Kosovo Women's Network
Serving, Protecting and Promoting the Rights of Women and Girls

# Access to Healthcare in Kosovo

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for the Kosovo Women's Network

Prishtina, Kosovo
2016

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ISBN 978-9951-737-07-4

Printed by: NGB GRAFOPRINT

This report was supported by the Kosovo Women's Network through self-financing, the United Nations Population Fund (UNFPA), the United Nations Development Programme (UNDP), UN Volunteers (UNV), Dartmouth College and the World Health Organization (WHO). The views expressed in this report are those of the authors and do not necessarily represent the views of UNFPA, WHO, UNDP, UNV or Dartmouth College.

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# Acronyms

| | |
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| CCK | Criminal Code of Kosovo |
| CDC | Center for Disease Control and Prevention (U.S.) |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| EU | European Union |
| HIS | Health Information System |
| ICESC | International Covenant on Economic, Social and Cultural Rights |
| IKS | Kosovo Stability Initiative |
| IUD | Intrauterine device |
| KAS | Kosovo Agency of Statistics |
| KDHS | Demographic, Social and Reproductive Health Survey in Kosovo |
| KMA | Kosovo Medicine Agency |
| KUH | Kosovo University Hospital |
| KWN | Kosovo Women's Network |
| MDG | Millennium Development Goal |
| MFMC | Main Family Medicine Centres |
| MICS | Multiple Indicator Cluster Survey |
| MoH | Ministry of Health |
| NGO | Non-governmental organisation |
| OSCE | Organisation for Security and Co-operation in Europe |
| OTC | Over the Counter (Medicine) |
| PHC | Primary Health Care |
| POM | Prescription Only Medicine |
| PPQ | Perceived Personnel Quality |
| PPR | Patient-Provider Relationship |
| PTSD | Post-traumatic Stress Disorder |
| SAA | Stabilization and Association Agreement |
| UCCK | University Clinical Centre of Kosovo |
| UN | United Nations |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |

# Acknowledgments

This research was carried out almost entirely thanks to the efforts of volunteers committed to improving the quality of healthcare available to people in Kosovo. The Kosovo Women's Network (KWN) wishes to extend its gratitude and appreciation to the researchers who volunteered hundreds, if not thousands, of hours of their time in order to make this research possible: Nicole Farnsworth, Adelina Berisha, Rina Dula, Rina Ajeti, Jetmira Morina, Rita Nikqi, Dr. Katja Goebbels, Natyra Hertica, Emily Gallina, Iliriana Banjska, Doruntina Fetahaj, Donjeta Morina, Hana Marku, Leurina Mehmeti, Rinea Mustafa, Antonia Hoidal, Deniz Pupus, Mirjeta Shatri, Nerina Guri, Marigona Kelmendi and Valdrina Murina. The team thanks KWN Executive Director Igballe Rogova, Finance Manager Besa Shehu and Program Manager Zana Rudi for their ongoing support.

This research was made possible through a partnership with the Rockefeller Center and Global Health Initiative at the Dickey Center for International Understanding. The research process and final product benefitted substantially from ongoing support provided by Dr. Ronald D. Shaiko, Anne Sosin and Dr. Lisa Adams from Dartmouth College. Dartmouth students Apoorva Dixit, Megan Mishra, Morgan Sandhu and Kristen Delwiche contributed significantly to the quantitative analysis and drafting related sections of the report. Dartmouth College also provided some financial support for research costs.

The University of Prishtina Department of Social Work, particularly Dr. Vjollca Krasniqi, also supported the research. Students surveyed citizens on a voluntary basis: Agensa Haliti, Amjeta Zeqiraj, Edilona Kamberi, Elfije Krasniqi and Lauretë Bekteshi. Enumerators contributing to this research included: Adelina Qoqaj, Adni Kukësi, Ardianë Hetemi, Armend Krasniqi, Bajram Ilazi, Bardh Ajeti, Bardhyl Rexhepi, Behar Ferizi, Biljana Kuzmanovic, Dren Tahiri, Enis Fazliji, Fjollë Kastrati, Florent Thaçi, Furkan Baruti, Gyltene Osmani, Leutrim Shahini, Lirona Rexhepi, Meray Tikves, Milica Barac, Onur Kovac, Qëndrim Thaçi, Ramadan Sokoli, Rita Nikçi, Sasa Stanistavljevic, Suzana Fazliji, Tringë Sokoli, Visar Fejza and Zihra Kuksi. Erica Browne supported the statistical analysis.

We thank the Ministry of Health for its support, encouraging health institutions to participate in this research and welcoming any resulting recommendations towards improving the health of women and men in Kosovo. Health practitioners and other key informants throughout Kosovo offered their precious time to participate in interviews.

KWN through self-financing supported several of the research costs that made this report possible. KWN's staff researchers conducted research and wrote this report on a voluntary basis, working extensive overtime to make this report possible. The United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), UN Volunteers and World Health Organization (WHO) also supported research costs.

The Advisory Group provided useful input on the survey instrument and final draft of the report: Anne Sosin from Dartmouth College, Dr. Ronald Shaiko from Dartmouth College, Dr. Lisa Adams from Dartmouth College, Dr. Vjollca Krasniqi from the University of Prishtina, Dr. Visare Mujko-Nimani from UNFPA, Dr. Skender Syla from WHO, Dr. Sami Uka from WHO, Sanije Uka from the Kosovo Agency for Statistics, Dr. Ilir Hoxha, Blerim Azizi from UN Volunteers, Shkipe Deda-Gjurgjiali, MSc, from UNDP, Dr. Valbon Krasniqi from the Ministry of Health, Edi Gusia from the Agency for Gender Equality in the Office of the Prime Minister of the Republic of Kosovo and Mrika Aliu from the Action for Mothers and Children.

# Executive Summary

In 2016, the Kosovo Women's Network collaborated with the Ministry of Health, Dartmouth College and the University of Prishtina to conduct the first ever comprehensive research on women's and men's access to quality healthcare in Kosovo. The research involved a household survey of 1,309 Kosovars; and interviews with 110 healthcare practitioners and key actors, among other methods. This report assesses the extent to which Kosovars utilize public and private healthcare services; face financial, geographic, ethnic, cultural and/or knowledge barriers in accessing healthcare; and are aware of their rights as patients. Quality of care is examined in terms of patient-provider relationships, perception of personnel quality and availability of medical services. Overall, 81% of Kosovars considered their health status to be good or very good, though women assessed their health status slightly worse than men did; 23% reported a limitation in daily life due to health reasons.

Women tended to use healthcare services more than men. However, utilization of preventive care remains low; 53.9% of survey respondents never had a general health examination. Very few people used screening tests to detect cancer. Low utilization may relate to a lack of knowledge regarding where people can seek care for which services. Only 35.3% of respondents knew that Main Family Medicine Centres provide reproductive health services. Lack of information also seems to be among the main reasons for low contraception use; only 20.5% of all respondents and 10.9% of women reported using modern contraceptives. Related, 11% of women said they have had an abortion in their lifetimes.

For approximately 26% of respondents, at least one time in the last year they should have consulted a doctor and did not. Respectively, 18% did not see the dentist when needed. Main reasons for not visiting a doctor included that they would 'wait and see' if their health improved and cost barriers. Financial barriers are a recurring theme in this report. At present, no public health insurance is available. Only six percent of Kosovars seem to have private insurance and significantly fewer rural women have it. While 59.2% of respondents preferred using public healthcare facilities, mostly due to their price, 32.3% preferred private clinics, primarily for the quality of care offered. The fact that healthcare workers can be employed in both private and public healthcare facilities may impact the quality of healthcare provided.

Overall, women and men tended to face similar barriers in accessing healthcare, though women seemingly had more sociocultural barriers than men. Rural women faced more financial, cultural and patient-provider relationship barriers in accessing healthcare than men or urban women. Bosnian and Turkish women tended to face more barriers than men of the same ethnicities, and significantly more barriers than Albanian women and men. Roma, Ashkali, Egyptian and Gorani women and men had among the most geographic, financial and cultural barriers to accessing healthcare.

A recurring theme among healthcare workers was that social stigma prevents both women and men from utilizing mental health services. Insufficient confidentiality may be a barrier precluding Kosovars from seeking healthcare services, particularly related to mental health. This may contribute to self-medicating. It seems easy to access any drug without a prescription, which can threaten individual and public health. Further, nearly all pharmacy employees interviewed observed collusion between doctors and pharmaceutical companies, though legally prohibited. Overall, while this research provides evidence that some violations of patients' rights seem to have occurred, such violations are rarely reported.

The report concludes with recommendations for further research, awareness-raising and policy.

# Introduction

In accordance with international law, the Government of Kosovo has an obligation to respect, protect and fulfil the rights to health for all persons in Kosovo.[1] The Ministry of Health has a comprehensive strategy for the health sector, as well as an Action Plan.[2] Kosovo institutions are obliged to collect and publicize gender disaggregated data in accordance with the Law on Gender Equality. However, health monitoring currently only considers data related to prevalence of diseases, morbidity and mortality. Although Kosovo seeks to establish the EU Gender Equality Index, it lacks data on key health indicators constituting this index.

An initial review of the existing literature related to women's and men's access to quality healthcare in Kosovo revealed a dearth of information. Neighbouring countries like Croatia have identified barriers to women accessing healthcare, such as financial, geographic (travel time and cost) and long waiting lists, especially for less fortunate economic groups. The rural population generally has faced more barriers.[3] In other countries like Albania, Serbia and Macedonia, ethnic minority women face additional barriers like informal payments and discrimination.[4]

Aside from some studies on corruption,[5] access to maternal and antenatal care,[6] and difficulties minorities face accessing care,[7] no known research comprehensively examines access to healthcare and potential barriers for women and men in Kosovo. Meanwhile, KWN has received several reports of gender discrimination occurring within the health sector, but the prevalence of such discrimination has been unknown.

This report seeks to address the dearth of existing research. It falls within the KWN Strategy for 2015-2018,[8] which has among its aims to improve women's access to quality healthcare as a human right. This report contributes to this objective by improving the availability of gender-disaggregated data. Key questions guiding this research included:

1. How do women and men utilize healthcare services?
2. What financial, geographical, ethnic, cultural and/or knowledge barriers exist to women and men accessing healthcare?
3. How do women and men evaluate the quality of healthcare in Kosovo?
4. How aware are women and men of their healthcare needs and rights?

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[1] For further information about the legal framework, see the next chapter.

[2] Ministry of Health, *Health Sector Strategy 2010 – 2014*, Prishtina, 2009; Ministry of Health, *Action Plan for Health Sector Strategy 2011 – 2014*, Prishtina, 2011.

[3] Bagat et al, *Influence of urbanization level and gross domestic product of counties in Croatia on access to health care*, Zagreb, 2008; and Pristas et al., *Health care needs, utilization and barriers in Croatia-regional and urban-rural differences*, Zagreb, 2009.

[4] Djurovic et al., *The health status of Roma children - A medical or social issue?*, Novi Sad, 2014; Colombini et al., *Access of Roma to sexual and reproductive health services: Qualitative findings from Albania, Bulgaria and Macedonia*, London, 2012; and Janevic et al., *'There's no kind of respect here' A qualitative study of racism and access to maternal health care among Romani women in the Balkans*, 2011.

[5] Levizja Fol, *Health Corruption Scan*, Prishtina, 2016, at: http://levizjafol.org/folnew/publications/?lang=en.

[6] UNICEF, *Antenatal Care in Kosovo*, Prishtina, 2009; and UNFPA et al., *Partnership to improve Women's and Children's Health in Kosovo,* Prishtina, 2012.

[7] Luta, Xh. and Dræbel,T., *Kosovo-Serbs' experiences of seeking healthcare in a post-conflict and ethnically segregated health system,* Copenhagen, 2013; KOSANA-Solidar Suisse, *Kosovo Roma, Ashkali and Egyptian Access to and Use of Health Care Services*, Prishtina, 2015.

[8] KWN, *Strategy for 2015-2018*, Prishtina, 2014, at: http://www.womensnetwork.org/documents/kwn_strategy_2015_2018_eng.pdf.

Written with support from and in collaboration with the Kosovo Ministry of Health, Dartmouth College, the University of Prishtina, the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the United Nations Development Programme (UNDP) and UN Volunteers, the report focuses on how gender, residency (urban/rural) and ethnicity affect barriers to accessing healthcare, quality of healthcare, utilization of healthcare services and knowledge of healthcare rights in Kosovo.

## Methodology

This report draws from a mixed methods research design. First, in order to ensure that this report could contribute to the existing literature, as well as guide stakeholders in Kosovo, a literature review was conducted using key databases, such as PubMed (see Appendix 4). KWN also examined grey literature by searching UN websites and Google Scholar. Studies from neighbouring countries were included for comparison in a regional context.

Second, from 7 to 16 June 2016, a national household survey of 1,309 respondents (52% women and 48% men) was conducted throughout Kosovo in urban (42%) and rural areas (58%) to understand their experiences with the healthcare system. The sample is representative of all ethnic groups in Kosovo. Respondents were selected using Multistage Random Sampling Method (see Appendix 1).

For the analysis of quantitative data, eight indices were constructed using questions from the survey, each focusing on different barriers to accessing healthcare.[9] Then, researchers used six stratifications, analysing the survey data by: gender, ethnicity, residency (urban/rural), age, region and education level (see Appendix 1).[10] The findings were not analysed by socioeconomic status as survey data were not internally consistent.[11] This report focuses on gender, ethnicity and residency analyses, as they yielded the most interesting results. Age, region and education level analyses can be summarized as follows:

- Age generally was not correlated with access to healthcare.
- The analyses of region presented disparities, with the capital region of Prishtina and the Serb-majority region of Mitrovica generally faring better than the other five regions. However, these results are difficult to interpret without further data on hospitals and providers.
- There was a positive correlation between education level and access to healthcare. More educated persons had better access and reported receiving better care.

This report utilizes a 0.05 level of significance ($p<0.05$) and all correlations presented are considered significant at this level. Readers can assume that the word 'significant' always means statistical significance. Generally, where gender-disaggregated data is not provided, no significant difference existed between women and men.

[9] Please see Appendix 1 for further information about these Indices.

[10] Education is presented in terms of number of years of schooling due to changes in the length of secondary school in Kosovo. Thus, 0-7 years can be understood as primary school, 8-11 as secondary school, 12-14 as a university degree and 15+ as a graduate degree and/or further education.

[11] Internal consistency reliability is a measure of how well different questions on the survey measure the same construct or idea. Survey respondents were asked for their individual monthly income and their household monthly income. About 54% of respondents reported their individual income to be higher than their household income. Thus, socioeconomic data were unreliable and were not analysed.

Third, KWN researchers conducted semi-structured interviews with 110 healthcare practitioners and key informants to better understand their perspectives and experiences, as well as to inform and contextualize survey responses. Respondents included doctors and nurses in primary care, obstetrics, gynaecology, psychiatry and cardiology units; psychologists; pharmacists; policymakers; and representatives of international organizations and non-governmental organisations (NGO). KWN used variation sampling to select diverse healthcare workers at different levels of care in public and private practices from rural and urban areas in all regions. While awaiting interviews, some researchers also observed the general situation within healthcare providers' offices, including equipment, cleanliness, waiting times, confidentiality and doctor-patient interactions.

Appendices 1 to 5 contain further details about the methodology.

## About This Report

This report begins with a summary of the relevant legal framework, which outlines the rights that Kosovars have to healthcare, as well as the roles and responsibilities of healthcare institutions. Brief chapters examine Kosovo's healthcare system and demographics. The report then presents research findings. When appropriate, findings are contextualized with information from the literature review. The report concludes with areas for further research and policy options. Appendices provide further information relevant to the research: a more detailed description of the survey methodology, including the index question matrices (Appendix 1): the survey questions (Appendix 2); interview guides for healthcare workers (Appendix 3); literature review (Appendix 4); difficulties and limitations (Appendix 5); and other findings unrelated to the focus of this report, but of interest (Appendix 6).

# The Legal Framework on Healthcare

This chapter summarizes the legal framework relevant to healthcare in Kosovo.[12] The International Covenant on Economic, Social and Cultural Rights (ICESC) tends to be referenced in referring to the right to healthcare. Article 12 provides an extensive definition of the right to health, recognizing 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' However, ICESC is not directly applicable in Kosovo.

The Constitution of the Republic of Kosovo does make several international conventions directly applicable in Kosovo, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[13] In case of a conflict of provisions, *inter alia*, CEDAW shall prevail. According to CEDAW Article 12, states are required to undertake measures to 'eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.' General Recommendation 24 on Article 12 reads that 'the duty of States parties to ensure, on a basis of equality of men and women, access to health care services, information and education implies an obligation to respect, protect and fulfil women's rights to health care.'[14] The CEDAW Committee further requires that 'States parties should not restrict women's access to health services or to the clinics that provide those services on the ground that women do not have the authorization of husbands, partners, parents or health authorities, because they are unmarried or because they are women.' Moreover, state parties have an obligation towards women to provide services in relation to pregnancy and the period after birth (post-partum period), as well as adequate nutrition during pregnancy and lactation. These services have to be provided free of charge when necessary. Further, States should ensure that women living in rural areas, have the right to access adequate healthcare facilities, including information, counselling and services in family planning.[15]

## European Union Law

The European Union (EU) grants Member States great autonomy to regulate their own healthcare systems.[16] However, EU law also sets out general principles with which Member States should comply. The EU legal framework provides for the right to non-discrimination,[17] which appears to be a legal ground for granting access to healthcare on a non-discriminatory basis. The Directive 2011/24 on Patients' Rights and Cross-Border Health Care regulates access to safe and high quality cross-border healthcare services. Hence, this Directive is only applicable when an EU citizen seeks healthcare services in a member state other than her or his own. This Directive aims at harmonizing healthcare systems in the EU. However, the Directive states that 'Member States retain responsibility for providing safe, high

[12] This section was written by Rina Ajeti for KWN.
[13] Constitution of the Republic of Kosovo, Art. 22.
[14] UN, CEDAW, General Recommendation 24 on Article 12 (Women and Health).
[15] UN General Assembly, CEDAW, 1981, Art. 14, para. 2.
[16] Consolidated version of the Treaty on the Functioning of the European Union, 2009, Art. 168, para. 7 and Art. 152.
[17] Ibid, Art. 10 and Art. 19, and Consolidated version of the Treaty on European Union, Art. 3.

quality, efficient and quantitatively adequate healthcare to citizens on their territory.'[18] While the aforementioned Directive is not applicable in Kosovo, Kosovo's laws have to be compatible with EU law as clearly stated in the Stabilization and Association Agreement (SAA) between Kosovo and the EU.[19]

## Kosovo's Applicable Law

The Constitution of the Republic of Kosovo states that healthcare and social assistance shall be regulated by law.[20] Although this constitutional article does not grant the right to healthcare *per se*, it clearly requires healthcare to be regulated by legislation. As mentioned, the Constitution also references CEDAW as directly applicable.

The Law on Health superseded previous laws relating to health, entering into force in 2013.[21] According to Article 1, it has the 'aim of establishing legal grounds for the protection and the improvement of the health of the citizens of the Republic of Kosovo through health promotion, preventive activities and provision of comprehensive and quality healthcare services.' This Law regulates rights and obligations, underlying healthcare principles, the healthcare system itself, healthcare institutions' activities and the supervision of healthcare services. Although the Law on Health mentions several rights and obligations of citizens, the Law on Rights and Responsibilities of Citizens in Healthcare should be consulted regarding patients' rights and obligations.[22]

Pursuant to Article 15 and 16 of the Law on Health, the healthcare system shall follow an institutional structure. Healthcare shall be implemented at three levels, namely primary, secondary and tertiary. Primary healthcare plays a crucial role within this three-level structure since it functions as an entrance into the health system. The strict implementation of the referral system from the primary level to the secondary level, and from the secondary to the third level, is a prerequisite for comprehensive healthcare services. Secondary healthcare is provided by general and special hospitals where patients receive more specialist healthcare services (Article 19). In accordance with Article 20, municipalities are allowed to organize secondary healthcare, provided that they have been requested to do so by their municipal assembly, and if this complies with the Decree of the Minister of Health. The regional hospitals that represent public secondary healthcare institutions, together with the only public tertiary healthcare institution, the University Clinical Centre of Kosovo (UCCK) in Prishtina, constitute the 'Hospital and University Clinical Service of Kosovo' (Article 62).

**Generally, it is prohibited to refer patients from a public secondary or tertiary healthcare institution to a private healthcare institution.**

In order to ensure the functioning of this three-level structure, it is prohibited to refer patients from a public secondary or tertiary healthcare institution to a private healthcare institution, unless the referral is clinically indicated as necessary. Notably, a person's position on a waiting list cannot be invoked (Article 41). A person has the right to be placed on a waiting list in case a medical treatment cannot be provided by any other healthcare institution or the citizen does not wish to be treated by

[18] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, Art. 4.
[19] Stabilization and Association Agreement (SAA) between Kosovo and the EU.
[20] Constitution of the Republic of Kosovo, 2008, Art. 51.
[21] Law No. 04/L-125 on Health, 2013, Art. 101.
[22] UNMIK, Regulation 2004/47 on the Promulgation of the Law on Rights and Responsibilities of Kosovo Residents in the Health Care System, adopted by the Assembly of Kosovo, 2004.

another institution.[23] Although patients waiting for treatment could technically be given medical treatment by private healthcare institutions, it is prohibited to refer patients from public to private healthcare institutions by virtue of law. Any form of award to a public health employee for referring a patient from a public to a private healthcare institution is strictly prohibited. Also, the Law on Health prohibits providers from maintaining profitable relationships with the pharmaceutical industry (Article 41). Article 26 states that medications prescribed by a physician or dentist only can be issued by or in the presence of licensed pharmacists.

Further, the Administrative Instruction on Preventing Conflicts of Interest in Health Institutions reaffirms the prohibition of referral from a public healthcare institution to a private one.[24] However, the fact that the Law does not prohibit doctors from being employed in both public and private sectors can give rise to potential conflict of interest.

The Law on Health stipulates several principles for providing healthcare. The following principle of 'inclusiveness and non-discrimination' is in line with the right to non-discrimination as established under the EU legal framework, requiring:

> equal healthcare for all citizens and residents by ensuring the standards during fulfilling the needs at all levels of healthcare as well as ensuring healthcare without discrimination on basis of: gender, nation, race, color, language, religion, political preferences, social status, sexual orientation, the level of physical or mental abilities, family status, or age.[25]

Besides the Law on Health, several other laws further detail legal rights relating to healthcare.

### Patient Rights

The Law on the Rights and Responsibilities of the Citizens in the Health Care recognizes the rights of Kosovo citizens, outlines mechanisms for enforcing these rights and states citizens' obligations.[26] Moreover, the Administrative Instruction on the Charter of Patient Rights and Responsibilities obliges healthcare institutions at all levels and health professionals to respect patients' rights. To that end, healthcare institutions of all levels are obliged to place the Charter of Patient's Rights and the Charter of Patient's Responsibilities in the waiting room and/or the patients' room.[27]

### Right to Access to Quality Healthcare

Every citizen in Kosovo has the right to healthcare.[28] Further, the Law on Rights and Responsibilities of Kosovo Residents in the Health Care System, Article 4 (1) states that 'health care should be adequate and continuously accessible to all without discrimination'. Continuously accessible means that healthcare shall be provided 24 hours a day. Every person is entitled to emergency healthcare with the purpose of prevention of permanent and serious health damage. The same Law entitles certain groups of citizens to healthcare services free of

[23] Ibid, Art. 4, para. 4.8.
[24] Administrative Instruction 11/2014 Preventing Conflicts of Interest in Health Institutions.
[25] Law on Health, Art. 5, para. 1.2.
[26] Law No. 2004/38 on the Rights and Responsibilities of the Citizens in the Health Care.
[27] Administrative Instruction 15/2013 Charter of Patient Rights and Responsibilities.
[28] Law No. 2004/38 on the Rights and Responsibilities of the Citizens in the Health Care Art. 4.

charge. The current Law on Health (2013) does not contain such a list. Nevertheless, the following groups of citizens are entitled to free healthcare services in public health institutions: all women, before and during pregnancy, birth and the post-partum period have the right to pre-conception advice, antenatal and post-partum healthcare;[29] close family members of martyrs, missing persons and disabled persons from the Kosovo Liberation Army;[30] and close family members of civilian victims of war (only entitled to primary and secondary healthcare).[31]

### Other Rights

During medical treatment, 'the citizen's human dignity, privacy, personal integrity and religious beliefs shall be respected'.[32] Citizens have the right to consult the physician of their choice. Patients have the right to leave a healthcare institution, unless leaving would constitute a threat to the well-being of others. The right to communication entitles every citizen to maintain contact with other persons and to receive visitors. Patients have the right to be informed about anything connected to their health status and possible medical treatments. The manner in which information is provided should be comprehensible for citizens irrespective of their ages, education and state of mind. Citizens have the right to access health documentation, including healthcare data related to their health.

Citizens are free to make personal decisions regarding medical treatment, including whether to make use of certain healthcare services. They have the right to consent to health interventions. However, if obtaining consent would endanger the citizen's health, neither the patient nor the patient's authorized representative need consent to the proposed treatment. Further, citizens have the right to confidentiality of personal data and information related to 'state of health and medical treatment', among other information.

Kosovo has an essential drug list, based on WHO recommendations, which specifies the types of drugs that should be provided free of charge by public institutions.[33] The current, slightly outdated list includes basic drugs for common diseases for inpatient and outpatient care, as well as some contraceptives.

### Right to File a Complaint

Every citizen is entitled to file a complaint against a health institution that has provided the citizen with a healthcare service within 60 days of the incident.[34] The healthcare institution is required to investigate the complaint within 10 days. A citizen can appeal against the healthcare institution's decision. The right to complain does not affect the citizen's right to address other institutions for investigating complaints, such as through criminal proceedings. Patients can claim compensation for damages. Such requests shall not be made later than one

[29] UNMIK, Regulation 2007/11 on the promulgation of the law on Reproductive Health adopted by the Assembly of Kosovo, 2007, Art. 8. Art. 18 of the Law on Health states these services can be provided at the primary healthcare level.
[30] Law No. 04/L-054 on the Status and the Rights of the Martyrs, Invalids, Veterans, Members of the Kosova Liberation Army, Sexual Violence Victims of the War, Civilian Victims of War and Their Families, Art. 8 and 9.
[31] Ibid, Art. 13.
[32] Law on Rights and Responsibilities of Kosovo of the Citizens in the Health Care Art. 6. The remainder of this paragraph and the next paragraph refer to articles 5, 8, 7, 9, 19, 10, 12, and 20 respectively.
[33] Republic of Kosovo, Ministry of Health, *Analiza e Prodkteve te Listes Esenciale per Vitin 2013 sipas Vend dhe ABC Indikatoreve* [Product Analysis and Essential List for 2013 by Location and ABC indicators], Prishtina, 2013, at: http://msh-ks.org/wp-content/uploads/2013/11/Lista-Esenciale-sipas-VEN-dhe-ABC-Indikatoreve.pdf.
[34] Law on Rights and Responsibilities of the Citizens in the Health Care, Art. 24.

year from the moment when citizens seeking compensation became aware of the damage. A commission on the evaluation and compensation of damage inflicted upon the health of the citizen shall be established. However, this Commission seems not to have been established yet.[35]

### Responsibilities of Patients

Patients are obliged to cooperate with health workers from the moment of diagnosis until they have carried out instructions received from health workers for treatment. This includes paying co-payments and providing proof of personal data. Article 23 of the Law on Rights and Responsibilities requires healthcare service providers to inform citizens who seek healthcare services about their rights to such services.

### Law on Health Insurance

All citizens and residents in the Republic of Kosovo have the right and obligation to mandatory health insurance, as stated under Article 6 of the Law on Health Insurance.[36] Health insurance covers basic healthcare services, called the 'basic package'.[37] Citizens who have health insurance are entitled to a list of services provided by primary, secondary and tertiary health institutions. A precondition for receiving these services is that citizens have paid premiums, unless they are exempt from payment. However, even citizens and residents without health insurance can benefit from 'guaranteed healthcare services', which shall be provided regardless of health insurance status. These include: emergency healthcare services; healthcare services to children under the age of 18 years; essential healthcare services for pregnant women and women after childbirth; and other essential healthcare services as determined by the Health Insurance Fund. These guaranteed services are provided free of charge as part of basic healthcare services in Kosovo.

The Law exempts particular groups of citizens from paying health insurance premiums, automatically insuring them. These groups include poor families receiving social assistance; prisoners; individuals living in state institutions; repatriated persons based on bilateral agreements between Kosovo and other states in the first year of repatriation; war invalids, their spouses and children under age 18; trafficking victims; permanent residents of informal settlements until the registration process ends; and victims of domestic violence. If qualifying as poor and eligible for social assistance,[38] the following groups also are exempt: aged and contributory pensioners; pensioners of 'Trepça' company; Kosovo Protection Corps and Kosovo Security Force retirees; martyrs' close family members; veterans of war and their spouses and children; former political prisoners and their spouses and children; the close family members of civilian victims of war; victims of sexual abuse during the war, in compliance with legal provisions in force; disabled persons; and students.[39]

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[35] Koha.net, *Pacientët e dëmtuar nga gabimet e mjekëve nuk kompensohen*, 19 May 2015, at: http://koha.net/?id=1&l=58155.

[36] Law No. 04/L-249 on Health Insurance, 2014. The sentences that follow in this paragraph and the next refer to articles 6(2), 13, 7, 16(2) and 11, respectively.

[37] See the Law on Health Insurance, Art. 14. A Commission shall define the services each year.

[38] See the criteria as established in the Law No. 04/L-096 on Amending and Supplementing the Law No. 2003/15 on Social Assistance Scheme in Kosovo

[39] Law on Health Insurance, Art. 11, para. 3.

Health insurance should be financed through a system of mandatory health insurance premiums in which every Kosovar pays a certain amount of his/her income into the Health Insurance Fund.[40] One study elaborated on health insurance and what it means for the population.[41] Kosovo's high unemployment rates and large percentage of the population believed to be working in the informal sector make it next to impossible for employed persons to pay in enough funds to cover the costs of healthcare for all citizens. Co-payments and new taxes, such as increasing taxes on tobacco, alcohol and luxury goods, have been suggested as solutions for covering the difference.[42] As of 2016, the Health Insurance Fund has not been operationalized yet, and the right to health insurance has not been implemented.

Implementing the Health Insurance Fund could affect the use of pharmaceuticals. According to the Law on Health Insurance, basic healthcare services for insured persons also shall include the use of medicines and consumable material from a list to be established by the Health Insurance Fund. Further, the Law states that these medicines and consumables are only reimbursed if they are prescribed on an official receipt in a generic name by a licensed medical doctor at a contracted healthcare institution, and if they are obtained at a private pharmacy contracted by this Fund.[43] If the Law were to be implemented, this procedure would provide a financial incentive for patients to buy drugs with an appropriate prescription.

### Laws Regulating Pharmacies and Pharmaceutical Products

In order to regulate the pharmaceutical market, ensure quality of products and safeguard the population, Law No. 04/L-190 on Medical Products and Medical Devices entered into force in 2014.[44] It regulates all products for medical and pharmaceutical markets, ranging from vitamins and herbs to radioactive substances. The Kosovo Medicines Agency (KMA) is responsible for control, while the Pharmaceutical Inspectorate under the Medicinal Inspectorate carries out inspections.[45]

KMA supervises the licensing process required to import medicines to Kosovo. A commission recommends and advises KMA before a Marketing Authorization is issued.[46] When this authorization is granted, KMA decides if the medicine requires a prescription (Prescription Only Medicine, POM) or not (Over The Counter, OTC). The Law specifies that medicinal products that can harm public health or be used incorrectly, require a prescription. Further conditions for POM are determined by a sublegal act, which enlists POM and OTC drugs.[47] KMA should issue a new list of authorized medicinal products each month. A list of all licensed pharmaceuticals authorized for marketing is available from 2014.[48] The selling of unauthorized drugs, meaning drugs not on that list, is forbidden by Article 9.2.

For selling pharmaceuticals, a license also is required and issued by KMA. Every pharmacy must be licensed and have a licensed pharmacist during working hours for selling

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[40] Ibid, Art. 21.
[41] KOSANA-Solidar Suisse, *A Proposal for a Health Insurance Plan How does it affect us?,* Prishtina, 2012.
[42] M. Zhara and A. Cucovi, *Public Health Insurance — Case Study: The Current Situation in Kosovo*, 2015.
[43] Law on Health Insurance, Art. 15.
[44] Law No. 04/L-190 on Medical Products and Medical Devices.
[45] Ibid Art. 5.
[46] Ibid, Art. 7.
[47] Udhëzim Administrativ (në Shëndetësi) Nr. 01/2010, *Recetat në Sistemin Shëndetësor në Republikën e Kosovës*.
[48] Kosovo Medicines Agency, *Drug Register Version 3*, 2014, at: https://akppm.com/en/category/publikimet/regjistri-i-barnave/.

medicinal products. Further, Article 14.6 states that a pharmacy shall purchase medicinal products and medical devices only from entities holding a pharmaceutical wholesale license.

A separate law from 2007 deals with narcotics and psychotropic substances,[49] which include potent opiates like fentanyl, morphine, methadone and tranquilizers such as diazepam or tetrazepam. Article 14.1 of this Law states that in order to buy, possess and consume narcotic medicaments and psychotropic substances, a competent doctor's special medical prescription is required in accordance with the Law on Medical Products and Medical Devices.

Both laws foresee penalties for violations, ranging from fines to prohibiting the activities of a trader or pharmacist.

## Abortion

According to Article 5 of the Law on the Termination of Pregnancy, any pregnant woman over 18 years old is entitled to request termination of her pregnancy. This form of abortion can be performed until the tenth week of pregnancy. The Law also allows women who 'are mature on their sixteen [*sic*]'[50] to request a termination of pregnancy with consent from their parents or a legal guardian. The precise meaning of 'mature' is not defined. Nor are the rights of young women under age 16 in terms of abortion clearly defined.

The family doctor or gynaecologist is obliged to inform and advise women seeking an elective abortion at least three days before the procedure. If the woman still expresses her will to induce abortion, she is required to give written consent. Procedurally, abortions may involve a surgical or medical methodology, though currently there is no licensed drug available.[51] No doctor or gynaecologist is obliged to perform an elective termination of pregnancy against his or her will, referred to as 'conscientious objection'.[52] However, the health institution is obliged to find a solution for the woman to have an abortion within the same health institution. The doctor also is obliged to provide the woman with information on family planning methods.[53] Until the 22nd week of the pregnancy, termination of pregnancy is allowed under special circumstances. These include medical reasons, such as pregnancy poses a threat to the mother's life or malformations affecting the life of the foetus; or pregnancy following rape, incest or sexual exploitation. Article 21 of this Law requires each institution to report statistical data related to the termination of pregnancy.[54]

## Criminal Provisions Relating to Healthcare

The Criminal Code of Kosovo (CCK) punishes various acts committed by healthcare providers. Physicians or healthcare workers who apply incorrect methods of treatment or fail to use hygienic measures, leading to the deterioration of a patient's health condition, will be punished by imprisonment up to three years.[55] Offences resulting in serious impairment of the person's health or death involve more severe punishment. The failure to provide medical assistance to a person in need, when the physician or medical worker should have been aware

[49] Law No. 02/L-128 on Narcotiv Medicaments, Psychotropes and Precursors.

[50] Law No. 03/L-110 for Termination of Pregnancy, 2009, Art. 5, para. 2.

[51] Despite mifepristone being on the Registry for 2014 (Kosovo Medicines Agency, *Drug Register Version 3*, 2014) and misoprostol being on the Essential Drug list for 2013 (MoH, *Listes Esenciale per Vitin 2013,* 2013), the MoH confirmed in Dec. 2016 that neither drug is registered in Kosovo.

[52] Law No. 03/L-110 for Termination of Pregnancy, 2009, Art. 13.

[53] Ibid, Art. 18.

[54] Ibid, Art. 21.

[55] CCK, Art. 260, para. 1.

that this would lead to serious bodily harm or death, is punished with three years' imprisonment.[56] A physician who discloses confidential information shall be punished with a fine or imprisonment up to one year.[57]

[56] Ibid., Art. 261, para. 3.
[57] Ibid., Art. 203, para. 1.

# Kosovo's Healthcare System

Kosovo's healthcare system is in transition. Kosovo inherited a so-called 'Semashko' healthcare structure from the former Yugoslavia, with the state acting as both the purchaser and the provider of health services. This system incentivized specialization, creating many inefficiencies and redundancies. Patients had little agency in choosing where to seek care.

When Kosovo's autonomous status was revoked by Belgrade in March 1989, the health sector also became a battleground between Kosovo's Albanian population and the Serbian government. The Serbian government assumed control of the Kosovo healthcare system while the University of Prishtina's medical faculty was closed, disrupting the training of many medical students. More than 60% of ethnic Albanian health workers (an estimated 2,400 people) left their jobs because they were fired, discriminated against or chose to leave.[58] Many other Albanians lost their jobs during this period and consequently lost their insurance coverage. During the 1990s, more than half the Albanian population lacked access to the public health system.

Albanian healthcare workers established a parallel primary healthcare system known as the Mother Theresa Society. This parallel system operated 96 clinics throughout Kosovo, many in remote areas. Healthcare workers served as volunteers. A parallel tax system funded supplies and medicines. Albanian healthcare workers also established private facilities such as clinics and laboratories. During this time, medical students and health workers received only limited training in parallel education systems without practical training. As a result, a generation of Albanian healthcare workers was left with gaps in their medical knowledge and differing credentials.

Despite the efforts of the parallel healthcare system, the health of Kosovo's population declined during the 1990s. Immunization rates dropped; vaccination coverage for children against diseases such as polio fell. The incidence of infectious disease rose, and polio subsequently re-emerged.

Kosovo's healthcare system also was seriously weakened by a decade without investment during the 1990s. The healthcare system was further damaged after armed conflict broke out in 1998. Approximately 90% of hospitals and clinics were damaged, and almost all private clinics operated by Albanian doctors were destroyed.

Since the war, several internationally-funded projects have invested in developing the healthcare system's infrastructure, focusing on primary health care (PHC) and rehabilitation of health infrastructure. Reconstruction was influenced heavily by international donor priorities, which strongly supported a primary healthcare model.[59] While reforming the healthcare system from centralized to decentralized, several programs sought to establish antenatal and maternal care at the primary care level.[60] The PHC model was meant to emphasize family medicine at the primary level and act as a gatekeeper to specialized care, provided at secondary and tertiary levels. In the early 2000s, primary care was decentralized, making

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[58] Percival, V. and Sondorp, E., *A case study of health sector reform in Kosovo*, Ottawa, 2010. The following paragraphs about the pre-war period draw from the same source.

[59] Buwa, D. and Vuori, H., *Rebuilding a health care system: War, reconstruction and health care reforms in Kosovo*, 2007.

[60] Homan et al, *Post-conflict transition and sustainability in Kosovo: establishing primary healthcare-based antenatal care*, Dartmouth, 2009; Kollisch et.al, *Improving family medicine in Kosovo with microsystems*, Dartmouth, 2011; and Tahiri et al, *Patients' evaluation of primary health care services in Gjilan region, Kosovo,* Gjilan, 2014.

municipal governments responsible for its management, while secondary and tertiary healthcare is controlled by the Ministry of Health. This resulted in fragmented oversight of public institutions by municipal governments and the Ministry of Health.[61] Thus, while progress has been made, a multitude of challenges and internal problems reportedly have limited proper functioning of the new healthcare system.[62]

Each of Kosovo's 38 municipalities has a Main Family Medicine Centre (MFMC) where citizens can access primary healthcare. These MFMCs should have at least one doctor and two nurses for every 2,000 people in the clinic's area. Primary care addresses the basic needs of the society including health promotion and public health related issues, such as data collection, diagnosis and treatment including minor surgical interventions, emergency services, reproductive health and mental health services. The number of mental healthcare facilities has grown from seven in 2000 to 28 in 2010.[63] In 2010, Kosovo had nine community-based mental health centres for adults, six inpatient wards in general hospitals for adults, eight residential facilities for adults, a community-based mental health centre for children and adolescents, two primary healthcare units for children and adolescents, and two residential facilities for them.

The shift toward MFMCs was intended to strengthen primary care and decrease reliance on specialists for routine healthcare. Many efforts also went into training family doctors.[64] However, in 2007 Buwa and Vuori reported that this reform had largely failed due to lack of behavioural and attitudinal shifts in patient populations. The primary care model still has not been embraced and continues to struggle.[65] Although some success was achieved in general, such as with decreased infant and maternal mortality rates and an increased life expectancy from 68 years in 2000 to 71 in 2014,[66] utilization of primary care remains low and people tend to seek specialist (secondary) care, as findings from this research, detailed later, seem to suggest.

Secondary care is accessible at any one of the seven regional hospitals. The regions of Ferizaj, Gjakova, Gjilan, Peja and Prizren each have one regional hospital. The region of Mitrovica has two: one in Mitrovica North and the other in Vushtrri. Mitrovica region includes all municipalities in northern Kosovo, where most of the Serb minority population lives. According to the Organisation for Security and Co-operation in Europe (OSCE), Serbs throughout Kosovo also use the hospital in Mitrovica North for tertiary healthcare.[67] At the secondary level, mental healthcare services are provided by the Department of Psychiatric units within General Hospitals, Mental Health Centres, 'integrating houses, and center for integration, rehabilitation, socialization of the chronic psychiatric sick people in Shtime'. The UCCK in Prishtina provides both secondary care for Prishtina and tertiary care for all of Kosovo. Tertiary care is *only* available at UCCK. Three additional institutions are associated with UCCK: the medical school, university clinical centre and clinical services unit. The public system lacks rehabilitation centres, or more specifically, tertiary prevention in order to restore health after a severe disease or accident.

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[61] Buwa, D. and Vuori, H., 2007.
[62] Ibid; and Percival and Sondorp, 2010.
[63] Epping-Jordan et al, *Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective*, 2015.
[64] Kollisch et al, 2011.
[65] Homan et al, 2009.
[66] World Bank, *Country Data Kosovo*, 2016 at: http://data.worldbank.org/country/kosovo.
[67] OSCE, *Municipal Profile of Mitrovica North*, 2015, http://www.osce.org/kosovo/122119?download=true.

Alongside public health institutions, numerous private clinics and hospitals exist throughout Kosovo, offering both specialized and general care. For healthcare personnel, private institutions offer a way of supplementing their public sector incomes, as this research later discusses. Patients may access private care and may move directly to specialty care.[68] Motivations for seeking public or private care are discussed later, in the chapter on utilization.

## Health Data Management

In 2010 the Health Information Strategy and Implementation Plan laid out the steps to further develop and implement a health information system (HIS) to improve evidence-based decision-making. It should also serve as the basis for a comprehensive cancer registry and screening programmes. According to the set timeline, it should be functioning throughout Kosovo by 2020. Thus, HIS is still not fully functional.

For further information about current health data management, this report drew from interviews with healthcare workers. Most stated that data is collected and maintained by nurses in their institutions or administrative staff. Data usually is recorded in writing and electronically on computers. However, some health workers said they lacked computers or adequate software to analyse data. Some doctors also reported using private devices to store information.

## Financing Healthcare

Currently, the public healthcare system is funded through the Budget of Kosovo, comprising approximately 6.4% of total planned government expenditures for 2016.[69] This included approximately 3.1% of all expenditures for healthcare in municipalities and 3.3% for the central level. Planned expenditures on healthcare amounted to roughly €108 million. This sum covers approximately 60% of all public health expenditures. Therefore, the remaining 40%, or so, of healthcare costs must be covered through patients' out-of-pocket expenditures.[70] Public health insurance is a right for all citizens, but the Health Insurance Fund has not been established yet (see the Legal Framework Chapter). Some companies offer private health insurance. However, as later elaborated survey findings suggest, only six percent of Kosovars seem to have private health insurance.

## Conclusion

Many structural problems remain in achieving a fully integrated healthcare system. The ongoing transition from a centralized socialist model, a weak data management system and the non-existent Health Insurance Fund all present challenges. Governance and accountability issues combined with limited funding and corruption impede the functionality and quality of healthcare.[71]

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[68] Buwa, D. and Vuori, H., 2007.

[69] Republic of Kosovo, Assembly, Law Nr. 05/L -071 for the Budget for the Republic of Kosovo for 2016.

[70] World Bank, *The World Bank Group in Kosovo – A country snapshot,* 2015, at: http://www.worldbank.org/content/dam/Worldbank/document/eca/Kosovo-Snapshot.pdf.

[71] Bloom, J.D. et al., *Ethnic segregation in Kosovo's post-war health care system*, Zagreb, 2007; and Levizja Fol, *Health Corruption Scan*, Prishtina, 2016.

# Demographics

This chapter summarizes general demographic information about Kosovo and its inhabitants, enabling comparison with survey sample demographics. In 2011, approximately 63% of the population lived in rural areas.[72] As of 2015, life expectancy for a citizen at birth was approximately 71 years,[73] lower than the 2014 EU average of nearly 81 years.[74] Kosovo is a young country, with a median age of 28.7 as of 2016 (28.3 for men and 29 for women).[75] The sex ratio at birth is higher than the world average, reportedly 110 boys to 100 girls born, indicating that many girls are not being born and sex-selective abortion may exist.[76]

Kosovo is a multi-ethnic society with a sizeable Albanian majority estimated at 92%. Approximately four percent of the population are Serbs and four percent are other ethnic groups: Roma, Ashkali, Egyptians, Bosnians, Turkish and Gorani. However, people living in northern Kosovo, primarily of Serb ethnicity, did not participate in the 2011 Kosovo census. Some Serb and other minority populations located in the southern part of Kosovo also boycotted the census. This precludes arriving at precise population estimates by ethnicity.

Roma, Ashkali and Egyptian populations often are grouped together and discussed collectively, though they do not prefer to be homogenized. They may lack access to benefits such as social welfare, unemployment and schooling.[77] Research has found that Roma are discriminated against in European countries regarding social and especially health issues.[78] Roma, Ashkali and Egyptians in Kosovo display higher morbidity, especially regarding chronic diseases.[79]

In the 2011 census, approximately 95.6% of the population identified as Muslim. The other most common religions are Roman Catholic (2.2%), Orthodox (1.5%), others (0.7%) and atheist (0.7%).[80]

According to the 2015 Labour Force Survey, the unemployment rate is estimated at 33%, with high youth unemployment figures; approximately 58% of youth ages 15-24 are unemployed. Unemployment is higher among young women (67%) than young men (54%).[81] In 2013, 40% of citizens lived in poverty, including 10.2% in extreme poverty.[82]

Since the end of the war, Kosovo has made significant progress on several health indicators. There has been no recorded outbreak of communicable, vaccine-preventable diseases, like measles. In 2000, the perinatal mortality rate was 29 deaths per 1000 births and

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[72] KAS, *KDHS, November 2009*, Prishtina: KAS, 2011.

[73] World Bank, *Country Data Kosovo*, 2016, at: http://data.worldbank.org/country/kosovo; 2011 census data gave a life expectancy figure of 76.6 years.

[74] *Mortality and life expectancy statistics*, Eurostat, Statistics explained, accessed 28 Nov. 2016, at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Mortality_and_life_expectancy_statistics.

[75] Central Intelligence Agency of the United States of America, *The World Factbook*, Field listing: median age, Kosovo, 2016 estimate, accessed 28 Nov. 2016, at: https://www.cia.gov/Library/publications/the-world-factbook/fields/2177.html.

[76] Christophe Z. Guilmoto and UNFPA, *Gender Bias in Kosovo*, Prishtina: UNFPA, 2016.

[77] KAS and UNICEF, *Roma, Ashkali and Egyptian Communities in Kosovo, Multiple Indicator Cluster Survey, (MICS) 2013-2014*, Prishtina: 2014.

[78] N. Parekh and T. Rose, *Health Inequalities of the Roma in Europe: A Literature Review*, London: 2011.

[79] KAS and UNICEF, *MICS*, 2014; Djurovic et al., 2014; KOSANA-Solidar Suisse, *Kosovo Roma, Ashkali and Egyptian Access to and Use of Health Care Services*, Prishtina: 2015; KOSANA-Solidar Suisse, *Prevalence of Disease in the Roma, Ashkali and Egyptian Communities,* Prishtina: 2014.

[80] KAS, *Census 2011,* 2012.

[81] KAS, *Labour Force Survey 2015*, Prishtina: 2016.

[82] UNDP, *The Real Value of Social Assistance*, Prishtina: UNDP, 2014.

has dropped to 12 per 1000 as of 2015.[83] Accordingly, neonatal mortality dropped to seven per 1000 in 2015.[84] Even so, other European countries have lower rates (e.g., ranging from 1.2 in Iceland to 5.5 in Romania in 2009).[85] In 2013, 2014 and 2015, no maternal death has been reported from public healthcare services to the Ministry of Health.[86] However, this may be attributable to underreporting.

From the Labour Force Survey in 2015 the total unemployment rate was estimated to be at around 33%, with higher youth unemployment figures (~58% of youth ages 15-24 are unemployed). Unemployment was higher among young women (~67%) than young men (~54%).[87]

## Sample Demographics

Table 1 displays the demographics of the survey sample population, disaggregating respondents by gender, residency, ethnicity, education level, religion, region, age and marital status. As explained in the methodology, KWN oversampled minority groups in order to be able to analyse the data by ethnicity. The data was subsequently weighted according to demographic estimates for data analysis.

Table 1. Unweighted Sample Statistics

| Strata | Women | Men | Total # | Total % |
|---|---|---|---|---|
| **Residency** | | | | |
| Urban | 280 | 272 | 552 | 42.2% |
| Rural | 396 | 361 | 757 | 57.8% |
| **Regions** | | | | |
| Ferizaj | 65 | 63 | 128 | 9.8% |
| Gjakova | 63 | 64 | 127 | 9.7% |
| Gjilan | 64 | 71 | 135 | 10.3% |
| Mitrovica | 114 | 105 | 219 | 16.7% |
| Peja | 52 | 54 | 106 | 8.1% |
| Prishtina | 184 | 152 | 336 | 25.7% |
| Prizren | 134 | 124 | 258 | 19.7% |
| **Ethnicity** | | | | |
| Albanian | 470 | 434 | 904 | 69.1% |
| Serb | 92 | 103 | 195 | 14.9% |
| Roma, Ashkali, Egyptian | 48 | 40 | 88 | 6.7% |
| Bosnian | 28 | 27 | 55 | 4.2% |
| Gorani | 14 | 14 | 28 | 2.1% |
| Turkish | 22 | 14 | 36 | 2.8% |
| Other | 2 | 1 | 3 | 0.2% |
| **Age Groups** | | | | |
| 16-24 | 148 | 146 | 294 | 22.5% |
| 25-34 | 152 | 112 | 264 | 20.2% |
| 35-44 | 130 | 102 | 232 | 17.7% |
| 45-54 | 121 | 109 | 230 | 17.6% |
| 55-64 | 84 | 94 | 178 | 13.6% |
| 65+ | 41 | 70 | 111 | 8.5% |

[83] MoH, *Report on Perinatal Situation in Kosovo*, Prishtina: MoH, 2016. The perinatal period is defined in varying ways. In Kosovo it includes stillbirths and death in the first week of life. Depending on the definition in other countries, it starts at the 20th to 28th week of gestation and ends one to four weeks after birth. This makes rates difficult to compare.

[84] Death at days 0-28 after birth.

[85] European Perinatal Health Report Group, *European Perinatal Health Report - Health and care of pregnant women and babies in Europe in 2010,* 2013.

[86] MoH, *Report on Perinatal Situation in Kosovo*, 2016.

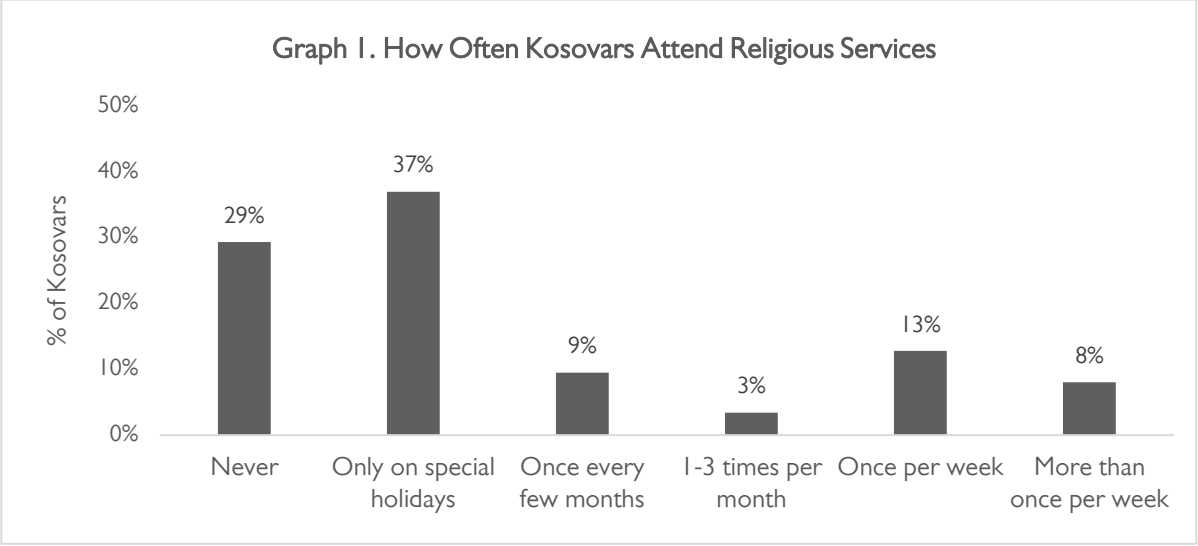
[87] KAS, *Labour Force Survey 2015*, 2016.

Religiosity, the extent to which people are religious, can be measured in part by how often people attend religious services. Approximately 24% of Kosovars said they attend religious services at least once per month (Graph 1). On average, men practiced their religion more than women with 34% of men attending religious services at least weekly compared to 8.6% of women ($p<0.001$).[88]

With regard to sexuality, less than one percent of respondents said they had ever engaged sexually with a person of the same sex. More specifically, 0.7% of women said they preferred to engage sexually with women; less than one percent of men said they preferred men; and only 0.2% of women said they preferred women and men. Although respondents self-completed these questions confidentially, providing false answers in line with cultural norms still may be likely on such questions.[89] The small sub-sample of homosexual or bisexual respondents made it impossible to examine how sexuality may impact access to healthcare.

Table 1. Unweighted Sample Statistics (Continued)

| Strata | Women | Men | Total # | Total % |
|---|---|---|---|---|
| **Religion** | | | | |
| Islam | 566 | 513 | 1079 | 82.4% |
| Catholic | 13 | 9 | 22 | 1.7% |
| Orthodox | 89 | 104 | 193 | 14.7% |
| Atheist/no faith | 2 | 4 | 6 | 0.5% |
| Agnostic/unsure | 3 | 2 | 5 | 0.4% |
| Prefer not to respond | 3 | 1 | 4 | 0.3% |
| **Marital Status** | | | | |
| Single | 168 | 188 | 356 | 27.2% |
| Married with certificate | 398 | 373 | 771 | 58.9% |
| Married without certificate | 55 | 44 | 99 | 7.6% |
| Co-habitating | 1 | 0 | 1 | 0.1% |
| Engaged | 24 | 15 | 39 | 3.0% |
| Divorced | 4 | 4 | 8 | 0.6% |
| Widowed | 26 | 9 | 35 | 2.7% |
| **Education Levels** | | | | |
| 0-7 years | 113 | 32 | 145 | 11.1% |
| 8-11 years | 223 | 122 | 345 | 26.4% |
| 12-14 years | 215 | 352 | 567 | 43.3% |
| 15+ years | 125 | 126 | 251 | 19.2% |
| Don't know | 0 | 1 | 1 | 0.1% |




[88] There was no significant difference by urban or rural residency or level of education.

[89] K.B. Coffman et. al., *The Size of the LGBT Population and the Magnitude of Anti-Gay Sentiment Are Substantially Underestimated*, 2016.

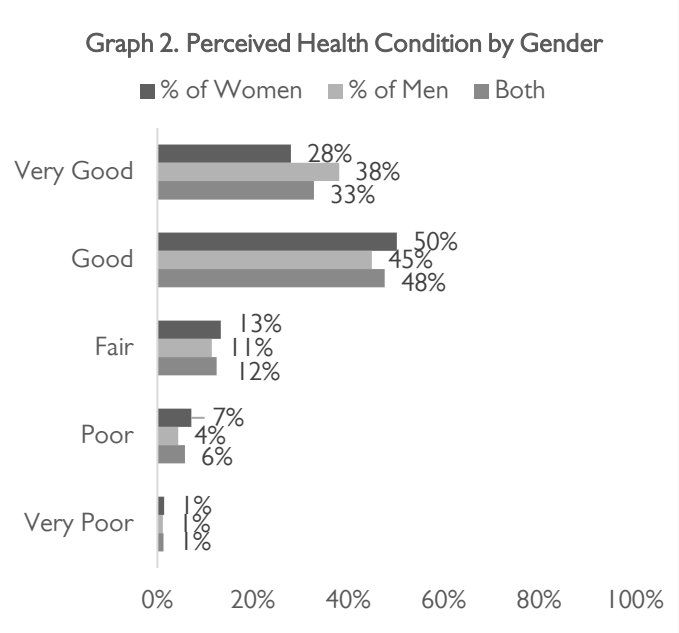
# Self-Assessed Health Status

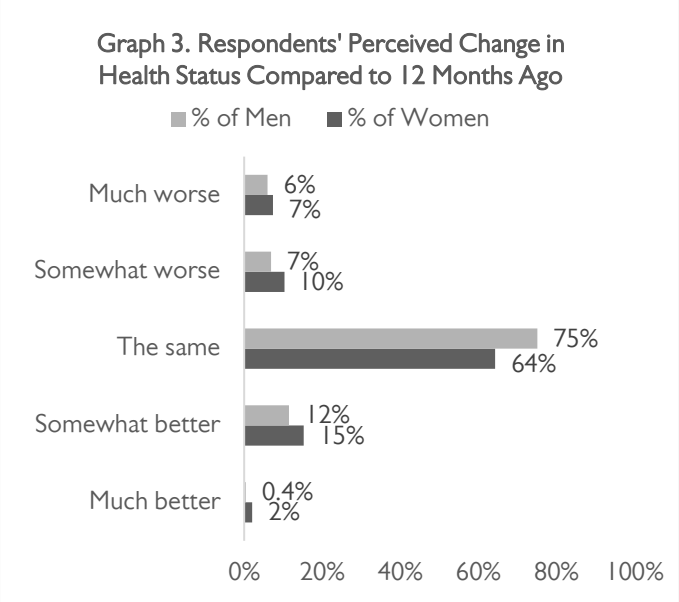
While this research did not examine the actual status of women's and men's health in Kosovo, this chapter briefly examines how Kosovars assess their own health. Eurostat regularly collects and reports information pertaining to self-assessed health, and these data form part of the EU Gender Equality Index. The Eurostat questions were used in this survey, enabling comparisons, which are made in this chapter. Further, understanding Kosovars' self-reported health status can serve as useful context for the rest of the report.

Overall, 81% of Kosovars assessed their own health condition as 'good' or 'very good', which is far higher than the EU-28 average of 67% and in the same range as Sweden, for example.[90] However, one should not forget that the age structure in Kosovo is very different from that in Sweden, which has a median age of 41.2 years.[91] The population in Kosovo is far younger, so chronic diseases would not be expected to impact health as much.[92] The situation may change as the population ages.

On average, women tended to assess their health status slightly worse than men (Graph 2, p=0.01).[93] The difference between women and men in Kosovo is similar to the average gender gap in the EU, five percentage points. Older persons were more likely to assess their health status as poor than younger persons (p<0.001).

Most Kosovars (70%) believed that their health situation has remained the same compared to 12 months ago. However, approximately 15% believed it has deteriorated and 15% thought it has improved. Compared to men, women were more likely to state that their health status had worsened or improved (p=0.006). Younger people were




[90] Only seven percent considered their health 'poor' or 'very poor', less than the EU average of 10%.

[91] Central Intelligence Agency of the United States of America, *The World Factbook*, Field listing: median age, Sweden, 2016 estimate, accessed 28 Nov. 2016,

[92] *Self-perceived health statistics*, Eurostat, accessed 28 Nov. 2016. The comparisons that follow also draw from this source.

[93] No significant difference existed according to municipality or rural/urban location.

more likely to think that their health status had worsened, whereas older people were more likely to say that it had improved ($p<0.001$).

Approximately 18% of Kosovars reported having a longstanding illness or health problem that has lasted, or is expected to last, for six months or longer. Women (21% of them) were significantly more likely to report having a longstanding health problem than are men (15%) ($p=0.04$). Older people also were more likely than younger people to report having long-term illnesses ($p<0.001$). For example, 52% of persons over age 65 and 30% of persons 55-64 reported having chronic illnesses, compared to approximately four percent of persons 16-24 and six percent of persons 25-34.[94]

In assessing their own health, the types of long-standing illnesses or health issues that more Kosovars reported having included: high blood pressure (18% of respondents), rheumatism (8%), chronic back pain (6%), pain in legs (6%), heart problems (6%) and pain or problems in genitalia (5%) (see Graph 4). There was no significant difference by gender.

In response to a separate question, 10% of respondents said that doctors had diagnosed them with a chronic illness or disability that has lasted more than three months. When compared to the aforementioned self-reported illnesses, this suggests that an estimated eight percent of Kosovars may not have sought care for a medical condition, been diagnosed for their ailments or understood the diagnosis they were given.

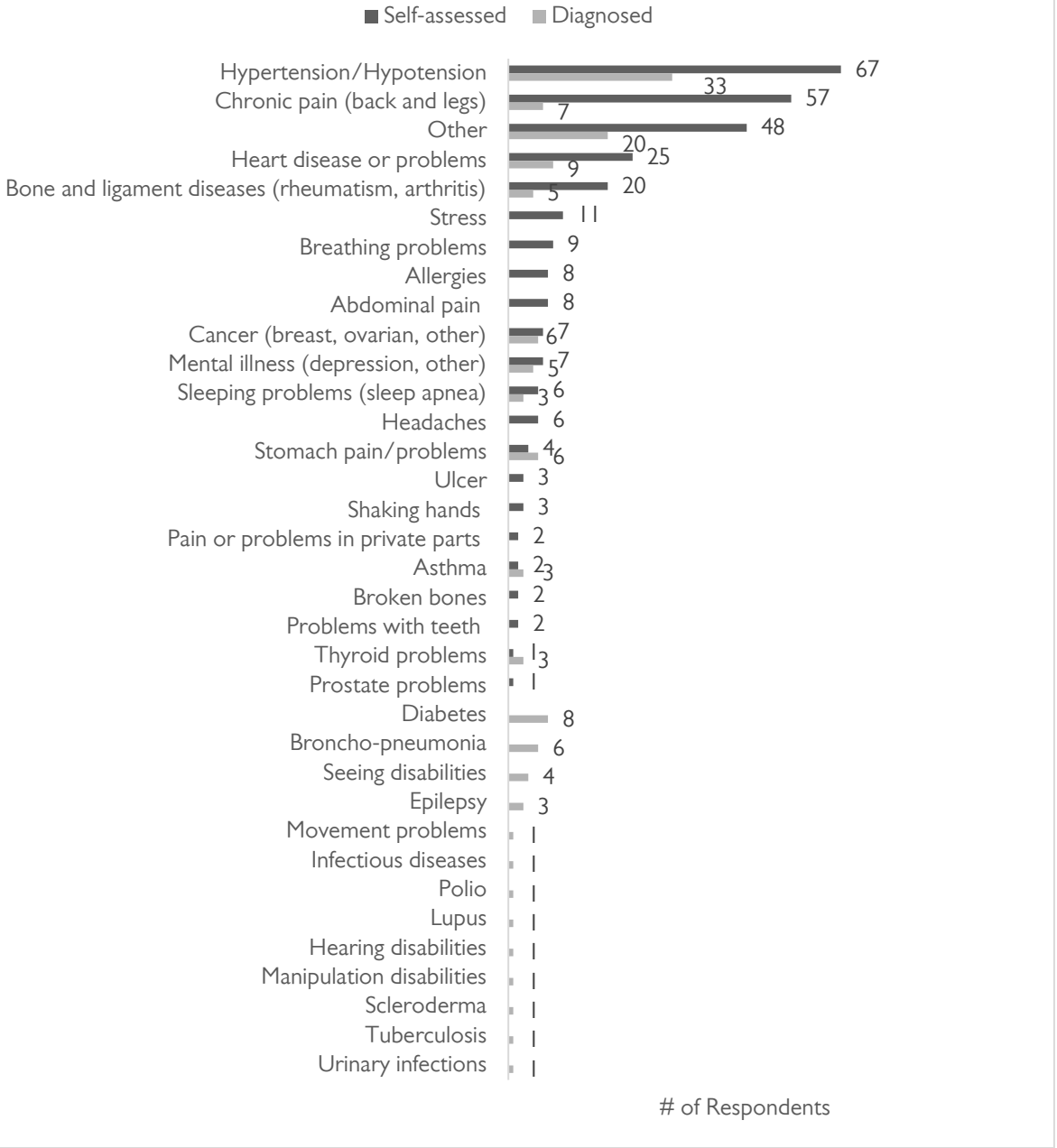
Graph 4 also illustrates in real numbers the types of illnesses reportedly diagnosed. Hypertension (high blood pressure) or hypotension (low blood pressure) reportedly affected the most respondents. Unfortunately, the survey neglected to separate these categories when asking about diagnosed chronic illnesses. However, from the aforementioned self-assessed ailments, 18% of respondents said they had high blood pressure, whereas only two percent said they had low blood pressure, which suggests that high blood pressure probably was diagnosed more often than low blood pressure. This also would reflect prevalence distribution worldwide.[95] Kosovars also reported being diagnosed with diabetes (7% of respondents), chronic pain (5%), heart disease (5%), mental illness (4%) and cancer (4%).

Graph 4 suggests that self-assessed health problems in genitalia may not be diagnosed by doctors. Perhaps a reason may be stigma or shame in discussing sexual health issues, as discussed in later chapters.

[94] The small number of cases reported makes it difficult to assess trends in types of diseases that persons of different ages have, though they were significantly different ($p=0.0001$). No difference existed according to rural or urban residency.

[95] WHO, Global Health Observatory (GHO) data, 2008, accessed 5 December 2016, at: http://www.who.int/gho/ncd/risk_factors/blood_pressure_prevalence_text/en/.

Graph 4. Diagnosed and Self-assessed Longstanding Illnesses or Disabilities

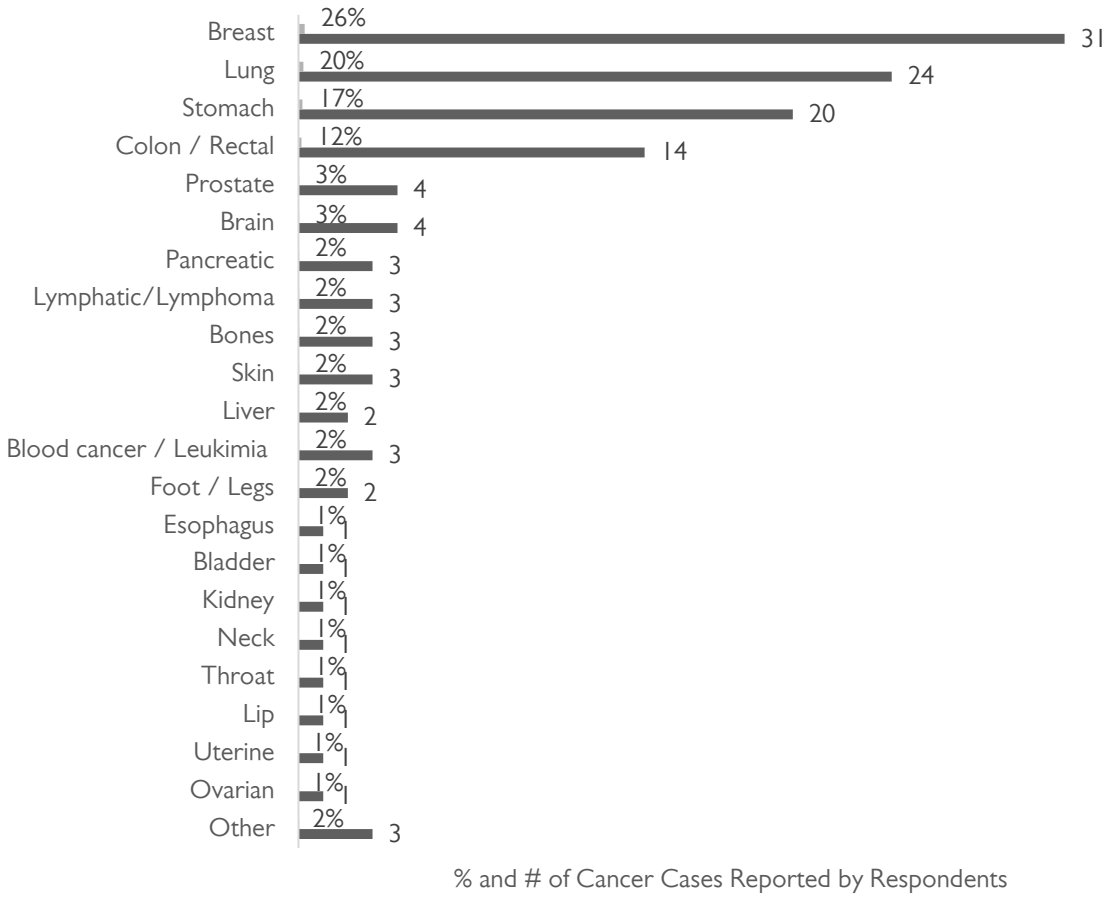



In an attempt to gain a better understanding of cancer in Kosovo, the survey contained questions about members of the same household who had been diagnosed with cancer. Household was defined as 'living under the same roof'. Seven percent of households reported having at least one case of cancer diagnosed within their household since 2000. Of the 121 cases reportedly diagnosed, breast cancer appears the most commonly diagnosed form of cancer, followed by lung, stomach and colon or rectal cancer (see Graph 5).[96] While the total number of cases is small, women tended to have been diagnosed with breast cancer, stomach cancer and colon cancer. Interestingly, this research did not identify a single case of cervical

[96] There does not appear to be a significant difference between rural and urban areas or regions.

cancer being diagnosed, though this does not mean that it does not exist. Men tended to have been diagnosed with lung cancer, colon cancer, stomach cancer and brain cancer.

Graph 5. Number and Percent of Cancer Cases Reported by Type




Based on the survey findings, the number of cases diagnosed each year seems to have increased steadily, with the most cases being diagnosed in 2015. Also, based on this research, more cases appear to have been diagnosed in Peja, Prizren and Prishtina municipalities. The average age at which persons were diagnosed with cancer was 55. However, given the small sample size it is not possible to infer which Kosovars in which areas may be most affected by cancer; further research is needed. The National Board on Cancer Control published a 'National Program for Cancer Control 2014-2020', which among other activities sought to re-establish the cancer registry within the National Institute of Public Health; however, it is not functional yet, mainly due to underfunding.[97]

Nearly six percent of Kosovars said that a health problem has 'severely limited' them and 17% said they have been 'limited' from doing activities that people usually do for at least the past six months. Thus, approximately 23% of the population seems to have some form of limited ability. Older persons tended to have more limited abilities than younger persons

[97] A comprehensive overview on cancer, cancer registry and screening in Kosovo was funded by UNFPA in 2015: P. Davies, et al., *Assessment to Characterise the Current Situation & Capacities for the Prevention & Control of Breast, Cervical & Prostate Cancers in Kosovo*, Prishtina, 2015.

($p<0.001$). In 2013, Eurostat reported that nearly 27% of adults have moderate to severe limitations due to health problems in the EU-28.[98]

## Conclusion

Overall, the health status of study respondents seems to be quite well, as self-assessed. When compared to EU countries, it lies in the range of the countries with best self-assessed health status. However, the age structure in Kosovo differs from other countries where health is assessed similarly, such as Sweden. Since Kosovo's population is far younger, chronic diseases would not be expected to impact health as much at this point in time.

Several mismatches exist between self-reported and reportedly diagnosed illnesses, the reasons for which are unclear. Based on respondents' reports, breast, stomach and colon cancer appear to be the three most common forms of cancer among women, while lung, colon and stomach cancer seem to be leading types of cancer among men. The cases seem to point to an increase in recent years. Unfortunately, the findings relating to cancer could not be compared to other scientific findings, as Kosovo's cancer registry is still not fully functional nor accessible via Internet. Comparing the survey findings related to self-assessed health to actual health statistics in Kosovo was outside the scope of this particular research.

The perceived and reported health status provides context for the chapters that follow, which examine how Kosovars utilize healthcare services and which barriers they may face in accessing healthcare.

[98] 'Statistics Explained: Functional and activity limitations statistics', Eurostat, accessed 28 Nov. 2016, at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Functional_and_activity_limitations_statistics.

# Utilization of Healthcare Services

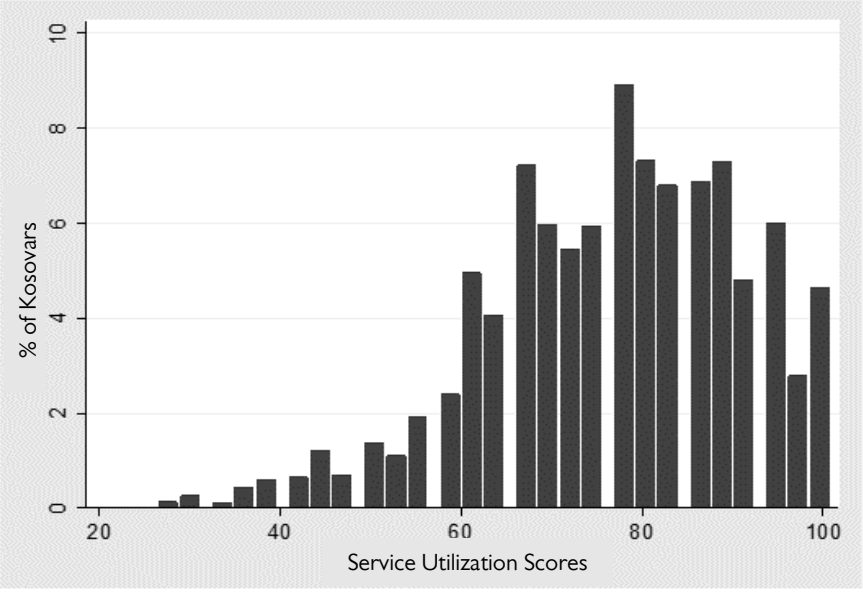
This chapter provides background to the rest of the report by discussing how women and men utilize healthcare services. Utilization is defined as how citizens use services within the healthcare system, addressing which services citizens seek and where they seek them. Utilization of healthcare services thus also includes context about the culture of care in Kosovo by discussing the different types of institutions and why patients choose to use the ones that they do.

An index was created using all questions related to service utilization, such as: 'have you ever had a check-up' and 'have you ever been treated for sudden illness'.[99] Most questions included in the index focused on primary and preventive care. The only specialties were gynaecology and urology. However, these too may offer preventive care, such as through screenings for rectal, prostate, cervical or breast cancer. This index was used to calculate scores for different cohorts, stratified by gender, residency, ethnicity, education and region. As is standard throughout the report, the *higher* the score on the index, the *worse* the situation. In this chapter, higher scores represent less utilization of healthcare services. The possible scores range from zero, full utilization of all healthcare services addressed by these index questions, to one hundred, no utilization of any healthcare services addressed by these index questions.

This chapter first reports on the Service Utilization Index and its correlation with residency, ethnicity and age. Second, it examines utilization of specific, individual services. Third, it discusses trends in service utilization, focusing on patients' use of primary and preventive care, and public versus private healthcare institutions, respectively.

## Service Utilization Index Findings

Figure 1. Distribution of Service Utilization Scores across Kosovo Sample




The findings demonstrate low utilization of health services. The mean score for the Service Utilization Index is 76.6. Scores ranged from 22.2 (more utilization) to 100 (no utilization). As Figure 1 illustrates, a very small proportion of the population had low scores (more utilization). Rather, most of the population was distributed among the higher scores, showing less utilization of healthcare services. Gender correlated significantly with service utilization. Women, with a mean of 74.0, were slightly more likely to utilize healthcare services

[99] For all questions included in the Index, see Appendix 1.

than men were (79.7). This finding was corroborated during interviews with healthcare professionals who tended to observe that women utilize healthcare services more than men. Healthcare workers also noted that women tended to bring their children to receive healthcare services more often than men did. Residency, ethnicity and age also were significant correlates, as discussed in the sections below. No significant trends arose when analysing service utilization by educational attainment.

### Service Utilization by Rural or Urban Residency

Rural Kosovars used fewer services than urban Kosovars ($p<0.001$). Rural citizens had a mean score of 78.6 while urban citizens have a mean score of 74.0 on the index. This trend holds for both men and women, with urban men using fewer services than urban women, and rural men using fewer services than rural women ($p<0.001$ for all). Rural men, with a score of 80.9, were the group least likely to use healthcare services. Healthcare practitioners interviewed through this research said they had observed similar behaviour.

### Service Utilization by Ethnicity

Ethnicity also correlated significantly with service utilization. Reflective of the population, most survey respondents were Albanian. Therefore, the research team chose to compare the status of all other ethnic groups to Albanians. The same approach is used throughout this report.

Albanians have a mean score of 77.2 on the Service Utilization Index. The only group that was statistically different is Serbs, who have a mean score about 10 points lower at 67.9 ($p<0.001$). While Serbs were not statistically different from other ethnic groups, they consistently scored the lowest. Therefore, Serbs seemed to utilize healthcare services more than all other ethnic groups in Kosovo. Albanians and Bosnians scored 77.3 and 77.6 respectively.

**Table 2. Service Utilization Mean Scores Stratified by Ethnicity and Gender (Standard Errors in Parentheses)**

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 74.4 (0.739) | 80.3 (0.620) | 77.2 (0.496) |
| Serbian | 66.0 (1.446) | 69.9 (1.444) | 67.9 (1.033) |
| Roma, Ashkali, Egyptian | 73.5 (1.315) | 72.9 (2.245) | 73.2 (1.225) |
| Bosnian | 75.7 (2.403) | 79.4 (1.874) | 77.6 (1.539) |
| Gorani | 72.4 (2.763) | 62.0 (8.044) | 69.2 (3.354) |
| Turkish | 67.3 (2.622) | 78.3 (3.481) | 71.3 (2.308) |

Within specific ethnic groups, both Albanian and Turkish women used more services than men of the same ethnicity. Albanian women scored 74.4 compared to 80.3 for men ($p<0.001$). Turkish women scored 67.3 compared to 78.3 for men ($p=0.02$).

### Service Utilization by Age

Generally, as age increases, the prevalence of chronic illnesses increases as well, as this research confirmed holds true in Kosovo.[100] Therefore, both men and women are more likely to use services as they grow older. Indeed, the Service Utilization Index revealed significant differences between the oldest groups (ages 55-64 and 65+) and the youngest (16-24) ($p<0.001$).

[100] For the global context, see Center for Health Workforce Studies, *The Impact of the Aging Population on the Health Workforce in the United States*: *Summary of Key Findings*, Albany: 2006. For Kosovo, see the prior chapter on Self-Assessed Health Status.

## Utilization of Specific Healthcare Services

This section examines the extent to which Kosovars appear to be using specific healthcare services, based on an analysis of individual survey questions.

### General Health Exams

Although Kosovo does not have any established screening program, this research sought to examine the extent to which individuals are seeking preventive care. General health exams and screenings are part of preventive care. They are used to detect common diseases or risk factors early enough to enable treatment, so harm can be averted. For example, general exams involving blood tests, measuring blood pressure, physical exam and urine sample are used for detecting cardiovascular disease and its risk factors such as hypertension and diabetes early enough. Of course anyone younger than the recommended age for undertaking screenings should visit a healthcare facility when having symptoms, potentially having the same tests done. This would then be called diagnostics, rather than a general exam.

The survey asked if respondents had ever had a general health exam ('check-up'). More than half the respondents had never had one (53.9%). A slightly higher percentage of men (48.7%) than women (43.8%) had undergone such an exam. Urban Kosovars (49.0%) were more likely to have had general exams than rural Kosovars (44.3%). As age increases, people were more likely to report having had an exam; 66.2% of persons 65 and older have had a general health exam. Diverse ethnic groups behaved very differently when it came to general health exams. Serbs were by far the most likely to seek such exams, with 79.0% reporting that they have had one. Gorani were the least likely to have had one, at 32.1%.

Of those who reported having had a general health exam and who remembered when their last one was, most had done so recently. Over 90% had an exam within the past five years (90.8%). The plurality, 35.1%, reported having had such an exam in the past six months. Another 29.0% had an exam within the last year, and 26.8% report getting an exam between two and five years ago.

When asked if regular exams are a waste of money, only 4.3% of respondents agreed or strongly agreed with this statement. Notably, such exams cost one Euro in public healthcare institutions.

### Cancer Screening

Screening programs can prevent deaths by detecting (pre)cancerous lesions early enough for treatment.[101] The survey conducted for this research contained several questions related to screening for colon, breast and cervical cancer. The latter two were asked only of women.

Approximately 97.4% of respondents never have been screened for colon cancer, and 95.3% never have had a colonoscopy. As the WHO does not provide detailed recommendations regarding screenings at age of onset, each country takes its own decision. For example, the U.S. Centre of Disease Control and Prevention (CDC) recommends starting to screen at the age of 50,[102] and the German Joint National Committee on Health recommends starting at the age of 50 with tests for occult blood in faeces and at 55 with

[101] P. Davies, et al., 2015.

[102] CDC, *Colorectal Cancer*, 2016, at: http://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm.

colonoscopies.[103] The efficiency is high: up to a 50% reduction of mortality when adenomas (precursors of cancer) are detected and removed.

Among all women respondents, 91.1% reportedly had not had a breast cancer screening in the last five years. The WHO recommends that women ages 50-69 should have breast exams every three to five years, and among women in this age group, only 14% had one in the last five years. Women also were asked if they had ever heard of a mammogram. If they responded affirmatively, they were asked whether they had ever had one. About 44.2% of all women had never heard of a mammogram. Of the 55.8% that had, only 18.1% had received a mammogram in the past three years. A body of evidence suggests that screening can prevent and detect breast cancer, contributing to reduced mortality, particularly in high-income settings with strong health systems.[104] Others in the medical world debate the effectiveness of mammograms and the harm they may have through over-diagnosis and radiation.[105] Also, mammogram screening programs may not be cost-effective in certain settings.[106] WHO calculations on breast cancer screening found that it is not cost-effective for lower middle income countries such as Kosovo.[107] The WHO recommends several steps before implementing such screening programs.

Among women, 92.4% reported never having been screened for cervical cancer. About 60% of women had heard of Pap smears. Of them, 37.5% had received this screening in the last three years. Further, 22.8% of women had received a Pap smear, and thus had been screened for cervical cancer. The discrepancy between the percentage of women who report having been screened for cervical cancer (9.6%) and the percentage that report having a Pap smear (22.8%) shows a lack of knowledge regarding the purpose of a Pap test.

Low screening rates are not driven purely by a deficit of knowledge among patients. Kosovo has limited availability of such services. Reportedly six mammography machines existed in Kosovo in 2015,[108] as well as a mobile vehicle that provides them in different locations.

Screening for cervical cancer faces different availability issues. Currently, even if MFMCs employ gynaecologists that can conduct Pap smears, they do not employ pathologists who can interpret results. The only public institution with the capacity to analyse Pap smears is the Pathology Institute in Prishtina. Pap smear samples must be transported to UCCK for analysis and results conveyed back to the regional centre, creating a slow and inefficient process.

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[103] German Guideline Programme in Oncology (GPPO), *Evidenced -based Guideline for Colorectal Cancer,* 2014

[104] Euroscreen, *Summary of the evidence of breast cancer service screening outcomes in Europe and first estimate of the benefit and harm balance sheet,* 2012. However, the studies that went into this report were more than 20 years old and there is uncertainty regarding the extent to which harm may have been done. Some countries such as Switzerland stopped screening due to highly unfavourable cost-effectiveness ratios and better survival rates through better treatment.

[105] B. Lauby Secretan, et al., *Breast-Cancer Screening — Viewpoint of the IARC Working Group*, 2015; Gøtzsche and Jørgensen, *Screening for breast cancer with mammography*, Copenhagen: 2013; WHO, *WHO Position Paper on Mammography Screening*, Geneva: 2014.

[106] Swiss Medical Board, *Systematisches Mammographie-Screening*, 2013.

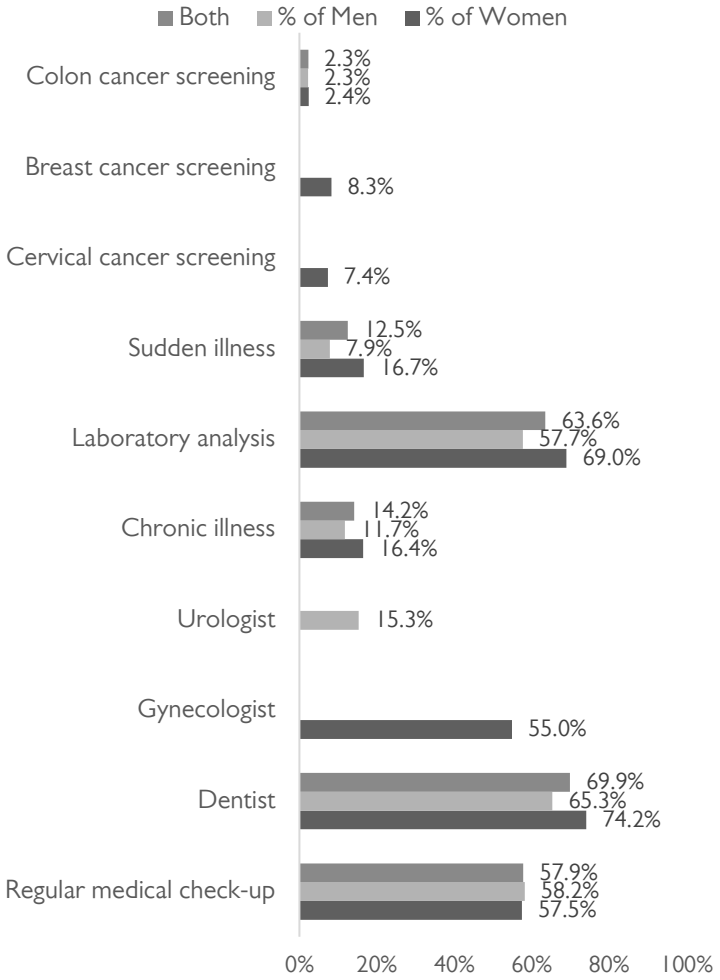
[107] WHO, *WHO Position Paper on Mammography Screening*.

[108] P. Davies, et al., 2015.

## Other Healthcare Services

Graph 6 summarizes the different types of healthcare services that survey respondents reported using at least once in the last five years. Aside from the already discussed regular medical exams and various cancer screenings, more than 55% of women visited a gynaecologist in the last five years (see Graph 6). The high discrepancy between visiting a gynaecologist and having received a screening reveals many missed opportunities. Among men, 15.3% had visited an urologist during this time period.

Graph 6. Percent of Kosovars Who Used Healthcare Services in the Last Five Years




Nearly 64% of Kosovars reported having a laboratory analysis in the last five years, including 69% of women and 58% of men.

Regarding the utilization of primary care in acute cases, only 12.5% of Kosovars reported receiving treatment for a sudden illness. More women reported receiving such services (16.7%) than men (7.9%) ($p=0.0002$). Considering that 18% of Kosovars reported having a chronic illness, interestingly only 16.4% of women and 11.7% of men said they were treated for a chronic illness in the last five years. Of them, 4.5% of women and 0.6% of men reported receiving such services more than once per year. This suggests that Kosovars suffering from chronic illnesses may not all be receiving the treatment they need.

With regard to visiting the dentist, 69.9% of respondents visited a dentist in the last five years (74.2% of women and 65.3% of men). Persons in rural areas utilized such services less; 32% of persons residing in rural areas have not visited a dentist compared to 25% of persons in urban areas ($p=0.003$). Albanians ($p=0.001$) and persons with higher education ($p<0.001$) were more likely to have visited the dentist. In the past 12 months, 18% said there was a time when they really needed a dental examination or treatment but did not get it.[109] The most commonly cited reasons were lack of money (36%), letting it heal by itself (16%), fear (15%)

[109] Gender, age and rural/urban residency do not seem to have any relationship with access to dental services.

and they could not take time off of paid or unpaid work (9%). In the EU-28, 7.6% did not visit a dentist despite need, mainly due to cost, travel time and the waiting list.[110]

## Abortion

As there are no exact figures available, data on abortion in Kosovo relies mainly on surveys and therefore is potentially inaccurate. In this study, approximately 11% of all women said that they had had an abortion in their lifetimes, including 7.4% of women ages 16-49. In 2009, KDHS similarly reported that 7.9% of all Kosovar women ages 15-49 have had an abortion and in 2013 MICS reported 7.5%. It is difficult to make comparisons with figures internationally, as they are mostly reported annually. For example, the global annual rate for developing countries is 3.7% for women ages 15-44 years.[111]

Of the women who have had abortions, 49% had more than one, with one woman having up to six abortions. Seven percent of all women surveyed had an abortion for reasons other than the health of the mother or foetus, comprising 60% of all abortions.[112] Aside from health related issues, the other main reasons women said that they had an abortion included: unwanted child, the costs affiliated with having a child and being too young. One woman said it was a girl, and they wanted a boy. This research provided further evidence that sex-selective abortion continues in Kosovo. Indeed, Kosovars on average still tended to want more boys (1.8) than girls (1.5); men were significantly more likely than women to want more boy children. On average, women wanted 1.6 boys and men wanted 2.0 boys ($p<0.001$).

Most women (44%) had their abortion at a public clinic, though 21% reported having abortions at private clinics. Astonishingly 27% said that they 'self-induced physically' the abortion, which may be attributable to respondents misunderstanding this response; perhaps they believed it meant miscarriage.[113] Only four percent of respondents said they had an abortion using pills. Misoprostol and mifepristone are substances used for abortion and are both available in Kosovo, though not registered for use.[114] Doctors and pharmacists have confirmed that both are widely used.

Overall, these findings reveal an unmet need for family planning services and accessible, reliable contraception methods (discussed later in the Knowledge and Rights to Healthcare Chapter and in Appendix 6).

## Mental Health Services

While the quantitative research in this survey did not examine utilization of mental health services directly, qualitative research did. This section draws also from quantitative findings from earlier studies to contextualise this research.

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[110] *Unmet health care needs statistics*, Eurostat, accessed on 29 Nov. 2016, at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics.

[111] Sedgh et al., *Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends*, 2016.

[112] These figures do not include miscarriages.

[113] The abortion figures were carefully checked by the research team to remove miscarriages. However, this was difficult with this particular question and response. As this part of the survey was self-completed by respondents, enumerators were unable to ensure respondents fully understood the question. The language explaining such terms perhaps can be clarified in future research.

[114] See the Chapter on the Legal Framework: M. Paçarada, et al., *Misoprostol-induced abortions in Kosovo*, 2011; Kosovo Medicines Agency, 2014; MoH, *Listes Esenciale per Vitin 2013,* 2013,.

As a post-conflict society, Kosovo faces a high burden of mental health illness. A survey with 1,161 participants in 2005 showed high levels of Post-traumatic Stress Disorder (PTSD), depression and correlating suicidal ideation (41.7% of respondents met criteria for moderate to severe depressive symptomatology, 41.6% had anxiety on a clinically severe level and 43.1% said they were under serious emotional distress).[115] A 2012 study showed that people with PTSD tend to use all healthcare services more, including to treat physical ailments.[116] This indicates a lasting need for mental health services, but also an additional burden on the healthcare system when war-related traumas are not tackled.

Approximately 18% of Kosovars (20% of women and 16% of men) considered discussing their mental or psychological health condition with their physician problematic,[117] suggesting that some Kosovars may not be willing to utilize mental health services. A recurring theme among healthcare workers, especially psychiatrists, was that social stigma prevents both women and men from utilizing mental health services. Instead they may use non-mental health services to treat physical ailments likely stemming from mental disease, such as PTSD. Based on his experience and patients, one psychiatrist observed that women may use mental health services less than men:

> This disease does not pick people based on gender. Maybe women are more prone to depression, but in general I have fewer women patients. It's because of families. We have come across cases when they were sick for a period of 10 years, but they hid it. [W]omen especially [hide it] because of stigma. Even here, one-third of my patients each day are women while the rest are men.

Another recurring trend among psychiatrists was an observation that patients prefer to seek mental healthcare from private practices. A psychiatrist working at both the public Mental Health Centres and his own private clinic commented, 'My clients come to my private clinic since they don't want people to know that they are dealing with psychological issues'. In a sense, the psychiatrist knowingly or unknowingly is profiting from this stigma through his private clinic and may lack an incentive for addressing it. A psychologist working at a public centre concurred, 'We mainly get visits from unemployed men who receive social assistance. The men who are employed go to private clinics because they do not want anyone to see them visiting a psychologist'. As this research did not examine specifically whether people seek private or public care for specific issues, such as mental health care services, this may be an area for further inquiry.

Untreated mental health illnesses may be a factor contributing to other ailments. Social stigmas against seeking treatment may lead patients to self-treat themselves, potentially involving misuse of pharmaceuticals, discussed in the next section.

**'[I had a] visit by a woman who complained about headaches, but during the discussion I learned she was a survivor of sexual violence during the war.'**

- Psychiatrist

[115] T. Wenzel, et al., *Suicidal Ideation, Post-traumatic Stress and Suicide Statistics in Kosovo,* 2009.

[116] A. Eytan and M. Gex-Fabry, *Use of healthcare services 8 years after the war in Kosovo: Role of post-traumatic stress disorder and depression,* Geneva: 2012.

[117] There was a weak statistical relationship between gender and considering discussing mental health issues with a physician problematic (P=0.05). There was no significant relationship with age or rural versus urban residence.

## Pharmaceutical Use

After utilizing healthcare services, the recommended therapy may involve medication. Therefore, medications can be considered part of health services. Additionally, with or without visiting a physician beforehand, pharmaceuticals are bought in pharmacies, which are part of the healthcare system. The survey asked about obtaining drugs with and without a prescription. Most citizens obtained drugs both with a prescription (79.7%) and without a prescription (63.6%) in the last five years. Non-prescription obtainment was not reported equally across gender, residency and ethnicity. Men (65.5%) were more likely to obtain, or admit to obtaining, drugs without a prescription at least once than women were (61.8%) ($p=0.0001$). Regarding regular usage, 16.6% of women said they use pharmaceuticals without a prescription multiple times per year compared to 11.9% of men. Urban inhabitants were more likely (72.3%) than rural ones (63.2%) to obtain drugs from a pharmacy without a prescription.

Different ethnic groups varied greatly in the rate at which they obtained drugs without a prescription. Albanians were the least likely to do so, with 65.2% of Albanians ever obtaining drugs without a prescription. Roma, Ashkali, Egyptian (89.6%), Turkish (88.2%) and Serb (87.1%) respondents were more likely to have obtained drugs without a prescription.

Higher levels of education corresponded with a higher likelihood of obtaining drugs without a prescription. Citizens who had 0-7 years of schooling reported a 54.8% rate of obtained drugs without a prescription. This number rose to 61.7% for those who had 8-11 years of education, 70.1% for those with 12-14 years of education and reached a peak of 74.0% among people with 15+ years of education.

A limitation of the survey was that it did not ask which drugs were bought without a prescription. People may have purchased vitamins, anti-flu or low dose painkillers, which do not need a prescription. Thus, it is difficult to know which drugs people are obtaining without a prescription and what motivates this behaviour. When asked about the types of drugs patients appear to be misusing without a prescription, pharmacists tended to mention Citotec (misoprostol, the abortion pill), contraceptives, antibiotics, antidepressants, tranquilizers and Trodon (tramadol, a low to middle potent opiate). None of these should be available without a prescription.[118] Misoprostol should not be available at all because it has not been licensed in Kosovo. However, doctors and pharmacists have confirmed that it is widely used, as it was on the Essential Drug List in 2013.[119] Further, an UCCK study on the outcome of abortions with Misoprostol showing less severe complications than surgical methods evidences its use in Kosovo since 2006.[120]

As a pharmacist noted, sedatives are requested 'mostly by elderly people, but also women with or without children who want to relax'. Indeed, approximately 27% of surveyed Kosovars agreed or strongly agreed that 'taking a tranquilizer is a normal way to calm down' when someone is very upset; 24% were

**'I want to tell why I take tranquilizers. I have a difficult period now. Within three months, I've lost my husband and my son.'**

- Survey respondent

[118] *Udhëzim Administrativ (në Shëndetësi)* [Administrative Instruction (on Health)] Nr. 01/2010.
[119] MoH, *Listes Esenciale per Vitin 2013,* 2013.
[120] M. Paçarada, 2011.

unsure. This suggests cultural acceptance of using pharmaceuticals to address psychological distress. Women appeared significantly more likely to accept tranquilizer use than men (p=0.0004).[121]

Thus, a potential reason as to why people may purchase prescription drugs without a prescription may be that they do not want someone to know about the issues they face or that they want or need pharmaceutical products. This explanation would be in line with the prior discussion about stigma for seeking mental healthcare services; people may rather try to treat themselves than allow others to know about mental health issues. Another equally plausible explanation is that people may seek self-treatment when they cannot access or afford a doctor consultation.

**'Pharmacies often don't sell what we prescribe, saying that they don't have that product. Instead they sell something else. It's a business.'**
- Gynaecologist, Prizren

The selling of drugs without a prescription or even without administrative authorization (see Legal Framework Chapter) seems widespread. Pharmacies often openly admitted such behaviour. For example, in Prizren, researchers observed a case in which a patient chose which antibiotic he wanted without visiting a doctor. Some respondents said their employers 'force' them to sell drugs without prescriptions, even if they disagree with this practice. As one pharmacist said:

> There is a lack of professionalism from all sides: patients and doctors. I don't want to give patients medication without a prescription, but patients come who request that. And I tell them that without a prescription we can't give medication. Then they say that they'll go somewhere else, and the chief says, 'Sell it to them.'

This suggests that profit may trump professionalism and legality in some pharmacies.

**'Here is a problem with doctors: they should write the substance in the prescription and not the firm. There are cases when firms make deals with doctors to the point where they send them on holidays.'**
- Pharmacist, Vushtrri

Further, nearly all pharmacy employees interviewed observed collusion between doctors and pharmaceutical companies, which is prohibited by law in Kosovo.[122] For example, in one pharmacy, nearly every patient purchasing drugs there had the exact same prescription, the pharmacist said.

KWN also observed that only pharmacy technicians tended to be working in several pharmacies. Without the presence of a pharmacist, the distribution of drugs is illegal.[123] Evidently, pharmacists work limited hours but allow their diplomas to be used by the directors of pharmacies in order to complete the paperwork for licensing.

Overall, in examining the utilization of medicine and use of pharmaceutical services, KWN observed a worrying trend of technicians simply selling products. Putting profit before patients can undermine the quality of healthcare provided, negatively impacting public health more broadly. When combined with people seeking drugs without a prescription, this could mean that there is no check whatsoever on the types of drugs taken, risking severe side effects, even death, such as through allergic shocks. Also, potent drugs, like the

[121] Very little difference existed when comparing the opinions of people in rural and urban areas (p=0.04).
[122] Law No. 04/L-125 on Health, 2013, Art. 41.
[123] Ibid, Art. 26.

aforementioned tranquilizers and painkillers, can lead to addiction, which has several negative health and social impacts. Antibiotics taken unnecessarily and in incorrect amounts and duration can lead to microbial resistance against available antibiotics and cause longer hospital stays, longer duration of treatment, higher costs and eventually, death.[124] The WHO has called on every country to take action.[125]

## Service Utilization Discussion

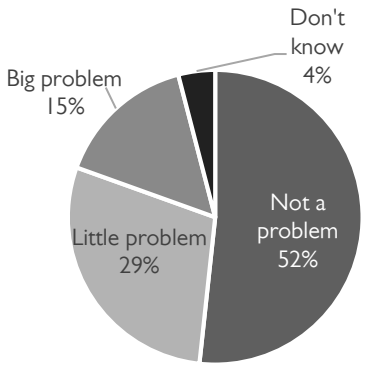
When discussing service utilization overall, one trend that emerged in analysing survey data is the gap between respondents' stated beliefs and their subsequent actions or practices. For example, 85.7% of respondents stated that if they were sick they would go to the doctor, though women (84%) were slightly less likely to go than men (87%) ($p<0.001$). Yet, for 25.9% of respondents, there was at least one instance in the past year when they needed to consult a doctor but did not (compared to 6.7% in the EU-28).[126] While there was no difference by gender, this seems to have affected older people (52% for 55-64-year-olds) more than younger people (20% for 16-30-year-olds) ($p=0.03$). The most commonly stated reasons for not consulting a doctor were that they 'wanted to wait and see if problem got better on its own' (34%) or they could not afford it (27%). Other reasons for not utilizing healthcare services included that they could not take time off from work or caring for others (11%); and fear of doctors, hospitals, examinations or treatment (5%), among other reasons.

One potential explanation for some respondents not utilizing healthcare services may be that they are unaware that care services are available and affordable at a location near them. 'People want a specialist', was a recurring theme among healthcare professionals. An interview respondent observed:

> They are more oriented to specialized care, [...] towards the specialist: the obstetrician for women and the paediatrician for child care. For example, if a woman is pregnant or has any problem with reproductive health, she would say, 'I do not have access because I need to go to a gynaecologist. I need to go to a specialist'.

Other healthcare professionals similarly underlined that people tend to seek specialist care, foremost for gynaecological and maternal services, as well as for paediatrics. Such care may be located farther away or be costlier than healthcare services offered at the nearby MFMC. This tendency to seek specialized care from secondary healthcare providers may stem in part from experience with the prior healthcare system, as well as a lack of knowledge that these services are available from primary care providers. Ensuring diverse women and men are aware of the services available from public primary care providers may

Graph 7. Perceptions: To What Extent is Trusting Doctors a Problem for Accessing Healthcare?




[124] WHO, *Antimicrobial resistance – Fact sheet*, 2016, at: http://www.who.int/mediacentre/factsheets/fs194/en/.
[125] Ibid.
[126] *Unmet health care needs statistics*, Eurostat, accessed on 29 Nov. 2016, at: http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics.

contribute to increasing utilization of primary care services.

In contrast, some healthcare workers disagreed, stating that primary care is used according to the foreseen referral system. In fact, in some cases, they said it is even 'overused': 'There are patients who within the same day visit three different doctors', a doctor said. This may relate to a lack of trust in the healthcare system, among some, and the interest in securing a second or even third opinion prior to continuing treatment. Indeed, 15% of Kosovars considered 'having trust in doctors to be honest and professional' a 'big problem' and 29% considered it a little problem for them in accessing healthcare.

The absence of a 'culture of preventive care' may be an additional factor to consider, regarding why some people do not utilize healthcare services. 'When it comes to prevention, it's not a habit in our society', a health professional said. 'We tend to visit the doctor when we have to. We have no other way. But, regularly visiting the doctor, just consulting, or going to general check-ups, that's not a habit.' Further, the culture around screening and preventive care, particularly for women, may be impacted by societal views of acceptable behaviour. When it comes to reproductive health, the same respondent explained:

> Visiting [the] OB/GYN for just [a] regular check-up is still ... kind of a taboo for a lot of women, especially young women. [W]e can see the women who attend our resource centres, women we work with or even my own network of friends, where they just don't think it's necessary if you're not sexually active, or if you're not married yet or if you don't have any partner yet.

She emphasized that low service utilization rates are often due to a 'mentality that it's not necessary.... rather than [a lack of] opportunities to get care'. Cultural barriers potentially impacting women's use of services are discussed further in the next chapter.

## Use of Public versus Private Healthcare

When asked which type of care facility they preferred using, 59.2% of survey respondents said they preferred public healthcare facilities, whereas 32.3% preferred private institutions. An additional 8.5% had no preference.

The reasons for preferring one or the other type of institution differed substantially for persons who selected public institutions and those who selected private institutions (see Table 3). For respondents who preferred public institutions, cost was the most important factor; 69.6% preferred public facilities because they were less expensive.

Table 3. Reasons for Public or Private Preference

| Responses | Public | Private |
|---|---|---|
| It's less expensive | 69.6% | 0.7% |
| It has better quality care | 12.6% | 79.0% |
| It's closer to me | 7.7% | 0.8% |
| I know people there | 3.1% | 2.9% |
| It has the specific type of care I need | 4.1% | 13.0% |
| Other | 2.9% | 4.1% |

Regarding average expenditures on healthcare, of the 42% of survey respondents who answered this question, women reported spending approximately €151 on healthcare for themselves only and men reported spending €123 in the last 12 months, without significant difference between women and men ($p=0.39$). Persons who said they preferred going to private clinics paid on average €217, whereas persons who preferred public clinics paid €82 ($p=0.001$). Notably, this is based on stated preferred preference, as the survey did not ask where they actually went. Further, on average, in the last year women said they spent €48 and men €42 on tests like blood analyses or X-rays. Persons preferring private care tended to spend €65, whereas those preferring public care spent €28 ($p<0.01$). With regard to

pharmaceutical products for themselves, women reported spending €110 and men €138 in the last year (p=0.51). These findings illustrate the significant difference in expenditures on healthcare in public and private healthcare institutions. The next most common response favouring public institutions was that public facilities provide better quality care. For those who preferred private facilities, they overwhelmingly cited better quality care as the reason for their preference. The next most common answer was that private facilities have the specific type of care they need.

Rural citizens (62.1%) were more likely to prefer public institutions than urban citizens are (54.7%). The preferences of ethnic groups differed. Most Albanians preferred public institutions (59.6%) to private institutions (31.8%). The same was true for Roma, Ashkali, Egyptians, Bosnians and Gorani. More Serbs, however, preferred private facilities (53.3%).

Educational attainment was correlated with preferences for private healthcare institutions; higher levels of education translated into a preference for private institutions. This reflected the trend that the more educated, and likely wealthier, someone was, the less likely they were to seek care from public institutions.

Respondents were asked how often they visited a public or private healthcare institution in the past 12 months. Unfortunately, this question was governed by skip logic: if a respondent answered that they had never had a general health exam, they were not asked how many times they had visited a healthcare facility in the past 12 months. Thus, the following numbers do not include persons who did not have a general check-up, but sought healthcare for another purpose. Of the 586 persons asked (45% of respondents), the median number of visits to a public health facility is two in the last year. The median number of visits to a private healthcare facility is one. This suggests that in practice respondents tend to use public health facilities more than private facilities.

**'People are sold unnecessary procedures in private facilities.'**
- Doctor, Prishtina

While some of the interviewed healthcare workers said that the conditions in private and public sectors are the same, generally healthcare workers' views on public versus private care tended to diverge substantially, usually depending on their workplace. Healthcare workers in private facilities tended to favour private care and vice versa. Some healthcare workers said that private facilities have better conditions, including equipment, materials, better services, more qualified staff, fewer patients, shorter waiting times and more privacy. Indeed, some healthcare workers in public facilities noted shortages in supplies (see box).

**'We lack surgical gloves, masks and caps, meaning basics. Also, we lack drugs, instruments and sheets rip. When we need something that we lack, women have telephones near. They call their husbands; we write down what we lack; and he goes and buys it.'**
- Gynaecologist, Regional Hospital, Mitrovica

In contrast, other healthcare workers said that public care offers well-trained staff, more materials and better conditions generally. They also spoke of their preference to work in the public system, which afforded them job security, less administrative work and better working hours. Some public healthcare workers also voiced their concern that private care is profit-based, which may create incentives for healthcare workers to misuse their positions for personal financial gain. Another concern mentioned was that some private sector facilities may be unregistered, creating accountability issues. 'The state has failed to check these private clinics since they inspect only those that are registered and that is only because they pay taxes', a doctor said. 'Nobody inspects how other private, nonregistered clinics work.' Even registered private clinics may have insufficient oversight, respondents also noted.

### Discussion on Public and Private Sectors

In Kosovo, the public and private systems are supposed to function separately and independently. By law, doctors are forbidden to refer patients from the public sector to the private sector. In practice, however, such referrals seemed to happen regularly. This illegal referral system also was noted by the Speak Out Movement (*Levizja FOL*) in their recent report on corruption in healthcare.[127]

It is common, and legal, for doctors to work in both sectors at the same time. Salaries from private clinics supplement public income. The prevalence of this practice was a recurring theme among interview respondents, some of whom pointed to their reliance on income from both sectors. 'It's so grave that sometimes someone is a director of one clinic and also [the director] of a private one', a doctor remarked. Working two jobs every day can impact the quality of care provided, a doctor employed in both sectors noted. Since working hours cannot simply be doubled, some physicians leave their public jobs early in order to work at their private clinic, one doctor explained. This may contribute to the lack of doctors at public facilities repeatedly mentioned during interviews. Employment in both sectors also can create conflict of interest and perverse incentives, ultimately worsening the care that patients receive in the public sector, as the following examples explain.

Conflict of interest for dually employed doctors may impact equipment availability, healthcare workers said. Doctors have an incentive to refer patients to their private clinic, where the costs of care tend to be higher for the patient. Thus, they have an incentive to be indifferent to the status of public facilities. One respondent suggested that when public equipment is broken, the doctor will refer patients to a private clinic, usually his or her own. Another interviewee offered a similar example, discussing instances when public hospital equipment was destroyed purposefully so private practices could benefit from more clients. Another respondent recalled instances when public healthcare workers falsely stated that equipment was broken, referring patients to their private clinics; only through political pressure were doors unlocked, revealing the perfectly functional equipment hidden behind them. Levizja FOL similarly found that approximately 73% of citizens 'often' or 'always' experienced situations in which public institutions did not provide particular health services and they had to seek private care as a result.[128]

> **'Due to economic reasons, I work in both: I work here at the hospital, but also in my private clinic. I think that it would be much better to work harder and put efforts only into the public sector. I think that organization [of the health sector] would be better. [...] It's not easy for a doctor to work two shifts every day. I think it would be good if there was a solution to be involved either in the public or private [sector]. However, this is not up to us, but to higher institutions.'**
>
> - Gynaecologist, Gjilan

## Conclusion

Patterns of healthcare utilization in Kosovo help define and contextualize access to healthcare and healthcare habits among citizens. Overall, use of healthcare services remains low in Kosovo, especially for preventive care. Rural Kosovars used healthcare services even less. As age increases, persons generally tended to use services more. With no comprehensive

[127] Levizja FOL, 2016.
[128] *Ibid.*

screening programs in place for cardiovascular or malign diseases, Kosovars' usage of screenings was very low.

Regarding primary care, up to a quarter of Kosovars tended not to visit a doctor or dentist, even if they perceive a need. The percentage of persons not seeking care when needed was far higher in Kosovo than in the EU. Reasons given included costs, a 'wait and see' strategy, fear and time constraints. These and other barriers will be discussed further in the chapters that follow.

Overall, in order to improve primary and preventive care utilization, the availability of such services must be better communicated and attitudes towards utilizing services changed. More specifically, the high lifetime prevalence of abortions shows a need for better family planning counselling and distribution of contraceptives in primary care.[129]

There is probably under-usage of mental health services, particularly considering the high prevalence of mental diseases following the war and stigma associated with mental illness that seemingly prevents citizens from seeking care. When mental diseases turn psychosomatic and are not diagnosed as such, this can lead to over-utilization of other healthcare services.

Medications seem to be utilized widely, but unfortunately this survey did not differentiate between medications bought with or without prescription. Even so, interviews and observations strongly suggest that drugs are being misused and bought without a prescription, particularly tranquilizers and strong pain killers. Illegally obtaining antibiotics based on self-diagnosis may pose a threat to the individual's health and especially to public health, regarding the creation of microbial resistance. Illegally obtaining narcotics for an addiction also harms the individual and can lead to psycho-social problems, especially in a society with a huge burden of untreated trauma. As the public and private systems continue to coexist, there must be better regulation and enforcement. Currently there appears to be good and bad in each system. However, patients ultimately suffer from reduced quality of care and conflicts of interest among providers. So long as doctors have a financial incentive to work in both sectors and to have more patients, it is unlikely that behaviours of employment in both sectors will change.

The next three chapters address more specifically what may be preventing citizens from accessing quality healthcare in Kosovo.

[129] Please see Appendix 6 for further information on family planning.

# Gender and Access to Healthcare

This chapter discusses the extent to which access to healthcare may differ according to one's gender. More specifically, it examines who makes decisions regarding access to healthcare, the prioritization of specific family members for healthcare and other sociocultural barriers that may impact women's and men's access to healthcare.

Given that the key research questions involved exploring potential differences in women's and men's access to healthcare, one of the biggest surprises resulting from the analysis was the apparent lack of disparities between men's and women's scores on indices. Many of the indices showed slight or no difference in women's and men's access to healthcare. However, several individual survey questions did reveal differences, discussed in this chapter.

## Who Decides about Healthcare?

When asked who has the final say when an important decision has to be made, most surveyed women said that either their husband or their father takes decisions. 'Husband' was selected by 46.9% of women respondents while 'father' was selected by 12.4% percent. Only 7.3% of women reported that they have the final say in an important decision. In contrast, most men responded that they (33.6%) or their fathers (25.6%) have the final say.

Regarding healthcare, most men (77.2%) and women (62.7%) said that they decide whether they should go to the doctor. However, for women, the next most common decision-maker was their male partner; 22.8% of women said that he decides if she can go to the doctor. For men, the next most common answer was their (female) partner, but only 6.5% of men had this response.

**'The husband and mother-in-law sometimes make it difficult [...] for women to have good access to healthcare.'**

- Doctor, Vushtrri

Another question asked who decides whether children should go to the doctor. In the survey sample, 25.9% of respondents did not have children. All subsequent responses are only from those with children. Almost half of the women respondents (46.3%) reported that their husband or male partner decides whether children should go to the doctor. For men, 31.5% responded that the decision is theirs and another 31.5% responded that their female partner decides. This suggests that some women and men may have differing perceptions regarding who decides about children's healthcare.

Finally, respondents were asked whether the decision to use contraceptives was mostly a joint decision, their decision or their partner's decision. The vast majority of women (79.8%) and men (70.7%) responded that it is a joint decision. However, in situations where it was not a joint decision, men tended to have control. A far higher percentage of men, 20.0%, responded that the decision to use contraceptives is theirs. Only 7.0% of women said it was their decision. Likewise, a higher percentage of women, 13.2%, said it is their partner's choice while only 9.2% of men responded similarly.

Related, instances may persist in which women lack decision-making power as to whether they should have an abortion; three percent of women stated that they had been pressured to have an abortion and 3.9% had been pressured not to have an abortion. While not commonplace, this suggests that not all women have full decision-making power over their own health.

## Prioritization of Family Members Accessing Healthcare

> **'When the prescription is for the child, they [customers] don't look at the price of the medication. They just take it. When it's for a woman, she leaves it aside or just doesn't take it. They usually back off and say, "It will pass. I'll get through it.'**
> - Technician, Pharmacy, Peja

When asked who in the family would be prioritized if only one person could be sent for a general health exam, the respondents overwhelmingly said, 'no one, we are all the same' (72.2%). However, of the respondents who prioritized care for particular family members, they almost always prioritized men, male children and older men. Men were especially likely to rank men first for healthcare. Healthcare practitioners observed during interviews that women's access to healthcare depends on the economic stability of the family; if the family cannot afford to provide healthcare for everyone, women may be the last to receive it. Women may choose to forfeit treatment for themselves due to the economic situation of the family (see box).

## Gender and Sociocultural Barriers to Accessing Healthcare

In addition to the aforementioned dimensions of decision-making and prioritization that were included in the Cultural Barriers Index,[130] other individual measures of potential social and cultural barriers to accessing healthcare warrant discussion. Here these are defined as 'sociocultural barriers'. 'Social' relates to the society and how it is organized, including the norms, customs and ideologies a particular society has in a specific time and place. 'Culture' refers to beliefs, attitudes, values, religion and roles. Sociocultural, then, refers to how the social and cultural may combine and interact, in this case potentially affecting women's and men's access to healthcare. More specifically, this research focused on gender norms and relations, including the ways in norms, roles and values for women and men in Kosovo may influence their ability to access healthcare. KWN identified several trends, some more prevalent than others, related to sociocultural barriers that women and men may face because of their gender.

First, due to social norms that tend to assign care work to women, time restraints may affect women's access to healthcare more than men's access. KWN's survey findings suggested that, on average, travel time to and from a healthcare institution takes 40 minutes in itself. Including waiting time, actual diagnosis, treatment, getting a prescription and payment, one visit to a healthcare facility can consume a lot of time. As a doctor observed, 'Women are busy with other things and leave [themselves] for last'. The fact that it is socially assumed that women will bear the brunt of care and other unpaid household labour, as part of traditional reproductive roles,[131] may mean that they do not feel they have sufficient time to visit the doctor amid their other responsibilities. Among the women who in the last year had not consulted a doctor when they felt they needed to, 11.9% said the main reason was that they 'could not take time because of work, care for children or for others'. Women carrying out unpaid care work at home may face difficulties leaving the person(s) for whom they are caring in order to seek healthcare for themselves. Employed women have the 'double burden' of

[130] For further information about this Index, please see the methodology in Appendix 1.
[131] For more information about women's unpaid care role, see Nicole Farnsworth, et al. for KWN, *Who Cares? Demand, Supply, and Options for Expanding Childcare Availability in Kosovo*, Prishtina: KWN, 2016.

unpaid house work and paid employment outside the home.[132] This in itself has been associated with a lower health status,[133] and may contribute to a lack of time for personal care. While most men tend not to have this 'double burden', 12% of those who did not visit a doctor when they believed it was needed similarly attributed this to a lack of time.

Second and related, social barriers can interact with financial barriers, preventing women from accessing healthcare. Considering women's low employment rates (18.1% in 2015),[134] related to their socially constructed reproductive role at home,[135] women may not have their own income to pay for healthcare. Women may not always be 'independent in managing their own finances', an interview respondent observed. In approximately one-third of Kosovo families, men remain primary decision-makers related to family finances.[136] While women can receive certain healthcare services free of charge at public institutions, some women prefer care at private institutions, in which case 'finances become a barrier for a lot of women', the same respondent said.

Third, cultural beliefs related to women and men could impact some people's access to healthcare. Approximately four percent of Kosovars believed that 'Women should be strong and not need to visit the doctor'. Those who were ages 45+ were more likely to say, 'I don't know' and those 16-44 were more likely to disagree (p=0.02).[137] In contrast, nearly five percent of Kosovars thought that 'men should be strong and not need to visit the doctor'. Although there was no significant difference in belief by residency, younger people were more likely to agree with this statement than older people (p=0.02). Of those who said women should be strong, 52% also said men should be strong.

Fourth, given the values held by some women, they may not want to be touched by men who are not their husbands, even if they are doctors, as healthcare professionals noted during interviews. Women were significantly more likely than men to consider having a health provider of another gender a problem (p=0.006); 23.8% of women considered this a problem limiting their access to healthcare compared to 18.4% of men. Such views were more widespread in rural areas where 25.3% of Kosovars considered this a problem compared to 15.0% in urban areas (p=0.001)

**'It's a bit difficult for female patients who are more religious or come from rural areas since often they loath talking in front of me only, or having me conduct a breast examination. They always ask for a nurse to be present or to perform the examination.'**

- Man, Gynaecologist, Prishtina

Fifth and perhaps related, religion may be a factor preventing access. The relationship between attending religious services and wanting a doctor of the same gender was significant for women (p=0.03), but not for men (p=0.1). However, survey data do not suggest that people attending religious services more often are necessarily more likely to consider having a doctor of another gender a problem. Even so, 16% of persons who attend services a few

[132] The 'double burden' faced by women has been extensively written about elsewhere (see Pollert, *Women, Work and Equal Opportunities in Post-Communist Transition*, Greenwich: 2003; Pascall and Manning, *Gender and social policy: Comparing states of Central and Eastern Europe and the former Soviet Union*, Nottingham: 2000).

[133] Väänänen et al., *The Double Burden of and Negative Spillover Between Paid and Domestic Work: Associations with Health Among Men and Women,* Helsinki: 2004.

[134] KAS, *Results of the Kosovo 2015 Labour Force Survey*, Prishtina: 2016, p. 10.

[135] Farnsworth et al. for KWN, *Who Cares?*, Prishtina: KWN, 2016

[136] Farnsworth et al. for KWN, *No More Excuses: An Analysis of Attitudes, Incidence, and Institutional Responses to Domestic Violence in Kosovo*, Prishtina: KWN, 2015, p. 29.

[137] Among persons who held this believe, there was no significant difference between women and men.

times per month and 9% of those who attend more than once per week said having a doctor of another gender is a 'big problem'. Further, 25% of women attending services one to three times per month, 30% of women attending once per week and 20% of those attending more than once per week considered this a 'little problem'. While the relationship seems somewhat inconsistent, concern over the doctor's gender may present a barrier for some women's access to healthcare due to religious reasons.[138] Healthcare workers have observed that more conservative Muslim women in particular request treatment by women doctors. This may present a barrier to access when women healthcare workers are unavailable.

Sixth, regarding access to reproductive health, according to hearsay, some Kosovars were thought to believe that single and widowed women do not need gynaecological exams. Therefore, the survey sought to examine the prevalence of this belief. Only four percent of Kosovars agreed or strongly agreed that 'women who are single, including widows, have no reason for gynaecological check-ups'. An additional four percent did not agree or disagree or did not know.[139] Similarly, only 3.7% agreed that 'women who have finished having children do not need gynaecological check-ups anymore'. Approximately 5% were unsure.[140] Rural inhabitants were slightly more likely to agree with this sentiment than urban inhabitants ($p=0.01$). Even so, only 4.7% of rural inhabitants and 2.3% of urban inhabitants thought women who had finished childbearing did not need gynaecological care. This research suggests that either such views were not widespread previously or they have diminished over time. Even so, when asked why they did not have adequate access to sexual and reproductive healthcare services if they need them, 11% of women said it is unacceptable for them to have such services because they are unmarried or widowed. This suggests a gap between what respondents know and how some may act in practice.

Seventh, bias or discrimination on behalf of healthcare professionals also could impact access to healthcare for women or men. A recurring theme among healthcare workers was that women are more gentle, sensitive and responsible, largely because they are mothers. In contrast, some healthcare workers considered men 'arrogant' and disinterested. Social assumptions about women and men can impact access to information. For example, the assumption among some healthcare providers that men do not need to know about contraception may impact men's access to information about contraception (see the box). As the right to information is enshrined in Kosovo law, this can represent a rights violation. Notably, qualitative interviews suggest that such assumptions seem to exist only among some healthcare workers; others emphasized the importance of treating women and men equally.

## Conclusion

Although the access indices did not reveal many significant differences between men and women, several individual survey questions did. Notable differences existed relating to decision-making and sociocultural barriers. In Kosovo, important decisions within the household including when women and children should go to the doctor remain overwhelmingly made by men, which can hamper women's access to healthcare. This holds

[138] Further, of women who attend religious services only for holidays, 11% said having a doctor of another gender is a 'big problem'. Of women who never attend religious services, 5% still considered this a big problem. Of those attending once per week, none thought this was a big problem. Other women who considered having a doctor of another gender a little problem included: 11% of women never attending service, 16% of those attending on holidays and 21% of those attending every few months.

[139] No significant relationship existed between agreeing and age or living in a rural or urban area, respectively.

[140] No significant difference in opinion existed by gender, age or rural/urban residency.

true for decisions regarding family planning, when not made jointly. Also, if family resources are scarce, male family members may be prioritized for receiving healthcare services.

Broader, interrelated socioeconomic factors like women's low employment rates that limit their access to finances, time restraints and women's unpaid caretaker role all may hamper women's access to healthcare. Cultural beliefs that women or men should 'be strong' and not seek healthcare, or that single, widowed or older women no longer need reproductive care exist in Kosovo, though they are not particularly prevalent. Cultural values relating to the gender of the health worker, especially the gynaecologist, may undermine some women's access to healthcare. Since free choice of the healthcare provider is a legal right in Kosovo,[141] this suggests rights violations possibly due to a lack of female staff. In some instances, healthcare workers' beliefs about women and men also may impact patients' access to information and care. Addressing gender-related sociocultural barriers to women and men accessing healthcare will require awareness-raising towards shifting social norms, beliefs and values so that everyone can access healthcare.

[141] Assembly of Kosovo, Law on Rights and Responsibilities of Kosovo Residents in the Health Care System, Art. 5.

# Residency and Access to Healthcare

Kosovo has seen a shift in the urban-rural divide in recent decades.[142] Meanwhile, the capital city of Prishtina has seen its population increase tenfold in the last sixty years. Even so, most of the population (62%) lives in rural areas. According to the Kosovo Agency of Statistics (KAS), rural populations consume less than urban populations, and they spend differently. An average urban household annually spends approximately €8,000, about €700 more than a rural household. In rural areas, people tend to spend more on food and transport, but slightly less on health and education.[143] This is reflected in disparities between urban and rural populations in accessing healthcare, identified through this research and discussed in this chapter. In relation to rural and urban residency, the chapter examines six indices, including potential financial, geographic, cultural and awareness barriers, as well as patient-provider relations and perceived personnel quality.

## Financial Barriers by Residency

**'Conditions are very poor. Patients are in a difficult economic position. Most of them are from villages and depend on social assistance.'**
- Doctor, Vushtrri

The Financial Barriers Index compiled questions relating to accessing money for healthcare or medication, reasons for not consulting a doctor, health insurance status and money as a perceived factor undermining access to reproductive healthcare. On this Index, Kosovars from rural regions faced slightly higher barriers when accessing healthcare than urban Kosovars ($p=0.001$). This disparity was driven primarily by rural women who faced significantly more financial barriers than urban women ($p=0.002$). In contrast, rural and urban men did not differ significantly ($p=0.12$).

When asked if obtaining money for medical care and services was a problem, 45.3% of rural women reported it was, while only about 30.4% of urban women said the same. Only a three percentage point difference existed between rural men (39.7%) and urban men (36.2%). Perhaps this disparity may be attributable in part to socially acceptable answer bias, as men may find it difficult to state that they do not have enough money for care.

Two-thirds of the privately health-insured persons were men, and one-third were women. Half of the insured were rural residents and half urban. However, the gender divide was very different in rural and urban areas. In rural areas, about 80% of the insured were men and 20% were women, whereas in urban areas half were women.[144] Without public or private health insurance, many Kosovars must pay for medical expenses out-of-pocket.

[142] Besim Gollopeni, *Rural Urban Migration in Kosovo*, Prishtina, 2015; The following sentences draw from the same source.
[143] KAS, *Results of Household Budget Survey 2015,* 2016
[144] Perhaps unsurprisingly, there is a significant relationship between employment status and having health insurance; persons who work in a paid position outside the home were more likely to have insurance than persons conducting unpaid work at home, who were unemployed or who were retired ($P<0.01$). Persons working in health, education, marketing, transport and law sectors were more likely to have insurance than persons working in other sectors. None of the survey respondents who were working in agriculture, food processing, government or finance sectors reported having private health insurance.

The fact that economic conditions present a barrier to people accessing healthcare, particularly those from rural areas, was a prominent theme among the healthcare workers interviewed. 'This means that many people because they are unable to pay, remain without access to care', a doctor said. In some instances, the perceived economic situation of patients also may have influenced the types of treatment they received, as the quotation by the doctor in the box illustrates. This suggests that in some cases patients may not receive the treatment they need, but rather only the treatment they can afford based on the doctor's perception. Such perceptions could undermine their access to quality care.

**'You look at the children. You look at their mother, their parent and in general. You should try to give them an adequate therapy and a therapy for the economic status that they have.'**

- Doctor, MFMC, Gjilan

With regard to specific diseases, financial and geographic barriers may interact, undermining access to healthcare. For example, of the 23 cases that could not receive treatment for cancer, the most common reasons included that the treatment is unavailable in Kosovo or it is unaffordable.[145] Some treatments may be available in private clinics, but they are unaffordable. Examining the types of illnesses for which treatment is unavailable in Kosovo was beyond the scope of this research, but may be an area for further investigation.

## Geographic Barriers by Residency

The Geographic Barrier Index considered travel time, method and distance to a healthcare facility, as well as perceived non-access to reproductive healthcare. Overall, urban citizens faced fewer geographic barriers than their rural counterparts. For example, 36% of rural Kosovars (compared to 22% of urban Kosovars) considered the distance to the health facility a problem for accessing healthcare ($p<0.01$). Kosovo has primary care clinics in all 38 municipalities, a secondary care hospital in each of the seven regions and a tertiary hospital only in Prishtina. Given this decentralized organization, only the most geographically isolated Kosovars may face geographic barriers in accessing primary care. However, the same cannot be said for more specialized care. In this regard, the level of the healthcare system citizens seek to access may be important, though the survey did not examine this.

This difference in geographic access was reflected in the different modes of transportation used by respondents to reach the healthcare facility. The plurality of both urban (47.6%) and rural (64.1%) citizens used a personal car. However, the second most popular options diverged significantly. The second most common choice for urban respondents was walking to a healthcare facility, selected by 37.1% of respondents. Only 8.3% of rural respondents said they walked. Rather, 19% of rural respondents said they took a bus or minibus.[146] Interview respondents from Peja noted that the lack of public transportation in some rural areas could create obstacles for rural residents seeking healthcare. Insufficient availability of public transport also can increase the cost of accessing healthcare services, as vehicle or cab fares may be more expensive.

[145] There was no significant difference by residency, ethnicity or gender.

[146] No significant difference existed between women and men.

## Cultural Barriers by Residency

Potential cultural barriers examined in the Cultural Barriers Index included having the power to decide to seek healthcare, the need to secure permission, the ability to travel alone and believing receiving reproductive healthcare is unacceptable. Rural Kosovars, with a mean score of 14.8, faced slightly more cultural barriers than urban Kosovars who had a mean score of 11.2 ($p<0.001$). In an urban context, men and women were not statistically different from each other. However, rural men and women differed, with rural women facing more barriers.

## Awareness by Residency

The Awareness Index included questions about respondents' perceived knowledge of their legal rights to health services, health insurance and filing complaints if dissatisfied with the quality of medical care received. Urban Kosovars, scoring 34.8 on the Awareness Index, were significantly more aware of their rights than rural Kosovars, with a score of 42.5 ($p<0.001$). When stratifying by urban or rural residency, there is a significant relationship between education and rights for both urban ($p<0.001$) and rural inhabitants ($p<0.001$). Thus, insufficient access to education in rural areas may be interrelated with rural inhabitants' comparably lower awareness of their rights.

## Patient-Provider Relationship by Residency

The Patient-Provider Relationship (PPR) Index examined the experiences and satisfaction of citizens with healthcare workers. Questions dealt with whether citizens feel comfortable being examined, whether understandable explanations were given, questions addressed and if health workers spent adequate time with patients. Questions related to family planning included whether they had been given information about birth control, including multiple options and side effects, and if the patient feels comfortable discussing sexually transmitted diseases.

As with all prior indices, rural and urban Kosovars scored differently ($p=0.03$). The quality of the PPR was slightly worse for rural Kosovars (53.8) than urban (51.4) Kosovars. Across both rural and urban regions, women maintained a better quality relationship with their healthcare providers than did men. Urban men, with a mean of 56.7, scored significantly worse on PPR quality than did urban women, with a mean of 46.9 ($p<0.001$). Similarly, rural men, with an average PPR score of 55.8, had worse relationships with their providers than rural women did, with a score of 51.9 ($p=0.007$). Rural women had worse relationships with healthcare workers than urban women did. However, there was no significant difference between rural and urban men's scores.

## Perceived Personnel Quality by Residency

The Perceived Personnel Quality (PPQ) Index examined patient satisfaction with care received, confidentiality and privacy. It also considered treatment by doctors, their competence, completeness and accuracy, including perceived misdiagnosis or inappropriate care. There was no significant difference in how rural and urban respondents perceived the quality of their healthcare providers. Both groups scored about 23 on the PPQ Index. However, when analysed by both gender and residency, significant differences existed between groups. Compared to urban women, urban men responded that their healthcare providers are of relatively lower quality. The same difference in perception did not exist for rural men and rural women, who had similar perceptions. Compared to rural men, urban men

also perceived their healthcare providers to be of a slightly lower quality. However, the same was not true of their female counterparts.

## Conclusion

Residents of rural areas had more limited access to healthcare than did their urban counterparts. Financing healthcare was especially difficult for rural women. The distance to the healthcare facility was considered a problem by more rural citizens than urban citizens, especially when a personal car was unavailable. Rural women, substantially more than urban women, also tended to need to ask for permission before visiting a doctor. Perhaps related to their average educational levels, rural inhabitants had less awareness of their rights to healthcare than their urban counterparts. Rural citizens also valued their relationship with healthcare providers worse, though urban men ranked the quality of providers lowest. Thus, residency was a significant factor when determining if a Kosovar will have access to healthcare despite the strategic location of primary care centres, which has sought to minimize geographic barriers.

# Ethnicity and Access to Healthcare

Kosovo's population features a large Albanian majority and several ethnic minority groups, including Bosnians, Serbs, Turks, Ashkali, Egyptians, Gorani and Roma. Seven indices[147] were analysed by ethnicity in the following sections. The *higher* the score on each index, the greater the barrier to accessing healthcare services. Possible scores range from zero, no barriers to healthcare, to one hundred, high barriers.

## Financial Barriers by Ethnicity

Ethnicity was highly correlated with financial access. On average, Albanians had a Financial Barriers Index score of 15.7. Again, since most survey respondents were Albanian, the status of all other ethnic groups was compared to Albanians.

Table 4. Mean Scores of Financial Barriers Stratified by Ethnicity and Gender (Standard Errors in Parentheses)

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 16.2 (1.018) | 15.2 (1.009) | 15.7 (0.717) |
| Serbian | 9.2 (1.789) | 9.8 (1.774) | 9.5 (1.261) |
| Roma, Ashkali, Egyptian | 40.1 (3.745) | 50.5 (4.006) | 44.8 (2.806) |
| Bosnian | 48.6 (4.918) | 24.1 (2.925) | 36.3 (3.312) |
| Gorani | 54.8 (5.699) | 53.6 (6.117) | 54.2 (4.194) |
| Turkish | 21.6 (4.490) | 6.7 (2.924) | 16.1 (3.258) |

Serbs had an average score of 9.52 and thus faced lower financial barriers than Albanians ($p=0.004$). However, not all Serbs were better off than Albanians. Serbs who live in Mitrovica were significantly better off than Serbs living elsewhere in Kosovo. Serbs who lived in Mitrovica averaged an extremely low financial barriers score of 0.9. For Serbs living elsewhere, the average financial barrier score was 22.5, meaning they faced more barriers than Albanians.

Bosnians, Roma, Ashkali, Egyptians and Gorani all faced significantly higher financial barriers than Albanians ($p<0.001$ for all). The Financial Barriers Index score of non-Serb, non-Turkish ethnic minorities was at least twice that of Albanians. When looking within ethnic groups, Bosnian and Turkish women faced significantly greater financial barriers than men of the same ethnicity. Bosnian women faced significantly higher barriers with a mean score of 48.6, compared to Bosnian men's 24.1 ($p<0.001$). Likewise, Turkish women scored 21.6 to Turkish men's 6.73 ($p=0.03$).

The score differences between genders of the same ethnicity illustrate a different pattern of financial barriers among men than among women. Bosnian men with a mean score of 24.1, were much closer in mean score to Albanian men, 15.2, and not statistically different ($p=0.38$). Only Roma, Ashkali and Egyptian men, with a score of 50.5, and Gorani men, with a score of 53.6, were significantly different from Albanian men ($p<0.001$ for both).

## Geographic Barriers by Ethnicity

Albanian respondents scored a mean of 38.3 on the Geographic Barriers Index. Overall, Serbs (30.6) faced the lowest geographic barriers ($p<0.001$). While statistically different from Serbs, Albanians were not much worse off. Bosnians and Turks scored similarly to Albanians. Roma, Ashkali and Egyptians faced more geographic barriers than Albanians with a score of 48.8 ($p=0.002$). However, Gorani were significantly worse off than all other groups with a score of 83.3 ($p<0.001$). Among the ethnic groups, Gorani tend to live in the most

[147] See Appendix 1.

isolated of Kosovo's rural areas, farther from healthcare institutions, which likely explains why they score the worst in terms of geographic access.

Serb women (36.6) faced significantly higher geographic barriers than Serb men (25.2) (p=0.001). While Serb women still scored the lowest among all women, meaning they faced the least barriers, the gap between Albanian women and Serb women was insignificant.

Table 5. Geographic Barriers Mean Scores by Ethnicity and Gender (Standard Errors in Parentheses)

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 39.1 (1.006) | 38.3 (1.099) | 38.8 (0.765) |
| Serbian | 36.6 (2.764) | 25.2 (1.802) | 30.6 (1.668) |
| Roma, Ashkali, Egyptian | 49.4 (4.151) | 48.0 (4.740) | 48.8 (3.123) |
| Bosnian | 40.5 (5.356) | 32.1 (4.362) | 36.4 (3.512) |
| Gorani | 84.6 (6.182) | 82.1 (7.362) | 83.3 (4.783) |
| Turkish | 37.1 (4.665) | 36.9 (5.880) | 37.0 (3.653) |

The mode of transportation used may impact disparities in geographic access among ethnicities. Transportation patterns in accessing healthcare differed widely among ethnic groups in Kosovo. Most Roma, Ashkali, Egyptians (50.8%) and Bosnians (68.2%) walked the last time that they visited the doctor. Fewer than 15% used a personal car. In contrast, over 60% of Albanian respondents used a personal car to travel to the doctor, and fewer than 20% walked. Among Gorani, the most geographically disadvantaged group, none reported using a personal car. Two-thirds said they took a taxi, and 22% walked.

## Cultural Barriers by Ethnicity

Based on the Cultural Barriers Index, the cultural barriers faced by citizens are highly correlated with ethnicity (p<0.001). Overall, the Serb population had the fewest cultural barriers, with the lowest mean, 8.4 (p=0.002). Albanians, the benchmark group, scored the second lowest with a mean score of 13.1. Roma, Ashkali and Egyptians scored a mean of 13.7, while Bosnians scored 20.4 and Turkish 21.0. Gorani scored 47.4, which means they faced the most cultural barriers. Bosnians, Turks and Gorani all faced significantly more cultural barriers than Albanians did.[148]

Table 6. Cultural Barriers Scores by Ethnicity and Gender

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 14.1 (0.755) | 11.9 (0.676) | 13.1 (0.511) |
| Serbian | 10.3 (1.498) | 6.6 (1.05) | 8.4 (0.912) |
| Roma, Ashkali, Egyptian | 11.6 (1.727) | 16.2 (2.712) | 13.7 (1.567) |
| Bosnian | 28.4 (4.838) | 11.7 (3.220) | 20.4 (3.177) |
| Gorani | 55.8 (8.856) | 32.8 (6.231) | 47.4 (6.514) |
| Turkish | 22.3 (5.012) | 18.8 (4.954) | 21.0 (3.640) |

Within ethnic groups, gender continues to play a role in the cultural barriers faced. Albanian women statistically faced more cultural barriers than Albanian men (p=0.03). Serb women also faced more barriers than Serb men (p=0.04). Bosnian men and women had the most significant difference with Bosnian women scoring 28.4 compared to Bosnian men's 11.7 (p=0.008). Among Gorani, Turkish, Roma, Ashkali and Egyptians, there was no statistically significant difference between men and women.

## Patient-Provider Relationship by Ethnicity

When data were stratified by ethnicity, there were two main clusters around the scores of 50 and 65, respectively. Respondents in the lower cluster, who reported a better patient-provider relationship, included Albanians (52.3), Turks (51.8), Roma, Ashkali and Egyptians (47.0). None of these ethnic groups differed statistically from Albanians.

[148] More specifically, p=0.016, p=0.048, p<0.001 respectively.

Respondents in the higher cluster, who reported a worse patient-provider relationship, included Serbs (59.4), Bosnians (69.4) and Gorani (64.3). All were statistically different from Albanians.[149]

Women and men within each ethnic group tended to report different relationships with their providers. For Albanian, Roma, Ashkali and Egyptian women, the overall trend of women reporting better patient-provider relationships than their male counterparts held true. Albanian men scored 55.9 compared to Albanian women's score of 49.1 ($p<0.001$). Roma, Ashkali and Egyptian men scored 62.1 while women scored 43.2. This 18.9-point gap between Roma, Ashkali and Egyptian men and women was the largest gap between any of the ethnic stratifications ($p<0.001$).

Table 7. Patient-Provider Relationship Mean Scores by Ethnicity and Gender (Standard Errors in Parentheses)

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 49.1 (0.953) | 55.9 (0.840) | 52.3 (0.650) |
| Serbian | 62.3 (2.243) | 56.6 (1.793) | 59.4 (1.448) |
| Roma, Ashkali, Egyptian | 43.2 (2.406) | 62.1 (2.427) | 51.8 (2.012) |
| Bosnian | 71.0 (2.403) | 67.8 (4.016) | 69.4 (2.328) |
| Gorani | 70.2 (3.410) | 55.8 (5.193) | 64.2 (3.276) |
| Turkish | 43.7 (4.796) | 52.6 (3.914) | 47.0 (3.423) |

For Serbs and Gorani, this trend was reversed. Serb men (56.5) reported better relationships with their providers than did Serb women (62.3; $p=0.046$). Gorani men similarly reported better relations (55.8) than did Gorani women (70.2) ($p=0.03$). The survey findings did not show a significant difference between Bosnian men and Bosnian women.

## Perceived Healthcare Personnel Quality by Ethnicity

Serb, Bosnian and Gorani people perceived the quality of healthcare personnel differently than Albanians did. Albanians tended to believe that personnel are of higher quality than other ethnic groups did; Albanians scored 22.6, compared to 31.7 for Serbs, 32.0 for Bosnians and 34.7 for Gorani. Roma, Ashkali, Egyptians and Turkish people did not differ statistically from Albanians.

Table 8. Perceived Healthcare Personnel Quality Mean Scores by Ethnicity and Gender (Standard Errors in Parentheses)

| Ethnicities | Women | Men | Both Genders |
|---|---|---|---|
| Albanian | 22.3 (0.710) | 22.9 (0.662) | 22.6 (0.486) |
| Serbian | 37.3 (1.823) | 27.2 (1.295) | 31.7 (1.149) |
| Roma, Ashkali, Egyptian | 17.4 (1.166) | 25.9 (2.238) | 21.2 (1.269) |
| Bosnian | 32.5 (3.264) | 31.6 (1.752) | 32.0 (1.833) |
| Gorani | 36.2 (2.041) | 32.0 (4.812) | 34.7 (2.219) |
| Turkish | 25.2 (2.915) | 14.3 (1.707) | 21.2 (2.155) |

When comparing by gender and ethnicity, Serb women reported significantly worse personnel quality (37.3) than Serb men (27.2) did ($p<0.001$). Roma, Ashkali and Egyptian women (17.4) rated their healthcare providers more favourably than their male counterparts (25.8) did ($p=0.001$).

## Availability of Healthcare Services by Ethnicity

The Availability Index included questions dealing with the availability of medicine, equipment, medical care in an emergency and the wait-time in accessing care. Most ethnic groups clustered around an availability score of approximately 30. There was no statistical

[149] More specifically, $p=0.016$, $p=0.048$, $p<0.001$ respectively.

difference between Albanians and most other ethnic groups. Gorani were the sole outliers. They scored significantly worse than any other ethnic group with a mean of 56.3.[150]

Within the Index, this disparity was partly driven by the Gorani population's concern regarding the lack of emergency care in their vicinity. About 32% percent of Gorani did not think that they would be able to access care easily if they had an emergency. In contrast, only about seven percent of Albanians, 10% of Serbs, one percent of Roma, Ashkali and Egyptians, 12% of Bosnians and 3% of Turks shared this concern.

Gorani also expressed concern that the equipment they need may not be available. About 80% of Gorani reported this concern. While more Gorani were worried about equipment availability, this concern was shared by the entire population. About 50% of Albanians, 40% of Serbs, 40% of Roma, Ashkali and Egyptians, 60% of Bosnians and 45% of Turks reported the same concern.

Overall, respondents agreed that waiting times when visiting a doctor are long. A plurality of respondents, 45.3%, either agreed or strongly agreed that they 'usually wait for a long time' when they visit the doctor. Another 28.1% neither agreed nor disagreed, while only 24.7% disagreed or strongly disagreed.

## Awareness of Patient Rights by Ethnicity

On the Awareness Index, most ethnicities' awareness aligned with Albanians' level of awareness. Albanians scored an average of 38.6 for awareness. Serbs (45.3), Turkish (45.6), Roma, Ashkali and Egyptians (33.6) differed slightly from Albanians, but not statistically. In contrast, Bosnians and Gorani were significantly less aware of their rights ($p<0.001$ for both). Bosnians scored an average of 62.0. Gorani were the least knowledgeable about their rights with a score of 73.2 ($p<0.001$).

Within ethnic groups stark gender disparities exist. Among Serbs, women were far less aware of their rights (59.8) than men were (32.4) ($p<0.001$). For Bosnians, the opposite was true. Bosnian women (52.4) were far more knowledgeable about their rights than Bosnian men (71.9) ($p=0.01$). When these gender discrepancies are considered, women ranked differently than the overall population did when split by ethnicity. Serb and Gorani women were the only groups significantly different from Albanian women ($p<0.001$, $p=0.04$, respectively).

## Conclusion

Most minority ethnic groups faced more difficulties accessing care than the Albanian majority population does. Economic barriers were highest for Bosnians, Roma, Ashkali, Egyptians and Gorani, while Serbs were better off. Due to their remote location, Gorani faced the most geographic barriers to healthcare, including unavailability of emergency services. None reported using a car, though this was by far the most common travel mode for Albanians to reach a doctor. Regarding cultural barriers, again Serbs scored better than all other ethnic groups, and Gorani faced the most barriers. Bosnians and Gorani knew least about their rights to healthcare. One potential explanation for the apparently better scores of Serbs may be the parallel healthcare system that exists in Mitrovica, where a large portion of the Serb population resides.

[150] More specifically, Gorani are significantly different from Albanians ($p=0.005$), Serbs ($p=0.036$), Roma, Ashkali, Egyptians ($p<0.001$), Bosnians ($p=0.024$) and Gorani ($p=0.002$).

# Knowledge and Rights to Healthcare

Patients' rights are intended to ensure the equal treatment of all patients by codifying what patients are entitled to and guaranteed under the law.[151] The relationship between doctor and patient relies on the patient's trust that the doctor is knowledgeable and an expert in health. This relationship has a natural element of hierarchy that leaves the patient in a more vulnerable position. Therefore, understanding how aware patients are of their rights, how well respondents understand the healthcare system and whether patients are able to assert their rights are all important to understanding how healthcare is delivered in practice.

## Knowledge Barriers

Insufficient information can be a barrier to receiving care. If people do not know how to access healthcare or what their healthcare rights are, it may be difficult for them to receive care or demand that their rights are respected.

Survey data provide strong evidence that inadequate knowledge about the healthcare system and services available create barriers to accessing healthcare. More specifically, when asked to assess their knowledge of their rights to healthcare, only 11.1% of Kosovars felt they knew 'a lot' about their rights. Women were significantly more likely than men to believe they knew their rights ($p=0.003$); 14% of women compared to 7.9% of men said they knew 'a lot' about their rights. Approximately 62% of respondents knew they had a legal right to health insurance.

While some healthcare workers interviewed believed that Kosovars are informed of their rights and/or their awareness has improved, others felt people still lack awareness. A hospital representative observed, 'There has not been sufficient work towards having citizens understand their rights when it comes to the rights of the patient or the rights to receiving care or confidentiality'. These points are discussed further in the sections that follow.

### Knowledge of Sexual and Reproductive Healthcare Services

Most survey respondents, 61.6%, indicated that they did not feel they had adequate access to sexual and reproductive healthcare services. The most common reason, cited by 65.5% of them, was that they did not know where to access these services. Survey respondents also demonstrated confusion regarding healthcare providers. MFMCs provide gynaecological and reproductive health services, as family medicine doctors can provide birth control and most reproductive health services. Further, many MFMCs have gynaecologists in residence. However, when asked if MFMCs provide such services, or if these are only available from gynaecologists' clinics, respondents were almost equally divided between the three options: 35.3% said MFMCs provide gynaecological and reproductive health services, 34% percent said such services could be provided only by gynaecologists and 30.7% did not know.[152] Insufficient knowledge about where reproductive health services are available may prevent people from seeking such services.

Another knowledge shortcoming that emerged from the data was the belief that certain services were unnecessary. For example, when asked why they did not seek prenatal care during their pregnancy, 23.8% of women believed it was unnecessary.

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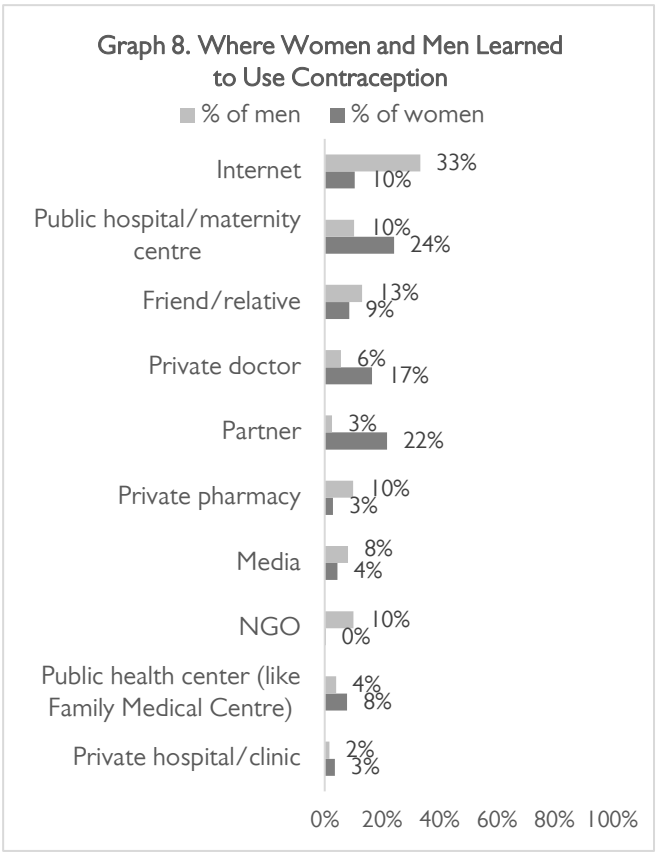
[151] The Legal Framework on Healthcare chapter outlines the relevant laws in Kosovo.

[152] No significant difference existed between rural and urban areas on this point.

Education about reproductive health and family planning should be available at the primary care level, including free distribution of contraceptives that are on the Essential Drug List. Survey respondents were asked several questions pertaining to family planning services, including from where they received information about family planning. As use of modern contraceptives remains low in Kosovo,[153] insufficient knowledge may be one reason why respondents do not use contraception.

Consistent with results of the prior survey question on accessing reproductive health services, 76.3% of respondents indicated that they did not know where to get family planning information and services. Slightly more women knew where to go (27.9%) than men (19.1%). Nearly 82% of respondents had never had a doctor or nurse explain a family planning method to them. Further, approximately 79% of women said a healthcare worker had never told them about multiple options for family planning or the potential effects, side effects or problems they may have with different family planning methods. Aside from persons ages 16-24, who may not have consulted healthcare workers regarding contraception yet, people in younger age groups tended to report receiving information from healthcare workers about various family planning options ($p<0.001$) and potential side effects ($p<0.001$) more than older people. This suggests improvements over time in healthcare workers' sharing of such information.

When the approximately 19% of persons using contraceptives were asked where they first obtained their current contraceptive method or learned how to use it, most respondents said that they learned from the internet (26%). Unsurprisingly, younger people were more likely to have learned about contraception from the internet than persons 35 and older ($p<0.001$). As Graph 8 illustrates, a public hospital or maternity centre was the next most common source of information (15%), though more common for women (24%) than men (10%). Friends or relatives (12%), private doctors (9%), partners (9%) and pharmacies (8%) also were sources of information for several respondents.

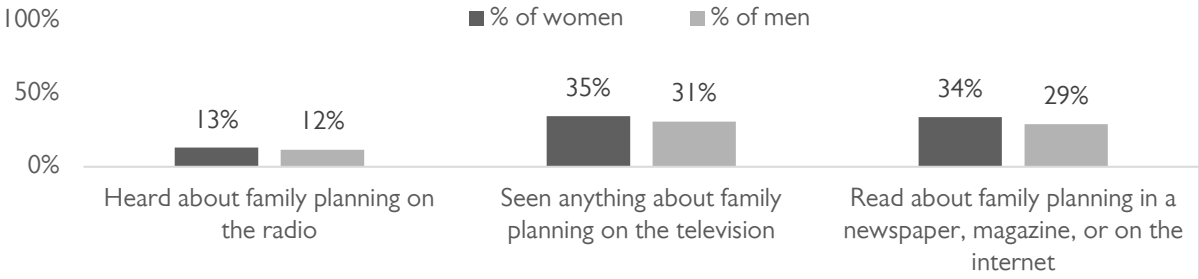



Information sources related to contraception differed significantly for women and men ($p<0.001$). Women seemed to receive their information primarily from public hospitals or maternity centres (24%) and their partners (22%). In contrast, more men tended to receive information from the internet (33%). Interestingly, many more men received information about contraceptives from NGOs than did women.

[153] Information about usage of contraceptives is in Appendix 6.

Respondents also were asked whether they had received any information about family planning from different sources in the last few months (see Graph 9). Understanding how best to reach specific target groups with information about family planning can be useful for planning effective awareness-raising programs in the future. Television appears to be the best method for reaching the most, diverse people with information about family planning, though the internet seems more effective for reaching people under age 35 ($p<0.001$).

Graph 9. Family planning information: In the last few months have you…




Knowledge gaps among providers also may impede access to quality healthcare. For example, researchers found that some healthcare providers relied on what they had been taught in university with regard to contraceptives, without continuing their education or staying informed of modern contraceptives (see box). Others stated that gynaecologists, especially, receive regular training and should know up-to-date information. However, healthcare workers may not always provide patients with this information. For example, a pharmacist stated that explaining side effects to patients is useless because they do not understand scientific language. In fact, this is a violation of Kosovo law,[154] which requires healthcare workers to provide comprehensive information, explaining difficult concepts in simple words so that persons of all educational levels understand. Perhaps some healthcare workers may lack education on how to explain medical terms understandably.

**'Usually, I try and advise women to take, as I learned in gynecology, *coitus interruptus* [withdrawal], as a natural protection, without pills.'**
- Woman, Doctor, Primary Care, Gjilan

## Patient Rights Abuses

In addition to their awareness of rights, respondents also were asked about specific instances of rights abuses. Some, albeit few, women and men reported instances of what they considered discrimination or insults by health professionals. Overall, 1.9% of women agreed or strongly agreed that they have felt discriminated against by a healthcare provider *because of* their gender, while 6.8% neither agreed nor disagreed. Approximately one percent of respondents (1.5% of women and 0.4% of men) felt they had been touched in an inappropriate sexual way during a health exam. However, this could be partially due to patients not knowing what particular procedures entail. Even so, if people have insufficient understanding of procedures, this means that the provider failed in explaining the procedure

[154] Assembly of Kosovo, Law on Rights and Responsibilities of Kosovo Residents in the Health Care System, 2004, Art. 9.

comprehensively. A few Kosovars, 0.72%, reported that a doctor took their blood to conduct an HIV test without their consent.

Based on perceptions, approximately seven percent of survey respondents believed a healthcare worker had misdiagnosed them. In one case, a respondent said misdiagnosis led her to lose her unborn twins and become sterile. One percent of respondents reported that their doctor diagnosed them with cancer without running any tests. For example, one respondent reported being diagnosed with bone cancer, but consultations with a second doctor revealed it was spondylosis. Approximately four percent of respondents believed that their doctors had recommended unnecessary surgery. This happened to approximately twice as many women as men. A respondent said that the doctor recommended surgical removal of the appendix, but the respondent later learned that this was unnecessary.

While these percentages may seem low in terms of the overall population, they do provide evidence that rights abuses are likely occurring in Kosovo. The fact that any segment of the population may suffer such abuses is noteworthy. Further, it is highly unlikely that these respondents are the only Kosovars who have grappled with such abuses. Anecdotal evidence of such abuses is widespread, indicating that the survey may have failed to capture more extensive rates of provider abuse of patient rights. At minimum, the statistical evidence is sufficient to raise concerns and motivate further research.

Interviews with healthcare workers revealed other rights abuses that occur within the healthcare system. For example, public health centres should have the appropriate basic conditions to provide services, including those foreseen by law as free. However, this is not always the case. As a doctor observed, 'Delivery is covered by the health system in Kosovo, or should be based on the law. [But] when you go, there is no stitches for you having a C-section. There's no white sheets for you to sleep, or there's other medication which is necessary but not available.' Insufficient materials, infrastructure (e.g., space, heating, water and beds), equipment and computers were all mentioned by healthcare workers as impacting the quality of care that they provide. In contrast, researchers observed generally better conditions and pharmaceutical supplies within Mental Health Centres, compared to other public and private health institutions.

Another recurring theme among healthcare workers was the lack of human resources, particularly nurses. This, they said, decreased the amount of time that they could spend with individual patients, hampering the quality of care. Some interview respondents cited an insufficient number of specialized doctors, so that some doctors perform duties outside their areas of specialization. These poor conditions within public institutions are a rights abuse.

In accordance with the Essential List, certain pharmaceutical products always should be available. However, the unavailability of drugs, including those on this list, was a recurring theme among healthcare practitioners. Rural areas in particular often lacked medicine from the Essential List, including contraceptives. A nurse said, 'Sometimes we lack, for example, Dexason, but it costs only 20 cents, so it's less than one coffee. Sometimes patients should not treat themselves with a coffee in order to buy for themselves three doses of Dexason.' Here the nurse is blaming the victim, based on an unfounded assumption that a person who can afford coffee should afford drugs, when in fact it is the duty of the institution to ensure that this drug is available.

A rights abuse within the healthcare system, documented in prior research, is corruption through money, goods or relations to obtain better or faster care. During interviews some healthcare providers also observed that nepotism impacted the quality of

healthcare provided. However, this research did not examine corruption in detail because it was examined thoroughly in a recent report by Levizja FOL.[155] In that report, 25% of the population admitted having given money or goods to a healthcare worker in 2015, with men tending to give money and women giving other goods. Money was given mainly based on requests from healthcare workers. Few corruption cases are reported and fewer completed, the report stated.

Another rights abuse observed by some healthcare professionals was that some doctors may make decisions without providing patients with options, and that care may not be patient-centred. This also is illustrated by the fact that certain healthcare professionals self-reported that they firstly, and sometimes only, inform family members about diagnoses instead of patients, as further discussed in the next section. This violates the patient's right to information.

**'Sometimes the family insists that the patient shouldn't know the diagnosis. We respect that [and don't tell the patient].'**
- Doctor, Prishtina

## Confidentiality

The patient's right to confidentiality is defined as the right of the patient for a doctor, nurse, pharmacist or other healthcare personnel to keep information about the patient or the patient's health confidential. The survey and interviews suggest that this right is not known by all patients, nor respected by all healthcare personnel.

When asked whether they have the right for doctors to keep information about them and their health confidential, 21.5% of respondents said that they do not have this right.[156] Younger people were more likely to know their right to confidentiality than persons of older generations (p=0.03). In 84.7% of cases, respondents ages 16-24 knew they had the right while 71.6% of respondents 65 and older did.[157] While no difference existed between rural and urban women's knowledge of their right to confidentiality, urban and rural men differed significantly (p=0.03) and rural men were the least knowledgeable; 69.8% of men in rural areas believed they have a right to confidentiality compared to 85% of men in urban areas.

When data were stratified by ethnicity, strong discrepancies in knowing the right to confidentiality were evident. Albanians had slightly better knowledge than the national average of 78.5%, with 80.1% of Albanians affirming their right to confidentiality. Every minority, other than Turks, had less knowledge of this right. Serbs and Gorani had especially poor knowledge with only 50.3% and 53.6% of respondents affirming this right, respectively.

Education was positively associated with knowledge of the right to confidentiality; 84.8% of persons with the highest level of education knew they had this right, whereas the least educated were more than 10 percentage points less likely to know this right.

Patient knowledge is only one side of the equation as providers also must respect the patient's right to confidentiality. This was tested twice in the survey and also discussed in interviews. When asked if the doctor keeps their personal information confidential and does not share it with anyone, 66.2% of patients agreed or strongly agreed that their information was kept confidential. Accordingly, 34.8% of the population either disagreed or did not know if their information is confidential. Some, 3.2%, reported that a healthcare worker spoke about their disease or treatment in front of or to other patients.

[155] Levizja FOL, 2016.
[156] No significant difference existed among rural and urban women and men.
[157] No significant interaction existed with gender and age (p=0.68).

Eleven percent of surveyed Kosovars felt that their privacy had been breached while receiving medical care. Respondents may lack knowledge regarding what privacy entails. With some exceptions, interviews conducted at public and private healthcare institutions illustrated a recurring lack of privacy and confidentiality. A contributing factor may be a lack of space within healthcare institutions, which can make it challenging to have a private conversation with a patient who is together with other patients in the same room. However, other reasons are behavioural.

Interviews and observations suggest that doctor-patient confidentiality is neither widely understood nor respected. For example, during interviews, some patients were asked questions regarding their health status with KWN researchers present. Often documents are not locked or are easily accessible for anyone. The lack of computers and adequate IT-systems leads doctors to store confidential information on their personal devices, observations illustrated. When doctors do not practice confidentiality, patients are 'either ... not aware or they think it is normal that the information should be given to other[s] or be revealed', a doctor said.

**'When the diagnosis is worse, we tell first a family member and not the patient directly.'**
- Doctor, Vushtrri

A related issue not fully controlled by the patient or the provider, is the role of the family (spouses, parents or extended family) in the healthcare process. Family members often attend the patients' healthcare appointments, allowing patients little privacy, interview respondents noted. As mentioned, informing family members regarding diagnoses and proposed treatments, even before informing the patient, appears commonplace. As a nurse said, 'Although it's up to patients if they want to tell their disease to their family, I would rather that they [patients] don't know about their disease, while family members should know. They [the family] would be more caring'. The healthcare workers interviewed tended to agree that family members must know the diagnosis, especially if severe. This is a sociocultural barrier to confidentiality, whereby the family is considered a protective and supportive mechanism for the individual and thus better suited to help the individual address healthcare issues than the individual would be alone.

A fear of breached confidentiality may be a factor dissuading individuals from seeking care, especially in a country the size of Kosovo where, as one respondent said:

> Everybody knows someone somehow, directly or indirectly. So on one hand, it is very hard to keep confidentiality [...] There are some reservations in terms of [...] women, especially young women, coming from other cities to Prishtina because they know the city is very small. Everyone knows, or if you enter the hospital, everyone will somehow find out that you went to the gynaecologist [...] Unfortunately, very often healthcare providers are speaking among themselves with names [of patients] and that is a big problem.

During interviews, multiple healthcare practitioners, particularly psychiatrists, noted that patients hesitated to seek care for fear of breached confidentiality. Until confidentiality becomes a priority, demanded by patients and prioritized by providers, its absence may hinder people's access to healthcare and affect negatively the quality of care provided.

## Knowledge and Use of Complaint Mechanisms

In 2013, through an administrative instruction, the Ministry of Health introduced a telephone line for complaints related to healthcare services.[158] The Administrative Instruction aims to 'increase the quality of care and protection of citizens from abuse in the use of health services, as well as identification of health professionals and health institutions that violate the law in the practice of their activity'. The hotline (0800 17777) is free and available 24 hours. People can directly file a complaint regarding health services provided to him or her through this hotline. Several healthcare centres also have 'complaints boxes' where people can address their complaints. KWN researchers observed that all healthcare institutions seem to be placing the Charter of Patient's Rights in visible locations, as required by law.

When asked if they knew how to file a complaint if they were dissatisfied with the quality of medical care they received, 67% of respondents said they knew. Women were slightly less likely than men to know how to file a complaint (p=0.002). In terms of actually filing complaints, of the 90% of respondents who reported dissatisfaction with the services they had received, only eight percent had ever filed a complaint. This substantiates Levizja FOL's findings in their recent report: only two percent of citizens had ever reported the corruption they allegedly faced.[159] Explanations for not reporting corruption included that it is commonplace, not worthwhile, not knowing how to complain and fear of consequences. More generally, there seems to be low trust in governing bodies to address complaints. Further research could examine why people tend not to report dissatisfaction, too.

Only 1.4% of survey respondents reported ever taking a healthcare worker to court. As Table 9 illustrates, very few cases relating to healthcare have been reported to the Kosovo police. Between 2013 and November 2016, police recorded in total only five complaints of 'unauthorized disclosure of confidential information'; 115 reports irresponsible medical treatment; and 21 reports of a 'failure to give medical assistance'.[160] Of the alleged victims during this time period, 51% were women and 49% were men.

Table 9. Cases Reported to Police Related to Healthcare, 2013-2016

| Alleged Crime as per the Criminal Code | Year | # of Cases |
|---|---|---|
| 203 Unauthorized disclosure of confidential information | Total | 5 |
| | 2013 | 1 |
| | 2014 | 0 |
| | 2015 | 3 |
| | 2016 | 1 |
| 260 Irresponsible Medical Treatment | Total | 115 |
| | 2013 | 29 |
| | 2014 | 30 |
| | 2015 | 29 |
| | 2016 | 27 |
| 261 Failure to Give Medical Assistance | Total | 21 |
| | 2013 | 6 |
| | 2014 | 5 |
| | 2015 | 5 |
| | 2016 | 5 |

## Conclusion

Insufficient knowledge of where and how to obtain care seems to prevent many citizens from seeking and accessing healthcare, including family planning information. Providers not knowing or wanting to know modern information hinders citizens' access to current health information. This was especially obvious when it came to family planning methods, as some healthcare workers still recommended withdrawal and demonized hormonal contraceptives due to their potential side effects.

When citizens did access the healthcare system, rights abuses have been reported to occur. Although the numbers of misdiagnoses and discrimination cases may seem small, they demonstrate that rights violations do exist. It seems that the patient's right to be informed

[158] Administrative Instruction (Health) No. 19/2013 Telephone line for citizen complaints in Health Service.
[159] Levizja FOL, 2016.
[160] Information provided to KWN by Kosovo police via email, 15 November 2016.

about his or her state of health may not always be respected, particularly if health professionals withhold such information at the request of the patient's relatives or on paternalistic grounds. One in five respondents did not consider confidentiality their right, and widespread violation of confidentiality seemed to occur. This includes reporting diagnoses in front of others or directly to family members, not storing records safely and doctors talking about which patients they saw. Violations of confidentiality prevent people from accessing care, particularly when they do not want others to know that they are seeking care.

Very few people reported rights violations when they occurred. This makes it difficult to address such violations and encourage improved behaviour, potentially preventing future rights violations.

# Recommendations

The recommendations are divided according to areas for further research, themes for awareness-raising and policy recommendations.

## Areas for Further Research

This report offers a first cut at a rich data set with great potential. Due to time and focus, several aspects of the survey findings are not analysed here and can inform future publications. There are several areas that the team felt merit further investigation:

- The current data does not delineate between each level of the public and private healthcare system, regarding where people access which services. Understanding how often people enter at the secondary or tertiary care level and for which services, despite current laws against this practice, is important.
- Preventive care such as general health exams and cancer screenings should be evaluated carefully in the socioeconomic context of Kosovo. WHO offers guidelines for low and middle income countries through its cancer control programme, including how to decide which program to implement.[161] Further research can examine different methods for screening, as well as which trainings related to such programmes would be suitable for healthcare professionals in Kosovo. If introduced, screenings should be monitored and evaluated scientifically.
- Further investigation into the non-prescription obtainment of prescription drugs is vital to ascertain what must be done to address it. Understanding what drugs are being obtained, under whose recommendation and why is critical.
- Given the prevalence of abortion, more data is needed including from regular reporting by public and private institutions. This research did not examine the timing or medical reasoning ('legacy') for abortions. Better understanding of the relationship between low contraceptive use and abortion also is needed. Such information could inform education programs for pupils and citizens about reproductive health in general.
- Further research about healthcare providers is needed. Little is known on how prescription and referral decisions are made, how hierarchy interferes with achieving health outcomes, how the pharmacy industry influences doctors' decisions or working conditions, including gender inequality at work.[162]
- The simultaneous employment of healthcare workers in both public and private healthcare facilities should be further investigated. Working hours and wages need to be examined, towards recommending evidence-based policies that address the conflict of interest that may arise from employment in both sectors. Perhaps examining experiences from Macedonia could be useful in considering a restriction of workplace for Kosovo.

[161] WHO, *WHO Position Paper on Mammography Screening*, 2014; WHO website on cancer, accessed 5 Dec. 2016, at: http://who.int/cancer/en/.

[162] The only published studies found on health workers and their education in Kosovo included: van der Veen et al., *Integrating staff well-being into the Primary Health Care system: a case study in post-conflict Kosovo,* 2015; and Goepp et al., *Challenges and promises for nurse education curriculum development in Kosovo: Results of an "accidental ethnography"*, Rochester: 2008.

- This research did not examine access to rehabilitation as part of the healthcare system. Little is known about inpatient or outpatient rehabilitative care (e.g., physiotherapy, supportive and psychosocial therapy).
- In this data set, socioeconomic data were not internally consistent. Therefore, findings could not be analysed by socioeconomic status. It would be interesting to examine the impact of socioeconomic status on access to and utilization of healthcare.
- Additional research could examine how to improve access to healthcare among ethnic minorities, as ethnicity consistently was correlated with differences in utilization of and access to healthcare. Further inquiry should focus on Bosnians, Turks and Gorani, particularly women, who tended to face more barriers than other minority ethnic groups.

## Themes for Awareness Raising

- A Kosovo-wide campaign explaining the healthcare system and providing information on which services can be obtained where could contribute to increasing utilization of primary healthcare. This should include information about where to obtain family planning information. Different options for screenings, including for cancer, can be better communicated to the public, improving understanding. Awareness-raising should target residents of rural areas, particularly women, with information about the services that MFMCs provide. This could contribute to increasing usage of primary healthcare and decreasing their perceived barriers to access.
- The widespread ignorance of the right to confidentiality and what this entails could be tackled in an awareness campaign, targeted at providers, patients and the public.
- The collusion of doctors with the pharmaceutical industry is illegal. An educational campaign for citizens and providers should encourage reporting of this crime.
- Public education regarding the legal requirements for and importance of prescriptions is needed, communicating the value that prescriptions have for both individual and public health and raising awareness about existing laws.

## Policy Recommendations

While further research is needed to make recommendations for specific actions on several of the aforementioned points, the research findings do point to a few areas for policy interventions.

- As cost was a consistent barrier to accessing healthcare and few people have private health insurance, the long-awaited Health Insurance Fund needs to be operationalized and a sustainable way of financing it identified.
- Continuing education of healthcare workers regarding family planning should be enforced to provide the public with more information about the different contraceptives available, their advantages and disadvantages, including strategies for discussing contraceptives with men. Perhaps nurses can play an enhanced role in providing family planning information.
- Existing drug regulations need to be enforced. The commonly reported practice of pharmacies selling prescription medication without a prescription, and/or without the presence of a licenced pharmacist, must have consequences, as stated by law. Drugs that are not registered in Kosovo, but seem widespread (such as misoprostol) should be evaluated and either licensed or forbidden with the respective consequences.

- Pharmacies need better oversight through unannounced inspections, which can identify and take measures against pharmacies providing prescription pharmaceuticals without or against a doctor's prescription.
- Regular inspections should involve visits to all public and private clinics, including seeking to identify any private clinics that may be operating without appropriate authorization. Attention should be paid to visible, obvious violations of patients' rights to confidentiality.
- HIS implementation, albeit within the foreseen timeline, could be improved, especially regarding confidentiality. Computers should be provided and systems updated to enable modern and accurate case management that protects the privacy of patients. Staff must be trained accordingly and use of such systems must be enforced.
- Related, the Ministry of Health should request the registration of abortion figures, including the sex of aborted foetuses from all institutions, public and private, that are performing abortions.
- Also for non-communicable diseases like cancer and cardiovascular disease, the planned disease register does not seem to be fully operational. Cancer data especially is needed to evaluate changes in prevalence and incidence, as well as to serve as a basis for calculating the cost of introducing screening programmes and healthcare measures.

# Appendices

## Appendix 1. Methodology

This appendix further details the research methodology. In order to respond to the research questions outlined in the introduction, the research involved mixed methods, described below.

**The Survey:** Quantitative data were gathered through a household survey of 1,309 individuals, carried out throughout Kosovo.

**Questionnaire:** The survey instrument contained 195 primarily closed-ended questions (see Appendix 2). Carried out using face-to-face interviews, most surveys lasted approximately 40 minutes. Data was collected on Samsung tablets or smartphones, using Kobo Toolbox Data Collection software.

**Piloting:** The survey was piloted in advance of the actual survey in rural and urban areas surrounding Prishtina. This enabled the research team to see if the survey instrument was properly designed and whether citizens understood it. Slight modifications were made based on the pilot.

**Enumerators:** KWN involved enumerators from minority ethnic groups and who spoke multiple languages for surveying diverse groups. Women enumerators interviewed women, and men interviewed men considering the sensitivity of some topics. A list of enumerators is in the acknowledgements.

**Enumerator training:** A mandatory training was organized for all enumerators. The training ensured that they were familiar with the research mandate, human ethics in research, the survey instrument, sampling method, Kobo Toolbox, control procedures and logistics. Students in Dr. Vjollca Krasniqi's course who volunteered as enumerators as part of their education had additional training in research methods and interviewing skills in the weeks leading up to the survey. The other enumerators had prior experience conducting interviews. All enumerators were observed by experienced researchers during their first interview(s) to ensure they were capable of conducting interviews independently.

**Research Sample:** KWN surveyed 1,309 citizens of all ethnic groups, ages 16 and older. KWN selected a random sample of the Kosovo population. The sample was drawn from rural and urban areas, involving randomly selected sampling points in 132 settlements in 36 municipalities. The sample is representative of all ethnic groups in Kosovo as the selection was done using Multistage Random Sampling Method. Stratification of respondents was based on ethnicity and region. Exclusions include people in hospitals, prisons, military facilities and similar.

**Sampling method:** For Albanians, each sampling point had eight households. In the Serb sub-set, each sampling point had five households and in the non-Serb minority sub-set, ten households. Using a randomly selected starting point, researchers used the random route method. Within households, respondents were selected using the 'nearest birthday' technique. After three unsuccessful attempts (first visit and two call-backs), a household/respondent was recorded as no contact.

**Ethnicity:** The sample included Albanians, Serbs and non-Serb minorities (Turkish, Bosnian, Gorani, Roma, Ashkali and Egyptian). Stratification principles were the same for all three ethnic groupings. In order to ensure that there were enough members of certain sub-groups of the population for reliable estimates for that group, KWN oversampled Kosovo Serbs and other minorities. The data was later weighted by ethnicity during the analysis to account for oversampling.

**Geographic Representation:** The research team conducted surveying in all regions and almost all municipalities of the Republic of Kosovo.

**Age and Gender:** Respondents from each household, age 16 or above, were selected randomly according to the nearest birthday technique. This naturally results in a proportional distribution of women and men similar to that of the population.

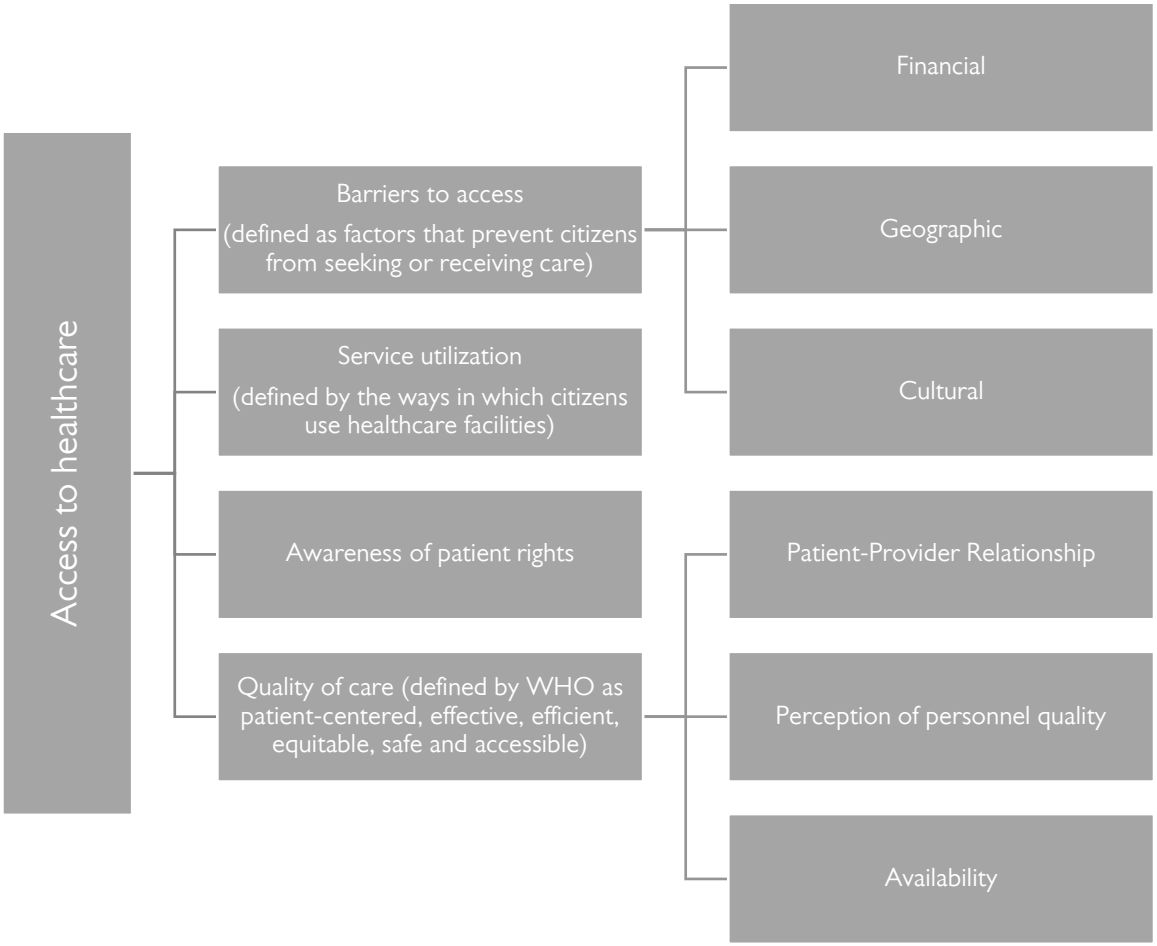
**Control:** Persons not involved in the surveying carried out controls of surveyors. This included random field visits to ensure they were following the sampling methodology and checking the quality of surveyors' work. Controllers also carried out check-backs on a randomly selected sample of 10% of completed surveys to ensure accuracy. The back checking procedure included a brief secondary interview with the selected sample, consisting of five questions from the first interview and a comparison of the first and the second responses of the sample.

**Data analysis:** The Dartmouth College team analysed the survey data using Stata software. Data were weighted by ethnicity to address the over-sampling of minority groups (necessary for drawing any existing statistically significant conclusions based on ethnicity). The data has been weighted based on the 2011 national census data, adding an additional 40,000 Serbs believed to be living in northern Kosovo who boycotted the 2011 census.

**Statistical Analysis:** This report utilizes a 0.05 level of significance. Correlations between strata (gender, residency, ethnicity, region, age and education) and the dimension or aggregate indices were assessed using one-way Analysis of Variance (ANOVA tests). Except for comparisons of scores between regions, significant differences between various sub-groups in the survey sample were assessed using the Šídák multiple comparisons test. For comparisons of scores between regions, mean index scores of a particular region were compared to the mean index scores of the remaining six regions combined using t-tests. Each index table features means scores for each subgroup and the standard error in parentheses.

**Index Scoring:** The researchers grouped questions from the survey into eight indices that correspond with the key research questions. The purpose of an index is to reveal trends across questions by assigning scores to different cohorts in the population surveyed. For example, one cohort analysed was rural women. Creating the index involved compiling all questions relating to service utilization and assessing how rural women answered those questions. Depending on how they answered those questions, they were assigned a score. The same analysis was repeated for rural men, urban women, urban men and so on for each cohort. This enables comparisons regarding how each group answered several questions.

This report includes eight indices (see Figure 2). The primary indices are barriers to access, service utilization, awareness of patient rights and quality of care. The barriers to access index was further delineated by types of barriers: financial, geographic and cultural. Quality of care was further assessed using three components that impact quality of care: patient-provider relationship (whether communication between healthcare providers and their patients is patient-centred and equitable), perception of personnel quality (whether patients receive effective and safe care) and availability (whether institutions have and efficiently use proper equipment and supplies).




Within each index, the included questions must be correlated with each other to ensure they are all measuring the same concept. To assess this, the researchers constructed correlation matrices. Questions that did not correlate with the others were excluded from the index, but are discussed in the body of the text. A list of the questions used to construct each index follows. The starred questions (*) were considered in constructing the index, but were not ultimately included due to lack of statistical fit (i.e. lack of variation in responses, too many missing responses because a segment of the population was not asked the question or chose not to answer, etc.). However, some of these questions are analysed in the report individually.

### Questions Used to Construct Service Utilization Dimension Index

- Have you ever visited the doctor for a general health check-up?
- Have you ever had a laboratory analysis?
- Approximately in which year was the last time that you visited a doctor for a general check-up?*
- Have you ever been treated for a sudden illness?
- Have you ever had a regular medical check-up?
- Have you ever had cervical cancer screening?*
- Have you ever visited the dentist?
- Have you ever had a breast cancer screening?*
- Have you ever received medication from a pharmacy WITHOUT a prescription?
- Have you ever had a colon cancer screening?

- Have you ever received medication from a pharmacy WITH a prescription?
- Have you had a mammogram in the last 3 years?*
- Have you ever visited the gynaecologist / urologist?
- Have you received a pap smear in the last three years?*
- Have you ever been treated for a chronic illness?*
- Have you ever received a colonoscopy?

In this index, while obtaining drugs with a prescription was coded as a positive response, obtaining drugs from a pharmacy without a prescription drug was not included in the index as it is more difficult to categorize.

### Questions Used to Construct the Financial Barriers Dimension Index

- What was the main reason for not consulting a doctor?
- Is getting money needed for medicine a big, little or no problem?
- Is getting money needed for medical care and services a big, little or no problem?
- What are the reasons why you do not feel that you have access to reproductive healthcare? [Recoded for answer choice 'It's too expensive']
- Do you have private health insurance?*

### Questions Used to Construct the Geographic Barriers Dimension Index

- Approximately how long did it take you to get to the facility (door to door)?
- What are the reasons why you do not feel that you have access to reproductive healthcare? [It's too far away]*
- Is distance to the facility a big, little or no problem?
- The last time you went to a health facility how did you get to that facility?*
- Is transportation a big, little or no problem?

### Questions Used to Construct Cultural Barriers Dimension Index

- Is getting permission to go for medical advice or treatment a big, little or no problem?
- Who decides whether you should go to the doctor?
- Is not wanting to go alone a big, little or no problem?
- What are the reasons why you do not feel that you have access to reproductive healthcare? [Family will not allow; unacceptable for me to have these types of services]
- The last time you went to a health facility did you need to ask permission from relatives in order to go?*
- Who decides whether children should go to the doctor?*

### Questions Used to Construct Patient-Provider Relationship Dimension Index

- I feel very comfortable being examined by my physician. [Strongly agree, agree, neither, disagree or strongly disagree]
- Has a doctor or nurse ever explained to you how the different forms of birth control work?
- In my last visit, the doctor explained things to me clearly in words that I could understand. [Strongly agree, agree, neither, disagree or strongly disagree]
- Did your healthcare worker tell you about multiple options for family planning?

- In my last visit, I feel the doctor spent adequate time addressing my concerns. [Strongly agree, agree, neither, disagree or strongly disagree]
- Did the health worker tell you about the potential effects, side effects or problems you might have with different family planning methods?
- During medical visits I am always allowed to say everything I think is important and to ask questions. [Strongly agree, agree, neither, disagree or strongly disagree]
- Do you feel comfortable talking about sexually transmitted diseases and HIV/AIDS with your physician?

Questions Used to Construct Perceived Personnel Quality Dimension Index

- I am very satisfied with the medical care I receive. [Strongly agree, agree, neither, disagree or strongly disagree.]
- I feel doctors respect me and treat me well. [Strongly agree, agree, neither, disagree or strongly disagree.]
- My doctors keep my personal information confidential; they don't share it with anyone. [Strongly agree, agree, neither, disagree or strongly disagree.]
- My doctors are very competent and well trained. [Strongly agree, agree, neither, disagree or strongly disagree.]
- My doctor provides complete and accurate information about treatments and medication. [Strongly agree, agree, neither, disagree or strongly disagree.]
- When I received medical care, I had full privacy (no one came in and out of the room except the doctor/nurse). [Strongly agree, agree, neither, disagree or strongly disagree.]
- A healthcare worker made a mistake with your diagnosis. [Strongly agree, agree, neither, disagree or strongly disagree.]
- The doctor or nurse made an inappropriate or offensive comment to you when you were seeking or receiving care.

Questions Used to Construct Availability Index

- Is it a big, little or no concern that the medicine you need may not be available?
- Is it a big, little or no concern that there may be no equipment available that you need?
- If I had an emergency, it would be easy for me to get medical care. [Strongly agree, agree, neither, disagree or strongly disagree.]
- I usually wait for a long time when I visit the doctor. [Strongly agree, agree, neither, disagree or strongly disagree.]

Questions Used to Construct Awareness Dimension Index

- How much do you think you know about your legal rights to health services?
- Do you have a legal right to health insurance?
- Do you know how to file a complaint if you are dissatisfied with the quality of medical care that you receive?
- Do you have the right for doctors to keep information about you and your health confidential?*

Every question within the index was coded on a 0 to 1 scale, where 0 corresponds with the answer that reflects no impediment to accessing quality healthcare and 1 corresponds with the answer that reflects the greatest barrier to accessing quality healthcare. Each index

represents the sum of all questions within it. Each index was then scaled to range from 0 to 100. A higher score always represents more barriers to accessing and utilizing healthcare. Thus, someone with a score of 0 faces no barriers, while someone with a score of 100 faces the greatest barriers for each indicator that the index addresses.

**Interviews:** Using variation sampling, in all seven regions, the research team conducted between 11 and 20 semi-structured interviews per region (Ferzaj 12, Gjakova 12, Gjilan 14, Mitrovica 11, Peja 13, Prishtina 20, Prizren 12, Vushtrri 11). An additional five interviews were conducted with key informants from NGOs, international organisations and other institutions based in Prishtina. Interviews in pharmacies were all conducted in cities. Of the 88 interviews with physicians and nurses, 16 were done in rural areas and 72 in urban areas with healthcare workers in private (20) and public healthcare institutions (68). This included seeking to interview respondents at a smaller and a larger private clinic in each region. Table 10 summarizes the categories of respondents interviewed.

Table 10. Respondents Interviewed in Health Institutions

| | Psychologist | Doctor | Nurse | Pharmacist | Pharmacy Technician | Other | Total |
|---|---|---|---|---|---|---|---|
| **Primary** | | | | | | | **39** |
| General | | 16 | 16 | | | | |
| Mental Health | 2 | 5 | | | | | |
| **Secondary** | | | | | | | **29** |
| Obstetrics & Gynecology | | 8 | 8 | | | | |
| Medicine specialties (Cardiology, Oncology) | | 6 | 7 | | | | |
| **Private system** | | | | | | | **20** |
| General | | 2 | 3 | | | | |
| Obstetrics & Gynecology | | 8 | 3 | | | | |
| Medicine specialties (Cardiology, Oncology) | | 3 | 1 | | | | |
| **Pharmacy** | | | | | | | **17** |
| Private | | | | 13 | 3 | | |
| Public | | | | 1 | 0 | | |
| **NGOs and International Organizations** | | | | | | | **5** |
| Respondents | | 4 | | | | 1 | |
| **Total of Columns** | **2** | **52** | **38** | **14** | **3** | **1** | **110** |

Within each institution, respondents were selected based on position and then availability. A letter encouraging participation from the Ministry of Health facilitated the process. Separate interview guides were made for different categories of respondents (see Appendix 3). During interviews, researchers also observed the physical situation within the healthcare institution, as well as interactions between personnel and patients, when public.

**Analysis of Qualitative Data:** All qualitative data was transcribed, or in instances when respondents refused to be recorded, notes were taken and later typed. The data then was coded separately by at least one and where possible up to three different researchers, towards triangulation. Interviews were coded as per the research questions, identifying recurring trends as well as variations on those trends. Differences according to public versus private workplace and gender of respondents also were analysed.

**Report Writing and Quality Control:** A diverse team with differing areas of expertise contributed to researching and writing this report, including with professional training in psychology, sociology, anthropology, medicine (doctors, a nurse and a pharmacist), law, international health and healthcare management. They reviewed the draft report for accuracy.

**Peer Review**: The final draft report was sent to members of the Advisory Group, as well as some researchers and key respondents for review and quality control. Revisions were made based on their input prior to publishing.

## Appendix 2. Survey Questions

1. Municipality

2. City/town

3. Type of household Apartment:
Apartment Single-family house Extended-family house / complex

4. Gender: Woman Man
5. In which year were you born? ___

### Ethnicity

6. With which ethnic group do you identify? Select all that apply.
Albanian Serb Roma Ashkali Egyptian Bosnian
Gorani Turkish Other - which other? _____ Prefer not to respond

### Education

7. Do you know how to read and write? Yes No
8. How many years of schooling did you complete? ___

### Household Demographics

9. What is your marital status RIGHT NOW?
Single Married with marriage certificate Married without marriage certificate
Co-habitating Engaged Divorced Widowed

10. How old were you when you were married for the first time?___

11. With whom do you live at home right now?
Immediate birth family (parents, brothers, sisters) Married immediate family (husband/wife, and/or children)
Partner's extended family (mother-, father-, brother-, sister-in-law, etc.)
My extended family (parents, brothers, sisters, and other relatives)
Friends Partner (unmarried) Alone Other – who? _____

12. Altogether, how many people are living in your household right now? ____

### Employment/income

13. What best describes your employment status right now
Work in a paid position outside the home
Do unpaid work outside the home (farming, caring for animals like cows/chickens, etc.)
Do unpaid work at home (childcare, care for elderly gardening, housekeeping, etc.)
Work from time to time (Consultant/seasonal employee)
Unemployed, but looking for a job
Unemployed, not looking for a job
Retired

-- based on this only 14 or 15 should be filled out not both

14. Which of the following best describes the type of employment that you have right now?
Agriculture Food processing Natural resources (mining)
Construction, other manual labor Arts, Audio/Video Business Management and administration
Education and Training Finance Government and Public Administration
Health Science Hospitality and Tourism Human Services
Information Technology Law, Public Safety, Corrections and Security
Manufacturing Marketing, Sales and Service
Science, Technology, Engineering and Mathematics
Transportation, Distribution and Logistics Other - Which other?

15. What are the MAIN reasons you are not working for money? Mark all that apply.
Have care work responsibilities at home (for children, elderly, persons with disabilities)
Have housekeeping work at home (cleaning, etc.) Have to work outside the home (farming, caring for animals like cows/chickens, etc.)
Have not been able to find a job
Do not need to work; family has sufficient income Family does not allow me to work

Still a student | It's not worth it (for the small salary)
Unable to work | Other – which? _____ | Don't know / no answer

16. What is your MONTHLY salary right now: _____

17. Is your partner employed with a salary?
Yes | No

18. Can you estimate your household income FROM THE LAST MONTH (May) from all people and sources? __

19. Does your household receive social assistance? Yes | No | Refuse to answer | Don't know

**Religion**

20. With which religion do you identify?
Islam | Catholic | Orthodox | Protestant | Atheist / no faith | Agnostic/unsure
Other – which? _____ | Prefer not to respond

21. How often do you attend religious services?
Never | Only on special holidays | Once every few months | 1-3 times per month | Once per week | More than once every week

**Political involvement**

22. How active would you say you are in a political party?
Not at all active | Not very active | Somewhat active | Active | Very active | Refuse

Now I would like to know more about you and your family. In the following situations, who would you say makes MOST of the decisions about … (Select all that apply)

**Decision making**

23. Big purchases like a new car or furniture?
I do | My husband / male partner | My wife / female partner | Father
Mother | Father in law | Mother in law | Brother
Brother in law | Grandma | Grandpa | Other – who? ____ | Don't know

24. Whether children should go to the doctor?
I don't have children | I do | My husband / male partner | My wife / female partner
Father | Mother | Father in law | Mother in law | Brother | Brother in law
Grandma | Grandpa | Other – who? _____ | Don't know

25. Whether you should go to the doctor?
I do | My husband / male partner | My wife / female partner | Father | Mother
Father in law | Mother in law | Brother | Brother in law | Grandma | Grandpa
Other – who? _____ | Don't know

26. Who in your family has the final say when an important decision has to be made?
I do | My husband / male partner | My wife / female partner | Father | Mother
Father in law | Mother in law | Brother | Brother in law
Grandma | Grandpa | Other – who? _____ | Don't know

**Now I have some questions about your surroundings and where you live. Please rate the situation in the environment where you live.**

27. Please rate the environment where you live:
Very poor | Poor | Fair | Good | Very good

27.1. How is the air quality where you live?
Very poor | Poor | Fair | Good | Very good

27.2. How is the water quality where you live?
Very bad | Bad | Neither good nor bad | Good | Very good

27.3. How is the quality of the soil where you live?
Very bad | Bad | Neither good nor bad | Good | Very good | Don't know

27.4. How is the situation with solid waste where you live (like garbage from households, industries or hospitals)?

Very bad Bad Neither good nor bad Good Very good Don't know

27.5. To what extent is contaminated food a problem for you and your family? Very big problem
Very big problem Somewhat a problem Not a problem at all Don't know

29. In your opinion is there anything in your day-to-day environment that affects your health or the health of your family? Yes No What? _____

30. In your opinion, to what extent does the environment where you work each day impact your health?
Very much Somewhat Very little Not at all Don't know

31. In your opinion, how clean is the air that you breathe on a day-to-day basis?
Very good Good okay bad very bad

32. To what extent do each of the following contribute to air pollution in your area?

32.1. Emissions from cars and trucks
Does not contribute to air pollution
Very little Little Somewhat A lot Extremely a lot / very much Don't know

32.2. Power plants
Does not contribute to air pollution
Very little Little Somewhat A lot Extremely a lot / very much Don't know

32.3. Factories
Does not contribute to air pollution
Very little Little Somewhat A lot Extremely a lot / very much Don't know

32.4. Gases from burning oil, gas, coal, or wood for heating and cooking
Does not contribute to air pollution
Very little Little Somewhat A lot Extremely a lot / very much Don't know

32.5. Smoke from tobacco
Does not contribute to air pollution
Very little Little Somewhat A lot Extremely a lot / very much Don't know

33. What is the primary source of heating in your home during the winter?
Wood Coal Electricity Pellets Oil Central heating Other – which? _____

Knowledge of rights

34. How much do you think you know about your legal rights to health services?
I have no knowledge on this topic I know a little about this topic I have average knowledge about this topic I know a lot about this topic

35. Do you have a legal right to health insurance? Yes No Don't know

36. Do you have the right for doctors to keep information about you and your health confidential? Yes No

37. Do you know how to file a complaint if you are dissatisfied with the quality of medical care that you receive?
Yes No

38. Can family medicine centres provide gynaecological and reproductive health services or are these only available from gynaecologists?
Family medicine centres can provide these services Only gynaecologists can provide these services Don't know

Attitude/opinion:

Now I have some questions about your opinion on different matters. For the following questions please tell me the extent to which you agree or disagree with the statements I'll read to you. For example, do you strongly agree (5), agree (4), neither agree nor disagree (3), disagree (4), or strongly disagree (5)?

39. Women should be strong and not need to visit the doctor
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

40. Women who are single, including widows, have no reason for gynaecological check-ups
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

41. Regular health check-ups are a waste of money
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

42. If I were sick I'd go to the doctor.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

43. When someone is very upset, taking a tranquilizer is a normal way to calm down.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

44. Women who have finished having children do not need gynaecological check-ups anymore
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

45. Men should be strong and not need to visit the doctor
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

Now I would like to ask you some general questions about your health…

Status of health

46. How is your health in general?
Very Good Good Fair Poor Very Poor Don't know

47. Compared with 12 months ago, would you say that your health is now:
Much better Somewhat better Same Somewhat worse Much worse Don't know

48. Do you have any longstanding illness or health problem? By longstanding, I mean illnesses or health problems which have lasted, or are expected to last, for 6 months or more. Yes No

49. What longstanding illness or health problems do you currently have?

| | | | |
|---|---|---|---|
| Chronic back pain | Chronic pain in legs | Broken bone(s) | Headaches |
| Abdominal pain | Pain or problems in private parts | Chronic coughing | Breathing problems |
| Problems with teeth | Stomach pain | Depression | Sleeping problems |
| Stress | Chronic nervousness | Low blood pressure | High blood pressure |
| Heart problems | Thyroid problems | Rheumatism | Difficulties remembering |
| Allergies | Prostate problems | Breast Cancer | Uterus Cancer |
| Ovarian Cancer | Other form of cancer | Asthma | Shaking Hands |
| Ulcer | Other – which? _____ | None (I have no health problems) | |

50. For at least the past 6 months, to what extent have you been limited because of a health problem in activities people usually do? Severely limited, Limited but not severely Not limited at all

Likelihood of consulting doctor/ access to

51. Was there any time during the past 12 months when you really needed to consult a doctor but did not?
Yes, there was at least one occasion No, there was no occasion

52. What was the main reason for not consulting a doctor?

Could not afford to (too expensive or not covered by insurance)
Still on a waiting list or the waiting list was too long
Could not take time because of work, care for children or for others
Too far to travel / no means of transportation
Fear of doctor / hospitals / examination / treatment
Wanted to wait and see if problem got better on its own Didn't know any good doctor
Other reason – which? _____ Don't know Refusal

53. Was there any time during the past 12 months when you personally really needed dental examination or treatment but did not get it? Yes, there was at least one occasion No, there was no occasion

54. What was the main reason for not consulting a dentist?

Could not afford to (too expensive or not covered by insurance)
Still on a waiting list or the waiting list was too long
Could not take time because of work, care for children or for others
Too far to travel / no means of transportation
Fear of doctor / hospitals / examination / treatment
Wanted to wait and see if problem got better on its own Didn't know any good doctor
Other reason – which? _____ Don't know Refusal

**Diagnosis?**

55. Has a doctor diagnosed you with any chronic illness or disability that has lasted more than 3 months (including severe depression)? Yes No Don't know

56. If you are willing to share such information with me, what type of illness(es) or disability(s) do you have?

Asthma Broncho-pneumonia Tuberculosis Autonomic dysregulation Deformities at birth
Cancer Chronic Fatigue Heart disease Crohn's disease Infectious diseases
Diseases of the blood (haemophilia, thalassemia, leukaemia, etc.) Diabetes
Hypertension/hypotension
Thyroid problems Lupus Multiple sclerosis Parkinson's disease Polio
Arthritis Scleroderma Epilepsy Sleep apnea Problems of the stomach
(ulcers, gastritis, etc.) Urinary infections Bone and ligament diseases Seeing disabilities
Hearing disabilities Problems speaking Mobility problems Manipulation disabilities
Mental retardation Mental illness Chronic pain Other – which? _____

57. Have you ever visited the doctor for a general health check-up? Yes No

58. Approximately in which year was the last time that you visited a doctor for a general check-up? _____

59. In the last 12 months how many times did you visit a PUBLIC health care institution? _____

60. In the last 12 months how many times did you visit a PRIVATE health care institution?_____

**Permission:**

61. Last time you went to a health facility did you need to ask permission from relatives in order to go? Yes No

**Distance:**

62. The last time you went to a health facility how did you get to that facility?

On foot On bus/mini-bus By taxi By personal car By animal/cart
Other – which? _____ Don't remember / Don't know

63. Approximately how long did it take you to get to the facility (door to door)? Minutes: _____

64. In total, approximately how much did the travel expenses cost to go there and return? _____

**Cost:**

65. In the last 12 months, approximately how much money have you spent in total on healthcare related services for yourself only, such as visits to the doctor and dentist? _____

66. In the last 12 months, approximately how much money have you spent in total on tests related to your health like blood analyses or X-rays? _____

67. In the last 12 months, approximately how much money have you spent in total on pharmaceutical products?

68. Can you receive any pharmaceutical products free of charge? Yes No Don't know

**How often have you received the following types of health services in the last 5 years?**

69. Regular medical check-up:

Never Once 2-4 times Every year >1 per year Don't know

70. Visit to dentist

Never Once 2-4 times Every year >1 per year Don't know

71. Medication from pharmacy WITHOUT a prescription

Never Once 2-4 times Every year >1 per year Don't know NA

72. Medication from pharmacy WITH a prescription

Never Once 2-4 times Every year >1 per year Don't know NA

73. Visit to the gynaecologist / urologist

Never Once 2-4 times Every year >1 per year Don't know NA

74. Treatment for chronic illness

Never Once 2-4 times Every year >1 per year Don't know NA

75. Laboratory analysis

Never Once 2-4 times Every year >1 per year Don't know NA

76. Treatment for sudden illness
Never Once 2-4 times Every year >1 per year Don't know NA

77. Cervical cancer screening
Never Once 2-4 times Every year >1 per year Don't know NA

78 Breast cancer screening
Never Once 2-4 times Every year >1 per year Don't know NA

78.2 Colon cancer screening
Never Once 2-4 times Every year >1 per year Don't know NA

**Persons prioritized for care**

79. In your family, if only ONE person could be sent for a regular check-up, who do you think the family would most likely send?

No one, we're all the same Woman Man Older man Older woman
Girl Boy Infant (male) Infant (female)

80. What is the MAIN reason this person would be sent?

The person is sick The person is more likely to be sick The person is more important to the family
The person is the decision-maker Other – which? _____

**Problems with access:**

Many different factors can prevent people from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, are any of the following issues a big problem, little problem or no problem for you?

81. Getting permission to go for medical advice or treatment
Big problem Little problem Not a problem Don't know

82. The distance to the health facility
Big problem Little problem Not a problem Don't know

83. Transportation
Big problem Little problem Not a problem Don't know

84. Not wanting to go alone
Big problem Little problem Not a problem Don't know

85. Getting money needed for medical care and services
Big problem Little problem Not a problem Don't know

86. Getting money needed for medicine
Big problem Little problem Not a problem Don't know

87. Concern that there may not be a health provider with the same gender as me
Big problem Little problem Not a problem Don't know

88. Concern that the medicine I need may not be available
Big problem Little problem Not a problem Don't know

89. Concern that there may be no equipment available that I need
Big problem Little problem Not a problem Don't know

90. Having trust in the doctors to be honest and professional
Big problem Little problem Not a problem Don't know

91. Discussing your mental or psychological health with your physician
Big problem Little problem Not a problem Don't know

92. Do you have private health insurance? Yes No

**Preference for private or public**

93. Do you prefer to go to public or private healthcare institutions? Public Private No preference

94. What is the MAIN reason that you have this preference? It's less expensive It's better quality care
It's closer to me I know people there It has the specific type of care I need Other reason – which?___

Access to Reproductive healthcare

95. Do you feel you have adequate access to SEXUAL and reproductive health-care services if you need them, including for family planning (like use of contraceptives)? Yes No

96. What are the reasons why you do not feel that you have access?
Family will not allow
It is unacceptable for me to have these types of services (e.g., because unmarried, widow, etc.)
It's too expensive It's too far away
I don't know where to go Other reason – which? _____

Now I have some questions about your experience accessing healthcare services. How strongly do you agree or disagree with each of the following statements:

97. If I had an emergency, it would be easy for me to get medical care
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

98. I feel very comfortable being examined by my physician
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

99. I am very satisfied with the medical care I receive
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

100. I usually wait for a long time when I visit the doctor
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

101. I feel doctors respect me and treat me well
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

102. In my last visit, the doctor explained things to me clearly in words that I could understand
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

103. In my last visit, I feel the doctor spent adequate time addressing my concerns
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

104. My doctors keep my personal information confidential; they don't share it with anyone
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

105. My doctors are very competent and well trained
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

106. During medical visits I am always allowed to say everything I think is important and to ask questions
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

107. My doctor provides complete and accurate information about treatments and medication
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

108. When I received medical care, I had full privacy (no one came in and out of the room except the doctor/nurse)
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

Discrimination

109. In my lifetime, I feel I have been discriminated against by a healthcare worker because of my gender.
Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree Don't know

110. Please tell me what happened if you are willing. _____

111. If you were ever dissatisfied with services, did you complain? Yes No N/A (I wasn't ever dissatisfied)

Experience accessing healthcare Have any of the following situations ever happened to you?

112. Doctors took your blood to do an HIV/AIDS test without your consent. Yes No

113. A healthcare worker spoke about your disease or treatment in front of other patients or to other patients.
Yes No

114. A healthcare worker made a mistake with your diagnosis: Yes No

115. You took a healthcare worker to court because he/she was unprofessional. Yes No

116. The doctor or gyneacologist diagnosed you with cancer without running any tests. Yes No

117. The doctor told you that it was essential for you to have surgery, but you later found out from other doctors that you did not need surgery. Yes No

118. The doctor or nurse made an inappropriate or offensive comment to you when you Yes No

119. The doctor or nurse touched you in an inappropriate sexual way that did not seem necessary as part of the procedure. Yes No

120. If yes to any of these, please tell me more about what happened if you are willing. _____

Sexual activity:

123. Have you ever been sexually active? Yes No

124. Are you sexually active currently? Yes No

125. Do you prefer to engage sexually with: Men Women Men and Women No one

126. Have you ever engaged sexually with a person of the same sex as you? Yes No

Contraception

127. Do you currently use any contraceptive method? A contraceptive method is way to prevent unwanted pregnancy. Yes No

128. What methods are you currently using to prevent pregnancy? Select all that apply.

No method Female sterilization Male sterilization Pill IUD
Injectables/injection of hormones Implants Condom Female condom
Diaphragm Foam/jelly Withdrawal
Rhythm method (meaning refraining from sex while ovulating, which is that time of the month when you are more susceptible to become pregnant) Other – which? _____

129. What is the MAIN (one) reason that you are NOT using a contraceptive method?

Not married I/we want to become pregnant Infrequent sex / no sex Menopausal / hysterectomy / mastectomy Physically unable to have children I'm opposed to using contraceptive
My husband / wife / partner is opposed to using contraceptives
My family members are opposed to us using contraceptives My religion prohibits it
I don't know how to use these methods I don't know about any method
I don't know where to get contraceptives Contraceptive methods don't work for me
I'm worried of how contraceptives will impact my health or their potential side effects
I do not have access to contraceptives or they are too far away Contraceptives cost too much
Contraceptives are inconvenient to use Contraceptives interferes with my body's normal processes
I /my wife just gave birth and/or still breastfeeding Other reason – which? _____ I don't know

130. Where did you first obtain your CURRENT contraceptive method or learn how to use the method you use?

Public hospital/maternity centre Public health center (like Family Medical Centre)
Private hospital/clinic Private pharmacy Private doctor NGO
Shop Church, mosque, religious institution
Friend/relative Husband/wife/partner Media Internet

131. Does your husband/wife/partner know that you are using a method of family planning? Yes No

132. Would you say that using contraception is mainly your decision, mainly your husband's/wife's/partner's decision, or did you both decide together?

Mainly my decision Mainly my partner's decision Joint decision

133. Do you know of a place where you can obtain a method of family planning? Yes No

134. Has a doctor or nurse ever explained to you how the different forms of birth control work? Yes No

135. Did your healthcare worker tell you about multiple options for family planning? Yes No

136. Did the health worker tell you about the potential effects, side effects or problems you might have with different family planning methods? Yes No

### Family Planning Campaigns

137. Heard about family planning on the radio? Yes No
138. Seen anything about family planning on the television? Yes No
139. Read about family planning in a newspaper, magazine, or on the internet? Yes No

### Pregnancy/Children

140. If you could go back to the time you did not have any children (or if you do not have any children), and you could choose exactly how many children to have in your whole life, how many would that be? _____

141.1. How many of these children would you like to be boys? _____

141.2. How many would you like to be girls? _____

142. Have you ever given birth? Yes No

142.1. How many children have you had in total? _____

143. How old were you when you had your first child? _____

144. At the time you or your wife became pregnant did you want [her] to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all? Then Later Not at all

144.2. Where did you give birth? (select all that apply) At home At a public hospital At a private clinic

145. When you were pregnant with your last child did you receive prenatal care? Yes No

146. What was the main reason or reasons why you did not receive prenatal care?
Don't think its necessary Partner would not allow Family would not allow
Too expensive Too far away Could not get time off of work
Didn't know it was important Other reason – which? _____

147. Whom did you see? Health personnel Family doctor Obstetrician/gynaecologist Nurse/midwife Other – which? _____

### Caesareans

148. From your births, how many deliveries involved a caesarean? _____

149. How many births were carried out naturally without a caesarean?_____

150. In any of your caesarean operations, did you feel pressured to have a caesarean by the doctor, even though you yourself did not feel you needed one? I felt pressured No, I did not feel pressured

151. While you were giving birth, were you allowed to have a close family member in the room with you?
Yes No

152. Have you ever had any of the following problems with your pregnancy? Select all that apply.
Miscarriage Abortion Stillbirth None of these

153. After you had a miscarriage, did doctors intervene in your fallopian tubes without your consent? Yes No

### Abortion

Now I have some more questions for you to respond to on your own using this device. Again, your responses will be completely anonymous. No one will know what you responded to these questions.

154. Have you ever felt pressured to HAVE an abortion? Yes No
155. Have you ever felt pressured NOT to have an abortion? Yes No
156. Have you ever felt forced to have additional children when you did not want to? Yes No
157. Do you feel comfortable talking about sexually transmitted diseases and HIV/AIDS with your physician? Yes No
158. Do you feel comfortable discussing family planning with your physician? Yes No
159. If you thought you might have a sexually transmitted disease, would you visit a doctor? Yes No
160. Have you ever had an abortion? Yes No
161. How many _____

162. How was the abortion(s) performed?
Self-induced with pills Self-induced physically At a private clinic At a public clinic
By family By persons known to family Other – which? _____

163. Did a doctor recommend that you take the pills? Yes No

164. For what reason or reasons did you decide to have an abortion?
Too expensive to have a child School Unwanted child It was a girl and I/we wanted a boy
It was a boy and I/we wanted a girl I was pressured by family Unmarried
Too young to have a child Other reason – which? _____

165. After having the abortion, did the health care provider inform you about different family planning and contraception methods available in Kosovo? Yes No

## Check-ups

166. Mammograms use X-rays to create a picture of the breast to detect cancer. Have you ever heard of a mammogram or breast cancer screening? Yes No
167. Have you received had a mammogram in the last 3 years? Yes No
168. Another diagnostic procedure is a pap-smear, in which a doctor or nurse scrapes cells from inside the vagina for examination under a microscope. It is used to detect cancer and changes that may lead to cancer. Have you ever heard of a pap-smear? Yes No
169. Have you received a pap smear in the last three years? Yes No
168.1. A colonoscopy is a test that allows your doctor to look at the inner lining of your large intestine (rectum and colon). He or she uses a thin, flexible tube. A colonoscopy helps find ulcers, colon polyps, tumours, etc. Have you ever received a colonoscopy? Yes No
169.1. Have you received a colonoscopy in the last five years? Yes No

## Cancer

170. If I may ask, has anyone in your household, meaning living under this roof, been diagnosed with cancer since 2000? Yes No
171. In total, how many people in your household have been diagnosed with cancer since 2000? _____
171.1. What is the gender of the person? Woman Man
171.1.2 What was the age of the person when they were diagnosed? _____
171.1.3. In what year was the person diagnosed?_____
171.1.4. What type of cancer did the person have?
Breast Colon Stomach Ovarian Brain Skin Lung Other Which? _____
171.1.5. Was the person able to receive treatment? Yes No
171.1.6. For what reasons was the person unable to receive treatment?
Its unavailable in Kosovo Unaffordable The person did not want treatment
The family did not support Other – which? _____

## Painkillers/Drug addiction

172. How often would you estimate you take pain killers like aspirin, acetaminophen, paracetamol, andol, naproxen, diclofenac, or brufen?
I never took them A few times per year Every few months Every month
A few times per month Every week Every few days Every day

173. How often would you estimate you take pain killers like morphine, opioids, oxycodone, methadone, trodon, or fentanyl?
I never took them A few times per year Every few months Every month
A few times per month Every week Every few days Every day

174. How often would you say you take pills that help you sleep like Bensedin or Diazepam?
I never took them A few times per year Every few months Every month
A few times per month Every week Every few days Every day

175. What made you decide to take these pills?
My choice A doctor recommended A friend suggested My family suggested

176. Who from your family?
Husband / partner Wife / partner Mother Father Sister Brother

Aunt Grandma Grandpa Cousin Other who? _____

177. When you get upset [nervous], do you sometimes take tranquilizers to calm down such as Xanax, Valium, Diazepam, Lexilium or Bensedine? Yes No

178. How often would you estimate you take tranquilizers?
I never took them A few times per year Every few months Every month
A few times per month Every week Every few days Every day

179. What made you decide to take these pills?
My choice A doctor recommended A friend suggested My family suggested Other _____

Smoking

180. Do you currently smoke cigarettes? Yes No
181. In the last 24 hours how many cigarettes did you smoke? _____
182. At what age did you start smoking regularly?_____
183. Have you tried to stop smoking in the past 12 months? Yes No

184. In what ways do you believe smoking can cause health problems?
Lung cancer Throat or larynx cancer Problems in the vocal chords or larynx Chronic bronchitis Asthma Heart disease Stroke Impotency in men
Complications in pregnancy Other – which? _____ Don't know

Alcohol

185. In the last 12 months how frequently have you had at least one alcoholic drink such as beer, wine, rake, or other spirits?
Never Less than once a month 1-3 times per month Every week 1-4 days per week 5-6 days per week Every day

186. When you drink alcohol, on average how many drinks do you have each time/day? _____

Discrimination

187. Have you ever felt that your rights to health services have been violated BECAUSE you are a woman?
Yes No

188. If you are willing, please tell me what happened, including if you reported the case. _____

189. Is there anything else you want to talk to me about or tell me about? _____

190. Can one of my colleagues contact you for further information about your responses in the future if needed?
Yes No

## Appendix 3. Qualitative Interview Guides

Interview Objective(s):
- Better understand the patient-provider relationship from the healthcare workers/key informants
- Understand the factors that may prevent the provision of comprehensive, quality care including structural/systemic issues and provider mentality

### 1. Introductions

| | | |
|---|---|---|
| Date | Name | Position |
| Institution | Phone | Email |

### 2. Questions

- I'm interested to learn more about you: why did you choose to work as a healthcare worker?
- In what year approximately did you start working in the field of healthcare?
- What are the biggest challenges that you face in your work as a healthcare worker?
  - Do policies exist to address these problems?
  - Why do you think they are not working?
- What do you consider the biggest challenges to **women's** access to healthcare in Kosovo right now?
  - What concrete steps do you think could be taken to address this?
- Is this the only health care facility you are currently working at? [Probe: do you work somewhere else as well like at your own private clinic or another clinic?]
  - Have you always worked in the (public/private) sector?
  - What is your main reason for working in both public and private clinics?
  - What was your main reason for switching from public to private/vice versa (if relevant)?
- As a healthcare provider, what are the differences you see between private and public facilities?
  - Is one better or worse than another?
  - For what reason?

*Health workers' place in the health system*

- Please describe what the conditions are like where you work.
- Have the conditions changed since you started working, and if so, have they improved or become worse?
- Have there been any key changes in regulatory or governmental policies that have improved or made your work more difficult?
- What does a typical day at the office look like for you?
  - How many patients do you see in a day?
    - How many of these are women?
  - Do you usually see patients of the same gender as yourself?
    - Has a patient ever expressed discomfort with your gender?
- What are the (three) most common reasons that people come to see you?
- To what extent do you feel confidentiality is respected in your institution?
  - For what reasons?
    - In your experience, does the examination and diagnosis of patients usually take place with the patient alone or with other patients present in the room?
    - If a patient arrives with his or her family, do the family members stay in the room while you examine the patient?
    - Should family members know the patient's diagnosis?
- When diagnosing a patient, how much do you normally discuss or explain the diagnosis to the patient?

- Why? (Or why not)?

*Challenges*

- What are some of main problems you have observed patients struggling with?
  - When a patient needs care/drugs but cannot pay, what do you do?
- About half of the survey respondents identified as a major concern that the medicine or equipment they need may not be available. Why do you think this may be?
- Have you been in a situation where the equipment you need to properly perform your job was unavailable or broken?

*If yes:*

  - Diagnostic vs surgical equipment?
  - What equipment?
  - Is this a reoccurring problem?
  - What happens to patients if you do not have the equipment that they need?
- Are the pharmaceutical supplies you need always available?

*If no:*

  - Are there any chronic shortages?
  - If what you need is unavailable, what do you do?

*Situation within the larger healthcare ecosystem*

- Do you feel supported by the infrastructure?
- Are you satisfied with the trainings provided by the government?

ADDITIONAL SPECIFIC QUESTIONS FOR EACH GROUP

*The following questions were asked of specific respondents based on their occupation.*

ALL DOCTORS INCLUDING MENTAL HEALTHCARE WORKERS

- To what extent do you feel the confidentiality is respected in your institution?
  - For what reasons?
    - In your experience, does the examination and diagnosis of patients usually take place with the patient alone or with other patients present in the room?
    - If a patient arrives with his or her family, do the family members stay in the room while you examine the patient?
    - Should family members know the patient's diagnosis?
- When diagnosing a patient, how much do you normally discuss or explain the diagnosis to the patient?
  - Why? (Or why not)?
- In your experience, do people in Kosovo go to see a physician, even when nothing is wrong, for a general check-up? Why or why not, do you think?
- Who is responsible for collecting data about patients?
  - How is it maintained: electronically, hard copy or both?
  - What is this data used for?
- If someone were to file a complaint against you, what would be the process for investigating or following up on the complaint?
- Generally, how do you think your facility/staff could improve the delivery of healthcare provided at your facility

BOTH PRIMARY CARE AND OB/GYN DOCTORS

*Contraceptives/family planning*

- Who usually initiates discussions of family planning: the patient or you?
- When in the process of providing treatment, if at all, do you discuss family planning / contraceptives with patients?

    - With women, men or both?
    - With women over which age or marital status?
- Do you tend to explain several potential methods or only recommend one that you think will be best for the patient?
    - How do you choose which method to recommend to a patient?
    - Do you explain the side effects of different methods or how they work?
- *Who should make the decision about a woman wanting to begin using a contraceptive method?*
    - *What if a woman wants to use or change her contraceptive against her partner's will?*
- If a woman wants to get access to family planning, can she do so easily?
    - Do families, religious institutions, or other actors create obstacles for women receiving family planning?
- *Do patients seem uncomfortable or embarrassed when discussing family planning with you?*
- How much do women pay for consultations related to family planning and contraceptives?

ONLY ASK IF PRIMARY CARE DOCTOR

- Does this Family Centre provide care to citizens who can't come to the centre, like through home visits?
    - How often do home visits take place?
    - What is the most common reason for home visits?
- What are the most common problems you refer your patients to specialists for: (rank top three)
    - When you refer, are patients able to get the care they need? (for example is the waiting list so long, it's too expensive, it's too far, etc. that they must come back to you for care?)
    - Do you usually refer patients to one specific specialist you know or to a list of potential specialists?
    - How do you decide to which specialist you refer patients?
    - Do you tell the person why you are referring them/what the next steps will look like?
    - Do specialists ever refer patients to you in case patients are seeking care at the wrong level?

ASK ONLY IF OBGYN DOCTOR

Abortion:

- What is the process if a woman wants an abortion?
    - Who do women usually come with to discuss or receive their abortion?
    - Do you discuss the women's decision to abort with her family members?
    - How do you decide whether it will be a surgical abortion or if you will prescribe abortion pills?
    - After a woman has chosen to have an abortion, do you discuss future family planning methods?

*Prenatal care*

- Do you regularly provide prenatal care?
- Do you encourage expectant mothers to get prenatal care and if so how?
- What do you see as the main reason women do not get prenatal care?

*Birth/delivery method*

- Do you tend to prefer or recommend C-section or natural birth?
- For what reasons?

ASK ONLY IF PSYCHIATRIST OR PSYCHOLOGIST

Barriers

- Please can you share with us what barriers prevent patients from seeking your help, if any?
- In your experience, how does social status like income, housing or education influence the kind of health issues your patients face, if at all?
    - Is there a difference between women and men?

- What do you consider the biggest challenges to **women's** access to mental healthcare in Kosovo right now?
  - What concrete steps do you think could be taken to address this?
- Are there any other specific influences of mental health issues that you have noticed, such as ethnicity, family issues, work, etc.?
  - Is there a difference between women and men?

*History*

- To what extent do you believe that untreated trauma from the war is affecting mental health issues in Kosovo?
  - How widespread do you believe trauma from the war is in Kosovo?
  - To what extent do you think trauma impacts physical health, if at all?
  - What types of impacts does this have on physical/mental health?
    - Is there a difference between women and men?
- To what extent have rape and/or sexual violence during the war been brought to your attention by patients?
    - Is there a difference between women and men?

Prescriptions/therapy:

- What are the possible therapies available?
- How often do you prescribe drugs?
  - Which types of drugs do you tend to prescribe more often? (antidepressants, tranquilizers, others?)
    - Are there differences between men and women in the types of drugs they tend to need more?
  - Do you explain the side effects of different drugs and how they work when you prescribe them?
- Is it possible to get these drugs without prescription in Kosovo?
- Do you perform psychotherapy?
  - If yes, how often do you treat with psychotherapy?
  - If yes, how long does one therapy last in general (how many times does a patient come?)
  - What are the main topics discussed? - (be general, like trauma, depression, anxiety, addiction etc.)
  - Do you see a difference between men and women?
- About 30% of women and 20% of men survey respondents believe it is normal to take tranquilizers when upset and 15% in total reported taking them. What do you think about this finding? Why may this be?

ASK NURSES

- How are responsibilities generally divided between you and a doctor?
  - What are your primary responsibilities?
- How much time do you spend with patients?
  - In which situations?
  - Is the doctor usually present when you are working with patients?
  - Do you work with the patients before or after diagnosis?
- After the doctor diagnoses a patient, how does he or she usually discuss or explain the diagnosis to the patient?
  - Do you discuss/explain the diagnosis to the patient?
  - For what reasons?

ASK BOTH PRIMARY CARE AND OB/GYN NURSES

*Contraceptives/family planning*

- Do you discuss family planning / contraceptives with patients?
  - With women, men or both?
  - With women over which age?
- If a woman wants to get access to family planning, can she do so easily?
  - Do families, religious institutions, or other actors create obstacles for women receiving family planning?
- Who usually initiates discussions of family planning: the patient or you?
- Do you tend to explain several potential methods or only recommend one that you think will be best for the patient?
  - How do you choose which method to recommend to a patient?
- What discussion or explanation usually follows after recommending a method to a patient?
- Who has the primary responsibility of educating someone about family planning? (i.e. husband, mother, school, government etc.)

ONLY ASK IF PRIMARY CARE NURSES

*Culture of primary care*

- What are the (three) most common reasons that you see people seek out primary care?
  - In your experience, do people in Kosovo go to see a doctor, even when nothing is wrong, for a general check-up? Why or why not do you think?
  - Does this Family Centre provide care to citizens who can't come to the centre, like through home visits?
    - How often do home visits take place?
    - What is the most common reason for home visits?
    - Who normally goes on the home visit?
  - What role do you play in the referral process from primary to secondary care?

ASK ONLY IF OBGYN NURSES

*Abortion*

- What is the process if a woman wants an abortion?
  - Who do women usually come with?
  - Do you discuss the women's decision to abort with her family members?
  - After a woman has chosen to have an abortion, do you ever discuss future family planning methods?

*Prenatal care*

- Do you regularly provide prenatal care?
- Do you encourage expectant mothers to get prenatal care and if so how?
- What do you see as the main reason women do not get prenatal care?

ASK PHARMACISTS

Pharmacists in the healthcare system: consultation

- What all does your job encompass?
  - Do you provide consultation to women on health issues?
  - Do you provide consultation after they have seen a doctor?
  - How often do women come to you without seeing a doctor?
    - Do your patients ever describe why this occurs?
- In which cases do you prescribe or distribute medicine that was not recommended or prescribed by a doctor?
  - Do you sell more medication to individuals without a doctor's order or with a doctor's order?
  - What kinds of medications can you give without a physician's prescription?
  - What kinds of medications will other pharmacists provide without a physician's prescription?
  - How do you decide which individuals to give non-prescribed medication to?

- Do you recommend a doctor's diagnosis and prescription before you hand out medication that hasn't been prescribed?
- Do you always follow the prescription guidelines given?
    - Why/why not?
- Are you ever asked to fill prescriptions that do not match the diagnosis?
- Before releasing medication to a person, do you ask what other medications they are currently taken to make sure there is no risk for adverse effects?

Supply and regulation
- How do you maintain a steady supply of the drugs that needed to fill prescriptions?
    - Are there any drugs that are more difficult to keep in stock?
    - Are there any you cannot get?
- Where are most of the drugs in your pharmacy imported from?
- Are there certain drugs that you prefer to recommend? (Why/why not)?

Financial Barriers
- Do patients ever come in to fill a prescription or purchase medication that they are unable to afford or pay for?
    - What do you do in these cases? (i.e. do you offer a cheaper alternative, etc.).

Women's reproductive health:
- What medication do women of reproductive age usually seek?
    - How often do you give out hormonal contraceptives (birth control pill, emergency contraceptive)?
    - Do you explain the side effects of medication (e.g. birth control pills) if you give them out?
- What medications do you most commonly give to pregnant women?
    - How common is it for pregnant women to ask for prenatal supplements?
    - Do you recommend these to pregnant women who come to fill other prescriptions?

ASK KEY INFORMANTS
- How did you come to work at ___?
    - What all does your job encompass?
    - What are the main issues related to healthcare in Kosovo that your organization works on?
        - What are you currently working on and/or planning to work on related to women's health in particular?
- How have conditions in the healthcare sector changed since you first started working in this sector?
    - How have conditions improved, become worse, or a combination of these related to different issues?
- Since the war in Kosovo, have there been any key changes in political policies that have impacted your work either positively or negatively? Please describe.
- What do you see as the biggest challenges to **women**'s access to healthcare in Kosovo right now?
    - What, if any, concrete steps do you think could be taken to address this?

Health Insurance Law
- What does the new timeframe look like on this?
- What do you see as the greatest remaining barriers to implementation of the health insurance law?
- How is it being decided what services will be covered by insurance?
- How will the provision of these 'free' services compare to what is currently in place?

Comment on Survey Findings

- Our survey suggests that women face more cultural barriers than men in accessing health care (for example, they have to ask for permission more, within a household men are prioritized more, etc.). What do you think of this finding?
- Other than when facing the aforementioned cultural barriers, women do not face a statistically significant disadvantage in accessing healthcare. What do you think of this finding?
    - Despite our statistical findings, anecdotally many women report problems within the healthcare system. Based on your experience, what, if anything, do you think the survey may have failed to capture?
- When analyzing the data, we found several disparities in how different groups access healthcare by strata such as ethnicity, region, residency, education. For example, rural populations often have less access to health care than urban populations.
    - Do you agree or disagree?
    - Could you think of an explanation for why the data are showing this?

Quality (i.e. Communication, Personnel, Infrastructure)

- In your opinion do health care institutions generally honour citizens' rights?
- About 350 citizens don't think they have a right to confidentiality. A third of these very citizens are confident they know their rights to health care.
    - According to your experience, what can explain this gap?
    - *[If within their expertise]* How is confidentiality supposed to work?
- Who tends to inform citizens of their rights related to healthcare the most in Kosovo?

Utilization of services

- Almost 90% believe general check-ups are NOT a waste of money, but half the population has never had a general check-up. What do you think explains this finding?
- Could you speak more generally about check-ups and preventative care in Kosovo?
    - What has been done by the government/ your organization to increase preventative care?
    - What would do you think remains to be done?
- Almost 10% of citizens don't think reproductive health is necessary, and about 60% of the population say they don't know where to get these services. Yet, most of the population responds that all women, including single women, women done having children and widowed women, should still get gynaecological check-ups. What do you think of this finding?
- Could you speak more generally about reproductive health and check-ups/preventative care within reproductive health in Kosovo?
    - What has been done by the government/ your organization to improve reproductive health?
    - What would do you think remains to be done?
- More people admit to getting medicine without prescriptions than with prescriptions. What do you think of this finding?
    - In your experience, do you agree or disagree?
    - Could you think of an explanation for why the data are showing this?

Barriers (i.e. Financial, Geographic, Cultural)

- Serb women are more likely to say they make the decisions on contraception methods, on big purchases, etc. than Albanian or other minority women are. For example, almost all of the Serb women vs only two-thirds of Albanian women and three-fourths other minorities women decide for themselves whether they visit the doctor. What do you think of this finding?
    - Could you think of an explanation for why the data are showing this?

<u>WRAP UP FOR ALL RESPONDENTS</u>

- Is there anything I forgot to ask? Additional thoughts you'd like to share?

## Appendix 4. Literature Review Details

A first search was conducted to find out whether there has been a similar study done in Kosovo and south-eastern Europe using the following terms in different variations for all countries in PubMed: 'Women OR female OR Gender OR minorities AND access to health care,' which resulted in 168 papers. The second search was conducted to retrieve all published studies of Kosovo with medical background, including also studies dealing with men, using the following terms in PubMed: '((kosovo[Title/Abstract]) OR kosovo[MeSH Terms]) AND health care[Title/Abstract].' This search had 230 results.

Then Google Scholar was searched with the very broad term 'access to health care Balkan' and retrieved around 16,900 results, of which only the first 500 were screened by title until there were 50 results in a row not matching our research questions. This resulted in 11 more papers.

All were screened by title first, and if not clear, by abstract. For eligible papers full-text was retrieved and read by a candidate for a MSc in International Health. This resulted in 103 articles and reports that were relevant for this research and went into the report either directly to contextualize and offer evidence for statements made, or indirectly by informing the researchers.

## Appendix 5. Difficulties and Limitations

This appendix summarises some of the limitations of the research and difficulties faced. Limitations related to the survey design, surveying technology, researcher training, respondent errors and literature availability.

First, the survey design had some limitations. On a few questions, respondents could select only one answer when multiple answers may have applied. As noted elsewhere in this report, some questions could have been phrased more clearly or specifically, particularly relating to where respondents tend to access healthcare services, diagnoses and diseases. Questions on abortion revealed a high lifetime prevalence of abortion, but there was no question regarding the last year, so rates could not be compared to international rates.

Second, the technology used for recording responses to the household survey was KoBoToolbox, a free and open source tool. While functional, it was in Beta phase of testing, which resulted in a few errors, such as with timekeeping and coding.

Third, not every surveyor received the exact same training as a couple surveyors joined the team after the initial mandatory training, creating the potential for inconsistencies.

Fourth, no-contact and non-response always have the potential to contribute to error as particular groups of people may tend to be unavailable or refuse to participate in the interviews, leading to bias in the findings. Overall, the survey process had 227 documented instances of non-contact (see Table 11) and 357 refusals. The main reasons for refusals included lack of interest (158), no time (141) and the person was too old (13).

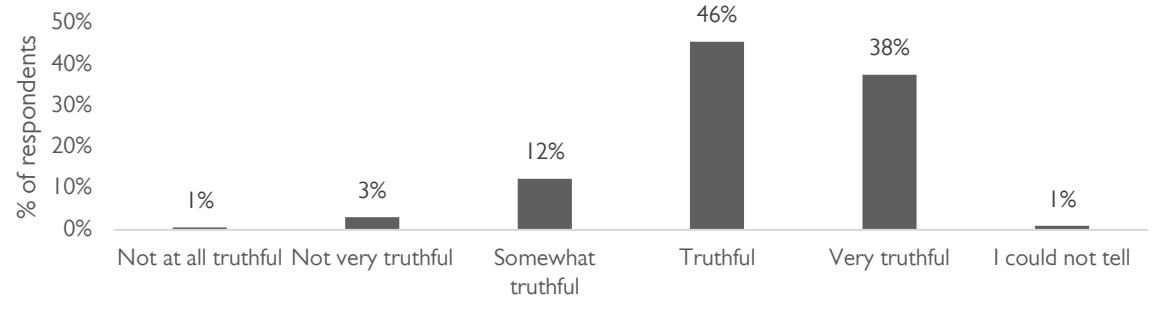
Table 11. Reasons for No-Contact

| Reasons | # |
|---|---|
| Non-residential building | 51 |
| Not able to enter residential building | 77 |
| No adult present at home | 27 |
| No one home after three visits | 20 |
| Household does not belong to the sub-sample | 18 |
| Other | 34 |
| Sub-Total | 227 |

Fifth, potential always exists for respondent error. Despite training that emphasized the importance of conducting interviews alone with respondents, a few interviews were conducted with other family members present, which may have impacted respondents' honesty. Several questions relied on respondent perceptions, for lack of other available measures, and these may not always accurately reflect reality. Self-reported numbers particularly relating to income were inaccurate and had to be excluded from the analysis. Finally, some questions may have solicited positive response bias, where people are likely to agree with a positive statement by default unless they are pushed or asked to further explain.

Enumerators were asked to observe respondents across several measures, including honesty, comprehension and comfort. These are important in estimating error and understanding the extent to which respondents answered honestly to sensitive topics. As Graph 10 illustrates, generally enumerators perceived that respondents were fairly truthful.

Graph 10. Enumerators' Perceptions of Respondent Honesty



Enumerators also were asked to assess how the respondents seemed to feel about the interview. In 63% of cases, enumerators considered that respondents were happy or very happy; indifferent in 35% of cases; and not so happy in 12% of cases. Respondents also had the opportunity to comment on the interview and its quality at the end of the interview as well as in cases that were controlled later on (see Appendix 1). Generally, respondents made very positive comments about the interview experience and thanked KWN for undertaking research on this important theme.

Sixth, refusals from interview respondents may mean that some healthcare workers' perspectives are under-represented in the findings. Several pharmacists, doctors and nurses (with the exception of mental health workers) were reluctant to participate in the research. Stories about malpractice and corruption in the healthcare sector, published in media when the research was being conducted, seemingly contributed to healthcare workers' hesitation, even though researchers made clear that they were not affiliated with media and were conducting research in close collaboration with the Ministry of Health. Cardiologists in particular tended to refuse interview requests, perhaps due to an ongoing scandal covered by media concerning the unnecessary implantation of stents.[163] Thus, the diversity of views and experiences held by healthcare workers may have been limited somewhat.

Seventh, qualitative interviews potentially involved some satisficing by respondents, whereby they relayed information that they considered 'correct' to satisfy researchers, rather than describing the actual situation. For example, researchers observed pharmacies providing drugs without prescriptions, though representatives of the same pharmacies said they do not do this during interviews. Doctors tended to speak to what *should* happen according to the law, while circumventing questions about what *actually* happens in practice. As all interviews were conducted by volunteers, primarily students, perhaps mentoring in probing and more advanced interviewing skills could have enabled them to solicit more, accurate information from healthcare workers. Also all interviewers were young women, which may have affected respondents' answers.

Eighth, time limitations presented several challenges. The data set involved a massive amount of information that could not be fully processed within the timeframe. Also due to time constraints, triangulation of researchers could not be applied fully in the coding of all qualitative interviews. Additional time may have allowed for further interpretation of findings and contextualizing in relation to other research.

Related, the literature mainly was searched for and evaluated by a non-Albanian researcher, which limited results mainly to English language papers. As data and literature in general on this theme with respect to Kosovo are scarce and hard to retrieve (e.g., websites not fully functionally, reports unavailable online), perhaps not all relevant literature was found.

[163] For example, see: First Channel, *Ekskluzive: Aktakuzë për rastin 'Stenta', 60 të akuzuar*, accessed 6 Dec. 2016, at: http://www.first-channel.tv/2016/06/15/ekskluzive-aktakuze-per-rastin-stenta-60-te-akuzuar/.

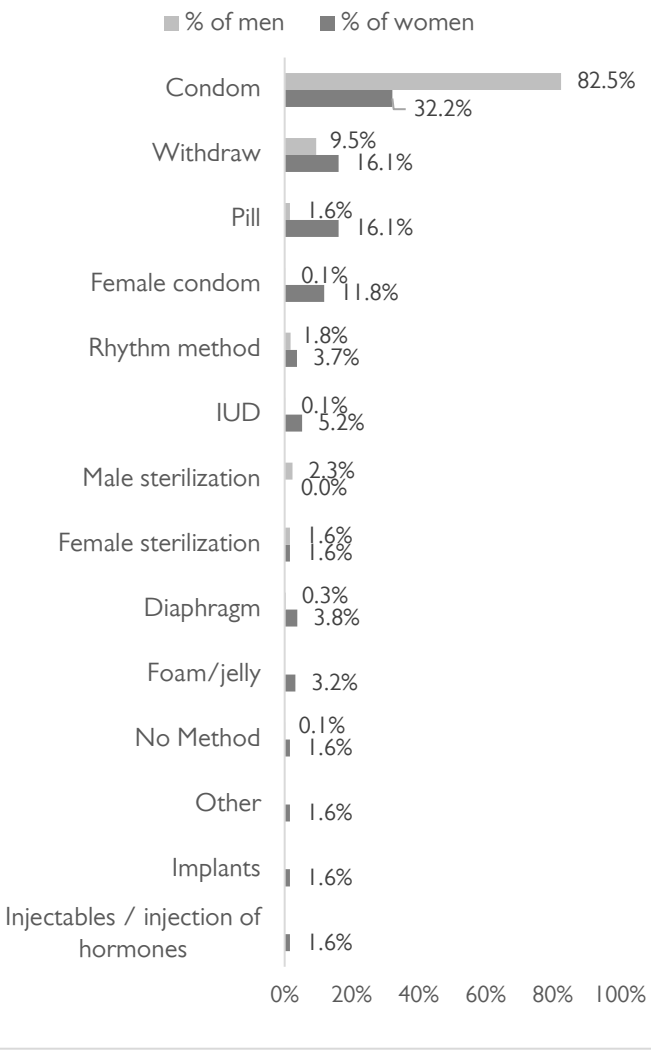
## Appendix 6. Other Research Findings

This report focused on access to quality healthcare and barriers to access for diverse women and men. Therefore, several topics addressed through the national household survey and in interviews were not included in the main text of the report. Additional key findings are included here so that stakeholders may use them to inform further research and work in these areas. These findings are divided topically in the subsections that follow: use of family planning methods, pharmaceuticals, cigarettes, alcohol, the environment and health and reasons for not accessing healthcare.

### Use of Family Planning Methods

The survey revealed very low use of modern contraceptives. Among respondents in their reproductive years (defined as ages 16-55) who are sexually active, 64% said that they do not use contraception. Only 20.5% of respondents, and 10.9% of women, said they use a modern contraceptive method.[164] Among women ages 15-49, the Kosovo Demographic, Social and Reproductive Health Survey (KDHS) reported a 17% use of modern contraceptives in 2009,[165] and the Multiple Indicator Cluster Survey (MICS) from 2013 showed 14% use of modern contraceptives.[166] This suggests a decline in recent years in use of reliable methods among women, though this research examined a slightly different age group. This decline may be due in part to decreased donations of contraceptives compared to shortly after the war and no free of charge contraceptives, as several healthcare professionals stated. If people must buy contraceptives, this could explain partly why cheaper methods are used more frequently (e.g., condoms and withdrawal).

Graph 11. Contraceptives Used by Women and Men




Of all persons under age 55 who said they use contraceptives, 85% used

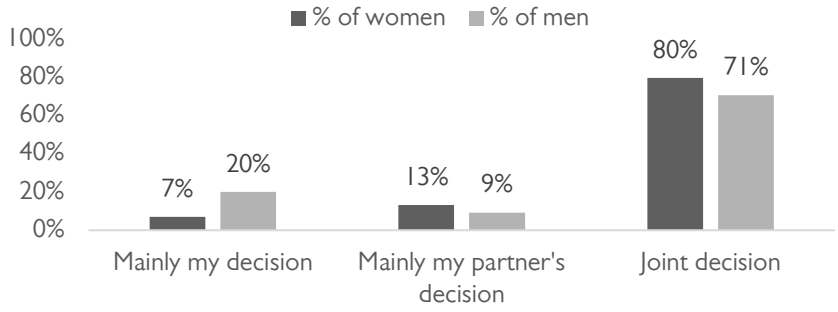
[164] The numbers are essentially the same for persons who are sexually active and those who are not. Of those using contraceptives, 28% were single, 59% married, 3% engaged, 0.4% divorced and 3% widowed. However, most said they use contraceptives.
[165] KAS, *KDHS*, 2011.
[166] KAS and UNICEF, *MICS*, 2014.

a modern method. Condoms were the most used form of contraception by both men (82.5%) and women (32.2%). Other forms of contraception used widely included withdrawal (12%), the pill (6%) and female condoms (4%). The type of contraception used differed significantly by age ($p<0.001$); persons ages 25-34 tended to use condoms and the pill; persons 35-44 used female and male condoms, among other modern forms; and persons ages 45-54 used condoms, the pill and diaphragms but were more likely to use the withdrawal method than were other age groups. However, this suggests that the use of withdrawal is decreasing.

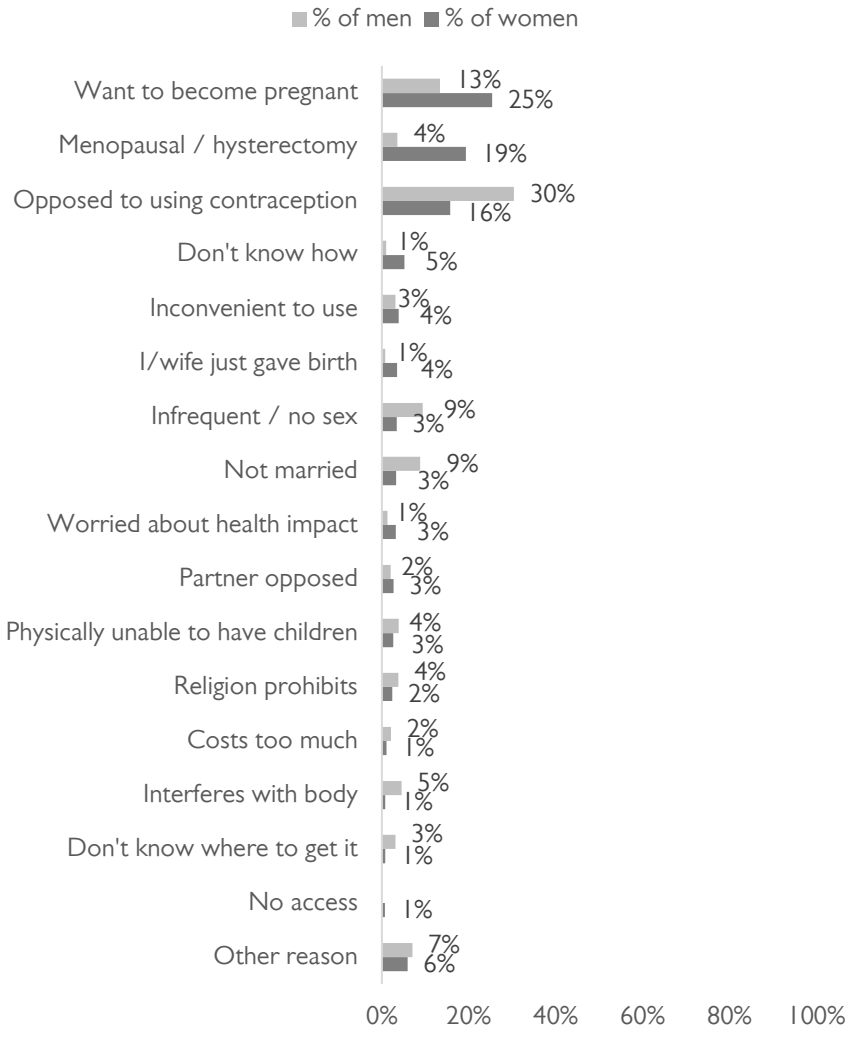
When asked who decides about contraception use, most respondents stated that it is a joint decision with their partner (75%). However, women and men had significantly different responses, suggesting that men tended to take decisions regarding contraceptives in more relationships than do women ($p<0.001$). Fewer older people seemed to have had the choice than younger people, on average; nine percent of 16-34-year-olds said it was their partners' decision compared to 13% of 45-64-year-olds ($p=0.01$). Among sexually active women using contraception, eight percent said they used it without their partners' knowledge.

When sexually active persons were asked why they do not use contraception, most said that they wanted to become pregnant, no longer needed contraception following a hysterectomy or menopause or were opposed to using contraception (Graph 13).

Graph 12. Who Takes Decisions Regarding Contraception Use




Graph 13. Why Sexually Active Persons Do Not Use Contraception

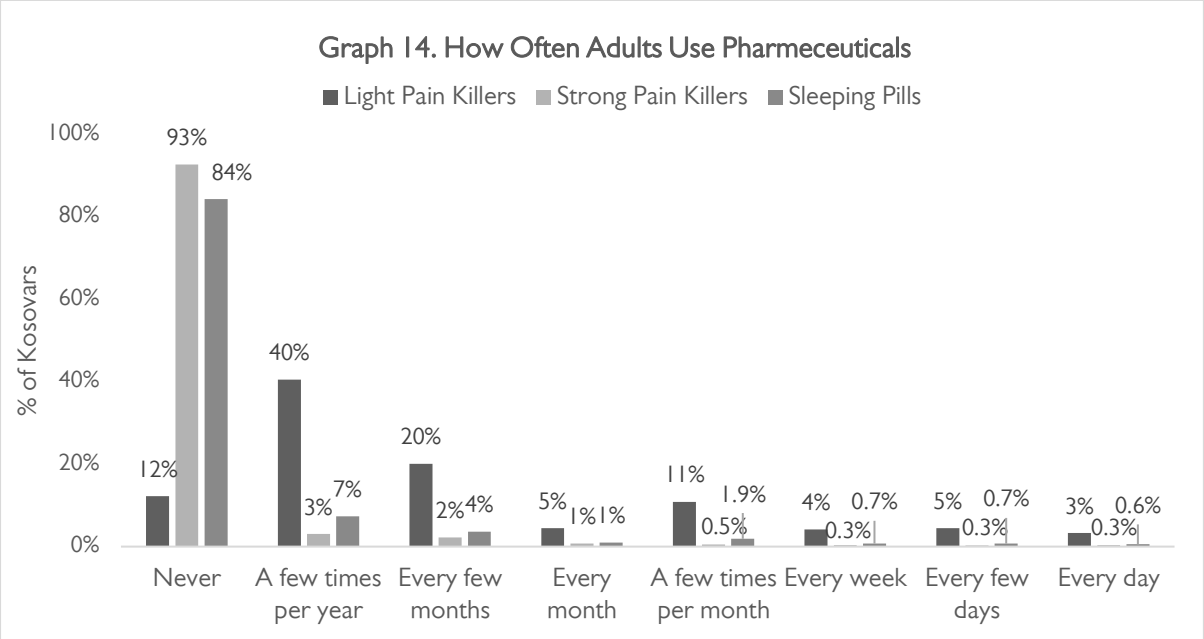


Religion may influence whether or not some people use contraception, as an interviewed gynaecologist also observed. However, only two percent of sexually active women and four percent of men said that this was the main reason as to why they do not use contraception.

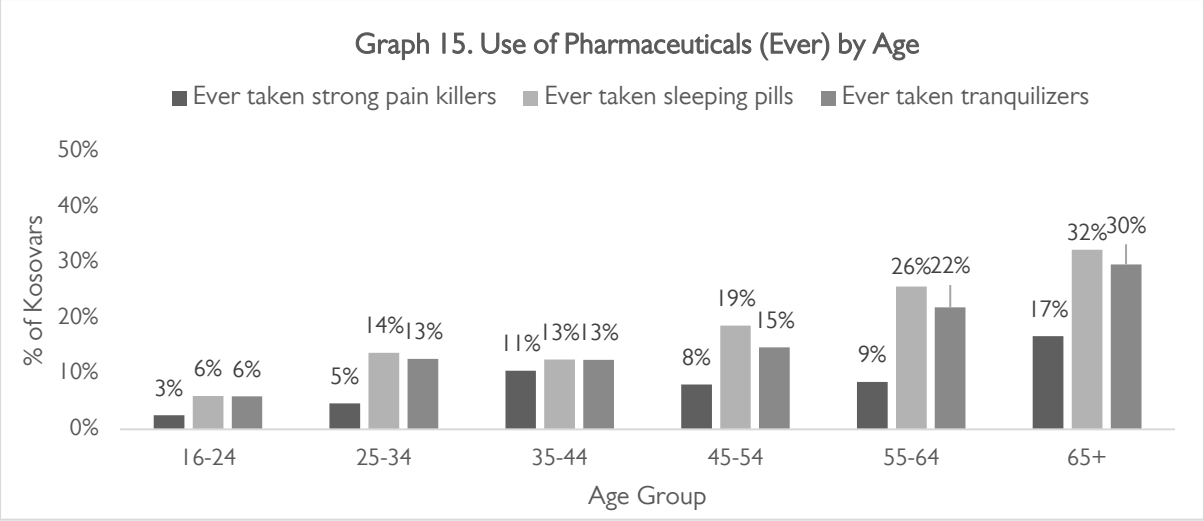
Overall, low usage of reliable contraceptive methods could explain in part the high prevalence of abortion in Kosovo. The high percentage of people who stated that they are opposed to contraceptives, fear health effects, lack knowledge, do not know where to purchase contraceptives or face financial barriers to buying contraceptives reveals a seemingly high unmet need for improved information about and access to contraception in Kosovo. This finding corroborates the aforementioned studies.

## Use of Pharmaceuticals

The survey asked several questions pertaining to various legal drugs. Graph 14 below displays how often respondents said they took light painkillers like acetylsalicylic acid (e.g., Aspirin, Andol), paracetamol, ibuprofen, naproxen or diclofenac; stronger painkillers like opioids (morphine, oxycodone, methadone, tramadol or fentanyl); and sleeping pills or tranquilizers like benzodiazepines. There was no significant difference between how women and men used any of these categories of pharmaceutical products.



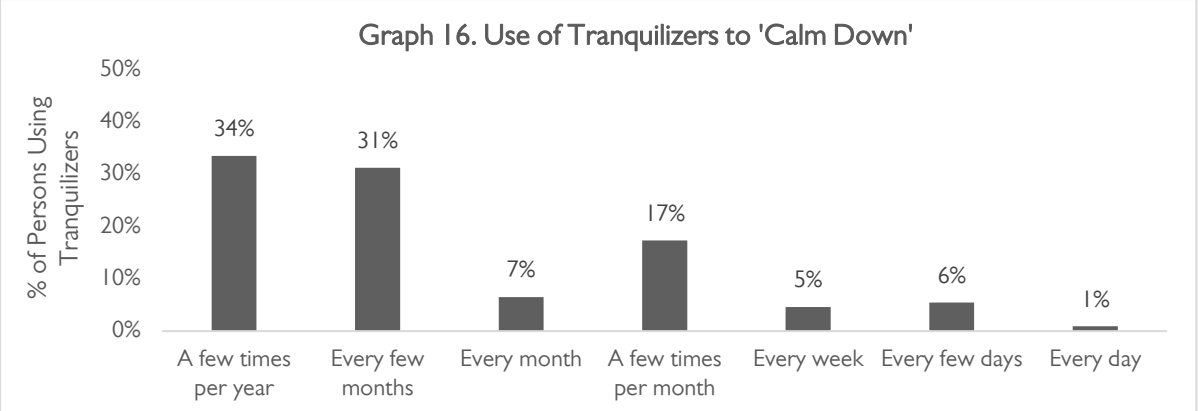

Perhaps unsurprisingly, there was a significant difference by age; older people, on average, tended to take lighter ($p<0.001$) and stronger ($p=0.002$) pain killers more often than younger people. Graph 15 illustrates the percentage of each group that reported ever taking each type of pharmaceutical product. Aside from persons who took sleeping pills a few times per month (a similar percentage across all age groups), persons over age 45 were more likely than younger people to take sleeping pills, as well as to take them more often ($p<0.001$). Light painkillers can have potentially grave side effects, especially on individuals with already compromised health conditions. Therefore, the fact that 12% of respondents take painkillers once per week, or more often, raises concerns. Education on side effects, especially on drugs usually bought without consulting a doctor, is needed both for patients and providers.




Of the approximately 16% of respondents who have taken sleeping pills like Bensedin and diazepam, half said that a doctor recommended they take them, and 45% said it was their own choice.[167] Three percent said that their family suggested, and two percent said that a friend suggested to take sleeping pills. A significant difference existed regarding what made women and men decide to take these pills ($p=0.0002$). Where approximately 60% of men decided to take sleeping pills of their own accord, roughly 66% of women took pills based on a doctor's recommendation, or so they said. There also was a significant difference by age ($p<0.001$). Persons under age 35 were more likely to decide to take pills on their own, whereas people 35 and over were more likely to have a doctor's recommendation. Persons ages 35-44 and over 65 seemed more likely to be influenced by friends and family to take sleeping pills. Some youth, ages 16-24, also said their family encouraged them take such pills.

Approximately 14% of Kosovars reportedly have taken tranquilizers 'to calm down', (examples in the questionnaire were Xanax, Valium, Lexilium or Bensedine, all belonging to the group of benzodiazepines). Of them, slightly more than one-third take tranquilizers a couple times per year and just under one-third take them every few months. More than 28% reported taking tranquilizers a few times per month or more often (see Graph 16). Use of tranquilizers appeared to increase with age ($p<0.001$). In 52% of cases, respondents said that doctors recommended they take tranquilizers. However, 43% said it was their own decision, three percent said friends suggested and two percent were encouraged by family members to take tranquilizers. Again, women were significantly more likely (30% of women) than men (22%) to say that a doctor had prescribed tranquilizers ($p=0.003$), whereas men were more likely to decide to take tranquilizers of their own accord (27% of men). People over age 35 were more likely to take tranquilizers following a doctor's prescription whereas younger people were more likely to do so on their own ($p<0.001$).[168] As benzodiazepines mentioned here have a highly addictive potential, the fact that 1.7% of the population takes them at least once a week, no matter if buying with or without prescription, could translate into 1.7% being at high risk of addiction.

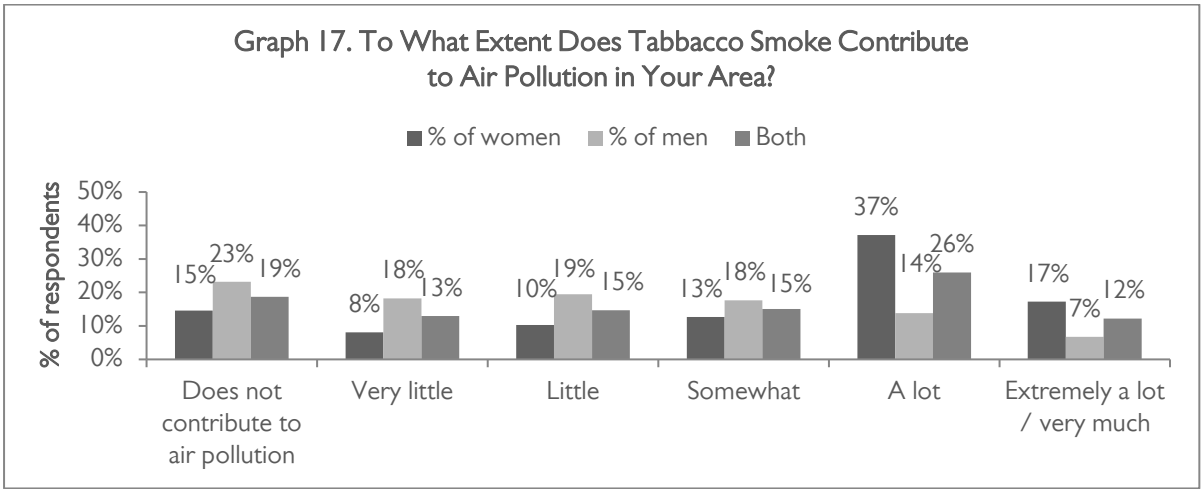
[167] The questionnaire did not distinguish between mere sleeping pills like zolpidem and tranquilizers like the benzodiazepines because the latter are used for both, which may be a shortcoming of the questionnaire. It mentioned Bensedine as an example related both to sleeping pills and to tranquilizers.
[168] There was no significant difference based on rural or urban residency.




## Use of Cigarettes and Perceived Air Pollution from Smoke

Approximately 28% of respondents reported that they smoke cigarettes. On average, they smoked approximately 19 cigarettes per day. However, on average, men said that they smoked almost twice as many cigarettes per day (23) as women did (13) ($p<0.001$). There was no statistically significant relationship between smoking and ethnicity or residency. On average, people started smoking at age 19. The youngest age to begin smoking, as reported by respondents, was age seven. Approximately 30% of smokers have tried to quit.[169] The sample size of persons with heart disease, lung cancer and other illnesses known to be linked with smoking was too small to examine accurately the correlation between these diseases and persons who smoke in Kosovo.[170]

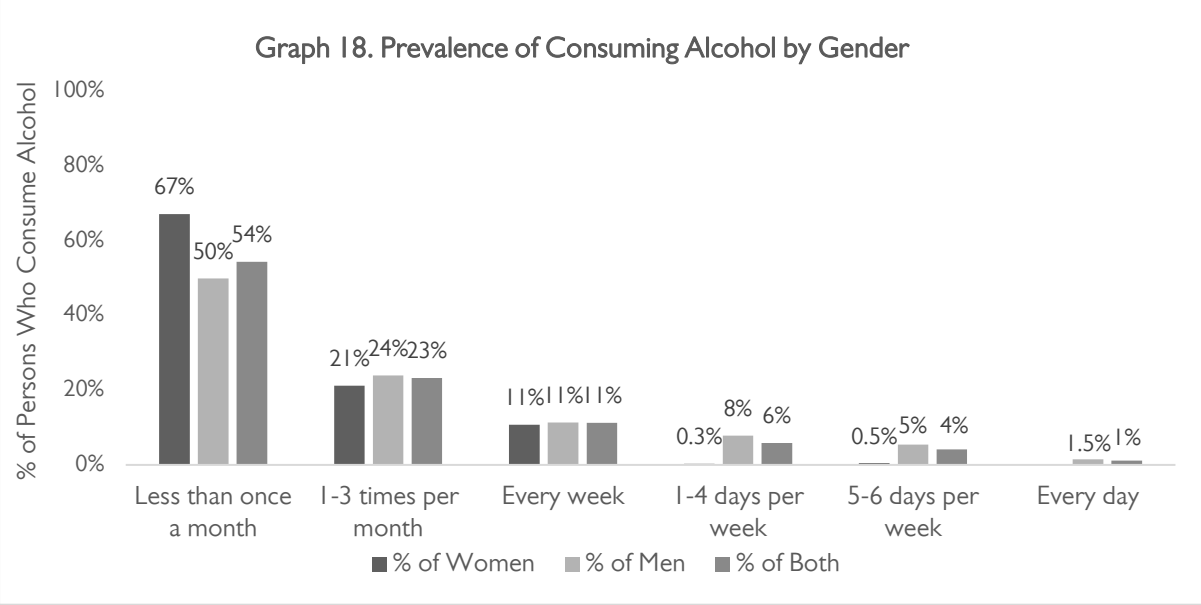
Kosovars' perceptions of how tobacco smoke impacts air pollution in their area differed substantially (Graph 17). While 38% felt smoke contributed a lot to air pollution, 15% said somewhat, 28% said little or very little and 19% did not think smoke contributed to pollution around them at all. Women were significantly more likely to consider smoke a cause of pollution than were men ($p<0.001$). Urban residents were significantly more likely to feel that smoke affected air pollution than were rural residents ($p=0.04$). Persons living in Prishtina, Ferizaj and Mitrovica were significantly more likely to consider tobacco smoke a polluter in their area than persons from other regions ($p=0.0003$).




[169] There was no significant difference by gender, ethnicity or residency regarding attempts to quit.
[170] WHO, 'Tobacco - Fact sheet', accessed on 5 December 2016, at: http://www.who.int/mediacentre/factsheets/fs339/en/.

## Use of Alcohol

In the 12 months before the survey, 23% of Kosovars said that they consumed alcohol at least occasionally. On average, more men drink (36% of men) than women (12%) ($p<0.001$). Men also tended to drink more often than women. Among persons who consumed alcohol in the last year, most (54%) said they drank less than once per month; 23% drank one to three times per month; and 11% drank at least every week (see Graph 18).




On average, more young people drank alcohol in the last year than older people ($p=0.01$). When people drank, on average they tended to drink 2.2 drinks per day. On average, men tended to drink slightly more than women ($p<0.001$), totalling 2.3 drinks per day compared to 1.9 for women.[171] Younger people, particularly those under age 25, tended to drink more in a day than older people ($p=0.007$).

## Environment and Health

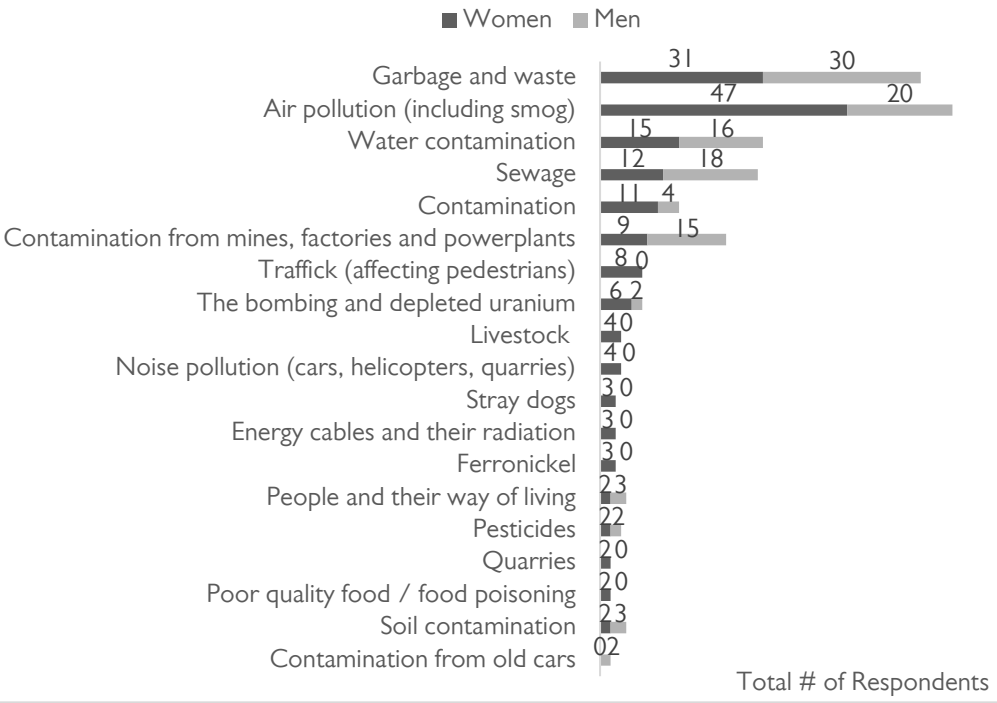
The survey used in this research contained several questions on the environment and its perceived health effects. As this topic was not the main focus of this report, only a rapid attempt to retrieve background information pertaining to Kosovo's environment and its potential impact on health was made. An overview of environmental issues in Kosovo can be found elsewhere.[172] However, this is clearly an area in need of further research.

When asked to rate the quality of the environment where they live, nine percent of respondents said it was 'poor' or 'very poor' and 71% said it was 'good'. A significant difference existed based on ethnicity ($p<0.001$); 64% of Serbs considered their environment 'poor' or 'very poor' compared to only seven percent of Albanians and nine percent of other ethnic groups. Residents of Mitrovica (24%), where more Serbs live, and Prishtina (11%) were significantly more likely than persons from other regions to consider environmental quality poor ($p=0.0005$). Urban inhabitants were significantly more likely to consider their

[171] No statistically significant difference existed based on residency or ethnicity.
[172] Kosovar Stability Initiative (IKS), *Thinking Green*, Prishtina: IKS, 2009; Kosovar Environmental Protection Agency, at: http://www.ammk-rks.net/?page=2,8.

environment poor than their rural counterparts (p<0.001). Older persons were more likely to consider their environment poor than younger persons (p=0.03). Based on their own perceptions, 80% of respondents felt that something in their day-to-day environment affected their health or the health of their family. When asked to describe in their own words what from their environment affected their health, most respondents identified air pollution, garbage, contaminated water and sewage (Graph 19).

Graph 19. What Affects Your Health or the Health of Your Family?




When asked the extent to which they believed the environment where they work each day impacts their health, 26% said 'very much' and 23% said 'somewhat'. Women were more likely to state that their daily work environment impacted their health than were men (p=0.003). People in Mitrovica were significantly more likely to believe that that the environment where they work affects their health 'a lot' (53% of residents) than persons in other regions (p=0.0005). In Prishtina, 33% of residents and in Gjilan 30% of residents thought similarly. Albanians (27%) were significantly more likely to feel that their work environment impacted their health than Serbs (19%) or other ethnic groups (18%) (p<0.001).

More specifically, considering Kosovo's air quality, a 2005 study showed that air pollution around Obilic lignite coal power plants exceeded EU standard by 400-500%.[173] In November 2016, the U.S. Consulate air pollution monitor in Prishtina displayed moderate to very unhealthy air pollution.[174] Interestingly, 69% of respondents considered the air quality where they live 'good' or 'very good'; only 14% considered air quality 'bad' or 'very bad'. Urban residents were significantly more likely to consider the air quality poor (24% of urban-

[173] Zeneli, L. et. al., *Impact of Environmental Pollution on Human Health of the Population Which Lives Nearby Kosovo Thermopower Plants,* Prishtina: 2011.

[174] During the writing of this report, a researcher consulted this website multiple times per week: Prishtina U.S. Consulate, *Air Pollution: Real-time Air Quality Index (AQI)*, at: http://aqicn.org/city/kosovo/pristina/us-consulate/.

dwellers) than rural residents (8%) ($p<0.001$).[175] There also was a significant relationship based on region ($p=0.009$); more inhabitants from Prishtina (24%), Mitrovica (21%) and Gjilan (16%) considered the air quality bad than residents of other municipalities. Serbian respondents (66%) were significantly more likely to consider the air quality bad than other ethnic groups (12-13%) ($p<0.001$).

On a similar question, 15% of respondents said that the air they breathe each day is 'bad' or 'very bad', whereas 24% evaluated the air 'okay' and 35% 'very good'. Urban inhabitants tended to consider the air they breathe worse that rural inhabitants ($p<0.001$). Persons residing in Prishtina (26% of inhabitants) and Mitrovica (22%) were significantly more likely to consider the air quality bad than persons in other regions ($p=0.03$). Kosovars tended to believe that emissions from cars and trucks contribute to air pollution in their area; only seven percent thought that emissions did not contribute pollution at all. Women were significantly more likely to consider vehicle emissions a greater cause of pollution than men ($p=0.0007$), just as urban inhabitants tended to consider emissions a more substantial cause of pollution than rural inhabitants ($p<0.001$). Serbs (62%) and Albanians (51%) were significantly more likely to consider vehicle emissions a serious contributor to air pollution in their area than other ethnic groups (32%) ($p<0.001$).

While 47% of Kosovars did not consider power plants a source of pollution and eight percent did not know, 32% believed that such plants contribute substantially to pollution. Younger people were more likely to believe that power plants contribute to pollution than older people ($p=0.02$). Urban respondents tended to consider power plants greater contributors to pollution than persons in rural areas ($p=0.0007$). Serbs (46%) and Albanians (32%) were significantly more likely to state that power plants contribute substantially to pollution than persons of other ethnicities (17%) ($p=0.0001$). People living in Prishtina (54% of inhabitants) and Mitrovica (48%) regions were significantly more likely to consider power plants polluters in their areas than persons in other regions ($p<0.001$). Considering the vicinity of these two regions to Kosovo's coal power plants, perhaps it is unsurprising that inhabitants tended to consider such plants major contributors to pollution.

In comparison to power plants, fewer Kosovars considered factories to be heavy polluters in their areas. While 21% of respondents considered them serious polluters, 20% said they polluted 'little' or 'very little' and 40% said not at all. Urban residents were significantly more likely to believe that factories contribute to pollution than rural residents ($p=0.003$). Respondents in Mitrovica (43%) and Prishtina (27%) tended to consider factory pollution a more serious problem than did persons in other regions ($p<0.001$). Again, Serbs (53%) were significantly more likely to consider factories serious contributors to pollution than Albanians (20%) or other ethnic groups (12%) ($p<0.001$).

Kosovars were less likely to think that gases from burning oil, gas, coal or wood for heating and cooking contribute to pollution. Fifteen percent of respondents said this does not contribute at all to pollution, 32% said 'little' or 'very little', 18% said 'somewhat' and 32% said 'a lot' or 'extremely a lot'. Younger people are more likely to think such gases contribute to pollution than older people ($p=0.02$), and urban residents more likely than rural ones ($p=0.0007$). People in Prishtina (42%), Mitrovica (37%) and Gjakova (34%) were more likely to consider such gases substantial polluters ($p<0.001$). Serbs (65%) also considered gases to be polluters in their area more than Albanians (30%) or other ethnic groups (34%) ($p<0.001$).

[175] There was no statistically significant difference based on gender or age.

The vast majority of Kosovars said that they use wood as their primary source of heating (83%). Eight percent used electricity, six percent central heating and two percent coal. Urban residents were significantly more likely to use electricity (15% of urbanites) or central heating (13%) than rural inhabitants ($p<0.001$). People living in Prishtina were significantly more likely to use central heating (19% of inhabitants) than persons in other regions, and inhabitants of Mitrovica (16%) and Prishtina (12%) were more likely to use electricity ($p=0.007$). A higher percentage of the population burned coal for heat in Prishtina (4.8%) and Prizren (4.5%) than in other regions. Serbs were significantly more likely to use electricity (29%) or coal (5%) than were the other ethnic groups, whereas Albanians were more likely than others to use central heating (7%) ($p=0.0006$). The main heating sources used may depend in part on their availability as well as affordability in different regions.

Regarding the quality of water, 20% of Kosovars considered it 'bad' or 'very bad' where they live, whereas 64% considered it 'good' or 'very good'. People's perceptions of water quality differed significantly based on region ($p=0.004$); 31% of Mitrovica's inhabitants, 30% in Gjilan, 22% in Ferizaj and 20% in Prishtina thought the quality was bad or very bad, compared to only five percent in Peja, 13% in Prizren and 15% in Gjakova.[176] Serbs were significantly more likely to consider their water quality poor than other ethnic groups ($p<0.001$); 69% of Serbs considered their water 'bad' or 'very bad', compared to 17% of Albanians and 22% of other ethnic groups.

Assessing soil quality may be difficult for most people to do, particularly urban residents. Only eight percent of Kosovars said that their soil quality was 'bad' or 'very bad'. Serbs (52% of them) were significantly more likely to consider their soil quality poor than Albanians (6%) or other ethnic groups (9%) ($p<0.001$). This may again relate to where Serbs tend to live: in Mitrovica region. A 2009 study from the area of Zvecan smelter, including Mitrovica, evidenced high soil pollution with heavy metals, also affecting the crops.[177]

With regard to solid waste like garbage from households, industries or hospitals, 24% of Kosovars believed that it was 'bad' or 'very bad' where they live. People in urban areas tended to consider the solid waste situation worse in their areas than did persons in rural areas ($p=0.049$). Again, significant differences existed according to region; 53% of inhabitants in Mitrovica considered the solid waste situation bad, compared to only five percent in Prizren, for example ($p<0.001$). Again, Serbs (41%) were significantly more likely to consider solid waste in their area bad than Albanians (22%) or other ethnic groups (23%) ($p<0.001$).

Contaminated food was a 'very big problem' for 30% of respondents and 'somewhat of a problem' for 24%. Urban inhabitants were significantly more like to consider contaminated food a problem than rural residents ($p=0.04$), and persons in Mitrovica region were significantly more likely (83% of inhabitants) than persons living in other municipalities ($p<0.001$). Again, Serbs (82%) were more likely to consider contaminated food a problem than Albanians (53%) or other ethnic groups (58%) ($p<0.001$). Interestingly, while over 50% considered food contamination a problem, they apparently disregarded the origin of food products: only eight to 20% considered water, air or soil pollution a problem. Further research on what exactly is understood by food contamination may shed light on this seeming discrepancy.

Overall, urban inhabitants, particularly from Mitrovica and Prishtina regions, perceive that most forms of pollution are worse in their areas than do their rural counterparts or

[176] No significant difference existed in perceptions of water quality by gender, age or rural/urban residency.
[177] Borgna, L. et. al., *The High Contents of Lead in Soils of Northern Kosovo*, 2009.

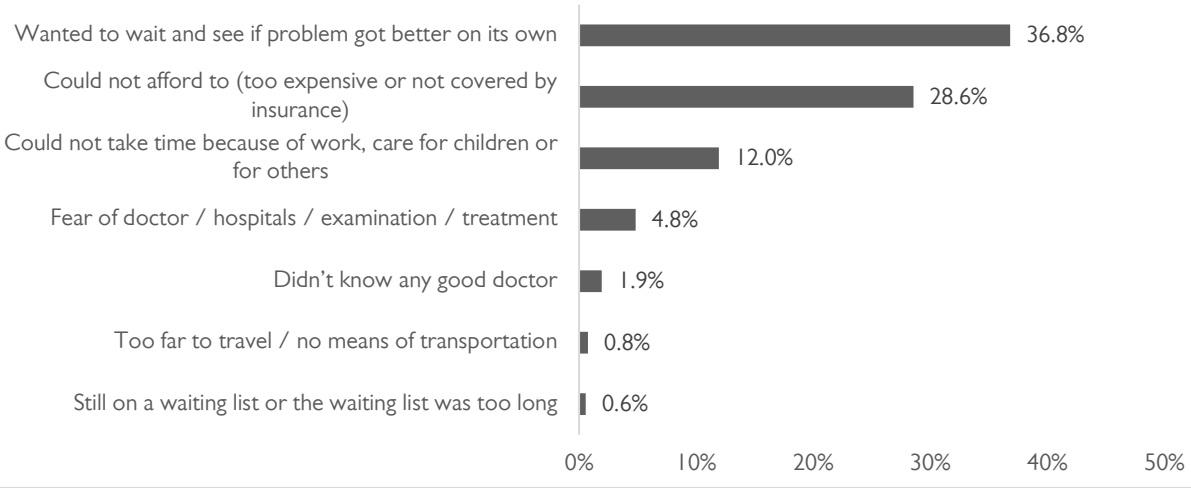
persons living in other regions. Perhaps due in part to the fact that most Serbs live in Mitrovica region, they consistently considered the various dimensions of pollution studied here to be worse in their area than did other ethnic groups.

This particular data set did not have sufficient information to arrive at conclusions regarding how pollution may impact the health of Kosovars. Perhaps future research related to pollution monitoring and longitudinal studies to investigate health effects could focus on regions where inhabitants perceived pollution to be worse like Mitrovica and Prishtina. A larger sample size in those specific regions may facilitate the investigation of potential health impacts in these areas. Additionally, the data do suggest that public education is needed related to the environment, different potential sources of pollution and the impact that these may have on health, based on research elsewhere.

## Reasons for Not Accessing Healthcare

As part of examining unmet healthcare needs, Eurostat measures the reasons why such needs are not met. While the findings from this question were discussed already within this report, a summary of these findings is presented in Graph 20. There was no significant difference by gender.

Graph 20. What Was the Main Reason for Not Consulting a Doctor?



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Katalogimi në botim – (CIP)
Biblioteka Kombëtare e Kosovës "Pjetër Bogdani"

61(496.51)(048)

Access to Healthcare in Kosovo / nga Nicole Farnsworth, Katja Goebbels, Rina Ajeti. - Prishtinë : Rrjeti i Grupit të Grave të Kosovës, 2016. – 116 f. ; 28 cm.

1.Farnsworth, Nicole 2. Goebbels, Katja 3. Ajeti, Rina

ISBN 978-9951-737-07-4

ISBN 978-9951-737-07-4