.
- 24% use home remedies such as yoghurt, lemon, coffee, garlic, etc. in this situation, 19% visit the doctor and 4% measure their own blood pressure.
- 62% check their blood pressure only when they feel they blood pressure is not stable (regardless if they were advised to check the pressure routinely).
- 9% measure their blood pressure themselves, 6% do so with the help of neighbour or family member and 6% go to their regional hospital.

- 84% of patients with hypertension were advised by a doctor or nurse to control their blood pressure while more than half of them
- Of these, 56% were informed by the doctor or nurses or someone at the health centre about the complications of hypertension.
- 66% of patients diagnosed with hypertension have taken medication prescribed by the doctor in the past 2 weeks.

%	Total	Albanian	RAE	Serb	Male	Female
	2021					
N						
Indicator 2.3 (of people consulting doctor if they feel that their blood pressure is up)	19.2	18.3	33.7	15.9	20.7	18.3

Table 2: AQH indicator - Percentage of people consulting doctor if they feel that their blood pressure is high

3.2.4 Chronic Respiratory Diseases

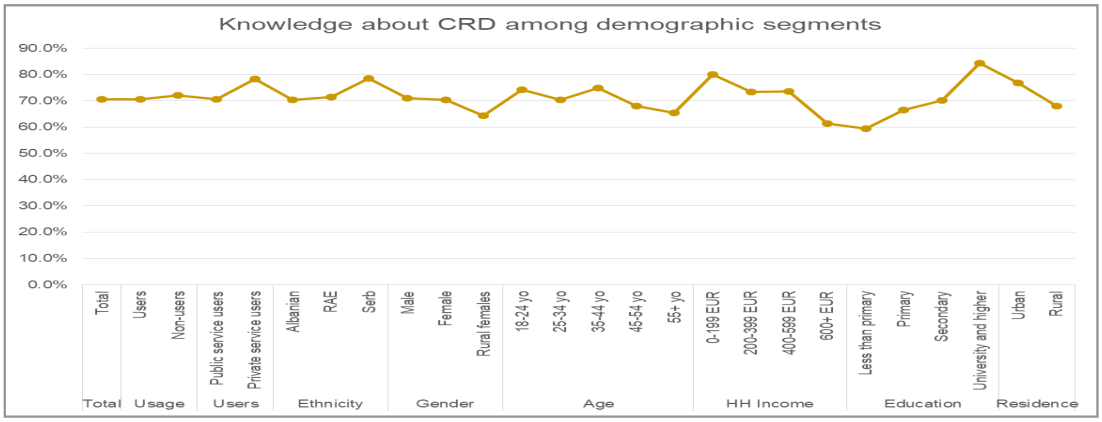
Data on chronic respiratory diseases are presented at Annex 10.

Knowledge

Knowledge: Chronic Respiratory Diseases

Topic	Result
Have heard of CRDs	71%
Overall knowledge of risk factors	12%
Knowledge of early signs	23%
Understanding of preventive measures	15%

- Percentage of population who have heard of chronic respiratory diseases (CRDs) is lower than CVDs, diabetes and hypertension.



Graph 13: Knowledge about CRDs

- Tobacco smoke (37%) is believed to be a leading cause of CRDs by all the demographic segments, followed by outdoor pollutants (15%) and second-hand smoking (14%).
- Shortness of breath is believed to be the most common early sign of CRDs (32%). A cough lasting for a month or longer is the second most mentioned early sign of CRDs (27%).
- Leading preventive measure identified was quitting smoking (29%).
- Spending time in mountains was the second most frequently mentioned preventive measure (17%) followed by avoiding passive smoking (10%).

Attitudes

Attitudes: Chronic Respiratory Diseases

Topic	Result
Would seek treatment if they thought they had the disease	65%
Patients are confident about when to seek care	35%
Patients feel informed about the disease	13%
Patients want to be better informed about the disease	83%

Practices and behaviours

- 38% stated that they have had a CRD.
- The most commonly reported CRD is asthma, chronic obstructive pulmonary disease and lung cancer but the numbers are so low that they cannot be considered as significant.
- 7% stated that, as well as themselves, they have a family member who suffers from CRDs.

3.2.5 Child diarrhoea

Data on diarrhoea are attached at Annex 11.

Knowledge

Knowledge: Diarrhoea

Topic	Result
Have heard of diarrhoea	92%
Overall knowledge of risk factors	9%
Knowledge of early signs	10%
Understanding of preventive measures	9%

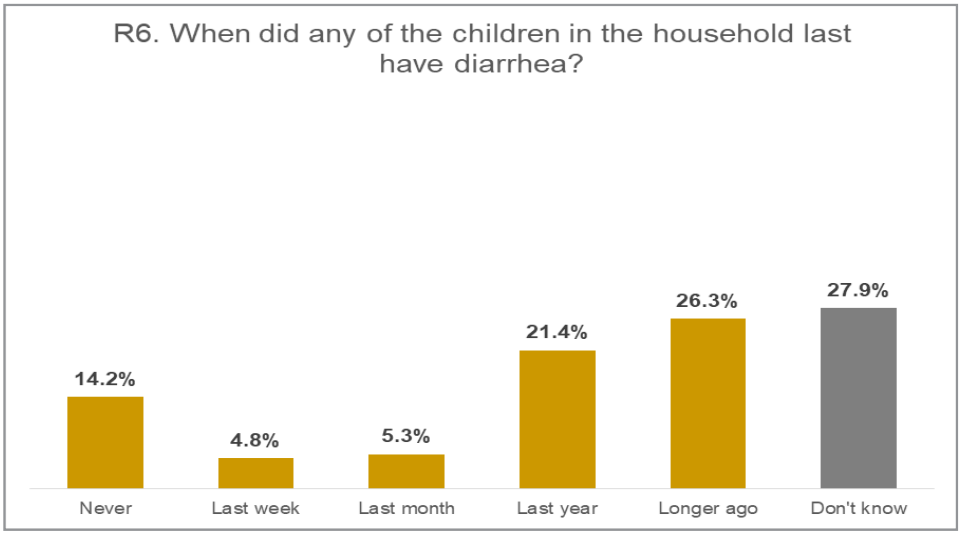
- As with other NCDs included in the study, although a very high percentage of respondents had heard of diarrhoea, the number of respondents with some knowledge of risk factors, early signs and preventive measures is extremely low.
- Two most commonly known risk factors are food poisoning (32%) and infection (15%).
- Only 4% are aware that poor sanitation causes diarrhoea.
- RAE community is best informed about the early signs of dehydration (12%) compared to Serbian (9%) and Albanian communities (9%).
- The most frequent symptoms of dehydration identified are lack of energy (16%), dizziness and light-headedness (16%) and dry, sticky mouth (29%).
- 25% of the targeted population with children are aware that 'watching what you eat and drink' is a preventative measure. Only 16% consider frequent hand washing.
- Least known preventive measures mentioned by this population are use of hand sanitizers when washing is not possible (3%) and the use of refrigerator to thaw frozen items (2%).

Attitudes

Attitudes: Diarrhoea

Topic	Result
Patients are confident about when to seek care	62%
Patients feel informed about the disease	29%
Patients want to better informed about the disease	92%

Practices and behaviours

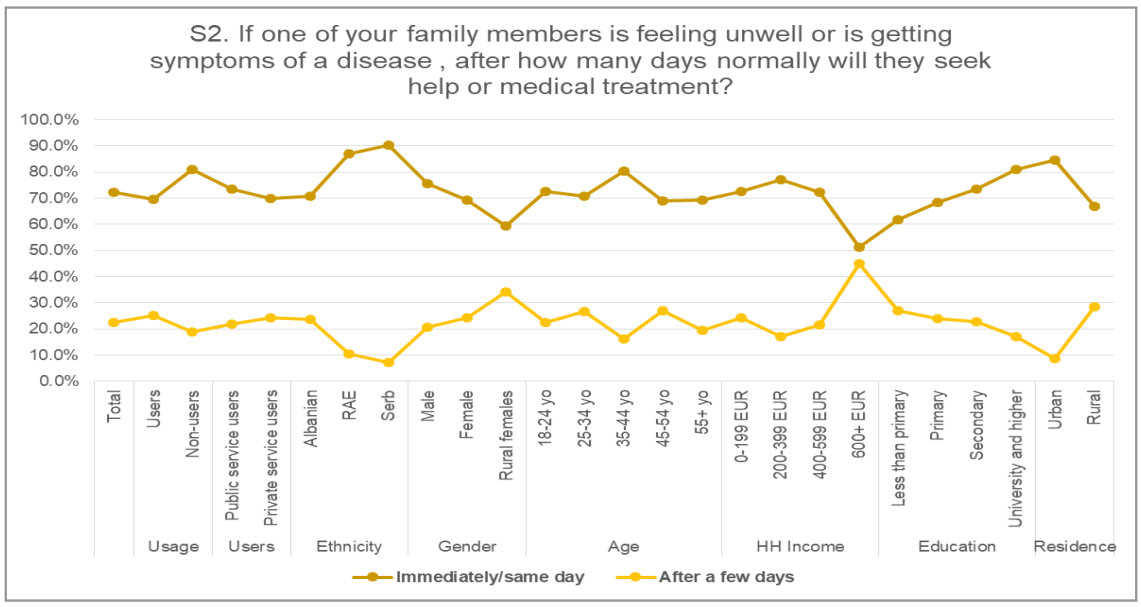


Graph 14: Frequency of occurrence of diarrhoea in children

- Of those respondents with children in their household that have had diarrhoea in the past, 46% first tried to treat it at home, while the rest (54%) took their child immediately to the doctor.
- 68% give liquids to their child when they have diarrhoea and 80% give their child food.
- 52% are aware of Oral Rehydration Salts (ORS) solutions.
- 68% of those who are aware of ORS's have used them to treat their child.

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

3.3.1 Healthcare Seeking Behaviour



Graph 15: Treatment seeking behaviour

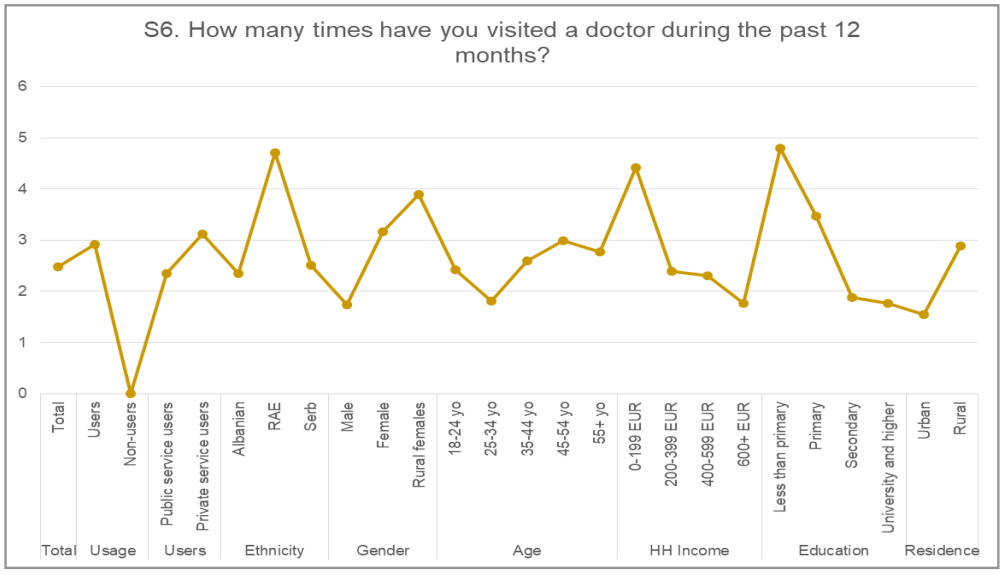
- 95% of the population had visited the doctor or a healthcare facility at least once in their life.
- 70% reported that in case their family members feel unwell or are getting symptoms of a disease (for example, coughing, headache, or chest pain), they seek treatment on the same day that symptoms occur, while the rest seek help a few days after the symptoms emerge.
- Immediate healthcare-seeking behaviour is highest among the Serbian community (90%), compared to RAE (87%) and Albanian (71%) communities.
- 51% of the population with household income of more than 600 Euros seek care immediately.
- Rural residents (85%) seek immediate treatment whilst only 67% of urban residents do the same.

3.3.2 Types of Services Used

- 89% use Family Medical Centres (FMC) as their first point of contact with health services, although this is lower amongst RAE community (79%).
- 83% of those who use private health care services still go the public FMC as their first point of contact.
- 42% use the regional hospital in case of any sickness while 34% use pharmacists at the drug store. 22% use Prishtina University Hospital.

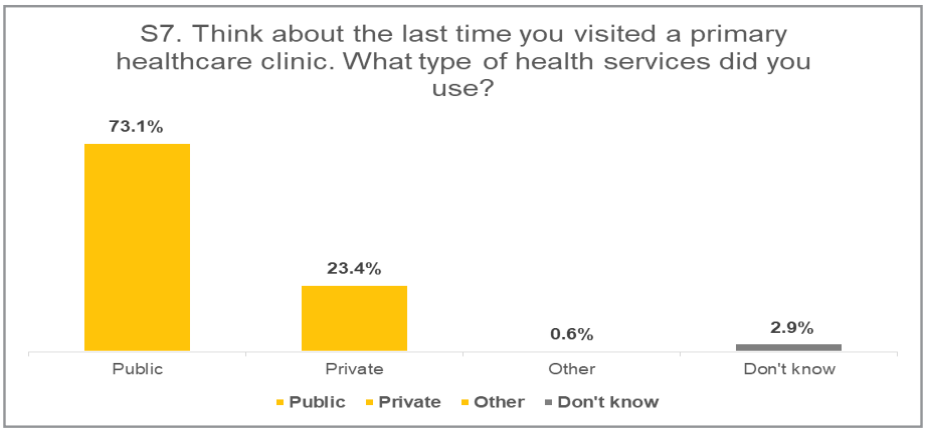
Last time visited the… (percent)	FMC	Private Facility
5+ years ago	5.7	3.8
3-4 years ago	6.4	4.5
1-3 years ago	13.7	8.1
6-12 months ago	11.0	4.3
1-6 months ago	26.3	19.7
Less than a month ago	21.7	16.2
Do not know	15.1	43.4

Table 3: Frequency of visits in public and private facilities



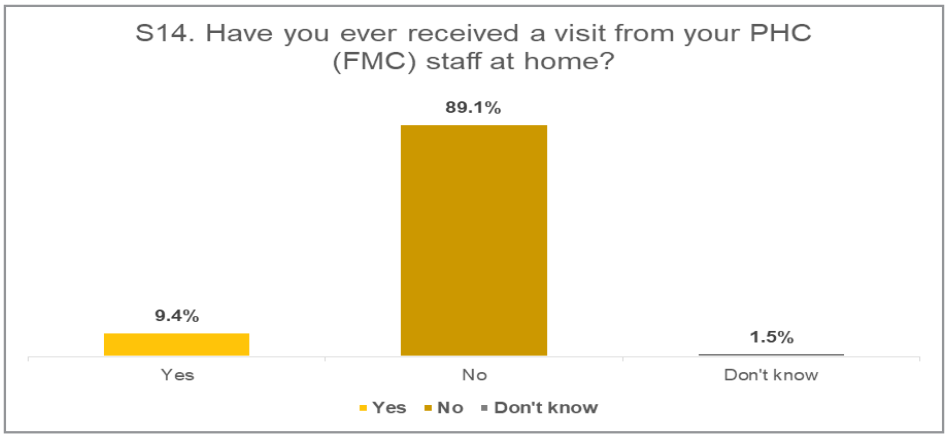
Graph 16: Frequency of visits to the doctor

- It is important to note that the frequency of recent visits to both FMCs and private facilities will likely have been impacted by the Covid-19 pandemic.
- Females (average number of visits - 3) and RAE community (average number of visits - 5) have visited the doctor more often on average compared to males (average number of visits - 2) and Albanian community (average number of visits - 2).
- While the average number of visits in the population increases with age, the number of visits is higher among the population with the household incomes no more than 199 Euro (average number of visits - 3) and among the 'no school completed' group (average number of visits - 3).



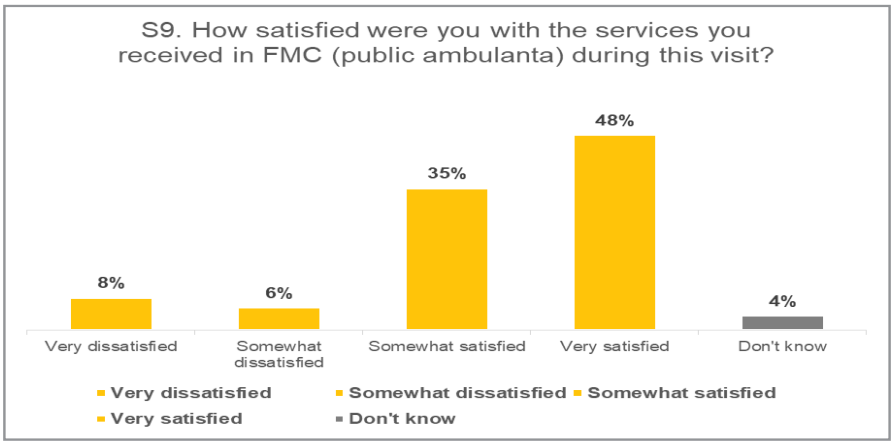
Graph 17: Share of visits between public and private healthcare clinics

- Of those visiting public facilities, 91% were from Serbian community compared to 77% from RAE and 72% from Albanian communities.
- 66% of last visits to the doctor were for the purpose of a check-up, followed by a current illness (19%). Only 5% of last visits were for screening.



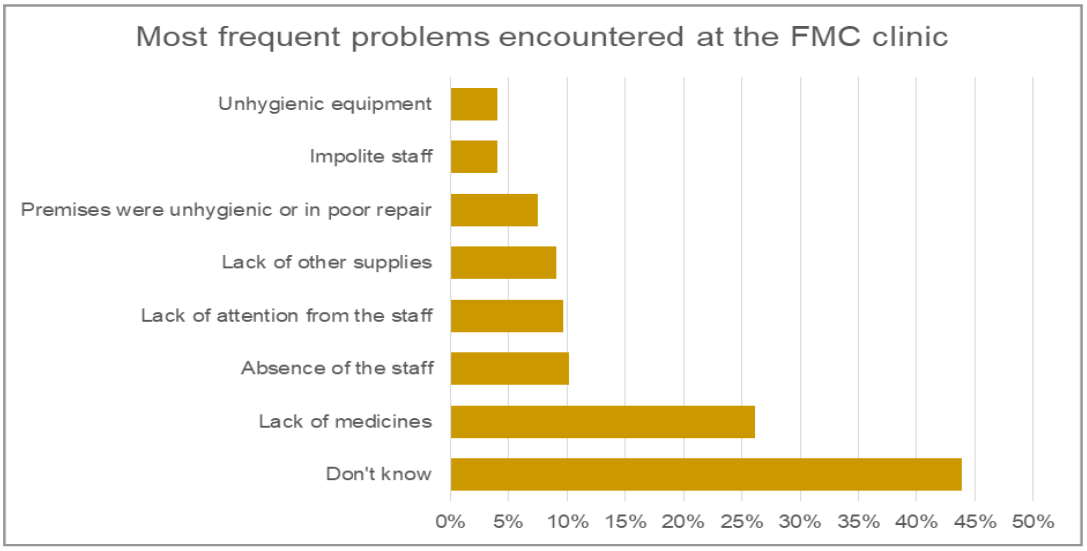
Graph 18: Reported visits from FMC staff at home

3.3.3 Patient Satisfaction



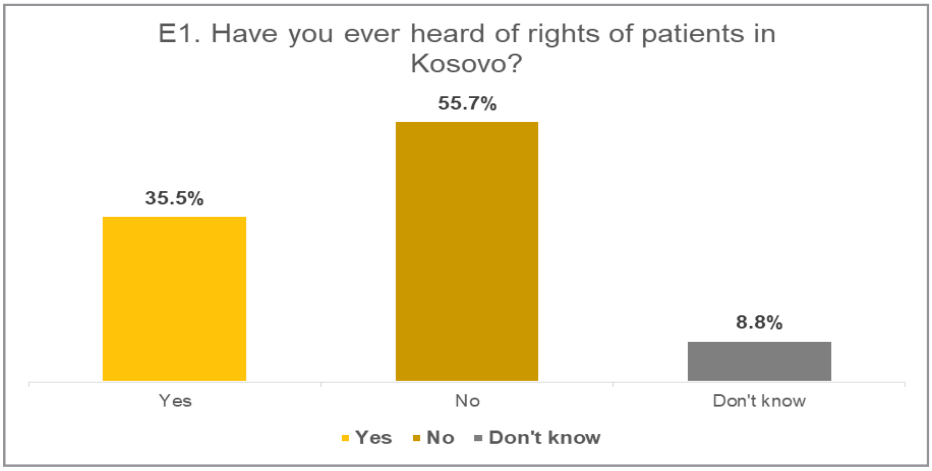
Graph 19: Satisfaction with services received in FMCs

- 48% reported to be very satisfied with the services they received in FMC during their visit.
- Of these, the Albanian population is the most satisfied (52%) compared to RAE and Serbs (44% each).
- 56% of women are more satisfied with the services received in FMCs compared to 46% of men.

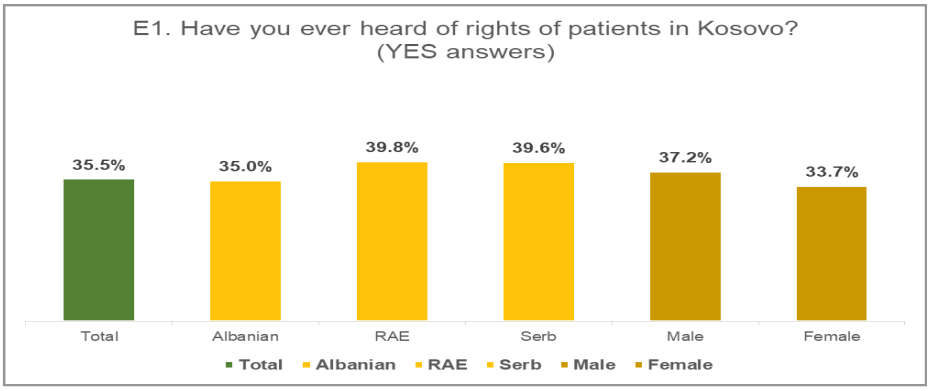


Graph 20: Most frequent problems encountered at FMC's

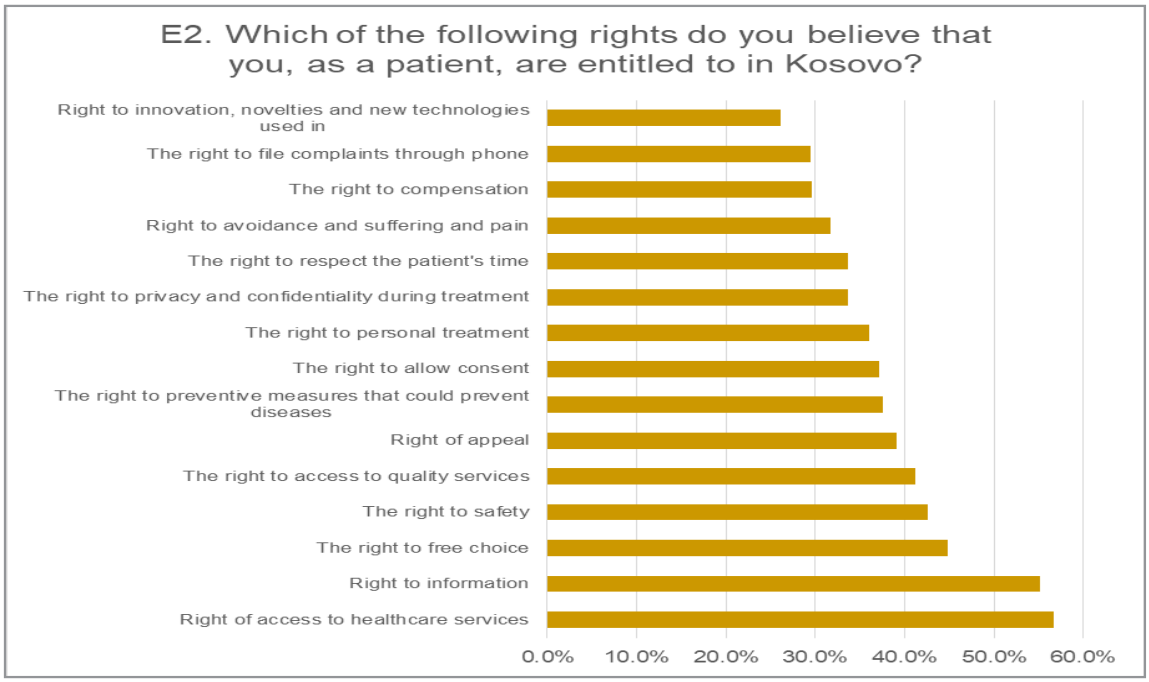
3.3.4 Patients' Rights



Graph 21: Level of awareness about patient rights



Graph 22: Level of awareness about patient rights by ethnicity and gender



Graph 23: Awareness about rights patients are entitled to in Kosovo

- Most frequently mentioned patients' right is the right to access to healthcare services (57%), followed by the right to information (56%).
- Least known rights are the right to compensation (29%), the right to file complaints by phone (29%) and the right to innovation, novelties and new technology (26%).
- 54% believe that patients' rights are enforced in Kosovo.
- Only 23% had seen the list of patient rights displayed in the FMCs they have visited.

3.3.5 Communication Channels

Data are presented at Annex 12.

- Top three most preferred communication channels for obtaining information about healthcare and health services in their areas are: 1) doctors or nurses (66%), 2) television (51%) and; 3) internet (43%).

4 Results – Qualitative Research

4.1 Section 1: Previous Experience in Public Healthcare Services

4.1.1 Perceptions about the public health system in Kosovo

- Most FGD participants consider the level of the satisfaction with public health service to be satisfactory.
- Almost all participants are satisfied with the service, behaviour, cleanliness and care provided by the medical staff.

  "They welcome us very well, they are very careful, but we pay for the medicine." ***(Peja_male_urban_RAE).***

- Many patients included in the study are forced to seek treatment in private clinics or, in some cases, abroad because of lack of specialists in the public sector. This necessitates absence from work for the patient as well as a financial burden.
- It is evident that the Serbian population receives most of their medical services in Nis or other cities in Serbia. Diabetics are particularly affected by this obstacle because of the absence of insulin and in some cases even other medications that you need to treat the disease.

  “I have had diabetes for 6 years. Here where I live I do not receive any medical services. If for various reasons the border with Serbia is closed, I will be left without therapy, without insulin! Here where I live I can not get my medicines. The health system of Kosovo but also that of Serbia is not taking even one step to regulate and advance the issue of providing insulin so that patients with diabetes are supplied with insulin. ***(Raniluga_male_urban).***

  "Us, here in the country where we live, when we are sick we only go (to the public healthcare institutions of Kosovo) to get guidance and they refer us to the state institutions of Serbia to be treated" ***(Raniluga_male_urban).***

- RAE participants report that they sometimes have to postpone their treatment for days, or stop their treatment altogether, because medicines are too expensive and they cannot cover the costs.

  "We must always reach out to others and cry to help us buy the medicine." ***(Peja_male_urban_RAE).***

  It often happens that we go to the doctor, he writes the prescription, but I cannot afford to buy them. ***(Peja_male_urban_RAE).***

4.1.2 Healthcare seeking behaviour

- In general, the population is more cautious about visiting healthcare facilities in times of pandemic and therefore they avoid having frequent check-ups.
- Serbian respondents state that people are generally not at all concerned about their health, do not treat their illnesses in time, and are not sufficiently informed about illnesses.

  "People are more afraid to go to the doctor because they dont want to find out out that they have serious diseases, such as tumors" ***(Raniluga_male_urban).***

- The reasons most frequently mentioned by participants who turn to the doctor are: heart disease, seasonal flu, cases of injuries, diabetes, hypertension and gynaecological examinations (mentioned by pregnant women).

- RAE community group declares that they visit doctors very often, on the grounds that they suffer from multiple diseases.
- Most participants believe that chronic diseases are a strong reason to visit the doctor often, arguing that caring for these diseases requires intensive care, physical activity and regular nutrition.
- Hypertension and diabetes are both considered to be valid reasons for going to see a doctor, but some people think that because they have been suffering from certain chronic diseases for a long time, they are able to manage it themselves.
- Diarrhoea is considered a less serious illness, where adults treat it with any medicine they have at home, while they take it more seriously when their child suffers from it. If home treatment does not work, they will then seek medical care.

  "Diarrhoea is not serious, it can be treated at home with drugs. Only if the condition worsens, we go to the doctor." ***(Kamenica_female_rural)***

  *"I sent my first son to the doctor very often in the beginning because I had no experience at first. But now I rarely send the little girl because now I have experience, even if she has diarrhoea I tried curing it myself with any light medicine, and usually it was successful.****" (Shtime_female_urban)***

- Participants in all FGDs agree that asthma is a very strong reason to go to the doctor and requires constant treatment. The Serbian group state that that they have many relatives who suffer from asthma but they never go to the doctor: 1) because people do not care about health and; 2) because of the lack of specialists and equipment needed to treat this disease.
- Participants state that it is not necessary to visit the doctor with every pain or health concern but people do not try to prevent the diseases by taking care of it in advance and they do not have regular check-ups. They justify this behaviour with the fear of finding out any disease or even because mistrust of doctors. Another reason is the high cost of the service, with some saying that doctors will prescribe medication just for a simple complaint.

  " I do not believe that today there are people who have never gone to the doctor! Now people are more aware, life is much different than our grandparents' life; there is information, there is technology that has made people much more aware of the importance of health." ***(Shtime _female_urban).***

  *"Awareness is higher now for healthcare. For very few problems, people immediately turn to the doctor, because they are afraid, they have more information about the consequences than what it brings if it does not take care of their health."****(Klina_ male_rural).***

4.1.3 Services in primary healthcare – public facilities

Feedback on public facilities is provided at Annex 13.

- Concerns reported by FGD participants relate mainly to healthcare infrastructure, highlighting the lack of medical equipment, technology, and lack of essential medicines.

  "You do not have diclofenac or even IV needle in the ambulantas, and they tell you to go out and buy it yourself". ***(Istog_female_rural)***

  "You rarely find a doctor in the public healthcare facility, he goes out in the morning and you have to wait for him for another 2 hours…They torture you

*because they lack a needle (indicating that you have to go and buy the needle), let's not mention the bigger issues."**(Istog_female_rural)***

- In rural areas, the location of health care institutions and the lack of staff are the main concern. Access to emergency services and after-hours care is not available on regular basis.
- The number of pharmacies is very limited in rural areas and in most cases, they lack supply of medicines.
- In case of emergencies rural patients either go to the nearest regional hospital or they are referred to it by the FMC that is unable to provide appropriate services.

  *"In our area it is a big problem because if you have something more serious you do not have service". **(Klina_rural_male)***

- Participants report that the attitude of medical staff towards patients, the level of respect and care, as well as hygiene, have all significantly improved when compared to few years ago, and that in very serious health cases staff now treat them more urgently and carefully.
- Cost is considered to be a major advantage of the public healthcare service, in that official payment is largely symbolic and children, pregnant women, retirees and people in social welfare are exempted from payment.

4.1.4Services in primary healthcare – private clinics

Feedback on private facilities is provided at Annex 14.

- Participants consider that in private clinics their concerns are heard and understood, and they receive detailed information about their health problem. Moreover, they get the chance to express themselves, and doctors spend time addressing them.

  *"In the state (public healthcare) you lack patience and the time you have to devote to the patient, you do not care much what problem you have. You can heal the patient even with kind words ". **(Istog_female_rural)***

  *"The disease does not wait. So you always have to pay so much for a service in private clinics." **(Klina_male_rural)***

  *"They work in the private sector as well as in the state (public healthcare), however they do not greet you the same as in their own clinic! It's all business. (indicating that doctors behave better in their own private clinics)" **(Klina_rural_male)***

- Another advantage of visiting private clinics is the short waiting time for check-ups and high satisfaction with the service.
- Reasons why people go to the private clinic instead of public one include: long waiting lists for diagnostics; more accurate diagnosis and increased patient care is required and; medical equipment for diagnosis or treatment is not available in the public health institutions.
- People would choose to take their children and elderly relatives to private facilities if they could, however this is not always possible because of cost.
- Private clinics are seen as a service for financially well-off population who visits them regardless of the seriousness of their condition.

- Even participants who are private healthcare facility users are labelled by others in the FGD as 'privileged'.
- Some of the participants state that the reason why they go to private clinics is because they do not want to change the doctor who has been monitoring their health condition for a long time.

> *"Very often I go to the state, but now I go completely private because I do not want to change doctors. I am familiar with him - he knows my condition, and I feel safer".* ***(Istog_female_rural)***
> *"I have a lot of confidence in my doctor because wherever you are going they are loading you up with a lot of therapy, and all the other things they are giving you".* ***(Istog_female_rural****)*

4.2 Section 2: Risk Factors

4.2.1 Attitudes and practices related to smoking

- Participants state that the percentage of smokers in Kosovo is very high, and that whilst all smokers know that it is harmful to health, they continue because the immediate consequences are not visible.
- They think that smokers continue to do this because it helps relieve anxiety, stress and anger by giving them a sense of relaxation.
- Children smoking, especially in schools, is a concern, however the general perception is that the biggest smokers are young people, regardless of gender. They attribute this to the fact that most young people are unemployed and lack activities, so they do not have much to do, they spend a lot of time in cafes and consequently start smoking.
- Participants from urban areas consider that people are starting to smoke less, and that anti-smoking law is being respected more. This is not stated to be the case in rural areas.
- Strengthening anti-smoking legislation is identified as one of the main opportunities to prevent smoking, together with campaigns to prevent children from starting to smoke.
- According to participants, public awareness campaigns through the media, including discussions, advertisements and interviews with health professionals, will play a major role in informing the population.

Indoor smoking

- Indoor smoking is very much present in the homes of the target population, especially among the elderly and guests.

> *"I leave my brother to smoke because he is older than me, because I can not intervene and tell him not to smoke inside."(****Novoberda_male_rural)***
> *"I quit smoking the moment my daughter underwent surgery. "I was hindered by the restrictions that I could not smoke inside, neither at work, so to save myself from stress, I quit smoking completely."* ***(Novoberda_male_rural)***
> *"When guests come to me, they all smoke. The mentality continues to be low among us. It harms children as well"* ***(FG4_Kamenica_female_rural)***

- Indoor smoking according to participants affects the health of other family members. They also believe that the harm is the same for passive smokers as is for active smokers.
- Participants raise concerns that children, seeing adults smoking constantly, think it is good and acceptable for them to smoke too.
- In urban areas, when the family is small, young parents are very careful not to smoke in the presence of their children, however the same is not true in rural areas, where parents fail to convince other family members not to smoke in the presence of children.

4.2.2 Attitudes and practices related to alcohol

- Attitudes and behaviours towards alcohol consumption appear to differ amongst ethnic groups. Albanian participants believe that despite unemployment being high in Kosovo, the level of alcohol consumption is low because of religious reasons and cost.
- Serbian FGD participants believe that alcohol consumption in their community is high and that it is an issue of concern. They agree that alcohol is consumed regardless of age and gender but consider that women in urban areas consume more alcohol than those in rural areas. These participants also stated that they believe that most of the men in RAE communities are alcoholics, especially young and middle-aged men.

  > “We mainly prepare brandy and wine ourselves. Beer is also consumed more. In the morning…we usually consume a small glass of rakija before coffee (rakijica). " ***(Raniluga_male_urban).***
  >
  > "Rakija is consumed throughout the day in our community." ***(Raniluga_male_urban).***
  >
  > “They have to engage in some work or engage in some activity. When he is busy at work, after work he will feel tired and rest (meaning that he will not have time to drink)." ***(Raniluga_male_urban).***

- Consumption habits vary from the age group - young people drink large amounts, sometimes excessively, during holidays and weekends, while middle-aged and elderly drink smaller amounts but more frequently.
- Participants state that the main reason for consuming alcohol is for fun and feeling happy, but another reason is that people have a lot of financial problems and they have the misconception that getting drunk will make them feel better and solve their problems.

  > "Many young people start with us (older ones) and then it sticks with them forever". ***(Raniluga_male_urban).***
  >
  > “People drink because they have a lot of problems, and for a moment he tries to forget those problems as much as he can under the influence of alcohol ". ***(Raniluga_male_urban).***

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

4.2.3 Attitudes and practices about physical activity

- For most participants, physical activity that includes sports such as running, fitness, etc., has the same effect with the daily activities performed during the day, such as going to work, gardening, walking in nature, etc.

  "Sophisticated exercises are also housework. We villagers are much more active because we also have lands we work, we go out to the field, to the mountains". ***(Novoberda_male_rural)***

- Most participants state that they do not engage in any specific physical activity although some mentioned that they walk outdoors because of health problems.
- Physical activity is mentioned to be especially important for people suffering from diabetes and hypertension and it is stated that older people often exercise more because they been advised to do so by their doctor.
- Men believe that women are more active, especially women in rural areas who deal with more difficult household chores.
- Some women say that they would like to exercise more to relax, but they are too tired from looking after children and household chores.

  "There is no one to take care of home and children. So at least until the children grow up, there is no chance of me finding time for physical activity." ***(Shtime_female_rural)***

- Women in rural areas state they are restricted in engaging in physical activity because they would be ashamed to be seen taking part in any sport, running, fitness, etc. Also, their family members would consider it unnecessary and unreasonable for them to leave children or household chores for that purpose.

  "Women in rural areas have trouble engaging in any physical activity because first the family does not support them… they do not consider it as a strong reason that the wife leaves the housework or the children and devote herself to physical activity". ***(Decan_female_rural)***

- Both male and female participants in urban areas believe that young people are more physically active because they have many sports centres and gyms nearby, while seniors and mothers with children are less active because there is a lack of hiking trails or parks.
- Most mention that they do not have enough time for sports or other activities because they devote a lot of time to work and family.

  "I cannot (exercise) because I have to help my wife around the house" **(Novobërda_male_rural)**

- All participants believe that generally people in Kosovo are not physically active because poor economic conditions do not allow them to think about physical activities, and because they do not understand the value that it brings to people's health. This view was especially evident among the RAE community.
- Almost every participant agreed that whilst there are activities that do not cost, people who are financially stable are more able to relax and think about themselves and their health.

4.2.4 Raising awareness about NCD risk factors

- In all focus groups, participants were not informed that there are organizations that aim to raise awareness about risk factors, for example consequences of cigarette and alcohol consumption, poor diet and physical inactivity, although men in the RAE community mentioned some examples of previous community-based health education programmes.
- Participants consider that these sorts of programmes would have had a positive impact on society.

4.3 Section 3: Diet

4.2.1 Eating habits

- Most participants state that they have two main meals a day.
- Breakfast usually contains products that are considered lighter, such as eggs, dairy products, cheese or in some cases, processed meat such as sausages, hot dogs, pastries, etc., which are mainly consumed by children.
- For the main meal they like to consume more liquid dishes, containing meat and vegetables. Meat and pastries are considered to be their favourite fast food and most participants declare that they eat this way every day.
- Also pickled salads are consumed at almost every meal.
- In between meals some mentioned consuming fruit or homemade cakes, black tea and coffee.
- When compiling the menu for each meal, the number of the products consumed is very limited and often repeated; only the preparation differs.
- All participants agreed that liquid vegetable dishes are healthier than baked or fried ones. They also pointed out that in order to have a healthier diet, the amount of fat, salt and sugar should be reduced.
- Soup is considered very healthy regardless of whether it is home-made or dried one, and that it should be used every day.
- Some mention that pastries need to be removed from the menu in order to have a healthy diet.
- Mostly women say that sunflower oil should be removed from use, and use only olive oil or even other types (such as corn oil).
- Some of the participants say that fish, cereals, honey and more types of vegetables should be included in their diet in order to be healthier.
- Participants from rural areas consider themselves as healthier since they do not eat fast food, do not buy canned food and most products (such as: fruits, vegetables, dairy products, meat, bread, pickles, etc.) they cultivate and prepare themselves at home.

  “We do not eat fast food, so I believe I am very healthy. Most of the products we produce ourselves, I believe it is healthy." ***(Klina_male_rural)***

  “We eat healthy because everything we consume is ours, we make it ourselves. They are 100% bio”. ***(Istog_female_rural)***

- When participants consume a third meal during the day, it usually leftovers from lunch or breakfast.
- The RAE community consumes the most limited range food products; potatoes prepared in various forms, as well as foods with dough content. Processed meat products are also consumed very often. Some participants say they sometimes have five meals a day, but sometimes only two meals, and that no day is the same.

  “We eat as much as we have. Some days we have more to eat, sometimes less, and sometimes not at all ”- ***(FG6_Peja_male_RAE_urban).***

- Feedback from RAE participants is that people should frequently consume plenty of food - at least three meals a day. They believe that healthy people should have meat every day, more fruits and vegetables, less fat for people with heart problems, hypertension or diabetes, and less sugar those who have a problem with diabetes.

  "It is not healthy when we sleep without dinner." ***(Peja_male_urban_RAE).***

  "Eating meat every day is good and healthy but we do not have these opportunities" ***(Peja_male_urban_RAE).***

  "We have a tradition of dough." ***(Novobërda_male_rural)***

- Across all FGDs, participants stated that healthy food is also costly, especially in urban areas where people do not cultivate anything themselves.
- Most believe that it would be very difficult to change eating habits but healthier products can be found if people are willing to make the effort.
- The majority of the participants declared that they drink mainly water, while some tend to consume soft drinks with their meals although fruit drinks that they buy in the store are more common.

4.3.2 Perception of healthy eating

- FGD participants claim that healthy eating is important for everyone but it is especially important for elderly people or people suffering from any disease.
- Young people are considered less vulnerable and therefore they should be allowed to eat whatever and how much they want, as long as they do not suffer from any disease.
- The same is thought of children, especially when it comes to the fast foods they consume, or processed meat foods (such as sausages, hot dogs, etc.); since children are growing up and every food is digested faster, their diets should not be restricted because it will not impact on their health.
- Mothers usually believe that they try to be careful, however they consider that it is not enough, with the excuse that "we prepare what the family wants".

  “Even if I want to make a healthy diet food, other family members want it differently, because they do not eat it ". ***(Istog_female_rural)***

- Most participants believe that they are very informed when it comes to knowing what healthy eating is and what is not.
- Participants state that the best way to eat healthily is to eliminate foods that contain fat, white flour, cakes and processed meat foods and instead add more dairy products, fruits and vegetables.

- In general, boiled foods are considered most healthy, and the least healthy are fried or baked foods.

  “For us who do not complain of any disease, whatever we eat does nothing for us. Those who need to eat healthy are people who have any disease. "I have not seen young people going to hospitals." ***(Klina_male_urban)***

- In urban areas, healthy food is perceived to be very expensive, with some saying that often they cannot afford it. Meanwhile people from rural areas do not see this as a problem because they produce most of the products themselves.

  “I think we do not have enough culture for healthy nutrition. Maybe the lifestyle imposes us not to be careful with food. Diets, they too are costly. Of course we know what is healthy these days." ***(Istog_female_rural)***

- According to participants, most of the foods they mention are healthy if eaten at home, but another issue is that those who work have to eat outside the home and therefore they are exposed to processed food, whether they like it or not.

  "People who work have a problem with eating healthy, because they have to spend their lunch time outside the home." ***(Shtime_female_urban)***

- It is also considered by some that preparing healthy meals is time-consuming.

  “Healthy eating requires more time, especially in the kitchen. But today very few people have enough time to stay in the kitchen all day." ***(Istog_female_rural.)***

5 Conclusions

Study context

The study was conducted in the midst of the Covid-19 pandemic which potentially influenced both the quantitative and qualitative components on the study. Data collectors report a high level of anxiety amongst participants, and these feelings could have potentially influenced their perceptions of the healthcare environment .

Health educator role

Study findings are that doctors and other health professionals have an important part to play in influencing and educating service users and the study appears to support the view that strengthening their role as health educators is beneficial to the quality of patient care, given that this continues to be the most used channel of communication.

Non-communicable diseases

Participants have very high level of awareness of the specific NCDs included in the study as most overall knowledge scores are greater than 90%, however they have very limited knowledge about risk factors, early signs, or complications of the diseases, where scores are typically only around 20%. Differences between Albanian, Serbian and RAE communities are not significant, nor is gender.

In particular, overall knowledge of CVDs and knowledge of CVD risk factors, early signs and preventive measures is remarkably low, and by far the lowest of all the NCDs considered in this study.

Only 20%- 30% of the study population report that they feel informed about the different NCDs and more than 80% want to be better informed, suggesting that there is a critical health education need.

Participants generally consider that NCDs are something that requires medical attention and most will visit a doctor immediately if they have any symptoms, and also if they need ongoing care, although costs of medical care are an important concern. Few visit the doctor regarding preventative measures.

Scores for awareness of diarrhoea are also very high, but again scores for risk factors, early signs and complications are very low at less than 10%. Diarrhoea is typically treated at home.

Lifestyle

Smoking is significantly more prevalent minorities amongst RAE and Serbian communities than Albanian. Smokers from the households with the least income, consume the highest amount of tobacco products.

As in previous KAPB studies, unemployment, stress, anxiety, and lack of other things to do are cited as reasons for smoking. Although participants are aware that smoking is bad for health, it is cost that is described as the main motivator for quitting smoking rather than health consequences. Indoor smoking is prevalent, and although many report that it is a concern they consider it disrespectful to ask older people or guests not to smoke.

Only 29% of the total population state that they have tried alcohol at least once in their life. Although it is reported as being higher in the Serbian community, this finding for the total community seems to be remarkably low, although it does mirror the findings of other KAPB studies.

The pattern of alcohol consumption differs between different communities. The Serbian community drinks frequently but in small amounts, while the RAE community drinks larger

amounts less frequently. Higher-income households with higher level education drink frequently in small amounts, whereas poorer households with lower education drink less frequently but in larger amounts.

Both Albanian and Serbian communities are aware that limited food intake and increased consumption of vegetables and fruit is crucial to maintain a healthy diet. Yet, healthy nutrition is considered as essential only for elderly or people suffering from any disease. RAE communities are less knowledgeable about eating healthily but have greater concerns about having access to food. Generally, participants believe they are quite knowledgeable about which foods are considered as healthy but this is sometimes inaccurate. Sugar consumption in tea and coffee is high, as is consumption of sugary soft drinks, cakes, biscuits etc. Almost all demographic segments do not meet the WHO dietary recommendations for fruit and vegetable intake.

Almost a third of the total study population do not meet the WHO recommendations on physical activity for health. Fewer women than men undertake physical activity because they feel it is not culturally acceptable or they feel unable to leave their children or household chores for the purpose of physical activity.

Healthcare services

Almost all the population had visited the doctor or a healthcare facility at least once in their life. Most report that they would seek treatment on the same day that symptoms begin, should they or a family member feel unwell or have symptoms such as coughing, headache, or chest pain.

Public PHC facilities are used far more often than private facilities. 79% had visited public facilities at least once in the last 5 years, compared to 52% visiting private facilities. Most respondents would choose to take their children or elderly relatives to a private facility if that were possible because they feel that they would receive better care, although costs are a prohibiting factor for many. The lack of equipment and essential medicines at public facilities, as well as poor staff attitudes, are identified as drivers for the utilisation of private facilities.

83% report that they are satisfied or very satisfied with their last FMC visit. This paradoxical finding mirrors the situation in other municipalities where KAPB studies have been conducted previously but, as is often seen with patient satisfaction surveys, this seems somewhat at odds with participants compliants about the poor quality of services received and should therefore be treated with caution. Research findings indicate that participants evaluate the quality of public healthcare facilities based on factors such as the doctor's commitment to patients, their professional conduct and, to some extent, the general management of the facility including cleanliness.

Amongst the total study population there was a low level of knowledge about patients' rights. Only a third had heard about 'patients' rights' whilst the knowledge about what this really mean in practice is even lower.

6 Recommendations

Recommendations are to*:*

1) In addition to interventions that increase knowledge, consideration should be given to interventions that promote behaviour change.
2) Continue to develop the health educator role of health professionals as a mechanism for quality improvement, focusing not only on patient education but also on facilitation of behaviour change.
3) Continue using television as a medium for health education/health promotion campaigns and explore options for development of internet campaigns as health professionals, television and internet are still the three most used channels of communication. Consider to emphasize on positive framing of campaign messages.
4) Offer education campaigns and training programmes on a recurring basis. Stand-alone activities may increase knowledge in the short-term, but repetition helps to refresh thinking and deepen knowledge. This is especially important in relation to training programmes for staff where there is frequent staff-turnover.
5) Support further activities to improve knowledge about healthy eating as feedback show that there is still somewhat limited understanding of what foods can be considered as healthy. Information should be based on WHO guidelines to avoid reinforcing any diet 'trends' that might be promoted by the television or internet.
6) Target more interventions at women given that they: usually control how families eat in the home; they do very little exercise themselves; they are able to influence the eating and exercise habits of their children; and they are often the care-givers for family members with chronic diseases that require long-term care..

Annex 1: Quantitative survey questionnaire

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
	per month ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋	D8
Taking **the past year**, can you tell me what the average **monthly** earnings of the household have been?	Refused 99999	
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 Once a day Several times a week Less often Never Don't know	1 2 3 4 5 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 Once a day Several times a week Less often Never Don't know	1 2 3 4 5 6	F6
In a typical week, how often do you eat cakes, sweets, chocolate or biscuits? SINGLE ANSWER	Several times a day Once a day Several times a week Less often Never Don't know	1 2 3 4 5 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 Once a day Several times a week Less often Never Don't know	1 2 3 4 5 6	F8
In a typical week, how often do you use sugar in your tea or coffee? SINGLE ANSWER	Several times a day Once a day Several times a week Less often Never Don't know	1 2 3 4 5 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 Once a day Several times a week Less often Never Don't know	1 2 3 4 5 6	F10
Packaged snack foods (crackers, popcorn, chips, candy, chocolate, biscuits)? SINGLE ANSWER	Several times a day Once a day Several times a week Less often Never Don't know	1 2 3 4 5 6	F11
Solid fats (margarine, vegetable shortening, butter, ghee and lard)? SINGLE ANSWER	Several times a day Once a day Several times a week Less often Never Don't know	1 2 3 4 5 6	F12
Fried foods? SINGLE ANSWER	Several times a day Once a day Several times a week Less often Never Don't know	1 2 3 4 5 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	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 ⌊__⌋⌊__⌋	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 Excess thirst Tiredness/lethargy Loss of appetite Weight loss Vision problems Skin and genital infections Other, specify Don't know	1 2 3 4 5 6 7 8 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 Weight control Weight loss Exercise Healthy diet/ eating habits Limit sugar Limit fatty foods Health checks/ screening Avoid stress Other, specify Don't know	1 2 3 4 5 6 7 8 9 10 11	B4
When you or your family member or friend has diabetes, should they seek medical treatment?	Yes No	1 2	B5
Have you ever had your blood sugar measured by a doctor or other health worker?	Yes No	1 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 No	1 2 *SKIP TO B12*	B7
How did you discover you had diabetes? Was it… READ OUT. SINGLE ANSWER	During routine check-ups After first symptoms appeared Check-up for other reasons After advanced Other, specify Don't know	1 2 3 4 5 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 Somewhat confident Somewhat unconfident Very unconfident Don't know	1 2 3 4 5	B9
In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor?	Yes No	1 2	B10
Are you currently taking insulin for diabetes prescribed by a doctor?	Yes No	1 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 No 2 Maybe 3 Don't know 4	SKIP TO C1	B16
Would you like to have more information about problems associated to diabetes?	Yes 1 No 2 Maybe 3 Don't know 4		B17

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		C4
	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		
What actions can you take to prevent developing cardiovascular diseases in the future? OPEN ENDED PRE-CODED, MULTIPLE RESPONSE	No action	1		C5
	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		
When you or your family member or friend has cardiovascular diseases, should they seek medical treatment?	Yes	1		C6
	No	2		
Have you ever had a heart attack or chest pain from heart disease (angina) or a stroke (cerebrovascular accident or incident)?	Yes	1		C7
	No	2		
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		C8
	Somewhat confident	2		
	Somewhat unconfident	3		
	Very unconfident	4		
	Don't know	5		
Are you currently taking aspirin or any other medication regularly to prevent or treat heart disease?	Yes	1		C9
	No	2		
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		C10
	No	2		
Is any of the household members taking aspirin or any other medication regularly to prevent or treat heart disease?	Yes	1		C11
	No	2		
Do you think you have enough information about problems associated to cardiovascular diseases?	Yes	1	SKIP TO C14	C12
	No	2		
	Maybe	3		
	Don't know	4		

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 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 No 2 Maybe 3 Don't know 4	SKIP TO H1	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		H6
	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		
Do you have any member of your household, other than yourself, that has ever had a chronic respiratory disease?	Yes	1		H7
	No	2		
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		H8
	Somewhat confident	2		
	Somewhat unconfident	3		
	Very unconfident	4		
	Don't know	5		
Do you think you have enough information about problems associated to chronic respiratory diseases?	Yes	1	SKIP TO R1	H9
	No	2		
	Maybe	3		
	Don't know	4		
Would you like to have more information about problems associated to chronic respiratory diseases?	Yes	1		H10
	No	2		
	Maybe	3		
	Don't know	4		

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	R6
	Last week	2		
	Last month	3		
	Last year	4		
	Longer ago	5		
	Don't know	6	SKIP TO R13	
How confident do you feel that you know what to do when a child has diarrhea? Do you feel…	Very confident	1		R7
	Somewhat confident	2		
	Somewhat unconfident	3		
	Very unconfident	4		
	Don't know	5		
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		R8
	Immediately to the doctor	2		
Do you give liquids to the child when he or she has diarrhea?	Yes	1		R9
	No	2		
Do you give food to the child when he or she has diarrhea?	Yes	1		R10
	No	2		
Have you ever heard of Oral Rehydration Salts (ORS) Solutions?	Yes	1		R11
	No	2	SKIP TO R13	
Have you ever used Oral Rehydration Salts (ORS) Solutions for treating diarrhea?	Yes	1		R12
	No	2		
Do you think you have enough information about causes and problems associated to diarrhea?	Yes	1	SKIP TO S1	R13
	No	2		
	Maybe	3		
	Don't know	4		
Would you like to have more information about diarrhea?	Yes	1		R14
	No	2		
	Maybe	3		
	Don't know	4		

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	1	S1
	Doctor or nurse at a local private clinic	2	
	Your regional hospital	3	
	The Prishtina Hospital	4	
	Pharmacy staff	5	
	Family members	6	
	Friends	7	
	Neighbors	8	
	Traditional alternative healer	9	
	Other, specify _____	10	
	Don't know	11	
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	1	S2
	After a few days	2	
	After a few weeks	3	
	After a few months	4	
	Never/wait until the symptoms disappear	5	
	Don't know	6	
Have you ever been to a doctor or a healthcare facility?	Yes	1	S3
	No	2	SKIP TO S14
	Don't know	3	SKIP TO S14
When was the last time you have visited a doctor or a nurse at a FMC or public ambulanta? SINGLE ANSWER	5+ years ago	1	S4
	3-4 years ago	2	
	1-3 years ago	3	
	6-12 months ago	4	
	1-6 months ago	5	
	Less than a month ago	6	
	Don't know	7	
When was the last time you have visited a doctor or a nurse at a private facility? SINGLE ANSWER	5+ years ago	1	S5
	3-4 years ago	2	
	1-3 years ago	3	
	6-12 months ago	4	
	1-6 months ago	5	
	Less than a month ago	6	
	Don't know	7	
How many times have you visited a doctor during the past 12 months?	__ __ times		S6
	Don't know	99	
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	S7
	Private	2	
	Abroad	3	
	Other	4	
	Don't know	5	
	Not applicable/No answer	6	

What was the reason for your last visit? SINGLE ANSWER	Checkup	1		S8
	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		
How satisfied were you with the services you received in FMC (public ambulanta) during this visit? SINGLE ANSWER	Very dissatisfied	1		S9
	Somewhat dissatisfied	2		
	Somewhat satisfied	3		
	Very satisfied	4		
	Don't know	5		
Did you encounter any of the following problems at the clinic? READ OUT. MULTIPLE RESPONSE	Under the table payments	1		S10
	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		
Did the doctor prescribe you to take medicine?	Yes	1		S11
	No	2	SKIP TO S14	
	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 No 2 Don't know 3	E1
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 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	E2
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 No 2 Don't know 3	E3
To what extent do you believe that these patients' rights are enforced in Kosovo? SHOW CARD. SINGLE ANSWER	Fully enforced 1 Somewhat enforced 2 Not enforced so much 3 Not enforced at all 4 Don't know 5	E4
Have you heard that there is a telephone number where you can call and complain about healthcare services?	Yes 1 No 2 Don't know 3	E5

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 TV 2 Radio 3 Newspaper 4 Internet 5 Family, friends, neighbors 6 Leaflets 7 Posters/Billboards 8 SMS 9 Other, specify _____ 10 None 11	E6

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

Annex 2: Survey sampling plan and selection method

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

	Population									
	Total	Albanian	Urban	Rural	RAE	Urban	Rural	Serb	Urban	Rural
Shtime	27220	26447	6742	19705	773	438	335	0	0	0
Peja	91811	87975	45915	42060	3836	1483	2353	0	0	0
Deçani	39870	39402	3781	35621	468	10	458	0	0	0
Istog	37848	36154	5043	31111	1694	46	1648	0	0	0
Klina	38313	37216	5339	31877	1097	180	917	0	0	0
Novobërdë	3122	0	0	0	0	0	0	3123	710	2413
Kamenica	35980	34186	6911	27275	240	37	203	1554	324	1230
Ranillug	3692	0	0	0	0	0	0	3668	3668	0
TOTAL	277856	261380	73731	187649	8108	2194	5914	8348	4702	3643

Table 4: Population estimates, 2016[5].

	Sample									
	Total	Albanian	Urban	Rural	RAE	Urban	Rural	Serb	Urban	Rural
Shtime	60	40	10	30	20	10	10	0	0	0
Peja	240	140	70	70	100	40	60	0	0	0
Deçani	70	60	10	50	10	0	10	0	0	0
Istog	100	60	10	50	40	0	40	0	0	0
Klina	80	60	10	50	20	0	20	0	0	0
Novobërdë	80	0	0	0	0	0	0	80	20	60
Kamenica	90	40	10	30	10	0	10	40	10	30
Ranillug	80	0	0	0	0	0	0	80	80	0
TOTAL	800	400	120	280	200	50	150	200	110	90

Table 5: Sampling plan

Selection 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 for each sub-sample was designed to have 10 households irrespective of the type of residence (urban or rural), with 80 sampling points in total. The residential split is 35% urban vs. 65% rural. For Albanian community, there were in total 40 sampling points while the residential split was 30% urban and 70% 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 20 sampling points in the RAE sub-sample and 20 sampling points in Serb sub-sample. The residential split in the RAE sub-sample is 25% urban vs. 75% rural whereas in Serb sub-sample, the split was 55% urban and 45% rural.

5 https://ask.rks-gov.net/media/1613/popullsia-sipas-gjinis%C3%AB-etnicitetit-dhe-vendbanimit.pdf

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 populations at the bottom. The step was defined by the population – for instance 277,856 (Albanian universe) was divided by 40 (number of sampling points) equals to approx. 6,946. 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.

Selected targeted areas are assumed to have a large population of the vulnerable population, residing mainly in rural areas (69%) than in urban (31%), proportionate to urban vs rural split of the population living in these settlements, majority being of an Albanian ethnicity (91%) and the remaining belonging to minority groups (RAE 6%; Serb 4%).

Random route selection of the respondents above the age of 18 in these areas yields almost half of the sample to be below the age of 34 (45%) while only 20 percent resulted to be above the age of 54, with an equal gender split (50% female; 50% male).

Around 70 percent of the sample have completed secondary school or lower (secondary school completed 50%; primary school completed 23%) while some 10 percent of the respondents fall into the category of the population who completed less than primary or no formal schooling. Percentage of the population living in these areas who have completed professional schools remains low (3%) while only 12 percent possess a university degree diploma and handful of the population (2%) have a post graduate degree.

Even though the targeted population is relatively young, the percentage of the population in these areas that are in a marital relationship is rather high (61%). Slightly less than a 30 percent of the target population have never been married while the percentage of widowed (6%), separated and divorced (2%) and cohabitating (2%) remains low.

Less than a third of this population (29%) have declared to have been working in the past 12 months and only another 20 percent are looking for work while the rest are mostly homemakers (26%), students (9%), retired (6%) or just unemployed and not looking for work (9%).

In terms of household composition, more than a half of the target population live in the households consisting of more than five family members (5-6 members 39%; 7+ members 16%) while the remaining half live in the households consisting of less members (3-4 members 32%; 1-2 members 14%) while only 22% of the sample has at least one child under the age of 5 (1 child 12%; 2+children 10%).

Although the population in the targeted areas is mainly young, more than a third of the households this population lives in, have elderly population above the age of 60 (1 member above the age of 60 26%; 2+ members above the age of 60 16%).

Looking at the household income of the targeted population, it is a bit difficult to tell as more than a third of the respondents in the sample refused to share that information with us. Nevertheless, it is evident that vast majority of those who declared their earnings fall into the category of the national household living standard, assuming that the average household size is 5 members (301-600 Euro 22%) while almost a third of the population live with less; respectively below 300 Euros a month. Only a handful of the households included in the study are a bit more privileged financially since their average household incomes reach more than 600 Euros per month (5%).

Taking the past year, can you tell me what the average monthly earnings of the household have been?	Valid %
up to 150 EUR	11.7
151-300 EUR	18.0
301-600 EUR	22.1
601+	5.4
Ref	42.9
Total	100.0

Table 6: Household earnings

Less than a quarter of this population lives under support of a social assistance scheme where some 15 percent receive a social assistance of up to 100 Euros while only 6 percent receive more than 101 Euros from the scheme. Vast majority do not fit into current Kosovo social assistance scheme (76%).

In terms of usage of the healthcare services, vast majority of the population (83%) declared themselves as users and vast majority of these (73%) are users of public healthcare facilities and less than a quarter (23%) mainly visit private facilities. A small proportion of the targeted population (5%) declared a firm no when asked if they use healthcare facilities while some 12 percent of the population were not really sure how to answer this question.

Profile of Users and Non-Users of Healthcare Services

In order to observe the behaviour patterns and the difference between different segments of the population, respectively distinguish the population by the types of healthcare services they use, for the purpose of this report, we have grouped the population by the frequency of their visit to the doctor. Hence, the population that has reported to have visited a doctor or a nurse in a public or private healthcare facility at least once in the past 5 years were identified as users of the healthcare facilities (referred to as 'users' in the graphs and charts) while the non-users are the population from the sample who have never visited a doctor in their life or in the past five years (found as 'non users' in the graphs and charts).

With this calculation, the majority of the population (95%) are grouped as users of the healthcare facilities whereas non-users consist of 4% of the population in this sample. The remaining sample where unable to say or recall their last visit to the doctor (1%), without major differences between different demographic segments.

Annex 3: Training and quality control measures

The training was organized online, due to the coronavirus precautions. 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 fieldwork started on January 15th and ended February 2nd 2021.

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 were recruited through an application process. First, the interested individuals were interviewed with the field manager and were asked to fill-in a simple application form. Potential interviewers were 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. The short-listed applicants from the application procedure were recommended for one-day training on sampling procedures and administration of questionnaires, which was conducted by the field manager. Interviewers' first experience in the field was accompanied by the respective regional supervisor, whereas the supervisor showed the interviewer how an interview is conducted, as well as closely observed the performance of the newcomer and gave recommendations for his/her work.

Quality measures

16% 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 were back-checked in person, field supervisors went back in the field with completed interviews and field documents submitted to them by the interviewer and they checked 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 were directly observed, regional supervisors accompanied the interviewers throughout the whole process and gave recommendations to the interviewers on the spot. If needed, the supervisors also conducted an interview in front of newcomer interviewers, in order to show them how to properly administer the whole process.

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

All quality control indicators related to sampling procedures and respondent verification were a part of an instrument (questionnaire) that was administered by regional supervisors during quality control. They completed this questionnaire with tablets, uploaded the data to the company server and the field manager, together with the project manager checked the validity of the data and compared them against the interview with the respondent. In cases when the inconsistencies emerged, they were reported back to the supervisors, who send back the interviewers to the field for correcting the inconsistencies or for making additional interviews.

Annex 4: 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, that was uploaded during the fieldwork, was 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 26 software, in Kantar (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 from 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 26 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 focused on the following factors by comparing the new data with KAPB Study 2016:

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 (GPAQ) Analysis
5. Demographic profile of users and non-users of healthcare services
6. Data analysis according to the LFA indicators.

Annex 5: FGD sample plan and selection method

	Group Discussion Sample									
	Number	**Albanian**	**Urban**	**Rural**	**RAE**	**Urban**	**Rural**	**Serbian**	**Urban**	**Rural**
Istog	1	1	0	1F	0	0	0	0	0	0
Deçan	1	1	1F	0	0	0	0	0	0	0
Shtime	1	1	1F	0	0	0	0	0	0	0
Kamenicë	1	1	0	1F	0	0	0	0	0	0
Ranillugë	1	0	0	0	0	0	0	1M	1	0
Pejë	1	0	0	0	1M	1	0	0	0	0
Klinë	1	1	0	1M	0	0	0	0	0	0
Novobërdë	1	1	1M	0	0	0	0	0	0	0
TOTAL	**8**	**6**	**3**	**3**	**1**	**1**	**0**	**1**	**1**	**0**

(M = male, F = female)

Table 7: FGD sample

FGD selection method

The selection was performed in three stages.

Stage 1: Even though the discussion was held through Zoom platform, considering the demographic structure of the target population and the sensitive nature of the study, the recruitment of the participants was conducted face to face in the house of the respondents. 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, are willing to participate in the group discussion, and are considered communicative enough so to contribute to the discussion by the recruiter. 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 a starting point and a 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.

Stage 4: The selected respondents were asked to join the focus group discussion at the specific time and date the group took place. At the day of the focus group, the respondents were provided by the interviewer with the tablet or smart phone to join the discussion (in cases when they did not have a smart phone, tablet or computer available) and they were provided with internet data for stable connection.

Annex 6: Discussion guide

Focus Group Discussion Guide

Knowledge, Attitudes, Practices and Behavior Survey in Kosovo
Non Communicable Diseases, Child Health and Citizens Right to Health

Objectives

1. Explore reasons for specific perceptions, attitudes and practices about risk factors related to specific diseases
2. Identify the rationale behind perceptions and practices about the influence of tobacco, alcohol, diet and physical activity in people's health
3. Explore reasons for healthcare seeking behavior in public vs. private primary healthcare facilities, as well as analyze drivers and barriers for public vs. private facilities
4. Identify reasons why non-users do not use healthcare services
5. Focus on the following diseases: diabetes, hypertension, asthma, diarrhea

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 snack. Encourage people to eat snacks 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 and beverages, napkins, cups, extra batteries, plates, trash bag. Bring a large sheet of paper/flipchart and colored 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 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):**

1. **Start with an open-ended ice breaker type question. To get people talking.**
   a. 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)

2. **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 diarrhea, diabetes and hypertension]

3. **Give some examples of your thoughts on primary healthcare facilities.**
   a. What do you like or don't like about the **primary healthcare**? **(Prepare two flip charts, one that says PROS, and the other that says CONS. Write list on flip chart. Example: PROS - free, convenient & CONS - long waits, extra costs from medicine…)**

4. **What are the purposes you mainly go to public tertiary facilities? (This maybe a very long list. Moderator should focus on KAPB priorities.)**

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

5. **Give some examples of your thoughts on private clinics.**
   a. 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…)**

6. **What are the key reasons due to which you mainly go to <u>private</u> clinics? (This maybe a very long list. Moderator should focus on KAPB priorities.)**
7. **Probe for each separately: What about for: Asthma, diarrhea, hypertension, diabetes)**
8. **Our prior research 4 years ago 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)

1. **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)

2. **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 to eat more healthy food? (Probe for: Food price, accessibility/available of healthy food: do you find these healthy foods in the nearest shop/market place? Are they easy to find?)

3. 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 4 years ago show that people in Kosovo generally are not very physically active. What are the reasons why these people are not very physically active? Do you think that varies on age and gender? How do they vary? Why is that?

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?

4. 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 years ago 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 difrent 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?

5. 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

Annex 7: Use of salt, sugar and fats

Usage of food in diet (percent)	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	20	22	28	21	5
Salt, salty seasoning or a salty sauce used in cooking or preparing foods in your household	40	24	26	9	-
Cakes, sweets, chocolate or biscuits	3	17	49	26	3
Soft drinks, such as Coca Cola, Fanta, energy drinks and similar	9	18	36	28	7
Sugar in your tea or coffee	60	21	9	5	4
Commercially baked goods	2	6	45	38	7
Packaged snack foods	2	13	44	35	4
Solid fats	2	17	36	33	10
Fried food	4	20	53	20	3

Table 8: Frequency of usage of food in diet

Annex 8: Data – Diabetes

Risk factors	Total	Albanian	RAE	Serb	Male	Female
Family history of diabetes	22.7	23.5	10.8	20.8	27.0	18.6
Eating too much sugar	44.9	45.3	49.5	29.4	43.8	46.0
Stress	37.8	37.4	27.5	60.7	41.6	33.9
Overweight	16.6	16.2	16.1	27.1	18.7	14.5
Overeating	14.2	14.4	15.0	7.8	14.7	13.7
Eating too much fat	24.2	23.9	27.0	25.7	24.5	23.9
Age over 40	8.3	7.7	4.9	29.5	9.6	7.1
Old age	20.4	20.6	6.4	35.5	21.9	18.9
Smoking	3.7	3.5	5.8	4.8	5.9	1.6
Lack of exercise	6.9	6.8	6.5	10.0	6.9	6.9
Alcohol	3.5	3.5	5.8	2.5	4.6	2.5
Ethnic origin	0.1	-	0.5	0.9	0.1	0.1
Other	0.2	0.2	-	-	-	0.4
Do not know	17.1	17.4	21.2	4.2	16.2	18.0

Table 9: Knowledge of risk factors for diabetes

Early signs of diabetes	Total %	Albanian %	RAE %	Serbian %	Male %	Female %
Excess thirst	42.0	42.0	38.0	46.3	38.4	45.5
Tiredness/lethargy	29.8	29.6	35.2	26.6	30.7	28.9
Vision problems	12.9	10.7	21.7	54.2	14.8	11.1
Weight loss	7.1	5.8	8.1	37.5	8.9	5.3
Passing lots of urine	10.4	10.5	11.9	5.6	13.9	6.9
Loss of appetite	5.7	4.8	12.0	18.7	7.8	3.7
Skin and genital infections	3.7	2.7	21.7	2.4	6.0	1.4
Other	4.0	4.4	0.8	-	2.5	5.5
Do not know	37.3	39.1	27.5	7.9	37.8	36.8

Table 10: Knowledge about early signs of diabetes

Preventive measures against diabetes (percent)	Total	Albanian	RAE	Serb	Male	Female
Limit sugar	30.4	30.1	41.4	21.0	28.3	32.4
Health checks/ screening	34.8	34.7	25.6	51.0	34.2	35.3
Healthy diet/ eating habits	29.0	27.7	31.9	54.5	32.9	25.1
Exercise	18.1	17.8	19.3	22.5	21.2	15.0
Weight control	15.0	14.4	17.3	25.6	16.8	13.2
Limit fatty foods	13.1	12.3	21.6	18.8	14.6	11.6
Avoid stress	14.5	14.5	11.5	18.1	18.3	10.8
Weight loss	7.0	6.6	10.7	11.5	10.0	4.0
No action	1.2	1.1	0.6	3.2	0.6	1.7
Other	0.1	0.1	-	-	-	0.3

Table 11: Knowledge about preventive measures against diabetes

Annex 9: Data – Cardiovascular Disease

Risk factors	Total %	Albanian %	RAE %	Serbian %	Male %	Female %
Stress	26.8	26.6	32.1	23.4	28.1	25.5
Family history of CVD	13.3	13.0	9.0	26.8	17.2	9.4
Overweight	11.8	11.8	7.5	17.9	14.6	9.0
Eating too much fat	21.0	20.8	19.8	27.1	24.2	17.7
Smoking	10.9	11.5	8.6	1.8	14.0	7.9
Overeating	7.3	7.1	9.5	10.9	8.5	6.2
Alcohol	9.5	10.2	4.0	1.2	12.0	7.1
Salty food	8.5	7.5	19.6	16.8	8.8	8.3
Age over 40	6.5	6.2	2.5	18.4	9.6	3.4
Old age	13.1	13.3	4.4	22.6	14.4	11.9
Lack of exercise	7.4	7.4	3.7	12.6	8.7	6.1
Ethnic origin	0.0	-	-	0.9	0.1	-
Other	0.1	0.2	-	-	0.3	-
Do not know	15.5	16.1	13.1	5.7	13.0	18.0

Table 12: Knowledge about risk factors associated with CVD

Early signs of CVD (percent)	Total	Albanian	RAE	Serb	Male	Female
Chest Discomfort	20.0	18.2	36.7	38.3	22.3	17.7
You Get Exhausted Easily	18.1	18.3	19.1	12.0	19.9	16.4
You Feel Dizzy or Lightheaded	9.1	8.4	15.2	17.5	10.7	7.5
Lack of breath during physical exercise	16.4	16.0	16.2	25.7	17.0	15.8
Irregular heart beat	7.2	7.1	6.7	10.3	7.6	6.7
Pain that Spreads to the Arm	7.6	6.7	12.4	21.6	8.4	6.8
Sweating	4.2	4.2	6.4	1.5	5.6	2.8
Legs, feet and ankles are swollen	3.8	3.9	1.7	3.1	4.2	3.4
Throat or Jaw Pain	1.4	1.4	0.9	2.8	2.6	0.3
Snoring	2.0	2.0	1.5	1.7	1.3	2.6
A cough that won't quit	2.9	3.1	-	2.8	4.9	1.0
Nausea, Indigestion, Heartburn, or Stomach Pain	4.5	3.6	15.9	8.6	5.7	3.3
Other	0.9	1.0	-	-	1.4	0.4
Do not know	25.8	27.1	15.3	8.8	24.2	27.3

Table 13: Knowledge about early signs of CVDs

Preventive measures against CVD (percent)	Total	Albanian	RAE	Serb	Male	Female
Health checks/ screening	29.4	29.5	21.5	38.8	25.8	32.9
Healthy diet/ eating habits	16.3	14.9	24.4	38.1	20.6	12.1
No smoking	12.8	11.9	28.9	12.1	18.6	7.1
Exercise	16.5	16.7	14.5	16.2	17.8	15.3
No alcohol	9.8	9.6	13.2	10.3	13.6	6.0
Weight control	10.1	9.8	9.1	20.0	10.7	9.6
Limit fatty foods	9.2	9.0	8.7	13.4	12.1	6.3
Weight loss	5.4	5.1	7.8	7.5	7.9	2.9
No action	0.5	0.5	-	2.1	1.0	0.0
Other	0.4	0.4	0.5	-	0.8	0.1
Do not know	14.4	14.8	15.2	3.4	17.2	11.7

Table 14: Knowledge about preventive measures against CVDs

Annex 10: Data – Chronic Respiratory Disease

Risk factors (percent)	Total	Albanian	RAE	Serb	Male	Female
Tobacco smoke	37.1	35.6	39.3	69.7	43.2	31.0
Second hand tobacco smoke	13.8	13.5	11.2	24.6	16.4	11.2
Outdoor air pollutants	15.4	16.0	9.6	7.7	15.6	15.1
Allergens	5.6	5.6	5.2	5.9	6.5	4.6
Other indoor air pollutants	8.3	7.8	5.4	24.8	10.8	5.9
Respiratory infections	7.5	7.2	6.4	16.1	7.7	7.2
Occupational agents	5.7	5.9	4.2	4.5	6.6	4.8
Diet and nutrition	4.9	4.9	4.0	5.9	6.8	3.0
Do not know	27.0	28.2	23.4	3.2	21.4	32.6

Table 15: Knowledge about risk factors associated with CRDs **s**

Early signs of CRD (percent)	Total	Albanian	RAE	Serb	Male	Female
Shortness of breath or difficult breathing	31.6	30.3	34.0	60.3	29.5	33.7
Wheezing, noisy breathing	20.1	19.1	28.5	29.8	21.8	18.3
A cough lasting for a month or longer	26.8	26.3	35.9	25.8	32.5	21.1
Chronic mucus production	11.7	11.1	24.1	8.6	12.2	11.3
Other	1.0	1.1	-	-	0.3	1.6
Do not know	25.1	26.0	21.4	9.2	26.0	24.2

Table 16: Knowledge about early signs of CRDs

Preventive measures against CRD (percent)	Total	Albanian	RAE	Serb	Male	Female
Spend time in mountains	17.0	16.0	24.5	28.2	21.3	12.7
Quit smoking	28.7	26.8	37.9	59.2	35.1	22.3
Avoid passive smoking	10.3	10.2	8.4	16.4	13.7	6.9
Avoid lung irritants at work	5.1	4.8	3.2	14.3	7.5	2.7
Do not know	32.1	33.0	29.8	15.0	27.9	36.3

Table 17: Knowledge about preventive measures against CRDs

Annex 11: Data – Diarrhoea

Risk factors (percent)	Total	Albanian	RAE	Serb	Male	Female
Food poisoning	32.2	32.2	34.5	30.3	31.9	32.6
Infection	15.0	14.9	19.9	9.3	15.0	14.9
Food allergies	6.0	5.8	9.0	5.5	5.3	6.6
Medications	5.4	5.1	2.0	15.7	4.3	6.4
Lack of clean water	7.4	7.7	4.0	5.7	6.8	7.9
Poor hygiene	8.1	8.3	3.5	10.5	7.7	8.4
Irritable bowel disease	3.2	2.7	1.3	16.9	2.9	3.5
Poor sanitation	4.4	4.4	3.5	5.2	3.3	5.4
Other	2.4	2.6	1.5	-	0.8	4.0
Do not know	6.7	6.4	9.1	10.9	8.3	5.2

Table 18: Knowledge about risk factors associated with diarrhoea

Early signs of dehydration (percent)	Total	Albanian	RAE	Serb	Male	Female
Dizziness and light headedness	15.8	15.0	25.4	18.8	12.9	18.6
Dry, sticky mouth	15.1	15.1	14.8	14.8	14.1	16.1
Lack of energy	15.9	15.3	31.4	8.2	16.2	15.7
Cool, dry skin	5.6	5.6	7.8	2.5	5.1	6.2
Dark yellow urine, or very little or no urine	5.2	5.3	3.6	6.1	5.0	5.4
Few or no tears when crying	2.4	2.5	1.5	1.0	1.7	3.1
Other	2.1	2.3	0.3	-	0.6	3.6

Table 19: Knowledge about early signs of dehydration

Preventive measures against diarrhoea (percent)	Total	Albanian	RAE	Serb	Male	Female
Watch what you eat and drink	24.5	23.8	30.7	32.1	21.5	27.5
Wash hands frequently	16.3	15.6	24.7	21.3	14.7	17.9
Ask your doctor about using antibiotics	9.9	10.2	7.9	5.3	9.7	10.0
Wash work surfaces frequently	5.0	4.7	3.7	11.9	5.3	4.6
Lather with soap for at least 20 seconds	4.2	4.0	2.0	13.8	4.6	3.9
Serve food right away or refrigerate it after it has been cooked or reheated	6.8	7.3	0.5	4.9	6.2	7.4
Use hand sanitizer when washing isn't possible	3.4	3.6	0.8	1.5	4.3	2.5
Use the refrigerator to thaw frozen items	2.3	2.4	0.9	2.3	1.4	3.1
Other	0.0	-	0.9	-	-	0.1
Do not know	10.1	10.2	14.2	0.8	10.9	9.2

Table 20: Knowledge about preventive measures against diarrhoea

Annex 12: Channels of communication about health issues

Channels of communication (percent)	Current	Preferred	Differential (current minus preferred)
Your doctor or nurse	55.7	65.5	-9.8
TV	53.9	51.1	2.8
Internet	49.2	42.7	6.5
Family, friends, neighbors	18.8	13.4	5.4
Newspaper	2.6	4.7	-2.1
Radio	1.5	2.7	-1.2
Leaflets	7.1	8.8	-1.7
Posters/Billboards	2.4	4.2	-1.8
None	6.1	3.1	3.0
SMS	0.3	3.2	-2.9
Public meeting in the neighbourhood/village	-	8.4	-8.4
Other	-	0.1	-0.1

Table 21: Current and preferred channels of communication about health issues

Annex 13: Perceptions of public and private facilities

Public healthcare clinics	
Advantages	**Disadvantages**
Public health care clinic is very near (in urban areas)	Lack of basic equipment (patches, syringes, etc.)
Benevolent staff	Lack of drugs
Urgent cases, do not have to wait in line	Lack of medical equipment
Some of the drugs very rarely – for free	Lack of staff (in some cases)
24 hours service	The staff do not respect the working hours
Do not have to pay	Lack of drugs
Elderly always have priority	Lack of communication with patients
Professionally qualified staff	Prescription of unnecessary drugs due to the personal interest of doctors to pharmacies (some mentioned)
Cheaper check-ups	Lack of communication with patients
Do not have to pay	The location of public health care clinic is very far (in rural areas)
Public health care clinic is very near (in urban areas)	No 24 hours health service in other public health clinics besides the central one.
Urgent cases, do not have to wait in line	

Table 22: Advantages/disadvantages – public facilities

Private healthcare clinics	
Advantages	**Disadvantages**
Good patient care / good service	Expensive
To devote time and importance	They select the cases they want to work with, they can refer you to the public hospital
Fast service	In case of complication, they do not hold themselves accountable.
Safer feeling	
Good hygiene	
Hospitality	
They have essential equipment	
Modern equipment	

Table 23: Advantages/disadvantages – private facilities