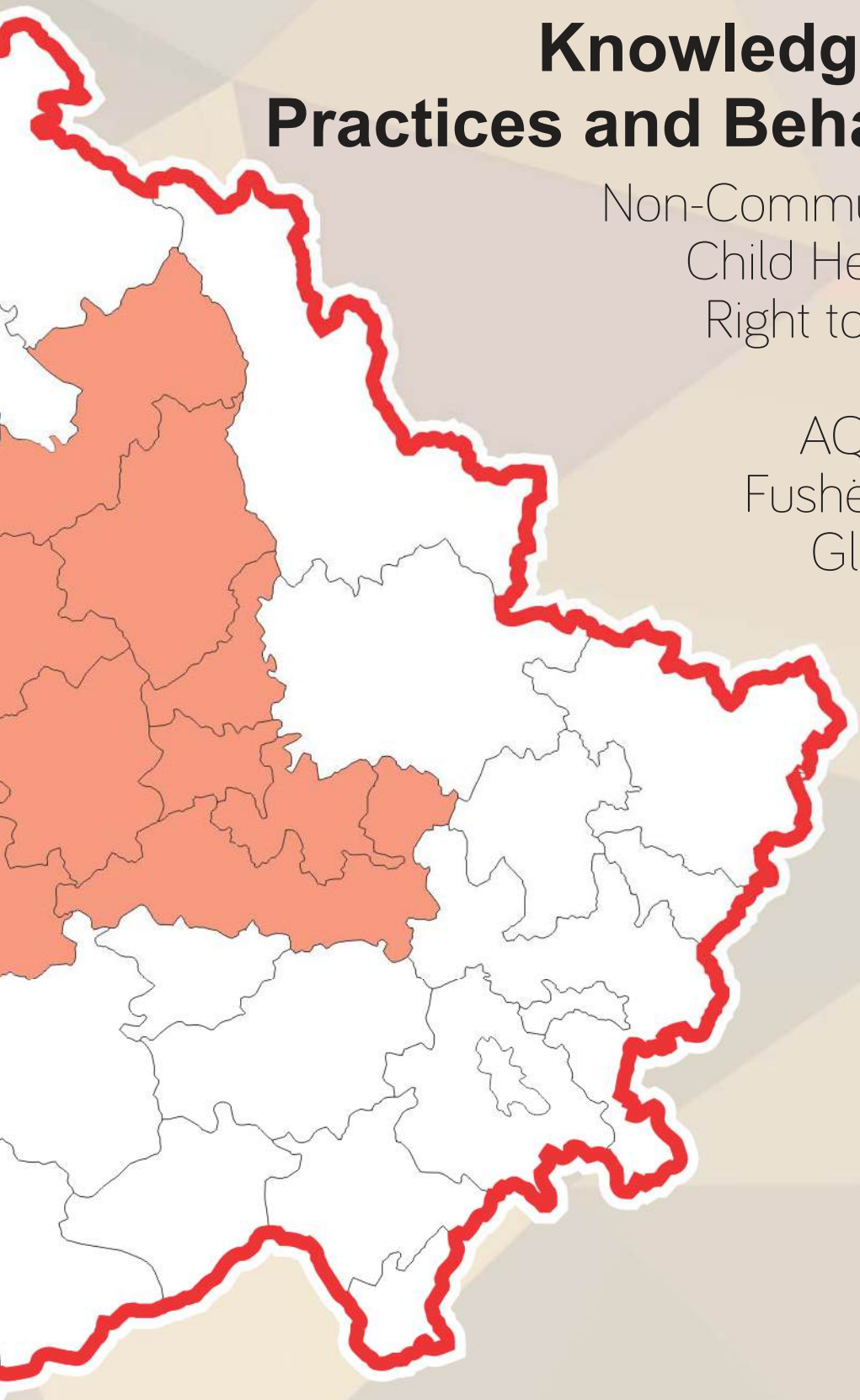

Knowledge, Attitudes, Practices and Behaviour 2020:

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

AQH I municipalities: Fushë Kosovë; Gjakovë; Gllogovc; Graçanicë; Junik; Lipjan; Malishevë; Mitrovicë; Obiliq; Rahovec; Skenderaj; and Vushtrri

July 2021

KANTAR TNS

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

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Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Agency For Development and Cooperation SDC

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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 non-communicable diseases (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 2020 KAPB Study was to provide a comparative analysis with the findings of the KAPB Study 2016 which was conducted in the 12 Municipalities supported during the first phase of the AQH project, namely: Fushë Kosovë, Gjakovë, Gllogovc, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skenderaj and Vushtrri.

The KAPB Study 2020 has two parts: 1) a quantitative study comprising 1229 questionnaire responses and; 2) qualitative research comprising data collection via 12 focus group discussions.

The study findings highlight that while the overall level of knowledge about NCDs is high and the level of knowledge about risk factors, early signs and preventive measures has marginally increased, there is no significant evidence of behaviour change. Across all studied NCDs at least 80% of the respondents want to be better informed, illustrating that health education remains an important issue. Health professionals are identified as being the most important channel of communication in relation to all health matters, followed by television and internet.

The awareness of smoking as a cause of NCDs has increased significantly, nevertheless, the percentage of the smokers across the population remains the same compared to 2016. A positive finding, however, is that there has been a marked decrease in the number of people smoking inside their homes – a major area of concern in 2016.
While there is an increase in fruit and vegetable consumption compared to 2016, the level of the consumption remains low and does not meet World Health Organization (WHO) recommendations, which states that consumption should be at least five servings per day. 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, remain areas of concern for service users and continue to be drivers for the utilisation of private health clinics. Out-of-pocket-expenditure and the costs associated with private care also remain as major concerns. Satisfaction with Family Medical Centres (FMCs) during respondents last visit has increased by 23% but, as is often seen with patient satisfaction surveys, this seems somewhat at odds with participants' reports about the poor quality of services received and should therefore be treated with caution. The total number of citizens who are aware of patient rights has not significantly increased.

The frequency of visits to healthcare facilities has dropped compared to 2016, and fewer people are using FMCs as the first point of contact for health services. Patients continue to state that they receive better quality care in private rather than public health facilities, but cost remains 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.

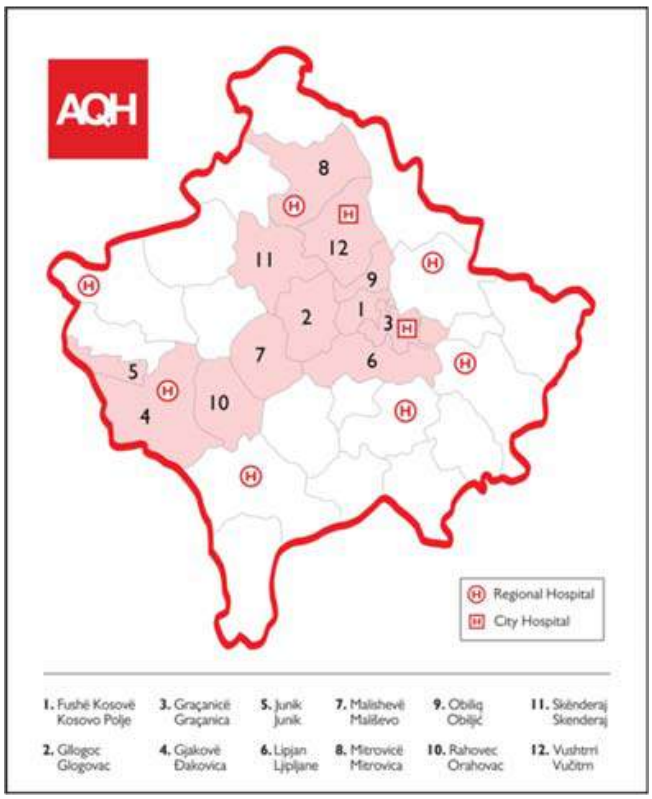
The project has the following expected outcomes:

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 Objective of the KAPB Study 2020



The purpose of the study was to assess the Knowledge, Attitude, Practice and Behaviour (KAPB) of general population in 2020, particularly focusing on vulnerable groups regarding selected NCDs and child health (specifically child diarrhoea and acute respiratory infections). In addition, the study provides information about the population's knowledge, attitude and behaviour regarding patients' rights.

The objective of the study was to provide a comparative analysis with the findings of the KAPB Study 2016, which was conducted in the 12 Municipalities which were supported during the first phase of the AQH project, namely: Fushë Kosovë, Gjakovë, Gllogovc, Graçanicë, Junik, Lipjan, Malishevë, Mitrovicë, Obiliq, Rahovec, Skenderaj and Vushtrri.

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

Survey design

The 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 survey comprised a questionnaire which was completed via face-to-face interviews, using the Tablet Aided Personal Interview (TAPI) method. The questionnaire is attached at Annex 1. Each interview was conducted in the respondents' home.

Study area & target population

The KAPB quantitative survey was conducted in the 12 project municipalities supported by the AQH project, 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 child health, then the interviewer collected this information from the person in the household who was the most knowledgeable about the child's health issues.

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: 980 effective interviews**
2. **RAE sub-sample: 249 effective interviews.**

This resulted in a total of 1,229 interviews.

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 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.

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

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.

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.

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

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, 12 Focus Group Discussions (FGDs) were conducted.

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:

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.

Sample and method

The study used the same sampling method used for the 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 that a variety of different age groups and social statuses were reflected in every group. Out of the total 12 group discussions, 9 of them were conducted with the Albanian community (6 with women and 3 with men) and 3 with the RAE community (1 with women and 2 with men). Also, out of the total number, 5 were in urban areas and 7 in rural areas.

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.

Quality control

Quality measures in the qualitative research included quality control 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 analysis.

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 the Covid-19 pandemic. It was difficult to focus the attention of participants on other topics besides the pandemic and many were concerned about having an unknown person visiting their home. Interviews were therefore conducted in the respondents' gardens where possible.

In this study, the total non-response rate was 45% compared to 16% in 2016, and a total of 2,086 contacts had to be made to reach a sample of 1,200 effective respondents. The number of non-contacts was 468 and the total number of refusals was 418.

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

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 1: Table of Key Staff

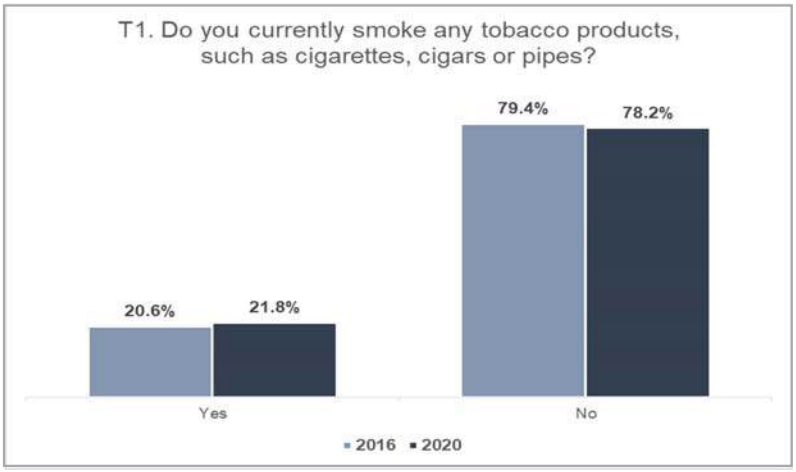
Field team:

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

3 Quantitative Survey - Results

3.1 Section 1: NCD Factors

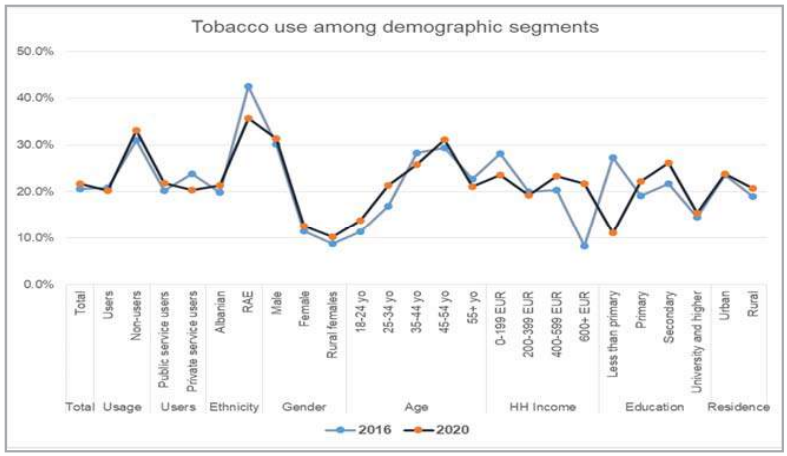
3.1.1 Tobacco Use



Graph 1: Percentage of smokers in total population

- No changes in smoking behaviour were found among the Albanian community (20% in both 2016 and 2020).
- The proportion of smokers is higher in the RAE community (36% in 2020), however this is a significant reduction since the previous survey (43% in 2016).
- No significant difference in smoking behaviour was recorded among males and females in 2020 (m 31%/f 13%) compared to 2016 (m 30%/ f 12%).
- Tobacco use continues to be slightly higher in urban areas compared to rural areas.
- The largest percentage of tobacco users fall in the age category 45-54 years old (29% in 2016/ 31% in 2020).

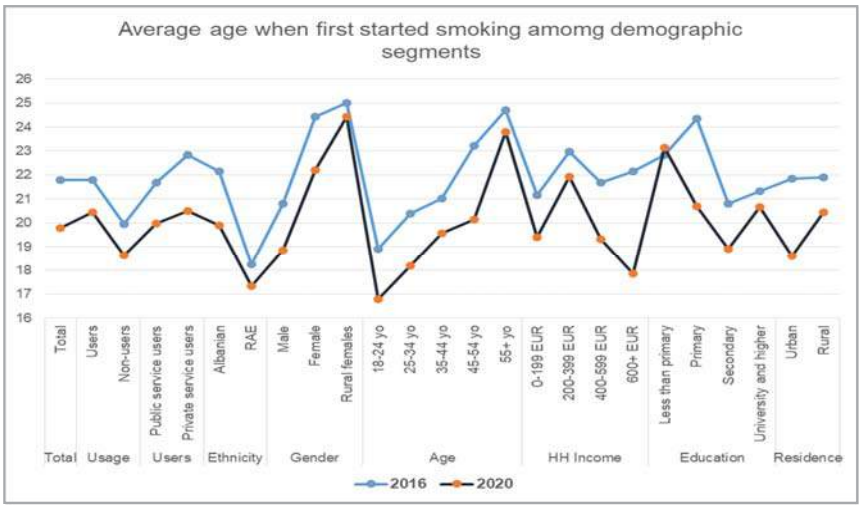
<u>Tobacco use among demographic segments</u>



Graph 2: Tobacco use among demographic segments

Age at which started to use tobacco

- The average age when people started using tobacco products has dropped (20 years old in 2020 and 22 years old in 2016).
- In 2020, males started smoking earlier (age 19) compared to 2016 (age 21).
- Females also started smoking earlier in 2020 (age 22) compared to 2016 (age 24).
- With the confidence interval in mind, there is an indication that the percentage of new coming smokers are mainly from Albanian community, as this has influenced the average of age when they started to smoke (age 20) compared to 2016 (age 22).
- The starting age of RAE community remains more or less the same, considering the confidence interval (age 19 in 2020/ age 18 in 2016).
- There is an indication that new smokers come from more affluent households. The starting age of smoking is younger among households who declared family income higher than 600 Euros per month (average age 18).



Graph 3: Average age for starting smoking among demographic segments

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%).

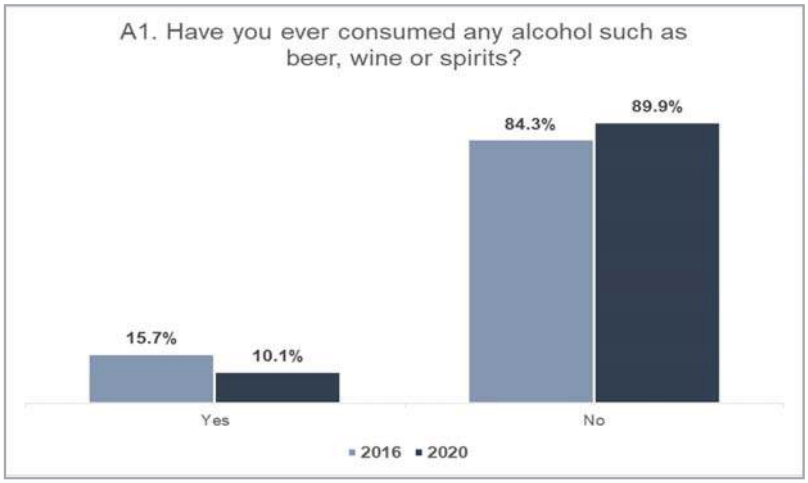
Indoor smoking

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%).

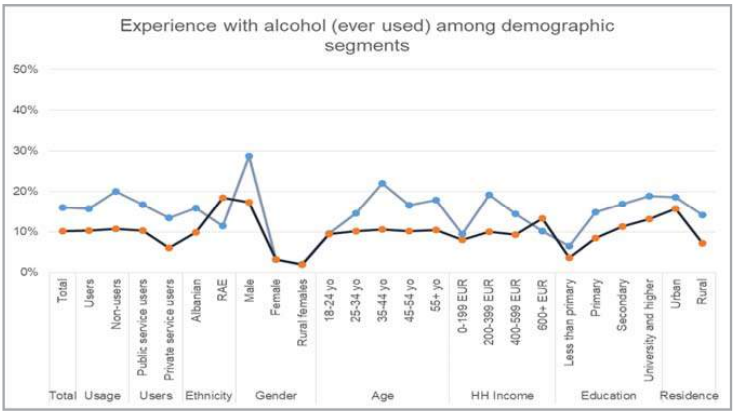
3.1.2 Alcohol Consumption

- The number of people among the total population reporting that they have never consumed alcohol has dropped (16% in 2016 / 10% in 2020), although both sets of figures seem remarkably low. However, it is noted that similarly low figures are also reported in the KAPB Study 2020 conducted in 8 other municipalities.



Graph 4: Alcohol consumption among total population

Alcohol consumption among demographic segments

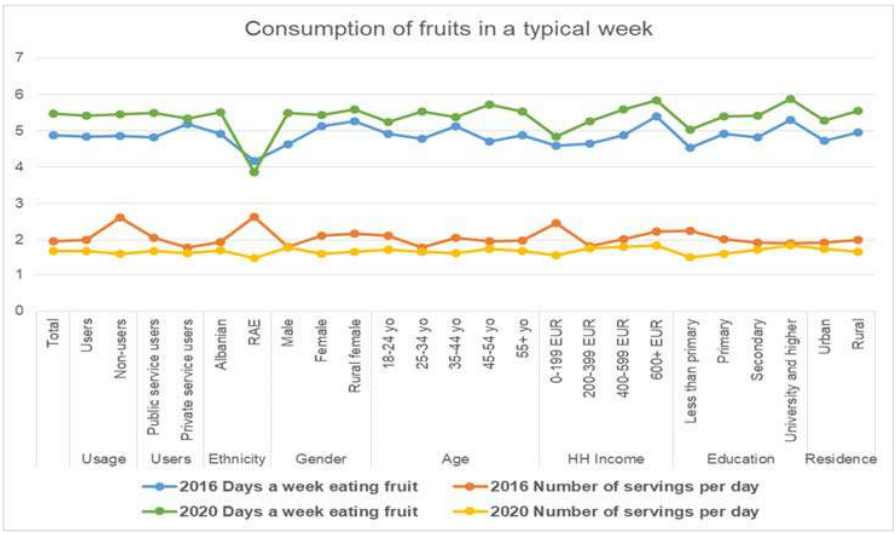


Graph 5: Alcohol consumption among demographic segments

- On days when they did drink alcohol, there has been no change in the amount of alcohol consumed among Albanian population (2 drinks in both 2016 and 2020).
- There is an increase in RAE community (2 drinks in 2016 / 3 drinks in 2020).

3.1.3 Diet

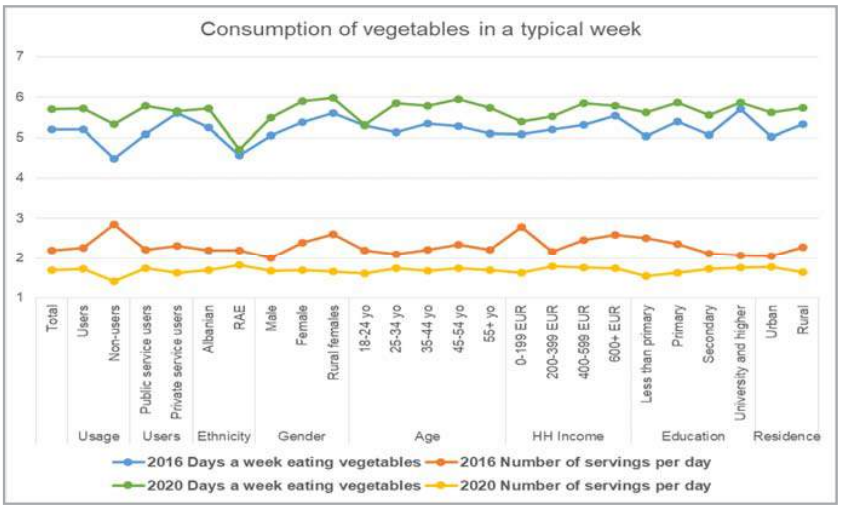
The survey tracked the consumption of fruit and vegetables, including the weekly consumption and number of servings per day among the adult population.



Graph 6: Fruit consumption per week among demographic segments

Fruit consumption

- The number of days per week when fruit is consumed has increased (5 days in 2016 / 5.6 days in 2020). The increase is constant among almost all demographic segments. The average number of fruit portions per day remains the same (2 per day in 2016 and 2020).
- Weekly fruit consumption has decreased among RAE community (4.2 days in 2016 / 3.8 days per week in 2020). The average number of fruit portions per day remains the same here also (1 per day in 2016 and 2020).



Graph 7: Vegetable consumption per week among demographic segments

Vegetable consumption

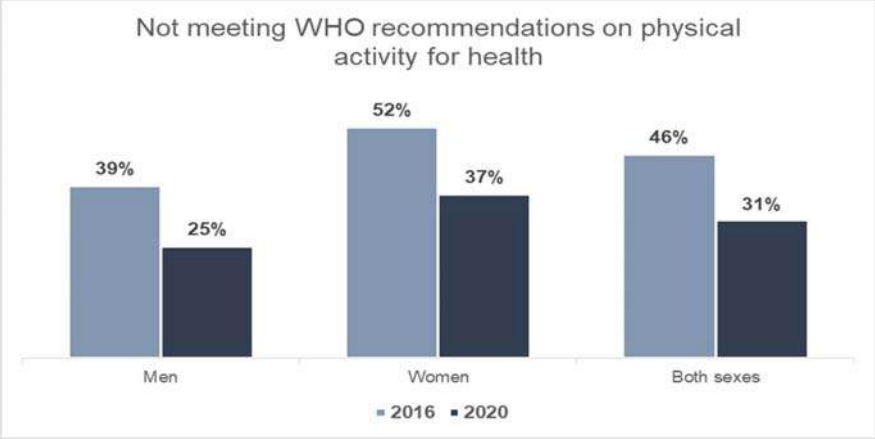
- The number of days per week when vegetables are consumed has increased (5 days in 2016 / 6 days in 2020).
- Respondents have declared that they eat on average 2 servings vegetables on those days when they do eat fruits and vegetables, same as in 2016.

Salt and sugar consumption

The 2020 survey revealed some changes in behaviour relating to salt consumption, potentially explained by the fact that because of the pandemic, people eat at home more often compared to 2016 .

- Consumption of salt or a salty sauce added to food right before it is eaten or as it is being eaten has increased (21% in 2016 / 27% in 2020)
- The use of salty seasoning or a salty sauce when cooking or preparing foods has increased (32% in 2016 / 42% in 2020).
- The frequency of consumption of sugar in coffee and tea several times a day has remained more or less the same (65% in 2016 / 67% in 2020),
- Frequency of use of salt, sugar and fats in 2020 compared to 2016 is detailed in Annex 7.

3.1.4 Physical Activity

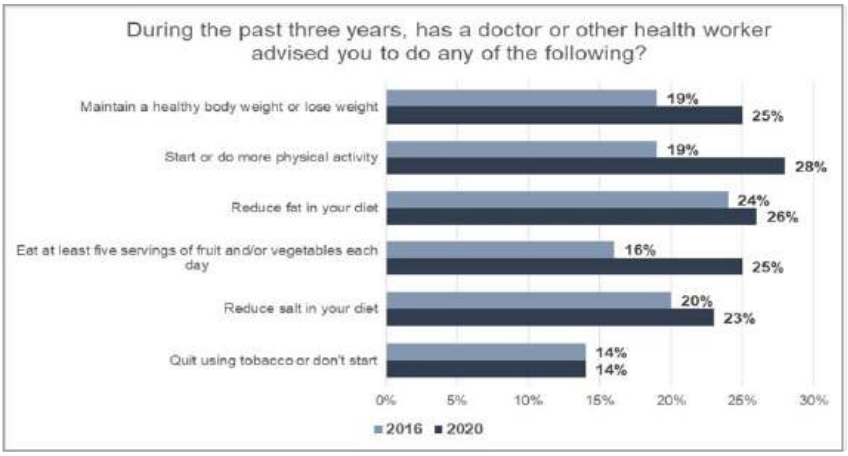


Graph 8: Respondents not meeting WHO activity recommendations

- Weekly recommended time for vigorous physical activity is 75 minutes. Whilst the calculated weekly average physical activity of the total population exceeds this, it is noted that the amount of activity has more than halved (203 minutes in 2016 / 89 minutes in 2020). Yet, the percentage of the population that does not meet the WHO recommendations on physical activity remains high (31%) but significantly lower compared to 2016 (46%).
- Moderate and vigorous physical activity remains mainly related to work. There is no increase in activity for recreation purposes.

3.1.5 Lifestyle Advice

- Survey data reveals that compared to 2016, more patients received advice from the doctor or healthcare worker in 2020 regarding health behaviour. Nevertheless, the percentage of the patients who ever received advice remains low.



Graph 9: Respondents advised about lifestyle by health workers

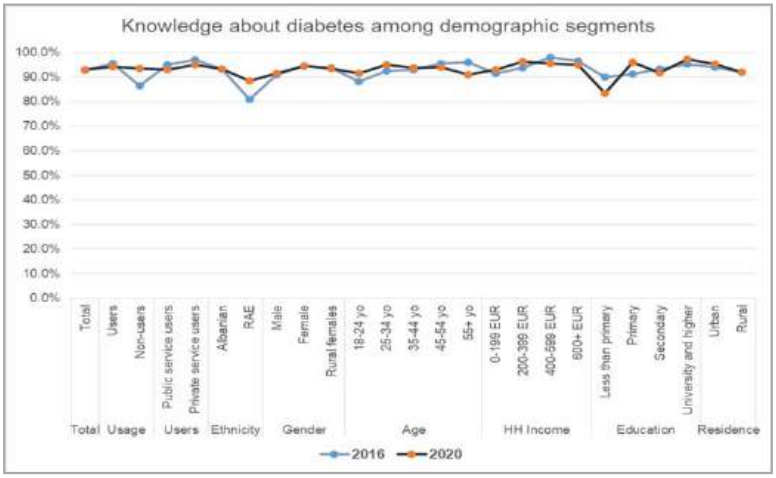
3.2 Section 2: Knowledge, Attitudes, Practices and Behaviours on NCDs and Child Health

For the analysis purposes and in order to be able to show the results about knowledge, attitudes, practices and behaviours 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 specific non-communicable disease, 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 on diabetes are presented at Annex 8.

- There is a continued high awareness of the population about the existence of diabetes (or "sugar disease") (93% in both 2016 and 2020).
- There are no significant differences in awareness on this disease among different demographic segments, although there is a slight indication that the awareness is more prevalent among Albanian community (93%) compared to RAE (86%).



Graph 10: Knowledge of diabetes among demographic segments

Knowledge

Knowledge: Diabetes

Topic	2016 result	Change	2020 result
Have heard of diabetes	93%	↔	93%
Overall knowledge of risk factors	15%	↑	20%
Knowledge of early signs	22%	↑	23%
Understanding of preventive measures	22%	↑	27%

- The overall knowledge of risk factors score has increased significantly, although it remains rather low across the total population (15% in 2016 / 20% in 2020).
- Awareness that eating too much sugar can lead to diabetes has shown the highest increase across all demographic segments (33% in 2016 / 55% in 2020), with a significant among RAE community (18% in 2016 / 45% in 2020).
- There is an increase of awareness of people knowing that stress is a risk factor associated with diabetes across all demographic segments (27.4% in 2016 / 38.8% in 2020).
- Overall knowledge scores about the early signs of diabetes have not changed and remain low (22% in 2016 / 23% in 2020).
- There is no significant difference between genders when it comes to knowledge on early signs of diabetes.
- Overall knowledge about preventive measures has increased to 27%, significantly higher statistically ($p<.05$) compared to the knowledge in 2016.
- The increase in knowledge of the total population is more or less proportional among all its indicators and across all demographic segments, apart from men (no significant increase of knowledge for any preventive indicator).

Attitudes

Attitudes: Diabetes

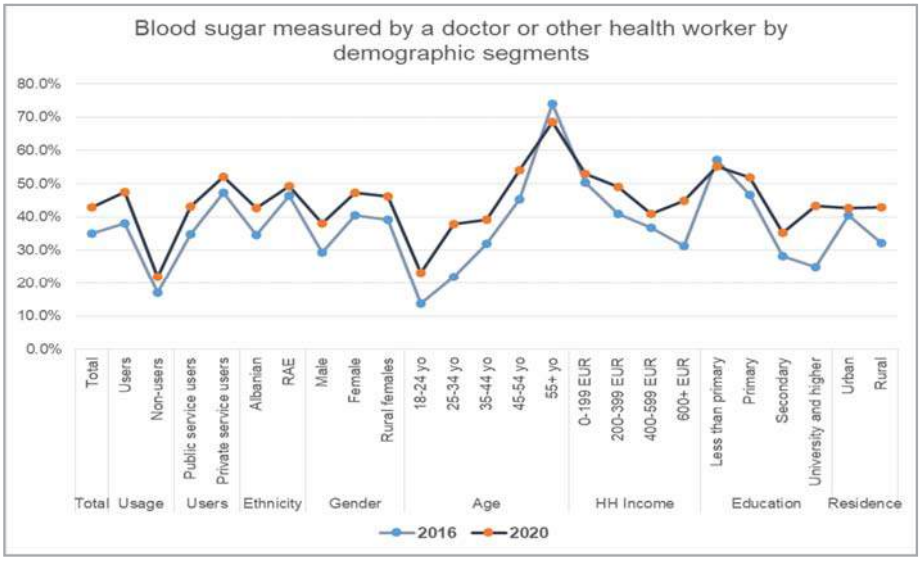
Topic	2016 result	Change	2020 result
Would seek treatment if they thought they had the disease	84%	↔	89%
Patients are confident about when to seek care	53%	↑	65%
Patients feel informed about their disease	16%	↑	25%
Patients want to be better informed about the disease	86%	↓	83%

- Scores related to attitudes about seeking medical treatment if the respondent or family member or friend has diabetes have increased (84% in 2016 / 89% in 2020).
- The level of confidence among diabetics regarding what to do when their blood sugar level goes higher or lower than it should be has increased significantly (53% in 2016 / 65% in 2020).
- The percentage of the diabetics feeling informed about problems associated with diabetes has also increased (16% in 2016 / 25% in 2020).
- This leaves the two thirds of the sample acknowledging that they are not sufficiently informed about this disease and even more (83%) would like to know more about the disease, reaffirming a similar level already observed in 2016.

Practices and Behaviours

Practices & Behaviours: Diabetes

Topic	2016 result	Change	2020 result
Have blood tested by health professional	35%	↑	43%
Taken oral diabetes medication prescribed by doctor in last 2 weeks	67%	↑	71%
Taken insulin prescribed by doctor in last 2 weeks	29%	↓	19%
Household member has diabetes	13%	↑	17%



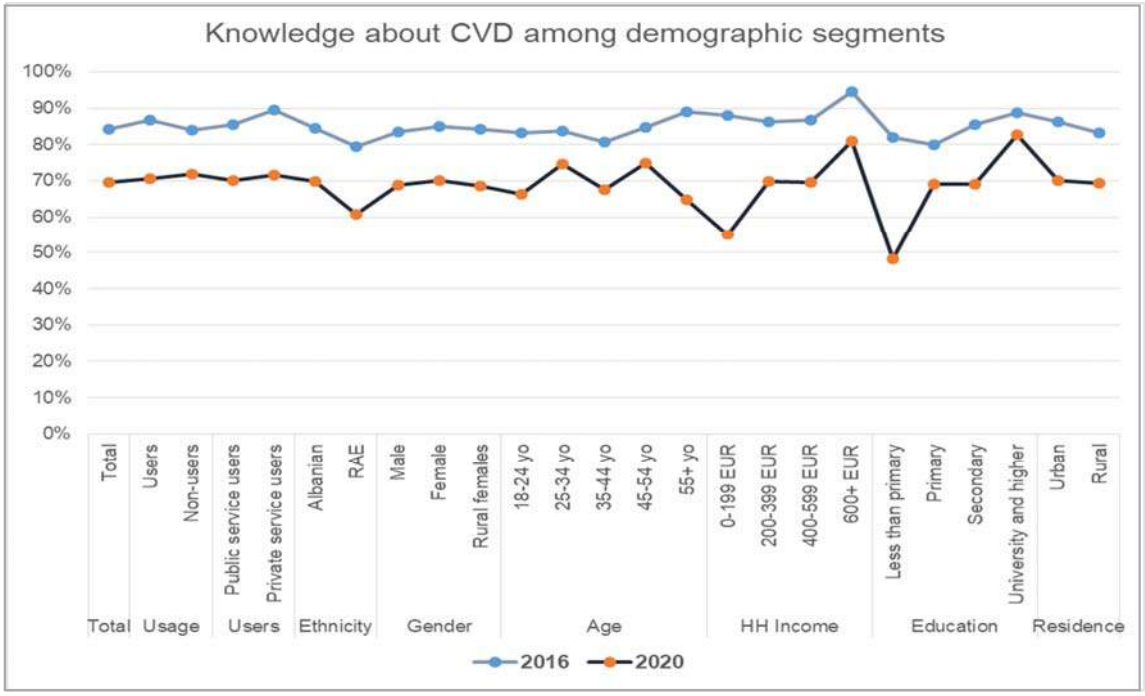
Graph 11: Blood sugar measurement practices by demographic segments

- Out of the population whose blood sugar was measured by the doctor or health worker, 17% were informed that they have raised blood sugar, more common among elderly older than 55 (34%) and population coming from low-income households (26%).

- Most diabetics discovered they had diabetes during routine check-ups (46%) and after first symptoms have appeared (26%).
- Few respondents discovered they had diabetes after developing advanced complications.

3.2.2 Cardiovascular Diseases

Data on cardiovascular diseases (CVDs) are presented at Annex 9.



Graph 12: Level of knowledge about CVDs among demographic segments

- Knowledge level for CVDs is significantly lower among the targeted population compared to 2016 and lower than the overall knowledge of diabetes.
- When comparing the data with 2016, the findings indicate that as far as the level of knowledge about associated risk factors of CVDs, early signs and preventive measures, no significant change was marked among the population.
- 70% of respondents have declared that they have heard of CVDs; 14% less than in 2016.

Knowledge: Cardiovascular Diseases

Topic	2016 result	Change	2020 result
Have heard of CVDs	84%	↓	70%
Overall knowledge of risk factors	14%	↑	16%
Knowledge of early signs	13%	↔	13%
Understanding of preventive measures	20%	↓	19%

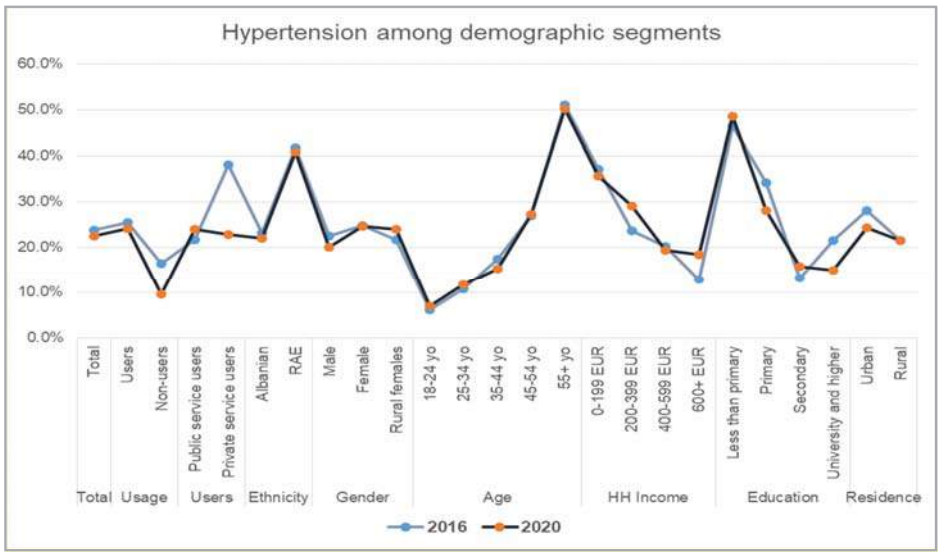
Practices and behaviours

Practices & Behaviours: CVDs

Topic	2016 result	Change	2020 result
Patient takes CVD medication	8%	↑	14%
Household member takes CVD medication	14%	↑	29%

- 4.5% of respondents had had a heart attack, chest pain (angina), or a stroke. The number of such reported cases is almost three time higher among the RAE community (12.6%) than among the Albanian community (4.3%). These cases are reported more from urban areas (7.1%) than from rural areas (3.3%).
- Out of the total population, 18% reported that they have at least one family member who had heart attack, chest pain or stroke at least once in their life.
- 14% of the population reported taking aspirin or other medication regularly to treat or prevent heart disease.
- 29% reported that their family members take aspirin or other medication for prevention or treatment of CVDs.

3.2.3 Hypertension



Graph 13: Percentage told they have hypertension among demographic segments

Knowledge: Hypertension

Topic	2016 result	Change	2020 result
Have heard of Hypertension	95%	↔	95%
Knowledge of complications	20%	↑	21%

- There has been a slight increase in knowledge of complications. As in 2016 the most frequently mentioned complications are heart attack or stroke (57%) and heart failure (56%).

Attitudes: Hypertension

Topic	2016 result	Change	2020 result
Patients are confident about when to seek care	60%	↓	59%
Patients feel informed about the disease	22%	↑	29%
Patients want to be better informed about the disease	90%	↓	88%

- There has been a 1% decrease in patients being confident about when to seek care but this is not considered significant.
- Although more people feel informed about the disease, the number remains low. This correlates with the number of patients that want to be better informed, which has decreased marginally but remains high

Practices & Behaviours: Hypertension

Topic	2016 result	Change	2020 result
Have blood pressure measured by health professional	73%	↑	82%
Told to monitor blood pressure by health professional	87%	↓	83%
Informed of complications by health professional	14%	↑	29%

- The number of people having their blood pressure measured by a health professional has increased significantly. This is slightly more prevalent among the Albanian community (83%) compared to RAE (75%), and more prevalent among women (84%) compared to men (81%).
- Among respondents that had their blood pressure measured by a doctor or other health worker, 23% were told they have raised blood pressure or hypertension, more prevalent among RAE community (41%) compared to Albanian community (22%).
- This variable correlates with age – the higher the age the more frequently they were told they have high blood pressure.
- Presence of hypertension drops with the increase of monthly household income, as well as with the increase in the level of education.
- The number of people told to monitor their blood pressure by a health professional has decreased slightly.

- Most respondents answered that in cases when they feel their blood pressure has increased, they take medication (65%), visit the doctor (30%) or use home remedies such as yoghurt, lemon, coffee, garlic, etc. (25%).
- 58% of respondents check their blood pressure only when they feel they blood pressure is not stable (regardless of whether or not they were advised to have routine check-ups).
- 19% follow doctors' advice to have routine check-ups.
- 20% have both routine check-ups and also visit the doctor when they feel their blood pressure is high/low.
- In most cases respondents measure their blood pressure themselves (50%) or with help from a neighbour or family member (45%), and in 16% of cases they go to their regional hospital.
- 60% of the patients diagnosed with hypertension report to have taken medication prescribed by the doctor in the past 2 weeks.

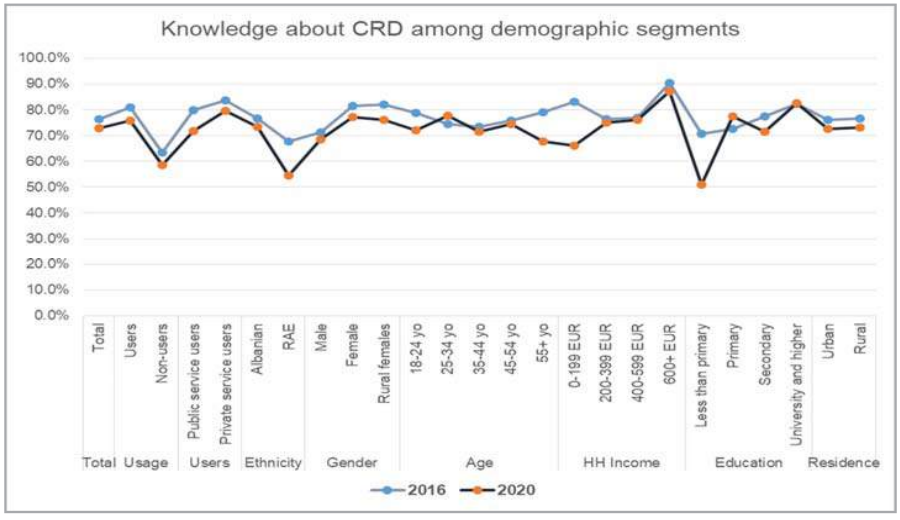
%	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Percentage of people consulting doctor if they feel that their blood pressure is high	22	30	21	30	32	19	19	32	23	28

Table 2: AQH indicator **-** Percentage of people consulting doctor if they feel that their blood pressure is high disaggregated by gender and ethnicity

3.2.4 Chronic Respiratory Diseases

Data on Chronic Respiratory Diseases (CRDs) are presented at Annex 10.

Knowledge



Graph 14: Knowledge about CRDs among demographic segments

Knowledge: Chronic Respiratory Diseases

Topic	2016 result	Change	2020 result
Have heard of CRDs	76%	↓	73%
Overall knowledge of risk factors	20%	↓	19%
Knowledge of early signs	30%	↑	31%
Understanding of preventive measures	29%	↔	29%

- The percentage of the population who has ever heard of chronic respiratory diseases (CRDs) remains rather low compared to awareness about diabetes and hypertension.
- Knowledge about associated risk factors, early signs and preventive measures for CRDs remains rather low.
- The drop in awareness remains proportional across most different demographic segments but awareness percent about the existence of CRDs is significantly lower among RAE (55%) compared to 2016 (69%), among the elderly (68%), lower income households (66%) and among population in the 'less than primary school completed' group (51%).
- The most mentioned risk factors are tobacco smoke (73%), outdoor air pollutants (36%), and allergens (17%).
- The increase against most knowledge indicators is more marked among RAE community.
- Overall, men are more knowledgeable about risk factors associated with CRDs, especially about tobacco smoke and outdoor pollutants.
- Knowledge level about early signs of CRDs remains very low.
- The knowledge level about early signs of CRDs has increased significantly among RAE community.
- Leading preventive measure against CRD is quitting smoking, mentioned by 70% of the population that has heard about CRDs, compared to 49% in 2016.

Attitudes

Attitudes: Chronic Respiratory Diseases

Topic	2016 result	Change	2020 result
Would seek treatment if they thought they had the disease	67%	↑	72%
Patients are confident about when to seek care	40%	↑	42%
Patients feel informed about the disease	12%	↑	17%
Patients want to be better informed about the disease	87%	↓	85%

3.2.5 Child diarrhoea

Data on Diarrhoea are presented at Annex 11.

Knowledge

Knowledge: Diarrhoea

Topic	2016 result	Change	2020 result
Have heard of diarrhoea	91%	↑	94%
Overall knowledge of risk factors	23%	↓	19%
Knowledge of early signs	22%	↑	24%
Understanding of preventive measures	17%	↑	20%

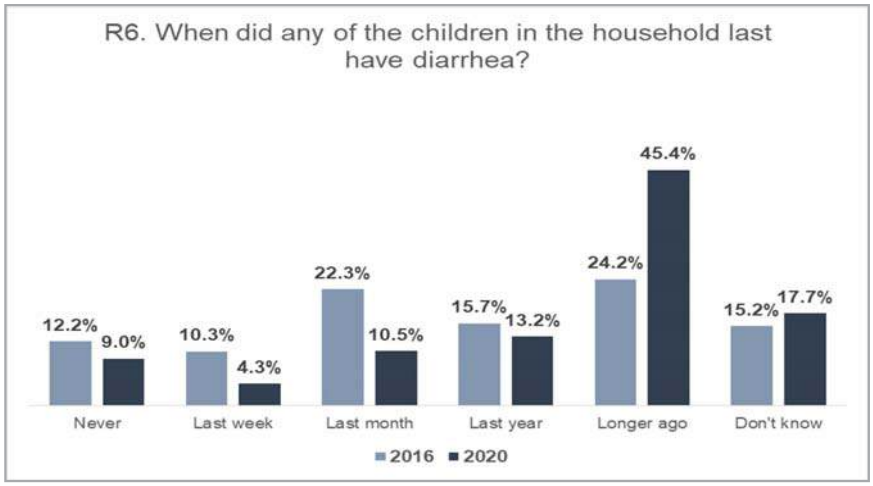
- The calculated knowledge scores for risk factors, early signs and preventive measures for diarrhoea remain low.
- Food poisoning and infection remain as the two most common risk factors identified.
- The level of knowledge about food poisoning and lack of clean water as a leading cause of diarrhoea has increased (70% and 15% respectively) across the population with children younger than 18 in the household.
- Other knowledge indicators have dropped significantly, especially among Albanian population.
- Knowledge of symptoms of dehydration has increased by 15% compared to 2016, and across all the demographic segments, but overall remains relatively low (42%).
- Watching what you eat and drink remains the most mentioned preventive method and it has increased by 27% compared to 2016 and across all demographic segments. Washing hands frequently (32%) and asking your doctor about using antibiotics (20%) are the other two most mentioned preventive measures.

Attitudes

Attitudes: Diarrhoea

Topic	2016 result	Change	2020 result
Patients are confident about when to seek care	53%	↑	63%
Patients feel informed about the disease	20%	↑	30%

- The level of confidence about what to do when a child has diarrhoea has increased but the level of patients that feel informed remains low at 30%.

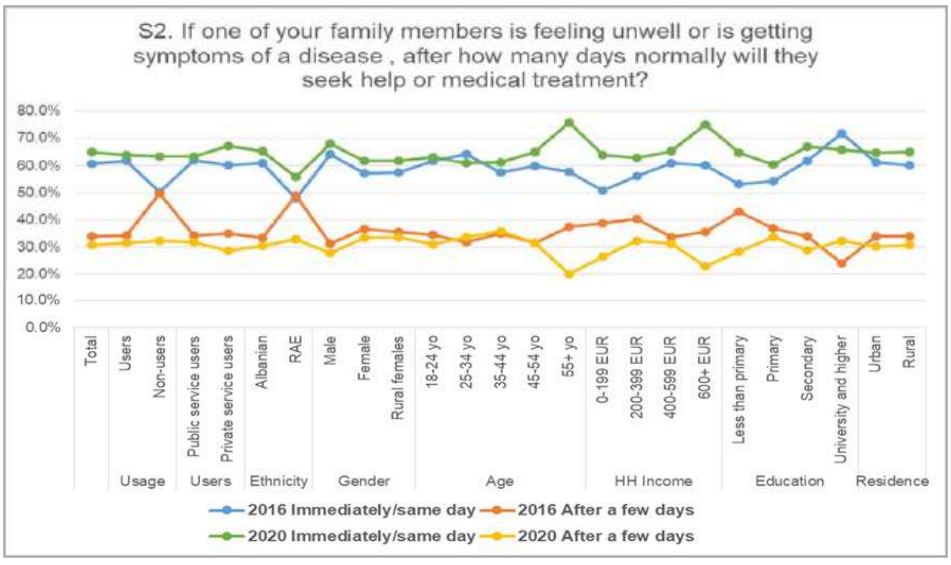


Graph 15: Frequency of occurrence of diarrhoea in children

- Reported cases of diarrhoea 'last week' and 'last month' dropped by approximately 60%.
- 39% of respondents with children in their household that have had diarrhoea in the past take their child immediately to the doctor and the remainder (61%) first try to treat it at home on their own.
- 48% give liquids and 85% give food to the child when they have diarrhoea.
- Less than half of respondents (44%) are aware of Oral Rehydration Solutions.
- 82% of those aware of Oral Rehydration Solutions have used them to treat diarrhoea.

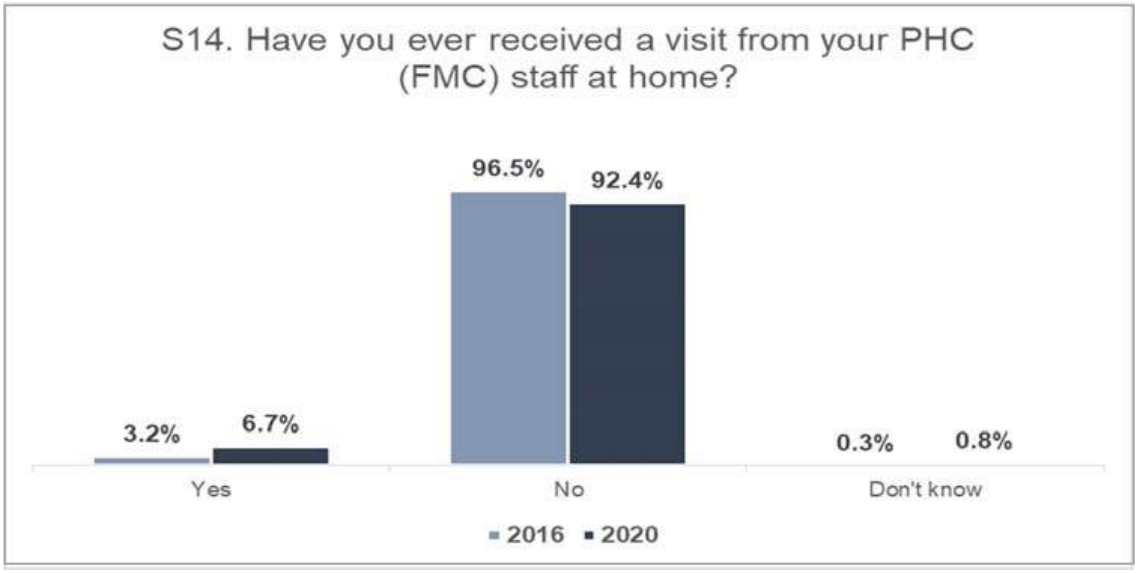
3.3 Section 3: Quality of Healthcare, Patient Rights and Communication

3.3.1 Healthcare Seeking Behaviour



Graph 16: Treatment seeking behaviour among demographic segments

- 93% had visited a doctor at least once in their life.
- 11% of RAE population had never, or did not recall, visiting a doctor. This was 7% for the Albanian population.
- More men than women had never visited a doctor.
- Fewer respondents sought service from public healthcare facility when they last needed medical care (77% in 2016 / 70% in 2020).
- More respondents sought medical care in private facilities (17% in 2016 / 24% in 2020).



Graph 17: Reported visits from FMC staff at home

3.3.2 Types of Services Used

- There is a decrease in the number of respondents using Family Medical Centres (FMCs) as their first point of contact (82% in 2016 / 75% in 2020).
- The number of respondents using regional hospitals as the first point of contact has decreased (61% in 2016 / 48% in 2020), as has utilisation of Kosovo Clinical University Centre in Prishtina (45% in 2016 / 40% in 2020).
- Private clinic utilisation has also decreased (56% in 2016 / 41% in 2020)
- FMCs are more preferred by the rural population (80%) compared to the urban ones (69%).
- FMCs are preferred slightly less by the population living in households with higher household incomes (600+ Euro) compared to lower income households.
- Women prefer private clinics (43%) more than men (39%), while more men would seek services of Kosovo Clinical University Centre compared to women (male: 46%; female: 33%), as well as those with university degree or higher (55%).

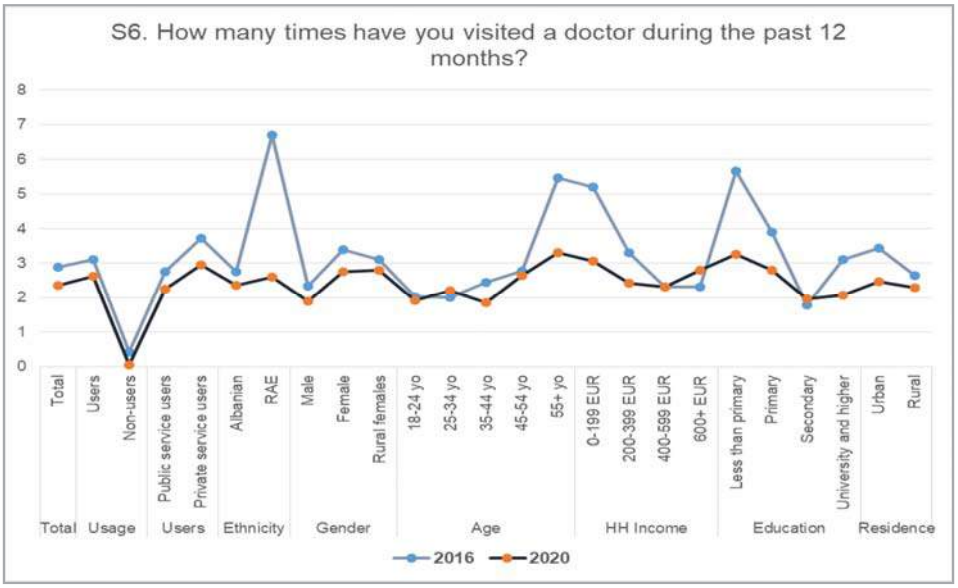
Frequency of health facility visits

- People continue visiting the public primary **healthcare** facilities more often than the private healthcare facility.

Last facility visit	FMC		Private Facility	
	2016	2020	2016	2020
5+ years ago	7.4	10.6	12.9	12.9
3-4 years ago	5.2	6.8	8.5	5.6
1-3 years ago	16.9	18.5	12.9	11.7
6-12 months ago	16.6	16.4	7.9	7.8
1-6 months ago	25.1	21.0	14.6	15.7
Less than a month ago	18.3	17.3	10.1	11.6
Do not know	10.5	9.3	33.0	34.8

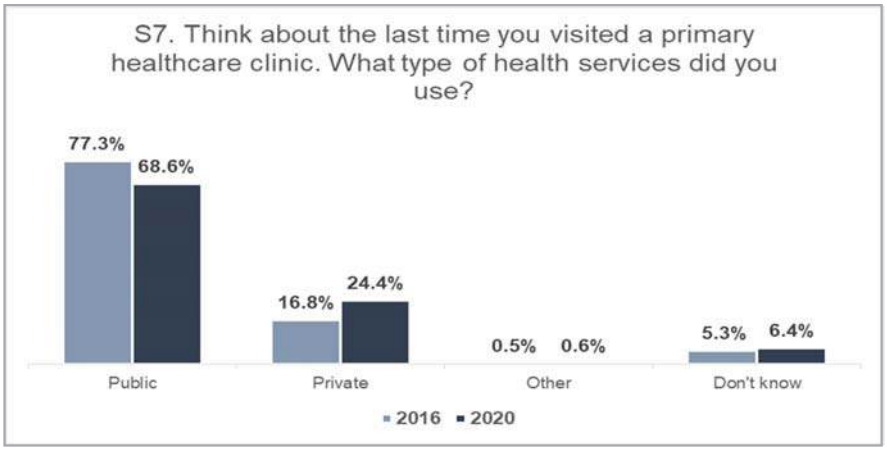
Table 3: Frequency of visits in public and private facilities

- The frequency of the visits to the doctor in the past 12 months has dropped to 2 times on average (from 3 times in 2016) in the past 12 months.



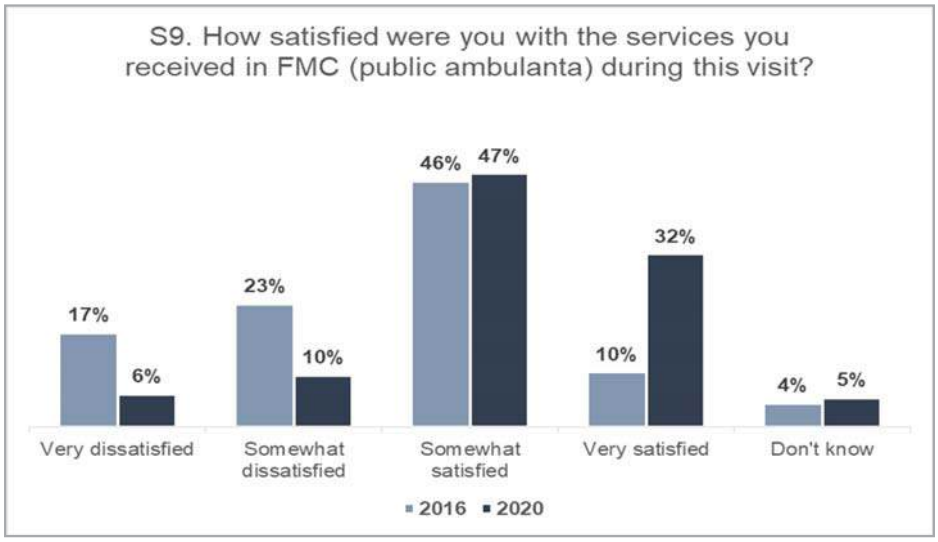
Graph 18: Frequency of visits to the doctor among demographic segments

- Two most frequently reported last visits to the doctor were for check-up (65%) and illness (15%), and majority of respondents used a public healthcare facility (68%).
- Medication was prescribed during 84% of last visits. 96% of these respondents stated that they took the prescribed medication. 4% stated they did not take the prescribed medication because they could not afford it.
- The average number of visits to the doctor in the past 12 months has dropped significantly (9.7 in 2016 / 4.7 in 2020).
- The number of chronically-ill persons visiting the doctor has markedly increased (11% in 2016 / 27% in 2020).

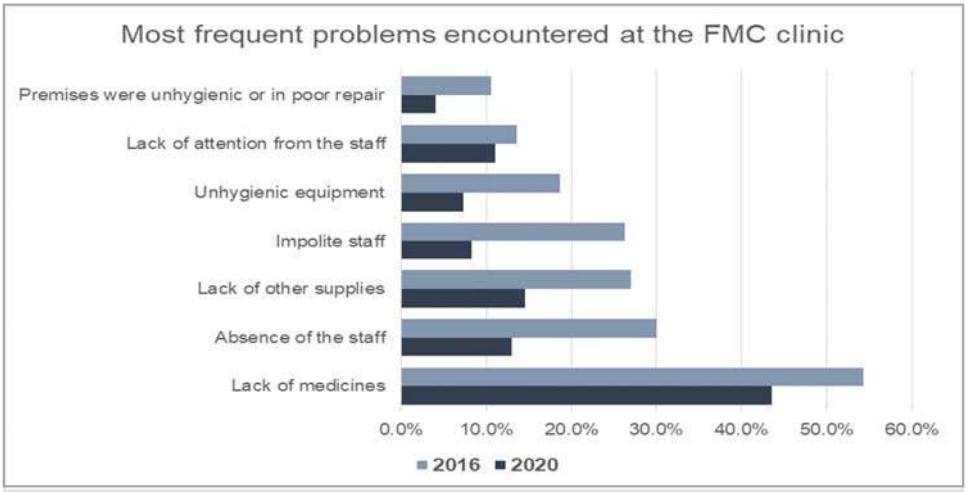


Graph 19: Share of visits between public and private healthcare clinics

3.3.3 Patient Satisfaction

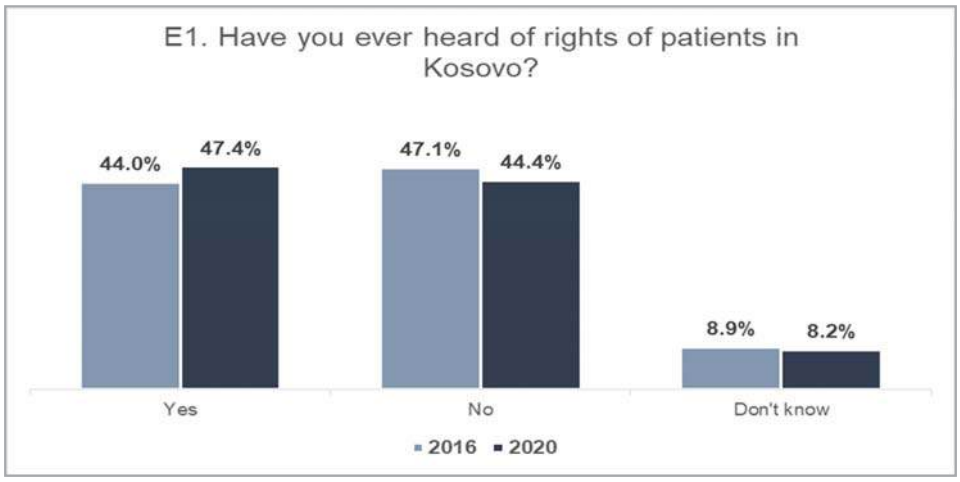


Graph 20: Satisfaction with services received in FMC's



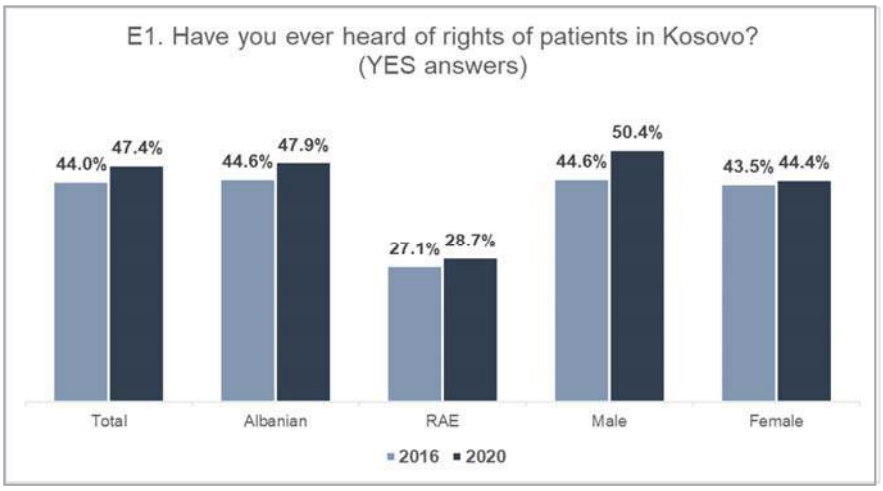
Graph 21: Most frequent problems encountered at FMC's

3.3.4 Patient Rights



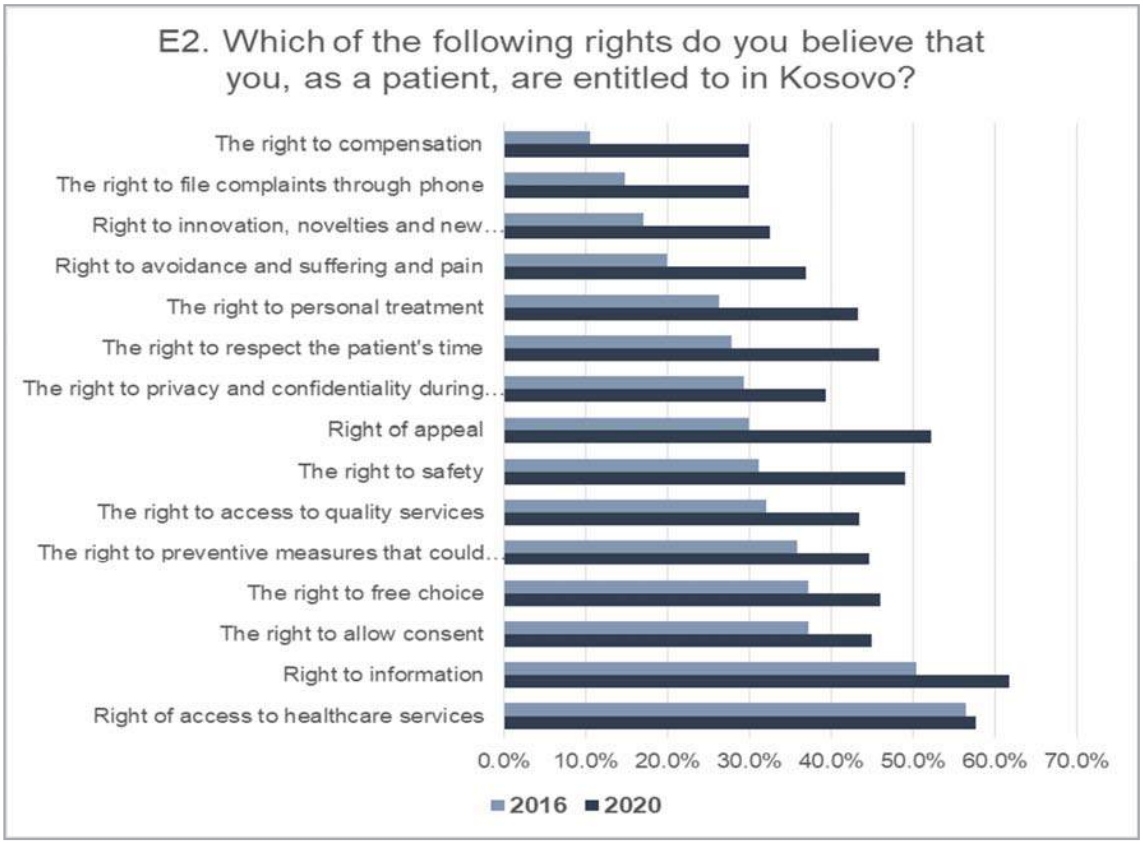
Graph 22: Level of awareness about patient rights

- Population group with university degree completed or higher (63%), population living in household with more than 600 Euros income (61%) and the age group 25-34 (55%) are predominantly more informed about the existence of the notion of patients' rights.



Graph 23: Level of awareness about patient rights by ethnicity and gender

- The number of respondents that have seen the list of patient rights displayed in healthcare facilities has increased (26% in 2016 / 32% in 2020).
- 49% of these respondents believe that patients' rights are only somewhat enforced, 22% believe that they are not enforced so much, and 10% believe that they are not enforced at all.
- There has been a major increase in the number of respondents aware that there is a telephone number they can call and complain about healthcare services (5% in 2016 / 42% in 2020).



Graph 24: Awareness about rights patients

3.3.5 Communication Channels

The targeted population currently uses three main communication channels for obtaining information about healthcare in general, and about health services in their areas specifically: 1) doctors or nurses; 2) television and; 3) internet. This remains unchanged from 2016 (see Annex 12).

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

- Perceptions about the quality of the public health system remain poor. As in 2016, this could be because of a lack of trust in the capacity of healthcare provision, however in 2020 this could have been influenced by concerns related to Covid-19 virus at a time when the public were being told by Government to avoid attending health facilities if at all possible.
- Although most participants in the group agree that the care by the medical staff has been improved in the past few years, in each group participants gave examples of the consequences of poor medical care and careless doctors.

  'I would recommend people to take care of themselves in order not to need to go to the doctor because the experiences with healthcare in Kosovo are not good' ***(Group with female, Vushtrri, rural)***

  'I hope God will take care of us because going there is a nightmare' ***(Group with female, Vushtrri, rural)***

- Larger towns and cities are considered to provide slightly better services for their patients compared to smaller urban areas and villages.f

  'The primary public healthcare provision conditions are very poor. You cannot get not even basic blood exam and let alone if you need an injection – you have to go to private doctor's office while for blood exam you have to go to Gjakova or Deqan, either at primary healthcare facility or private one. ***(Group with female, Junik, urban)***

- Despite participants from RAE community reporting situations when they were discriminated and insulted because of their ethnicity, they appear more satisfied with the healthcare services.
- Compared to 2016 there are fewer complaints about the level of doctor's commitment to patients and their professional responsibility. The lack of essential drugs continues to be a major concern for patients. Both issues motivate patients to seek treatment in private clinics.
- Health care costs are a critical issue, especially for chronic diseases, since these costs are paid out of pocket, imposing a heavy burden for patients or their family members.

  'My son suffers from diabetes; it has cost me 800 EUR to pay for his hospital bill and for the tests. I had to seek for help in Nish, because I did not have any more money to continue my son's treatment here. In Nish (Serbia), the service was cheaper and they made my son better. Here, his health situation got only worse. ***(Group with male, Obiliq, rural, 2016)***

  'I sufferr from asthma since 2012 and as a chronic disease, it costs some 300-400 Euros every time you get sick.. It is the duty of the state to care about people with chronic diseases who cannot afford treatment themselves. Those who cannot afford to pay, have to die because there is no other way… and paying for it costs so much and we barely manage it. ***(Group with female, Gjakova, urban, 2020)***

- Lack of service provision, especially the lack of essential medications for chronic diseases, continues to push patients to seek treatment in bigger cities and at private clinics. Both factors create a burden for patients and for family members, not just financial but also physical burden because of the difficulties to travel.

4.1.2 Healthcare seeking behaviour

- There is change in healthcare seeking behaviour across all the focus groups. Patients are very cautious because of the fear of being exposed to the Covid-19 virus and the continuous calls of Ministry of Health to avoid the use of healthcare facilities unless absolutely necessary.

  'People are aware now that you can't go to primary healthcare facility for anything… especially during pandemic I have noticed that the elderly are hesitating to go, me also because I know that they won't give me a proper treatment ..… It is an overall impression nowadays that at the moment you arrive at the healthcare facility, you will be referred to department for infections and they hesitate to go' ***(Group with female, Skenderaj, rural)***

  *'Lately because of the pandemic we had to be extra cautious about our health because doctors had a difficult job during this period, they were risking their lives because of the virus' (****Group with female, Rahovec, rural).***

- Participants emphasised that visits to the doctors were made only when the symptoms worsened and participants were extra cautious when children were involved.

  'I don't go to the doctor and I don't send my children either. I become a doctor myself, I take care of them, give them medication and go out and buy if any is missing. The reason I don't send them to the doctor is because I am afraid they might get a virus from other children'. ***Group with female, Vushtrri, rural)***

- RAE healthcare seeking behaviour does not appear to differ to other communities.

- While all the participants are fully aware about the cost of visits, medication, the waiting and care procedures, the level of awareness about patients' rights and their right to complain is limited.

4.1.3 Utilisation of public PHC facilities

- Many of the concerns about public PHC facilities that were highlighted in 2016 remain (see Annex 13). Again, participants highlighted the lack of medical equipment, technology, long waiting lines, lack of hygiene, and lack of essential medicines as areas of concern.

- The lack of staff in smaller PHC facilities remains challenging.

  'Our ambulanta works until 14:00, and in case you need a medical service after that time, you have to go to Obiliq (for health centre), which is very far' ***(Group with male, Obiliq, rural, 2020)***

- Reports of patients being referred to their private practices, by doctors claiming that treatment in the public facility is not possible, are frequently highlighted.

  'After I gave birth, a nurse came to me and gave me the address of the doctor and she said that the doctor said, because of the pandemic, I should

visit her in her private practice. After I was discharged from the hospital, I sent my newborn to her private practice and the length of the visit was 2 minutes because she had a long line of patients waiting – I paid 10 euros for that' (mothers and children are exempted from payment in public healthcare facilities) – ***(Group with female, Gjakova, urban, 2020)***

"To me the public healthcare facilities are the meeting points where you go and they orient you elsewhere" ***(Group with male, Gllogovc, rural, 2020)***

*"The same doctors, when we go to their private clinics, they behave very differently [behave much better]"-****(Group with female, Junik, urban, 2016)***

- Lack of hygiene, especially in the toilets, is a concern however this depends on the management of the facility and sometimes on the timing of the visit.

  'The public primary healthcare facility is dirty, it also depends on the time of your visit and who is working there' -" ***(Group with female, Rahovec, rural, 2020)***

- Medical staff in public facilities were described as 'polite and caring'.
- Participants suggest that when staff attitudes are poor it is usually because of the poor working conditions for doctors in these institutions making it difficult for the doctors to provide excellent care and short waiting time.
- Complaints about neglected patients and discrimination of the RAE community continue in 2020, although they appear to be less evident compared to 2016.
- Although out-of-pocket expenditure was raised as a major concern, participants also stated that there is an advantage to using public facilities when official costs are observed because these costs are low, for example for check-ups, and there are exemptions in place for certain groups.
- Participants continue to rely on the doctors in the public healthcare service for hypertension and diabetes care, but mainly for diagnosis and check-ups only. While for the blood examination they are mainly referred to private clinics because that service is not available.

  "You go to public clinic for the hypertension but the doctor prescribes the blood exam and most of them you cannot do in public clinic (they do not offer those blood analysis), so you have to go to private clinic. We send our mother twice a month for blood work for cholesterol, diabetes and hypertension. ***(Group with male, Gllogovc, rural, 2020)***

- For asthma and diarrhoea, patients usually treat themselves home with the prescribed medication because the public healthcare clinics lacks the treatment equipment, or they go to private clinics if their health situations deteriorates.

  "You cannot go to the public health clinic for asthma, because they do not have anything. We do not send our children there for asthma." ***(Group with female, Junik, urban, 2016)***

  "For asthma we go to private clinic because of the oxygen equipment … I haven't seen such equipment in public facilities" ***(Group with male, Gllogovc, rural, 2020)***

4.1.4 Utilisation of private healthcare facilities

Feedback from FGD participants on utilisation of private healthcare facilities is attached as Annex 14.

- Private clinics are perceived as offering better care i.e. better infrastructure and more 'professional' staff behaviours.
- Participants report that one factor which distinguishes the doctors' treatment in private facilities compared to public facilities is the level of attention that they are given, generating the feeling of 'being heard'.
- Private clinics are visited in cases when the patients know that a certain service is not provided in the public health facilities or when an urgent treatment is required. As in 2016, the most common reasons given are: emergency cases; because the waiting list gets too long in public health institutions; or when public healthcare doctors ask them to go to their private clinics.

  > *"We go to private clinics because we cannot wait for two or three months in the public health institutions."* ***(Group with male, Obiliq, rural, 2016)***
  >
  > *"You go to ambulanta and the doctor checks you out and says you have problems with your kidneys, go to the private clinic as the conditions are better there"* ***(Group with female, Junik, urban, 2020)***
  >
  > *"I had problems with kidneys and went to a private clinic, I did a scan, and had to break the stones in the private clinic as well and it all costed 720 Euros and now the problem has reappeared as well"* ***(Group with female, Junik, urban, 2020)***

- Private clinics are most commonly used for diagnostics such as ultrasounds, CT scans, MRI etc. because the waiting list is at least 6 months in University Clinical Centre.
- Private health clinics are mainly chosen for treating children and elderly as the two most vulnerable groups of population.

  > *"I send my mother mainly to the private clinic because it's better, the care is better and its cleaner"* ***(Group with male, Obiliq, rural, 2020)***

- Cost is considered to be a major disadvantage of private health care.

  > *"10 euros for a visi, is very expensive… I have 4 children and they get the flu or cold once a month at least and that costs me 40 euros only for the check-ups, medication is an additional cost"* ***(Group with male, Gllogovc, rural, 2020)***

- Participants also complained about doctors in the private clinics prescribing further unnecessary examinations, which they consider to be driven by monetary profit for the clinics. Some complain that doctors also prescribe certain brand of the medication because they have relationships with the supplier.

  > *"They prescribe expensive medication because they have a deal with the pharmacy… they even tell you exactly in which pharmacy to go"* ***(Group with female, Junik, urban, 2020)***
  >
  > *"I believe doctors are connected. You go to the public primary healthcare facility, they check your stomach and your blood pressure and then refer you for a scan or an echo in the private clinic, most likely without any need for a scan or echo"* ***(Group with male, Gllogovc, rural, 2020)***

4.2 Section 2: NCD Risk Factors

4.2.1 Attitudes and practices about smoking

- There is no evident change in smoking behaviour when comparing the outputs of focus groups from 2016 with 2020.
- Perception that youth are the heaviest smokers continue to dominate in each discussion as in 2016. The majority of participants consider that youths smoke because it is 'trendy'.

  "They start smoking at school because they think they're becoming cool. Nowadays everyone smokes while in the past, it was a shame for women to smoke" ***(Group with male, Gracanica, urban, 2020, RAE)***

  "As a nation, we always follow fashion trends" ***(Group with female, Skenderaj, rural, 2020)***

- Participants consider that parents fail to educate their children about smoking side effects and schools do not have a program integrated in the curriculum that make children aware about the causes of this behaviour.

  *"Parents do not spend much time with their children; they do not talk to them. They give money to their children and have no idea what they do with that money."****(Group with male, Mitrovice, urban, 2016)***

  "Lack of awareness of children regarding what smoking causes. I never encountered a teacher that takes an hour to talk about smoking risk factors. I started smoking at a very early age and packages did not have a non-smoking sign on them – I wouldn't have started if there were signs like there are today" ***(Group with male, Gllogovc, rural, 2020)***

- Although smoking in closed environment is prohibited by law there is still a lot of smoking in cafes and restaurants.
- A noticeable change since 2016 is that participants did not suggest that it is normal for them smoking freely indoors at home.

  '*Most people are aware now, they smoke in the balconies because of the children and other family members'* ***(Group with male, Gllogovc, rural, 2020)***

  "I don't allow smoking in my house" ***(Group with female, Lipjan, rural, RAE, 2020)***

- Children, at any age, can purchase cigarettes at any time.

  "This is Government's fault because they allow the children to be able to buy cigarettes. The inspectors, police – should monitor the selling of the cigarettes. This would decrease by 50% the consumption among children" ***(Group with male, Gracanica, urban, 2020, RAE)***

4.2.2 Opportunities to prevent smoking

- As in 2016, participants continue to agree that strengthening the law and applying strict fines for those who smoke, is a crucial way to prevent smoking.

  "It is not enough if we say that they are harmful, because they have it written on the cigarette packages. People need to be 'served' the damages so they can really understand them" ***(Group with male, Mitrovice, urban, 2016)***

  "The Government should increase the price of cigarettes to 10 Euros so that people can stop" ***(Group with male, Gllogovc, rural, 2020)***

- The responsibility of schools was emphasised, suggestions include talking more with children about smoking risk factors.

  "The children should be aware. Schools should contain lessons on smoking risk factors, including the impact that it has on health, their surroundings. It is very important for these activities to take place - we do not have them for the moment" ***(Group with male, Gllogovc, rural, 2020)***

4.2.3 Attitudes and practices about physical activity

- In 2016 participants defined physical activity as being every body movement and any activity carried out during the day - in 2020 they highlighted jogging, exercise, biking and walking as physical exercise along with gardening and working on the land.
- Similar to 2016, most participants do not consider themselves physically active. All participants believe that generally people in Kosovo are not physically active because they do not know the value it brings to personal health.
- The number of participants who declared that they do sports regularly was low and exclusively among men.
- Both women and men declared that the only activity women do is housework and running after children, neither of which were considered to be 'proper' or 'sufficient' physical activity. Walking, on the other hand, is seen as an activity for younger women.

  "Women in the villages don't do sports because the mentality is low while in western countries women of all ages do sports. Here, women may only go out for a walk but if they go for example out to play football, everyone would say 'did you see the wife of John Doe is running after the ball'" ***(Group with male, Gllogovc, rural, 2020)***

  "I've been married for 9 years now and I haven't ever encountered a woman here that does sports. I don't feel comfortable to do sports alone" ***(Group with female, Lipjan, rural, RAE, 2020)***
  "I only do housework. It is good to do sports. I wish I had a bike and find a friend to go out with biking. I suffer from back pain and 40 minutes a day biking would be perfect for me' ***(Group with female, Lipjan, rural, RAE, 2020)***

  "Young women walk (occasionally) but I am not young anymore to do sports [participant is 37 years old"] ***(Group with female, Malishevë, rural, 2020)***

- Some younger women, however, do exercise occasionally.

  "I do dance for three times a week for 11 years now and I feel amazing, I never get tired". ***(Group with female, Skenderaj, rural, 2020)***

  "I go out walking once a week" ***(Group with female, Skenderaj, rural, 2020)***

- Out of those who declared to be physically active regularly, at least walking for 30 minutes or an hour for at least few times per week, were women who walk with their husbands - one of the main obstacles for women to exercise was stated to be concerns about 'gossip', particularly in RAE communities.

  "Women hesitate to do physical activity (biking) because people will gossip. It is humiliating to see a woman on a bike here, while in Germany even the elderly ride a bike" ***(Group with male, Fushë Kosovë, rural, RAE 2020)***

> *"I usually walk with my wife every evening. Sometimes the children join us as well but we walk at least 30 minutes"* ***(Group with male, Gracanica, rural, RAE 2020).***

- Men most commonly stated that they did not exercise because of a lack of time or a lack of energy and initiative.

> *"When you have a family, there is no time for physical activity"* ***(Group with male, Mitrovica, urban, 2020)***
>
> *"We are lazy to even go out for a walk. We say 'I'll start tomorrow, I'll start tomorrow' and for some reason it never happens"* ***(Group with male, Obiliq, rural, 2020)***

- While most men do not consider themselves as physically active, a few do engage in regular sports activities such as football and walking. Football is more common among younger age groups while walking is more common for middle aged men.

4.2.4 Attitudes and practices about alcohol

- Participants still consider that although Kosovo has a high level of unemployment, the level of alcohol consumption is less in comparison to other countries in the region and Western countries, because of :1) its' culture or tradition, 2) Muslim majority and 3) cost of alcohol. This is the same situation as 2016.

> *"Finances do have an impact on this. For example you go to a coffee place and you can have a coffee with 50 cents but you cannot order wine or beer for that"* ***(Group with female, Skenderaj, rural, 2020)***

- Participants consider that alcohol is mainly consumed by young people and that compared to men, the number of women who consume alcohol is significantly lower and is mainly in urban areas.
- Participants from the RAE community consider that the alcohol consumption among RAE men has dropped down compared to few years ago.
- Participants believe that alcohol consumption causes many diseases but some do also believe that if consumed in smaller doses, it has a positive effect mainly in eliminating bacteria and removing stones from kidneys. The most commonly mentioned side effects are considered to be: addiction, depression, heart disease, liver failure and hypertension.

4.2.5 Raising awareness about 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.

4.3 Section 3: Diet

4.3.1 Eating habits

Details of food consumption are attached at Annex 15.

- There is a noticeable difference compared to 2016 in terms of participants' knowledge about what participants need to do to eat healthier. Keeping the consumption of dough to a minimum was the most frequently mentioned measure followed by less use of fat, salt and sugar, avoiding fried food and consuming more boiled dishes. Adding fish and switching to olive oil and additional fruit consumption in the evening were considered as healthy.
- Unlike in 2016 when big meals were considered as important in maintaining a healthy diet, this year there is a significant change in this attitude among the RAE community – smaller amounts of food eaten more frequently is now considered to be more healthy.
- As in 2016, two meals per day are the routine for most participants. Breakfast is commonly substituted for coffee or tea. The first meal for most of the participants is between noon and 14:00 while dinner starts no earlier than 18:00.
- People who eat breakfast are mainly those who usually have lunch at around 16:00 and then have dinner at around 19:00 to 21:00.
- The types of foods that they consume for breakfast, lunch and dinner are almost the same for the majority of participants, with additional specific products depending on the season.
- Breakfast food usually contains dairy products, fried eggs and dough products with milk content, and in some households, they consume traditional sausage in winter.
- At dinner, the menu is similar to the lunch menu, either because they eat the leftovers or in cases when the dinner is the main course for the household. Alternatively, for dinner they usually eat lighter food, which is considered to be: pasta, pizza, bread, corn bread, instant soups, etc.
- Children, as in 2016, consume more processed meat (salami, sausage) and also chocolate cream even though that they are considered as unhealthy by the focus group participants. According to mothers, children mainly request these types of food and it is difficult to change their habits.
- In all groups in general the diet is significantly limited by the variety of products. Except that the way of cooking is different, in many cases the same products are used. People often eat the same type of foods for all meals and do not eat differently at breakfast and dinner.

4.3.2 Perception of healthy eating

- Healthy eating is stated as being important for everyone, but especially critical for people over the age of 50 and those suffering from hypertension and diabetes.
- Youth is considered less vulnerable in this matter and in some cases, there were discussions that youth should be allowed to eat whatever and as much as they want because it is important for their growing process.
- Children on the other hand, have their preferred food such as pate and sausage and often, mothers say that they have to let go of the fact that they are unhealthy food.

"Kids can't stand a moment without salami and pate". ***(Group with female, Skenderaj, rural, 2020)***

- In 2016 the main opinion was that 'a way to eat healthier is by not getting too full with food, eliminating one of the three main meals and not eating at late hours', however in 2020 regular eating at the same time every day, having frequent meals with smaller portions of food are perceived as healthy eating.
- Eliminating foods that contain fat, white flour, pasta, sweets and processed meat foods, and adding more dairy products, meat, fruits and vegetables are emphasised in 2020.
- Healthier eating is still considered as consuming foods that are boiled, and less healthy is consuming those that are fried or baked.
- In urban areas, eating healthy is perceived to be very expensive, however people from rural areas consider this less of a concern because they produce their own vegetables and fruits.
- Most participants report that food is healthier when they eat at home but they are exposed to processed food if they have to eat away from home, for example when they are at work.

  "I eat around 2 pm everyday outside… its either beans, goulash, pie or toast". ***(Group with male, Obiliq, rural, 2020)***

  *"All these above mentioned food are healthy if you eat at home but if you work, you have to eat fast food because it is impossible otherwise… for example, during pandemics I had time to cook and I lost 6 kilos…"****(Group with female, Skenderaj, urban, 2020)***

5 Conclusions

Comparison of findings from 2016 and 2020 studies

This report presents the findings of the 2016 and 2020 studies and identifies areas where there may have been changes during the 4-year period. Scores against almost all indicators in the quantitative study have been maintained or improved, with only a few indicators showing scores lower than in 2016.

However, whilst changes in scores are highlighted for the purposes of this comparative report, in many cases the difference is only marginal (sometimes only 1-2%) and cannot indicate a trend based on such a small percentage change. Therefore, it is important to exercise caution in drawing conclusions about improvements or deteriorations in performance based on these findings alone.

Study context

The 2020 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 how they perceive the healthcare environment compared to the totally stable environment that was in place when the 2016 was conducted.

Health educator role

Doctor 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

Knowledge about NCDs remains high and almost all of the knowledge scores are similar to 2016, even showing some slight improvement. Comparing the overall knowledge scores for risk factors, early signs and preventive measures between 2016 and 2020 does not indicate any major change. However, there are changes – both positive and negative - when scores are considered at individual indicator level. Importantly, the most noticeable increased awareness about these factors is noted among RAE community.

Whilst knowledge of NCDs factors has increased, the data suggests that this has not resulted in significant behaviour change. For example, knowledge that “eating too much sugar can lead to diabetes” has shown a 22% increase across all demographic segments but there does not appear to have been any impact on consumption of cakes, sweets, chocolate or biscuits, sugary drinks etc. which has remained the same as in 2016.

Many more patients seem to be receiving advice from their doctor or healthcare worker regarding risk-taking behaviour that might worsen their health condition but this is still less than 30% therefore it remains an area of concern that 70% are not being educated by their doctor. This is reflected in the finding that around 80% of the respondents do not feel sufficiently informed about NCDs and want more information.

Lifestyle

The awareness of smoking as a cause of NCDs has increased but the percentage of the smokers across the population remains the same compared to 2016 – echoing what was stated previously about increased knowledge not appearing to translate into behaviour change. That said, one important area where some positive change looks to have

occurred is in relation to indoor smoking. This was a major concern in 2016 when 70% of people stated that they smoked inside their homes, regardless of whether or not children were present. However, in 2020 this dropped by some 25% amongst the total population and by 30% amongst the RAE community.

The number of people among the total population that say that they have consumed alcohol at least once has dropped from a reported 16% in 2016 to 10% in 2020. This means that 90% say that they have never consumed alcohol – both 2016 and 2020 figures seem remarkably low.

The number of days where fruit and vegetables are consumed has risen marginally, but still does not meet the WHO recommendation of at least 400 grams of vegetables and fruits intake per day - equivalent of five servings each day. Meat consumption remains high as does children's consumption of processed foods. Knowledge about what food products are healthy is sometimes inaccurate.

The amount of physical activity taken has more than halved since 2016 and does not meet WHO recommendations on physical activity for health. Activity continues to be associated with work and there has been no increase in activity for recreational purposes. Women continue to undertake physical activity significantly less than men.

Healthcare services

The frequency of visits to healthcare facilities has dropped compared to 2016. Significantly fewer people report visiting any type of health facility, including primary, secondary and tertiary care facilities, as well as private clinics, however the impact of the pandemic must be taken into consideration here. FMCs are the facility most preferred by the rural population compared to urban ones, potentially because they have limited access to other healthcare facilities rural areas, while private clinics are more preferred by women compared to men.

Lack of equipment and essential drugs, and poor infrastructure in the public health sector, remain as areas of concern for service users and continue to be drivers for the utilisation of private health clinics. Out-of-pocket-expenditure and the costs associated with private care also remain as major concerns.

The satisfaction with FMC's during respondents last visit has increased by 23% but, as is often seen with patient satisfaction surveys, this seems somewhat at odds with participants reports about the poor quality of services received and should therefore be treated with caution. The total number of citizens who are aware of patient rights has not significantly increased.

6 Recommendations

Recommendations are to*:*

7) In addition to interventions that increase knowledge, consideration should be given to interventions that promote behaviour change.

8) 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.

9) 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 3 most used channels of communication. Consider to emphasize on positive framing of campaign messages.

10) 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.

11) 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.

12) 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 Somewhat confident Somewhat unconfident Very unconfident Don't know	1 2 3 4 5		C22
In the past two weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor?	Yes No	1 2		C23
Have you been informed by the doctor or nurses or someone by the health center about the complications of hypertension?	Yes No	1 2		C24
Do you think you have enough information about hypertension?	Yes No Maybe Don't know	1 2 3 4	SKIP TO H1	C25
Would you like to have more information about problems associated to hypertension?	Yes No Maybe Don't know	1 2 3 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 No	1 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 Second hand tobacco smoke Other indoor air pollutants Outdoor air pollutants Allergens Occupational agents Diet and nutrition Respiratory infections Other, specify Don't know	1 2 3 4 5 6 8 9 10 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 Shortness of breath or difficult breathing Chronic mucus production Wheezing, noisy breathing Other, specify Don't know	1 2 3 4 5 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 Avoid lung irritants at work Spend time in mountains Avoid passive smoking Other, specify Don't know	1 2 3 4 5 6		H4
When you or your family member or friend has chronic respiratory diseases, should they seek medical treatment?	Yes No	1 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: Quantitative survey – sampling plan and survey method

Sampling Plan

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

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

Table 4: Population figures for sample frame for quantitative survey (population estimates 2016)

Sample							
	Total	Albanian	Urban	Rural	RAE	Urban	Rural
Fushë Kosova	114	54	34	20	60	60	0
Gllogovc	91	91	10	81	0	0	0
Obiliq	51	31	10	21	20	0	20
Gracanica	29	0	0	0	29	29	0
Lipjan	120	90	10	80	30	20	10
Gjakova	250	170	80	90	80	60	20
Rahoveci	114	104	32	72	10	10	0
Malisheva	92	92	11	81	0	0	0
Junik	30	30	30	0	0	0	0
Mitrovica	143	123	83	40	20	20	0
Vushtrri	113	113	40	73	0	0	0
Skenderaj	82	82	10	72	0	0	0
TOTAL	1229	980	350	630	249	199	50

Table 5: Sampling plan for quantitative survey

Exclusions included people in hospitals, prisons, military facilities and similar. The breakdown of the population by municipalities was based on the latest census[2] from 2011, broken down by municipality and type of residence (urban and rural). There were two conditions that were taken into account for the calculation of the sample size. One was that the total sample size should allow an acceptable confidence interval when the data analysis is performed for all municipalities altogether (±2.83%). The other one was to have on average 100 respondents per municipality and at least 30-50 respondents in the small municipalities, in order to provide better representation of small municipalities for comparative analysis across municipalities.

Survey Method

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

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

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

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

Each sampling point in the Albanian sub-sample was designed to have 10 households irrespective of the type of residence (urban or rural), with 95 sampling points in total. The residential split is 36% urban vs. 64% rural. For the RAE minority population, each sampling point is designed to have 10 households irrespective of the type of residence (urban or rural), with 25 sampling points in the RAE sub-sample. The residential split in the RAE sub-sample is 80% urban vs. 20% rural.

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

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

Step Three: Selection of starting points within each sampling point

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

2 Statistical Agency of Kosova

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..

Annex 3: Quantitative survey - training and quality control measures

Interviewer training

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

Quality control measures

Regional supervisors observed the initial performance of the interviewer in the field and gave recommendations for his/her work.

Around 15% 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.

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 was made of the first and the second responses.

The majority of interviews were back-checked in person, in the rest of the cases back-check was carried out by phone or 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 sent the interviewers back to the field to correct inconsistencies or conduct additional interviews.

Annex 4: Data processing and analysis

Data was processed during the interview 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. Uploaded data 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 2011 Census, 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 for further analysis and interpretation. Microsoft Excel 2013 was also used for performing specific analysis, as well as for creating charts and tables.

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: Qualitative study – sampling

The selection was performed in three stages.

Stage 1: At least two sampling points were allocated in order to recruit participants for one group discussion within the designated municipality. Each sampling point produced at least 3 effective participants who fulfil the criteria of the target universe, 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% 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.

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

Table 20: Group Discussion Sample

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

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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 private 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	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Salt or a salty sauce to your food right before you eat it or as you are eating it	21	27	22	22	29	18	18	24	7	8
Salt, salty seasoning or a salty sauce used in cooking or preparing foods in your household	32	42	24	23	28	20	12	12	3	1
Cakes, sweets, chocolate or biscuits	5	6	18	19	35	36	25	33	12	5
Soft drinks, such as Coca Cola, Fanta, energy drinks and similar	16	13	22	19	28	28	21	31	8	8
Sugar in your tea or coffee	65	65	15	19	9	6	5	7	3	4
Commercially baked goods	2	3	8	14	40	31	33	42	14	8
Packaged snack foods	3	4	11	17	40	40	26	31	13	6
Solid fats	2	3	18	11	30	26	15	44	5	14
Fried food	12	4	23	17	32	42	17	31	13	4

Table 6: Use of salt, sugar and fats

Annex 8: Data – Diabetes

Risk factors (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Family history of diabetes	35.2	33.3	35.6	33.4	24.3	28.8	32.3	34.4	38.0	32.2
Eating too much sugar	32.6	54.7	33.0	55.0	17.7	45.4	29.1	52.4	35.8	56.8
Stress	27.4	38.8	27.7	38.8	18.3	39.0	26.6	38.9	28.1	38.6
Overweight	24.5	26.6	24.8	26.3	15.5	36.9	20.7	27.5	28.0	25.8
Overeating	18.4	19.6	18.8	19.6	4.8	19.8	17.3	20.4	19.4	18.8
Eating too much fat	18.2	30.0	18.5	30.2	7.0	23.6	14.0	26.0	22.0	33.7
Age over 40	11.9	12.5	11.9	12.4	10.5	14.4	11.1	14.5	12.5	10.6
Old age	10.1	15.8	10.1	15.9	9.4	14.3	7.3	15.4	12.6	16.2
Smoking	3.5	5.8	3.5	5.6	3.4	10.9	3.9	5.9	3.1	5.7
Lack of exercise	3.0	8.1	3.1	7.9	0.4	13.4	3.3	6.0	2.8	10.0
Alcohol	2.7	7.5	2.8	7.3	2.3	13.0	2.9	8.5	2.6	6.6
Ethnic origin	0.8	0.4	0.8	0.4	-	-	0.2	0.6	1.3	0.3
Other	1.4	1.3	1.4	1.3	0.7	-	2.1	1.3	0.7	1.2
Do not know	25.0	12.2	24.7	11.9	33.4	20.6	31.6	12.6	18.8	11.7

Table 7: Knowledge about risk factors

Early signs of diabetes (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Excess thirst	54.2	53.0	54.4	53.1	46.2	49.4	52.0	52.0	56.1	53.9
Tiredness/lethargy	37.4	43.3	37.9	43.6	20.5	33.8	36.4	43.5	38.3	43.1
Vision problems	19.4	21.4	19.8	21.4	6.2	23.7	17.8	21.3	20.9	21.5
Weight loss	17.3	17.6	17.3	17.5	18.3	21.1	14.1	18.0	20.3	17.1
Passing lots of urine	16.2	19.8	16.6	19.5	5.0	29.5	15.3	19.4	17.1	20.1
Loss of appetite	14.2	13.5	14.5	13.4	5.2	16.4	12.7	11.6	15.6	15.2
Skin and genital infections	4.8	7.7	4.8	7.7	4.4	8.8	4.4	6.1	5.2	9.2
Other	2.9	3.8	2.9	3.9	1.5	1.2	2.7	3.1	3.0	4.4
Do not know	27.8	26.0	27.4	25.9	40.4	30.6	32.0	26.7	23.9	25.3

Table 8: Knowledge about early signs

Preventive measures against diabetes (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Limit sugar	34.6	48.7	34.9	48.8	25.2		44.2	44.1	37.6	52.9
Health checks/ screening	33.0	27.8	33.2	27.5	26.3	38.4	26.7	26.3	33.1	29.1
Healthy diet/ eating habits	28.0	33.7	28.3	33.8	18.4	31.5	31.6	31.1	30.9	36.1
Exercise	21.7	26.2	22.3	26.2	4.6	25.9	24.8	24.6	22.1	27.6
Weight control	20.8	26.2	20.8	26.2	18.1	25.5	28.6	28.3	21.3	24.3
Limit fatty foods	18.7	24.7	19.0	24.7	6.6	27.0	21.2	20.8	22.2	28.4
Avoid stress	17.5	26.2	17.9	26.2	6.6	25.3	27.6	27.0	18.9	25.4
Weight loss	13.6	16.5	13.8	16.4	5.9	18.7	14.9	15.0	13.3	17.8
No action	2.2	1.5	2.2	1.5	3.5	3.9	2.3	2.4	2.7	0.8
Other	1.2	1.3	1.2	1.3	0.5	0.7	1.2	1.3	0.7	1.2

Table 9: Knowledge about preventive measures against diabetes

Annex 9: Data – Cardiovascular Disease

Risk factors (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Stress	34.3	48.0	34.7	47.8	21.0	60.0	31.6	45.8	36.8	50.1
Family history of CVD	27.1	26.4	27.5	26.5	16.5	21.4	26.6	26.8	27.6	26.0
Overweight	22.4	29.4	22.6	29.3	15.1	33.5	20.9	30.6	23.8	28.3
Eating too much fat	19.8	37.6	19.9	37.6	15.6	35.9	18.4	37.3	21.1	37.8
Smoking	16.7	20.2	16.9	20.1	11.2	27.3	19.3	16.3	14.3	23.9
Overeating	14.2	19.4	14.6	19.4	3.2	20.7	13.5	21.3	14.9	17.7
Alcohol	14.2	14.4	14.5	14.3	5.8	23.2	16.7	11.4	11.9	17.3
Salty food	13.8	25.4	14.0	25.5	6.6	23.6	14.3	26.8	13.4	24.1
Age over 40	12.3	14.2	12.5	14.3	5.5	10.7	11.2	16.3	13.3	12.3
Old age	12.0	22.1	11.8	21.9	16.5	32.1	11.5	20.6	12.4	23.4
Lack of exercise	5.7	14.3	5.9	14.2	0.6	17.8	4.7	14.0	6.7	14.5
Ethnic origin	0.7	0.1	0.7	-	0.7	2.8	0.4	-	1.1	0.1
Other	2.5	1.4	2.6	1.4	0.3	-	1.9	1.5	3.1	1.3
Do not know	26.7	17.0	26.2	17.1	39.8	14.8	29.3	17.2	24.2	16.8

Table 10: Knowledge about risk factors associated with CVD

Early signs of CVD (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Chest Discomfort	51.8	62.3	52.4	72.1	32.8	62.6	48.5	60.1	54.9	64.4
You Get Exhausted Easily	28.0	34.5	28.5	25.1	13.8	34.5	27.4	33.3	28.6	35.6
You Feel Dizzy or Lightheaded	21.0	21.4	21.5	29.9	6.7	21.4	18.6	18.1	23.3	24.4
Lack of breath during physical exercise	19.5	32.3	19.6	34.9	15.7	32.3	18.0	30.7	20.8	33.8
Irregular heart beat	17.1	16.5	17.4	18.7	5.8	16.3	15.5	13.5	18.6	19.3
Pain that Spreads to the Arm	16.2	23.6	16.5	37.3	7.4	23.5	17.6	21.8	14.9	25.3
Sweating	9.9	14.0	10.1	20.1	2.6	14.1	10.3	15.9	9.5	12.2
Legs, feet and ankles are swollen	6.6	9.3	6.6	16.6	4.1	9.3	5.9	5.4	7.2	12.8
Throat or Jaw Pain	5.7	2.8	5.8		2.3	2.7	5.9	2.3	5.5	3.2
Snoring	4.8	4.2	4.8		2.7	4.3	4.7	5.1	4.8	3.4
A cough that won't quit	4.5	4.1	4.5	8.3	3.4	4.0	4.3	4.2	4.7	3.9
Nausea, Indigestion, Heartburn, or Stomach Pain	3.3	5.3	3.3	4.6	0.7	5.0	3.5	6.4	3.0	4.2
Other	1.5	0.4	1.6	0.0	0.3	0.5	1.7	0.7	1.4	0.2
Do not know	24.6	19.9	24.2	12.8	36.3	19.9	28.9	20.5	20.6	19.3

Table 11: Knowledge about early signs of CVD

Preventive measures against CVD (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Health checks/ screening	41.4	40.2	41.5	40.2	38.3	42.1	43.4	35.9	39.5	44.3
Healthy diet/ eating habits	28.0	32.1	28.3	32.1	19.7	30.3	23.1	26.4	32.6	37.4
No smoking	25.0	28.7	25.4	28.5	12.1	39.6	24.8	27.7	25.2	29.7
Exercise	22.2	30.4	22.8	30.3	3.0	36.3	21.4	29.7	22.9	31.1
No alcohol	20.9	21.0	21.3	20.7	9.2	33.9	19.9	18.5	21.9	23.3
Weight control	19.9	26.0	20.4	26.0	5.6	23.9	19.6	28.4	20.2	23.8
Limit fatty foods	16.1	27.4	16.3	27.6	12.2	19.7	14.0	24.1	18.1	30.6
Weight loss	13.1	19.6	13.3	19.7	6.9	14.6	12.5	18.2	13.6	20.9
No action	2.6	2.2	2.4	2.2	9.0	1.4	3.1	3.6	2.2	0.8
Other	1.2	3.5	1.2	3.6	0.4	2.6	1.3	4.4	1.2	2.7
Do not know	21.1	19.0	20.8	19.1	31.1	14.7	23.0	19.5	19.3	18.5

Table 12: Knowledge about preventive measures against CVD

Annex 10: Data – Chronic Respiratory Disease

Risk factors (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Tobacco smoke	61.4	73.3	61.2	73.2	69.1	76.6	57.2	79.2	64.9	68.3
Second hand tobacco smoke	35.0	22.4	35.7	22.1	10.4	34.9	32.4	20.4	37.1	24.1
Outdoor air pollutants	27.3	36.3	27.9	36.5	6.4	24.7	25.2	42.5	29.0	31.0
Allergens	25.3	17.0	26.0	17.2	2.3	12.2	21.2	14.0	28.7	19.7
Other indoor air pollutants	22.3	23.1	22.9	22.8	3.7	34.9	19.3	24.8	24.9	21.6
Respiratory infections	16.6	15.2	16.7	15.1	12.8	18.8	15.2	12.9	17.8	17.2
Occupational agents	15.1	11.9	15.2	12.0	9.4	9.5	13.7	11.8	16.2	12.0
Diet and nutrition	7.2	13.4	7.0	13.5	11.5	8.5	7.7	15.4	6.7	11.7
Do not know	18.3	15.2	18.1	15.2	26.4	14.1	22.2	12.3	15.1	17.6

Table 13: Knowledge about risk factors associated with CRD

Early signs of CRD (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Shortness of breath or difficult breathing	46.1	44.5	46.3	44.2	40.6	57.0	41.6	42.5	41.6	46.1
Wheezing, noisy breathing	42.6	43.6	43.3	43.7	21.7	37.3	40.3	45.1	40.3	42.3
A cough lasting for a month or longer	42.2	60.2	42.2	60.1	42.7	62.6	42.0	63.0	42.0	57.8
Chronic mucus production	26.6	24.4	27.0	24.3	12.0	28.2	22.9	25.3	22.9	23.6
Other	1.5	2.7	1.6	2.8	-	0.7	1.7	1.7	1.7	3.6
Do not know	27.6	18.3	27.6	18.3	30.2	16.3	30.7	17.3	30.7	19.1

Table 14: Knowledge about early signs of CRD

Preventive measures against CRD (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Spend time in mountains	49.7	45.3	50.8	45.3	16.3	44.7	46.0	51.6	52.9	39.8
Quit smoking	48.5	69.4	48.2	69.4	57.5	69.2	45.5	73.8	51.0	65.6
Avoid passive smoking	28.6	20.8	29.2	20.6	9.9	29.9	22.0	21.8	34.1	20.0
Avoid lung irritants at work	25.5	21.9	26.3	21.8	1.3	27.6	26.5	22.9	24.7	21.0
Do not know	27.8	19.0	27.6	19.0	34.1	18.8	32.1	14.7	24.2	22.6

Table 15: Knowledge about preventive measures against CRD

Annex 11: Data – Diarrhoea

Risk factors (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Food poisoning	60.1	70.2	61.3	70.5	43.2	62.6	58.0	73.2	61.9	67.8
Infection	48.7	34.8	50.2	34.4	25.3	47.0	44.5	37.8	52.2	32.4
Food allergies	19.0	2.6	19.7	12.1	7.8	25.0	17.8	8.2	20.0	16.2
Medications	17.9	7.2	18.1	6.5	14.9	26.4	11.5	7.4	23.3	7.1
Lack of clean water	12.4	16.8	12.3	16.5	13.9	25.3	10.9	17.1	13.7	16.6
Poor hygiene	10.9	13.4	11.2	12.9	6.2	28.8	9.0	10.3	12.5	16.0
Irritable bowel disease	9.0	6.9	9.6	6.4	0.9	22.9	6.9	5.2	10.8	8.4
Poor sanitation	7.6	8.3	7.7	8.2	5.4	10.5	6.1	8.0	8.9	8.5
Other	6.5	9.9	6.7	10.2	3.3	4.2	6.1	5.3	6.9	13.8
Do not know	12.2	13.4	12.2	13.5	12.8	10.5	17.0	14.5	8.2	12.5

Table 16: Knowledge about risk factors associated with diarrhoea

Early signs of dehydration (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Dizziness and light headedness	35.7	29.8	35.7	29.5	19.6	38.1	30.6	32.2	40.0	27.9
Dry, sticky mouth	30.0	28.5	30.0	28.0	19.9	40.7	23.8	31.9	35.2	25.7
Lack of energy	27.2	42.4	27.2	42.7	13.3	33.9	23.5	38.1	30.3	45.9
Cool, dry skin	15.1	26.6	15.1	26.8	6.5	20.0	13.2	23.1	16.7	29.3
Dark yellow urine, or very little or no urine	14.7	10.8	14.7	10.3	3.3	26.9	10.0	9.6	18.6	11.8
Few or no tears when crying	7.2	6.7	7.2	6.6	1.6	10.7	7.1	7.0	7.2	6.5
Other	4.6	14.0	4.6	14.5	2.9	0.9	6.1	8.5	3.3	18.5

Table 17: Knowledge about early sings of dehydration

Preventive measures against diarrhoea (percent)	Total		Albanian		RAE		Male		Female	
	2016	2020	2016	2020	2016	2020	2016	2020	2016	2020
Watch what you eat and drink	32.6	59.5	33.1	59.8	25.0	52.0	24.8	58.2	39.1	60.6
Wash hands frequently	30.2	32.1	29.9	31.8	35.1	40.1	21.9	37.7	37.2	27.4
Ask your doctor about using antibiotics	23.4	19.5	24.8	19.4	3.6	24.7	19.8	13.9	26.5	24.1
Wash work surfaces frequently	15.3	11.9	16.2	11.8	2.1	15.1	13.5	12.8	16.9	11.2
Lather with soap for at least 20 seconds	11.8	17.4	12.1	16.8	6.9	34.7	10.0	21.5	13.2	14.0
Serve food right away or refrigerate it after it has been cooked or reheated	9.3	10.3	9.6	10.0	4.8	19.1	5.5	8.2	12.5	12.0
Use hand sanitizer when washing isn't possible	7.8	8.2	8.1	7.5	4.8	28.4	3.2	8.8	11.7	7.8
Use the refrigerator to thaw frozen items	3.9	4.0	3.8	3.6	4.3	12.6	4.4	4.1	3.4	3.8
Other	1.7	0.7	1.7	0.8	1.6	0.3	2.5	1.3	1.0	0.3
Do not know	31.2	17.3	30.8	17.4	36.7	13.4	39.2	18.9	24.5	15.9

Table 18: Knowledge about preventive measures against diarrhoea

Annex 12: Channels of communication about health issues

Channels of communication	Current %		Preferred %		Differential % (current minus preferred)	
	2016	2020	2016	2020	2016	2020
Your doctor or nurse	52.7	38.4	68.2	57.1	-15.5	-18.6
TV	50.1	61.1	45.9	56.5	4.2	4.6
Internet	31.7	55.3	37.7	46.3	-6.0	9.0
Family, friends, neighbours	27.1	18.5	19.5	16.7	7.6	1.8
Newspaper	16.3	5.1	18.6	7.5	-2.3	-2.4
Radio	13.7	5.8	16.4	6.8	-2.7	-1.0
Leaflets	5.6	3.0	11.4	11.2	-5.8	-8.2
Posters/Billboards	2.2	1.2	3.7	5.7	-1.5	-4.5
None	1.6	5.1	0.1	0.6	1.5	4.5
SMS	0.7	1.3	6.1	11.0	-5.4	-9.6
Public meeting in the neighbourhood/village	-	-	11.0	14.0	-11.0	-14.0
Other	0.3	0.5	-	0.5	0.3	0.03

Table 19: Communication channels

Annex 13: FGD feedback on public healthcare clinics

Public healthcare clinics (Advantages)	
2016	**2020**
Cheaper check-ups / do not have to pay	Cheaper check-ups / do not have to pay
Insulin supply	
Urgent cases, do not have to wait in line	Urgent cases, do not have to wait in line
Some of the drugs (very rarely) – for free	Some of the drugs (diabetes and hypertension) – for free
Public health care clinic is very near	Public health care clinic is very near
24 hours service (only in the main clinic in the centre)	
Elderly always have priority	Elderly always have priority
Professionally qualified staff	Professionally qualified staff
	Caring staff
	Available at any time
	We know the staff/from the village/region
	They have the latest technologies and equipment
	Polite staff /caring
	They have a structure and can deal with every problem
	They call when you're late for regular check-ups
	Clean
	Safer
	Lack of parking space in front of the entrance

Table 21: Reported advantages of public healthcare clinics

Public healthcare clinics (Disadvantages)	
2016	**2020**
Lack of medical equipment	Lack of (functional) medical equipment
Lack of paediatrician, dentist, etc.	Lack of paediatrician, dentist, etc.
Lack of staff	Lack of staff
Staff do not respect working hours	Staff do not respect working hours
Lack of drugs	Lack of drugs
Lack of basic equipment (patches, syringes, etc.)	Lack of basic equipment (patches, syringes, etc.)
Doctors sending patients to private clinics	Doctors sending patients to private clinics
Prescription of unnecessary drugs due to the personal interest of doctors to pharmacies.	
If they are on their lunch break, they do not care about the urgent cases.	
Their bad attitude towards patients	
Lack of communication with patients	
Racism (for the RAE community)	Racism (for the RAE community)
The location of public health care clinic is very far (in rural areas)	
No 24 hours health service in other public health clinics besides the central one	
Lack of hygiene	Lack of hygiene
	Nepotism
	Lack of ambulance cars
	Neglecting (send the patients back and forth)
	Medical staff do not respect the working hours
	In rural areas you have to wait 4 days for basic blood work
	Prescription of drugs that you cannot find in local pharmacies (Serb populated areas).
	They don't give you IV if you need it
	Expensive (children above 5 y.o have to pay and adults pay 2 euros)
	Long waiting lines

Table 22: Reported disadvantages of public healthcare clinics

Annex 14: FGD feedback on private healthcare facilities

Private healthcare clinics (Advantages)	
2016	**2020**
Fast service	Fast service – no waiting time
Good service	Good service (professional)
Hospitality	Hospitality (polite and caring)
They have essential equipment	They have essential equipment
Modern equipment	Modern/full equipment
Advice from doctor	
Safer feeling	Safer feeling/reliable
Good hygiene	Good hygiene
	Immediate diagnosis
	They don't discriminate
	24 hour service
	They do home visits
	Safer (especially during pandemic)
	Doctors show more interest in patients
	Doctors can be reached via phone as well

Table 23: Reported advantages of private healthcare clinics

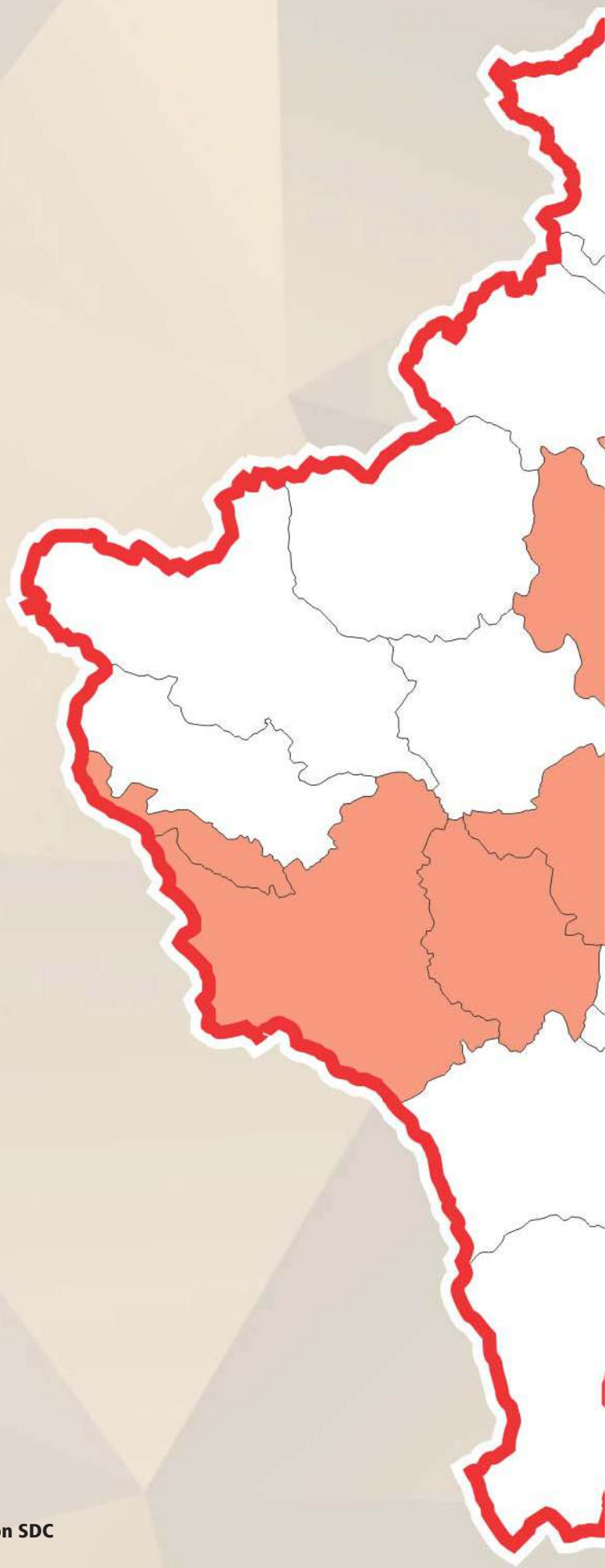
Private healthcare clinics	
2016	**2020**
Expensive	Expensive
They perform medical services in fields where they are not qualified	They perform medical services in fields where they are not qualified
In case of complication, they do not hold themselves accountable in front of state.	In case of complication, they do not hold themselves accountable in front of state. They perform the surgery and they leave
	They perform more exams than necessary for monetary purposes
	They prescribe more expensive medication because they have agreements with producers
	They make mistakes in diagnosis

Table 24: Reported disadvantages of private healthcare clinics

Annex 15: FGD feedback on food consumption

The increase in consumption of fruits and vegetables does not meet the WHO recommendation of at least 400 grams of vegetables and fruits intake per day equivalent of five servings each day.

- Jam falls is considered a healthy product but it is not suitable for people above the age of 50 as they might suffer from diabetes and not be aware of it.
- Honey and hot milk are considered to be added value to a healthy breakfast especially for those who do sports.
- Eggs are considered healthy because of their protein content, but all agreed that they have to be cautious in quantity.
- Most people consider butter to be healthy because of the type of fat it contains.
- Processed meat as in pate or salami, is considered as very unhealthy because it is processed food and they contain remains of real meat.
- Pancakes are also considered unhealthy if consumed in the evening.
- Meat continues to be consumed almost every day with the only variation being how the meat is prepared and what other accompanying dish is served.
- Any dish is considered as healthier if less fat is added to it in preparation. Dough continues to be consumed at least twice a week.
- The most common is white bread baked in the oven. Integral bread continues to be used mainly by people with diabetes and those living in better financial conditions.
- Soup is considered very healthy regardless whether it is homemade or bought.
- Chinese instant food is an addition mentioned by some participants and the value in it is considered to be the timing – you can practically cook it in 10 minutes.
- The food that contains water are considered healthy, the most common among them are beans and goulash.
- Rice and potatoes are more preferable especially when prepared in the oven.
- Fried peppers with cheese, French fries, fried chicken and especially fried traditional sausage are also very common in their menu.
- Salads (tomato, onion, green salad, cabbage, cucumbers) are the most common in all focus groups followed by yoghurt and ayran.
- Seafood continues to be less commonly consumed.
- Most people consume black tea, chamomile tea or dairy products such as yoghurt depending on a meal but also packed fruit juices and water are part of their daily menu, especially for lunch and dinner.
- Fruits are consumed mostly between main meals, as were black tea, flower tea and coffee while very few mention cereals as food on their menu.
- Compared to the previous round of KAPB, honey was mentioned as a part of the breakfast much more this year.



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