The Republic of Kosovo
The Ministry of Health

Data Collection Survey on Health Sector to Build Resilient Health Systems toward Universal Health Coverage in the Republic of Kosovo

Final Report

February 2022

Japan International Cooperation Agency

Koei Research & Consulting Inc.

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Abbreviations

Abbreviation	English
AIS	Agency for Information Society
AQH	Accessible Quality Healthcare
COVID-19	Coronavirus Disease of 2019
DF/R	Draft Final Report
DHS	Demographic and Health Surveys
ELM	Essential List of Medicines
EU	European Union
F/R	Final Report
FMA	Family Medicine Ambulatory Clinic
FMC	Family Medicine Center
GDP	Gross Domestic Products
GDPR	General Data Protection Regulation
GNI	Gross National Income
GOK	The Government of Kosovo
HCI	Human Capital Index
HDI	Human Development Index
HIF	Health Insurance Fund
HISHIF	Health Information System of Health Insurance Fund
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP	Health Nutrition and Population Statistics
HUCSK	Hospital and University Clinical Service of Kosovo
IC/R	Inception Report
ICT	Information and Communication Technology
I/R	Interim Report
JICA	Japan International Cooperation Agency
KHP	Kosovo Health Project
KMA	Kosovo Medicines Agency
LuxDev	Luxembourg Development Cooperation Agency
MFMC	Main Family Medicine Center
MICS	Multiple Indicator Cluster Surveys
MLSW	Ministry of Labour and Social Welfare
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NDS	National Development Strategy
NHA	National Health Account
NIPH	National Institute of Public Health of Kosovo
OOP	Out-of-Pocket
PHC	Primary Health Care
PPP	Purchasing Power Parity
RAE	Roma, Ashkali and Egyptian
SDGs	Sustainable Development Goals
TB	Tuberculosis
TAK	Tax Administration of Kosovo
UCCK	University Clinical Center of Kosovo
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMIK	United Nations Interim Administration Mission in Kosovo
WHO	World Health Organization

Part 1

Chapter 1 Overview of the Survey

1.1 Background

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (hereinafter referred to as COVID-19), which has caused a worldwide pandemic, made severe social and economic impact on the countries of the Western Balkan region without exception. According to the World Bank report, the Western Balkan region had problems in financing and providing health services even before the pandemic, highlighting inadequate public spending on health care, including high rates of out-of-pocket expenses (hereinafter referred as to OOP). The problem was that the health care service delivery system was not working efficiently and effectively to address disease trends in the region...Concerned with increased vulnerability of patients with non-communicable diseases, the report elaborated that the governments of the Western Balkan region will have to assure financial sustainability and efficient and effective, high quality health service delivery in order to countermeasure COVID-19 and future pandemics. (The World Bank, 2020).

Among the Western Balkans countries, the Republic of Kosovo (hereinafter referred to as Kosovo), which is located in the center of the Balkan Peninsula and has borders with Serbia, North Macedonia, Albania, and Montenegro has a high poverty rate and the spread of the coronavirus nationally, and especially among the poorer people progressed rapidly. From the perspective of regional stability and human security, it is crucial that Kosovo through building a resilient health system, should be able to curb future epidemics of infectious diseases, including COVID-19, and even in the event of an epidemic should be able to provide basic health services at the level of normal times, and furthermore, the use of the health services should not impose an excessive financial burden on the citizens.

Kosovo has achieved a relatively stable economic growth among the Western Balkan countries since 2015, with growth rate of around 4% of Gross Domestic Products (GDP), and The World Bank predicted a per capita Gross National Income (hereafter GNI) to reach 4,640 USD (The World Bank, 2019), placing Kosovo in the category of a middle-income country. However, the economic stability of the country is highly dependent on income from tourism and remittances of overseas workers, while high unemployment rate being as high at 29.4% (source: The World Bank, 2018) and the levels of self-employment and temporary employment among workers, show the weaknesses of the system. Moreover, Kosovo has a fragile economic and social structure, susceptible to external shocks, with a high dependency rate reaching to 79.5% in the second quarter of 2018 (Source: The World Bank, Vienna International Economic Research Institute). However, the economic growth of the country has not been distributed evenly. According to the Household Survey in 2017 (Data from the Kosovo Statistics Agency of Kosovo), about 18% of the population lived below the absolute poverty line (1.85 EUR per day), of which 5.2% was also below the absolute extreme poverty line (1.30 EUR per day). In addition, geographical differences are also huge, the income disparity between cities and regions, and within the cities are also a policy challenge. According to the report of the European Union (EU), about 20% of the population does not have access to health services due to extreme poverty. Thus, measures to achieve Universal Health Coverage (UHC), in which people can receive adequate quality health services at affordable costs become an important development challenge for sustainable economic growth in Kosovo.

In its "National Development Strategy 2016-2021", Kosovo has set the development of human capital as one of the top strategic goals in order to realize sustainable economic development, also being an important steppingstone towards future EU accession. In addition, in its "Health Sector Strategy 2017-2021" the government has set three strategic objectives to improve health services: (1) health communication and promotion of healthy lifestyles (maternal and child health, measures against infectious diseases / chronic diseases, etc.), (2) introduction of compulsory health insurance and construction of a sustainable financial system for health services and (3) reorganization and comprehensive reforms of the health sector. Although the national policies are clearly directing towards health care reforms, these reforms are slow to materialize.

In Kosovo, about 71.1% (2015) of the total health spending is covered by public health expenditure, and the remaining about 30% relies on OOP expenses financed mainly by patients. This level is high, it is above the 15-20% OOP rate recommended by the World Health Organization (WHO) and it is also high compared to the 14% EU average. High levels of OOP expenses create a barrier for poor people to access health services. High levels of OOP expenses places greater burden on poor families and contributes to inequality in healthcare use. Thus, the aim is to create a system which enables poor people to use public health services at an affordable cost. The Government of Kosovo has been trying to introduce, with the support of donors such as the World Bank a compulsory health insurance system with an exemption for OOP for low income families. Although the health insurance law was enacted in 2014 but the reform stated in ‘Health Sector Strategy 2017 - 2021’ including health insurance system has not been introduced yet. This delay also means that the public health insurance system is the most delayed among the Western Balkan countries.

Besides affordable financing, the third strategic goal of the government includes the provision high quality health services. At present, approximately 70% of public health expenditure is spent on fixed costs such as wage costs for health personnel and maintenance costs of the public health facilities, leaving only about 30% to be spent on medical device and services. Thus, there is only a limited budget available for each health facility to purchase new device and improve the quality of health services, such as making necessary capital investments. A newly introduced incentive for high quality service provision is the newly introduced remuneration system including elements such as the "performance-based subsidy system," through which each health facility will be able to earn additional state and health insurance fund revenues to continuously improve the quality of services.

Additionally, the third strategic goal also includes the reorganization of the health sector to be more efficient and to provide the necessary treatments at the lowest possible level of health facilities. Health care provision in Kosovo is represented by a limited level of medical care at primary and secondary health facilities, therefore patients use proportionately more often the only tertiary health facility in the country, which puts extra burdens to finance the health sector. Hence, there is an urgent need to expand the functions of the secondary health facilities (maintenance of medical facilities and device, strengthening the capacity of health personnel, etc.).

For a multi-level health care provision system, it is necessary to strengthen the coordination of information within and in between health facilities. With the support of the Luxembourg Development Cooperation Agency (hereinafter referred as to LuxDev), and other aid agencies the Government of Kosovo is already working on the development

of a modern, digital health information system (hereinafter referred as to HIS) including also electronic medical records.

The Government of Japan has set “administrative capacity improvements and human resource development” as one of the priority areas of its cooperation with Kosovo, and the Japan International Cooperation Agency (JICA) conducted a survey ‘Information Collection Survey on the Health Sector of Kosovo and Albania in 2014’. Through the survey, the general conditions and the challenges of the health sector were analyzed, and the direction of possible cooperation was comprehensively set. Based on the results of the survey, the Government of Japan through grant aid (economic and social planning) has provided medical device, including products made in Japan, to the University Clinical Center of Kosovo (UCCK), which is the core tertiary health facility in Kosovo. Also, thanks to this grant aid the UCCK, where more than 20,000 people are treated annually, has improved its capacity, and contributed to the economic and social development of Kosovo.

The COVID-19 pandemics has created a difficult situation for the health system in Kosovo. Besides the deteriorating economic situation, the existing health care system is under pressure to provide response measures to halt the spread of the coronavirus, such as conducting large scale testing and the treatment of infected people, also widening regional disparity in health services. Bearing in mind the above mentioned challenges, the Government of Japan, aiming at contributing to control the spread of the infectious disease and strengthen the health system of Kosovo, dedicated grant aid for health and medical device (Economic Social Development Plan) on September 23, 2020 by exchanging letters. The plan expects to provide health and medical device to Kosovo shortly.

Based on the achievements accomplished within the health sector through cooperation with JICA in the past, the Ministry of Health (hereinafter referred as to MOH) of Kosovo has requested JICA to conduct the present survey in order to promote comprehensive reforms based on the “Health Sector Strategy 2017-2021”, while MOH has pledged to provide the necessary support to conduct the survey.

Therefore, the Survey Team examined the possibility of effective cooperation between Japan and Kosovo utilizing Japan's technology, knowledge, and experience in the field of health sector. Based on the findings of the survey and the result of analysis, and taking into consideration the effects of COVID-19 pandemic on the health sector, the survey focused on strengthening health financing including the establishment of a health insurance system, and on strengthening health service provision with the aim to establish a resilient health system in Kosovo.

1.2 Objectives of the Survey

In order to contribute to building resilient health systems towards UHC in Kosovo, the Survey has been conducted with the following objectives.

(1) To analyze and identify the development needs/challenges of Kosovo’s health sector in order to build resilient health systems towards UHC, which provides all people (particularly the poor and vulnerable) with access to needed and essential health services of sufficient quality even under COVID-19 pandemic, and ensure that the use of these services does not expose the user to financial hardship. The Survey Team reviews all related information with the special focus on laws and regulations, health financing and health service delivery at all levels as well as COVID-

19 responses.

(2) To identify future possible technical and financial cooperation with Kosovo by taking advantage of Japanese knowledge, technologies and experiences in health sector.

1.3 Methodology

In order to achieve the objective of this study, which is to make a proposal on the possibility of cooperation by JICA to Kosovo, the necessary information was collected in following 3 ways.

a) Obtaining information and data from existing literatures.

b) Interviewing with stakeholders by the research team

c) Information and data obtained through subcontracted surveys.

In order to ensure the smooth implementation of the survey, preparations were made in advance and interviews with the relevant institutions were coordinated. In this study, information on the Zvecan and North Mitrovica Hospitals in Mitrovica District, the Gracanica Hospital in Pristina, which are classified as secondary health facilities, and the 3 MFCs located in the respective cities in the Serb residential areas, were not accessible and information on them were not available.

1.3.1 Subcontracted survey

Following the selection and negotiation of the contractor for the subcontracted survey, the subcontracted survey was conducted between 19 April and 18 June 2021. The subcontracted survey consisted of a questionnaire survey and focus group discussions (FGDs). A summary of each survey is provided below.

Table 1-1: Outline of Subcontracted Survey

Period	Middle of April 2021 - End of June 2021
Target of survey	- Questionnaire survey： 56 health facilities (1 tertiary health facility, 7 secondary health facilities, 38 primary health facilities and 10 private health facilities) and 38 cities were surveyed. health facilities - Focus Group Discussion： Participant group：Minor ethnicity, unemployed youth, worker in information sector, mother with under two year old child
Survey Contents	- Questionnaire survey： Collection of information on Basic information (facilities, device, beds, specialties, etc.), human resources (number of medical personnel, number of specialists, etc.), Medical services (number of outpatients and inpatients, average hospitalization days, number of operations, number of births, number of deaths, breakdown of diseases, number of examinations, etc.), Health and medical related finances (income, expenditure, breakdown of procurement costs for medicines, etc.) - Focus Group Discussion： Five times Focus Group Discussion were held and information on health service usage situation for various social and economic group were collected.
Method	-Questionnaire survey： The subcontracted Survey Team collected data with using questionnaire sheet prepared by KRC Survey Team. Data collection was implemented by field trip and hearing based on questionnaire sheet. Field visit was not mandatory, but picture of each facilities was required.

	- Focus Group Discussion： Focus Group Discussions were implemented online with using discussion guide made by KRC.
Deliverables	- Deliverable (1)： Result of secondary and tertiary questionnaire survey - Deliverable (2)： Result of primary, private and municipality questionnaire survey - Deliverable (3)： Result of Focus Group Discussion

Source: The Survey Team

Focus group discussions were conducted with 5 target groups in order to gather information on differences in access to health services according to socio-economic strata and in order to identify whether or not there are "people left out of health services" in Kosovo. Due to the governmental ban on gatherings of more than 10 people because of COVID-19 epidemic and the need to avoid the risk of infection among participants, all 5 FGDs were conducted online and attended by the Survey Team members. The target groups and discussion topics are shown in Table 1-2.

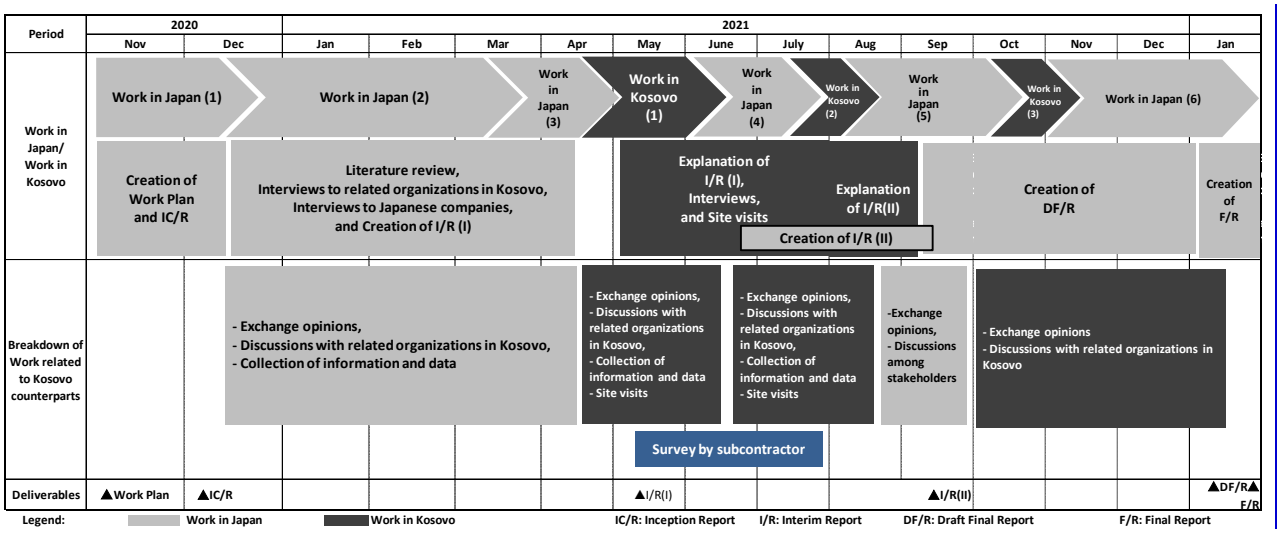
Table 1-2: Target Group and Discussion Themes of FGD

	Participants	Discussion theme
FGD1	Minor ethnicity (Gorani, Roma)： 6 men and women	Experience of using health and medical service, idea on public health facilities, idea on private health facilities, lifestyle
FGD2	Minor ethnicity (Ashkali, Egypthian, Turk)： 7 men and women	Experience of using health and medical service, idea on public health facilities, idea on private health facilities, lifestyle
FGD3	Unemployed youth (under age of 30)： 6 men and women	Experience of using health and medical service, idea on public health facilities, idea on private health facilities, lifestyle
FGD4	Worker in informal sector : 5 men and women	Experience of using health and medical service, idea on public health facilities, idea on private health facilities, lifestyle
FGD5	Women with under 2 years old child： 6 women	Experience of antenatal care, idea on public health facilities, idea on private health facilities, lifestyle

Source: The Survey Team

1.4 Workflow

Workflow is shown as Figure 1-1. While confirming the status of COVID-19 infection, the Survey Team flexibly responded to the on-site interview schedule in coordination with related organizations.

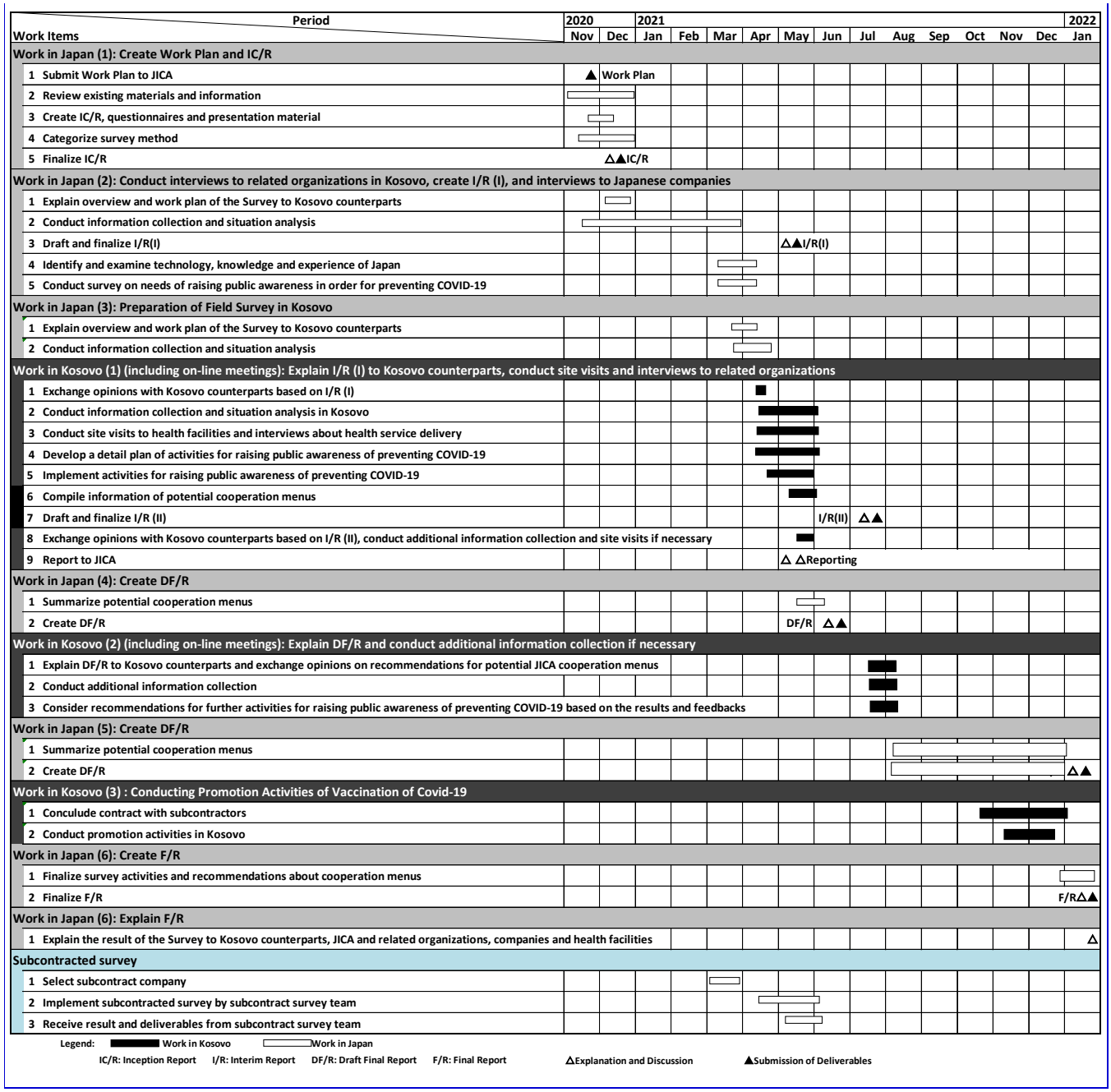


Source: The Survey Team

Figure 1-1: Workflow

1.5 Work Plan

The work plan of this survey is shown as Figure 1-2. The timing and duration of the survey in Kosovo was decided in coordination with related organizations.



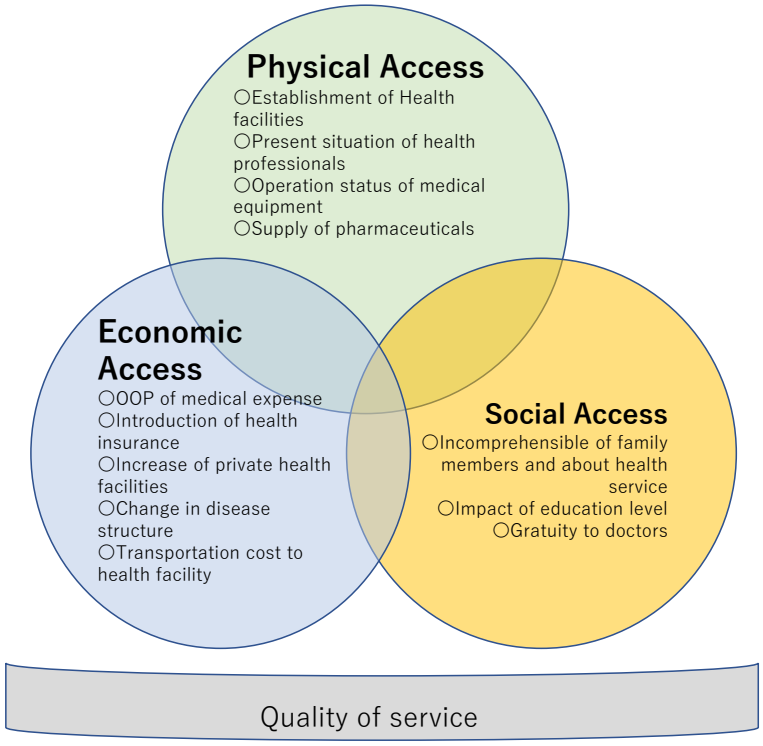
Source: The Survey Team

Figure 1-2: Work Plan

Chapter 2 Situation of Universal Health Coverage in Kosovo

In this Chapter, the Survey Team summarizes the current status of UHC in Kosovo. Firstly, the Survey Team analyzed the situation of UHC in Kosovo from the viewpoints of “Accessibility of health services” since JICA believes that improvement of accessibility of health services such as physical access, social habitual access and economic access would make to achieve UHC.[1] WHO defines Universal Health Coverage (UHC) as "all individuals and communities receive the health services they need without suffering financial hardship.".

The Survey Team also analyzed the status of UHC in Kosovo from these three viewpoints of governance, health finance and service delivery in reference to the UHC 2030’s report "Healthy systems for universal health coverage --a joint vision for healthy lives" published in 2017. In addition to these three aspects, the Survey Team examined the perspective of quality service provision.



Source: The Survey Team

Figure 2-1: Three Aspects of Access for UHC

2.1 Physical Access

Physical access generally means geographical/physical distance to health facilities, as well as the availability of medicines and medical device at health facilities. Physical access should also cover human resources, such as readily available doctors and nurses and available medical services within health facilities. Since it is not possible to provide quality health services without proper device and without adequate number and quality of doctors; and it is not possible to achieve user satisfaction. There are some areas in Kosovo, where doctors and medical materials are in

[1] https://www.jica.go.jp/aboutoda/sdgs/uhc.html (Accessed on September 30, 2021)

short supply, creating health inequalities. The situation of UHC in Kosovo from the viewpoint of physical access is as follows.

(1) Public Health facilities - numbers and physical access in Kosovo

Health facilities can be reached by basically all citizens[2] within 30 minutes at primary level, including the Main Family Medicine Center (hereinafter referred as MFMC), within 1 hour at secondary level and within 2 hours at tertiary level of the heath care provision. It has been confirmed through interview with international donors that citizens face no particular problem with physical access of the health facilities in Kosovo. Thus, the network of health facilities established is sufficient. The network of health facilities includes 38 MFMC, 169 Family Medicine Centers (hereinafter referred to as FMC), and 255 Family Medicine Ambulance (hereinafter referred to as FMA) as primary medical facilities, seven (7) general hospitals (GH) as secondary health facilities and the University Clinical Center of Kosovo (hereinafter referred to as UCCK) as the tertiary health facility located in the capital city of Pristina. The areas with relatively high proportion of minority Serb population have their own general hospitals such as North Mitrovica, Zvecan and Gracanica which are supported by Serbia.

(2) Situation of medical professionals

The total number of doctors and nurses in Kosovo is 2,591 and 7,117, respectively. The number of health care workers, including doctors and nurses per 10,000 population is 54.5 per 10,000 population (14.54 per 10,000 population for doctors only). If the number of physicians and nurses working in primary health facilities is 1,142 and 3,108, respectively, the number of health care workers (including 1,142 physicians and 3,108 nurses) will be 23.8 per 10,000 population, which is the minimum number of health care workers required to provide primary health care as defined by WHO. The number has just reached 23 per 10,000, the minimum number of health care workers required to provide primary health care as stipulated by WHO. Table 2-1 gives a comparison of doctors across western Balkan countries. This table explains Kosovo has relatively lower number of doctors in proportion to its population.

Table 2-1: Comparison of Number of Doctors per 1,000 People (primary level)

Country	No. of Doctors per 10,000 people
Kosovo	2.4
Serbia	3.0
North Macedonia	3.0
Montenegro	2.7
Bosnia Herzegovina	-
EU	3.8

Note: Health Statistics 2019, MOH, Kosovo is utilized for data of Kosovo
Source: Health at a Glance Europe 2020

It should be noted that MFMCs have full-time doctors on duty every day, while FMCs and FMAs have limited consultation days and do not have medical personnel on duty every day. This trend is particularly evident in rural

[2] In this survey, the area of residence of Serbians was not included, so the total population here does not include the situation of Serbians.

areas. The reasons for this are that experienced doctors tend to refuse to work in rural health facilities, that there is an absolute shortage of doctors, and that even when doctors are assigned, they are only relatively inexperienced and not ready to provide the necessary health services at all times.

In addition, it has been also confirmed that some medical professionals after finishing their shift at their primary workplaces, tend to take up a second job at private medical facilities for night shifts or during their day-offs. This is caused by low wage levels. A pay raise should be necessary if quality work is expected at public health facilities.

(3) Installation and maintenance of medical device

Regarding medical device, since primary health facilities are under the administration of municipalities, and financial resources are provided through municipalities, relatively new device could be installed. On the other hand, secondary health facilities are under the supervision of the MOH, and they also receive their budgets from the ministry. This centralized budget management, which permanently faces shortage in fund' is resulting in chronic budget shortages and there is small financial space to renew and well maintain medical device. As a consequence, many medical device was broken or was not functioning during Survey Team visit.

As a result, for example, it has been confirmed that there are health facilities where the functions of secondary health facilities are more limited than those of primary health facilities with regard to examination functions using medical device such as blood chemistry tests, X-ray examinations, and echo examinations, which are performed in primary and secondary medical care.

Technicians to maintain and repair medical device are assigned to UCCK and secondary health facilities, but not to primary health facilities.

(4) Medicine supply as part of physical access

Because the government is unable to procure and distribute sufficient quantities of medicines due to the constraints of the national health budget, there are very limited health facilities that provide enough medicines for treatment, and it has been confirmed that patients often purchase medicines at their own expense from pharmacies near health facilities.

2.2 Social Access

Social access is influenced by cultural and habitual factors and schooling level, and it is said that low health literacy, language barriers, and the demand for bribes can limit social access. Through the survey, the challenges of social access in Kosovo have been identified as described below.

(1) Low Level of Health literacy

The results of this survey confirm that the MOH and the various health facilities are making efforts to eliminate

barriers to women's access to health services. However, the UNICEF study[3] found that as patients' schooling level lowers, so does their health literacy. In addition, the utilization of health facilities and services often depends on the will of the decision makers in the household, which in turn depends on the economic situation in the household and the decision makers' health literacy. The report has pointed out that due to the influence of the economic situation in the household and the health literacy of the decision maker, the types of services received are reduced due to lack of permission from the decision maker. In particular, certain segments of the population, such as ethnic minorities and the poor, who are considered to have a low level of schooling in Kosovo, are not considered to have a high level of health literacy. Additionally, it is believed that there are still people who have difficulties in accessing social customary services. For example, while 94% of the normal population had four or more prenatal checkups, a large difference was observed for ethnic minority and poor women, 77% (see Table 5 20)

(2) Language barriers

Albanian and Serbian are the official languages in Kosovo, and the treatment of patients in health facilities is thoroughly handled regardless of ethnicity, such as in any language.

(3) Corruption in health services

Some survey results confirm that there is a proportion of the population in Kosovo who feel they have to give gratitude money (on top of user fees) to win the goodwill and attention of medical personnel and receive high quality services. Specifically, according to the Corruption Risk Assessment in the Health Sector in Kosovo (UNDP, 2014), 16% of those surveyed said they gave gratitude money at health facilities, and 70% said corruption is a common issue within health facilities. A World Bank Study[4] reported that this was due to low salaries of civil servants, including doctors, and the use of gratitude money is common in other public sectors as well.

2.3 Economic Access

Economic access can be measured in terms of OOP rates for health care services, transportation costs to nearby health facilities, and also in terms of the financial impact of reduced income due to illness.

(1) Low Public Health Spending

Chatham house's Shared responsibilities for health. (2014) reports that "to guarantee the health of the population, the government needs to spend at least 5% of GDP or $86 per capita on public health expenditure (target public health spending as a percentage of GDP). However, in Kosovo, public health spending is overwhelmingly low at 2.83% of GDP, resulting in increased OOP (40%), shortages of medicines, and insufficient maintenance of medical device. In addition, there are many users who are exempted from medical expenses due to poverty (80-95% of

[3] United Nations Children's Fund. 2019-2020 Kosovo (UNSCR 1244) Multiple Indicator Cluster Survey and Roma, Ashkali and Egyptian Communities in Kosovo Multiple Indicator Cluster Survey. 2020.

[4] Kosovo Health Financing Reform Study,2008, the World Bank

secondary facility users), which places a heavy burden on the already small health financing.

In addition, with the evolution of medical technology and changes in the disease structure (increase in non-communicable diseases such as cardiovascular diseases and cancer), public health facilities are required to maintain and update expensive medical device.

The instability of health financing in the country as a whole is considered to be an impediment to economic access.

(2) High OOP ratio

As stated in the World Bank's Country Partnership Framework 2017 - 2021, the patient OOP share of health care costs is set at 40 percent[5], with 70 percent of that being OOP costs for medicines. Specifically, although the cost of medical services is inexpensive (between 1 and 2 Euros), patients are required to pay for all medicines and medical materials necessary for treatment, which increases the OOP. This figure exceeds the upper limit of 15-20% recommended by the WHO, and the high percentage of OOP expenditure in Kosovo can be seen as an impediment to access in terms of economic access, as well as an issue that contributes to the increase in poverty due to the increased burden of medical costs.

(3) Health Insurance System is not yet introduced

In Kosovo, the Health Insurance Law was enacted in 2014 and the Health Insurance Fund was established in 2017, but as of July 2021, public health insurance system has not been introduced. Implementing a national health insurance system with national solidarity in mind should lead to increased public spending in the health sector through increased financial resources from premium income. This higher financial opportunity in turn would improve the quality of care and the supply of medicines. It is expected that this process could lead to a reduction in OOP and improve economic access to the healthcare. The implementation of the health insurance system is expected to lead to increased spending in the health sector. Specifically, the current ratio of about 3% of GDP on the health sector is expected to increase by 2% to 5%.

(4) Transportation cost

In most cases, access to health facilities is by foot, public transportation, private vehicles, or free ambulances, and this is not an impediment to economic access, including for the poor and ethnic minorities. It was confirmed that most of the ambulances were provided by donors.

2.4 Governance, Health Financing, Supply and Quality of Services

(1) Governance

The health strategy is not well positioned in the national development strategy, which is thought to have an impact on the realization of health policy and the stabilization of health financing. In addition, there are some practical

[5] In the World Bank's Country Partnership Framework 2017-2021, the OOP is reported to be 40%. The National Health Account (2018) by the Government of Kosovo, on the other hand, reports an OOP of 23%; the National Health Account (2018) is the first attempt by the Government of Kosovo, and as a research team, we adopted 40% because of the low reliability of the figures .

issues that need to be addressed, such as the governance capacity of health sector-related institutions, including policy formulation, administrative execution (including management and coordination), and motivation to work.

It is expected that the effects and outcomes of the various training programs currently being implemented with donor support to improve the governance capacity of health sector-related institutions will be realized in the future. In the area of policy making, the improvement of data analysis capability for evidence-based planning instead of sensory and empirical planning, and in the area of administrative execution, the improvement of appropriate monitoring capability for policies and plans are areas that continue to require support.

(2) Health Financing

Public health expenditure is overwhelmingly low at 2.83% of GDP, causing an increase in the OOP rate of patients (about 40% of National Health Spending), a shortage of medicines, and an observed lack of maintenance of medical device, are observed. In addition, many patients are exempt from medical expenses due to poverty, etc. (80 to 95% of secondary facility users), and the burden on health finance is already significant.

The government of Kosovo is preparing to improve this shortage of financial resources by introducing a health insurance system, but it has not yet been implemented. In addition, the instability of health financing is thought to affect not only hard problems such as the renewal of medical device, but also soft problems such as the lack of knowledge and technical skills of doctors and nurses due to the lack of a training system. Such hard and soft issues related to health facilities and medical personnel are thought to have led to a decline in people's satisfaction with health services, suggesting that the shortage of health budget is affecting all activities in the health sector.

(3) Delivery of Quality and Quantity of Health Services

Based on the aforementioned considerations from physical access, social access, and economic access, a certain level of health services is considered to be provided to the people of Kosovo at the required level. On the other hand, due to challenges in governance and health financing, the quality of health services is considered to have room for improvement.

According to the results of the patient perspective surveys (QOC 2018 and UNDP 2013 surveys), almost 80% of the population uses public health facilities, which can be judged as a general acceptance of the content and quality of services by the population. However, the survey results also show that 40% of the residents are dissatisfied with the content of the services, indicating that there is a need to improve the quality of health services. Satisfactory and unsatisfactory points pointed out by the residents are as follows.

(Satisfied)

- Low medical examination fee
- Located at a close distance
- Available 24 hours in big cities
- Medical staff with regular qualifications will respond
- Free medicine and insulin depending on the timing

(Dissatisfied)

- Bribery request Payment under the sleeve
- Staff attitude
- Long waiting time
- No medicine
- Absence of staff in rural areas

2.5 The Status of Relevant Indicators from the Sustainable Development Goals (SDGs)

The Goal 3 (Ensure healthy lives and promote well-being for all at all ages) in the SDGs can be achieved through the provision of UHC. Thus, ensuring that health services are 1) provided within easy reach and 2) at bearable cost should be achieved. In addition, at the United Nations General Assembly in July 2017, it was adopted to use "availability of essential public medical services" and "the ratio of the population with high health-related expenditures burdening the household financial balance" as UHC indicators in the SDGs. Specifically, the following specific indicators can be confirmed as important indicators in Kosovo[6].

Goal 3: Ensure healthy lives and promote well-being for all at all ages Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

With regard to 3.1, Kosovo's maternal mortality rate (7.2 per 100,000 live births in 2011) meets the target of the SDGs (less than 70). It should be noted that the number of births in Kosovo is around 23,000 to 27,000 per year, and one maternal death has a greater impact on the mortality rate than in other countries. With regard to 3.2, the neonatal mortality rate (11 per 1,000 live births, 2018) and under-five mortality rate (16 per 1,000 live births, 2018) meet the SDG indicators. However, the number of deaths due to "conditions occurring in the perinatal period (P00-P96)" in accordance with the International Statistical Classification of Diseases and Related Health Problems (hereinafter referred to as "ICD"[7]) is still low. Considering that the number of deaths due to "conditions occurring in the perinatal period (P00 - P96)" is 210 (2018) and 126 (2019) per year (see Table 4 2), there is a need and room for further improvement in the SDG indicator of eradication of preventable deaths of newborns and children under five. It should be noted that the infant and newborn mortality rates in Kosovo's ethnic minority communities (Roma, Ashkali, Egyptian) are approximately three times higher than in the general population (41 per 1,000 live births and 29 per 1,000 live births, respectively). In terms of UHC in Kosovo, it is necessary to address these disparities in mortality rates (see Chapter 4).

[6] SDGs Indicator 3.8 is not available in Kosovo

[7] A classification developed by the World Health Organization (WHO) in accordance with the Charter of the World Health Organization for the systematic recording, analysis, interpretation, and comparison of death and disease data compiled from different countries and regions at different points in time.

Chapter 3 General Information about Kosovo

In this chapter, the Survey Team organized the collection and confirmed basic information on Kosovo (see Appendix 1 for the detailed version).

3.1 General Information

Kosovo is a landlocked country and located in the center of the Balkan Peninsula and it is almost in the center of South-East Europe. It is surrounded by Serbia in the northeast, North Macedonia in the southeast, Albania in the southwest and Montenegro in the northwest. It has a strategic position to connect Central Europe with South East Europe as well as provide an inland corridor between the Adriatic Sea and the Black Sea regions. It is a state occupying an area of 10,908 km^2, with a population of approximately 1.78 million (2019, Kosovo Agency of Statistics) (its area and population are approximately equivalent to those of Gifu Prefecture). Surrounded by mountains, the country belongs to two different climatic zones: The South and the North of Kosovo. The South has a Mild Mediterranean climate characterized by hot and dry summers and mild and rainy winters; while the North is characterized by European Continental Climate affected from the northwest such as the Mediterranean Sea and the Alps. The climate is characterized by hot summers and cold winters, and the temperature sometimes reaches over 30°C in summer and below −10°C in winter seasons.

Kosovo is divided into 7 districts, an increase in the number of districts by two following an administrative reform suggested by the United Nations Interim Administration Mission (hereinafter, UNMIK) in 2000. The districts are further subdivided into 38 municipalities. The largest and most populous district is Pristina, including the capital city Pristina.

The major ethnic groups in Kosovo are Albanians (89%), followed by Serbs (5%) and other ethnic groups, including Bosniaks and Turks (4%), and Romani, Ashkali and Egyptian (RAE, 2%). Both Albanian and Serbian are official languages of Kosovo. Islam is the most widely practiced religion in Kosovo (Albanians), followed by Easter Orthodox Christianity (Serbians).

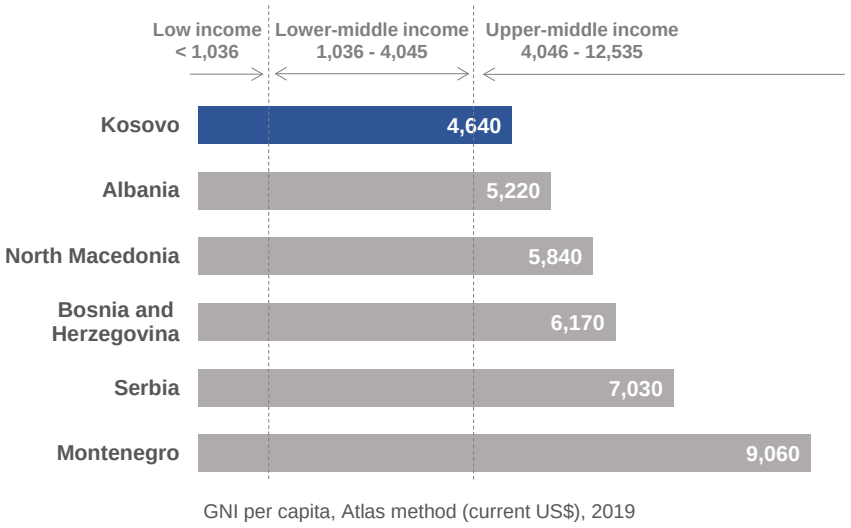
International recognition of Kosovo, since its declaration of independence from Serbia in February 2008 following the conflicts in the 1990s, has been mixed. The number of states that recognize Kosovo's independence (approximately 100 states, as of September 2020. Japan recognized Kosovo’s independence in March 2008) have risen to nearly 100 and the country expressed its willingness to join various intergovernmental organizations, such as the United Nations and the EU. Kosovo joined the World Bank and the International Monetary Fund (hereinafter, IMF) in 2009 and also established diplomatic relations with Japan.

3.2 Economy and Industry

This section explores the economic situation of Kosovo, its industry and the economic sectors by studying major macroeconomic indicators and other social indicators including employment and poverty levels.

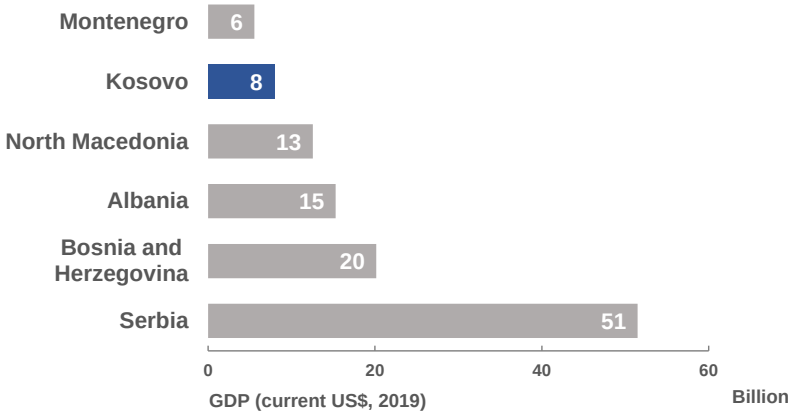
3.2.1 National income level and economic growth

The per capita gross national income (GNI per capita, Atlas method) in 2019 stood at 4,640 USD in Kosovo which was lowest among its neighbors (Figure 3-1). The Gross Domestic Product (GDP) value of Kosovo was worth approximately 8 billion USD (approximately 840 billion JPY) in 2019, the second smallest in the Western Balkans (Figure 3-2).



Source: World Development Indicators

Figure 3-1: GNI per capita (2019, Atlas method, current US$)

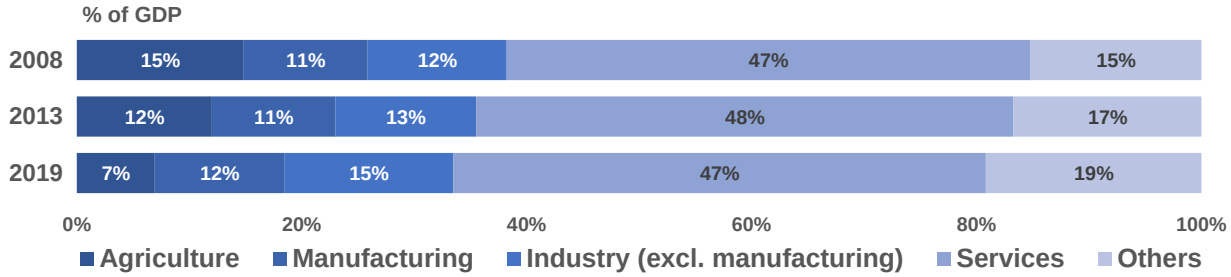


Source: World Development Indicators

Figure 3-2: Gross Domestic Product (GDP) (2019, current US$)

3.2.2 Industrial structure

The last decades has not shown large scale structural changes in the industrial structure of Kosovo. Figure 3-3 shows changes in the share of economic sectors in GDP in the country. Between 2008 and 2019, while the ratio of agriculture, forestry, and fisheries contributing to GDP gradually decreased from 15% to 7%, the ratio of industry and services have little increased.

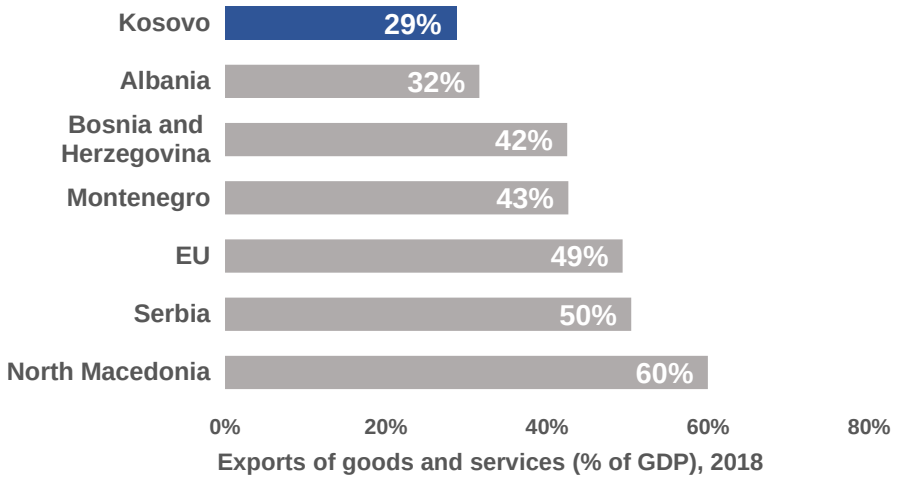


Source: World Development Indicators

Figure 3-3: Industrial Structure as Percent of GDP

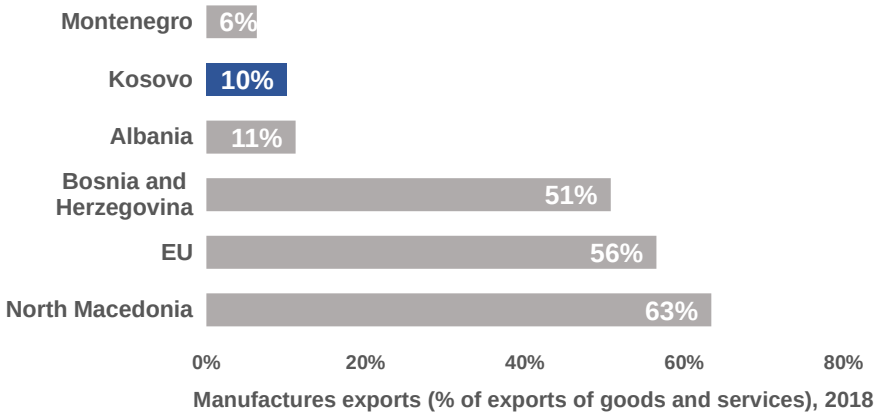
3.2.3 Trade (export)

The trade balance of Kosovo suggests that the growth of major industries may be insufficient to counterbalance imported goods and services. Figure 3-4 shows the value of export of goods and services as percent of GDP (export dependence). There is a global understanding that the higher the export dependency of a country the more advanced its economy is. In contrast, the export dependency ratio of Kosovo was 29% in 2018, being the lowest among the Western Balkans countries. Figure 3-5 shows the presence of manufactured exports in exports of goods and services (% of total exports of manufactures). This ratio is thought to be an indicator of industrialization and generally tends to increase with industrialization. In 2018 ratio of manufactured export was as low as 10% in Kosovo, comparable to those of Montenegro and Albania.



Source: World Development Indicators

Figure 3-4: Export of Goods and Services as Percent of GDP (export dependence) (2018)

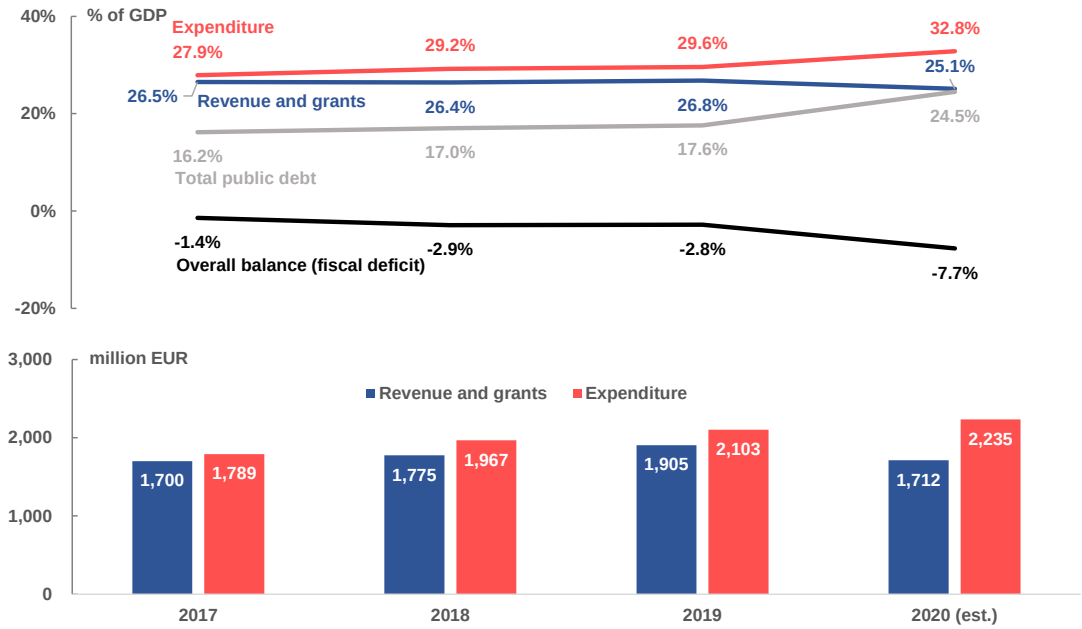


Source: World Development Indicators

Figure 3-5: Ratio of Manufactured Exports in Exports of Goods and Services (2018)

3.2.4 Finance

Figure 3-6 shows changes in basic fiscal data: in government gross revenue and expenditure (lower section of the figure) as well as the fiscal balance and level of public debt (as % of GDP) (upper section of the figure). The fiscal deficit of Kosovo has been growing in recent years and it is expected to soar to 7.7% of GDP due to a significant decrease in tax revenues caused and large-scale financial support measures necessitated by the COVID-19 pandemic.

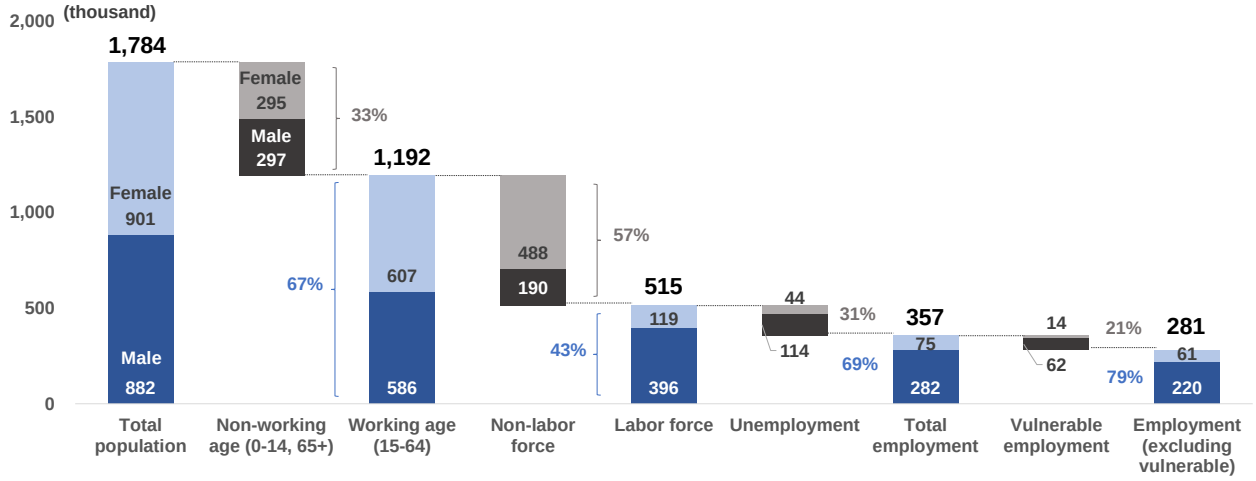


Source: Staff Report for the 2020 Article IV Consultation (IMF, 2021)

Figure 3-6: Basic Fiscal Data

3.2.5 Employment

The employment status also needs to be examined since it is closely related to economic and industrial development of a country. Figure 3-7 shows basic demographic data including: total population, working age population, labor force population, the number of employed people and employment rate in Kosovo in 2017.



Source: Kosovo Agency of Statistics

Figure 3-7: Population of Working age, Labor force, Employment (2017)

The total population of Kosovo in 2017 was 1.784 million people (882,000 men and 901,000 women), out of which 1.192 million people (586,000 men and 607,000 women) 67% of total population belonged to the working age group. Only 515,000 people, 43% of working age population were active (labor force population). The remaining 57%, 678,000 people were economically inactive. Within the economically active population, only 357,000 people are employed, thus unemployment rate was as high as 31%. Employed people are also encountering insecurity: 21% of them were in unstable forms of employment[8], while 70% of them is in temporary employment.

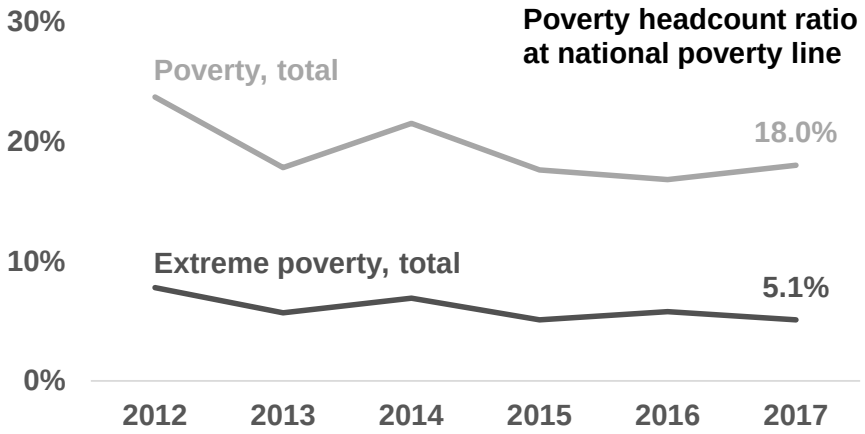
As a comparison, the level of labor force participation rate in other countries are as follows: 80% in Japan 74% in the EU; 73% OECD average; 67% Croatia; and 66%. in North Macedonia. Thus, Kosovo's labor force participation rate at 43% is extremely low and it is even worse for women.

3.2.6 Poverty

Kosovo is one of the poorest countries in Europe. Absolute poverty (a condition where income or expenditure is below a certain level to purchase the minimum required food and other necessities) has been a challenge in Kosovo. In this analysis the Survey Team uses poverty indicators based on the national poverty line established/set by the Government of Kosovo based on the Household Budget Survey. Figure 3-8 shows changes

[8] Sole proprietors and family workers who contribute to their family business

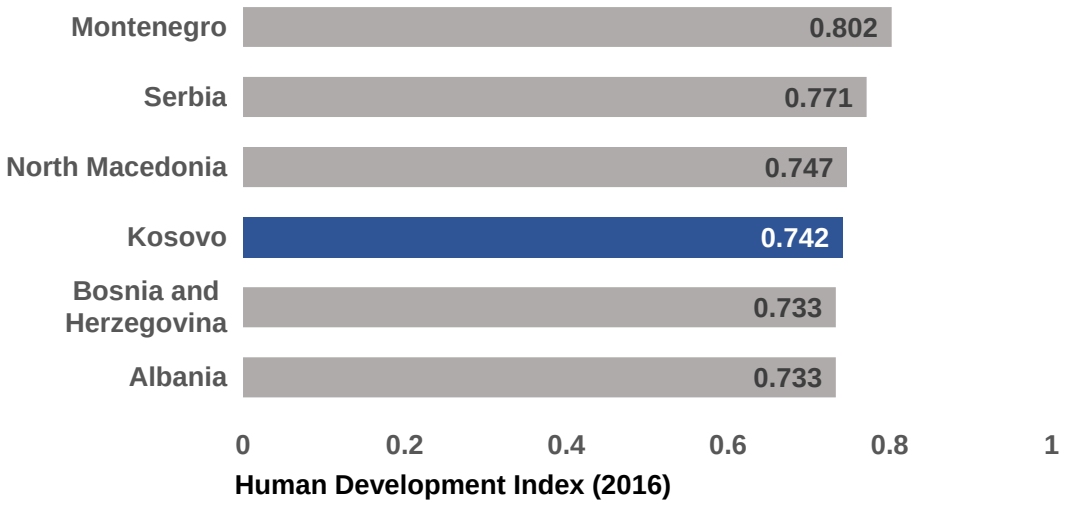
in the poverty rate published by the Kosovo Agency of Statistics. Nationally approximately 18% of the people (approximately 1 in 5 people) lived below the poverty line (1.85 EUR per day), and approximately 5% (approximately 1 in 20 people) lived below the extreme poverty line (1.31 EUR per day) in 2017. In both standards, the poverty rate in rural areas is higher than that in urban areas, and the gap between urban and rural areas has been growing.



Source: Kosovo Agency of Statistics

Figure 3-8: Changes in Poverty Rate (national level)

It is also important to consider the Human Development Index (hereinafter, HDI) which is a composite measure of average achievement in key dimensions of human development (1. average life-expectancy, 2. education [enrollment rate, adult literacy rate], and 3. living standards [real GDP per capita]). This is to counterbalance sole monetary considerations. Figure 3-9 shows the HDI of Kosovo and other Western Balkans states in 2016. The HDI is classified into the following four categories according to the standards of the United Nations Development Program (UNDP): low HDI countries (less than 0.550), medium HDI countries (0.550 to 0.699), high HDI countries (0.770 to 0.799), and very high HDI countries (0.800 or higher). Kosovo and most of the other Western Balkans states fall under high HDI countries, while Montenegro classifies as very high HDI country.



Source: UNDP

Figure 3-9: Human Development Index (2016)

3.3 Overview of Political Situation

Regarding Kosovo's internal politics, it is characterized by frequent changes of government evidenced by the five parliamentary elections (in 2010, 2014, 2017, 2019, and 2021) held following the declaration of independence in 2008. During hearings with the World Bank and other donors such as LuxDev, it was commented that the consistency and sustainability of policies were not maintained, and the construction and operation of aid projects had been greatly affected by these political turmoil. It is said that Kurti's second government reaching single-party majority in the parliament with its Self-determination Movement (LVV) has a good chance to become the first government to remain in office until the end of its term.

To add to the political instability of the country, the reconciliation and harmony with the Serb minority of Kosovo, which largely opposes the declaration of independence also constitutes a challenge, which also affects the political and administrative management related to health care. For example, Serbia does not recognize Kosovo as an independent state and the Serbian Government offers health services for Serbian residents in North Kosovo. Thus, the health care provision system is complex in Kosovo.

3.4 National Development Strategy

3.4.1 National Development Strategy 2016-2021

Kosovo has adopted the National Development Strategy 2016-2021 (hereinafter, NDS 2016-2021) in which national development directions are laid down. In the NDS 2016-2021, priority sectors were defined including infrastructures, energy supply and generation, governance, human resources development and the improvement of business environment. Within this document little attention was given to the health sector. For example, the NDS 2016-2021 limits itself to the strengthening of health facilities and utilization of HIS as strategic goals of the health sector, with many other important areas, such as health insurance coverage and tertiary health institutions are being left out. When the NDS was formulated in 2015, 7 years had just passed since the

independence declaration. Therefore, this suggests the background of those days that economic growth and its environmental improvement, and human resources development were recognized as more important.

Table 3-1: Priority Sectors in National Development Strategy 2016-2021

Priority sectors	Description
1 Human resources	Improvement of pre-school education, linkage between education and employment, etc.
2 Governance and Law	Evidence-based policy making, etc.
3 Industrial development	Promotion of small and medium enterprises, utilization of resources, etc.
4 Infrastructure development	Development of power infrastructure, etc.
5 Implementation of the National Development Plan	-

Source: National Development Strategy 2016-2021, GOK

3.4.2 Next National Development Strategy

The next National Development Strategy is being prepared by the Office of the Prime Minister and would be finalized in 2021. As described in the previous subsection, the health sector is not well represented within the present NDS 2016-2021. However recent events, such as the COVID-19 pandemic from early 2020, raised awareness of the importance of public health measures, the fight against infectious diseases. Thus, the MOH highly expects that the health sector will get a higher importance in the coming Next National Development strategy.

At the same time, the results of the existing NDS 2016-2021 are being evaluated, and its evaluation report is planned to be compiled in the near future.

3.5 Political and Economic Relations with Japan

Japan has provided humanitarian and restoration assistance to Kosovo through international organizations since 1998 when the situation in Kosovo deteriorated. In January 2018, the former Prime Minister Abe announced the Western Balkan Cooperation Initiative and stated that Japan will support economic and social reforms of the Western Balkans countries which are aiming at joining the EU and will enhance Japan's cooperation in the Western Balkan area.

On the other hand, it cannot be said that the economic relation between Japan and Kosovo is strong. At present, there are only two Japanese companies operating in Kosovo, Hirano mushroom LLC (mushroom cultivation) and Japan Tobacco Inc. (tobacco sales).

Chapter 4 Overview of the Health Sector in Kosovo

4.1 Overview of the Health Sector

This chapter provides an overview of the health sector in Kosovo, which includes national health status, demographic prospects, national health sector strategies, health finance, administrative institutions for health sector and so on. In addition, cooperation programs with other donor organizations summarized. National Health Status

4.1.1 Health status based on specific indicators

Table 4-1 presents the health status of the people of Kosovo based on some indicators. It also shows a comparison with neighboring countries. Some of these indicators are also targets of Goal 3 “Ensure healthy lives and promote well-being for all at all ages” of SDGs.

Taking into account changes in the health system so far, it is expected that values of many of the indicators in relation to the neighboring countries will improve. Individual indicators are explained below. Of these indicators, neonatal mortality rate and under-five mortality rate, which are especially important in the health system, will be analyzed in more detail, including time-series descriptions, in a later section (4.1.3Maternal and child health).

- Maternal mortality rate in Kosovo (7.2 deaths per 100,000 live births in 2011) has achieved the target of the SDGs (less than 70 under the same conditions) and is the same level as that of neighboring countries. However, considering that the number of births in Kosovo is quite small, about 23,000 to 27,000 a year, it is necessary to understand this figure is sensitive to any change in the number of maternal deaths.

- Infant mortality rate and under-five mortality rate (11 and 16 per 1,000 live birth, respectively) have met the targets of the SDGs (12 and 25 per 1,000 live births, respectively), but do not reach the levels of neighboring countries. However, considering that the number of deaths due to “certain conditions originating in the perinatal period” defined in the International Statistical Classification of Diseases and Related Health Problems (hereinafter referred to as ICD)[9] is 210 (2018) and 126 (2019) per year, there is a need and scope for further improvement towards achieving the SDGs indicator of eradicating preventable deaths among newborns and at under 5 years of age. Special attention should be given to vulnerable groups, since there is a disparity in mortality rates among ethnic minorities in Kosovo (Roma, Ashkali and Egyptian (RAE)) and that of Kosovo as a whole.

- The incidence of tuberculosis has been decreasing. In 2019, the number of tubercular patients is 25 cases per 100,000 inhabitants, which is almost the same as the level of neighboring countries.

- The average life expectancy in Kosovo is 72, which is 5 years below the level of neighboring countries.

- The total fertility rate (TFR) of 2.0, which is higher than that of the neighboring countries, nevertheless it is

[9] A classification developed by the World Health Organization (WHO) in accordance with the Charter of the World Health Organization for the systematic recording, analysis, interpretation and comparison of data on deaths and diseases compiled from different countries and regions at different points in time.

almost equal to the population replacement level. However, there is a global trend that TFR decreases with economic development and urbanization, and thus it is expected that TFR in Kosovo will fall below the replacement level in the near future and Kosovo is anticipated to enter an era of fewer children (and even an era of population decline).

Table 4-1: Various Indicators of National Health Conditions

	Source	Kosovo	RAE in Kosovo[10]	Montenegro	Serbia	North Macedonia	Albania	Bosnia and Herzegovina
Maternal mortality rate (per 100,000 live births)	HNP/2017	7*		6	12	7	15	10
Infant mortality rate (per 1,000 live births)	HNP/2018	11**	21***	1.7	3.4	7.4	6.5	4.1
Under-five mortality rate (per 1,000 live births)	HNP/2018	16**	27***	2.5	5.5	9.9	8.8	5.8
Incidence of tuberculosis (per 100,000 inhabitants)	HNP/2019	25		15	14	12	16	27
cancer (per 100,000 inhabitants)	WHO2016	148		394			189	
Life expectancy at birth	DHS2016	71.6		76.8	76.3	75.9	76.4	77.3
Total fertility rate	HNP/2018	2.0		1.75	1.49	1.50	1.62	1.27

Remark: DHS (Demographic and Health Survey), HNP (Health Nutrition and Population Statistics), WHO (WHO Regional Officer for Europe, As for source for Kosovo: * MOH (Ministry of Health) 2011,** MICS (Kosovo Multiple Indicator Cluster Surveys) 2019－2020, ***MICS (RAE communities in Kosovo Multiple Indicator Cluster Surveys) 2019－2020

4.1.2 Current status of diseases

(1) Disease structure in terms of cause of death

As shown in Table 4-2, diseases of circulatory system (47%) were the most common cause of death in 2018, followed by cancers (28%). The disease structure is relatively similar to that of Western countries, with non-communicable diseases such as disease of circulatory system and cancer comprising about 75% of the total deaths, without major changes in the past decade.

Table 4-2: Cause of Death in 2007, 2017 and 2018

	2007		2017		2018	
	Group of diseases (ICD-10)	No. of cases (% of subtotal)	Group of diseases (ICD-10)	No. of cases (% of subtotal)	Group of diseases (ICD-10)	No. of cases (% of subtotal)
1	Diseases of the circulatory system (100-199)	2,561 (62.6%)	Diseases of the circulatory system (100-199)	4,649 (61.7)	Diseases of the circulatory system (100-199)	4,249 (46.7%)
2	Neoplasms (C00-D48)	573 (14. 0%)	Neoplasms (C00-D48)	1,107 (14.7%)	Neoplasms (C00-D48)	2,543 (28.0%)
3	Certain conditions originating in the perinatal period (P00-P96)	257 (6.3%)	Disease of the respiratory system (J00-J99)	663 (8.8%)	Disease of the respiratory system (J00-J99)	1,031 (11.3%)
4	Disease of the respiratory system (J00-J99)	145 (3.5%)	Diseases of the genitourinary system (N00-N99)	185 (2.5%)	Diseases of the genitourinary system (N00-N99)	281 (3.1%)

[10] Roma, Ashkali and Egyptian lived in Kosovo

	2007		2017		2018	
	Group of diseases (ICD-10)	No. of cases (% of subtotal)	Group of diseases (ICD-10)	No. of cases (% of subtotal)	Group of diseases (ICD-10)	No. of cases (% of subtotal)
5	Diseases of the genitourinary system (N00-N99)	133 (3.2%)	Certain conditions originating in the perinatal period (P00-P96)	184 (2.4%)	Certain conditions originating in the perinatal period (P00-P96)	210 (2.3%)
6	External causes of morbidity and mortality (V01-Y98)	129 (3.2%)	Endocrine, nutritional and metabolic diseases (E00-E90)	172 (2.3%)	Endocrine, nutritional and metabolic diseases (E00-E90)	204 (2.2%)
7	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R-99)	75 (1.8%)	External causes of morbidity and mortality (V01-Y98)	157 (2.1%)	External causes of morbidity and mortality (V01-Y98)	186 (2.0%)
8	Diseases of the digestive system (K00-K93)	66 (1.6%)	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R-99)	128 (1.7%)	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R-99)	108 (1.2%)
9	Endocrine, nutritional and metabolic diseases (E00-E90)	60 (1.5%)	Diseases of the digestive system (K00-K93)	96 (1.3%)	Diseases of the digestive system (K00-K93)	91 (1.0%)
10	Infectious and parasitic diseases (A00-B99)	34 (0.8%)	Infectious and parasitic diseases (A00-B99)	74 (1.0%)	Infectious and parasitic diseases (A00-B99)	78 (0.9%)
	Other diseases	61 (1.5%)	Other diseases	121 (1.6%)	Other diseases	116 (1.3%)
	Subtotal of diagnosed - coded	4,094 (100.0)	Subtotal of diagnosed - coded	7,536 (100.0)	Subtotal of diagnosed - coded	9,097 (100.0)
	Undiagnosed - uncoded	2,587	Undiagnosed - uncoded	2,134	Undiagnosed - uncoded	911
	Total	6,681	Total	9,670	Total	10,008

Source: Causes of Death in Kosovo 2006/2007,2017/2018, 2018/2019, Statistical Agency of Kosovo

(2) **Major diseases**

Table 4-3 and Table 4-4 are based on data provided by the National Institute of Public Health of Kosovo (hereinafter called NIPH) and show the relative frequency of diseases by the level of health facilities (primary, secondary and tertiary facilities[11]) in 2019.

The following diseases are listed within primary health facilities column of the table.

- The majority of the diseases are bacterial or viral acute upper respiratory tract infections (acute tonsillitis, acute pharyngitis, acute bronchitis, acute nasopharyngitis) and influenza. There is also a large number of gastrointestinal diseases (diarrhea, gastroenteritis, gastritis, duodenitis).
- Chronic diseases such as hypertension and diabetes are also listed in primary health facilities.
- Besides, "mental health problems" such as schizophrenia, depression and mania are also present in primary health facilities.

[11] Health facilities of each level are described in detail in Chapter 5.

Most common diseases treated in secondary health facilities include the following. These diseases are similar to those in tertiary health facilities shown in the following paragraph, but some of them are common to those in primary health facilities. This may be partly due to the fact that secondary health facilities are positioned between primary and tertiary health facilities and the sharing of functions based on the referral system[12] is insufficient (see 5.1.1 Referral System for details).

- Diseases in secondary facilities include the same diseases as in primary facilities, both acute and chronic, such as diarrhea/gastroenteritis, bronchitis, hypertension, and diabetes.
- Many diseases are common to tertiary health facilities, including diseases related to the circulatory system such as ischemic heart disease (myocardial infarction, angina), chronic renal failure and chronic obstructive pulmonary disease (COPD).
- There are no diseases specific to secondary health facilities that are not found in primary or tertiary health facilities.

Diseases listed in the column of tertiary health facilities column of the tables are described below.

- Diseases of circulatory system, the leading cause of death as shown in Table 4-2, such as ischemic heart diseases (myocardial infarction, angina) and cerebral infarction are listed here. These are typical lifestyle-related diseases which are caused by hypertension and lipid abnormality.
- Diabetes, which is one of the important lifestyle-related diseases and causes various complications such as nephropathy and retinopathy, is also shown in the table.
- An important group of diseases is chronic obstructive pulmonary disease (COPD), which is a general name of diseases formerly known as emphysema and chronic bronchitis. Lifestyle and smoking, including passive smoking can have a strong effect on the development of these respiratory diseases, which takes the third place in the cause of death as shown in Table 4-2.
- Complications around the childbirth process and treatment during delivery are also specific to the tertiary facilities.

In addition to Tables 4-3 and 4-4, cancer is also represented in the Health Statistics of Kosovo Agency of Statistics (see Table 4-5). According to the statistics, the number of newly diagnosed cases of cancer in Kosovo is on the rise and has reached 2,652 cases in 2019. The distribution of cancers by affected body parts shows that breast cancer (C50) was the most numerous (505 cases), followed by cancer of digestive organs (C15-C26) (471 cases) and skin cancer(C43-C44) (333 cases).

We can conclude that treatment of lifestyle-related diseases is becoming widespread from primary to tertiary health facilities. Many of these diseases could be prevented if conducting a healthier lifestyle. Thus, there should be a

[12] A referral system is a mechanism for referring and transporting patients who are difficult to diagnose and treat at lower-order facilities (for instance, clinics) to higher-order facilities (hospitals) with advanced medical equipment and skills

strong focus on the prevention and treatment of these diseases. "Health Sector Strategy 2017-2021" (refer to 4.3.1 Health sector strategy) sets "Draft Strategy for the prevention and control of chronic non-communicable disease" as an outcome objective. However, according to the midterm assessment report of the Health Sector Strategy (December 2020), no project has been implemented yet to this aim and thus the objective has not been achieved yet.

Table 4-3: Disease by Level of Facilities

	Primary level facilities		Secondary level facilities		Tertiary level facilities	
	disease	%	disease	%	disease	%
1	Acute tonsillitis	9.9	Arterial hypertension	12.5	Complications of the neonatal birth process	11.8
2	Arterial hypertension	8.5	Anemia and iron deficiency	9.2	Treatment at birth	3.1
3	Acute pharyngitis	4.7	Chronic renal failure	8	Essential hypertension	2.9
4	Acute bronchitis	3.7	Diarrhea and gastroenteritis	2.9	Bronchopneumonia	2.2
5	Diarrhea and gastroenteritis	3.1	Insulin-independent diabetes mellitus	2.3	Diarrhea and gastroenteritis	2.2
6	Influenza	2.7	Biliary stone disease	1.9	Insulin-independent diabetes mellitus	1.9
7	Acute nasopharyngitis	2.6	Chronic unspecified bronchitis	1.7	Myocardial infarction	2.2
8	Insulin-independent diabetes mellitus	2.6	Chest angina	1.5	Cerebral infarction	1.2
9	Gastritis and duodenal inflammation	2.3	Chronic obstructive pulmonary disease	1.3	Pneumonia	1.1
10	Insulin-dependent diabetes mellitus	2.0	Chronic bronchitis	1.3	Acute appendicitis	0.8

Source: NIPH (2019)

Table 4-4: Chronic Disease by Level of Facilities

	Primary level facilities		Secondary level facilities		Tertiary level facilities	
	disease	%	disease	%	disease	%
1	Essential hypertension	8.49	Essential hypertension	12.5	Essential hypertension	2.9
2	Insulin-independent diabetes mellitus	2.53	Chronic renal failure	8	Insulin-independent diabetes mellitus	1.9
3	Insulin-dependent diabetes mellitus	1.97	Insulin-independent diabetes mellitus	2.3	Myocardial infarction	2.2
4	Chronic obstructive pulmonary disease	0.43	Chronic bronchitis	1.7	Chronic renal failure	0.8
5	Chronic bronchitis	0.26	Chest angina	1.5	Unspecified Chronic obstructive pulmonary disease	0.7
6	Schizophrenia	0.22	Chronic obstructive pulmonary disease	1.3	Chest angina	0.4
7	Bronchial asthma	0.17	Chronic bronchitis (cause unknown)	1.3	Unspecified Chronic bronchitis	0.2
8	Depression	0.15	Myocardial infarction	0.6	Skull cancer	0.2
9	Manic	0.02	Insulin-dependent diabetes mellitus	0.6	Skin Cancer	0.1
10	Myocardial infarction	0.01	Chronic ischemic heart disease	1.3	Insulin-dependent diabetes mellitus	0.1

Source: NIPH (2019)

Table 4-5:Trends in Morbidity of Malignant and Benign Tumors

	2013		2016		2019	
1	Melanoma and other malignant neoplasms of skin (C43-C44)	282	Melanoma and other malignant neoplasms of skin (C43-C44)	614	Malignant breast neoplasm (C50)	505
2	Malignant breast neoplasm (C50)	224	Malignant breast neoplasm (C50)	380	Malignant tumors of the digestive organs (C15-C26)	471
3	Malignant tumors of the digestive organs (C15-C26)	177	Malignant tumors of the digestive organs (C15-C26)	363	Melanoma and other malignant neoplasms of skin (C43-C44)	333
4	Malignant tumors of respiratory and intrathoracic organs (C30-C39)	173	Malignant tumors of respiratory and intrathoracic organs (C30-C39)	316	Malignant tumors of respiratory and intrathoracic organs (C15-C26)	327
5	Primary malignant tumors of lymphoid tissue, hematopoietic and related tissue (C81-C96)	105	Malignant tumors of the female reproductive system (C51-C58)	225	Malignant tumors of the female reproductive system (C51-C58)	283
6	Malignant tumors of the female reproductive system (C51-C58)	103	Malignant tumors of the urinary tract (C64-C68)	160	Malignant tumors of the urinary tract (C64-C68)	194
7	Malignant tumors of the eye, brain and other parts of central nervous system (C69-C72)	93	Malignant tumors of male genital tract (C60-C63)	132	Malignant tumors of male genital tract (C60-C63)	172
8	Malignant tumors of the urinary tract (C64-C68)	59	Primary malignant tumors of lymphoid tissue, hematopoietic and related tissue (C81-C96)	84	Malignant tumors of the eye, brain and other parts of central nervous system (C69-C72)	83
9	Malignant tumors of male genital tract (C60-C63)	50	Malignant tumors of the eye, brain and other parts of central nervous system (C69-C72)	70	Primary malignant tumors of lymphoid tissue, hematopoietic and related tissue (C81-C96)	73
10	Malignant tumors of the lips, the oral cavity and larynx (C00-C14)	15	Malignant tumors of the lips, the oral cavity and larynx (C00-C14)	53	Malignant tumors of the lips, the oral cavity and larynx (C00-C14)	69
	Others	35	Others	74	Others	142
	Non-codified	167	Non-codified	43	Non-codified	0
	Total	1,483	Total	2,514	Total	2,652

Source: Health Statistics 2019

4.1.3 Maternal and child health

According to the Kosovo Multi Indicator Cluster Survey (MICS) 2019-2020, as shown in Table 4-6, the under-five mortality rates in Kosovo have been decreasing. In the past decade, regarding the rate of deaths per 1,000 live births, the neonatal mortality rate decreased from 19 to 11, a decrease of 8 and the post-neonatal mortality rate decreased from 8 to 4, a decrease of 4, and the infant mortality rate decreased from 27 to 15. On the other hand, the child mortality rate hasn't changed.

However, compared with neighboring countries, the neonatal mortality rate (11 deaths per 1,000 live births) of Kosovo in 2018 was still much higher than that of other Western Balkan countries (2 to 7) and the post-neonatal mortality rate (4 deaths per 1,000 live births) was also higher than that of the Western Balkan countries (around 1). On the other hand, the child mortality rate (1 death per 1,000 live births) is almost the same as the average of the Western Balkan countries and in the EU. We can conclude from these data that while the mortality rate among the under-five age group is improving, there is still scope for improvement to reduce infant mortality rate and it is especially important to address neonatal mortality rate.

Table 4-6: Trends in Mortality of Children (per 1,000 live birth)

	2008	2013	2018
Neonatal mortality rate (probability of dying within the first month of life)	19	10	11
Post-neonatal mortality rate (probability of dying between the first month of life and the first birthday)	8	4	4
Infant mortality rate (probability of dying between birth and the first birthday)	27	14	15
Child mortality rate (probability of dying between the first and fifth birthday)	2	0	1
Under-five mortality rate (probability of dying between birth and the fifth birthday)	29	14	16

Source: MICS(Kosovo Multiple Indicator Cluster Surveys)2019－2020

Remark: MICS uses a direct method for estimation of child mortality, instead of data collection from hospitals and registry records. This involves collecting full birth histories whereby women age 15–49 years are asked for the date of birth of each child born alive, whether the child is still alive and, if not, the age at death. For the data analysis, collected data on live birth is separated into three groups at intervals of 5 years. Therefore, the displayed number of 2018 on the above table corresponds to birth between the year of 2014 and 2018. In a similar way, the numbers of 2013 and 2018 correspond respectively to birth between 2009 and 2013, and between 2004 and 2008.

Table 4-7: Comparison of Mortality of Children in 2018 (per 1,000 live birth)

	Kosovo	Montenegro	Serbia	North Macedonia	Albania	Bosnia and Herzegovina	EU
Neonatal mortality rate (probability of dying within the first month of life)	11	1.7	3.4	7.4	6.5	4.1	2.3
Post-neonatal mortality rate (probability of dying between the first month of life and the first birthday)	4	0.6	1.4	1.3	1.3	0.9	1.0
Infant mortality rate (probability of dying between birth and the first birthday)	15	2.3	4.8	8.7	7.8	5.0	3.3
Child mortality rate (probability of dying between the first and fifth birthday)	1	0.2	0.7	1.2	1.0	0.8	0.6
Under-five mortality rate (probability of dying between birth and the fifth birthday)	16	2.5	5.5	9.9	8.8	5.8	3.9

Source: Kosovo: MICS(Kosovo Multiple Indicator Cluster Surveys)2019－2020、Others: HNP

4.1.4 Overview of health risks

This section summarizes health risks in terms of lifestyle habits and living environment.

(1) Health risks due to lifestyle habits

Within this section, different aspects of lifestyle related health risks will be analyzed. Habits related to smoking, drinking, dietary habits and physical activities will be taken into consideration using the result of the KAPB study[13].

[13] Report of Knowledge, Attitudes, Practices and Behavior by the AQH Project (December 2016). In this survey, interviews with 1,200 people aged 18 and older, etc. were conducted in 12 cities in Kosovo. Also, it is said that Albanians (950 samples) and RAE (250 samples) were surveyed.

1) Smoking

- The smoking rate (the percentage of those who currently smoke cigarettes, etc.) is 21%.
- The smoking rates vary depending on the characteristics of respondents. The smoking rate is significantly higher in the RAE community (43%) than in the Albanian community (20%). The smoking rate of men (30%) is higher than that of women (12%). In terms of age, smoking rate increases with age from 11% among 18-24 years old to 29% among 45-54 years old. However, smoking rate decreases to 23% among 55 years old and above. In addition, there is a negative correlation between smoking rates and household income. Smoking rate is 28% among the lowest income households (199 Euro/month or less) while it drops to 8% among the highest income households (600 Euro/month or more).
- Differences can be observed between social groups based on the age at which they started smoking. Respondents from the Albanian community have started smoking much later (age 22), compared to respondents from the RAE community (age 18). Also, men started smoking earlier (age 21) than women (age 24).
- Additionally, 70% of the smokers reported that they smoke also inside their houses and 21% of smokers smoke inside their houses with children under 18 years old living with them.
- A law has been passed to curb smoking (Law on Tobacco Control, 2013).

2) Drinking

- Drinking rate (the percentage of those who drink alcohol such as beer, wine or spirit habitually) is 16%. 49% of respondents drunk alcohol within 30 days immediately prior to the KAPB survey.
- Drinking rate is higher among men (29%) and remarkably lower among women (3%). Other social characteristics do not show significant differences, such as highlighted in the smoking rate.

3) Dietary habits

- Regarding eating habits, reducing salt and sugar intake is known to help reduce hypertension, heart diseases and strokes among adults. From such a viewpoint, the KAPB Study included several questions related to dietary habits (see Table 4-8).
- 43% of respondents use salt or salty sauce with meals at least once a day. More than half (56%) of respondents use salt, salty seasonings or salty sauce in cooking at least once a day.
- 38% of respondents consume soft drinks every day. Two thirds of respondents (65%) take several cups of tea or coffee with sugar every day.

Table 4-8: Frequency of Usage of Food in Diet (%)

Usage of food in diet	Several times a day	Once a day	Several times a week	Less often	Never
Salt or a salty sauce to your food right before you eat it or as you are eating it	21	22	29	18	7
Salt, salty seasoning or a salty sauce used in cooking or preparing foods in your household	32	24	28	12	3
Cakes, sweets, chocolate or biscuits	5	18	35	25	12

Usage of food in diet	Several times a day	Once a day	Several times a week	Less often	Never
Soft drinks, such as Coca Cola, Fanta, energy drinks and similar	16	22	28	21	8
Sugar in your tea or coffee	65	15	9	5	3
Commercially baked goods	2	8	40	33	14
Packaged snack foods	3	11	40	26	13
Solid fats	2	18	30	15	5
Fried food	12	23	32	17	13

Source: KAPB Study (2016)

4) Physical activities

- Using the WHO's Global Physical Activity Questionnaire (GPAQ), the KAPB study evaluates the situation of physical activities of respondents by applying the following WHO standards:
  - moderate-intensity physical activities for 150 minutes,
  - vigorous-intensity physical activities for 75 minutes, or
  - the combination of moderate-intensity and vigorous-intensity physical activities which is equivalent to 600 Metabolic Equivalents (MET[14]) or more.
- The result of the survey showed that 46% of all respondents exceeded the WHO recommended physical activity standards in terms of health. By gender, 39% men and 52% women meet the standards recommended by the WHO.

(2) Health risks due to living environment

Air pollution, drinking water and sewage have been selected from living environmental factors that may pose health risks. Their current situations are summarized based on the existing surveys.

1) Air pollution

Monitoring data on air pollution in Kosovo are not properly accumulated, making it difficult to examine the causal relationship with health risks. However, the following is pointed out in the Detailed Planning Survey Report for the Capacity Development Project for Air Pollution Control in the Republic of Kosovo by JICA (February 2017).

- Annual average values of PM10 and PM2.5 from 2012 to 2014 exceed environmental standards of 40 μg/m^3 (PM10) and 25 μg/m^3 (PM2.5) set by the Air Quality Monitoring Station (AQMS).
- The main sources of these emissions are thermal power plants (five plants in operation, accounting for 97% of the total power generation) fueled by lignite, low quality coal produced abundantly in Kosovo. In addition, firewood for heating and cooking at home and exhaust gas from automobiles (mostly diesel engine cars) are also considered to contribute to some extent to air pollution.
- Air pollutants other than PM10 and PM2.5 are generally considered low. However, monitoring of air pollution has not been sufficient, so it is hard to conclude on results with certainty. Also, there is neither sufficient data available for fixed source pollutants other than the thermal power plants

[14] It is a unit to be used to indicate the intensity of physical activities. 1 MET is equivalent to the calorie consumption of a sitting and resting state (1 kcal/kg/hour).

2) Drinking water and sewage

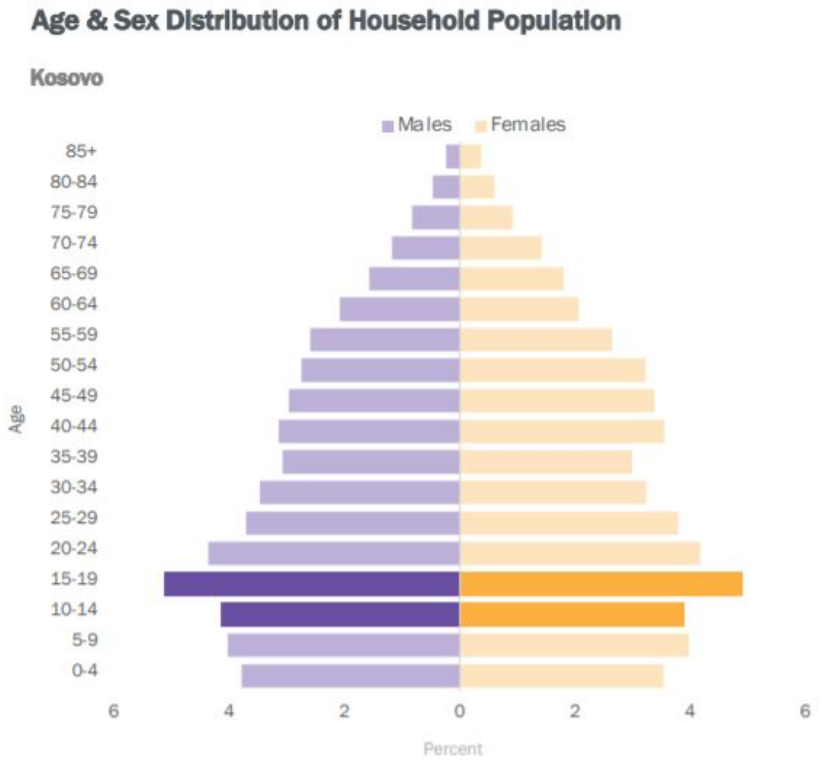
According to the Kosovo Mosaic Survey 2012[15], 91% households have access to safe drinking water, and the rest (7%) use driven wells.

As for sewage, we do not have survey data on the proportion of specific wastewater treatment methods. The only information comes from the Kosovo Mosaic Survey 2016, which gives satisfaction level[16] with sewage and sewerage (13.4), relatively high compared to the satisfaction level of water supply (10.4) and compared to the average of satisfaction levels of 26 different public services (0.1).

Based on the situation indicated by these data, it is expected that the provision of drinking water and sewage is at a certain level, but it is difficult to conclude the degree of risk that could lead to health problems.

4.2 Current Situation and Prospects of the Population Structure

This section describes the changes in the population structure that can have a direct or indirect (e.g., economic) impact on the formulation of policies on healthcare. Figure 4-1 shows Kosovo's population pyramid in 2020. The proportion of teenagers and twenties is high. However, the shape of the pyramid changed to a tile or hanging bell shape. This indicates that the proportion of children is declining.



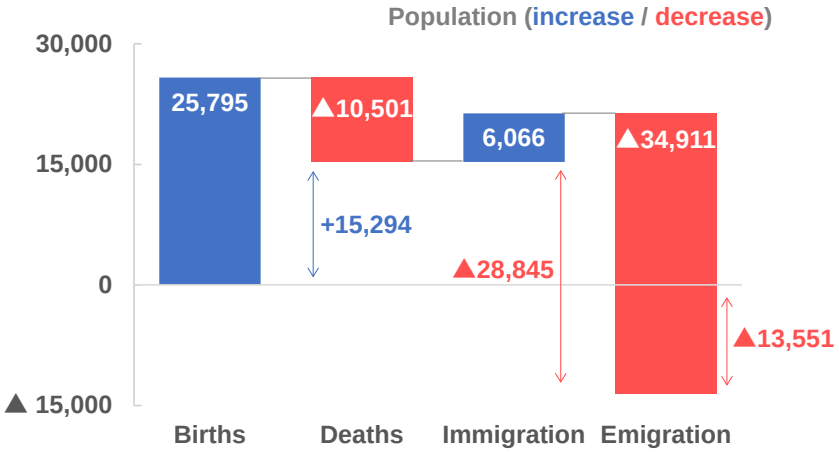
Source: 2019-2020 MICS in Kosovo

Figure 4-1: Population Pyramid

[15] This survey was conducted by UNDP and USAID on a large scale with 6,700 samples covering the entire Kosovo. The main purpose of the survey is to grasp the awareness for public services and cities.

[16] Respondents evaluate each public service on a scale from −100 (very dissatisfied) to 100 (very satisfied). The average of these ratings is used as satisfaction level of the public service in question.

It is worth noting that population decline has already started in Kosovo. Figure 4-2 shows the demographic movement of Kosovo in 2019.

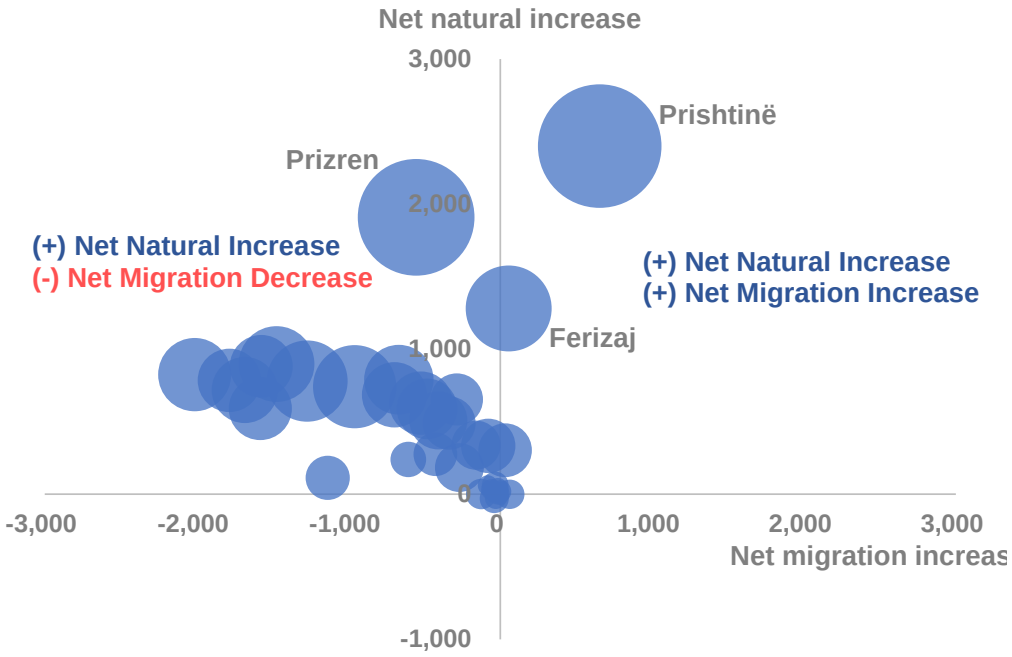


Source: Kosovo Agency of Statistics

Figure 4-2: Demographic Dynamics (2019)

According to the Kosovo Agency of Statistics, the total population of Kosovo in 2019 was 1,782,115. Natural increase, which shows the difference between live births and deaths was 15,249. However, the demographic result of international migration decreased the population by 28,845. Due to the above mentioned two factors the total population decreased by 13,551 (0.8%). According to UNFPA, it is understood that outmigration affects younger generations more.

The declining working age population due to the demographic outmigration is a negative factor for the country's economic growth and it may become an inhibitor for the achievement of UHC. Also, the demographic movement differs depending on the geographical area. Fig. 4-3 shows the demographic movement of 38 cities in Kosovo in 2019.



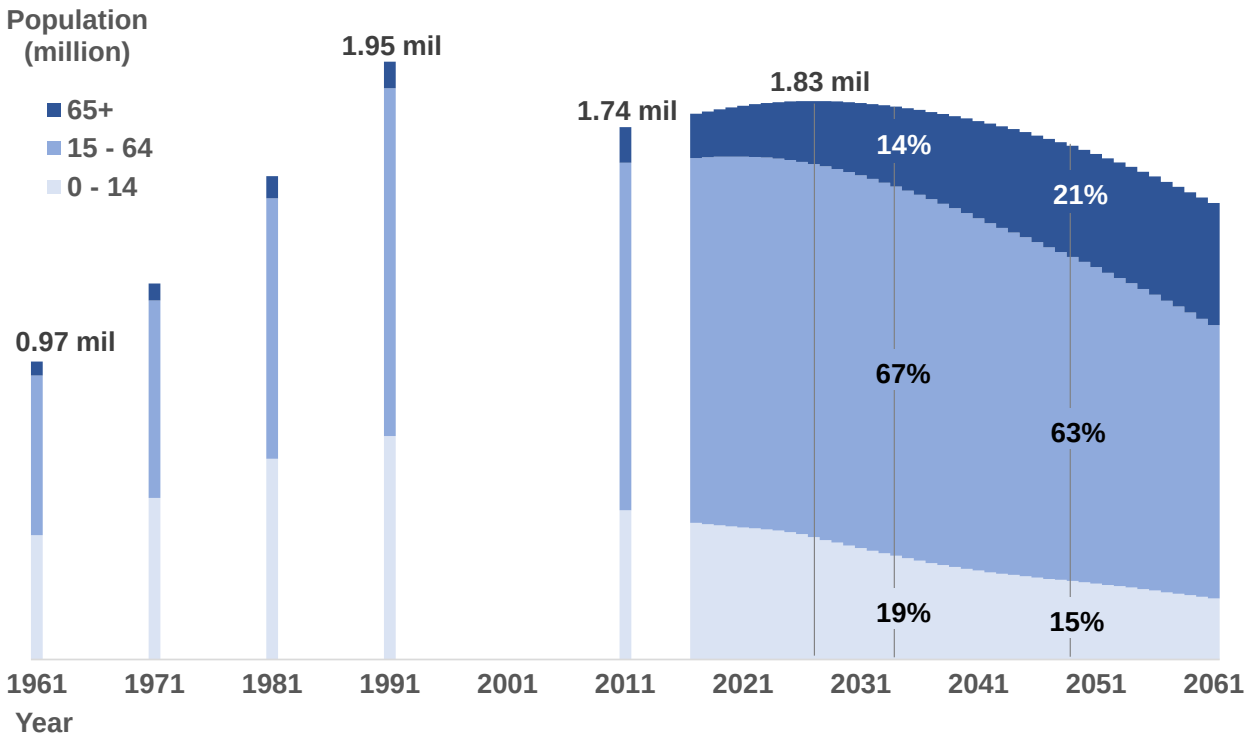
Source: Kosovo Agency of Statistics

Figure 4-3: Demographic Dynamics by Municipality (2019)

The circle areas indicate the population size in 2019, the X-axis indicates the average of the net migration increases/decreases for the past 3 years, and the Y-axis indicates the average of the net natural increases/decreases for the past 3 years. For Pristina (capital), net increase is observed for both natural and migratory demographic movement (the first quadrant). On the other hand, even for the second biggest city Prizren, net natural demographic increase was observed which was coupled by net migratory decrease (the second quadrant). Many of other cities also have net natural demographic increase but large net migratory decreases. This fact reveals that people have been moving from the country to the capital city and abroad. It is assumed that the regional differences in the demographic trends will lead to regional difference in demand structure for medical services. If the demand for medical services will differ according to the geographical area, naturally the health and medical service provision system shall be appropriately planned to best fit to the actual need of each area.

Next, as a reference, the point of view of backcasting[17] is taken into account based on the long-term population forecast. Figure 4-4 shows the change in the composition of the population and age structure in Kosovo based on the 2017 population forecast issued by the Kosovo Statistical Agency. This information is "for information only" because the forecast is already different from the actual situation of population decline, which started in 2019, and the preconditions for the forecast were not yet confirmed.

[17] Backcasting is the method of predicting the situation of any point in the future and looking back what to be done from the present point. This concept is heavily used/promoted in the SDGs of the United Nations.



Source: Kosovo Agency of Statistics

Figure 4-4: Demographic Transformation

There are four major points to be concluded from the data collected and presented above, based on the estimates of the Kosovo Agency of Statistics although accessible data is fragmented

The first point is declining overall population. The overall population of Kosovo doubled in 30 years from 970,000 in 1961 to 1,950,000 in 1991. On the other hand, it declined to 1,740,000 in 2011 after the 1999 Kosovo Conflict. It means that it decreased by about 210,000 (approx. 12%) in 20 years from 1991. After that, the overall population increased again slowly. However, according to the projections, it will start decreasing again after reaching its peak of 1,830,000 in 2027. It is projected that it will be 1,490,000 in 2061.

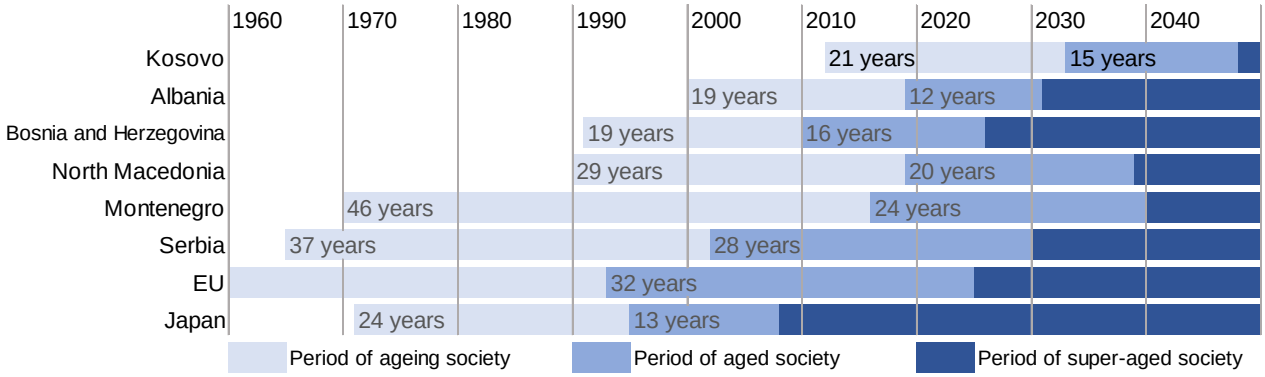
The second point is the aging of the population. According to forecasts, the elderly population (aged 65 and over) continues to grow from 140,000 in 2017 to 400,000 in 2061. The elderly population refers to the proportion of persons aged 65 years or older in the total population. The World Health Organization (WHO) and the United Nations define “aging society” as one in which more than 7% of the population is 65 years or older, “aged society” as a society in which more than 14% of the population is 65 years or older, and a “super-aged society” as a society in which more than 21% of the population is 65 years or older. The ratio of elderly population (rate of people aged 65 or older to the overall population) was 6.7% in 2011, but it exceeded 7% in 2012, from which time Kosovo became an aging society. According to the forecasts Kosovo will become an aged society (aging rate: 14% to less than 21%) in around 2033 and super-aged society (aging rate: 21% or higher) in around 2048.

The third point is declining size of the economically productive population (population of 15 years old to 64 years

old). It is expected that the productive population of Kosovo will reach its 1,220,000 peak in 2028 and will decrease afterwards and without changes in the population trends it will hit the bottom of 890,000 in 2061. On the assumption that the labor force participation rate will remain the same, changes in the productive populations will proportionately affect working population. Demographic changes will create a 25% decrease in the potential labor force from 2028 to 2061 and thus will be a determining factor slowing down economic growth.

The fourth element to be considered is the increase in old-age dependency ratio (ratio of the number of persons aged 65 and over (age when they are generally economically inactive) per people of working age (persons aged between 15 and 64)). The inverse age dependency ratio gives insight into the amount of people of working age that provide for one dependent, pension beneficiary person. A high ratio means the economy can easily provide for the beneficiaries, and a low ratio means those of working age - and the overall economy - face a greater burden in supporting the beneficiary population. In 2017 the inverse age dependency ratio stood at 8.2, meaning that the burden supporting 1 aged person was shared among this many people. This inverse dependency ratio will decrease to 2.2 meaning that the burden of intergenerational solidarity will be shared by much less people

It is worth looking at the accelerating aging in Kosovo from an international perspective. Fig. 4-5 shows the comparison between Kosovo and other Western Balkan countries, EU and Japan about the timing of the transformation from the aging society to the aged society and from the aged society to the super-aged society and the length of years required for those transformations.



Source: Prepared by the Survey Team based on World Development Indicators, UN World Population Prospects

Figure 4-5: Comparison of Speed of Ageing

As already stated, Kosovo became an aging society in around 2012. This timing was the latest among the Western Balkan countries, so Kosovo is relatively a young country. On the other hand, the expected time required for Kosovo to transform from an aging society to an aged society is 21 years, which is the shortest after Albania and Bosnia-Herzegovina (19 years). For comparative perspective, it took 24 years in Japan for this transformation. It is expected that the aging of Kosovo, Albania and Bosnia-Herzegovina will be faster than that of Japan.

In the official statistical paper on long-term population forecast prepared by Kosovo Agency of Statistics (released in December 2017), it was expected that population decline will start in around 2028. However, as stated earlier at the beginning of this section, population decline has already started in 2019. Thus, just 2 years after the publication of the long-term forecast, population decline began about 10 years before the estimates. This is an

unusual gap, which hardly ever happens in long-term demographic projections, since natural demographic change is usually slow. The only acceptable reason is that the rate of outmigration was much faster than expected in 2017. Therefore, the Survey Team can also assume that with the current pace of outmigration, the decline in the working age population will continue to increase and the progression of aging will be much faster than projected in 2017.

Meanwhile, national population census will be held in 2021 for the first time in 10 years. It is difficult to get the result of the census during our survey period, but it will be necessary to review each estimate based on the result of the national population census.

The changes in the population structure can be summarized here. Just as in Japan, Kosovo is also characterized by the advancement of aging and population decline although it stands at a different stage and causes of demographic changes are also different. Nevertheless, aging has and will have a heavy toll on the health sector. Generally speaking, aging is one of the major causes in the increase for medical services and medical expenses. In addition, aging and declining populations are causing declining economic growth rates, resulting in severe economic conditions. Kosovo is now struggling to provide the necessary financial resources to provide stable health and medical services to all of its population through UHC. In addition to these difficult issues, the country faces rising age-related health expenditures under "no economic growth" conditions. Important decisions need to be made about what to prioritize and how to promote policies and systems to achieve UHC within a limited timeframe.

4.3 National Health Policy and Health Sector Strategy

In the current Kosovo National Development Strategy (NDS 2016-2021), the health sector is not positioned as a priority area and its description is limited. In effect, only the sectoral Health Sector Strategy 2017-2021 developed by the MOH in 2016 provides the basic direction and focus of governmental policy.

4.3.1 Health Sector Strategy

(1) Overview of the Health Sector Strategy 2017-2021

Health Sector Strategy 2017-2021 has three strategic objectives: "Protection and advancement of health," "Ensuring of sustainable health financing" and "Reorganization of the health sector." Under these strategic objectives, a total of 15 specific objectives were defined and each specific objective was detailed into 50 outcomes (see Table 4-9). Characteristics of the Health Sector Strategy are as follows.

Characteristics of the content of the strategy

- The structure of the objectives of the Health Sector Strategy 2017-2021 starts with “Strategic objective 1: Protection and advancement of health” directly dealing with the health status of Kosovo’s citizen, followed by two strategic objectives on financial and organizational aspects of the sector (Strategic objective 2 and 3), which are crucial preconditions for challenge of improving the health status of Kosovo’s citizen.
- “Strategic objective 1: Protection and advancement of health” is well-balanced, with five specific objectives corresponding to each of the following areas: health education, maternal and child health, infectious disease

control, non-communicable disease control, and others (mental health, environmental health, etc.).

- "Strategic objective 2: Ensuring of sustainable health financing", is focusing to restructure health financing based on health insurance system and to promote the compulsory health insurance, sets a total of three specific objectives.
- "Strategic objective 3: Reorganization of health sector" with a total of 7 specific objectives sets up policies for restructuring and strengthening the institutions of the health sector including the MOH, the HUCSK and organizations related to family medicine through means of capacity building of human resources, functionalization and integration of organizations, strengthening of cooperation and so on. The Strategic objective 3, also sets up policies on cross-cutting issues common to the provision of various healthcare service, such as development of HIS and improvement of quality and safety of healthcare service.

Characteristics of the structure of the strategy

- The main body of the strategy is concise (total of five pages), consisting of strategic objectives, specific objectives and outcomes. The appendix of the Strategy contains the logical framework (LF), which has been developed with reference to the outcomes in the main body text, with indicators and corresponding targets.
- The logical framework (LF) is implemented through action plan (AP).
- Implementation of the objectives of the health policy is evaluated according to monitoring and evaluation of LF and AP. For this reason, the MOH attaches great importance to monitoring and evaluation, and decides the method on how to monitor the implementation status.

Table 4-9: Objectives of the Health Sector Strategy 2017-2021

Strategic Objectives	Specific Objectives	Outcome
1 Protection and Advancement of Health	1.1 Promotion of healthy lifestyle	R1.1.1 Action plan for education and health promotion implemented R1.1.2 Project 'School for health promotion' implemented
	1.2 Improve health of mother and child	R1.2.1 Action plan to improve health of mother and child implemented
	1.3 Reducing the incident of infectious diseases	R1.3.1 Action plan for HIV/AIDS implemented R1.3.2 TB action plan implemented R1.3.3 Action plan for Antimicrobial Resistance implemented R1.3.4 Measures to prevent hospital infection implemented R1.3.5 Strengthening the monitoring system in infectious diseases
	1.4 Prevention and control of chronic conditions	R1.4.1 Draft strategy for the prevention and control of chronic con-communicable diseases
	1.5 Health policies for all	R1.5.1 Strategy for mental health implemented R1.5.2 Healthy ageing strategy implemented R1.5.3 State Committee for environmental health functionalized R1.5.4 Health of vulnerable groups improved
2. Ensuring Sustainable Health Financing	2.1 Reorganization of health financing	R2.1.1 Health financing agency functionalized R2.1.2 Health insurance fund functionalized R2.1.3HIF financial resources used effectively
	2.2. Inclusion of the population in the compulsory health insurance	R2.2.1 Basic package of health services implemented
	2.3 Providing accessible and equal health services	R2.3.1 Contract with the three levels of healthcare institutions signed
3. Reorganization of Health Sector	3.1 Reorganization of MOH	R3.1.1 Reform consultative committee (RCC) of health sector established R3.1.2 Plan of huma resources and development of MOH approved R3.1.3 Capacity of staff strengthened R3.1.4 Partnership in health sector coordinated R3.1.5 Monitoring mechanisms functional
	3.2 Functionalization of chambers of health professionals	R3.2.1 Physical infrastructure for all CHP provided R3.2.2 CHP administration functional R3.2.3 Public functions transferred from MOH to CPP R3.2.4 CHP fulfil competences based on their annual plan

Strategic Objectives	Specific Objectives	Outcome
	3.3 Strengthening of hospital and university clinical service of Kosovo	R3.3.1 Management structure of HUCSK strengthen R3.3.2 Capacities of the health inspectorate advanced R3.3.3 Professional capacities increased based on needs identified R3.3.4 Contracting services defied by each organizational unit of HUCSK
	3.4 Implementation of the concept of family medicine	R3.4.1 Capacities of family medicine team strengthened R3.4.2 Managerial capacities at PHC improved R3.4.3 Raising awareness of the population for services of Family Medicine R3.4.4 Provision of medical device for meeting the conditions for equal access to health services R3.4.5 Revised standards of quality and safety in PHC implemented R3.4.6 MOF teams provide services based on GCP (Guides and Clinical Protocols
	3.5 Integrated and functional HIS in all institutions	R3.5.1 IT infrastructure in all health institutions integrated R3.5.2 HIS software in all health institutions integrated R3.5.3 Legal framework for HIS completed R3.5.4 Capacities for operation and maintenance of HIS provided R3.5.5. Training for system administrators and managers implemented R3.5.6 Inter-sectorial, regional and international cooperation for collecting and reporting data advanced
	3.6 Continuous improvement of quality and safety, standards and accreditation	3.6.1 Healthcare standards implemented 3.6.2 National accreditation plan drafted
	3.7 Improving the delivery of health services	3.7.1 Health services integrated at all levels of healthcare 3.7.2 Screening program designed 3.7.3 Construction of functional health infrastructure 3.7.4 Capacities for assessment of medical technology advanced 3.7.5 Management of medical products in primary healthcare improved

Source: Health Sector Strategy 2017-2021

(2) **Implementation status of the Health Sector Strategy 2017-2021**

The implementation of the Health Sector Strategy 2017-2021 was evaluated in a midterm assessment conducted by an external consultant. In the midterm assessment report (assessment period: 2017 to 2019) released in December 2020, indicators in the strategy were assessed. The results were harsh in general as shown in the following table.

Especially for strategic objective 2 (Ensuring Sustainable Health Financing), five out of six indicators were evaluated as red (fail), implying that the strategic objectives are far from being achieved.

Table 4-10: Summary of Midterm Assessment on the Health Sector Strategy 2017-2021

	Green (Goals achieved)	Yellow (Goals not achieved, but on the right track)	Red (failed)	Total
Strategic Objective 1: Protection and Advancement of Health	2(20%)	1(10%)	7(70%)	10(100%)
Strategic Objective 2: Ensuring Sustainable Health Financing	0 (0%)	1(17%)	5(83%)	6(100%)
Strategic Objective 3: Reorganization of Health Sector	10(30%)	7(21%)	16(48%)	33(100%)
Total	12(24%)	9(18%)	28(57%)	49(100%)

Source: HSS Evaluation Report for the period 2017-2019 (December 2020)
*: Indicators not measured were excluded from the assessment.

(3) Development of the health sector strategy for the next term

It is said that the new government, formed in March 2021, has reaffirmed the importance of the health sector. Therefore, it is hoped that the Health Sector Strategy for the next term will be positioned as a priority for the Government and will be used as a key document to set out the future priorities of the health sector.

The next health sector strategy is scheduled to be finalized by the end of 2021 with the cooperation of LuxDev. However, the development process seems to be delayed because of the spread of COVID-19 pandemic. A survey for collecting basic data and information for the development of the next health sector strategy was scheduled to be conducted by March 2021, but it has not been started yet as of the end of May 2021.

4.4 Health Finance

4.4.1 National Medical Expense

Kosovo's government spending on health was 2.83% of the GDP (2017). The average spending on the health sector of the EU member states in the same year was 7% of the GDP (Eurostat), leaving Kosovo's spending on health lowest in Europe.

Table 4-11: Health Expenditure in Kosovo (Source, % of GDP) (2017)

	Expenditure (Euro)	%	% of GDP
Public Health Expenditure	180,362,069	63%	2.83%
MOH	57,567,776		
HUCSK*	70,553,112		
Primary Health facilities	52,241,181		
Private Health Expenditure	103,672,370	37%	1.65%
OOP by Patients	67,248,090	(23%)	
Private Health Insurance	16,996,000		
Donors	11,680,730		
Rehabilitation Center	7,747,549		
Total	285,362,070	100%	4.47%

Source: National Health Account 2017, MOH
Note: Expenditure to HUCSK is distributed to Secondary and Tertiary health facilities

Kosovo' national medical expenses (the total of government and private expenditures) stood at 4.47% of the national GDP. As shown in the table below, it is in the lowest level among the Western Balkan countries.

Table 4-12: International Comparison of Health Expenditure by % of (2017)

Kosovo	Romania	Albania	North Macedonia	Croatia*	Slovenia*	Serbia	Bosnia &Herzegovina
4.47%	4.1%	6.0%	7.1%	7.5%	8.5%	8.8%	8.9%

Note: Data of Croatia and Slovenia is of 2015
Source: WHO health for all database

According to the National Health Account (NHA) in 2017, the percentage of medical costs paid by the patient is 23% of the national medical costs in Kosovo. However, since Kosovo created NHA for the first time as an experimental activity in that year, they could not collect a fully collection of data and items such as payment in

private health facilities and payments to overseas treatment are missing from these statistics. Therefore, the data on medical expenses paid by the patient is a minimum estimate to the actual costs. Because of this, the World Bank made an initial estimate based on the data from household budget surveys. It reported that the percentage of the medial costs paid by the patient was 28.9%[18] in 2015. Thus, percentage of the medical costs paid by the patient exceeded 40% in 2007 and it has been gradually decreasing. However, it is still higher than 13.9%, which is the average of EU in 2014, and exceeds the percentage recommended by the WHO (15 to 20%).

Reviewing the distribution of the medical expenses paid by patients, 70% is it is paid for medical products, 20% is for using private health facilities and 5% is for overseas treatments. The reason of high percentage for medical products is that essential medical products are out of stock in many public health facilities, so patients have to purchase them from private pharmacies.

Source: Social protection and health expenditure note, The World Bank 2018

Figure 4-6: Ratio of OOP (5) in 2015

4.4.2 Health budget

Between 2015 and 2018, Kosovo's GDP grew at a good rate of 4.1% per year on average. However, the net contribution of government budget expenditure to GDP has consistently been 3% or less, and the ratio of the health budget to the government budget has remained at 10%.

Total government spending in 2019 was € 2.15 billion, with the largest allocation to social security, as shown in the table below. Social security spending has continued to increase with spending on pensions and veterans' pensions, and its share of total government spending has increased significantly from 18.5% in 2015 to 22.8%. Such a rapid increase in social security costs has resulted in pressure on budget allocation to important areas that will support future economic growth, such as education and health.

In fact, the health sector budget has increased by 7.6% on an annualized basis from 160 million euros (2015) to 220 million euros (2019), but as mentioned above, its share of the government budget has remained flat.

Table 4-13: Government Budget by Sectors 2015-2019 (in million Euro)

sector	Actual (in million Euro)					Ratio (%)				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Social protection	298	386	401	440	490	18.5	21.9	21.8	22.2	22.8
Economic affairs	322	385	418	450	404	20.0	21.8	22.8	22.8	18.8

[18] Special Protection and Health Expenditure Note, World Bank, 2018

General services	369	179	270	245	336	22.9	10.1	14.7	12.4	15.6
Education	261	280	282	301	323	16.2	15.9	15.4	15.2	15.0
Health	164	168	178	199	220	10.2	9.5	9.7	10.1	10.2
Others	198	366	287	343	378	12.3	20.7	15.6	17.3	17.6
Total	1,612	1,764	1,836	1,978	2,151	100.0	100.0	100.0	100.0	100.0

Source: Kosovo government accounts 2015-2019, Kosovo Agency of Statistics

Kosovo aims to create a health finance that builds on both tax revenues and social security revenues. To this end, the Health Insurance Act was enacted in 2014. However, as the health insurance system is not yet operational for a variety of reasons, the health sector is today funded by taxes and fixed patient contributions. However, as shown in the table below, most of the financial resources are taxes, and other income is extremely limited (see "5.4.2 Expenses for using health facilities" for details on service usage fees).

Table 4-14: Breakdown of Health Budget (MOH・HUCSK) (2015 Actual, in thousand Euro)

Government (Taxes)	OOP (Service Fee)	Loan	Fund by Donors	Total
114,549	3,017	57	1,175	118,798
96.4%	2.5%	0.0%	1.0%	100.0%

Source: Kosovo government accounts 2015-2019, Kosovo Agency of Statistics

The health budget for 2019 is 220 million euros, and by service level, the primary level budget is 62 million euros (27.7%), and the secondary and tertiary level budget are 125 million euros (55.8%). These central government budgets are financed by the Ministry of Finance as Specific Health Grants for primary health facilities and distributed to facilities through each municipality. Budgets of Secondary and tertiary health facilities are allocated to each health facility by HUCSK. In the past, MOH was directly in charge of secondary and tertiary level health facilities, but since the establishment of HUCSK (2014), HUCSK has compiled a budget plan for each health facility, and after the negotiation with the central government, the budget amount will be allocated to each health facility.

Table 4-15: Health Budget by Service Level 2015 - 2019

Institution	Actual (in million Euro)					Ratio (%)				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
MOH	31.7	49.9	57.6	58.6	27.1	18.8	29.3	31.9	29.0	12.1
HUCSK (Secondary and Tertiary level)	86.1	69.2	70.6	85.0	124.7	50.9	40.6	39.1	42.1	55.8
Municipalities (Primary level)	51.2	51.3	52.2	57.3	61.9	30.3	30.1	29.0	28.4	27.7
Health Insurance Fund					9.8					4.4
Other Ministries				1.2					0.6	

Total	169.1	170.4	180.4	202.1	223.5	100.0	100.0	100.0	100.0	100.0

Source: MOH, Division of Budget

The table below shows the health budgets for 2019 by category. For the budgets for HUCSK and the primary health facilities, labor costs (salary) exceed 50%.

Table 4-16: Health Budget by Items (2019) (in Thousand Euro)

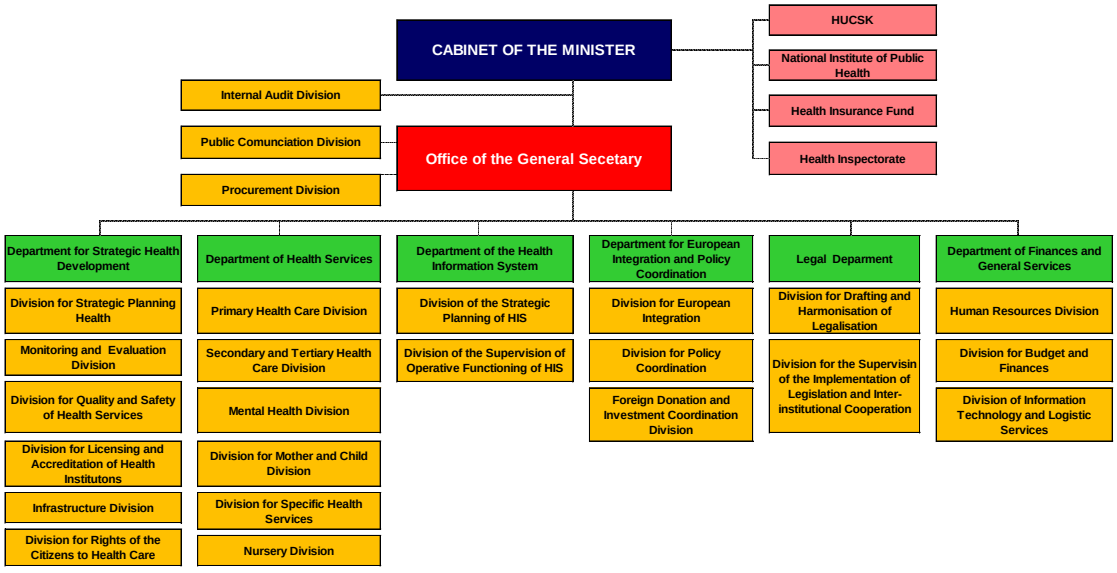
Item	Actual (in Thousand Euro)				Ratio (%)			
	MOH	HUCSK	Primary Health facilities	Total	MOH	HUCSK	Primary Health facilities	Total
Labour Cost	7,464	62,737	42,610	112,810	27.6	50.3	68.9	52.8
Goods and Service	10,435	41,284	8,015	59,735	38.5	33.1	13.0	28.0
Utility Cost	159	3,767	1,460	5,386	0.6	3.0	2.4	2.5
Subsidy	2,571	0	1,293	3,864	9.5	0.0	2.1	1.8
Capital Investment	6,455	16,873	8,505	31,833	23.8	13.5	13.7	14.9
Total	27,084	124,661	61,883	213,628	100.0	100.0	100.0	100.0

Source: MOH, Division of Budget

4.5 Administrative Institutions Responsible for the Health Sector

(1) Structure of the Health Administration and functions of MOH

The MOH is the governmental body with ultimate responsibility for the health sector. It is in charge of the development and adjustment of health policies, legislation, issuing various standards and guidelines, etc. All policies are enforced by executive agencies set up separately from the MOH. The structure of the health administration structure is shown in the figure below.



Source: Website of MOH

Figure 4-7: Organogram of MOH

The MOH has 7 departments, which are structured into sub-departments. The structure of departments and sections work as follows.

Table 4-17: Function of Departments and Divisions of MOH

Name of Department	Function
Department of Finance and General Services Human Resources Division Budget and Finance Division Information Technology and Logistics Services Division	Manages and maintains information on human resources of the Ministry Provides administrative, logistical and information technology services in the Ministry Ensures the implementation of procedures for the selection and employment of qualified personnel, in accordance with applicable law Coordinates the preparation, implementation, reporting and evaluation of the budget of the Ministry Coordinates the timely implementation of the financial disseverment of the Ministry Manages the archive system and internal documents of the Ministry Maintains information technology in the Ministry Provides logistics services to the Ministry
Department of HIS HIS Strategic Planning Division HIS Operational Operation Oversight Division	Proposes, drafts and ensures the implementation of policy documents / strategies and legislation related to the development of HIS Monitors and reports on a regular basis on the implementation of policies / strategies and legislation for HIS, including its maintenance and operation Plans financial, human and technological resources for the proper functioning of the HIS Contributes to quality and reliable SIS data Provides authorizations on access to data sources and registers, upon request and relevant data protection legislation
Department of Health Services Primary Health Care Division Secondary and Tertiary Health Care Division Mental Health Division Maternal and Child Health Division Nursing Division Special Health Services Division	Monitors the quality of management of institutions at all levels of the health sector Provides support in coordinating the functioning of health institutions and ensures optimal integration of health services at all levels including emergency health services Ensures the connection of public and private health services with health services provided by governmental and non-governmental organizations Assists in drafting policies / strategies and legislation related to health services Monitors and reports on the activities of health services that take place within the public-private partnership Provides support to the professional development of human resources in the nursing sector
Legal Department Division for Drafting and Harmonization of Legislation Division for Oversight of Legislation and Inter-Institutional Cooperation	Provides legal support in drafting strategic documents from the scope of the Ministry Provides legal support in drafting primary and secondary legislation within the scope of the Ministry Ensures the compliance of the legislation within the scope of the ministry with the legislation of the European Union (Acquis Communautaire) as well as with the applicable laws in Kosovo Provides recommendations and legal advice to the structures of the Ministry upon request Provides support to the Ministry of Justice in representing MOH in the judiciary.
Department for European Integration and Policy Coordination Division for European Integration Policy Coordination Division Division for Coordination of Foreign Donations and Investments.	Provides support in coordinating activities for the European integration process Monitors and reports on the implementation of European Commission recommendations Provides support in harmonizing the legislation of the Ministry with the Acquis Communautaire Coordinates the activities of the Ministry for financial support from the Instrument for Pre-Accession (IPA) and other European Union funds Contributes to the exchange of information in function of the European integration process for the field of activity of the ministry
Department of Health of Prison	Coordinator for health services in prisons Mental Health Coordinator in Prisons Coordinator for pharmaceutical services in prisons Coordinator for data, appointments and coordination with HUCSK
Department of Strategic Health Development Strategic Planning Division Monitoring and Evaluation Division Health services Quality and Safety Division Licensing and Accreditation Division of Health Institutions	Proposes, drafts and ensures the implementation of policy documents / strategies for health services through the defined monitoring and evaluation system Proposes, drafts and ensures the implementation of the legal framework for the improvement of the health care system, in accordance with international standards and norms Plans activities for the development and strategic management of the

Name of Department	Function
Infrastructure Division Citizens' Rights in Health Care Division	health sector in accordance with the available financial opportunities including the public health sector Provides professional advice on the implementation of legislation and policy documents in the field of health system Provides support to the professional development of human resources in the health sector Provides support in identifying needs for health infrastructure development, including medical buildings and device of integrated medical services Plans possible public-private partnership projects in the health sector Ensures the coherence of health policies and strategies in the country

Source: Website of MOH

The number of staff of the MOH is limited as shown in the table below. Therefore, each executive agency is responsible, for example, for the preparation of bills and revision bills, and the legal department of the MOH reviews, verifies the content, and presents the bills to the Congress.

Table 4-18: Number of Officials of Each Department of MOH (As of February 2021)

Department	Number of Officials
Department of Finance and General Services	27
Department of Health Services	9
Department of Strategic Health Development	21
Legal Department	6
Department for European Integration and Policy Coordination	6
Department of Health of Prison	6
Department of HIS	8
Below, direct control of the Minister	
Office of General Secretary	4
Internal Audit Division	3
Public Communication Division	3
Procurement Division	6
Total	99

Source: MOH

(2) Major Implementing Agencies

The major executive agencies are as follows. These agencies have more staff than the MOH because they have to implement concrete measures. (See Table 4-19. However, the HIF has a limited number of staff because the health insurance system has not been implemented yet.)

- National Institute of Public Health of Kosovo (NIPH): Implements strategies for combating infectious diseases and non-infectious diseases.

- Hospital and University Clinical Service of Kosovo (HUCSK): In charge of provision of services in the secondary and tertiary health facilities. (Each municipality is in charge of their primary health facilities.) The contents of the work are shown in "5.1.3 Operation of public health facilities". The organizations under the administration of HUCSK are shown in Table 4-20.

- Health Insurance Fund (HIF): responsible for financial operations related to the health insurance

system and management of domestic and foreign health care costs (overseas treatment costs)(For the organization of the HIF, see "6.2 Organization and budget of the HIF.")

Table 4-19: Number of Officials of MOH related Organizations (As of February 20121)

Organization	Number of Officials
Health Insurance Fund	44
National Institute of Public Health	289
Health Inspectorate	14
University Hospital of Clinical Service of Kosovo (HUCSK)	7,297

Source: MOH

Table 4-20: Institutions administered by HUCSK

- University Clinical Centre of Kosovo (UCCK)
- Dental University Clinical Centre of Kosovo
- National Centre of Labour Medicine in Gjakova
- National Centre of Sports Medicine
- National Centre for Blood Transfusion
- National Telemedicine Centre
- General Hospital in Mitrovicë
- General Hospital in Gjilan
- General Hospital in Pejë
- General Hospital in Gjakovë
- General Hospital in Prizren
- General Hospital in Ferizaj
- General Hospital in Vushtrri
- Community based Mental Health Centres and Houses for Integration
- The Centre for integration and rehabilitation of chronic psychiatric patients in Shtime

Source: Statue of the hospital and university clinical service of Kosovo

4.6 Human Resources of Healthcare

The table below shows the total number of health workers in Kosovo. Compared with the number from the survey conducted by the JICA in 2014, the number of health workers has been increased.

The total number of doctors is 2,591 the number of doctors per 10,000 residents is 14.4. Calculated on the basis of 1,142 doctors working in primary health facilities, the number of doctors per 10,000 population is 6.3, which is less than the minimum of 23 doctors defined by the WHO who are required to provide primary health care.

Kosovo is characterized by more than half of doctors (56%) working in secondary and tertiary health facilities, so the workforce in primary health facilities is not necessarily strong.

Table 4-21: Number of Staffs working at Primary Health Facilities (2019)

Region	Doctor	Dentist	Nurse	Pharmacist	Others
Nationwide	1,142	309	3,108	24	923

Source: Health Statistics 2019

Table 4-22: Number of Staffs working at Secondary Health Facilities (2019)

Region	Specialist	Nurse	General Staff	Staff without payment	Total
Prizren	168	426	131	4	729
Peja	106	302	148	4	560
Gjilan	116	330	98	4	548
Vushtrria	52	92	36	0	180
Mitrovica	89	256	104	2	451
Gjakova	99	339	123	3	564
Ferizaj	69	159	64	2	294
Total	669	1,904	704	19	3,328

Source: Health Statistics 2019

Table 4-23: Number of Staffs working at Tertiary Health Facility (UCCK) (2019)

Clinic	Doctors			Nurses				Non-Medical	Total
	Total	In Specialization	Specialists	Total	Midd	Lower	Other		
Gynecology and Obstetrics Clinic	56	-	56	245	245	-	-	31	332
Dermato-venereology Clinic	19	-	19	25	25	-	-	17	61
Abdominal Surgery	58	-	58	52	52	-	-	14	124
Maxillofacial Surgery Clinic	13	-	13	20	20	-	-	11	44
Orthopedics and Traumatology Clinic	34	-	34	80	80	-	-	20	134
Thoracic Surgery Clinic	13	-	13	29	29	-	-	20	62
Gastroenterology Clinic	11	-	11	22	22	-	-	12	45
Hematology Clinic	7	-	7	17	17	-	-	11	35
Neonatology Clinic	12	-	12	106	106	-	-	16	134
Infectious Disease Clinic	24	-	24	71	71	-	-	11	106
Ophthalmology Clinic	29	-	29	52	52	-	-	16	97
Nephrology Clinic	17	-	17	62	62	-	-	10	92
Orthopedics Service	6	-	6	65	65	-	-	30	101
Pulmonology Clinic	16	-	16	37	37	-	-	13	66
Cardiology Clinic	30	-	30	85	85	-	-	20	135
Infectious Clinic Disease	52	-	52	137	137	-	-	30	219
Endocrinology Clinic	13	-	13	16	16	-	-	11	40
Intensive Care Clinic	60	-	60	192	192	-	-	28	280
ENT Clinic	16	-	16	59	59	-	-	14	89
Neurology Clinic	24	-	24	65	65	-	-	10	99
Medical Biochemistry Clinic	20	-	20	82	82	-	-	9	111
Nuclear Medicine Service	6	-	6	11	11	-	-	7	24
Emergency Clinical Service	27		27	91	91	-	-	11	129
Physiatrist Clinic	16	-	16	63	63	-	-	10	89
Plastic Surgery Clinic	11	-	11	23	23	-	-	9	43
Neurosurgery Clinic	9	-	9	29	29	-	-	12	50
Urology Clinic	19	-	19	35	35	-	-	13	67
Oncology Clinic	20	-	20	45	45	-	-	11	76
Cardio-Surgery Clinic	22	-	22	56	56	-	-	22	100
Psychiatric Clinic	17	-	17	54	54	-	-	8	79
Radiology Clinic	28	-	28	61	61	-	-	11	100
Rheumatology Clinic	12	-	12	12	12	-	-	9	33
Children Surgery Clinic	13	-	13	24	24	-	-	24	61
Institutes	34	-	34	21	21	-	-	12	67
Vascular Surgery Clinic	9	-	9	30	30	-	-	21	60
Forensics	7	-	7	28	28	-	-	22	57
Total	**780**	**-**	**780**	**2,105**	**2,105**	**-**	**-**	**556**	**3,441**

Source: Health Statistics 2019

Table 4-24: Total Number of Staffs at Health Facilities (2019)

Municipality	Institution	Profession							TOTAL	
		Doctor (Physician)	Dentist	Pharmacist	Bachelor of Physiotherapy	Nurse	Health Co-worker	Non-medical	No	%
Deçan/Dečani	MFMC	25	4			74		13	116	0.9
Dragash/Dragaš	MFMC	18	5			59		17	99	0.8
Drenas/Glogovac	MFMC	41	3	1		104		32	181	1.4
Ferizaj/Uroševac	MFMC	54	23	2		175	1	50	305	2.3
	RPHC	10				13	3	9	35	0.3
	CBMHC	1				24	2	1	28	0.2
	Hospital	84		2		164	1	57	308	2.4
	Total	149	23	4		376	7	117	676	5.2
Fushë Kosovë/ Kosovo Polje	MFMC	24	5	1		51		23	104	0.8
Gjakovë/Đakovica	MFMC	71	47	1		203	1	25	348	2.7
	NCMC	13				36		26	?	0.6
	RPHC	4				6	2	4	16	0.1
	CBMHC	1				22	1	5	29	0.2
	Hospital	101		1	4	325		122	553	4.2
	Total	190	47	2	4	592	4	182	1021	7.8
Gjilan/Gnjilane	MFMC	55	17	1		152	2	46	273	21
	RPHC	7				17	1	4	29	0.2
	CBMHC	1				21	1	9	32	0.2
	Hospital	113		1	1	330	6	87	538	4.1
	Total	176	17	2	1	520	10	146	872	6.7
Hani i Elezit/Elez Han	MFMC	7		1		19		4	31	0.2
Istog/Istok	MFMC	24	6			65	1	22	118	0.9
Junik/Junik	MFMC	8	2			16	1	4	31	0.2
Kamenicë/Kamenica	MFMC	21	2			66		15	104	0.8
Kaçanik/Kačanik	MFMC	20	4	1		80		35	140	1.1
Klinë/Kljina	MFMC	32	1			85	1	16	135	1.0
Lipjan/Lipljane	MFMC	43	8			132		47	230	1.8
Malishevë/Mališevo	MFMC	25	4			76		16	121	0.9
Mamushë/Mamuša	MFMC	6	1	1		17		1	25	0.2
Mitrovicë/Mitrovica	MFMC	42	15			151		51	260	2.0
	RPHC	5				17	1	8	31	0.2
	CBMHC	1				19	1	5	26	0.2
	Hospital	79			7	252		98	436	3.3
	Total	127	15	1	7	439	2	162	753	5.8
Novobërdë/Novobrdo	MFMC	2	1			24		10	37	0.3
Obiliq/Obilić	IOM	15	1		1	25	1	28	71	0.5
	MFCH	25	5			52	1	19	102	0.8
	Total	40	6		1	77	2	47	173	1.3
Pejë/Peć	MFMC	78	27	2		178	11	33	329	2.5
	RPHC	10				17	1	11	39	0.3
	CBMHC	1				16	1	7	25	0.2
	Hospital	114		1	4	306	5	148	578	4.4
	Total	203	27	3	4	517	18	199	971	7.4
Podujevë/Podujevo	MFMC	56	6			127	1	52	242	1.9
Prishtinë/Priština	NIPHK	41				43	8	23	115	0.9
	Preclinical institutes	47				18			65	0.5
	MFMC	178	47	1		422	1	74	723	5.5
	UCCK	719	1	19	11	2079	24	529	3382	25.9
	UDCCK		77	1		51		57	186	1.4
	ECC	20				47		21	88	0.2
	MHCHIC	2				23	2	14	41	0.3

	Total	1007	125	21	11	2683	35	718	4600	35.2
Prizren	MFMC	106	39	1		251	1	69	467	3.6
	RPHC	9				15	4	5	33	0.3
	CBMHC	2				18	2	7	29	0.2
	Hospital	171		1		428		125	738	5.6
	Total	288	39	2	13	712	7	206	1267	9.7
Rahovec/Orahovac	MFMC	36	9	1	13	71	1	18	136	1.0
Shtime/Štimlje	MFMC	18	1			46		15	80	0.6
Skenderaj/Srbica	MFMC	30	3	1		105	1	30	170	1.3
Suharekë/Suvareka	MFMC	28	8			86		19	141	1.1
Viti/Vitina	MFMC	27	3			86		18	134	1.0
Vushtrri/Vučitrn	MFMC	39	8	1		127	3	27	205	1.6
	Hospital	38			1	92		33	164	1.3
	Total	77	8	1	1	219	3	60	369	2.8
TOTAL		2748	383	42	42	7524	94	2244	13077	100.0

Source: NIPH 2019

4.7 Medical Products

4.7.1 Medical products procurement

(1) License to sell medical products

For production and sales of medical products and device in Kosovo, the Kosovo Medicines Agency (hereinafter called KMA)[19], subsidiary of the MOH, is responsible for approving economic operators wishing to manufacture, import and/or sell medical devices and for other operations, such as quality and safety management of these devices, pursuant to the Law on Medical Products and Medical Devices, LAW NO 04/L-190, 07 April 2014. The KMA approval department is responsible for testing and approving the import and export of medical device, test reagents, dietary supplements, and for issuing marketing authorizations.

Table 4-25: Role and Responsibility of KMA

- Issuing license for companies producing and/or selling pharmaceuticals and medical device products
- Issuing license for companies importing pharmaceuticals and medical device products
- Issuing marketing authorization of pharmaceuticals and medical device products
- Management and update record of marketing authorization
- Quality control and safety management of medical products and medical device products in Kosovo
- Surveillance of side effect of medical products

Source: The Survey Team

(2) List of Essential Medicines

The MOH defines essential medicines that shall be stocked in public health facilities in Kosovo based on the Model List of Essential Medicines (ELM) by the WHO. The list consists of more than 1,000 medical products and is called Kosovo's ELM.

Since the Kosovo's ELM had not been updated since 2013, it was pointed out that the difference of content from the needs of the patients in the audit of the Board of Audit in 2017. After that, it was updated in 2019. The table

[19] There is a law relating to the operations of the KMA: Administrative Instruction (MOH) No. 01/2014 for Tariff for Services Provided by KMA.

below shows the overview of the Kosovo's ELM.

Table 4-26: Outline of Kosovo's ELM

No	Composition of medical products
1	ANAESTHETICS, PREOPERATIVE MEDICINES AND MEDICAL GASES
2	MEDICINES FOR PAIN AND PALLIATIVE CARE
3	ANTIALLERGICS AND MEDICINES USED IN ANAPHYLAXIS
4	ANTIDOTES AND OTHER SUBSTANCES USED IN POISONINGS
5	ANTICONVULSANTS/ANTIEPILEPTICS
6	ANTI-INFECTIVE MEDICINES
7	ANTIMIGRAINE MEDICINES
8	ANTINEOPLASTICS AND IMMUNOSUPPRESSIVES
9	ANTIPARKINSONISM MEDICINES
10	MEDICINES AFFECTING THE BLOOD
11	BLOOD PRODUCTS OF HUMAN ORIGIN AND PLASMA SUBSTITUTES
12	CARDIOVASCULAR MEDICINES
13	DERMATOLOGICAL MEDICINES (topical)
14	DIAGNOSTIC AGENTS
15	DISINFECTANTS AND ANTISEPTICS
16	DIURETICS
17	GASTROINTESTINAL MEDICINES
18	HORMONES, OTHER ENDOCRINE MEDICINES AND CONTRACEPTIVES
19	IMMUNOLOGICALS
20	MUSCLE RELAXANTS (PERIPHERALLY-ACTING) AND CHOLINESTERASE INHIBITORS
21	OPHTHALMOLOGICAL PREPARATIONS
22	OXYTOCICS AND ANTIOXYTOCICS
23	PERITONEAL DIALYSIS SOLUTION
24	MEDICINES FOR MENTAL AND BEHAVIOURAL DISORDERS
25	MEDICINES ACTING ON THE RESPIRATORY TRACT
26	SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID–BASE DISTURBANCES
27	VITAMINS AND MINERALS
28	EAR, NOSE AND THROAT MEDICINES
29	SPECIFIC MEDICINES FOR NEONATAL CARE
30	MEDICINES FOR DISEASES OF JOINTS

Source：MOH

(3) Medical products procurement system

For medical products required in the primary, secondary and tertiary health facilities, each facility submits a request of medical products necessary for the following term (types and quantity) from the Kosovo's ELM. (The primary health facilities submit the list to their city administrations which forward it to the MOH. The secondary and tertiary facilities submit the list to the HUCSK.) The MOH or the HUCSK examines the requests and determines the quantity and the types of medical products to be approved. (In this case, it is not uncommon that the quantity of requested medical products are largely reduced because of budgetary constraints.) [20] Medical products for the primary facilities are bulk procured by the MOH and those for the secondary and tertiary facilities are bulk procured by the HUCSK by holding public billings. Generally, medical products are procured once or twice a year. However, they are distributed to each health facility by the MOH (for primary health facilities) or

[20] It is regulated that each health facility submits a list of necessary medical products to the MOH and the HUCSK twice a year (January and July).

HUCSK (for primary and secondary health facilities) on monthly basis. In addition to the medical products, medical consumables and cell-growth inhibitors (anticancer medicines) are distributed to each health facility by bulk procurement. (Anticancer medicines are distributed to the UCCK only).

(4) Price regulation for medical products

The MOH was aware that there were cases prices of medical products procured by the government were higher than market prices. Therefore, in 2019, the ceiling price setting system was introduced. In short, the Commission for Pricing of the Medicinal Products, consisting of 7 members from the MOH, KMA, the Chamber of Pharmacists of Kosovo, HIF director, etc. and NGO related personnel (observers), was established. The purpose of the committee is to determine each year the ceiling prices of medical products included in the Kosovo ELM on the basis of DDP (delivered duty paid) prices in Pristina and pharmaceutical prices in four countries, Albania, Macedonia, Montenegro and Croatia. According to the MOH, however, this Commission is not functioning well due to objections from pharmaceutical companies and medicine distributors.

4.7.2 Basic problems in procurement of medical products

In Kosovo, chronic shortage of medical products in public health facilities and increase of patients' OOP resulting from such shortage is significant problem. The basic factor for the shortage of medical products in public health facilities is an absolute shortage of the budget for purchasing them. For example, the budget for purchasing pharmaceuticals to be distributed to the primary health facilities is 5,500,000 EUR (budget for 2021. It is equivalent to about 3EUR per capita) and that for the secondary and tertiary health facilities is about 30,000,000 EUR (result for 2019. It is equivalent to about 17 EUR per capita). Thus, the public budget for purchasing medical products for the entire public health care system is only 20 Euro per capita (Expense dor medical products are included in item of “Goods and Service” of Table 4-16). This budget is remarkably low compared to those European countries which have a relatively low budget for purchasing medical products (Denmark: 203 EUR, Romania: 255 EUR, Estonia: 262 EUR, Poland: 267 EUR, etc. These costs are annual expenditure per capita.)[21]. From this comparison it is obvious that this is a serious problem. As far as the primary health facilities are concerned, 80 percent of the total budget of 5,500,000 EUR is occupied purchasing insulin (medicines to lower blood glucose). Therefore, increase of the budget for purchasing medical products is an urgent issue.

Medical products including medicines are basically distributed free of charge for patients visit public health facilities. However, in case the medical products are out of stock at the public health facility, patients purchase medical products by themselves. The price of medical products differs by each pharmacy. At the moment, patients purchase medical products from the private pharmacies based on doctors' prescriptions when they are not provided by the MFMC and the FMC. However, prices of the medical products are differing depending on the pharmacy (see Table 4-28), so the price control has not been functioning. According to an officer in charge of medical products in the MOH, introduction of a system that the payment for medical products is shouldered by the government (medical product purchase cost refund system) it is expected to be realized in the next year at the

[21] Health at a Glance: Europe 2018, OECD/European Union

earliest.

Table 4-27: Movement of Purchasing Medical Products Amount by Secondary and Tertiary Health Facilities (Unit: EUR)

Health facilities	2017	2018	2019
UCCK	18,059,300.84	22,263,388.85	24,219,200.28
Gjilan General Hospital	726,499.78	847,331.00	802,473.00
Prizren General Hospital	1,490,314.07	1,607,872.84	1,262,853.37
Gjakove General Hospital	778,219.15	772,089.03	1,014,652.12
Peje General Hospital	1,035,756.94	1,489,645.90	1,093,317.00
Mitrovice General Hospital	554,547.26	811,901.34	563,405,.00
Vushtri General Hospital	146,453.58	171,614.32	227,110.07
Ferizaj General Hospital	519,602.09	419,745.61	622,664.37
Mental Health			122,554.46
Total	23,310,692.97	28,383,588.89	29,928,229.98

Source: HUCSK annual report (2019)

Table 4-28: Prices of Medical Products at Pharmacy (in May 2021 at Pristina City, Unit: EUR)

	Name, Specifications		Price (EUR)			
			Public health facility	Pharmacy A	Pharmacy B	Pharmacy C
1	Ibuprofen 400mg (Non-steroidal anti-inflammatory)	Turkish	Free	1.5	1.5	1.5
		Germany	Free	2.9	2.9	2.8
2	Ampicillin 500 mg (Antibiotics for infectious diseases)		Free	1.5	1.6	1.5
3	Diazepam 2mg (Hypnotic sedative)		Free	0.7	0.8	0.7
4	Dexamethasone tab. (Steroidal anti-inflammatory)		Free	1.5	1.4	1.5
5	Gentamicin amp. 80mg (Aminoglycoside antibiotic medicine)		Free	0.3	0.3	0.3

Source: Hearing at pharmacy by Survey Team (May 2021)
Note: Type of medicine is selected by Survey Team from Kosovo's ELM

4.8 Cooperation with Other Donors

This section summarizes the trend of donor intervention in the health sector in Kosovo. This information is useful in order to identify areas in which Japan can corporate with other donors in order to work together to avoid duplication of activities and to create synergies with other aid.

4.8.1 Donor coordination framework

The Department of European Integration and Policy Coordination of MOH has been managing donor coordination. It has been negotiating with each donor individually and collectively. In addition, as a framework for coordination among the donors, Donor Coordination Meetings have been periodically held. At the moment, the World Bank is

responsible for organizing the meetings.

4.8.2 The World Bank

The World Bank is the largest aid organization for the health sector of Kosovo. The World Bank believes that patients' contributions in Kosovo in the use of the health and medical service (which is said to be 40%（See 4.4.1 National Medical Expense)[22], as described in Country Partnership Framework 2017–2021) is a heavy burden for the people so it is important to promote the introduction of the health insurance system to reduce the individual OOP ratio and to share health service related costs by the population more evenly. Besides, the World Bank believes that primary health facilities should also be improved, so it is giving active support to them such as providing training opportunities to doctors. In the Health Financing Report, it was pointed out that economic barriers hinder people to use health services, which has a detrimental effect on various health indices (The World Bank 2012). Prior to the Health Financing Report, the World Bank released the Health Financing Reform Study in 2008 in order to prove that the reform within Kosovo's health sector should be a priority. Since then, based on the findings of the Study, the World Bank has been actively engaged to support the financial sustainability of the health sector, provide support to form the directions of government health policy and to develop the future health insurance system (already planned).

Against this backdrop, the World Bank has been conducting the Kosovo Health Project (KHP) as a loan project since 2015 and was planning to finish it in June 2021[23]. Within the KHP, the World Bank has been supporting the introduction of the health insurance system, primary health and service delivery, the establishment of the HIS and the development of human resources for project management enhancement, etc. while especially focusing on health finances. Incidentally, the KHP is scheduled to continue as a new project. It was evaluated as a new project in May 2021. It is scheduled to start in the first half of 2022 at the earliest.

Table 4-29: Overview of Kosovo Health Project

Name of the Project	Kosovo Health Project
Project Period	July 2015 - October 2021
Total Project Cost	25 Million USD
Components and Budget	■ (Component 1) Support capacity building and establishment of building blocks for introduction of Social Health Insurance:(€5.20 M) ■ (Component 2) Support primary health care strengthening:(€$4.90 M) ■ (Component 3) Project management and communications:(€0.70 M) ■ COVID-19 emergency response:(€4.00 M) ■ (Added)Response to COVID-19(Establishment of Cold Chain, etc.) (€ 50M+15M) ■ (added)Support for medical device at primary health facilities[24]

Source: Website of the World Bank

Local staff of the World Bank affirmed during our interviews, that the activities planned under the KHP went smoothly. Notwithstanding the success of activities, the introduction of health insurance system has not been

[22] Some reports state that it is 20 to 30%. Most of the self-pay is related to medical products

[23] The period was extended to October 2021 for the support for COVID-19 related matters and procurement of equipment to be provided to the primary health facilities.

[24] Cooperative support of the Swiss government for the provision of equipment to the primary health facilities in the AQH project

achieved and measures towards this goal consisted only of developing the "system for medical products for outpatients" (block). Since it has taken long time to obtain approval from the government, the legislation to revise the Health Insurance Act still on table The World Bank is convinced that the health insurance system is an important tool for stabilizing the health finances, so the organization is planning to continue its support activities. The Capitation Based Performance Payment (CBPP)was introduced in many municipalities, an issue related to health insurance, and established by the World Bank on the basis of the results of the KHP. It is managed and operated by the health insurance fund.

In the KHP, training for the staff of the primary health facilities has been conducted and main teaching materials such as guidelines and protocols have already been prepared.

Major indicators for the KHP confirmed on the website of the World Bank

Project indicators
- Establishment of a system of medical products for outpatients
- Number of municipalities which will participate in the Capitation Based Performance Payment (CBPP) based on the results
- Activation of HIS

Indicators for the midterm assessment results
- Conducing the training for health personnel (number of people)
- Number of health personnel who received training for infection prevention
- Construction and refurbishment of health facilities and installation of device
- Payment of salaries to volunteers
- Registration of patients to the HIS
- Satisfaction ratio of the users of the primary health facilities
- Ratio of municipalities which participate in the CBPP
- Ratio of municipalities which have created action plans for the purpose of performance improvement and participate in the plans

Source: Website of the World Bank

4.8.3 European Union (EU)

According to the hearing with EU officials, it was revealed that the EU had been supporting Kosovo to reach the goals set out in NDS 2016-2021. Although EU supported the health sector in the past. it has not given any direct support to the health sector since 2012. The reason for this is that the commitment of MOH for EU supported projects was felt insufficient. As a result, positive impact was not generated. However, MOH is seeking support from the EU, nevertheless the loan project developed and supported by the European Investment Bank (EIB)[25] have not progressed yet due to insufficient preparation on the Kosovo side.

According to the EU some important issues arose when considering support for the health sector in Kosovo. Resolving these challenges seems to be the shortest path to give EU consent for financial and technical support. The challenges are shown below.

According to the EU some important issues arose when considering support for the health sector in Kosovo. Resolving these challenges seems to be the shortest path to give their supports. The challenges are shown below.

[25] To be added the name of the report by EU

① The political condition is not stable. Measures of the previous administration are rejected, so no continuity of policies achieved.

② Unmotivated MOH staff. The lack of motivation of MOH staff for the success of policies has hampered coordination with other government agencies (e.g., Ministry of Finance).

③ Health workers provide low quality health services. The training system for health workers is inadequate and needs to be improved. It is a recognized fact that Kosovo has a physically (travel time) adequate number of health facilities, so its main task is to improve the quality of services.

4.8.4 Luxembourg Development Cooperation Agency (LuxDev)

According to the website of LuxDev, LuxDev has been supporting the health sector in Kosovo since 2004 and has been conducting the Project on Strengthening the General Hospital of Prizren and the Kosovo Health Sector Support Project. At Present, LuxDev is working on the Kosovo Health Sector Support Project (Phase II) (hereinafter called KHSSP2), which is scheduled to be implemented within 7 years from January 2016 to December 2022. The budget for the KHSSP2 for 2019 is 1,200,000 Euro and LuxDev covers 45.8% of the support amount to Kosovo.

In the KHSSP2, activities in coordination with the Health Sector Strategy 2017-2021 are implemented with the following main objectives

1) Re-defining the role of the MOH—Enhancing responsible management and operation, supervision and evaluation capacity

2) Decentralizing the major functions and management responsibilities to the health facilities and specialized organizations

3) Improving the quality of health and medical service and the synergy with the private health providers

4) Using the approach of "learning with working"

At the same time, LuxDev has been supporting the establishment of Doctors' Chamber which is now perfectly functioning. It is said that LuxDev is now supporting them to create clinical protocols that can be used in each health facility.

On the other hand, development of HIS [26] which LuxDev had supported until 2017 is suspended because the minister for health at that time canceled the contract with the subcontracted IT supplier, although it had a good reputation among health workers.

4.8.5 Swiss Agency for Development and Cooperation

The Swiss Agency for Development and Cooperation is implementing Phase 2 of the Accessible Quality

[26] Department of Health Information System of the MOH is now developing a system called Basic HIS on their own with support of the World Bank.

Healthcare (AQH) Project with a project duration of 4 years from January 2020 to December 2023. AQH Project (Phase 1) stated in 2015 in order to support primary health facilities with focusing on Non-communicable diseases.

The following three objectives were set in AQH project.

- Output 1: Improving the quality of basic health services at primary health facilities (MFMC, MFC, MFA) in order to satisfy the needs if the communities including vulnerable people.
- Output 2: Continuous improvement of quality of services through capacity development in management in order to satisfy the needs of the communities
- Output 3: Improvement of activities for awareness raising for healthy living and personal care for health of the citizens including vulnerable groups and empowerment of communities (demand for rights of high accessibility to high quality services)

AQH Project since 2016 is also promoting awareness raising activities against non-communicable diseases focusing on the prevention for high blood pressure and diabetes. In addition, AQH Project has been continuously giving trainings to health workers (doctors and nurses) such as about how to develop an integrated card model. It also includes Training of Trainers (TOT) for those who have already received training, AQH Project also support health workers so that they can carry out voluntary activities according to the WHO protocol.

AQH Project is targeting 20 municipalities (expanded from 12 municipalities in Phase 2 to 20 municipalities in Phase 2), with the intention to gradually expanded to the total of 38 municipalities in the future. For the provision of basic device to the primary health facilities, the World Bank has been supporting 18 municipalities other than initial 20 target municipalities.

One of the expressed goals of AQH project is the social inclusion of the most vulnerable, especially RAE (Roma, Ashkali and Egyptian) people.

Also, in collaboration with the World Bank, AQH Project has been actively supporting the introduction of Basic HIS and the Capitation Based Performance Payment (CBPP). Such activities are gradually making good results for collection of patients' data[27], etc.

4.8.6 United Nations Population Fund (UNFPA)

The UNFPA has a long history of working in Kosovo (it has been active since 1999). UNFPA has been focusing especially on socially vulnerable mothers and children and ethnic minorities such as the Roma, Ashkali and Egyptians. One of the major results in recent years was an attitude survey conducted in cooperation with the Kosovo Women's Network. This survey reveals socially vulnerable peoples' access, expectations, feelings and fears of towards health and medical services. In the report, it was pointed out that education and awareness raising activities were insufficient and the medical costs paid by patients hindered the readiness of such people to access health services. Major items pointed out in the report are as follows.

[27] By the support of the World Bank, 2.4 Euro is supplied to one patient input.

Major Points of 'Access to Health Care' Survey

1. Eighty-one percent of the surveyed people believe that they are healthy.
2. More women than men think that their health condition is slightly bad.
3. Twenty-three percent of such women believe that their health problems are disrupting their lives.
4. More women use the health and medical service than men. However, 54% of the respondents have never had a prevention related service such as health check.
5. Only few people have had a cancer screening. This is so because many people don't know that such what services exist.
6. Thirty-five percent of the respondents did not know that the MFMC has been providing service for maternity care.
7. Twenty percent of the respondents (10% of women) use contraceptives, but other respondents don't use them because of lack of information. As a result, 11% of women have experienced abortion in life.
8. Twenty-six percent of the respondents had a doctor's examination maximum once in the past 1 year.
9. The reasons why they do not have a doctor's examination are that they hate to wait for the examination and have an economic barrier.
10. The health insurance system has not been implemented. Six percent of the population participated in private medical insurance. The participation rate of women and children is very low.
11. About 60% of the respondents prefer public health facilities because of low prices, and 32% of the respondents prefer private clinics.
12. As a whole, both men and women have similar barriers to access to the healthcare, but women have more social and economic barriers.
13. Women in rural areas have economic and cultural and difficulties because of the human relationship with health workers.
14. The Roma, Ashkali, Egyptians and Gorani have serious geological, economic and cultural barriers when they try to access healthcare.
15. Since they can get medical products easily, they purchase them without doctor's examination nor prescriptions.
16. It is illegal to do so, but people are guided to specific pharmacies by agreement between most doctors and pharmacies.

Source: Kosovo Women's Network, 2016

The UNFPA Official, based on their past experiences, believes that the following items are major challenges for the health sector in Kosovo

a) In general, there is no problem with the physical accessibility to the health facilities. However, improving the quality of the health services is a major issue. Doctors and nurses have no further training opportunities after their graduation so they cannot update their skills and knowledge.

b) Many socially vulnerable people do not understand the importance of maternal care. Awareness raising activities and support services, such as maternal care, are important to reduce neonatal mortality rate. This is a necessary activity in Kosovo, where the population has begun to decline.

c) Political stabilization is an important challenge for Kosovo. There are many harmful effects such as important policies such as health insurance being ignored due to the volatility of political parties and frequent changes of governments.

d) MOH officials need to broaden their mindset. It is desirable that donor organizations continue to provide trainings to MOH officials.

With the onset of population decline in Kosovo, it is expected that policies aiming to maintain present to hold population levels will rise. Especially in light of the fact, there is a trend that young families with children move out to other countries as migrant workers. The reasons are: (1) It is difficult for them to find jobs in Kosovo. There are not enough quality jobs in Kosovo and thus unemployment rate is very high. (2) They move abroad for seeking better education for their children. It was pointed out that young families in Kosovo felt discouraged about the future of Kosovo, so many of them left Kosovo in order to provide a better future for their children.

4.8.7 .United Nations Children's Fund (UNICEF)

Between 2016 and 2020, UNICEF has focused on supporting children, with a focus on the following six areas

1. Monitoring of children's rights and social protection
2. Inclusive education and early childhood development
3. Adolescents, youth and innovation
4. Health
5. Child protection and social inclusion
6. Communication and Partnership

UNICEF places great importance on the health sector, and in their report (Kosovo MICS 2020), they noted that infant and newborn mortality in the RAE community, an ethnic minority in Kosovo, is three times that of the general population and needs support (41 per 1.000 live births and 29 per 1,000 live births, respectively), In these communities mortality rate is 4 per 1,000 live births and 29 per 1,000 live births, respectively.) In these communities, it is estimated that one out of every four children are in the poorest households, and child immunization rates are lower than in Kosovo as a whole (73% in general and 38% in RAE). Against this background, UNICEF has continued to provide support to the RAE, including activities such as the provision of lunch boxes to children from poor households, from the perspective of child nutrition.

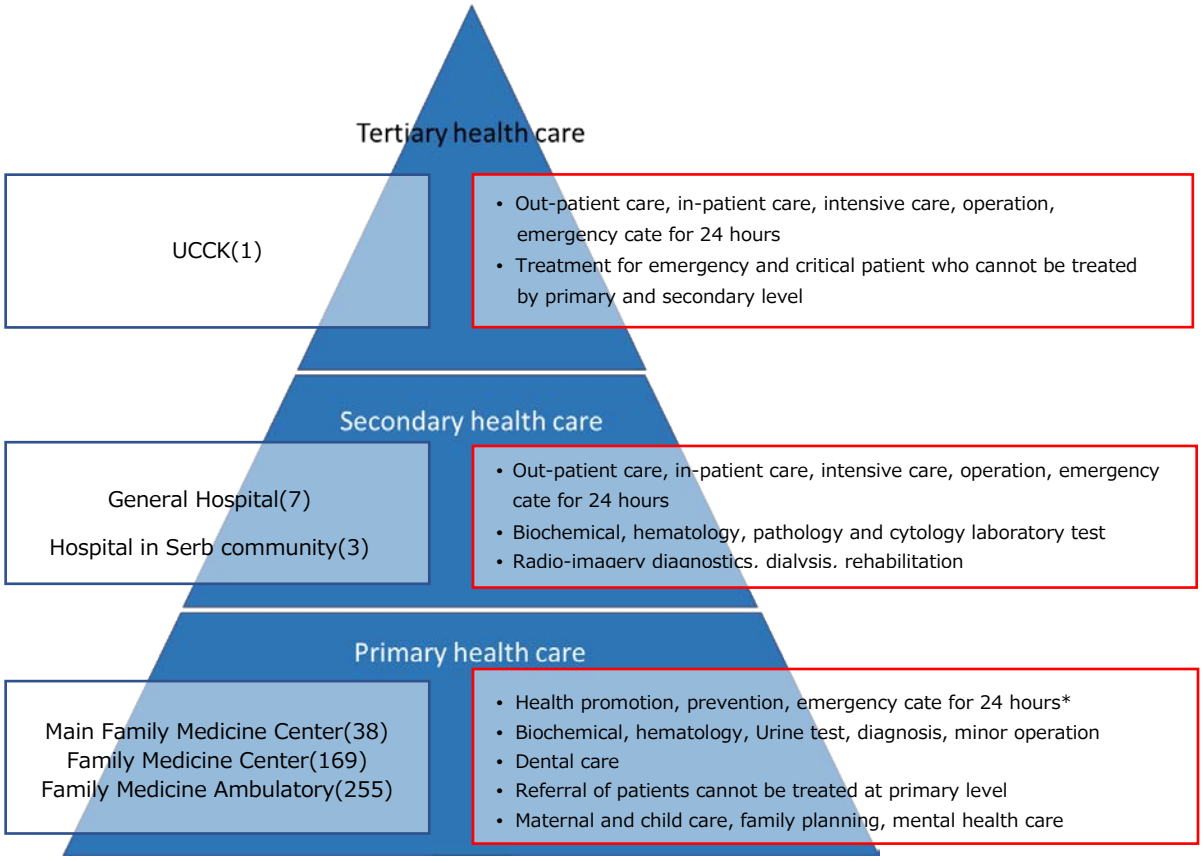
In addition, after the COVID-19 outbreak since February 2020, UNICEF has been playing a central role in the fight against COVID-19 in Kosovo. Specifically, UNICEF has made a significant presence by creating vaccination schedules and supporting the establishment of cold chains. In addition, to avoid confusion among young people due to misinformation, it has developed an app called Health Buddy+, which provides correct information on COVID-19 and vaccines, and is actively engaged in other prevention awareness activities.

Chapter 5 Health and Medical Services and Patient's Consultation Practices

5.1 Referral System and Health facilities

5.1.1 Referral system

According to the Kosovo Health Law, a referral system is used whereby health facilities are categorized into primary, secondary and tertiary levels in Kosovo. Health care provision is based on collaborating and complementing within and in between these levels, in order to provide consistent and comprehensive health and medical services effectively. A diagram of the referral system within health and medical service provision is provided in Figure 5-1.



*Family Medicine Center and Family Medicine Ambulatory are not providing emergency cate for 24 hours
Source: Survey team

Figure 5-1: Image of Health and Medical Service Provision

The purpose of the referral system is to attempt reduced congestion of secondary and tertiary health facilities and effective use of healthcare resources based on fundamental principles by constructing a system whereby: (i) patients undergo diagnoses at the primary health facilities first; (ii) if necessary, doctors introduce patients to secondary health facilities; and (iii) furthermore, doctors introduce patients to tertiary health facilities.

In order to ensure the effectiveness of this system, different diagnostic charges have been introduced in Kosovo to be paid by patients depending upon whether the patient arrived with or without a referral. For example, the

price of a visit could cost 3 EUR at secondary health facilities when the patient has been referred by a doctor at primary level or a private health facility. Meanwhile, the same visit could cost 10 EUR if the patient arrives without such referral. The visit fee is 4 EUR at a tertiary health and health facility when the patient has been referred by a doctor from a lower level or private health facility, but it would cost 12 EUR if the patient arrives without it. (see Table 5-29).

5.1.2 Geographical distribution of facility classified by level

(1) Primary health facilities

In Kosovo there are different primary-level health facilities, namely MFMC, FMC and FMA. According to MOH regulations, an MFMC has to be established within the central zone/inner city area of all 38 municipalities. Based on population size and distribution additional FMCs and FMAs are required to be established. As of May 2021, 38 MFMCs, 169 MFCs, and 255 MFAs exist.

Family doctor teams (each team comprises a single family doctor and two nurses) are assigned to MFMCs and FMCs. Such teams are regulated to cover 2,000 residents each. Moreover, when there are residents whose home have more than 5-km distance to the closest primary health facilities, each city is able to request MOH to establish an FMA[28]. FMAs are in charge of health and medical services for agricultural and mountain and village regions that are located at a remote distance from central urban areas.

Table 5-1: Number of Health Facilities in Each City

District	Municipality	MFMC	MFC	MFA	Total
Ferizaj	Ferizaj	1	8	7	16
	Hani i Elezit	1	-	1	2
	Kacanik	1	4	8	13
	Shterpce	1	-	1	2
	Shtime	1	4	0	5
Gjakova	Decan	1	3	6	10
	Gjakova	1	10	16	27
	Junik	1		-	1
	Rahovec	1	7	7	15
Gjilan	Gjilan	1	12	9	22
	Kamenica	1	3	17	21
	Kllokot	1	-	-	1
	Partesh	1	-	2	3
	Ranillug	1	-	-	1
	Viti	1	4	7	12
Mitrovica	Leposavic	1	-	1	2
	North Mitrovica	1	-	-	1
	Mitrovica	1	11	11	23
	Skenderaj	1	5	8	14
	Vushtrri	1	10	9	20
	Zubin Potok	1	-	1	2
	Zvecan	1	-	1	2
Peja	Istog	1	4	7	12
	Kline	1	3	9	13

[28] Administrative Instruction 04/2020 Primary Health Care

	Peja	1	10	10	21
Pristina	Fushe kosova	1	5	3	9
	Gllogovc	1	5	7	13
	Gracanica	1	3	11	15
	Lipjan	1	4	7	12
	Novo Brdo	1	1	-	2
	Obiliq	1	2	3	6
	Podujevo	1	4	18	23
	Pristina	1	15	15	31
Prizren	Dragash	1	5	8	14
	Malisheve	1	6	7	14
	Mamusha	**1**	-	-	**1**
	Prizren	1	15	27	43
	Suhareka	1	6	11	18
Total		38	169	255	462

Source: MOH

(2) Secondary and tertiary health facilities

There are 7 general hospitals, and another 3 hospital facilities within place whose majority population is Serb. A general hospital has been established in the central city of each district (Ferizaj, Gjakova, Gjilan, Mitrovica, Peja, and Prizren) and in Vushtrri City of Mitrovica District. General hospitals of each district basically cover residents living in the given district. Exceptionally, in Mitrovica District, the Mitrovica General Hospital covers all residents within Mitrovica District and the Vushtrri General Hospital only covers residents in Vushtrri City. Pristina District has no secondary-level health facilities, and the UCCK, which is the tertiary level, provides secondary-level and tertiary-;eve; services to the residents in the district. The three hospital facilities within Serbian majority areas are located in: North Mitrovica, Zvecan, and Gracanica. The budget for these hospitals is distributed by government of Serbia because of political matter. According to MOH some of such hospital possibly have more than secondary level function but there is no detailed information. The Survey Team included one of these hospitals within its target groups in the subcontracted survey. However, the surveyors were not accepted by the hospital and the Survey Team could not collect data about these institutions.

As the sole and only tertiary health and health facility within Kosovo, UCCK, which has 22 clinical departments, has been established in capital city of Pristina. Table 5-2 and Figure 5-2 list location municipalities and provide a location map of general hospitals, MFMCs, etc.

Furthermore, based on information gained from secondary and tertiary health facilities via the subcontracted survey, diagnostic charges for health facilities are listed in Table 5-3. Visible from the table, that despite the fact that secondary health facilities have set clinical departments, due to lack of personnel, devices, materials, and personnel competencies, many of such clinical departments are not providing sufficient services. In particular, all facilities which set up thoracic surgery department, hematology department, neurosurgery department for example, have replied to our inquire that they were not providing sufficient services.

(3) The special situation in the capital Prishtina

The capital city, Pristina, in Kosovo has a tertiary health facility, UCCK, but no secondary health facilities, and the large-scale MFMC (primary health facility) serves as a substitute for the secondary health facility. Therefore,

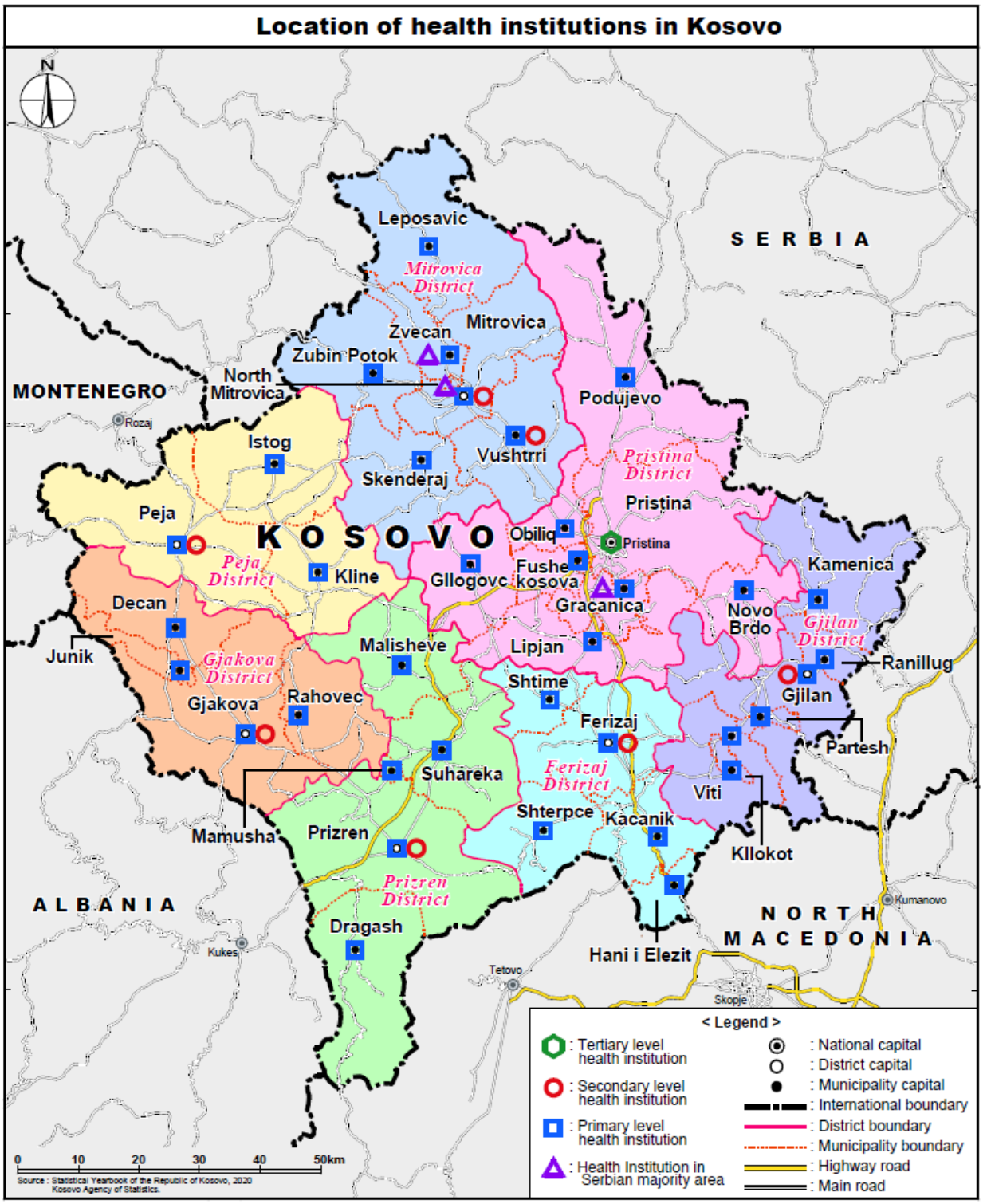
patients who cannot be treated by the primary health facilities are directly referred to UCCK. This is one of the reasons for the concentration of patients in UCCK. In addition, UCCK is located in the center of a densely populated city, and it has been confirmed that many patients visit directly UCCK without bypassing primary health facilities due to its easy accessibility. In order to alleviate the excessive concentration of patients at the UCCK in the future, the Kosovo government is considering the idea of establishing a secondary health facility in Pristina. (No specific plans have been confirmed.)

Table 5-2: Allocation of MFMC and general hospitals and their coverage area

District	Municipality	Population
Ferizaj	Ferizaj	108,610
	Hani i Elezit	9,403
	Kacanik	33,409
	Shterpce	6,949
	Shtime	27,324
Gjakova	Decan	40,019
	Gjakova	94,556
	Junik	6,084
	Rahovec	56,208
Gjilan	Gjilan	90,178
	Kamenica	36,085
	Kllokot	2,556
	Partesh	1,787
	Ranilluk	3,866
	Viti	46,987
Mitrovica	Leposaviq	13,773
	North Mitrovica	12,326
	Mitrovica	71,909
	Skenderaj	50,858
	Vushtrri	69,870
	Zubin Potok	6,616
	Zvecan	7,481
Peja	Istog	39,289
	Klina	38,496
	Peja	96,450
Prishtina	Fushe Kosova	34,827
	Gllogoc	58,531
	Gracanice	10,675
	Lipjan	57,605
	Novo Brdo	6,729
	Obiliq	21,549
	Podujevo	88,499
	Prishtina	198,897
Prizren	Dragash	33,997
	Malisheve	54,613
	Mamusha	5,507
	Prizren	177,781
	Suhareka	59,722

General Hospital
MFMC

Source: Survey Team



Source: Survey team developed based on map of Kosovo Agency of Statistics

Figure 5-2: Map of MFMC and general hospitals

Table 5-3: Clinical Department of General Hospitals and UCCK

	UCCK		Gjakove		Mitrovica		Prizren		Vushtrri		Ferizaj		Gjilan		Peja	
	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not	Clinical departme	Clinical departme nt not
01.Gynecology and Obstetrics	✓		✓		✓	-	✓		✓		✓		✓		-	-
02.Dermato-venerology			✓		✓	-	✓		✓	✓			✓		-	-
03.Abdominal surgery			✓	✓	✓	-			✓				✓		-	-
04.Maxillofacial Surgery						-	✓	✓							-	-
05.Orthopedics and Traumatology					✓	-							✓		-	-
06.Thoracic Surgery			✓	✓		-	✓	✓							-	-
07.Gastroenterology	✓		✓		✓	-	✓		✓		✓		✓	✓	-	-
08.Hematology	✓		✓	✓		-	✓	✓							-	-
09.Neonatology	✓		✓			-	✓		✓	✓	✓		✓		-	-
10.Infectious Disease	✓		✓		✓	-	✓				✓	✓	✓		-	-
11.Ophthalmology	✓				✓	-	✓				✓	✓	✓		-	-
12.Nephrology	✓		✓	✓		-	✓						✓		-	-
13.Pulmonology	✓		✓	✓	✓	-	✓				✓		✓		-	-
14.Cardiology	✓		✓		✓	-	✓		✓	✓	✓		✓		-	-
15.Infectious Disease	✓		✓	✓	✓	-	✓				✓		✓		-	-
16.Endocrinology	✓				✓	-	✓		✓	✓	✓				-	-
17.Intensive Care	✓		✓			-	✓		✓		✓	✓	✓		-	-
18.Ear, nose and throat	✓		✓	✓	✓	-	✓				✓	✓	✓		-	-
19.Neurology	✓		✓		✓	-	✓						✓	✓	-	-
20.Emergency Clinical Service	✓		✓		✓	-	✓				✓				-	-
21.Physiatrist Clinic	✓		✓		✓	-	✓		✓	✓			✓		-	-
22.Neurosurgery	✓					-	✓	✓			✓	✓			-	-
23.Urology	✓		✓		✓	-	✓		✓	✓	✓		✓		-	-
24.Oncology	✓					-	✓	✓							-	-
25.Cardio-Surgery	✓					-	✓	✓							-	-
26.Psychiatric	✓		✓			-	✓						✓	✓	-	-
27.Radiology	✓		✓		✓	-	✓		✓		✓		✓		-	-
28.Rheumatology	✓				✓	-	✓		✓	✓	✓				-	-
29.Pediatrics	✓		✓		✓	-	✓		✓		✓		✓		-	-
30.24hrs emergency service	✓		✓		✓	-	✓		✓		✓		✓	✓	-	-
31.Other	✓					-										

Source: Subcontracted survey. Answer from Peja is not received.
In UCCK, there are Institute of Pathology, Orthoprosthetics, Institute of Forensic Psychiatry, Pediatric Surgery, Nuclear Medicine, Allergology as other clinical department
*The clinical department which is not functioning well because of luck of human or facility etc. For Mitrovica general hospital, it is answered that all the clinical department is not functioning well.

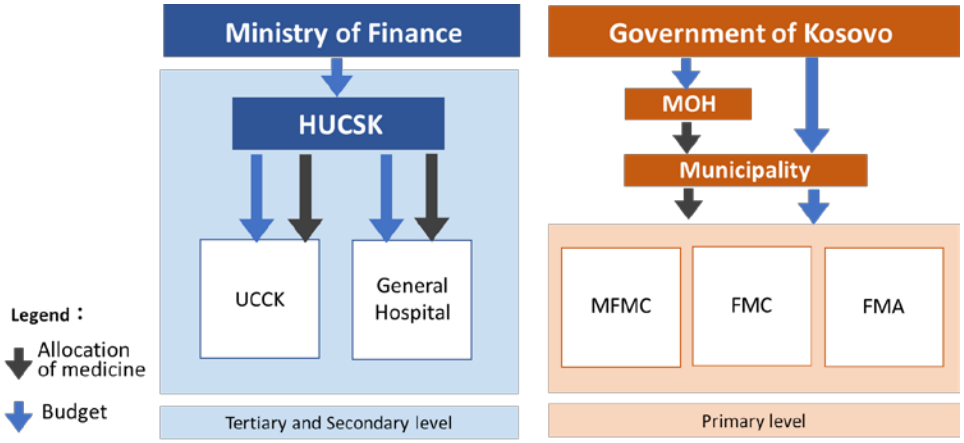
5.1.3 Administration of public health facilities

(1) Management and administration

Each city has jurisdiction over the primary health facilities (i.e., MFMCs, MFCs, and MFAs). For example, city

governments appoint the heads of MFMCs, and allocate budgets. However, MOH collectively procures pharmaceutical products for 38 municipalities and deliver to each facility through city governments.

HUCSK, whose purpose is to improve provision of public health services, has jurisdiction over management and administration of secondary facilities (i.e., 7 general hospitals) and tertiary facilities (i.e., UCCK). Budgets for general hospitals and UCCK are distributed to HUCSK by the Ministry of Finance, and distributed to each general hospital and UCCK by HUCSK. The administration system and process of the budgets for the primary, the secondary, and the tertiary levels are shown in Figure 5-3.



Source: Survey team developed based on hearing from MOH

Figure 5-3: Management Structure and Budget Flow of Primary, Secondary and Tertiary Level

HUCSK, which has jurisdiction over management and administration of the secondary and tertiary facilities, is established in 2014 to improve the provision of public health and medical services. It took over the responsibilities of the MOH to the general hospitals and UCCK financially, technically and administratively. Statute of HUCSK defines its function and responsibility (1) to provide quality health services by aiming at improving the efficiency and effectiveness and (2) to create synergy effects through the coordination of specialized health services. Meanwhile, currently the main duties of HUCSK head office are approval of the medicine procurement plan developed by the general hospitals and UCCK, publishing of an annual report on health services and budget execution, public relations, etc. It seems that the institution is not yet capable to control and coordinate the service provision of different health facilities and thus create synergy. The most probable reason for this shortcoming is a shortage of human resources and lack of clear legislative mandate. The administration and management of 15 facilities including 7 general hospitals and UCCK is done by around twenty full-time staffs of HUCSK head office. In addition, statutes of HUCSK does not define the detailed role of the HUCSK head office, and it seems the specific scope of duties is not shared among the staffs. In order for HUCSK to fulfill its function of improving health services as mentioned in its statutes, it is necessary to review and define specific scope of duties of the HUCSK head office, increase and strengthening human resources.

(2) Revenue and expenditure

The financial situation of secondary and tertiary health facilities can be analyzed through their revenue and

expenditure data, which information collected through subcontracted survey, is as the following table. Budget from government is biggest source of revenue, and medical fee accounts for 17% in largest case (Vushtrri General Hospital). There are some facilities including UCCK, whose medical fees are quite low with accounting for 2% to 3 %. Meanwhile, salary accounts for up to 70% to 90% of all expenditures for all facilities.

Table 5-4: Revenue and Expenditure of Secondary and Tertiary Health Facilities in 2019

(in EURO)

	UCCK	Ferizaj	Gjakova	Gjilan	Mitrovica	Peja	Prizren	Vushtrri
Revenue	50,686,180	3,989,390	NA	5,525,858	5,221,327	NA	9,933,859	2,478,220
Budget from government	49,308,684	3,441,630	-	5,525,858	5,112,015	-	9,586,682	2,109,389
Medical fee	1,377,496	547,760	-	-	109,312	-	347,177	368,831
Assistance from donor	0	0	-	-	-	-	-	-
Others	-	-	-	-	-	-	-	-
Expenditure	42,585,234	2,709,245	NA	4,393,240	4,423,063	NA	9,586,673	1,710,539
Salary	29,720,316	2,647,932	4,715,027	4,356,240	3,907,719	5,029,574	6,667,970	1,490,065
Procurement of Medicine	4,662,379	-	-	-	68,043	-	-	67,962
Procurement of device	5,491,210	-	-	-	269,248	-	943,170	70,000
Maintenance fee	1,766,090	-	-	37,000	68,816	-	144,787	59,611
Reagent and consumption	-	-	-	-	59,741	-	411,888	-
Hospital meals	945,240	61,313	-	-	49,496	-	317,123	22,901
Others	-	-	-	-	-	-	1,101,735	-

Source: Developed based on information collected by subcontract survey. For Gjakova and Peja, answers were not collected, and HUCSK annual report data was used for salary. Obvious mistaken answer such as difference of amount digit was modified by Survey Team with utilizing HUCSK annual report data. Comparing to Table 5-15, some amounts were answered less. The reason for this is assumed as following. Since detailed category of revenue and expenditure were specified for subcontracted survey in order for increasing answer collection rate, then some amounts, which were included in Table 5-15, were probably excluded from answer.

5.1.4 Private health facilities

Private health facilities are required to obtain licenses from the Licensing Board of Private Health Care Institutions[29] in order to provide health and medical services. The number of private health facilities in 2015 and 2019 is shown in Table 5-5. The number of the secondary-level health facilities in 2015 and 2019 have not changed. Meanwhile, the number of doctors, nurses and beds at secondary health facilities have increased approximately 75% to 80% over the five years from 2015 to 2019. Moreover, the number of primary-level health facilities have increased by 48%[30]. Due to extensive increase of private primary level health facilities over the five years, demand for private health and medical services are assumed to have been increasing.

[29] This Board has been established subject to the Law No. 2004/50 LAW ON PRIVATE PRACTICES IN HEALTH and comprises five members. MOH serves as the secretariat for such Board.

[30] In terms of clinics, the number of professional specialization departments that has been licensed by the Licensing Board of Private Health Care Institutions in lieu of the number of facilities has been shown and a single facility may contain multiple professional specialization departments. Some facilities have made each registration classified by the department and some facilities have made a single registration that considers multiple departments collectively as a single facility. Therefore, the method of registration has not been unified.

Table 5-5: Trend in Numbers of Private Health Facilities

Type of health facilities	Number of health facilities		Number of doctors		Number of nurses		Number of beds	
	2015	2019	2015	2019	2015	2019	2015	2019
General hospital and special hospital	**25**	**25**	**243**	**429**	**446**	**839**	**328**	**576**
General hospital	7	5	104	117	180	252	100	155
Special hospital for ophthalmology	2	2	12	32	24	61	20	38
Special hospital for cardiovascular disease	2	2	10	38	18	65	20	33
Special hospital for gynecology, infertility and endocrinology	6	5	50	91	104	181	66	82
Special general rehabilitation hospital	2	3	18	27	28	79	50	89
Special hospital for Urology	1	2	4	11	8	31	10	38
Special hospital for Orthopedics	2	2	19	29	32	59	24	39
Special hospital for Surgery	3	4	26	84	52	111	38	102
Clinic	**1037**	**1536**	**-**	**-**	**-**	**-**	**-**	**-**
Polyclinics	60	112	-	-	-	-	-	-
Gynecological clinic	88	142	-	-	-	-	-	-
Pediatric clinic	49	113	-	-	-	-	-	-
Dental clinic	447	415	-	-	-	-	-	-
Intern clinic	67	86	-	-	-	-	-	-
Laboratory	96	141	-	-	-	-	-	-
Diagnostic Center	11	150	-	-	-	-	-	-
Pulmonology clinic	12	-	-	-	-	-	-	-
Surgery clinic	36	74	-	-	-	-	-	-
Ophthalmologic clinic	23	-	-	-	-	-	-	-
Oral clinic	22	76	-	-	-	-	-	-
Physiatry clinic	47	69	-	-	-	-	-	-
Allergy clinic	2	-	-	-	-	-	-	-
Dermatological clinic	18	-	-	-	-	-	-	-
Neurological clinic	15	68	-	-	-	-	-	-
Infectious diseases clinic	6	-	-	-	-	-	-	-
Orthopedic clinic	37	-	-	-	-	-	-	-
Nuclear medicine	1	-	-	-	-	-	-	-
Cabinets	-	43	-	-	-	-	-	-
Pathological clinic	-	47	-	-	-	-	-	-

Source: Health Statistic 2019 and 2015

Table 5-6 shows private special and general hospitals with their locations. Half of them (i.e., 12 out of 25 facilities) are located in capital Pristina. On the other hand, some districts have no private general hospitals or private special hospitals at all, such as the Mitrovica District. Some districts have private hospitals of physical therapy and rehabilitation but no department of gastroenterology or cardiac surgery.

Additionally, total number of private general hospitals and special hospitals of Table 5-5 and Table 5-6 is the same but breakdown number of clinical departments is partially different.

Table 5-6: Licenced Private General and Special Hospitals

	Name of hospital	Clinical department	City
1	International Hospital	Special hospital (Cardiovascular diseases)	Gjakova
2	EUROPIAN CLINIK	Special hospital (Gynecology and Obstetrics)	Gjakova
3	Mendja e Integruar mjekësore	Special hospital (Urology)	Gjakova
4	Medical Center	Special hospital (Urology)	Gracanica
5	DEUTSCHE FRAUENKLINIK	Special hospital (Obstetrics and Gynecology)	Gracanica
6	SANTE PLUS	General hospital	Gracanica
7	Royal Medical L.L.C	General hospital	Gracanica
8	AKSOY GROUP	General hospital	Gracanica
9	Onix SPA	Special hospital (Physical therapy and Rehabilitation)	Istog
10	Banja e Kllokotit	Special hospital (Physical therapy and Rehabilitation)	Kllokot
11	Internacional Hospital	Special hospital (Surgery)	Peja
12	LINDJA	Special hospital (Gynecology, Infertility and Endocrinology)	Pristina
13	SIRONA	Special hospital (Obstetrics and Gynecology)	Pristina
14	American Hospital	General hospital	Pristina
15	Klinika Amerikane	Special hospital (Obstetrics and Gynecology)	Pristina
16	OTRILLA	Special hospital (Otorhinolaryngology and Orthopedics)	Pristina
17	BAHCECI HEALTHCARE	Special hospital (Gynecology, Obstetrics and Surgery)	Pristina
18	KAVAJA HOSPITAL	Special hospital (Surgery, Orthopedics and Otorhinolaryngology)	Pristina
19	ALOKA	Special hospital (Surgery, Orthopedics and Cardiology)	Pristina
20	AnaDerm Aesthetic Surgery	Special hospital (Surgery)	Pristina
21	Qendra Laserike e Syrit, KUBATI	Special hospital (Ophthalmology)	Pristina
22	KESTRINA	Special hospital (Gynecology and Obstetrics)	Pristina
23	Vita Hospital	Special hospital (Urology)	Pristina
24	AKAT	Special hospital (Orthopedics and Surgery)	Prizren
25	Nëna Naile	Special hospital (Physical therapy and Rehabilitation)	Viti

Source: MOH

5.2 Major Medical Devices

5.2.1 Current status of medical device in public health facilities

Based on the literature survey, it was found that the UCCK and the General Hospitals are required to have the relevant medical services (and the list of standard device necessary to provide the services) according to the "Administrative Instruction (MH) No. 06/2015, General and Special Hospital Conditions" stipulated by the Government of Kosovo. However, through the field survey, it was found that there were some discrepancies between the above-mentioned Administrative Instruction and the actual situation. For example, services defined in the Article 26 Cardiology and Invasive Cardiology Service, Article 37 Cardia Surgery Service, Article 38 Otorhinolaryngology Service, Article 39 Ophthalmology Service, and Article 42 Neurosurgery Service, are difficult to be provided in general hospitals due to lack of medical device, and thus, many patients are referred to use the UCCK[31]. These medical services (and the list of standard device required to provide them) are also areas that require efforts to achieve standardization.

(1) Procurement system and budget scale for medical device, medicines and medical consumables

As already mentioned, the management structure of primary health facilities, and secondary and tertiary health facilities is different in Kosovo. The municipality is responsible for the operation and management of primary health facilities, while HUCSK is responsible for secondary (general hospital) and tertiary (UCCK) health facilities.

The budget for the procurement of medical device and supplies (consumables used for medical and clinical services) is allocated to primary health facilities from government grants and MOH budget. The total budget is centrally managed by the MOH, which periodically procures them in bulk and supplies them to each primary health facility via the municipalities. Secondary and tertiary health facilities procure through a bidding process based on the budget received from HUCSK. The budget for the procurement of medical device is recorded in the Budget for Capital Investment, while the budget for medicines and medical consumables is recorded in the Budget for Goods & Services.

Expenditures for medical device and medical supplies are shown in Tables 5-7 and 5-8. Based on the amount of expenditure on medical device procurement, it can be judged that UCCK has a certain level of budget for device replacement. Each general hospital also receives a budget of tens of millions of yen every year to update basic device that are used universally in each department with priority.

Table 5-7: Capital Investment Budget for General Hospitals and UCCK

	Name of Hospital	2017 (in euros)	2018 (in euros)	2019 (in euros)
1	Gjilan General Hospital	367,780.00	376,386.00	349,139.24
2	Prizren General Hospital	489,639.68	526,572.14	947,819.37
3	Gjakova General Hospital	146,440.00	276,089.00	427,074.71
4	Peja General Hospital	410,005.12	406,686.00	398,129.26
5	Mitrovica General Hospital	270,000.00	267,728.00	412,282.08

[31] Based on the interviews to General Director or Director of Medical Services of health facilities.

6	Vushtrri General Hospital	105,000.00	104,993.00	160,439.00
7	Ferizaj General Hospital	166,110.00	276,064.00	231,816.24
	Total of general hospitals	**1,777,928.00**	**2,234,518.14**	**2,926,699.90**
8	UCCK(Pristina)	1,648,004.00	6,610,351.38	9,492,822.50
	Total of general hospitals and UCCK	**3,425,93200.**	**8,844,869.52**	**12,419,522.40**

Remark: 70-80% of the capital investment budget was spent for procuring the medical device.
Source: Work Report, HUCSK, 2019

Table 5-8: Expenditures on Goods and Services for General Hospitals and UCCK by HUCSK

Account No.	Account items	2017 (in euros)	2018 (in euros)	2019 (in euros)
13610	Procurement fees for office supplies	481,358.28	598,364.60	603,170.85
13611	Procurement fees for business management forms	14,995.00	12,562.13	
13620	Procurement fees for ingredients of patient's meals	2,217,001.89	1,954,630.33	2,204,832.28
13630	Procurement fees for medicines and medical consumables	2,149,430.23	4,021,945.40	29,831,702.28
13640	Outsourcing fees for cleaning (linens, etc.)	374,006.87	286,405.85	369,054.96
13650	Procurement fees for Staff uniform	101,941.63	76,048.03	222,140.81
13660	Allowance of staff night duties	1,190.03	5,077.37	4,184.94
13600	**Total expenditures of goods and services**	**5,339,923.93**	**6,955,033.71**	**33,235,086.55**

Source: Work Report, HUCSK, 2019

Table 5-9: Breakdown of Medicines and Medical Consumables by General Hospitals and UCCK (2019)

	Name of hospitals	2019 (in euros)
1	Gjilan General Hospital	802,473.00
2	Prizren General Hospital	1,262,853.37
3	Gjakova General Hospital	1,014,652.12
4	Peja General Hospital	1,093,317.00
5	Mitrovica General Hospital	563,405.00
6	Vushtrri General Hospital	227,110.07
7	Ferizaj General Hospital	622,664.37
	Total of general hospitals	4,963,810.56
8	UCCK (Pristina)	24,219,200.00

Source: Work Report, HUCSK, 2019

(2) Major existing medical device in public health facilities

Major existing medical device were confirmed through the field survey. Specifically, in light of the fact that each public health facility is proceeding with medical service activities for local residents with great care under Covid-19 pandemic, the field survey at each public health facility mainly consisted of interviews with the general directors and other responsible persons in the departments and divisions, and the survey was conducted based on the exchange of opinions with the MOH. Based on discussions with the MOH, priority was given to departments with a low risk of COVID-19 infection. As a result, the Survey Team limited its interview survey to the radiology/imaging and hemodialysis departments of UCCK and the general hospitals, and the radiology/imaging and laboratory departments of the primary health facilities (MFMCs).

1) Radiology and diagnostic imaging departments of UCCK and general hospitals

Although these departments use expensive device such as CT scanners and general X-ray machines, the Survey Team confirmed that most of the expensive medical device are provided by international donors and institutions (USA, LuxDev, EU, etc.) and wealthy individuals (CT scanners were provided to general hospitals of Prizren, Gjakova, Gjilan, etc.). Gjakova General Hospital was equipped with a CT scanner in 2020 with support from the United States.

Some general hospitals (Prizren, Gjilan, etc.) have CT scanners and general X-ray machines in their radiology and diagnostic imaging departments as well as in their emergency departments (where the device is generally outdated).

These high-priced device are considered high-profile device not only by local residents but also by donor countries, institutions, and even politicians, and despite their high cost, they are likely to be upgraded on an ad hoc basis as they outdate.

Ferizaj General Hospital, one of the general hospitals, is preparing to renovate its existing facilities and equip them with device such as general X-ray machines, mammography and CT scanners (which are being procured by UNOPS). Meanwhile, construction of a new general hospital is underway based on the plan to relocate the general hospital to the suburbs, about 2 kilometers away from the current general hospital located in the center of the municipality. According to the general director of the hospital, the new facility will be a six-story building with a total area of approximately 26,000m2 (the current facility is a two-story building with approximately 8,000m2) and 500 beds (the current facility has 120 beds). However, the construction work has been suspended because there is no prospect of securing the total construction budget (about 22,000,000 Euros) that was estimated when the construction started.

2) .Hemodialysis treatment department of UCCK and general hospitals

The following is a description of the current situation of the dialysis departments at the surveyed facilities. As diabetes is said to be one of the major diseases requiring dialysis treatment, the percentage of diabetic nephropathy is also high in Kosovo. For this reason, many dialysis machines (including water treatment machines) are installed and treated in each general hospital. The Survey Team observed that a small number of dialysis machines were being upgraded on a regular basis. However, while the status of updates varies among general hospitals, and some general hospitals were not at a satisfactory level, it was confirmed that general hospitals were trying to standardize manufacturers in consideration of maintenance services and sustainable procurement of consumables such as hemodialysis membranes (dialyzers). Baxter of the U.S., and the UCCK uses Fresenius and B Braun of Germany)

3) General Hospitals (Others)

In general, while high-priced device such as CT scanners have been equipped with the support of international donors and institutions, interviews with officials of health facilities indicate that there are some departments and divisions (medical device) that have not been updated and maintained. For example, there is a high need for maintenance related to operating rooms, sterilization departments, and intensive care units (ICUs) (sterilizers, shadowless lights, operating tables, suction device, electric scalpels, vital sign monitors, etc.). However, a

considerable number of ventilators have been procured due to COVID-19 response (procurement funds are soft loans/financing by the World Bank).

4) Primary health facilities

Among the primary health facilities, the Survey Team visited four MFMCs (located in the central cities of Pristina, Prizren, Gjakova, and Peja) that perform as coordinators of health facilities in each municipality (38 municipalities). At all the MFMCs, the device in the radiology/imaging and laboratory departments had been well updated with the support of the local government (typical device included general X-ray machines and mammography at the former departments, and biochemical and hematological analyzers at the latter departments). However, some municipalities have FMCs, which are generally positioned as subordinate institutions to MFMCs, but have facilities that are equivalent to MFMCs, and these FMCs seem to be equipped with the same device as MFMCs. For example, in Pristina City, there are 15 FMCs and FMAs (30 facilities in total), and 3 FMCs with device equivalent to MFMCs, and these facilities need to update the device used in the radiology and diagnostic imaging departments and laboratory departments. Although donor countries and institutions are interested in providing support to MFMCs, which are easily visible even at the primary level of health facilities, there may be medical device that needs to be updated and maintained in lower-level FMCs and FMAs.

5.2.2 Maintenance of medical device

(1) Maintenance management system and staffing

UCCK and secondary health facilities have technicians (engineers and technicians) who are responsible for the maintenance and repair of medical device. The technician in charge is primarily responsible for the regular replacement (or replacement as soon as a problem occurs) of accessories and consumables that make up the device, as well as mechanical breakdown[32]. If the technicians at the health facilities are not able to provide the service, they will ask a private medical device service provider to do so. Primary health facilities do not have technicians who are responsible for the maintenance of medical device.

Table 5-10: Status of Device Maintenance Staffs on General Hospitals and UCCK (2019)

Hospitals	Engineers	Technicians	Total
Mitrovica General Hospital	-	3	3
Vushtrri General Hospital	-	1	1
Peja General Hospital	-	4	4
Gjakova General Hospital	-	4	4
Prizren General Hospital	1	4	5
Ferizaj General Hospital	-	1	1
Gjilan General Hospital	1	1	2
Total of general hospitals	2	18	20
UCCK (Pristina)	4	13	17
Grand total	**6**	**31**	**37**

Source: Hearing from respective hospitals, May 2021

[32] According to the Japan's technical cooperation projects, when articles of consumption are regularly replaced or immediately replaced at the time of occurrence of failure, it is instructed that 60% of all case examples designated as failures can be prevented (National Maternal and Child Health Center, Shimizu [2005] p.1, p.13). Even regarding domestic examples in Japan (i.e., Yokohama Rosai Hospital), it has been reported that 91% of 787 failure cases occurred due to deterioration (Nasuno and others [2005] pp.333–336).

Remark: Those who have acquired biomedical engineer qualifications in abroad are called engineers, and those who have acquired qualifications such as electricians at local educational institutions and are subsequently engaged in the medical device maintenance at hospitals are called technicians.

(2) Budget for maintenance

The amount of budget allocated for maintenance is shown in Table 5-11. The majority of the amount is allocated to the repair of medical device and the purchase of replacement parts, and the total amount spent for maintenance is increasing every year. This can be attributed to the increase in repair costs due to the increase in outdated device and the increase in the introduction of expensive device represented by CT scanners (resulting in higher maintenance management costs).

Table 5-11: Maintenance Expenditures of HUCSK for General Hospitals and UCCK

Account No.	Account	2017 (in euros)	2018 (in euros)	2019 (in euros)
14010	Vehicles	104,003.79	119,910.29	132,832.06
14020	Building	219,326.80	332,645.86	409,911.15
14024	Building utilities	1,485,362.31	1,629,410.94	1,591,729.70
14030	Road maintenance	2,437.50	-	0.00
14040	IT devices	45,941.04	48,722.57	39,030.86
14050	Medical furniture & medical devices	140,125.24	185,470.04	368,114.20
14060	Routine	-	-	-
14000	**Total**	**1,997,196.68**	**2,316,159.70**	**2,541,617.97**

Source: Work Report, HUCSK, 2019

(3) Access to maintenance services for medical device

In the past, medical device were procured under the condition of one year of maintenance service, but since four to five years ago, medical device have been procured under the condition of two or three years of maintenance service (condition at the time of public bidding). In Kosovo, it has not been possible to conclude a new contract for maintenance services only after the warranty period has expired, even for advanced and expensive device such as CT scanners and MRIs. Therefore, when a problem occurs, the maintenance technician at the health facilities first takes care of the problem by themselves, and if the problem cannot be solved by the technician, the technician asks the medical device service provider to take care of the problem.

According to the interview with the medical device service provider, if no maintenance service is provided, the technician's labor cost will be charged for the time spent on repairing the device (for example, a charge of 60 euros per hour), and if the maintenance requires replacement of parts, the cost of the parts will be also charged. Although there are only a few cases, looking at the contents of contracts covering only maintenance services that were concluded after the expiration of the maintenance service contract at the time of device purchase, it can be inferred that maintenance services are generally provided under the following conditions.

Services provide monthly or quarterly periodic check (overhaul, accuracy check/accuracy control), and repair in case of malfunction or failure. The contract period is about two to three years. In the case of repairs that require replacement of parts, the cost of the parts will be charged separately (this is often the case for device directly related to life-saving measures, such as anesthesia machines and ventilators). In addition to these, there are cases where contracts are concluded under conditions that include reasonable replacement parts (e.g., general X-ray

machines, CT scanners, and MRI. (However, expensive parts such as X-ray tubes are not included in the list of replacement parts.)

In addition, since Kosovo has borders with Albania in the southwest of the country and North Macedonia in the southeast, when they need urgent or specialized maintenance services, they can get them not only from Pristina, but also from Tirana (the capital of Albania) and Skopje (the capital of North Macedonia). (Examples include diagnostic imaging device from Siemens and GE Healthcare).

5.2.3 Operation of medical device in terms of examination and diagnoses

As shown by the shading in Table 5.12, there are several health facilities where the number of examinations and diagnoses using mammography and general X-ray machines has reached zero or decreased significantly. The following is an examination of one aspect of the operational status of medical device based on the trends in the number of such diagnostic imaging examinations and information obtained through site visits.

1) Mammography Examinations

A campaign of mammography examinations using mobile screening vehicles was carried out from 2015 to 2016. Although some general hospitals had mammography systems in place before that time, the campaign led to an increase in the number of general hospitals introducing mammography. However, the level of awareness of breast cancer among medical personnel is not high, and in addition, mammography is more difficult than other X-ray machines in terms of accuracy control, reading and imaging techniques. In addition to maintenance and management technicians, radiologists and radiographers must also have technical skills to properly utilize the device. For these reasons, breast examinations using mammography and ultrasonography have not taken root. For this reason, the priority of device maintenance for other medical device naturally increased, and mammography was sometimes left unattended after a breakdown. As a result, it has been confirmed that the number of mammography examinations and diagnoses had decreased.

Later, with the increase in the number of deaths due to breast cancer, the need for mammography and ultrasound examinations was reconfirmed, and around 2018, mammography began to be introduced in primary health facilities with the growing awareness of the importance of early detection (Confirmed with MFMCs and MFCs in Prizren, Gjakova, Peja, and Prizren). Municipalities with a strong interest in organized screening (e.g., Pristina) seem to have an intention to improve the device and skills of technicians, and some MFMCs are interested in installing a second or third device in their FMCs.

2) General X-ray Examinations (UCCK)

The device for general X-ray examination at UCCK, which was procured between 2000 and 2010, began to show a series of breakdowns between 2018 and 2019, and although efforts were made to update and maintain the device on a priority basis, it was difficult to meet the examination needs of the patients. The maintenance technician explained that most of the device that had malfunctions or breakdowns had reached the point where they needed to be renewed (durability limit), but they were unable to do updated.

3) Angiography

Angiography is used for catheterization and treatment of cardiovascular diseases such as angina pectoris, myocardial infarction, and arrhythmia, cerebrovascular diseases such as cerebral infarction and cerebral aneurysm, and hepatic artery embolization for liver cancer. Although the guidelines stipulate that angiography can be treated in general hospitals, it has not been performed in general hospitals other than UCCK for the five years from 2015 to 2019. Considering Kosovo's small land area, it is desirable that two or three public general hospitals should be equipped angiography with skilled technicians, including technical training, to perform angiography.

Although some general hospitals are equipped with C-arm X-ray fluoroscopy device for surgery, it is difficult to use this device for catheterization and treatment under fluoroscopy because of its low X-ray dose, although it can be used to view fluoroscopic images of blood vessels for a limited period of time. Therefore, it cannot be a substitute for angiography.

Table 5-12: Trend of Number of Imaging Diagnosis at General Hospitals and UCCK

Hospitals	Examination/Diagnosis	2015	2016	2017	2018	2019
Vushtrri	CT	0	386	413	461	371
	MRI	0	0	0	0	0
	Ultrasonography	1,258	436	702	1,851	2,818
	General X-ray	843	740	1,502	2,514	3,281
	Angiography	0	0	0	0	0
	Mammography	208	233	233	0	0
Gjakove	CT	538	1,720	2,438	2,177	2,540
	MRI	0	0	0	0	0
	Ultrasonography	10,776	11,209	11,075	12,339	12,236
	General X-ray	10,565	10,262	12,186	16,164	12,926
	Angiography	0	0	0	0	0
	mammography	0	0	0	0	0
Mitrovica	CT	834	946	869	1,066	1,284
	MRI	0	0	0	0	0
	Ultrasonography	1,944	1,375	2,125	2,002	1,661
	General X-ray	8,186	2,256	2,400	1,647	2,536
	Angiography	0	0	0	0	0
	Mammography	117	64	64	0	0
Ferizaj	CT	0	0	0	0	0
	MRI	0	0	0	0	0
	Ultrasonography	4,136	4,739	4,696	3,396	3,411
	General X-ray	4,168	4,308	3,615	7,606	13,272
	Angiography	0	0	0	0	0
	mammography	0	0	0	0	0
Gjilan	CT	1,864	1,790	1,587	1,755	1,758
	MRI	0	0	0	0	0
	Ultrasonography	2,001	3,458	1,979	2,159	2,261
	General X-ray	10,968	11,168	10,995	13,727	13,473
	Angiography	0	0	0	0	0
	Mammography	0	0	0	0	0
Prizren	CT	3,344	3,700	2,629	4,395	3,817
	MRI	0	0	0	0	0
	Ultrasonography	7,164	7,340	7,947	7,175	8,288
	General X-ray	24,157	34,273	27,073	24,185	22,082
	Angiography	0	0	0	0	0

Hospitals	Examination/Diagnosis	2015	2016	2017	2018	2019
	Mammography	201	63	0	0	0
Peja	CT	3,833	3,938	4,281	4,472	4,802
	MRI	0	0	0	0	0
	Ultrasonography	11,029	11,853	29,710	23,252	20,561
	General X-ray	23,644	24,540	24,178	25,801	23,455
	Angiography	0	0	0	0	0
	Mammography	979	0	0	0	0
UCCK	CT	19,033	19,714	20,203	29,883	21,501
	MRI	6,312	6,204	4,971	5,826	7,295
	Ultrasonography	16,895	18,775	19,125	27,692	22,452
	General X-ray	158,940	151,698	150,978	115,108	77,338
	Angiography	96	184	978	597	1,088
	mammography	6,492	19,852	12,716	16,548	3,396

Source: Kosovo Health Statistics, 2015-2019

5.3 Provision of Health and Medical Services

5.3.1 Health and medical service by each health facilities

(1) Primary health facilities

Primary health facilities don't provide hospitalization service but only provide diagnoses for outpatients, which are the most familiar health and medical services in the referral system.

Table 5-13 shows the number of outpatients in primary health facilities distributed for the 38 municipalities and the 7 districts. In 2019, the total number of outpatients per capita in Kosovo was 2.14. Distributed between districts, we can observe large variations from 0.77 (Gjakova District) to 3.52 (Pristina District), which also reflect regional differences. For example, outpatients' number of both primary health facilities (0.13) and secondary health facilities (0.42) are low in the municipality of Gjakova. This shows that residents in Gjakova visit health facilities less often, or out of town.

In Pristina District, the number of doctors in primary health facilities is the highest in the country (180) and the number of outpatients per capita is also the highest in the country (5.60). It also means that the doctors /1000 residents ratio is favorable. Because of this, many outpatients come to Pristina City from the wider surround areas. This movement is reflected in the statistical data in Pristina District such as number of annual outpatients per population of Pristina District except for Pristina City is 2.03.

There are health facilities in areas whose majority residents are Serbs, and data from these facilities were not included in Kosovo Health Statistics, so the number of outpatients is shown as "-."

Table 5-13: Situation of Primary Health Facilities in 38 Municipalities (2019)

District / Municipality	Population	Outpatients	Outpatients/Population	Medical staffs					Doctors per 1,000 people	Outpatients/(Doctors＋Dentists)	Nurses/(Doctors＋Dentists)	Notes
				Doctors	Dentists	Nurses	Others	Total				
Ferizaj	185,695	442,307	2.38	93	26	305	95	519	0.50	3,717	2.56	
Ferizaj	108,610	252,892	2.33	54	23	175	51	303	0.50	3,284	2.27	
Hani I Elezit	9,403	27,051	2.88	7		19	4	30	0.74	3,864	2.71	
Kacanik	33,409	100,487	3.01	21	1	66	18	106	0.63	4,568	3.00	

Shterpce	6,949	3,029	0.44	2	1	10	6	19	0.29	1,010	3.33	△
Shtime	27,324	58,848	2.15	9	1	35	16	61	0.33	5,885	3.50	
Gjakova	196,867	151,621	0.77	142	63	365	83	653	0.72	740	1.78	
Decan	40,019	42,482	1.06	26	5	75	19	125	0.65	1,370	2.42	
Gjakova	94,556	12,636	0.13	71	47	201	31	350	0.75	107	1.70	
Juniku	6,084	17,731	2.91	9	2	18	4	33	1.48	1,612	1.64	
Rahovec	56,208	78,772	1.40	36	9	71	29	145	0.64	1,750	1.58	
Gjilan	181,459	316,890	1.75	102	24	321	108	555	0.56	2,515	2.55	
Gjilan	90,178	171,868	1.91	55	17	149	50	271	0.61	2,387	2.07	
Kamenica	36,085	58,864	1.63	20	4	80	37	141	0.55	2,453	3.33	
Kllokot	2,556	-	-	-	-	-	-	-	-	-	-	△
Partesh	1,787	-	-	-	-	6	1	7	-	-	-	◎
Ranilluk	3,866	-	-	-	-	-	-	-	-	-	-	◎
Viti	46,987	86,158	1.83	27	3	86	20	136	0.57	2,872	2.87	
Mitrovica	232,833	366,026	1.57	112	26	374	134	646	0.48	2,652	2.71	
Leposaviq	13,773	-	-	-	-	-	-	-		-	-	◎
North Mitrovica	12,326	-	-	-	-	-	-	-		-	-	○
Mitrovica	71,909	131,381	1.83	42	15	142	62	261	0.58	2,305	2.49	
Skenderaj	50,858	71,339	1.40	30	3	105	40	178	0.59	2,162	3.18	
Vushtrri	69,870	163,306	2.34	40	8	127	32	207	0.57	3,402	2.65	
Zubin Potok	6,616	-	-	-	-	-	-	-		-	-	◎
Zvecan	7,481	-	-	-	-	-	-	-		-	-	◎
Peja	174,235	188,967	1.08	127	39	329	112	607	0.73	1,138	1.98	
Istogu	39,289	41,945	1.07	23	8	66	29	126	0.59	1,353	2.13	
Klina	38,496	7,961	0.21	30	1	86	31	148	0.78	257	2.77	
Peja	96,450	139,061	1.44	74	30	177	52	333	0.77	1,337	1.70	
Prishtinë	477,312	1,679,051	3.52	383	74	928	263	1648	0.80	3,674	2.03	
Fushe kosova	34,827	117,048	3.36	24	4	52	22	102	0.69	4,180	1.86	
Gllogovc	58,531	110,769	1.89	42	3	103	33	181	0.72	2,462	2.29	
Gracanice	10,675	-	-	9	3	16	9	37	0.84	-	1.33	○
Lipjan	57,605	177,091	3.07	43	8	132	37	220	0.75	3,472	2.59	
Novo Brdo	6,729	4,287	0.64	2	1	24	6	33	0.30	1,429	8.00	△
Obiliq	21,549	57,052	2.65	25	5	52	19	101	1.16	1,902	1.73	
Podujevo	88,499	98,262	1.11	58	4	127	52	241	0.66	1,585	2.05	
Pristina	198,897	1,114,542	5.60	180	46	422	85	733	0.90	4,932	1.87	
Prizren	331,620	623,652	1.88	183	57	486	157	883	0.55	2,599	2.03	
Dragash	33,997	31,287	0.92	18	5	59	25	107	0.53	1,360	2.57	
Malisheve	54,613	76,509	1.40	25	4	76	20	125	0.46	2,638	2.62	
Mamusha	5,507	19,994	3.63	6	1	15	4	26	1.09	2,856	2.14	
Prizren	177,781	319,739	1.80	106	39	251	74	470	0.60	2,205	1.73	
Suhareka	59,722	176,123	2.95	28	8	85	34	155	0.47	4,892	2.36	
Total	1,780,021	3,768,514	2.12	1,142	309	3,108	952	5,511	0.64	2,597	2.14	

Source: Health Statistics 2019 KAS, Statistical Yearbook 2019 KAS, Municipal Profiles 2018 OSCE (Organization for security and Co-operation in Europe) Mission in Kosovo
Note: Number for District shows accumulated number of cities. Note shows serb residents rate in cities(◎：more than 90%、○：90～60%、△：60～40%)

(2) **Secondary and tertiary health facilities**

The current situation of secondary and tertiary health facilities in Kosovo is presented in Table 5-14. It should be noted that UCCK plays the role of a secondary facility in Pristina District, however for the sake of this survey, UCCK is categorized as a tertiary facility and the 3 Serbian hospitals are excluded from our analysis.

Comparing the secondary and tertiary health facilities focusing on an inpatient treatment functions, which are different from primary health facilities, the tertiary health facility (UCCK) is significantly larger than the secondary health facilities (7 general hospitals) in terms of the size of the facility and its activities as a medical

facility.

In terms of the size of the facility, the number of hospital beds at UCCK is close to the total number of hospital beds in the 7 general hospitals, and the total number of doctors, medical experts and nurses at UCCK exceed those of working in the 7 general hospitals.

As for activities as a medical facility, the number of inpatients at UCCK is close to the total of those at 7 general hospitals, and the number of operations at UCCK exceeds the total of those in the 7 general hospitals. As a result, the number of operations per inpatient at UCCK is about 1.5 times of those at secondary facilities.

Looking at the bed occupancy rate as the overall performance of the hospital, that of UCCK (71.2%) is significantly higher than that of the general hospitals total (52.6%).

It should be noted that the following factors are also related to this difference.

- As shown in Table 5-12, at general hospitals, not even a single examination or diagnosis using an MRI or angiography was implemented during the five-year period from 2015 through 2019. Naturally, there is a limit to suppliable health and medical services.
- The total number of outpatients at general hospitals is about 1.5 times the number at UCCK.

From a slightly different perspective, the current status of the 7 general hospitals varies significantly from one facility to another, as shown in Table 5-14. Therefore, in considering the future of general hospitals, it is required to examine the role and potential of each facility in each district individually.

Table 5-14: Situation of Secondary and Tertiary Health Facilities (2019)

Hospital	Population	Hospital beds	Inpatients	Outpatients	Operations	Hospital beds per 1,000 people	Average hospitalization days	Bed occupancy rate (%)	Operations per inpatient	Outpatients per population	Doctors/Nurses		
											Special doctors	Nurses	Nurses per special doctor
(Secondary health facilities)													
Prizren	331,620	521	23,244	158,551	5,403	1.57	4.48	54.4	0.232	0.48	168	426	2.54
Pejë	174,235	376	14,698	211,624	3,037	2.16	5.08	54.0	0.207	1.21	106	302	2.85
Gjilan	181,459	368	14,563	189,551	1,879	2.03	4.03	43.5	0.129	1.04	116	330	2.84
Vushtrri	69,870	63	4,350	50,171	1,707	0.90	3.80	71.8	0.392	0.72	52	92	1.77
Mitrovica	232,833	158	9,431	132,751	2,304	0.68	3.83	62.4	0.244	0.57	89	256	2.88
Gjakova	196,867	418	16,205	81,762	2,281	2.12	4.72	49.8	0.141	0.42	99	339	3.42
Ferizaj	185,695	77	4,104	55,957	1,588	0.41	3.82	55.7	0.387	0.30	69	159	2.30
Sub-total	1,372,579	1,981	86,595	880,367	18,199	9.87	4.39	52.6	0.210	0.64	699	1,904	2.72
(Tertiary health facilities)													

UCCK	1,849,891	1,874	78,662	596,632	23,905	1.01	6.26	71.2	0.304	0.32	780	2,105	2.70
(Secondary and tertiary health facilities)													
Total	1,849,891	3,855	165,257	1,476,999	42,104	2.08	5.29	61.6	0.255	0.80	1,479	4,009	2.71

Source：Health Statistics 2019 KAS, Statistical Yearbook 2019 KAS,

The Table 5-15 provides a comparison with neighboring countries and the EU for the number of hospital beds per population, for average hospitalization days, and for bed occupancy rate. In Kosovo, the number of hospital beds per population is about 40% of EU average and about 50% comparing to those of neighboring countries. Even considering that Kosovo's data does not include information on private health facilities, the number of hospital beds is clearly low.

The bed occupancy rate and the average number of days of hospitalization is lower than the EU average and those of neighboring countries. In general, low average hospitalization days is considered ideal for effective use of medical resources, and it has been steadily declining around the world. In Kosovo, while the average hospitalization days is low, the bed occupancy rate is also very low. (As a side note, the bed occupancy rate in Kosovo has improved from 55.5% in 2010.) It is found that the relatively small number of hospital beds are not efficiently utilized in Kosovo.

Table 5-15: Statistics Related to Number of Hospital Beds of Kosovo and Neighboring Countries (2018, 2019 for Kosovo)

	Kosovo	Serbia	North Macedonia	Montenegro	EU
Hospital beds per 1,000 people	2.1	5.6	4.3	3.9	5.0
Average hospitalization days	5.3	10.3	5.9	8.3	7.5
Bed occupancy rate (%)	61.9	65.3	-	72.2	73.5

Source: Survey team developed based on Health at a Glance: Europe 2020、Kosovo Health Statistics 2019
Note1: Number of Kosovo is number of only public health facilities
Note2: Bed occupancy rates in Kosovo vary widely among hospitals. Bed occupancy rate in tertiary facility (UCCK) is 71.2%, which is on the similar level as the EU average and neighboring countries, while rate in secondary facilities varies widely from 43.5% to 71.8% (see Table 5-15)

Table 5-16 shows breakdown of operations held in UCCK and general hospitals. Information of general hospital is data of three general hospitals collected through subcontracted survey. It is shown that UCCK implemented operations at variety of surgery clinical department including thoracic surgery clinic, vascular surgery clinic, neurosurgery clinic etc. while, 70% of operations implemented at general hospital are comparatively not difficult operation including cholelithiasis, caesarean section, hernia inugamis and appendicid[33]. There are also cases that patients wait for operation for more than several months depends on operations or hospitals. Therefore, it is required to strengthen its capacity for operation through improving facility and device and strengthening human

[33] Website of The Japanese Society of Gastroenterological Surgery, https://www.jsgs.or.jp/modules/others/index.php?content_id=7

resources' ability including doctors and laboratory medical technologist.

Table 5-16: Breakdown of Operation of General Hospitals and UCCK (2019)

UCCK

Clinical department	Operations
Gynecology and Obstetrics Clinic	6,253
Abdominal surgery	2,843
Maxillofacial Surgery Clinic	1,142
Orthopedics and Traumatology Clinic	1,947
Thoracic Surgery Clinic	525
Ophthalmology Clinic	2,933
ENT Clinic	2,215
Plastic Surgery Clinic	1,47
Neurosurgery Clinic	541
Urology Clinic	1,185
Cardio-Surgery Clinic	320
Children Surgery Clinic	1,425
Vascular Surgery Clinic	1,106

General hospitals

Clinical department/ detail of operations	Operations			
	Ferizaj	Vushtrri	Mitrovica	Total
Cholelithiasis and cholecystitis	362	939	-	1301
Caesarean section	237	116	485	838
Hernia ingunalis	357	294	-	651
Appendicid	236	114	-	350
Hernia femuralis	1	77	-	78
Hemorroids	-	44	-	44
Histerectomy	-	41	-	41
Sinus	-	35	-	35
Diseases of the intestine and perineum	3	13	-	16
Cystis	2	8	-	10
Fistul	-	9	-	9
Ileus	3	5	-	8
Hyplatia of the prostate	2	-	-	2
Kidney Insuytinea	1	-	-	1
Orthopedics clinic	-	-	347	347
Urology Clinic	-	-	101	101
Ophthalmology Clinic	-	-	284	284
ENT Clinic	-	-	543	543
Obstetrics Clinic	-	-	69	69
Others	57	0	475	532

Source：Health Statistics 2019 KAS、Subcontracted survey

5.3.2 Measures against non-communicable diseases

(1) Diabetes and high blood pressure

There are many patients suffering from high blood pressure and diabetes, and in recent years, non-communicable diseases related to these conditions accounted for a large percentage of death causes. (see Table 4-2 and Table 4-4). High blood pressure and diabetes are chronic diseases deeply related to lifestyle. Therefore, first of all, diagnoses at primary health facilities are important.

The Accessible Quality Healthcare (AQH) project, which focuses on primary health facilities, points out the followings based on result of a national survey from 2018,

- Diabetes: Advice regarding diagnosis of symptoms, etc. and the importance of early treatment was appropriately provided. However, the following measures were not implemented for even half of all clinical cases: (i) measurement of weight and BMI and diagnosis of eyes and legs (4%, 15%, and 15%); (ii) guidance for smoking cigarettes and drinking alcohol (18% and 16%); (iii) guidance for exercise (35%); (iv) leg care (16%); and (v) explanation about possibility of complications (40%).
- High blood pressure: Advice regarding diagnosis of symptoms, etc. and medication was appropriately provided. However, the following measures were not implemented for even half of all clinical cases: (i) measurement of weight and BMI (7%); (ii) palpation of liver and kidney (7%); (iii)

explanation of signs that blood pressure is becoming high (39%); and (iv) explanation of self-treatment when blood pressure is high (33%).

Regarding diagnoses of diabetes and high blood pressure, explanations of symptoms and medication have been appropriately performed. However, advice about care that patients themselves can do as and about lifestyle, etc. has not been properly provided. Moreover, possible risks that could lead to serious future diseases are likely to be overlooked (e.g., non-measurement of weight and BMI, and nonperformance of diagnosis of eyes and legs).

However, in this regard, the MOH in collaboration with the AQH project created clinical guidelines classified by type of disease and distributed to health facilities nationwide. As of December 2021, diagnosis guidelines have been developed for twenty diseases, including diabetes and high blood pressure, and effort to improve diagnosis at health facilities has being progressing.

(2) Cancer

The morbidity rate[34] for cancers and benign tumors in Kosovo is 148 persons per 100,000 persons and less than neighboring countries[35]. However, cancers and benign tumors are the second highest cause of death in recent years.

With looking by type of cancer, breast cancer is around 20% and biggest, followed by cancer of digestive organs, and then skin cancer. This trend has not changed over the last three years. Examining the situation of cancer detection at health facilities, in 2019, as per Table 5-17, UCCK, which is the sole and only public tertiary health and health facility (50%), and private health facilities (23%) account for over 70% of all diagnoses. Detection at public primary and secondary health facilities remain at about 20%. This detection rate trend has not changed from 2014.

Early detection is particularly important as countermeasures against cancers, and Kosovo Health Sector Strategy 2017-2021 raised implementation of screening program for breast cancer, cervical cancer and colorectal cancer as one of objectives. However, the drafted program of them has not been approved as of December 2020 (according to the mid-term evaluation report for such strategy). The pilot project for cervical cancer screening utilizing assistance from UNFPA commenced in 2016. In this way, annual screening of about 1,300 to 2,000 cases have been implemented at primary health facilities in the three cities of Pristina, Prizren, and Mitrovica.

Table 5-17: Morbidity of Malignant and Benign Tumors (2019)

Diagnosis groups	Female	Male	Total	Total (%)
Malignant breast neoplasm (C50-C50)	501	4	505	19%
Malignant tumors of the digestive organs (C15-C26)	182	289	471	18%

[34] Such rate was obtained when the total number of cancer types was divided by the population and the resultant was represented in the form of "per 100,000 persons." The term "population" refers to the 1,782,115 persons comprising the total population in Kosovo in 2019.

[35] This numerical value was obtained from the WHO regional office for Europe; 189 persons in Albania (2015), 437 persons in Bulgaria (2016), and 394 persons in Montenegro (2013).

Diagnosis groups	Female	Male	Total	Total (%)
Melanoma and other malignant neoplasms of skin (C43--C44)	131	202	333	13%
Malignant tumors of respiratory and intrathoracic organs (C30-C39)	48	279	327	12%
Malignant tumors of the female reproductive system (C51-C58)	283	-	283	11%
Malignant tumors of the urinary tract (C64-C68)	49	145	194	7%
Malignant tumors of male genital tract (C60-C63)	-	172	172	6%
Malignant tumors of the eye, brain and other parts of central nervous system (C64-C68)	34	49	83	3%
Primary malignant tumors of lymphoid tissue, hematopoietic and related tissue (C81-C96)	35	38	73	3%
Malignant tumors of the lips, the oral cavity and larynx (COO-C14)	33	36	69	3%
Malignant tumors of non-specified parts (C76-C80)	32	28	60	2%
Malignant neoplasms of mesothelial and soft tissue (C45-C49)	15	25	40	2%
Malignant tumors of the thyroid and other endocrine glands (C73-C75)	19	10	29	1%
Malignant tumors of the bone and joints (C40-C41)	3	7	10	0%
Benign tumors (D10-D36)	2	-	2	0%
Neoplasms in situ (D00-D09)	1	-	1	0%
Unspecified and non-recognized neoplasms (D37-D48)	-	-	-	
Total	**1,368**	**1,284**	**2,652**	**100%**

Source: Health Statistics 2019, Kosovo Agency of Statistics

Table 5-18: Institutions that Detected Malignant and Benign Tumors (2014 and 2019)

	2014		2019	
	Number of diagnoses	Ratio (%)	Number of diagnoses	Ratio (%)
Family Medicine Centers	545	16.4	462	17.4
General hospital	221	6.7	339	9.7
UCCK	1,879	56.6	1,414	49.6
Private institution	675	20.3	437	23.3
Total	3,320	100	2,652	100

Source: Health Statistics 2014 and 2019, Kosovo Agency of Statistics

5.3.3 Countermeasures against infectious diseases

Looking at the number of infectious diseases cases in 2019, out of total 195,360 cases, diarrhea (44.9%) and seasonal influenza (40.2%) account for 85.1%. With adding varicella (6.4%) and acute respiratory infection (ARI)

(6.3%), the total account to 98%. However, in many case, symptoms of these diseases are mild, and account for only 1% of all deaths (see Table 4-2). Thus, here, mainly the current situation for Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome ("HIV/AIDS") and tuberculosis, which is set as SDGs target 3.9 to exterminate them by 2030, is to be examined. In addition, the outline for COVID-19, whose worldwide outbreak currently continues, is provided hereinafter.

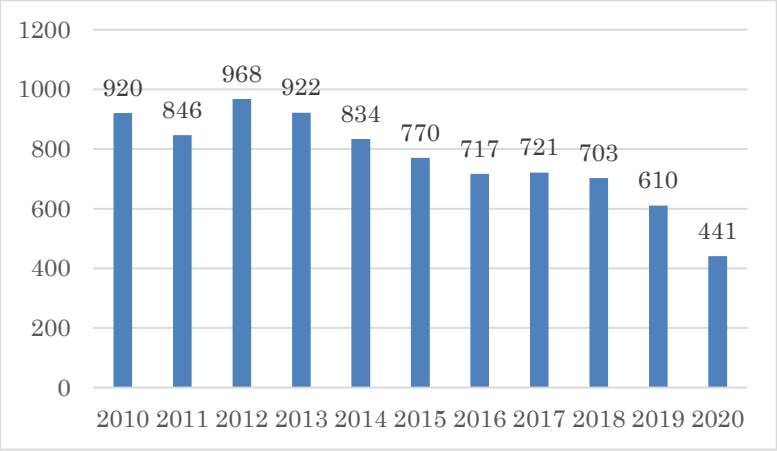
1) HIV/AIDS

According to Health Statistics 2016, the total number of people infected by HIV in the 21 years from 1986 through 2016 in Kosovo was 111 persons. Among these 111 persons, 69 persons have already developed AIDS and 46 persons have died due to diseases associated with AIDS. Looking at the infection rate per population, in comparison to member states of the European Union, which is 0.1% (CIA 2018) [36], the figure for Kosovo's rate, which is less than 0.01%, is extremely low.

The Kosovo National HIV/AIDS Strategic Action Plan has been formulated and implemented (primary planning period: 2009-2013; secondary planning period: 2015-2019). Currently, the Action Plan 2018-2022 is being implemented. In addition, the number of newly infected people has been restrained with the assistance of the Joint United Nations Program on HIV/AIDS ("UNAIDS"), the U.S. Agency for International Development ("USAID") etc.

2) Tuberculosis

The number of tuberculosis patients are continuously declining as shown in the following table. The number of patients in 2020 was 441 persons, and only a single case of death has been confirmed. The number of patients per 100,000 persons was reduced from 85.9 in 2001 to 43.7 in 2013, and further to 24.5 in 2020. At present, the level in Kosovo is approaching the level in the Western Balkan countries (see Table 4-1).



Source: Survey team developed based on information from Kosovo MOHMOH and NIPH

Figure 5-4: Number of Tuberculosis Patients (2011-2020)

[36] https://www.cia.gov/library/publications/the-world-factbook/fields/363rank.html

3) COVID-19

The COVID-19 extensively and rapidly expanded since the beginning of 2020, and finding countermeasures to this global pandemic is a pressing issue.

Even in Kosovo, on May 31, 2021, there were 28 newly affected patients. In total, 107,739 infected persons and 2,233 deceased persons have been confirmed (WHO dashboard, accessed on 31 May 2021: https://covid19.who.int/region/euro/country/xk). In relation to this issue, emergency support has been provided by EU and the World Bank. A peak of a third wave of infections had set in by the beginning of April 2021, and a temporal suspension of accepting outpatients and inpatients took place (which was a sign of collapses of health and medical system). However, subsequently, number of newly infected people decreased. And, as of the end of May 2021, accepting of inpatients was being appropriately performed. 55,237 vaccinations had been administered by May 19. The World Bank and UNICEF have continuously provided assistance, such as cold chain construction and vaccination recommendations (and update information associated with COVID-19 measures at the time of submission of a draft final report will be performed).

5.3.4 Maternal and child health services

(1) Government strategies and goals

In 2020, the MOH developed Maternal and Child Health and Reproductive Health Strategy 2020-2021. The purpose of this strategy is to continuously improve the quality of maternal and child health and reproductive health services, and to reinforce efforts for national citizens' lifestyles for better maternal and child health. Goals set under such strategy are shown in Table 5-19.

Table 5-19: Goals of Maternal and Child Health and Reproductive Health Strategy 2020-2021

1. Reducing the morbidity and mortality of children by providing quality care for all newborns, infants and children
2. Reducing maternal mortality through improving antenatal, prenatal and obstetric care including obstetric emergency care
3. Improving the health and development of children, adolescents and young people, children with disabilities.
4. Reducing the number of unwanted pregnancies and abortions.
5. Reduction of risk factors for Sexual Transmitted Diseases and HIV / AIDS.
6. Reduction of the rate of births by cesarean section.
7. Promoting gender equality and reducing domestic violence and violence against children.
8. Reinforcing and implementing of legislation and the legal framework.
9. Improving the quality of reproductive health services (access to services and adequate infrastructure)
10. Strengthening health promotion, information and education.
11. Capacity development of professionals
12. Improving the monitoring and evaluation system

(2) Regional comparison of indicators related to reproductive health

Kosovo's level regarding prenatal checkups, assisted delivery by midwifery specialists, percentage of delivery by hospitalization, and maternal mortality rate is maintained high as the case in neighboring countries, except for minor ethnicities within Kosovo (Roma, Ashkali and Egyptians). On the other hand, the infant mortality rate and the neonatal mortality rate in Kosovo are higher than those in neighboring countries.

Table 5-20: Data of Reproductive Health for Kosovo and Neighboring Countries

	Unit	Period	Kosovo	Kosovo RAE**	Montenegro	Serbia	North Macedonia	Albania	Bosnia and Herzegovina
Demand for family planning satisfied with modern methods (Women aged 15–49)	%	2013-18*	12.5	17.1	43	39	22	5	22
Antenatal care: at least one visit	%	2013-18*	99	97	92	98	99	88	87
Antenatal care: at least four visit	%	2013-18*	94	77	87	94	94	78	84
Delivery care by skilled birth attendant	%	2013-18*	99	99	99	98	100	100	100
Institutional delivery	%	2013-18*	99	98	99	98	100	99	100
Cesarean section	%	2013-18*	31	20	20	29	25	31	14
Maternal mortality ratio (deaths per 100,000 live births)	-	2017*	7	-	6	12	7	15	10
Infant mortality rate (deaths per 1,000 live births)		2018*	15	26	2	5	9	8	5
Neonatal mortality rate (deaths per 1,000 livebirths)		2018*	11	21	2	3	7	7	4

Source: The State of World's Children 2019, UNICEF, Kosovo MICS 2019-2020
*data for Kosovo is data of 2019-20 **Data for minor ethnicity in Kosovo (Roma, Ashkali, Egyptian)

The medical examination rates and inspection items for prenatal checkups in Kosovo are shown in Table 5-19 and Table 5-20. Data for Kosovo nationwide and for RAE Communities are shown separately.

Looking at Kosovo as a whole, the percentage of pregnant women who had four or more medical examinations is 94%, which is high. However, contents of the examinations seem to be partially insufficient. The percentage of pregnant women who have undergone ultrasonography is over 90%, meanwhile, the percentages to have taken measurement of uterine height (67%) and blood sugar tests (61%) are lower. Moreover, rate of recording and update of mother and child health handbooks, which can be source of information about the examinations taken and conditions of pregnant women, was not high (62%).

Furthermore, when the prenatal medical examination rate and examination items of Kosovo nationwide and RAE were compared, the data for RAE is clearly low and worse. In particular, the percentage of uterine height measurement and blood sugar test are notably lower than those for Kosovo. It can be thought that this fact

influences RAE's high neonatal mortality rate.

Moreover, examining the vaccination rate, over 90% of many vaccines are given for Kosovo as a whole. Even for vaccines requiring several injections, over 85% of children under the age of two years received third injections of such vaccines, evidencing a high vaccination rate. However focusing on infants from RAE communities, the vaccination rate is lower, reaching over 80% for the first injections of vaccines, while repeated vaccination rate drops to 60% to 70% for the second occasion and to 50% to 60% for the third occasion, which is extremely low.

Table 5-21: Rate of Receiving Antenatal Care at Least Four Times (%)

Year	2014	2018
Kosovo	92	94
RAE	77	77

Source: MICS(Kosovo Multiple Indicator Cluster Surveys)2019－2020、
MICS(RAE Communities in Kosovo Multiple Indicator Cluster Surveys)2019－2020

Table 5-22: Rate of Receiving Antenatal Care by Detailed Contents (%)

	Kosovo	RAE		Kosovo	RAE
Blood pressure measurement	91	85	Ultrasound scan	100	97
Urine test	92	82	Weight measurement	83	64
Blood test	94	89	Uterine height measurement	67	45
Blood pressure measurement, urine test, Blood test	84	74	Blood sugar analysis	61	40
			Pregnancy book update	62	54

Source: MICS(Kosovo Multiple Indicator Cluster Surveys)2019－2020,
MICS(RAE Communities in Kosovo Multiple Indicator Cluster Surveys)2019－2020
Note: Number is implementation rate when assuming pregnancy women taking antenatal care as 100

Table 5-23: Percentage of Children under Two Years Old Vaccinated (%)

	Kosovo	RAE
Polio		
First	95	85
Second	92	70
DTP		
First	96	83
Second	93	69
Third	87	57

	Kosovo	RAE
BCG	99	99
Hepatitis B		
First	94	85
Second	86	62
Third	86	55

Source: MICS(Kosovo Multiple Indicator Cluster Surveys)2019－2020、
MICS(RAE Communities in Kosovo Multiple Indicator Cluster Surveys)2019－2020

There have been several projects aiming at improving services in the field of maternal and child health. For examples, "Improving Health of Maternal and Child Health of Kosovo" (2007 through 2010) was a joint project among UNICEF, WHO and UNFPA, and the "Kosovo Health Project" (2015 through 2021) was conducted by the World Bank. As the outcomes of these projects, the percentage of pregnant women to have taken prenatal examination (four times or more) in Kosovo as a whole and the vaccination rate are maintained at high levels.

However, regarding the quality and examination results of prenatal checkups, there are concerns on implementation of subsequent appropriate care remained. For example, the contents of the examinations and the update of mother and child health handbooks are insufficient. According to the Kosovo Health Project's Appraisal Document[37], "over one third women, who have had a prenatal checkup, have not taken basic examinations. Especially, counselling and diagnoses for danger signs are weak. Even if the diagnosis guidelines and procedures are developed, the tendency to comply with them is low." The statements above suggest there are challenges relating medical personnel. In addition, there are challenges related to accessing maternal and child health services for RAE as minority ethnicities in Kosovo.

The above mentioned challenges seem to be related to the fact that the neonatal mortality rate remains higher than neighboring countries, and there have been many deaths of newborn babies due to "certain conditions originating in the perinatal period (P00-P96)" (see Table 4-6).

5.3.5 Disease prevention and health promotion

In 2020, the MOH formulated Health Promotion and Health Education Strategy 2021[38] with the purpose to reinforce and enhance citizens' health. According to this strategy, in the relationship between the economic situation (e.g., poverty), the smoking rate, etc. and health, and with focusing on cross-sectoral approaches, multiple action plans have been established for the five goal items in the following table. Based on such action plans, a budget of 730,750 EURO, including cooperation and assistance from donors in 2021, is expected.

Table 5-24: Five (5) Objectives of Health Promotion and Health Education Strategy 2021

1. Continuous development of cross-sectoral cooperation
2. Involvement of the community in health promotion and education
3. Training of health and non-health workers for health promotion and education
4. Health education for patients and families
5. Development of appropriate media platforms for health promotion and education

Moreover, MOH administrative instruction defines that primary-level facilities are responsible for health promotion, vaccinations, health checkups, prenatal checkups, etc., and describes contents and activities to be implemented by primary health facilities in administrative instruction. It includes information on health services for infants, children, and youths, health services for females, reproductive health, oral hygiene, etc. Information on health promotion implemented by primary health facilities as well as the examinations implementable by primary health facilities are contained in Attachment.

Through subcontracted survey, it can be ascertained that almost all MFMC which accept subcontracted survey implement more than one health promotion program. In detailed, their health education programs included issues on diet preventing diabetes and high blood pressure, campaign for early detection of cancer, health education for

[37] World Bank, October 2014
[38] Name of original: PLANI I VEPRIMIT PËR PROMOVIM DHE EDUKIM SHËNDETËSOR 2021 (Original written in Albanian has been only publicized.)

maternal and child health care, general hygiene and Sexual Transmitted Diseases, prevention of sexual assault, prevention of smoking etc. Some of them such as health education for Sexual Transmitted Diseases were implemented in cooperation with schools.

Moreover, AQH project has being carried out health promotion for prevention of non-communicable diseases, such as diabetes and high blood pressure in collaboration with primary health facilities in 20 cities nationwide. Their activities include health education about lifestyle including diet and factors causing non-communicable diseases, fostering health promotion personnel, development of educational materials in video and radio format, etc.

Table 5-25: Health Promotion Implemented by MFMC

	MFMC	Health promotion implemented	
Ferizaj	Ferizaj	・Diabetes campaign ・Health education for breast cancer	・Awareness for RAE community
	Hani i Elezit	NA	
	Kacanik	NA	
	Shtime	NA	
Gjakova	Decan	No active program	
	Gjakova	・Home visit (UNICEF program)	・AQH program
	Junik	・COVID-19 education ・Professional education (AQH program)	・Advice and protection for diabetes and hypertension
	Rahovec	NA	
Gjilan	Gjilan	・General hygiene education for ・COVID-19 education ・Identification and care of children with special needs	・Education on non-use of narcotic substances ・Contraception education
	Kamenica	・Promoting oral health ・Sexual Transmited Diseases education	・Hand hygiene education ・Body hygiene education
	Viti	・Bllod donation campaign	・Campaign on International Uterine Cancer Day
	Mitrovica	・Counselling for people with diabetes and hypertension	
	North Mitrovica	-	
	Skenderaj	・Maternal and child health education ・Health education for elderly people	・Chronic non-communicable diseases education ・Hypertension and Diabetes education
	Vushtrri	・Health education for diabetes	
Peja	Istog	・Sexual Transmitted Diseases education ・Fight against breast cancer	・Family planning campaign ・Child nutrition education
	Kline	・School visit ・Continuing professional development for doctor	
	Peja	NA	
Pristina	Fushe kosova	・Integrated care for patients with type 2 diabetes	
	Gllogovc	・Care for hypertension and diabetes (AQH program)	
	Lipjan	・Management of non-communicable diseases	
	Obiliq	・Hypertension and Diabetes education (AQH program) ・Sexual assault education for Roma community in school	・Hypertension check up ・Health education of smoking ・Health education for family

	Podujevo	・Campaign on the day of International Diabetes Day and International Hypertension day ・Transmitted sexual diseases education	・Campaign on Mental Health Day ・Breast cancer education
	Pristina	・Campaign on the day of International Diabetes Day	
Prizren	Dragash	・Protection and healthy eating ・Prevention of domestic violence	・School visit
	Malisheve	No data	
	Mamusha	・Home visit	
	Prizren	・Detection of cervical cancer (NGO: Action for mother and children program)	
	Suhareka	・Visit people with diabetes	

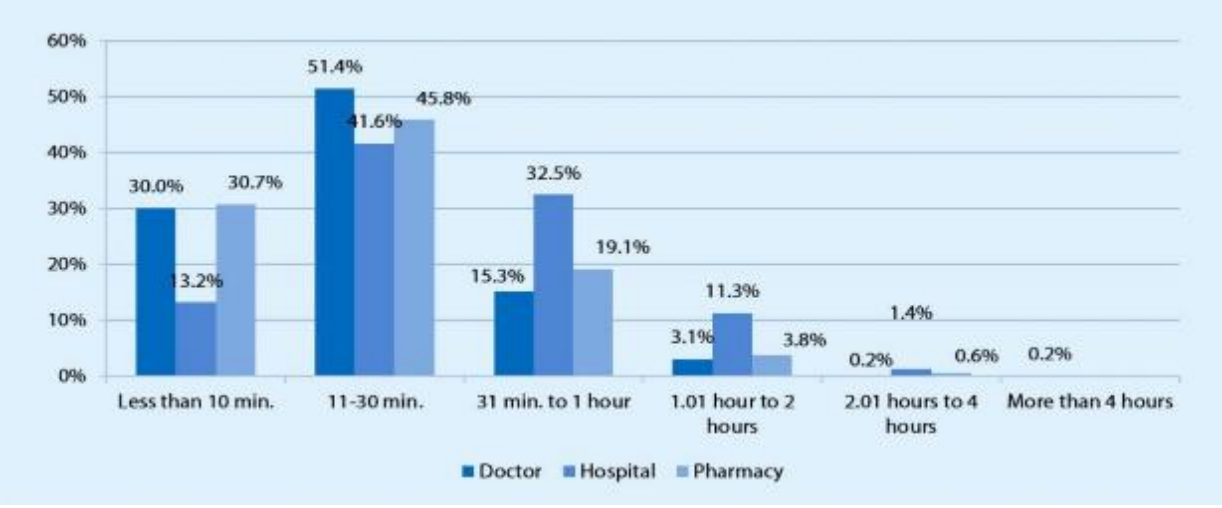
Source：Subcontracted survey NA means no answer. Column for Shterpce, Kllokot, Partesh, Ranillug, Leposavic, North Mitrovica, Zubin Potok, Zvecan, Gracanica, Novo Brdo who showed refusal for subcontracted survey is not included.

5.4 Patient's Consultation Behavior and Satisfaction

5.4.1 Accessibility to health facilities

(1) Geographical accessibility

In Kosovo, the access for health facility or pharmacy is easy. In particular, 81.4% of the population can access the nearest primary health facility within 30 minutes on foot or by public transport, and 76.5% can access a pharmacy within 30 minutes. On the other hand, 54.8% of the population can reach a General Hospital within 30 minutes on foot or by public transport, and 87.3% within an hour. (Kosovo Mosaic 2015, UNDP, Ministry of Local Government Administration, USAID).



Source: Kosovo Mosaic 2015, UNDP, Ministry of Local Government Administration, USAID
Doctor means primary health and health facility, hospital means general hospital

Figure 5-5: Population Rate of Time from Home to Health Facilities on Foot or by Public Transportation

However, there are some cities that require longer times to access health and medical institution. Table 5-26 provides a list of cities whose accessibility is particularly poor, according to the MOSAIC survey.

Only 3.3% of the population nationwide requires an hour or longer to travel to primary health facilities. Meanwhile,

for Novo Brdo and Zubin Potok, those percentage are 57.3% and 58.9%, respectively. Moreover, the percentage of residents requiring an hour or longer to access general hospitals are 81.2% for Novo Brdo, 60% for Zubin Potok, and 55.1% for Shterpce. Percentage for residents requiring an hour or longer to access pharmacies are 83.3% for Novo Brdo and 61.1% for Zubin Potok, which are quite high compared with the Kosovo nationwide average. However, in cities where a longer time on foot and via public transportation is required, the percentage of owning private cars is higher than the national average. It can be assumed that there are many cases that people visit hospitals using private cars.

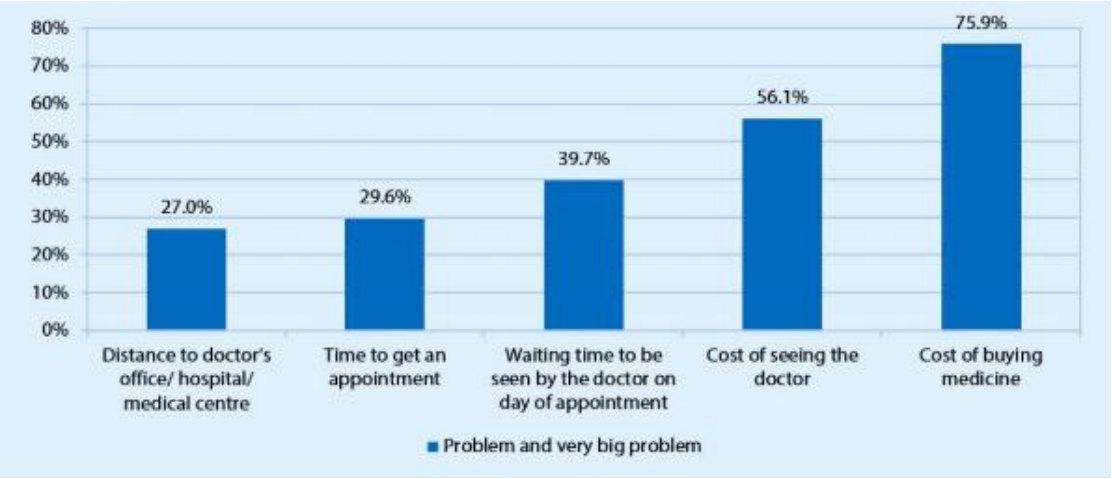
Table 5-26: Time to Access Health Facilities on Foot or by Public Transportation (Cities with Poorest Accessibility)

		Less than 10 min.	11-30 min.	31 min. to 1 hour	1.01 hour to 2 hours	2.01 hours to 4 hours	More than 4 hours
Novo Brdo (74.0%) *	Doctor	8.3%	16.7%	17.7%	57.3%	0.0%	
	Hospital	1.0%	6.3%	11.5%	78.1%	2.1%	1.0%
	Pharmacy	0.0%	6.3%	10.4%	79.2%	3.1%	1.0%
Zubin Potok (69.2%) *	Doctor	0.0%	13.3%	27.8%	52.2%	6.7%	
	Hospital	0.0%	10.0%	30.0%	38.9%	21.1%	0.0%
	Pharmacy	1.1%	12.2%	25.6%	40.0%	20.0%	1.1%
Shterpce (70.0%) *	Doctor	14.4%	57.5%	21.3%	5.6%	1.3%	
	Hospital	6.9%	21.3%	16.9%	26.3%	28.8%	0.0%
	Pharmacy	10.0%	48.8%	31.3%	7.5%	2.5%	0.0%
Kosovo 平均 (64.4%) *	Doctor	30.0%	51.4%	15.3%	3.1%	0.2%	
	Hospital	13.2%	41.6%	32.5%	11.3%	1.4%	0.0%
	Pharmacy	30.7%	45.8%	19.1%	3.8%	0.6%	0.0%

Source：Kosovo Mosaic 2015, UNDP, Ministry of Local Government Administration, USAID
*Percentage of owning cars. The category is doctor, hospital, pharmacy with following original documents, but in most cases, doctor seems to be used as primary health and health facility

(2) Obstruction to access

Figure 5-6 represents obstruction to access health facilities by distance, diagnosis reservation, diagnosis waiting hours, diagnosis fee, and pharmaceutical fee as a result of questionnaire survey of Kosovo Mosaic 2015. Regarding distance, there is no access difficulty on a nationwide scale, as mentioned above, and percentage of people feels distance for health facilities as obstruction to access is lowest. More than a half of people answered, "there is a problem or a very big problem" concerning pharmaceutical fees (75.9%) and diagnosis fees (56.1%). Moreover, Table 5-27 represents the number of cities in which more than fifty percent of residents recognize each factor as obstructive. In relation to pharmaceutical fees, 25 cities and to diagnosis fees thirty-one cities out of 38 cities answered, "there is a problem or a very big problem." This shows that issues of cost for diagnosis and pharmacy have been recognized as most obstructive throughout Kosovo.



Source: Kosovo Mosaic 2015, UNDP, Ministry of Local Government Administration, USAID

Figure 5-6: Obstruction to Access Health Facilities

Table 5-27: Number of Cities in which More than Fifty Percent of Residents Recognize Each Factor as Obstructive

	Distance	Appointment	Waiting time to see doctor	Diagnosis cost	Pharmacy cost
Number of cities in which more than fifty percent of residents recognize each factor as obstructive (out of all 38 cities)	1 city (2.6%)	4 cities (10.5%)	14 cities (36.8%)	25 cities (65.7%)	31cities (81.5%)

Source: Survey team made based on Kosovo Mosaic 2015, UNDP, Ministry of Local Government Administration, USAID

As part of the survey, we collected information in order to identify the people left behind by health services. However, we could not collect any infomation that health services provided unfairly, or some people have difficulty accessing health services through questionnaire surveys and hearings. Following the questionnaire and hearing survey, FGDs were conducted targeting ethnic minorities, unemployed youth and informal sector workers who were expected to have difficulty in access to health care in Kosovo.

Table 5-28 shows the main remarks made by FGDs' participants regarding access to health services. In the FGDs of ethnic minorities (Gorani, Roma), there were remarks by participants "the last time I saw a doctor was 10 years ago" or "I don't need a doctor because I don't get sick". But it is found that even those people visit doctors when having serious symptoms. Other participants were found to be using health facilities, although there is issue of choosing public or private health facilities. Therefore, people with significant restrictions on access to health services or left behind by health services could not be identified even in the FGDs.

Table 5-28: Remarks of Participants of FGDs

Participants	Main remarks on access to health and medical services
Ethnic minorities (Gorani, Roma)	・ Due to high blood pressure, I am taking examination at FMC about 3-4 times a month. ・ A few years ago, I had surgery at a general hospital because of cholelithiasis. The service was appropriate. ・ In case of a cold or headache, I take a medicine and stay at home, I don't see a doctor. The last time that I went to see a doctor was 10 years ago.

	・ At a public health and health facility, a doctor requested me money in addition to the service usage fee. If I didn't pay, I couldn't receive examination. ・ I don't get sick, so I don't see a doctor. ・ At public facilities, you need to buy medicines (which are supposed to be free), you cannot make reservations immediately, and some doctors have bad attitude. On the other hand, the private facility, you can make reservations immediately and the doctors are kind.
Ethnic minorities (Ashkali, Egypthian, Turk)	・ My mother has diabetes and has been taking treatment at FMC for 9 years. ・ If I have symptoms such as high blood pressure or diarrhea, I go to a public health and health facility. ・ If I have a symptom that requires detailed examination such as headache, I take examination at a private facility which have high medical technology. ・ Health information is usually obtained from the internet or government websites, but many of them are written in Albanian and difficult to read. ・ We need to wait long time at public health and health facility, but it is good that we can get medicines for free. On the other hand, waiting time is short and the medical staff are kind at private facility. But user fee is very high for private facility.
Unemployed youth (less than thirty years old)	・ I went to the emergency section of a public health and health facility, but the doctor was absent. ・ I don't trust MFMC since they gave an expired medicine ・ I think doctors at public health and health facility are kind, but device there is insufficient. ・ The FMC near my home opens only 3 days a week, in which case I need to go to MFMC where is far from home. ・ I go to a public health and health facility as first option, and if I cannot receive appropriate services, I will go to a private. ・ I take blood laboratory tests, etc. at private health and health facility.
Informal sector workers	・ When I went to an emergency section at a public health and medical health facility, I was suggested to switch going to a private facility by doctor. ・ At MFMC, doctors are sometimes absent even during opening hours. ・ When I went to FMC to get an injection, the facility didn't have injection. I didn't have the injection liquid and I bought it at the pharmacy and provided it to them in order to be injected. ・ At public health and health facility, even if I was in seriously bad condition, I had to wait for a long time. ・ We need to wait long time at public health and health facility, but it is cheaper. We can take quality health service at private facility.

5.4.2 Expenses for use of health facilities

(1) Health and health facility service user fees

User fees classified by services provided at public health facilities have been set subject to the administrative instruction of MOH. In the case of diagnoses in line with the referral system (in the case of "secondary," diagnoses referred from "primary"), user fees are relatively low with ranging from 1 EURO to 4 EURO for primary, secondary, and tertiary health facilities. Moreover, user fees for CTs and MRIs are as well low with ranging from 20 to 30 EURO. Furthermore, there are no service user fees for poor persons who are receiving public assistance, disabled persons, veterans, pension recipients, widows, victims of conflicts, etc.

Table 5-29: User Fee Table of Public Health Facilities

Primary	
Service	EURO
Medical examination without laboratory analyses or without additional diagnostic procedures	1.0

Secondary	
Service	EURO
Medical examination according to the referral of the doctor of the clinic, FMC, MFMC or private health care institution	3.0

Tertiary	
Service	EURO
Medical examination according to the referral of the doctor of the secondary or for the municipalities of the region of Pristina, from the clinic, FMC, MFMC or	4.0

				private health care institution	
Specialist examination with the prescription of the Family Doctor	2.0	Medical examination without the referral of the doctor of the clinic, FMC, MFMC or private health care institution	10.0	Medical examination without referral of the doctor of the secondary or for the municipalities of the region of Pristina, from the clinic, FMC, MFMC or private health care institution	12.0
Specialist examination without the prescription of the Family Doctor	5.0	Stay in hospital／day	3.0	Stay in hospital／day	4.0
Examination at home, except emergency cases	6.0	Determination of HIV	5.0	Aesthetic rhinoplasty surgery	100.0
Standard ultrasound	2.0	Determination of T-3, T-4, TSH	5.0	EEG	10.0
Radiography	2.0	Tumor markers	1.5	EMNG	10.0
ECG	0.5	Bronchoscope	5.0	ECG	1.0
Hemogram and urine laboratory analysis	1.0	Gastroscopy	5.0	CT	25.0
Other laboratory analysis	3.0	Colonoscopy	5.0	MRI	30.0
Determination of sugar in blood	1.0	Abortion surgery	30.0	Temporary “pace maker”	50.0
Intravenous injection	1.0	Surgical intervention with total anesthesia	10.0	Catheterization	70.0
Treatment of wounds including sewing and cleaning	3.0	CT	20.0	Arteriography of peripheral arterials	100.0
Treatment with infusions	1.0			Stent implantation	350.0

Source: Administrative Instruction 04/2007

According to result of subcontracted survey, the rate of patients using health service with free are 70% for primary, 80% for general hospital and 80% for UCCK. This leads to the total amounts of service user fees collected at health and health facility remain very small. In fact, according to the Medium Term Expenditure Framework 2017-2019 of the Ministry of Finance, the total service user fees amounted to 3,010,000 EURO out of 117,000,000 EURO as the total amount of expenditure for secondary and tertiary health facilities in 2015, which account for only 2.5%.

(2) **Bribing of health workers**

Service user fees are very small, as described in the preceding paragraph. However, in fact, many people think they need to provide bribes in addition to service user fees.

According to the Corruption Risk Assessment in the Health Sector in Kosovo (UNDP, 2014) implemented as part of activities to prevent corruption, 16% of survey respondents answered that they paid bribes to health facilities and 70% of the respondents answered that there are bribes or corruption in the health sector. Moreover, according to the Action Paper On Healthcare in Kosovo (UNDP, 2013), 52 (4%) out of 1,334 respondents were told to provide bribes as a condition for receiving health services, and about 90% of such respondents were requested bribes at secondary and tertiary health facilities. The most common purpose of a bribe was to shorten the waiting time for a diagnosis.

The report made by the World Bank[39] cited the low salaries of civil servants and doctors as causes of such bribery and corruption. Bribery and corruption can be observed in other sectors than the health sector.

[39] Systematic Country Diagnostic,2017, World bank

5.4.3 Evaluation of public health care services by residents

(1) Choice between public and private facilities in primary health facilities

As for the choice of health facilities by residents, a survey by the AQH project (Knowledge, Attitude, Practices and Behavior, conducted in 2016, hereafter referred to as KAPB 2016) is useful, which, unlike other surveys, targets randomly selected residents. The results of the survey are shown in Table 5-30. As for the "type of primary health facility last visited", public facilities accounted for the majority of 77.3%, much higher than the 16.8% of private facilities.

Table 5-30: Type of Primary Health Facility Last Visited

Public	Private	Abroad	Others	Don't know
77.3%	16.8%	-	0.5%	5.3%

Source: Knowledge, Attitude, Practices and Behavior (Quantitative Research), AQH Project (KAPB2016)
Note1：The survey covered 1,200 randomly selected men and women aged 18 and over in 12 municipalities in Kosovo
Note2：The figure of option "Abroad" is not shown in the results.

(2) Attributes of users of public health facilities

In Kosovo, low-income persons (e.g., pension recipients and unemployed persons) can receive health and medical service for free of charge. In fact, as shown in the following, there are many low-income users of public care facilities, and a significant proportion of users are free of charge. The figure for those who can receive such free services amounts to 42% (unemployed persons (28%) and pension recipients (14%)) according to the QOC 2018 survey (see Figure 5-7). Moreover, UNDP2013 survey found that the proportion of unemployed and pensioners among the users is similar to that of the QOC 2018 survey (see Figure 5-8) and that 51% of the users of public health facilities have no income of their own, and even those who are working earn 20 EUR per month on average, which is quite low.

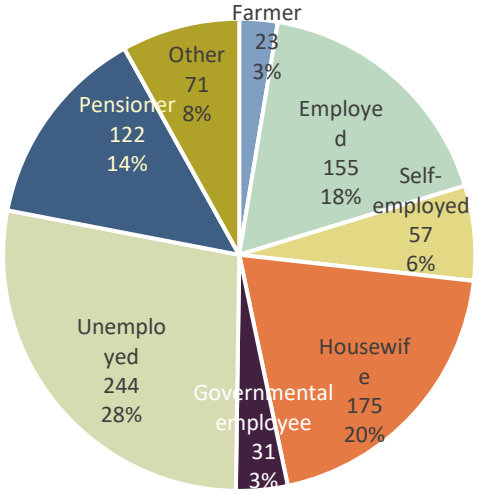


Figure 5-7: User of Primary Facility

Source: Quality of Care Study 2018, Accessible Quality Healthcare project

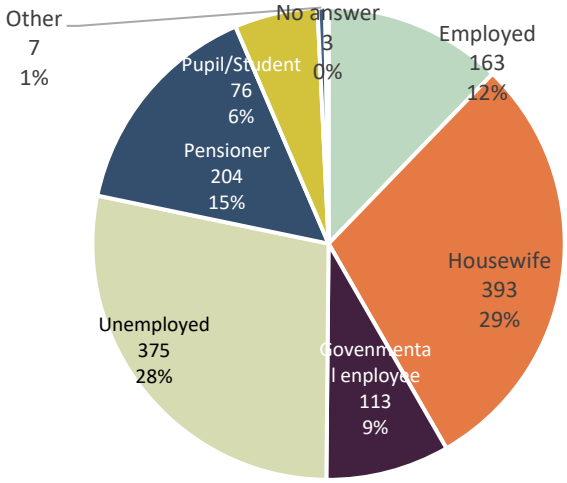


Figure 5-8: User of Secondary Facility

Source: Action Paper on Healthcare in Kosovo, 2013, UNDP, USAID

Furthermore, according to result of subcontracted survey, the rate of patients using health service with free are

70% for primary, 80% for general hospital and 80% for UCCK.

In addition, according to the QOC2018 survey, 8% out of those who used public health facilities for free were using medical insurance. Comparing those who received economic and social assistance, such as public assistance and those who not receiving such economic assistance, the former with medical insurance amounts to 7% and latter with medical insurance amounts to 10%.

(3) Satisfaction of residents in using health facilities

For the level of satisfaction of residents in the use of public health facilities, three survey results are available, as summarized in Table 5-31. Table5-32 shows the breakdown of satisfaction levels from the KAPB2016, , which covers all citizens regardless of whether they use public health facilities or not.

According to the results, the level of satisfaction with public primary health facilities is 56% in KAPB 2016, 75% in UNDP 2013, and 95% in QOC2018. These satisfaction levels cannot be compared simply due to the difference in the target groups in each survey.

However, the target groups for each survey is as follows, and the satisfaction level is might be affected by the usage (whether or not and how often) of public facilities (especially public primary health facilities).[40]

- Target of KAPB 2016: All citizens (including those who do not use public facilities)
- Target of UNDP2013: Users of public secondary and tertiary health facilities
- Target of QOC2018: Users of public primary health facilities.

Table 5-31: Satisfaction Rate of Patients for Health Facility
(Rate of “satisfied" or "very satisfied”)

Name of survey	Target facilities	Satisfaction rate	Method of sampling
QOC2018	Public primary health facility	93%	Sampling at exit for patients of public primary health facilities in 12 municipalities (1,000 people)
UNDP2013	Public primary health facility	75%	Sampling at exit for patients in secondary and tertiary health facilities (1,300 people)
	Public secondary health facility	74%	
	UCCK	68%	

[40] The following factors may also contribute to the difference in satisfaction of residents between QOC2018 and UNDP2013.
In QOC2018, 35% of the residents surveyed had visited the sampled health facility four or more times in the past three months. This situation leads to a larger selection of residents who use the service more frequently compared to sampling from the list of recipients, which results in a greater reflection of the ideas of residents who use facilities more frequently. In this survey, patients with chronic diseases accounted for 28% of the respondents, and this may be linked to the high number of residents who use the service frequently.
On the other hand, in UNDP 2013, since the sampling target is users of public secondary and tertiary health facilities, the reflection of the intentions of residents who frequently use public primary health facilities is relatively small compared to the sampling target of QOC2018.

	Private health facility	84%	
KAPB2016 (aforementioned)	Public primary health facility	56%	Random sampling of men and women over the age of 18 in 12 cities nationwide (1,200 people)

Source: The Survey Team made based on following survey report.
: QOC2018：Quality of Care Study 2018, AQH Project
: UNDP2013：Action Paper On healthcare in Kosovo, 2013, UNDP
: KAPB2016：Knowledge, Attitude, Practices and Behavior, AQH Project

Table 5-32: Satisfaction with Public Primary Health Facilities

Very satisfied	Somewhat satisfied	Somewhat dissatisfied	Very dissatisfied	Don't know
10%	46%	23%	17%	4%

Source: KAPB2016 (Quantitative Research)

Based on the survey results shown above, the use of public primary health facilities can be summarized as follows and public primary health facilities are considered to be accepted by the residents in a large sense. However, about 40%[41] of the residents are dissatisfied with public health facilities, and there is certain amount of dissatisfied users of public facilities because of practical constraints on their choices. Therefore, public primary health facilities need further improvement.

- The majority of residents, nearly 80%, choose and use public facilities, while only about 20% use private facilities[42].
- In terms of residents as a whole, more than half of them are satisfied with the use of public facilities.[43]
- On the other hand, when restricting it to users of public facilities, about three quarters of them are satisfied with the facilities.[44]

According to the UNDP2013, satisfaction with the use of public health facilities is comparable for primary and secondary facilities, but slightly lower for tertiary facilities. In addition, the satisfaction level for private facilities is higher comparing to public facilities. As a side note, data on the percentage of residents who choose public facilities for secondary and tertiary facilities is not available.

(4) Merits and demerits of public and private health facilities

Based on the results of KAPB 2016 and the subcontracted survey (FGDs) in this survey, the merits and demerits of health facilities for residents are summarized below.

Table 5-33: Problems Encountered at the Public Health Facilities

Problems	Response Rate	Remarks (Problems with a response rate of less than 10%)

[41] Sum of "Somewhat dissatisfied" (23%) and "Very dissatisfied" (17%) in Table 5-32
[42] Values are based on Table 5-30, "Public" (77.3%) and "Private" (16.8%)
[43] Values is based on Table 5-31 (KAPB2016), "Satisfaction rate" (56%)
[44] Values is based on Table 5-31 (UNDP2013), "Satisfaction rate for Public primary health facility" (75%)

Lack of medicines	54%	Under the table payments
Absence of the staff	30%	No service available in your language
Lack of other supplies	27%	Discriminative behavior from the staff
Impolite staff	26%	Discriminative behavior from other patients
Unhygienic device	19%	Other
Lack of attention of the staff	13%	Don't know
Premises were unhygienic or poor repair	10%	

Source：Made by the Survey Team based on KAPB 2016 (Quantitative Research)
Note：The interviewer reads out a list of 13 problem items prepared in advance and the respondent selects the appropriate items (multiple responses).

Table 5-34: Pros and Cons of Public and Private Health Facilities from Citizen's Point of View

Type	Merits	Demerits
Public health facilities	・Low user fee (free for children, pregnant women, retirees and low income) ・It is relatively close to you anywhere nationwide ・24 hours service (only in the major cities) ・No need to wait in line in case of urgent situations ・Professionally qualified staff ・Medicines and insulin are free	・The staff's attitude toward the patient is bad ・In pocket money thought to be required ・You may have to wait 3 to 6 months to receive an examination ・There are cases where the facility does not have medicines and cannot be obtained free of charge (you have to purchase them at your own expense). ・Absence of the staff (in rural areas)
Private health facilities	・Easy communication with doctors, and high reliability ・They have essential device ・Good hygiene ・Good quality service ・No waiting time	・High user fee ・There are doctors who provide service on area out of their specialty ・You may be forced to have unnecessary examinations for profit

Source：Made by the Survey Team based on KAPB 2016 (Qualitative Research)[45] and subcontracted survey in this study

5.5 Challenges related to Health Services

Based on what we have learnt from the surveys and analyses described thus far, the challenges ahead of health service provision is described in this section.

(1) Challenges in specialized service provision (primary health facilities)

Primary health facilities are located throughout the country and provide services closest to the residents, and their physical accessibility is already satisfactory. These are generally accepted by the population as a relatively

[45] Apart from the quantitative survey (interviews with 1,200 randomly selected residents), KAPB2016 conducted qualitative survey (one discussion in each of 12 municipalities in Kosovo with small groups of four to five people organized according to age, gender, ethnicity and medical history). Table 5-35 is taken from the results of the qualitative survey.

accessible and affordable facilities to receive services.[46]

In terms of service content, in Kosovo where the disease structure is changing, primary health facilities are increasingly important in their role as centers for the prevention and early detection of lifestyle-related diseases. To address this issue, the Swiss Development Agency has been implementing the AQH project since 2015, which includes a wide range of activities such as improving the quality of basic healthcare services and health promotion activities for local communities (including vulnerable groups such as RAEs), of which target area will be gradually expanded to 38 municipalities nationwide.

In terms of diseases, the AQH project focuses on measures to control diabetes and hypertension, which lead to cardiovascular diseases (which account for 46.7% of deaths in Kosovo, 2018). However, for cancer (28.0%), UNFPA has conducted a limited pilot project to screen for early detection, but the program set out in the Health Sector Strategy 2017-2021 has not been implemented, and efforts for early detection are still a challenge (see 5.3.2(2)).

In addition, some residents have pointed out that the content of doctor's consultations and patient counseling are inadequate at primary health facilities, and that medical staff are absent or have unfavorable attitudes toward patients, so the quality of service provision needs to be improved.

(2) Challenges in specialized service provision (secondary and tertiary health facilities)

The number of beds per population in the 7 general hospitals as a whole is smaller compared to neighboring countries, but even in this situation, the bed occupancy rate is lower, and they are not functioning adequately (Tables 5-15 and 5-16). On the other hand, the bed occupancy rate in tertiary health facilities (UCCK) is remarkably high, and combined with the fact that there are no secondary health facilities located in the capital city of Pristina, this has led to a concentration of patients and increased burden, which might mean that medical services that should be provided in tertiary health facilities are not being provided in a timely and appropriate manner. For this the referral system as a whole should be considered for improvement.

In this context, considering that Kosovo has a relatively small land area and not a large population size, and the current situation of the 7 general hospitals differ widely (Table 5-15), it is conceivable that, based on the characteristics of the region and the current situation of the hospitals, for example, the role of each general hospital should be reexamined, and the focused development of several secondary health facilities and reorganization, etc. as necessary. In addition, some municipalities are moving forward with upgrading the functions of their primary health facilities (MFMC and FMC), such as introducing mammography to improve the screening system, and it is essential to examine the upgrading of primary health facilities, and the strengthening and restructuring of secondary health facilities at the same time. In order to improve the overall referral system, it will be indispensable in the future to strengthen cooperation between primary and secondary health facilities having different authorities.

[46] Residents most frequently pointed out the lack or shortage of medicines as a problem with primary health facilities (Table 5-34), but this is a constraint caused by limited public health spending and there are huge limitations to primary health facilities' handling of this problem.

(3) Challenges related to medical personnel

In terms of medical personnel, there are issues in terms of both quantity and quality.

As for the number of medical personnel, the number of doctors per capita is much lower than the average for neighboring countries, while the number of nurses per capita is at the same level as the average for neighboring countries. On the other hand, the number of hospital beds per capita is also less than half of the average for the neighboring countries, which could mean that the number of beds and the number of doctors is in balance. However, this is a balance at a low level, so to speak, and given the explanations in the previous chapters, the number of doctors in addition to the number of hospital beds is considered to be insufficient.
One of the factors contributing to the shortage of doctors is the outflow of doctors from Kosovo (information from interviews at the MOH). Outmigration is a country-wide problem that is not easy to deal with, which is especially crucial in high qualified professions. In the case of doctors, it has been pointed out that their salaries are not sufficient, especially in public health facilities, and incentives such as introducing performance bonuses and other financial benefits needs to be examined.

Furthermore, experienced doctors tend to avoid working in rural areas (information from interviews at the MOH). For this reason, rural areas are either staffed with young and inexperienced doctors or may be devoid of doctors, which needs to be addressed.

Regarding quality of doctors, Quality of care study 2016 and 2018 (AQH project) focused on clinical primary health facility units (MFMC and FMC) nationwide where doctors provide medical care for diabetes and hypertension. The main findings can be summarized as follows.[47]

- About 20% of doctors have patient record and use it during consultations.
- Very few doctors adhere to measures for prevention and control of infection during consultations. For example, less than 5% of doctors wash hands with soap before or after medical procedures, 8% of doctors puts on gloves and/or mask where required, and about 35% of them applied proper decontamination procedures.
- Very few doctors adhere to general treatment guidelines for diabetes or hypertension. For example, in majority of cases not even half of the expected questions are asked during the anamnesis and necessary examination are performed even less often.
- Counselling on smoking, alcohol consumption and physical activity is often not provided for patients with diabetes or hypertension.

In this contexts, doctors and other medical personnel are required to adhere to various guidelines such as diagnosis procedures and infections control measures[48], and to acquire medical treatment methods systematically in line with advances of medical technologies. Currently, training for doctors and nurses is conducted individually at each health facility, but in smaller facilities, it is difficult to develop and implement appropriate training content

[47] The Appraisal Document for Kosovo Health Project (World Bank 2014), for example, suggests that there are similar problems with the quality of medical personnel,

[48] The implementation of measures to prevent hospital infection was incorporated into health sector strategy 2017-2021, with an indicator of 65% hand hygiene implementation rate, which was evaluated as red (failure) in the midterm assessment report.

on their own. Therefore, there is also a requirement for efficient and effective implementation of systematic training appropriate for health facilities at each level, through the development of standardized training menus and the implementation of group training at a central location.

(4) Challenges related to arrangement, maintenance management, and repair of medical devices

While the introduction of advanced medical device contributes greatly to the maintenance and improvement of people's health by enabling early diagnosis of diseases and new treatments, its maintenance tends to be more difficult both technically and in terms of budget.

In light of these basic issues surrounding medical device, the following is a summary of the issues identified in this survey.

① It is necessary to clarify the expected role and positioning of each hospital, and then consider device maintenance and renewal plans. Most of the expensive device, such as CT scanners, are provided with support from donor countries and institutions. In Kosovo as a whole, it is difficult to say that such device is being efficiently and effectively maintained and utilized. For example, the general hospital (secondary health facility) in Prizren, which is located farthest from the UCCK (tertiary health facility) needs to be equipped and functionally strengthened so that it can provide advanced medical services comparable to those of the UCCK.

② Due to a lack of device maintenance and renewal plans, there are much health facilities that do not sufficiently maintain and renew medical device necessary for medical treatment, resulting in a lack of medical device necessary for medical treatment. According to the interviews, there are none, and it was confirmed that medical device in operating rooms, sterilization departments, and intensive care units (ICUs) are outdated and have not been updated. Although the general hospitals are trying to maintain and update the device every year according to priority with a small budget, basic medical device such as sterilizers, operating lights, operating tables, anesthesia machines, suction machines, electrosurgical units, and vital sign monitors are also inadequate. These basic medical device are indispensable for medical services and need to be systematically maintained and renewed.

③ Maintenance and repair of medical device is also an issue. It is important to avoid breakdowns of medical device and to utilize them in a stable manner for a long time by conducting regular maintenance and inspection and taking appropriate actions when problems occur, but unfortunately, regular maintenance of medical device is not being conducted. The maintenance management system, including the maintenance management plan and human resource allocation, is not sufficiently developed due to the lack of awareness of those responsible for device maintenance management at each medical facility and insufficient allocation of maintenance management technicians. In addition, the cost of maintenance and management of medical device continues to increase due to the aging of medical device and the increase in the number of expensive device, but the budget is not allocated sufficiently, resulting in the poor maintenance described above. It is important to allocate the necessary budget based on the maintenance and renewal plan of medical device and to establish

an efficient device maintenance system.

④ The device management ledger, which is the basis of the device maintenance and renewal plan, has not been properly updated. In Kosovo, there are some trainees who participated in JICA's training program "Quality Improvement of Health Care Services through Kaizen" in the past, but unfortunately, the results of the program have not been fully utilized, and this survey confirmed that the information in the device management ledger is not sufficiently updated and is not shared among device managers. It is important to improve the material management method using kaizen, develop an device management system using IT, and establish a system for sharing device management information among related parties to ensure that the device management ledger is updated, and to use this information to formulate device maintenance and renewal plans and as a material for budget requests.

(5) Challenges related to health resources

Kosovo's national medical expenses (the sum of public and private health expenditures) stood at about 4.5% of the GDP (2017), which is about 1/2 to 3/4 of the level of neighboring countries and the lowest among them. (see Table 4-12).

Public spending on health accounts for about 60% of the national health expenditure, but as a percentage of GDP, it is less than 3%, which is less than half the average of 7% for EU member countries. The public health budget has been increasing in real terms, but its share of the total government budget has been leveling off at around 10%. This may be due to the fact that budgets for other sectors are constrained by the rapid increase in social security spending (see 4.4.2). On the other hand, most of the private expenditure in national health care expenditure is patient OOP, which accounts for 40% of national health care expenditure. While the cost of medical products accounts for about 70% of the total, the total amount of medical service fees is also very limited because they are relatively inexpensive, and many people use them free of charge (see 5.4.2).

Under these circumstances, the establishment of health financing is recognized as a crucial issue for the provision of stable and high-quality health care services. The Health Insurance Act was enacted in 2014, and the Health Sector Strategy 2017-2021 positions "ensuring sustainable health financing" as one of the three strategic goals, centered on the introduction of a health insurance system. However, the specifics of the health insurance system have yet to be fully examined due to the frequent changes of government which hinders the continuity of policy, and due to the stagnation in practical work resulting from the lack of highly specialized human resources (see Chapter 6).

Chapter 6 Health Insurance System

6.1 Background

The introduction of the public health insurance system in Kosovo has been examined as one of the main pillars in the health sector reform, as a tool for aiming to achieve UHC, the study also covered issues related to better access to health service by users including the poor population and the improvement of efficiency and quality of the service provision.

Table 6-1: Historical Development of Health Insurance System in Kosovo

Year	
2002	Establishment of Health Care Commissioning Agency
2014	Approval of Health Insurance Law
2015	Establishment of Health Financing Agency in MOH
2017	Establishment of Health Insurance Fund (Independent from MOH)

Source; the Survey Team

In 2014, the Law on Health Insurance that stipulated the overview of the health insurance system was approved by the Diet/Parliament. The HIF is the legal successor of the Health Financing Agency that has become independent from the MOH in 2017, under the supervision of the MOH. The tasks of the HIF are primarily to manage all transactions related to health insurance, collecting premiums and OOPs, manage subscribers' health insurance registration and purchase health services.

Table 6-2: Overview of Health Insurance System

Law	Law on Health Insurance 2014 (Law No. 04/L-249)
Responsible organization	Health Insurance Fund (Established in 2017)
The insured	Civil servants, Employees with labor contract, informal sector workers, the poor and ethnic minorities
contribution	□7% of income(employer： 3.5%, employee： 3.5%) □Informal sector workers： 2% of minimum wage □the poor and ethnic minorities： Free(Subsidized by the Government,： 2% of minimum wage)
Method of collection of contribution	Contribution to be collected by Tax Administration of Kosovo (HIF does not collect contribution by themselves)
Supply system of medical service	Primary：Municipalities administers, and medical services are supplied through MFMC, MFC, and FMA (Not applicable by Health Insurance). Secondary： HUCSK administers, and 7 General Hospitals supply medical services Tertiary： HUCSK administers, and UCCK supply medical services.
Co payment	Not defined by now. Certain percentage of OOP will be defined by Administrative Instruction.
Provider Payment Method	Not defined by now. High possibility to introduce fee-fer-service mechanism
List of benefit	Lists of medical services, medicine list, and consumable have not defined. (Out-patient's medicine list has been created by the World Bank)

Source: the Survey Team created from Health Insurance Law, 2014

Although premium collection was going to begin in 2017, the health insurance system has not been introduced until the present day in 2021. Based on responses collected during interviews conducted by the survey group the

main reasons for the delay are revealed as follows.

- Volatile political situation and frequent change of administration

Even Since 2014 when the Law on Health Insurance was approved, change of administration occurred 4 times. New public administrations did not approve the systems promoted by the previous administrations, so continuity of policies was not ensured. As a result of the nationwide election supervised by the EU, a new administration was created in March 2014. It is expected that the new administration elected in March 2021 would be able to finish its 4-year term after gaining single-party majority of seats in the new parliament.

- Complexity of issues at stake and lack of long-term political vision

There is a shortage of understanding among the highest ranking government members on the complexity of the health insurance system, and they prefer to get quick results of the introduced policies. The implementation of the health insurance system is regarded as involving high political risks, therefore there is no politician to embrace the idea. However, the COVID-19 pandemic created a situation which demonstrated also to politicians the vulnerability of the health insurance system. Therefore, the new government is promptly examining the possibilities to reform the health system, including health insurance.

- Lack of highly trained professional human resources and other staff

The number of officials at the HIF has increased from 10 at the beginning of the establishment in 2017 to 44, in 2021 but it is still not sufficient to run the health insurance fund operations. Although there were plans to increase the number of personnel in 2020, the plans were abandoned due to the expenditure required for COVID-19 measures . In addition, there is lack of experts within the Health Insurance Fund who specialized in health finances. A health insurance system operated, within the former Yugoslavia, however since the collapse of Yugoslav state about 30 years ago, a tax utilization system was introduced, and knowledge and experiences used during socialist arrangements are out of date and are not helpful for social insurance systems requiring premium collection and co-payment methods.

- Legal framework (The amended law has not been approved)

The Law on Health Insurance was approved in 2014 which only governs basic operations of the fund. To test the system in real life, subordinate regulations such as enforcement orders that stipulate detailed procedures and required systems are needed to be introduced. The draft of the amended Law on Health Insurance for stipulating such regulations had been already prepared by civil servants, however the MOH, responsible for the drafting, could not ensure necessary political support through lobbying.

6.2 Organization and Budget of the Heath Insurance Fund

According to the HIF's annual report from 2019, the board consisted of 7 members representing the Treasury Department of HIF, the MOH, the Ministry of Labor and Social Welfare, the Hospital and University Clinic Service of Kosovo (HUCSK), representatives of medical associations, city associations and patient associations respectively.

The organizational structure of HIF consists of 4 departments and 3 offices. The number of staff is 44. (The

number of employees was planned to be increased by 250, also establishing local offices in the future.) The departments/sections and their number of employees are given below:

- Management Board: 4
- Medical Service Department: 10
- Finance and General Affairs Department: 15
- Medical Product Service Department: 6
- Information System Management Department: 1
- HR Personnel Office: 3
- Legal Office: 3
- Procurement Office: 1
- Internal Audit Unit: 1

The table below shows the budget of the HIF for 2019. Due to the low number of employees (44 persons), the share of management costs in the budget is low. Ninety-two percent (92%) of total expenditure is spent on items which belong to Medical Treatments Outside the Public Health Institutions (MTOPHI) category covered by the government subsidiaries. Since the health insurance system is not functioning, there are no revenues generated by OOP or premium income for medical service fees.

Table 6-3: Budget and Expenditure of Health Insurance Fund (2019) (in Euro)

	Budget	Expenditure	% of expenditure
Labor Cost	357,960	357,960	3.8
Goods and service costs	360,137	269,304	2.9
Capital Investment	90,000	61,804	0.7
Utility costs	36,160	22,217	0.2
Government Subsidy	8,700,000	8,699,979	92.4
Total	9,544,257	9,411,265	100.0

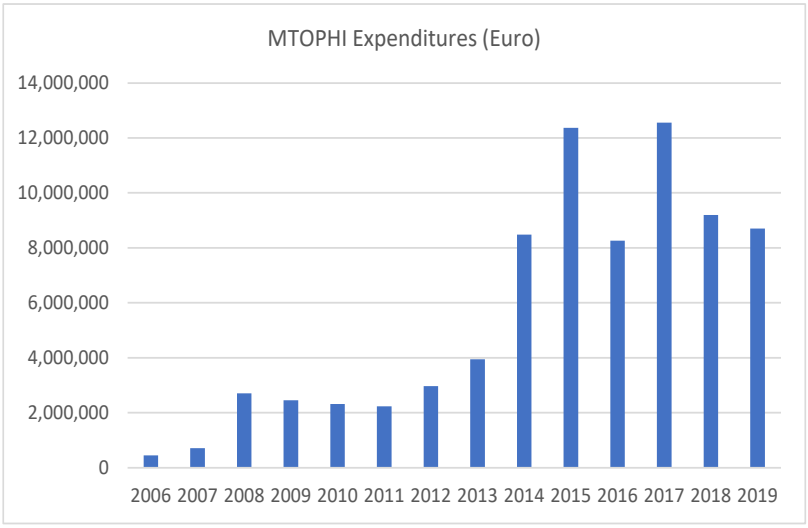
Source: Annual Report 2019, Health Insurance Fund

6.3 Medical Treatments Outside the Public Health facilities

The Medical Treatments Outside the Public Health facilities (MTOPHF) programme was initiated and was running by the MOH following internal instructions in 2006 offsetting the lack of sufficient health services resulting after the Kosovo Conflict when many health facilities were destroyed.

Using tax revenues this program reimburses the cost of medical care induced at overseas health facilities or domestic private health facilities for diseases that cannot be treated at domestic public health facilities. When the HIF was established, the management of this programme was transferred to the HIF from the MOH.

The graph below shows how the programme budget has changed over time. In 2006, at the beginning of the program, the expenditure was 447,862 Euro. In 2019, it was increased 19.4 times to 8,699,979 Euro. The maximum number of claims was 1,500 per year. In 2019, 1,436 applications were made out of which 124 applications were disapproved. They were not accepted due to insufficient paperwork and/or procedural issues.



Source: Annual Report 2018, HIF

Figure 6-1: Trends in Medical Treatments Outside the Public Health Facilities (MTOPHF) Programme

The table below shows the top 6 countries who accepted those patients whose applications were approved, as well as the total medical care costs and the average medical care cost per case. Turkey accounts for 60% of the total approved medical care cost. It has multiple reasons including the fact that Turkey has a higher health service level than Kosovo, Kosovo people can enter there without visa, and Turkey is actively marketing and giving TV commercials, etc. for their health facilities. The second largest amount of approved application comes from private health facilities in Kosovo, followed by Germany, Albania, North Macedonia and Italy. It is worth noting that the number of treatment cases is higher within Kosovo's private health facilities than within Turkey. However, Turkey has higher medical care cost per case (20,875 Euro) than Kosovo's private health facilities. Turkey is the leading destination for private health services in terms of total medical care cost, which is about 8 times as much as the average medical care cost of the private health facilities of Kosovo.

Table 6-4: Amount and Number of Medical Treatments Outside the Public Health Facilities (MTOPHF) Programme (2018)

	Country	No. of Cases	Amount (Euro)	Amount per case (euro)	% of total cost
1	Turkey	267	5,573,723	20,875	60.6%
2	Private health facility in Kosovo	485	1,272,259	2,623	13.8%
3	Germany	60	934,411	15,574	10.1%
4	Albania	76	500,511	6,586	5.4%
5	North Macedonia	149	451,127	3,028	4.9%
6	Italy	10	243,972	24,397	2.6%
	TOTAL	1,068	9,192,553	11,526	100%

Source: Annual Report 2018, HIF

The following table below shows the number of MTOPHI approved treatment cases by the type of clinical department. It shows that ophthalmology has the largest number of cases, followed by pediatric service and orthopedic surgery. Regarding the diseases, acute leukemia and retinal detachment involved the largest number

of patients seeking treatment outside of the public health services.

Table 6-5: Number of Case by Department

	department	Case in 2018	Case in 2019
1	Ophthalmology	437	414
2	Pediatrics	200	224
3	Orthopedics	240	135
4	Oncology	97	108
5	Chest surgery	22	61

Source: Annual Report 2019, HIF

6.4 Development Partners Supporting Health Insurance Fund

(1) The World Bank

The World Bank has been supporting the health insurance system as one of the components of its Kosovo Health Project (hereafter called KHP). As regard to the HIF, the World Bank dispatched 5 specialists (legal system, finance, IT) to support the establishment of the health insurance benefit package, the development of the IT system and enhance the service purchase capabilities of the HIF staff.

Progress regarding the benefit package was achieved in defining the outpatient medicine benefit scheme. On the other hand, the list of approved medical products has not been created yet. Regarding the IT system, it completed the design and development of the E-Prescription system and in 2019, it provided training to about 1,000 pharmacists.

It was decided that the KHP was going to be extended to October 2021, extending its original term from June 2021. While the KHP is running, the World Bank is planning to support anti-COVID-19 measures, procure device and materials to the MFMC and so on. At the same time, the World Bank is evaluating the options to develop a new project as the successor of KHP. This project is planned to start in 2022 at the earliest.

(2) Luxembourg Agency for Development Cooperation (LuxDev)

LuxDev has been supporting the enhancement of the health system and sectoral reforms within the Health Sector Support Program (Phase 2). Regarding the health insurance fund, it has been examining the possibilities to introduce the reporting system using DRG (Diagnosis Related Group), it has been giving support for the result-linked Capitation Based Performance Payment methods at primary care level facilities. just as the World Bank does, etc.

(3) AOK (Die Gesundheitskasse)

AOK started the support in January 2020. This program was initiated to enhance the capacities of HIF in a wide range of health insurance operations such as examination of entitlement of people applying for health insurance and contact management with health facilities. However, because of the shift in efforts due to the COVID-19 pandemic, it is now on a temporary break and has not dispatched any specialists. yet

6.5 Issues for the Introduction of the Health Insurance System

Interviews conducted with the MOH, HIF, HUCSK and the World Bank during the last 6 months revealed implementational challenges for the health insurance as follows.

1) No road map or strategical plan for the implementation of the health insurance system has been established. In addition, the MOH and the HUCSK, and other government-affiliated organizations who are deeply related to the health insurance system, have not yet held inter-institutional discussions.

2) Preparation for the drafting of the so-called Sub Legal Acts, which has to be prepared after the amendment of the Law on Health Insurance.

3) Health insurance is implemented within the social insurance system. Therefore, the idea of the benefits for the people who pay insurance fees and the people who receive government support must be coordinated. It is because social insurance is principally based on the compulsory collection of insurance fees.

4) Since the introduction of the social insurance system requires a move from tax-based service provision to co-payment and insurance based service provision, any people who could participate in the social insurance system have to be notified and requested to pay insurance fees.

5) No payment system related to 4) has been developed.

6) Advantages people can receive within the health insurance system are not clear. The biggest change is that the costs for the medical products and materials required for treatment will be paid by the insurance system. However, since the details of the system (e.g., OOP ratio) have not been determined yet, no active publicity and educational/promotional activities can be taken.

7) Possibilities for benefit package or list have not been examined or created.

8) No medical service fees and medical product prices have been examined or established.

9) No medical billing procedure has been studied and selected.

10) No review system has been studies with the HIS.

11) No Standard Operating Procedure (SOP) about the office work of each department/section has been created with the future expansion of the organization in mind.

12) Development of Human resource development needs for the management of the system has not been established

6.6 Private Health Insurance

The following table shows the increase in the number of private medical insurance contracts and the amount of insurances. The number of contracts increased 2.3 times and the amount of insurances increased 2.2 times over

the 6 years from 2013 to 2019.

Table 6-6: Trends in Number of Contract of Private Health Insurance

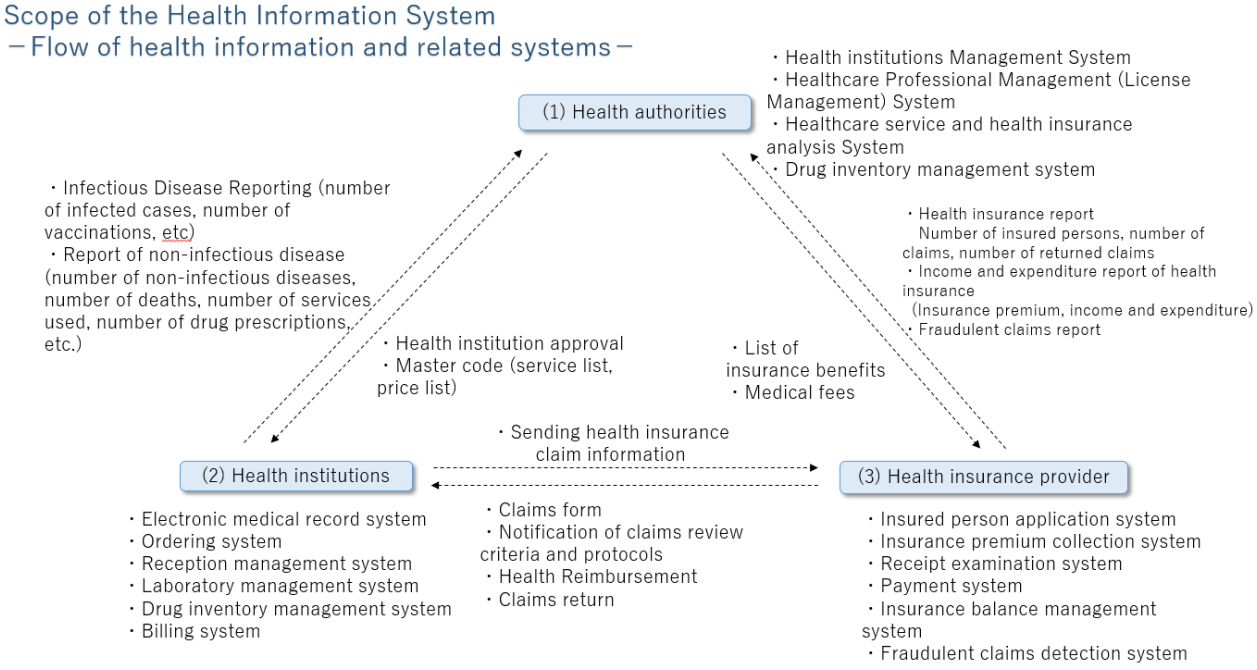
Year	Number of Contract	Amount (Euro)
2013	120,103	8,807,943
2014	105,319	8,613,668
2015	39,678	13,378,121
2016	138,677	16,292,554
2017	170,758	16,996,000
2018	214,475	18,040,766
2019	276,413	19,600,812

Source: Health Statistics 2019, Kosovo Agency of Statistics

Chapter 7 Health Information System (HIS)

7.1 Scope of HIS

HIS is a broad concept, as shown in Figure 7-1. Besides including information systems such as electronic medical records within health facilities, it also involves health management institutions such as the MOH, NIPH and HUCSK.



Source: Created by the Survey Team

Figure 7-1: General Scope of HIS (flow of health information and related systems)

(1) Health authorities

The systems used by health authorities are as follows: Health facilities Management System which manages health facility standards; Healthcare Professional Management (License Management) System which manages licenses and work practices for health workers such as doctors and nurses; Analysis System which collects information received from health facilities and health insurance providers for health insurance policy decision; and finally an intergrated medicine inventory management system.

(2) Health facilities

The systems used by health facility are as follows: Electronic Medical Record System which manages patient's basic information such as the name, medical history, treatment history etc.; or Ordering System, Reception Management System, Lab test Information Management System, Medicine Inventory Management System, and the Billing System. All these systems support the integration of diagnosis, treatment, examination, and medication when the patient visits the hospital.

(3) Health insurance provider

When a health insurance system is in place, the following systems are used by the health insurance provider: Registration System for citizens with health insurance, for registering and managing the enrollment in the health insurance; Insurance premium collection system for managing the insurance premiums collected by each type of subscription; Claims review system for checking its completeness, accuracy and whether the service is covered under the patient's health insurance plan; Payment system for approved transactions; and an Health Insurance fund management system for managing the balance of payments and predicting future usage. In addition, if fee-for-service payment method or a comprehension payment method are introduced, a "Fraudulent Claim Detection System" is introduced to detect overspending or duplicate health care claims.

7.2 Government Strategy, Policies and Plans on HIS Development

The main laws and regulations related to the development of HIS are as follows.
(The validity/invalidity status of each law/notice is still being confirmed with the MOH)

Table 7-1: Main Laws and Regulations related to HIS

Law/ Administrative Instruction	Main contents of the regulations
Health Law (04/L -125)	This is the legal grounds which defines rights and obligations in the field of health, healthcare principles, healthcare systems, healthcare institutions' activities, and supervision of health services.
	Regulations on health facilities, training, healthcare financing, etc.
Law on information society government bodies (No.04/L-145)	This law determines the competent institutions, their functions and responsibilities in the development and implementation of information technology at the institutions of Kosovo
Law on Electronic Communications (04/L-109)	The purpose of this Law is to regulate electronic communications activities based on the principle of technological neutrality and EU regulatory framework for electronic communications. The competent bodies in the electronic communications field are the Ministry (the Ministry is responsible for electronic communications and postal services), and The Authority of Electronic and Postal Communications (RAEPC).
Law on the information society services (04/L-094)	The purpose of this law is to establish convenient possibilities and circumstances for development of electronic trade, use of electronic transactions and electronic signature by the Government, businesses and citizens
Law on prevention and fight of the cyber crime (03/L-166)	This Law aims to prevent and combat the cyber-crime with concrete measures, prevent, discover and sanction violations through computer systems, by providing observance of the human rights and safeguard of the personal information.
Law on the protection of personal data (03/L-172)	This Law determines the rights, responsibilities, principles and measures with respect to the protection of personal data and sets up an institution responsible for monitoring the legitimacy of data processing.
Administrative Instruction (Health) No.11/2013 (June 2013)	The purpose of this Administrative Instruction is to regulate the way of functioning of HIS as well as reporting of statistical data collected by the system.
	-Definition of data registered in HIS -Usage of HIS - Responsibilities in HIS Management
Administrative Instruction No. 01/2010-MPA on the safety and access to databases	This instruction includes procedures for the organization and setting data in the server, safety and data management by administrators, as well as access to these data by officials of Kosovo institutions.
Administrative Instruction No. 02/2010 for information security management	This Administrative Instruction determines the way the information security is managed by responsible people for implementing and maintaining information security. In particular, this instruction includes a provision stipulating the responsibilities of Information Security Institution. The institution, in accordance with Government security measures in information technology, undertakes the following activities for the advancement of information security: a) Approval and review of information security policy and overall responsibilities. b) Supervision of important changes in the exposure of information to risks. c) Review and supervision of information security-related incidents. d) Initiation and adoption of initiatives to improve information security
Electronic Communication sector Policy – Digital Agenda for Kosovo 2013–2020	This document contains the Electronic Communications Sector Policy of the Government of Kosovo as proposed by the Ministry of Economic Development for medium to long term
National Cyber Security Strategy and Action Plan 2016 – 2019	The purpose of this document was to establish the general foundation about National Cyber Security Strategy for following four years in Republic of Kosovo. Furthermore, this document outlines the vision of Government of Kosovo about the cyber security and its corresponding action plan. National Cyber

Law/ Administrative Instruction	Main contents of the regulations
	Security Strategy is part of the Government Programme 2015-2018 and linked with the National Plan for the adoption of the Acquis.

Source: the Survey Team

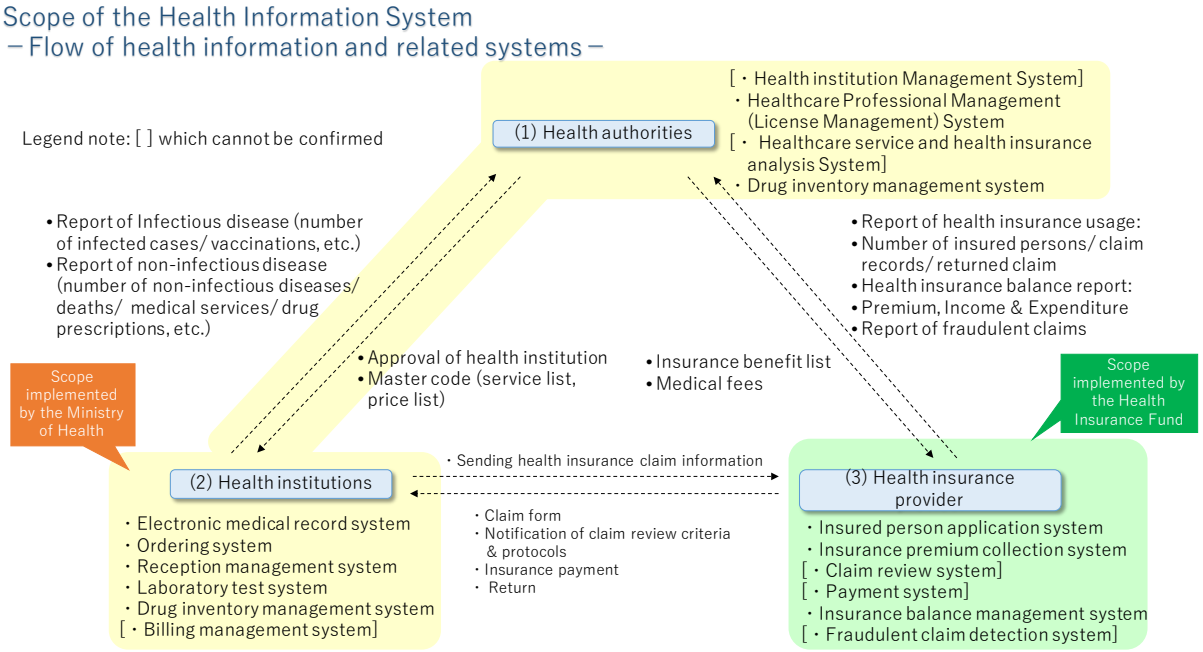
Table 7-2: HIS Implementation Plan and Achievements

Category	Achievement (Health Sector Strategy 2017 - 2021)	Challenges (HIS assessment by the National Audit Office in 2017[49])
IT Infrastructure in health facilities	By the end of 2017, all health facilities will be systematized.	Lack of necessary hardware equipment
HIS software	All health facilities are supposed to send reports via HIS software since end of 2017	HIS is not functional in all Healthcare institutions at primary health care level. Database is not accurate and complete due to duplicate patient registrations.
System administrator and Administrator Training	100% of operators receive HIS training	A number of health personnel, neglected to record the data, while others due to the lack of basic knowledge for the program did not use the system at all even though they attended the organized trainings.

Source: the Survey Team

The regulations issued by the Government of Kosovo do not give a clear priority among the different elements of HIS. The audit report by the National Audit Office simply states that "the objective of HIS is creating a centralized (unique and integrated) data system.

Within this report the Survey Team will focus on the implementation of HIS from the perspective of health authorities (1) and health facilities (2) which are introduced mainly by the MOH, andHealth insurance provider (3), which are being introduced mainly by the Health Insurance Fund.



Source: the Survey Team

Figure 7-2: Scope of HIS Implemented by the MOH and the Health Insurance Fund of Kosovo (including planning)

[49] Audit report on "Efficiency and Effectiveness in Implementation of Unified and Integrated Health Information System" by the National Audit Office

7.3 Situation of HIS Implementation

7.3.1 Development, operation, and maintenance of HIS at primary, secondary and tertiary health facilities

(1) Overview:

In Kosovo, several HIS projects have been implemented since 2009.

1) Project supported by LuxDev (AVICENNA-HIS)

In 2009, a HIS (AVICENA-HIS) implementation project was launched with the support of Lux-Dev. Six modules were implemented and installed in 30% of the health facilities at the pilot stage. However, the project was stopped in 2018 and Lux-Dev no longer supports the system and since then it has been abandoned. According to interviews with the Department of HIS[50], the deployment was halted due to intellectual property issues related to software modifications, high maintenance cost, too many functions, and user interface issues. However, according to interviews with Lux-Dev officials[51], the decision was made arbitrarily by the newly appointed Health Minister. Furthermore, according to interviews with HUCSK representatives[52] (one of the users), AVICENNA-HIS was easy to use with many good functions. The opinions of the primary and secondary health facilities are being collected by a subcontracted survey.

2) Project supported by the World Bank (PRA-HIS)

This HIS (PRA-HIS) implementation project was started in 2015 as a component of the Kosovo Health Project (KHP) of the World Bank. According to an interview with the Department of HIS within the MOH, the issues of intellectual property rights and high maintenance costs, which had been the issues of HIS implementation supported by Lux-Dev mentioned above, had been resolved.

3) HIS (BHIS) Implementation Project by the MOH

In 2018, a pilot project was initiated by the MOH for introducing the Basic Health Information System (hereinafter referred as to BHIS)- a web-based HIS in all public health insitutions[53]. The BHIS-Web application was introduced in 29 MFMCs in PHCs, in emergency departments in some GH (secondary health insitutions), and in emergency departments in UCCK. In the future, the system will be will be extended and will be introduced in all public health facilities.

This BHIS is assumed to be an additional module based on PRA-HIS which was supported by The World Bank

[50] March and May 2021 (Interview with HIS Director and staff, MOH)
[51] April 2021 (based on interviews with Lux-Dev stakeholders)
[52] April 2021 (based on interviews with HUCSK representatives)
[53] Basic Health Information System in 2020

(2) BHIS Implementation and usage status

1) Number of implemented BHIS

- As mentioned above, as of May 2021, BHIS-Web applications were introduced in 29 MFMCs. It was also introduced to emergency departments at GH (secondary health facilities) and UCCK (tertiary health facilities) in the Gjilan area.
- The BHIS has not been introduced within the remaining 9 municipalities (including Serbian majority municipalities), due to software incompatibility and other technical problems.

Table 7-3: Percentage of BHIS Implementation (%)

Level	Implementation percentage (%)
Primary	29 health facilities (76.3%)
Secondary	1 health facilities (- %)
Tertiary	1 health facilities (- %)

Source: MOH

- BHIS is a Web application system that the health facilities can use by connecting to it via internet.
- One reason for the delay of implementation in all MFMCs is that access to the network environment is under the authority of the Ministry of Public Administration. And, although MOH has requested the Ministry of Public Administration to improve it, the problem has not been resolved"[54].
- According to the MOH, a total of 29 modules are planned to be installed, but as of May 2021, only 3 modules have been installed[55]. At present, its introduction into secondary and tertiary health facilities is still limited, but in the future, new modules for each level will be developed, and the roll-out of the BHIS will be progressed at all public health facilities.
- The present work-distribution using the BHIS is based on additional employees who enters the data into the computer system what previously doctors, and nurses wrote by hand. This duplication is also regarded as a problem, which is going to be solved in the future

2) BHIS's functions and user interface

- BHIS was planned to cover a range of patient activities including medical visits, such as "Appointment", "Reception", "Clinical Information Management by doctors", "Laboratory Information Management", "Invoicing", "Referral to higher-level health facilities" etc. BHIS consists of the modules listed below:
  - ✧ Personnel and Credential Module
  - ✧ Reception Module
    - ➢ Patient registration Submodule
    - ➢ Queue Management Submodule
    - ➢ Medical Report Submodule
    - ➢ Invoicing Submodule

[54] KHP Report by WHO
[55] April 2021 (Interview with HIS Department in MOH)

- ✧ Medical History Module
- ✧ Medical Visit Module
  - ➢ Anamnesis Submodule
  - ➢ Examination Submodule
  - ➢ Diagnostic Submodule
  - ➢ Treatment Submodule
  - ➢ Referral Submodule
  - ➢ Conclusion Submodule
- ✧ Reporting Module
- ✧ Personalized Dashboard Module
- ✧ Auditing Module
- ✧ Appointment Module
- ✧ Vaccination Management Module (COVID-19 Vaccination Module)

- The BHIS is also planned to generate the following data reports per health facilities to report to the MOH and other health authorities. (excerpt)
  - ✧ Number of patients (based on ICD 10)
  - ✧ Number of procedures (based on ICD 9)
  - ✧ Number of patients per treatment day
  - ✧ Number of patients by gender
  - ✧ Treatment Data Reports by Health workers
  - ✧ Number of visits by age group
  - ✧ Number of visits by gender
  - ✧ Number of patients by age group (by diagnostic group classification)
  - ✧ Number of diagnoses per doctor
  - ✧ Number of deaths by age group and diagnostic group
  - ✧ Number of deaths by gender and diagnostic group classification
  - ✧ Number of nursing work
  - ✧ Treatment status by doctor

- The BHIS is actively used by receptionists, nurses, and doctors at health facilities.
- It is connected and linked to an external database that of the city's citizen registration system in order to acquire the personal information upon arrival of the patient to the health facility.
- The implementation status of each module, as collected through interviews in the General Hospital Gjilan where the BHIS has been introduced, is as follows. The actual status of BHIS in other health facilities will be added as soon as the information is collected.
- The implementation status of each module was collected through the survey conducted at 26 health facilities. There were 16 health facilities used BHIS, 6 health facilities did not use, and 4 health facilities did not answer.
- As shown below, the most popular modules are Personnel and Credential Module, Reception Module, Medical History Module, Medical Visit Module, and Reporting Module.
- There were many comments that BHIS user interface was easy to use.

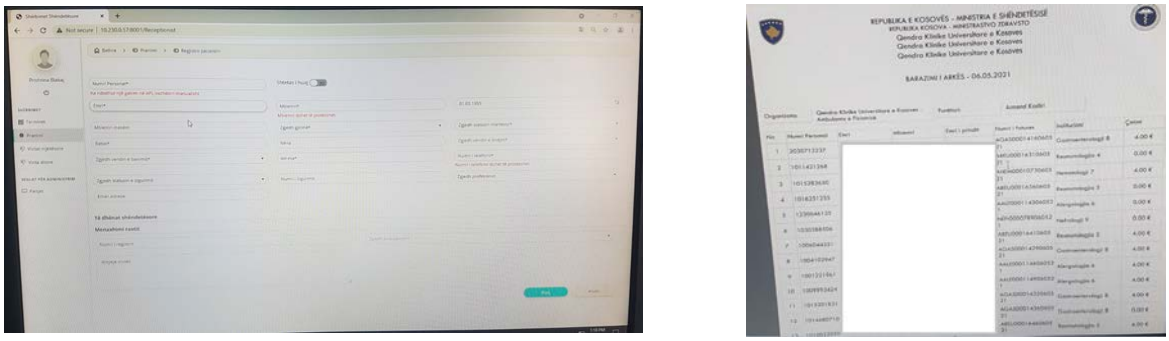
Table 7-4: Implementation Status of BHIS Modules by Health Facilities

No.	Module being used	Yes	No	N/A
1	Personnel and Credential Module	14	1	10
2	Reception Module	14	2	9
3	Medical History Module	15	1	9

4	Medical Visit Module	16	1	8
5	Reporting Module	16	0	8
6	Personalized Dashboard Module	6	8	11
7	Auditing Module	6	9	10
8	Appointment Timetable Module	7	10	8
9	Vacation management Module	11	3	11

Source: Survey conducted at health facilities

- The Survey Team is presenting in Figure 7-3 the screenshots of the “Patient registration submodule” and the information exported from the “Invoice submodule” of the BHIS. The screenshot of the "Invoice submodule" includes the following information: the patient's health registration code, the patient's name, the diagnosis, the code for the health care unit, and the cost of the treatment.



Source: Survey conducted at UCCK

Figure 7-3: Patient Registration and Invoice Screen Images on BHIS

3) Information managed on BHIS

The MOH issued a Health Computer Sheet (Form 001) which is produced by BHIS. The Form 001 includes the following information:

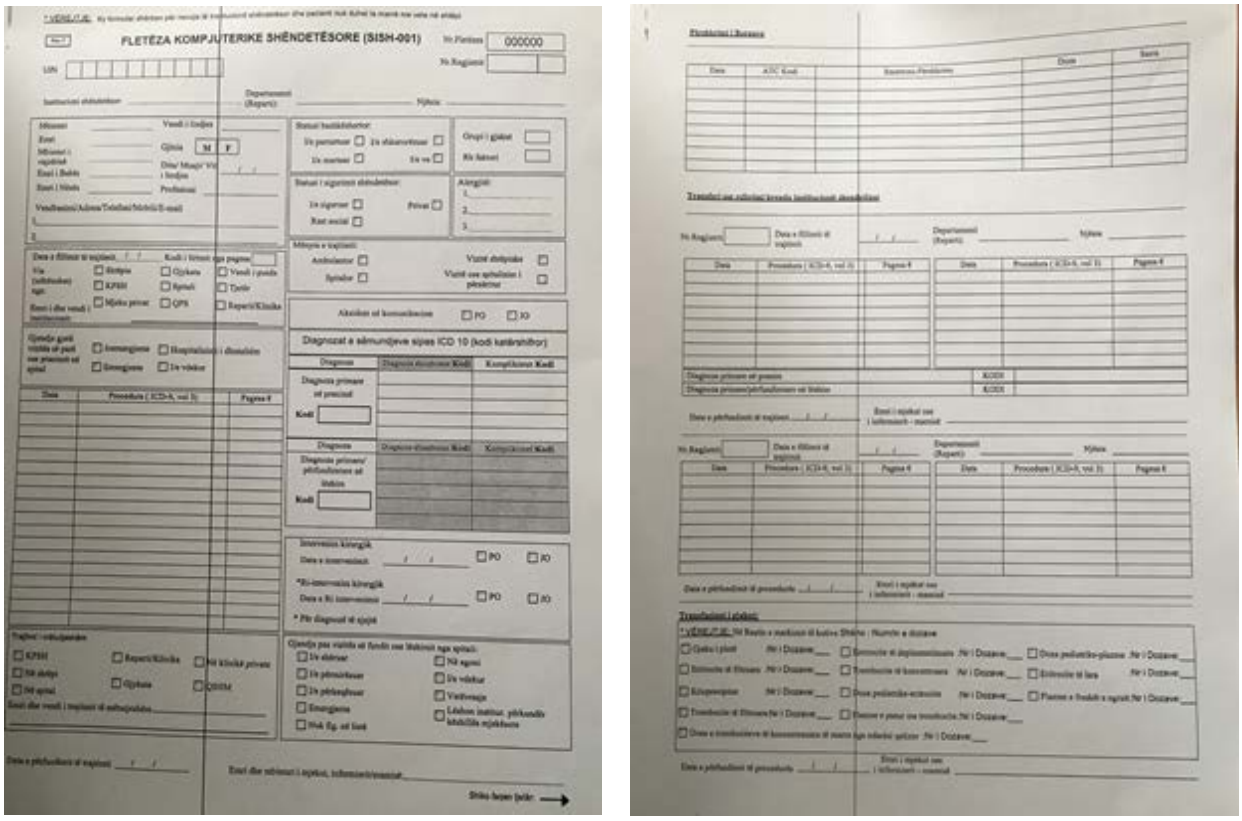
Table 7-5: List of Information Specified in Form 001 (excerpt[56])

No.	Category	Item name	Remarks (Options, etc.)
1	Patient’s basic information	Name	-
2		Sex	M / F
3		Date of birth	-
4		Birthplace	-
5		Blood type	-
6		Allergy information	-
7		Occupation	-
8		Address	-
9		Phone number	-
10		Marital status	-
11		Health Insurance Status	Insured, private insurance, etc.
12	Health facility information	Health facility name	-
13		Referral Information	Start/End date of treatment, transfer to another hospital, department, etc.
14		Name of doctor, nurse, or midwife	-

[56] Although we requested MOH for original files, we just got the scanned image. These descriptions here are what we could get from the image.

15	Treatment information	Start date of treatment	-
16		Type of medical care	Outpatients, inpatients, home visits, etc.
17		Conditions at the first visit and admission	Emergency/non-emergency, death, etc.
18		Diagnostic content	Diagnostic code
19		Complication information	Complication code
20		Surgical information	Situation on the day of surgery and at the time of discharge
21		Transfusion information	Type of blood transfusion, number of doses, etc.
22		Medication information	Code, name and description, dose, etc.
23	Billing Information	Exempt Code	Freestyle input

Source: MOH



Source: MOH

Figure 7-4: Form 001 Image

4) Requests for BHIS improvement at facilities using BHIS

The following requests were found in the survey at health facilities:

- Implementing Examination Module
- Direct input and integration of physician diagnosis information
- Implementing Age Group and Gender Determination Modules
- Implementing more modules (currently just some modules are available)
- Be able to export more reports.

5) The reasons that BHIS is not used/ not available

Based on the survey conducted at health facilities, the reasons that BHIS is not used/ not available are “network problems", or "the system crashes and is unavailable," or "it does not work.".

And the answer for how they manage information and report to health authorities when BHIS is not available or is not used is that they manage and report by paper.

6) COVID-19 related functionality in BHIS

Regarding the implementation of COVID-19 modules in BHIS, the answer is as below. The vaccination module was added to BHIS, but the vaccine management system was developed by NIPH.

Table 7-6: Usage Status of COVID-19 related Functionality in BHIS

No.	Function	Yes	No	N/A
1	Patient reporting system	9	9	7
2	Vaccine management system	11	7	7
3	Bed number management system	3	14	8

Source: Survey conducted at health facilities

(3) Information on IT costs by health facilities

The information of IT budgets of health facilities is as below. The survey could not get the sufficient answer from the health facilities.

Table 7-7: Healthcare IT Budgets (as of May 2021)

		Total Budget (Euro)					Of which, IT-related budgets (euro)				
		2016	2017	2018	2019	2020	2016	2017	2018	2019	2020
Secondary health facilities	General Hospital Prizren	1436826	1542436	1788483	1835846	2225509	7,437	7,000	5,491	7,915	6,525
	General Hospital Gjilan						4,000	4,000	4,000	4,000	4,000
	General Hospital Ferizaj	9,734,50	8,318.00	9.550,00	990,00	996,00					
Primary health facilities	MFMC Rahovec	1.378,926	1.442,080	1.746,697	1.873,676	1.051,227					
	MFMC Malisheve	1.279.930	1.348331	1.4887,835	1.673,906	1.784,404					
	MFMC Suhareke	1.436.825	1.542.436	1.788.483	1.835.846	2.225.509					
	MFMC Peje	2.558.622	3.059.500	3.220518	3.383580	3.519.197					
	MFMC Vushtrri	282, 446	315.792	475.811	847.904	624.039					
	MFMC Podujeve	2.164.382	2.263.818	2.757.138	2.998.448	3.131.872					
	MFMC Decan	965.200	1.005,630	1.100,361	1.208,898	1.351,544					
	MFMC Prizren	1.436 825	1 542 436	1 788 483	1 835 846	2.225.509					

Source: Survey conducted at health facilities

MFMC Decan and MFMC Prizren are introduced as an example of the budget breakdown of MFMC.
Traditionally, the ratio of subsidies from the government was high, but in recent years the ratio has been around 100%. Regarding the reason for this, a healthcare facility said that, "As a result of the application of the Act on Social Protection for the Elderly with Disabilities, the number of residents belonging to such facilities has decreased.". It is assumed that the budget is calculated by capitation payment method.

Table 7-8: Health Facility (MFMC)'s Budget Breakdown

Health facilities	Item		2016	2017	2018	2019	2020
MFMC Vushtrri	Total Budget		282,446	315.792	475.811	847.904	624.039
	Breakdown	Own income	14.1%	4.7%	7.3%	4.7%	0%
		government subsidy	85.9%	95.3%	92.7%	95.3%	100%
MFMC Decan	Total Budget		965.200	1.005,630	1.100,361	1.208,898	1.351,544
	Breakdown	Own income	2%	1.4%	1%	1%	0.3%
		government subsidy	98%	97.6%	99%	99%	99.7%

Source: Survey conducted at health facilities

(4) IT infrastructure (Hardware and software used) at health facilities (by health care level)

The implementation status of each hardware in health facilities is shown below.

Table 7-9: Hardware used in Health Facilities

No.	Equipment type	Status of introduction		
		Available be in use of	Not available not in use	N/A
1	Dabase server	14	3	12
2	Web server	11	3	15
3	Operation terminal	7	1	19
4	Network Equipment (router, hub)	13	2	13
5	Display device for patient	12	3	14
6	Tablet terminal	8	3	18
7	Uninterruptible power supply	10	1	16
8	Mobile devices used in hospital	9	2	17

Source: Survey conducted at health facilities

The most common answer for the question about the timing of each hardware implemented was around 2018 to 2020. It is estimated that this was improved when the Ministry of Health introduced BHIS. On the other hand, some health facilities said that they have been using the equipment implemented since AVICENA-HIS was introduced in 2013. In addition, some health facilities said that they have been using network equipment since 2006 to 2007.

Regarding the network environment of health facilities, among of 26 institutions, there were 12 institutions answered that both external networks and in-house networks use fiber-optic lines.
The status of the introduction of each software in health facilities is shown below.

Table 7-10: Software used in Health Facilities

No.	Types of ystems	Usage status		
		in use	not in use	N/A
1	Electronic medical record	16	1	8
2	Drug inventory management system	16	2	8
3	Drug prescription management system	14	1	11
4	Patient medical care reservation and reception management system	13	4	9
5	Ordering system	9	4	13
6	Hospitalization information management system	9	5	12
7	Diet system	1	5	20
8	Radiology information system	9	5	12
9	Clinical laboratory information system	6	7	13
10	Medical image management system	5	5	16
11	Personnel management system and medical worker management system	15	4	7
12	Accounting system	13	5	8

Source: Survey conducted at health facilities

(5) Experience with HIS supported by donors in the past

A survey was conducted to consider whether health facilities had previously introduced HIS supported by donors. The number of institutions which had experience with the project supported by LuxDev (AVICNNA-HIS) and the the World Bank (PRA-HIS, BHIS) is as follows.

Table 7-11: Experience with HIS Supported by Other Donors

No.	Experience with HIS	Yes	No	N/A
1	VAMED/Avicenna system Lux Dev	12	8	7
2	HIS introduced with the support of the World Bank	12	6	9

Source: Survey conducted at health facilities

Many of the health facilities said that the introduction of HIS supported by LuxDev (AVICENA -HIS) started around 2002 to 2006, and the use of HIS was almost completed between 2018 and 2019. Patient data entry, exporting report, and reference functions were implemented.

Many institutions answered that the introduction of the World Bank-supported project (PRA-HIS) started between 2018 and 2019. This is the base system for the current BHIS.

Some health facilities did not introduce AVICENA -HIS or PRA-HIS in chronological order, and some said that only one of them was introduced.

(6) Systematization status of each hospital business process

The following answers were obtained from a survey of the systematization status of each work process in health facilities. The systematization of "treatment process", "prescription process ", and the "accounting process" were ahead.

Table 7-12: Systematization of Hospital Operations

No.	Hospital operation	Yes	No	N/A
1	Reception	9	8	8
2	Medical consultant by physician	10	7	8
3	Diagnosis	10	7	8
4	Treatment	13	4	8
5	Prescription (Prescription and Administration)	13	4	8
6	Payment	12	5	8
7	Reservation	5	10	10
8	Referrals	10	6	9

Source: Survey conducted at health facilities

(7) Usage of information security products and services

Regarding the use of security products and services in health facilities, the answer were as follows.

Table 7-13: Usage Status of Information Security Products and Services

No.	Security Products and Services	Yes	No	N/A
1	Authentication information management and ID management	6	4	14
2	Measures against information leakage	4	7	13
3	Cyber Attack Countermeasures (Log analysis, information protection, intrusion prevention, etc.)	5	6	13
4	Measures against unauthorized access (Firewalls, electronic document warranties, etc.)	5	6	13
5	Email security measures	7	4	13
6	Access control	9	2	13
7	Use of IC cards and biometric authentication systems	4	7	13
8	Video management system	6	5	13

Source: Survey conducted at health facilities

At health facilities using BHIS, most of answer were that BHIS can be used only in closed government networks, and security measures are under control of AIS which provides data centers. On the other hand, the answer for the security measures, security awareness and human resources from the user side (healthcare facilities) were not sufficient.

Since there is no common guideline which defines the security measures and security levels for health facilities, the development of such guidelines is a challenge in future.

(8) IT personnel within health facilities and related organizations (Number of staffs, scope of work, specialty, academic attainment)

1) MOH

The HIS Department employs 9 people, including part-time staff. They are responsible for project management, cooperation with donors, and contracting with IT vendors. The MOH contracted with 3-4 companies to carry out IT operations (including medical device manufacturers such as PACS). The following views were given by interviewees within the HIS Department of the MOH:

- There are excellent IT engineers in private enterprises in Kosovo. However, public institutions such as the MOH are not attractive workplaces for IT specialists due to low salary levels.
- Private companies are sometimes contracted for software development, and their IT specialists are good, and their services are high quality

2) HIF

In addition to the director of HIF, 2 other staff members are engaged in the management and operation of IT systems at the Health Insurance Fund. They perform a series of tasks from cooperation with donors to development and implementation of IT systems. They are also involved in the creation and coordination of SOPs to facilitate data exchange between connected institutions, including the MOH, the Tax Agency, the Ministry of Labour and Social Welfare, and the central bank. The following comments were heard from interviews with the Health Insurance fund

- During the project initiated by the World Bank, 2 IT specialists were assigned through the World Bank to support the introduction of the IT system at the Health Insurance Fund. However, their mission ended last year, and since there are only 2 employees in charge of the Information Management System, which is not sufficient. Currently these 2 employees are only in charge of help desk work.

3) Health facilities

There were only 1 or 2 employees in the IT department at the 3 general hospitals where the survey was conducted, (there are no concurrent employees, and all are full-time). In UCCK, there were 8 employees. It seems that realization and running of HISs (such as: system maintenance, medical staff's lectures, master maintenance) as well as implementation of information security measures are not sufficient.

From the above data, the Survey Team can assume that human resources allocated to IT management are insufficient in terms of quality and quantity not only within health authorities and management institutions such as the MOH and the Health Insurance Fund but also within health care institutions.

7.3.2 Relevant organizations related to health information

(1) National Council for Health Information System (NCHIS)

The establishment of the Council was proposed to ensure general coordination of relevant partners at national level and to assist in drafting technical, legal and organizational principles for HIS. NCHIS is made up of representatives from all relevant partners of HIS, including MOH, service purchasers, patient associations, the Ministry of Public Administration (MPA), National Institute of Public Health of Kosovo (NIPH), cities and health facilities.

(2) Agency for Information Society (AIS)

AIS manages and oversees the implementation of information technology related projects in public institutions. Its responsibilities cover the cyber-security and protection of electronic communications and data infrastructure, provides storage capacities and conditions for the proper functioning of HIS equipment and operations which are

confined to it. Since the start of HIS implementation, AIS supported processes for proper implementation, providing necessary professional support and technical infrastructure within its capacities and capabilities.

One of the most important processes allowing proper functioning of the HIS was the activation of the national data center. The deployment of central devices for processing, transmitting and storing data from HIS was planned for this data center. This data center, after various delays, was put into operation in February 2014.

7.3.3 Role of municipalities in the introduction and operation of HIS

(1) Collected information and management flow of municipalities

The main information collected and managed by municipalities from health facilities in the controlled areas are "information on infectious diseases," "information on injuries and diseases," "information on drugs," and "information on health facilities and medical devices.".

- Infection-Related information is reported mainly by municipalities to NIPH, but some health facilities report it to MOH.
- While many municipalities reported injury and disease information to MOH, some reported it to NIPH. The reason is unknown.
- Municipalities reported information on pharmaceuticals, health facilities and medical devices to MOH.
- With regard to the frequency of reporting, no common pattern was found for each type of report or reporting location, but there are answers such as "on a case-by-case basis," "monthly," "every six months," "quarterly," and "once a year". As a general trend, information on infectious diseases is frequently reported.

(2) Status of computerization

When asked how they report information (such as infectious disease-related information, injury and disease information, pharmaceuticals information, and information on health facilities and medical devices) to MOH and NIPH, many municipalities answered that they submit information electronically, but some municipalities answered that they submit information only in paper form.

(3) Data aggregation, analysis, and report to residents

When asked about the perspective of totalling and analysing the collected data , many municipalities did not respond, but some municipalities answered that there were no specific guidelines or instructions from the MOH, etc. regarding the perspective of analysis. Some municipalities answered that they are disclosing (returning) the collected and analyzed information to residents.

When asked about the use of software used by municipalities to compile, aggregate and analyze information, the responses were as follows. Some municipalities said they use advanced analysis software such as SPSS and SAS.

Table 7-14: Software Usage

No.	Software	Yes	No	N/A
1	Microsoft Word	8	0	5
2	Microsoft Excel	9	0	4
3	Microsoft PowerPoint	6	1	5
4	Microsoft Access	3	4	5
5	Tableau	1	5	5
6	SPSS	3	4	5
7	SAS	1	5	5
8	Power BI	3	4	5

Source: Survey of health facilities

Next, when the Survey Team surveyed with multiple answers what kind of support municipalities are providing for the introduction of IT in primary health facilities, the largest number of municipalities answered "technical support", followed by "budget support" and "human resources support".

Table 7-15: Local Government Support for Primary Health Facilities (Introduction of IT)

No.	support domain	Yes	No	N/A
1	technical aspect	7	1	4
2	financial aspect	5	3	4
3	human resources aspect	5	3	4

Source: Survey of health facilities

7.3.4 Major IT Vendors

(1) IT Vendors for MOH

The BHIS and the other systems within the MOH have been developed by 2 local companies in Kosovo. Those IT vendors are as follows:

Table 7-16: IT Vendors in Kosovo (MOH)

	Company name	Overview/ Achievements
1	PBC	- Number of employees: approximately 200 - Established in 2003 - Achievements : developed HIS、e-Prescription、LIS - Website: www.pbc-ks.com
2	Data Prog Net	- Number of employees: approximately 50 - Established in 2004 - Website: www.dataprognet.com

Source: Survey Team

The General Data Protection Regulation (GDPR) is one of the points mentioned by MOH staff as an important issue to cover in IT service procurement, however there was no other specific, detailed procurement standards mentioned.

(2) IT Vendors for HIF

The Fund's Information System (HIFFIS[57]) is developed and maintained by several different IT vendors (domestic

[57] Health Information System of Health Insurance Fund

and international). According to the Health Insurance Fund, system development procurement is based on EU standards and on the national Law on public procurement, and depending on the project characteristics, on free contracts, or on multi-offer contracting, using lowest price method for selecting providers. Since in the past it has happened that the offers with the lowest price could not stipulate sufficient quality, in recent years, value for money considerations were also incorporated into the tenders.

Main IT vendors are as follows

Table 7-17: IT Vendors in Kosovo (Health Insurance Fund)

	Company name	Overview/ Achievements
1	CONSEIL SANTÉ	- Number of employees: Hundreds - Established in 1987 - Achievements in Kosovo: development of e-Prescription and capacity building within MOH to implement health care reform (2011 -2012) - Website: http://www.conseilsante.com

Source: Survey Team

7.3.5 Implementation status of health information management for handling the COVID-19 epidemic

As it has been described previously the national aggregation of information on infectious diseases is accumulated by NIPH. IT management systems is still under investigation as of May 2021 and will be included in the Final report under the following themes:

- Infectious diseases information management.
- Pharmaceuticals and medical devices resources management
- Status of provision of infection information management software and educational software for citizens

7.3.6 IT system built by MOH

According to the report of the Audit Office of Kosovo, the following systems exist.

Table 7-18: List of Systems Built by MOH

NO.	System name	Overview / Purpose of use
1	The system for licensing private health facilities	Mainly used by the MOH in order to follow-up, issue and/or withdraw the licenses of private institutions providing health services
2	Health Inspection System	Used for inspecting institution's compliance
3	Medical human resource system	Manage the licensing of professional medical personnel; -Manage and register the medical personnel specialization; - Manage and register the continuing professional education of medical personnel; - Manage the contracts of medical personnel.
4	Pharmaceutical Inventory Management System	Provide accurate information on the pharmaceutical stock. Divided into two (2) parts: -Primary health care: under the responsibility of MOH - Secondary and Tertiary health care: under the responsibility of the Kosovo Hospital and University Clinic

		Service (HUCSK) and the Health insurance agency.
5	Health Statistics Information System	Used by NIPH to collect statistical data
6	The HIS for detainees	A modified HIS system used by the service to manage prisoner health information. It includes following functionalities - Human resources system; - Pharmaceutical stock management system; - Information system for health statistics

Source: The reports of the National Audit Office (2019)[58]

7.3.7 Challenges and needs related to HIS

Challenges and needs related to HIS can be summarized as follows.

(1) Network development

A survey of health facilities found multiple reasons for not using or cannot using BHIS: "network problems may prevent its use.". Of the 26 facilities surveyed, 12 responded that both external and internal networks use fiber optic lines, but other facilities did not respond or responded that they use ADSL lines. Equipment and technical support for a stable network connection was called as a challenge.

(2) Expansion of BHIS modules to nationwide health facilities

A health facilities survey found that the reasons for not using BHIS were "the system crashes and cannot be used" and "it does not work.". In addition, there is an opinion that the available modules are limited, and it is necessary to develop and provide the necessary modules as soon as possible for the health facilities to carry out their work. In addition, some health facilities are still using AVICNNA-HIS. It will be necessary to promote the introduction of BHIS in a nationwide manner while expanding the functions of BHIS.

(3) Political stability, clear implementation plan

As mentioned earlier within the section explaining the introduction of HIS in Kosovo, that there has been a forerunner project which has been introduced and abandoned due to political reasons, and another project has been started from scratch. The objective with large scale IT project development is that regardless of high-level political changes, the practical implementation of policies should be continued to be carried out.

(4) Allocation of sufficient human and financial resources by the MOH

It is argued that until now the support of donors was needed to advance with HIS due to human and financial constraints. However, it seems that political considerations overrode economic ones at the MOH when they proceeded with HIS implementation without considering the advice feasibility analysis offered by donor organizations. The fact that the MOH did not fully consider the feasibility of donor proposals and advice and proceeded with the implementation of HIS may have caused confusion such as delays, cancellations, and replacements. In the future the Survey Team expect to focus on expanding the number of health facilities using

[58] http://www.zka-rks.org/wp-content/uploads/2018/03/Raporti_auditimit_SISH_eng.pdf

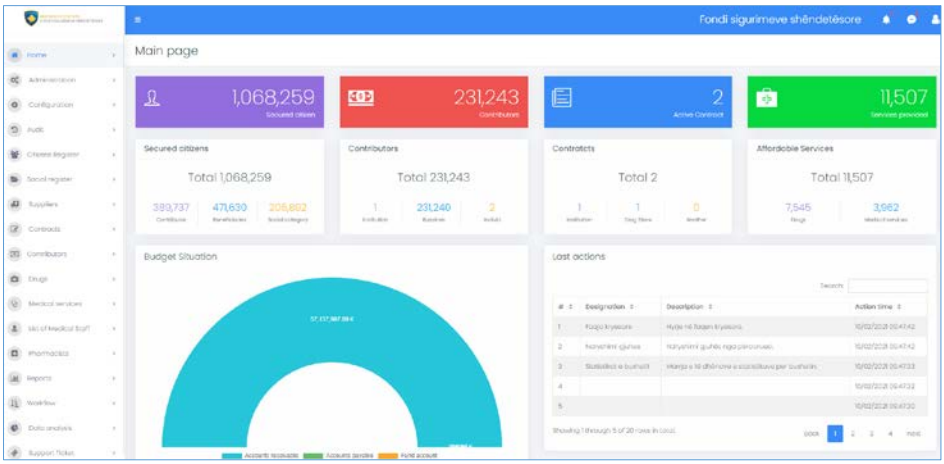
BHIS and expanding the functions of BHIS. Nevertheless, routines how MOH allocates sufficient human and financial resources is still considered a challenge.

7.4 Health Insurance related IT Systems

7.4.1 Health Insurance Fund Information System (HIFIS [59])

HIFIS is a system that comprehensively manages information on insured, on the status of insurance premium collection, registration and treatment patients visiting a health facility, information on costs endured, etc. Although the design of the system has been completed, the workflow for the use of health insurance is not clearly defined since the health insurance system itself has not started due to delays in legislation. Meanwhile, HIF is working to finalize HIFIS with the support of the World Bank to prepare to be able to start operating health insurance. The outline of HIFIS is described below.

- The hardware infrastructure is based on the data center provided by AIS.
- The software manages HIFIS, e-Prescription, and connections with external organizations.



Source: Information provided by HIF

Figure 7-5: Main Page of the Health Insurance Fund Information System

HIF collaborates with other organizations through the HIFIS to exchange important information related to health insurance. Information items exchanged and cooperation methods with each organization are as follows.

[59] HEALTH INSURANCE FUND INFROMATION SYSTEM

MOH: Ministry of Health
TAK: Tax Administration of Kosovo
CBK: Central Bank of Kosovo
KMA: Kosovo Medicines Agency
MLSW: Ministry of Labour and Social Welfare
KCHP: Kosovo Chamber of Pharmacists

Source: Information provided by HIF

Figure 7-6: HIFIS and Information Coordination with Other Institutions

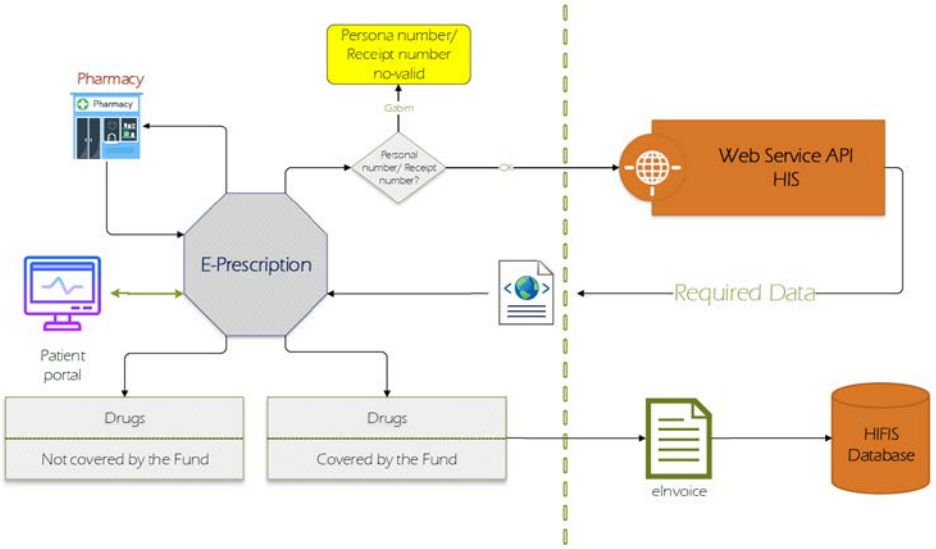
- HIF receives patient information, treatment information, etc from MOH. It is made possible through the efforts of MOH, which conducted a pilot project in 2020 to deploy basic HIS applications in all public health facilities. Health facilities input information from the HIS web application and send it to MOH. HIF receives this information and cooperates with HIFIS. The connection method is via API and it is updated monthly.
- Information (For companies, employee information, etc.) on insurance premium payments is received from the TAK (Tax Administration of Kosovo). It is connected to HIFIS and updated daily.
- HIF receives information from Ministry of Labour and Social Welfare (MLSW) on groups of people who are exempt from premium payments. People on low or no income, veterans, etc. may be exempted from health insurance payments. Continuous update in the database is required in order to avoid confusion if a co-paying insured person gets into one of these groups and the OOP rate changes.
- In December 2019, it was reported that an electronic prescription module was connected to HIFIS and was functioning. According to a World Bank report[60], as of 2019, "HIFIS meets the design specifications", and "the final adjustment is carried out and the finalization of the standard operation procedure is advanced".
- At present, the health insurance fund is not yet operating, so thus processes to review of insurance claims could not been carried out yet. MOH administrative instruction No. Section 3.2017 contains the basic review rules how to manage non-internal public health facilities' claims but it is yet in an abstract manner.
- In the future, when the health insurance system is launched, it will be necessary to review the contraindications of diseases, the relationship between diseases and medicines, the prescriptions for expensive medical services and medicines. The mechanisms of detecting fraudulent claims such as double claims and overcharged claims will also be necessary.

[60] Kosovo Health Project (Loan No. 5442-XK) and Swiss Trust Fund “Improving Financial Protection and Quality of Care” (TF072309)

7.4.2 E-prescription system

- The e-prescription system can allow pharmacists to make electronic claims to HIF for medicines prescribed at pharmacies that are covered by health insurance. In addition to this feature, HIF can update the list of reimbursed medicines, and patients can access the portal themselves for prescription information.

- The design and development of an e-prescription system has been completed in cooperation with the World Bank. About 1,000 pharmacists were trained in 2019. However, the law has not been approved by the government for political reasons, and the system has not been put into practice yet. Neither the list of reimbursable medicines has been updated in the database due to this lack of approvement. HIF officials affirmed that they are ready to start if the legal issues were resolved[61].



Source: Information provided by HIF

Figure 7-7: Conceptual Diagram of E-prescription

7.4.3 Evaluation by the World Bank

According to the report on the Kosovo Health Project published by the World Bank in November 2019, the status of major elements of HIFIS and e-prescription system is the following:

- The HIFIS and e-prescription system is mostly ready to be used. Its implementation is pending on some technical fine-tuning, as well as amendments to the Health Insurance Law. Based on the current framework, the three indicators as follows are expected to be achieved by the end of the project.
  - Outpatient medicine benefit scheme established.
  - Health Insurance Fund Information System (HIFIS) functional
  - Number of municipalities participating in Capitation Based Performance Payment Scheme (CBPPs)
- During our meeting with HIF, which coordinates the design, development, and future use of HIFIS,

[61] February 12, 2021 Interview with HIF

representatives of HIF gave a presentation and live demonstration on HIFIS. More elaboration is needed, but from the presented information, the Survey Team can conclude that the system largely meets design specifications. The Memorandum of Understanding (MOU) and Standard Operating Procedures (SOP) have been signed with a number of leading agencies (Kosovo Civil Registration Authority, Tax Administration of Kosovo (TAK), Kosovo Medicines Agency, Ministry of Labour and Social Welfare (MLSW), etc.) for data exchange. Also, the interfaces for data exchange were under test as of December 2019.

7.4.4 Issues related to the information system of the HIF

(1) Business design in anticipation of the start of system operation

- As of May 2021, although the actual operation of the health insurance system has still not yet started, HIF has established a connection method with Tax Administration of Kosovo (TAK) and Ministry of Labour and Social Welfare (MLSW). The linkage system was developed, and a practical connection contract was concluded. However, variable values within the system, such as the types of health insurance subscribers (public sector employees, private sector employees, self-employed people, the poor, etc.), payment methods (fee for service payment, comprehension payment, capitation provider payment, etc.), insurance premium rates, OOP amounts, have not been determined. It is unknown whether the existing system can incorporate these variable factors.

- In addition, at present, there are no studies on the IT solution connecting the HIFIS to those of other health facilities including the claim review system, and fraudulent claim detection system, which are greatly dependent on unambiguous knowledge on the payment method. There is an understanding that claim information will be received via the MOH[62] . In anticipation of starting to operate the HIFIS system, it is necessary to promptly resolve business and system requirements for components which have not currently been considered.

(2) Development of human resources capable to define system requirement

- As of May 2021, the Health Insurance Fund Information Systems Administration has a director and 2 staff members in charge of managing and operating IT systems. Once the health insurance system starts to operate, it is clear that there will be a shortage of personnel to sort out business requirements and system requirements, coordinate supplier procurement and conduct project management.

7.5 Status of Maintenance, Master Codes and Other Management Information

In order to build an IT system that contributes to the steady and efficient operation of the health system, it is necessary to prepare three types of information (Master code, reporting format, claim review rules in health insurance).

[62] February 2021 (Interviews with HIF stakeholders)

7.5.1 Master Code

(1) Master Code Usage Status

The master code is information on medical services, medicines, etc., and their costs, which is commonly referred to in practice and treatment.

Table 7-19: Master Code Usage Status

NO.	Master Code Type	Health facilities responses (total: 26)		
		YES	NO	N/A
1	ICD 10	24	0	2
2	ICD9-CM	19	4	3
3	drug code	24	0	2
4	Medical Institution Code	20	2	4
5	medical material code	17	3	6
6	inspection code	8	10	8
7	technical service code	21	2	3
8	Other	1	5	20

Source: Survey team

Interviews with health facilities show that ICD 10 and Drug Code are used in more than 90% of cases. The technical service code, health facilities code, ICD9-CM, and medical material code are then used in 7- 80%.
As for the source of each code, many responded that it was MOH, but some responded that it was health facilities or Supply Company. As for the timing of updating each code, many MFMC responded "once a year," but some MFMC responded "on a case-by-case basis.".

As for the price list, the price list for technical services is used by almost all health facilities. On the other hand, many respondents said they did not use drug price lists, which may not yet be implemented in BHIS. Bed price lists are not used in MFMC because there are no hospital facilities. There were responses that these price lists were managed by some kind of system, but there were also responses that they were managed by a system other than the BHIS system of MOH, showing some variations.

(2) Price list issued by the MOH

Administrative Instruction 04/2007 issued in 2007 sets the prices for health services as follows: Since it has not been renewed, it still has to be confirmed whether it is still in use within the health facilities.

Table 7-20: Price List According to Types and Numbers of Health Services Included

No.	Document name	List name	Number of service
1	Annex 1– a	Pricelist of copayments for primary health services	21
2	Annex 1 – b	Pricelist of copayments for secondary health services	39
3	Annex 1 – c	Pricelist of copayments for tertiary health services -UCCK	38
4		Radiography	8
5		Nuclear medicine	3
6		Physiology institute	2
7		Institute of Pathologic Anatomy	1
8		Institute of legal medicine	4

9		Institute of Pathological Physiology	1
10		Institute of Biochemistry	2
11		Cytogenetic Analyses	1
12		Hematology Service	2
13		Gastroenterology Service	4
14		Cardiology Service	5
15		Invasive Cardiology	12
16		Other Services	7
17	Annex 1 – d	Pricelist of copayments for tertiary health services -NIPH	2
18	Annex 1 – e	Pricelist of copayments for tertiary health services - NATIONAL BLOOD TRANSFUSION CENTER	26
19	Annex 1 – f	Pricelist of copayments for tertiary health services - NATIONAL INSTITUTE OF LABOR MEDICINE	21
20	Annex 1 – g	Pricelist of copayments for tertiary health services - SPORT MEDICINE CENTER	14
21		Intervening	4
22		Physiotherapy – rehabilitation	13
23	Annex 2 – a	Pricelist of copayments for dentistry services of the first level – MFMC of municipalities and FMC	21
24	Annex 2 – b	Pricelist of copayments for dentistry services of the secondary level – MFMC (centers of regions)	46
25	Annex 2 – c	Pricelist of co-payments for tertiary level dentistry services UNIVERSITY DENTISTRY CLINICAL CENTER OF KOSOVO	54
26	Annex 2 – c 1	Copayments for aesthetic dentistry services in the UDCCK	20

Source: MOH

For reference, Annex 1-a (price list of OOP costs for primary health services) includes the following.

Table 7-21: List of OOP Amount for Primary Health Services

No.	Type of service	Euro
1	Medical examination in the center, FMC or in the MFMC, without laboratory analyses or without additional diagnostic procedures	1.0
2	Specialist examination in the FMC/MFMC with the prescription of the Family Doctor	2.0
3	Specialist examination in the FMC/MFMC without the prescription of the Family Doctor	5.0
4	Examination at home, except emergency cases	6.0
5	Medicament from the essential list, offered in the public pharmacy	0.3
6	Standard ultrasound	2.0
7	Radiography	2.0
8	ECG	0.5
9	Laboratory analyses – only hemogram and urine	1.0
10	Laboratory analyses (complete)	3.0
11	Determination of sugar in blood with the glychometer according to the request of the health care user	1.0
12	Audiogram	1.0
13	Ear cleaning	1.0
14	Intramuscular injection at home, except emergency cases	1.0
15	Intravenous injection at home, except emergency cases	1.0
16	Treatment of wounds including sewing and cleaning until the healing of the wounds (only in the first visit)	3.0
17	Daily treatment with infusions in the health facilities	1.0
18	Certificate for the driving license from the professionals	18.0
19	Medical certificate issued according to the request of the health care users	18.0
20	Provision of medical reports, certificates or other documents based on the request of the health care user	5.0
21	Provision of health services during sport activities – per hour	25.0

Source: MOH

7.5.2 Reporting format from health facility to health authorities

As the second type of information an IT system has to cover - after the master codes - reporting formats have also been studied. In accordance with Administrative Instruction (Health) No. 11/2013, Article 11 (Data Collection for DB/HIS), health facilities are required to prepare and periodically report the following forms.

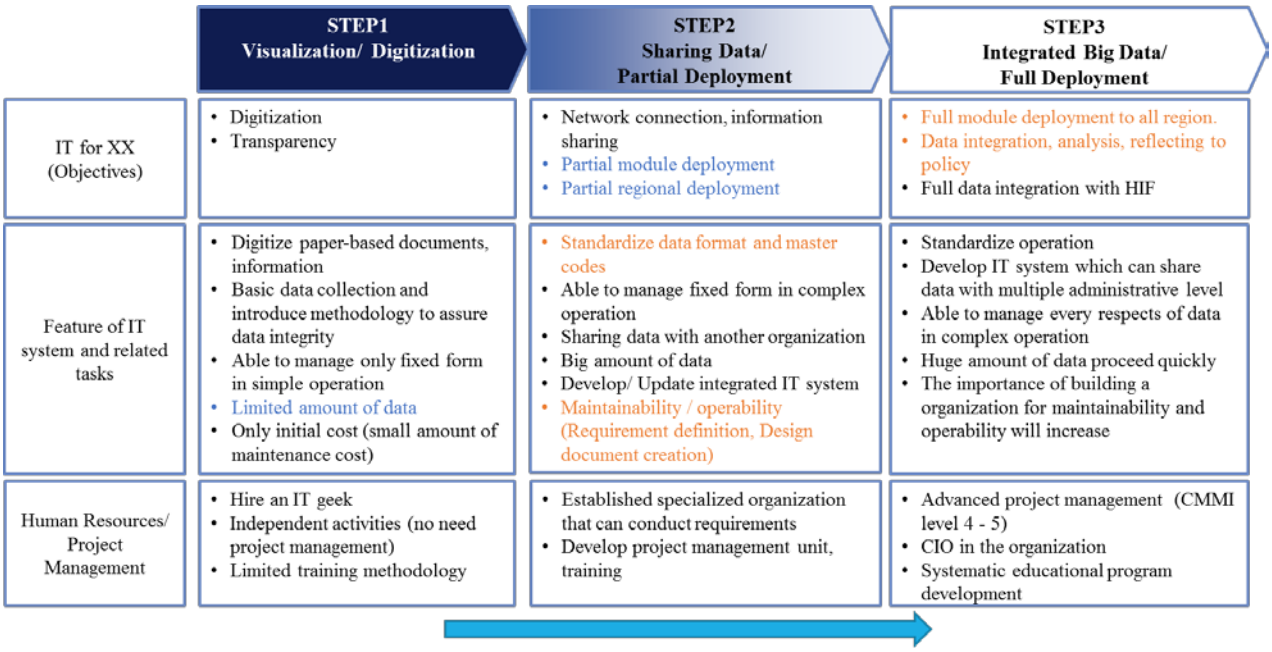
- Health Certificate (HIS-01)
- Birth Certificate (HIS-02)
- Certificate for infants ((HIS-03)
- Malign disease certificate
- Massively contagious certificate
- Non-contagious certificate
- Dental certificate
- Pharmaceutical certificate (prescription)

7.6 dical Card and Health Insurance Card

Since the health insurance system has not yet started, the health insurance card has not been introduced yet. However, it is planned to be introduced in the future. The Ministry of Internal Affairs is planning to introduce a national ID card (Uses biometric authentication and electronic signatures) to all citizens also including the medical ID number as well.

7.7 HIS Maturity and Action Steps

From the information collected in this survey, the IT maturity of the Kosovo Health Information System is in the middle of Step 2. In the future, it is recommended to start "standardization of data and master", "ensure maintainability and operability (maintenance of requirement definition document / design document)" and promote STEP3 "introduction of all modules to all regions", "data integration, analysis, reflection in policy".



Source: Survey team

Figure 7-1: HIS Maturity and Action Steps

Part 2

Chapter 8 Proposed Approaches to Cooperation, Based on Development Needs in the Health Sector

8.1 Current Situation and Challenges in the Health Sector in Kosovo

The survey examined the possibility of cooperation that can be utilizing Japan's technology, knowledge, and experience in the health sector to build a resilient health UHC system in Kosovo. Based on the information and analysis organized in the previous chapters, the main challenges are summarized as follows:

- **The disease structure** of Kosovo is relatively similar to that of Western European countries. The main causes of death are **non-communicable diseases**: 1) cardiovascular diseases (46.7%), 2) malignant tumors (28.0%), and 3) respiratory diseases (11.3%) including both acute and chronic diseases.
- **Health Care Service Delivery System** could be improved by strengthening the functions of secondary health facilities, and by strengthening cooperation between primary health facilities and secondary/tertiary health facilities with different competent authorities. The referral system is functioning to some extent, and most of the population has access to public and private health facilities. On the other hand, there are many calls for improving the quality of health care services.
- **Governance** should be strengthened. Although the Health Sector Strategy (2017-2021) has been formulated, its priority in the national development plan is low, and the progress of the health strategy is minimal. Currently, the next National Development Plan is being formulated, and it is expected that the priority and importance of the health strategy will rise.
- **Health Financing** should be improved and strengthen. Public health expenditure is very low, at 2.83% of GDP, and there are many issues (quality of services, shortage of medicines, maintenance of equipment, etc.) arising from health financing. In order to provide stable and high-quality health care services, the stability of health financing is the most important issue, and efforts to secure financial resources are necessary. The introduction of a health insurance system supported by the World Bank will contribute to the stabilization of health financing and is considered to be an area where Japan/JICA could consider cooperation.

＜Points to be noted when considering cooperative approaches>

- According to other development partners, Kosovo's challenges in the health sector include (1) inferior priority given to the health sector due to unstable internal politics, (2) lack of capacity (including lack of motivation) of MOH and health institutions, and (3) poor quality of health services.
- According to demographic projections, the total and the working populations are expected to decline, and the aging of the population is expected to accelerate, leading to slower economic growth and further pressure on public financing.
- It should be noted that development issues in the health sector are complex and intertwined, and in order to resolve issues in a particular sector, many issues outside of that sector need to be addressed in parallel.

The following is an overview of the analysis of challenges other than those mentioned above:

(Outline by disease classification)

- Infectious disease control: Policies and measures against infectious diseases such as tuberculosis need to be continued, but there is no need for cooperation from Japan/JICA in this case.
- Maternal and child health: UNICEF plays a central role in strengthening the health checkup system and consultation capacity, as well as conducting awareness-raising activities to improve health literacy among children, pregnant and nursing mothers, and vulnerable groups such as ethnic minorities (RAE). No need for cooperation from Japan/JICA has been identified at this time.
- Nutrition: Since nutrition is closely related to lifestyle-related diseases, there is a need for further awareness-raising activities as part of prevention and health promotion activities at the primary level. At the primary level, the World Bank and the Swiss Development Agency are engaged in cooperative activities, and there is no need for cooperation from Japan/JICA at this time.
- Non-communicable diseases: As mentioned above, non-communicable diseases are critical to address. The Swiss Development Agency is currently implementing activities targeting all primary health facilities, and it is expected that plans will be formulated, and measures implemented at the national level. In addition, it is thought that the early detection of cancer and the strengthening of cancer treatment systems will be necessary in the future. When Japan/JICA considers cooperation, those that contribute to measures against non-communicable diseases are considered to have a high priority.

(Overview of issues related to other components of the health system)

- Health administration: There is room for improvement in the capacity for policy planning and formulation and policy implementation. Given that the evaluation of the Health Sector Strategy (2017-2021) is currently underway, and the drafting of the next Health Sector Strategy is in progress, it is not the right time to consider cooperation.
- HIS: The development of a HIS is very important for building a health system that is highly responsive to ever-changing conditions, but it is too early to discuss this issue because the policy within the government has not been finalized and there is no material available at this time to consider specific cooperation.
- Medical personnel: There is room for improvement in the continuous capacity building of medical personnel such as doctors and nurses. On the other hand, detailed analysis of effective measures and approaches for capacity building is needed, and further information collection, analysis, and verification are necessary when considering cooperation in this field in the future.
- Medical equipment: Although necessary medical equipment has been provided with the support of development partners, appropriate equipment has not been deployed or updated in primary, secondary, and tertiary health facilities due to insufficient budget and inadequate equipment maintenance plans. In addition, there is room for improvement in the equipment maintenance and management system, and it is necessary to consider improvements in the referral system as a whole.

8.2 Status of Cooperation with Development Partners

The World Bank, the Swiss Development Agency, and the Government of Luxembourg are the main development partners working in the health sector in Kosovo, as well as other UN agencies such as WHO, UNICEF, UNFPA, etc. The EU and the Global Fund were active in the past but are no longer active. The World Bank has a wide range of activities in the health sector, while the Swiss Development Agency focuses on primary health care and lifestyle-related diseases. When Japan/JICA considers cooperation, it is necessary to avoid duplication of activities with other donors and to be aware of synergistic effects.

The status of support by each donor is shown in the table below. (For details, please refer to "4.8 Cooperation of Other Donors".)

	Infection Control	Maternal and Child Health	Nutrition	Non-Communicable Disease Control	Health Personnel Development	Medical Equipment	Health facilities	HIS	Health Financing	Governance
The World Bank	○ C-19	○	○	○	○	○	○	○	○	○
LuxDev					○		○	▲		○
Swiss Development Agency	C-19			○	○	○				○
WHO	C-19	○								
UNICEF	C-19	○	○							
UNFPA		○	○	○						
EU		▲				△		▲		▲
Global Fund	▲									

Legend: ○Currently Supporting △Possible Future Cooperation ▲Supported in the Past
C-19 means supports against COVID-19
Source: the Survey Team

8.3 Consideration of a Proposed Cooperative Approach

Based on the aforementioned issues, it is thought that effective cooperation is possible by utilizing Japan's technology, knowledge, and experience in the field of health and medical care in order to improve the quality of health and medical services, with regard to strengthening the functions of secondary health facilities that contribute to the improvement of the referral system and the development of the health insurance system supported by the World Bank. In addition, since there are many issues related to the knowledge and skills of physicians, we believe that country-specific trainings are highly effective form of technical cooperation projects. For example, training on medical checkups for pregnant and nursing mothers, training on examination and treatment of cancer, which has a large number of cases, and training on measures against lifestyle-related diseases can be assumed as themes for which there is a need through country-specific training.

In terms of achieving UHC and improving the quality of healthcare services in Kosovo, there are many other

challenges that need to be addressed as described in 8.1, and there is a possibility that further cooperation will be considered in the future. For example, cooperation focusing on hardware, such as maintenance and renovation of health facilities, maintenance and renewal of healthcare equipment, and maintenance of healthcare information systems, as well as cooperation on software, such as strategy formulation, improvement of healthcare facility management, and capacity building of healthcare personnel, could be considered. However, these considerations require a detailed analysis of the issues in detail of the entire health system, which this survey does not cover, so it is too early to consider them, and it is desirable to further consider them through future cooperation.

The following section describes the strengthening of secondary health facilities and the development of a World Bank-supported health insurance system that will contribute to the improvement of the referral system for improving the quality of health care services at the beginning of this section.

(1) Strengthen the functions of secondary health facilities (see Table 8-2)

Based on the survey, it can be hypothesized that if secondary health facilities are able to perform their required functions to the fullest extent, the entire referral system can be improved in a chain reaction. In other words, cooperation in strengthening the functions of secondary health facilities is likely to reduce the burden on primary and tertiary health care, while at the same time strengthening their functions.

Based on 4.8, it is confirmed that international organizations, other donors, UN agencies, etc. are not providing much support to secondary health facilities, and there is no overlap with other support projects.

Of the 7 secondary health facilities nationwide, several could be selected after a careful examination of the following items, and technical and financial cooperation project could be considered to improve medical services by strengthening the functions of secondary health facilities. When considering the details of the project, it may be effective to add activities such as handling medical fee billing and forming a model for hospital management in consideration of the health insurance system that is scheduled to be implemented in the near future.

(Items for selecting secondary health facilities for cooperation)

- ✓ Basic information (target area/population, number of health care workers, number of primary health facilities in the area, morbidity, and mortality of non-communicable diseases in the target area)
- ✓ What issues and support needs exist (e.g., what kind of patients do primary health facilities in the target area want to refer to the regional general hospital, what medical equipment is lacking in each hospital, what kind of training is needed for medical staff, etc.)

(2) Development and introduction of health insurance system

As explained in the previous section, strengthening the financial foundation for health is a critical issue for achieving UHC, and preparations for the implementation of a health insurance system have been underway since 2014 with the support of the World Bank, but the system has yet to be implemented. The health insurance system is a system that protects people from the risk of incurring high medical expenses OOP, but it is also a system that imposes a burden on people by collecting insurance premiums from them. In light of the current situation, the

scale and content of cooperation need to be carefully considered. First of all, it is necessary to enhance the Kosovo government's ownership and leadership through participation in issue-specific training programs such as JICA Tokyo's "Strengthening the Medical Security System to Achieve Universal Health Coverage" to help them understand the image of implementing specific systems, and through presentations and interviews on the progress in Kosovo. It can be said that it is important to enhance the ownership and leadership of the Kosovo government.

<Note>

The issues in the field of health and medical care in Kosovo are intricately related, and it is not easy or effective to consider and implement individual direct measures for each issue. In this context, it is necessary to confirm and scrutinize the factors that hinder the continuous and stable implementation of policies by MOH and other related organizations in order to consider effective cooperation proposals that utilize Japan's technology, knowledge, and experience in the field of health care, while aiming to create synergy effects with support from international organizations and donors.

Table 8-1: Project Summary Table for the Project for Strengthening Secondary Health Care Facilities (Tentative)

1 Project Name	Project on Strengthening Capacity of Secondary Health facilities (Tentative)
2 Outline	
(1) Project Period	2022-2027
(2) Counterpart Organization	MOH, HUCSK, health facilities (about 3 secondary health facilities)
3 Project Overview	
(1) Overall Goal	The quality of and access to health sector services in Kosovo will be improved to help achieve UHC.
(2) Project Goal	The functioning of secondary health facilities will be strengthened.
(3) Outcome	1) The number of examinations using the installed medical equipment will be increased. 2) The number of surgeries and treatments in the established departments will increase. 3) Patient satisfaction will increase. 4) The number of refers from primary health facilities will increase, and the number of refers to secondary and tertiary health facilities will also increase.
(4) Project sites	MOH, HUCSK, Selected secondary hospitals
4. Necessity and positioning of cooperation	
(1) Current status and challenges	-It is becoming difficult for many secondary health facilities to provide essential health care services, including testing, due to the aging of equipment. -As a result, there are many cases where people do not respect the referral system and use UCCK[63]. -The scale of secondary health facilities varies, and due to the size of the country, "selection and concentration" is important, such as prioritizing the strengthening of general hospitals to serve as base hospitals. -On the other hand, since 80% of the deaths in Kosovo are caused by diseases related to non-communicable diseases (NCDs), it is important to take measures against NCDs. In Kosovo, 80% of the deaths are related to non-communicable diseases (NCDs).

[63] HUCSK said that UCCK would not refuse even if patients visit directly without a referral letter.

(1) Strengthening of secondary health facilities	1) Selection of base hospitals 2) Consideration of necessary medical departments 3) Planning and implementation of human resource allocation 4) Consideration of necessary equipment
(2) Support for countermeasures against NCD	1) Examination of non-communicable diseases to be treated at base hospitals 2) Planning and implementation of medical personnel deployment 3) Formulate action plans for the four major non-communicable diseases 4) Implementation of pilot projects 5) Verification of effectiveness
(3) Strengthen the diagnostic ability of physicians	1) Formulate a training program for physicians 2) Implementation of training programs 3) Implementation of country-specific training 4) Identification of future training needs 5) Formulate future human resource development
(4) Strengthening Referral System	1) Set up a forum for communication between MFMC and secondary health facilities and between secondary health facilities and UCCK 2) Conducting regular consultations 3) Establishment of a system to enhance the effectiveness of referrals 4) Verification of the functioning of referrals after the establishment of the base hospital
6. Project Process	

Source: the Survey Team

Table 8-2: Subject Specific Training Program (Tentative)

1 Project Title	Strengthening Social Health Protection Towards Universal Health Coverage
2. Outline of Cooperation	
(1)Project Period	2023-2025
(2)Counterpart Organization	HIF, MOH, HUCSK ＜Target Officials＞ 1) Section chiefs and officer of implementing organizations involved in the planning of policies and measures for the medical insurance system and health delivery 2) Administrative officials with at least three years of experience in the field of policy and measure making for the medical insurance system and medical care delivery system.
3. Outline	Japan achieved UHC in 1961, and has maintained UHC through a series of policy measures, including a system for collecting insurance premiums. Although the necessary measures for each country vary depending on the conditions, the policy measures taken by Japan to achieve and maintain UHC during the process of its economic growth and maturity can provide significant suggestions for countries facing similar challenges.
(1) Objective	Through Japan's knowledge and analysis of health policies in other countries, the capacity of government officials to build and operate systems to provide universal health coverage will be enhanced.
(2) Outcome	1) To understand what universal health coverage (UHC) is, and to learn the methods and conditions for achieving it. 2) To analyze the current status and challenges of policies and systems related to health care delivery systems and health care coverage in their own countries, and to share their understanding of the current status in other countries 3) To be able to explain the history of Japan's achievement of UHC and the social, economic, policy and administrative conditions that made it possible. 4) To be able to explain the challenges that Japan has faced in the past and present in maintaining UHC and how it has responded to them. 5) To be able to explain the characteristics of health care coverage in other countries and the differences between Japan and participating countries and their backgrounds. 6) To be able to analyze the challenges faced by one's own country and future responses based on the above, and to prepare a discussion note.
(3) Contents	1) WHO strategy for disseminating UHC 2) Introduction of trainee's own organization 3) Japan's medical supply system and medical insurance system 4) Quality control of medical care in Japanese hospitals 5) Medical management in medical institutions, including medical fees, medical fee claims and receipt billing 6) Medical fee claim billing at medical institutions 7) Economic evaluation of medical technology and medicines 8) Factors for the realization of universal health insurance system in Japan 9) Factors necessary for the realization of universal health insurance system in each country (discussion) 10) Inspection of activities of local governments (examples of regional comprehensive and insurance operations and regional cooperation, etc.) 11) Approaches to the quality of medical care 12) Public health and remote area medical system in Japan 13) Issues of Japan's insurance medical system 14) Strategies for the realization of UHC 15) Site visit of claim review 16) New coronavirus response and UHC 17) Preparation and presentation of discussion notes

Other	As a step after the above training, if there is a strong sense of awareness on the part of Kosovo towards the implementation of the health insurance system, there is room to consider implementing a project that envisages the following components. Support for strengthening the capacity of health insurance practices 1) Examination and preparation of benefit packages and lists 2) Examination and formulation of unit prices for medical fees and medicines 3) Examination of administrative procedures for medical cost 4) Study of HIS and claim review system 5) Create SOPs for the work under the jurisdiction of the department with future organizational expansion in mind 6) Plan to train necessary personnel for implementation 7) Pre-implementation coordination with relevant agencies (Department of Revenue, Department of Labor and Social Welfare)

Source: the Survey Team

Appendix 1:
Basic Information of Kosovo (detailed version)

Appendix 1 General Information about Kosovo (detailed version)

In this Chapter, the Survey Team organizes and confirm the details of basic information of Kosovo.

A.1.1 General Information

Kosovo is a landlocked country and located in the center of the Balkan Peninsula and it is almost in the center of South-East Europe. It is surrounded by Serbia in the northeast, North Macedonia in the southeast, Albania in the southwest and Montenegro in the northwest. It has a strategic position to connect Central Europe with South East Europe as well as provide an inland corridor between the Adriatic Sea and the Black Sea regions. It is a state occupying an area of 10,908 km2, with a population of approximately 1.78 million (2019, Kosovo Agency of Statistics) (its area and population are approximately equivalent to those of Gifu Prefecture). Surrounded by mountains, the country belongs to two different climatic zones: the South and the North of Kosovo. The South has a Mild Mediterranean climate characterized by hot and dry summers and mild and rainy winters; while the North is characterized by European Continental Climate affected from the northwest such as the Mediterranean Sea and the Alps. The climate is characterized by hot summers and cold winters, and the temperature sometimes reaches over 30°C in summer seasons and below −10°C in winter seasons.

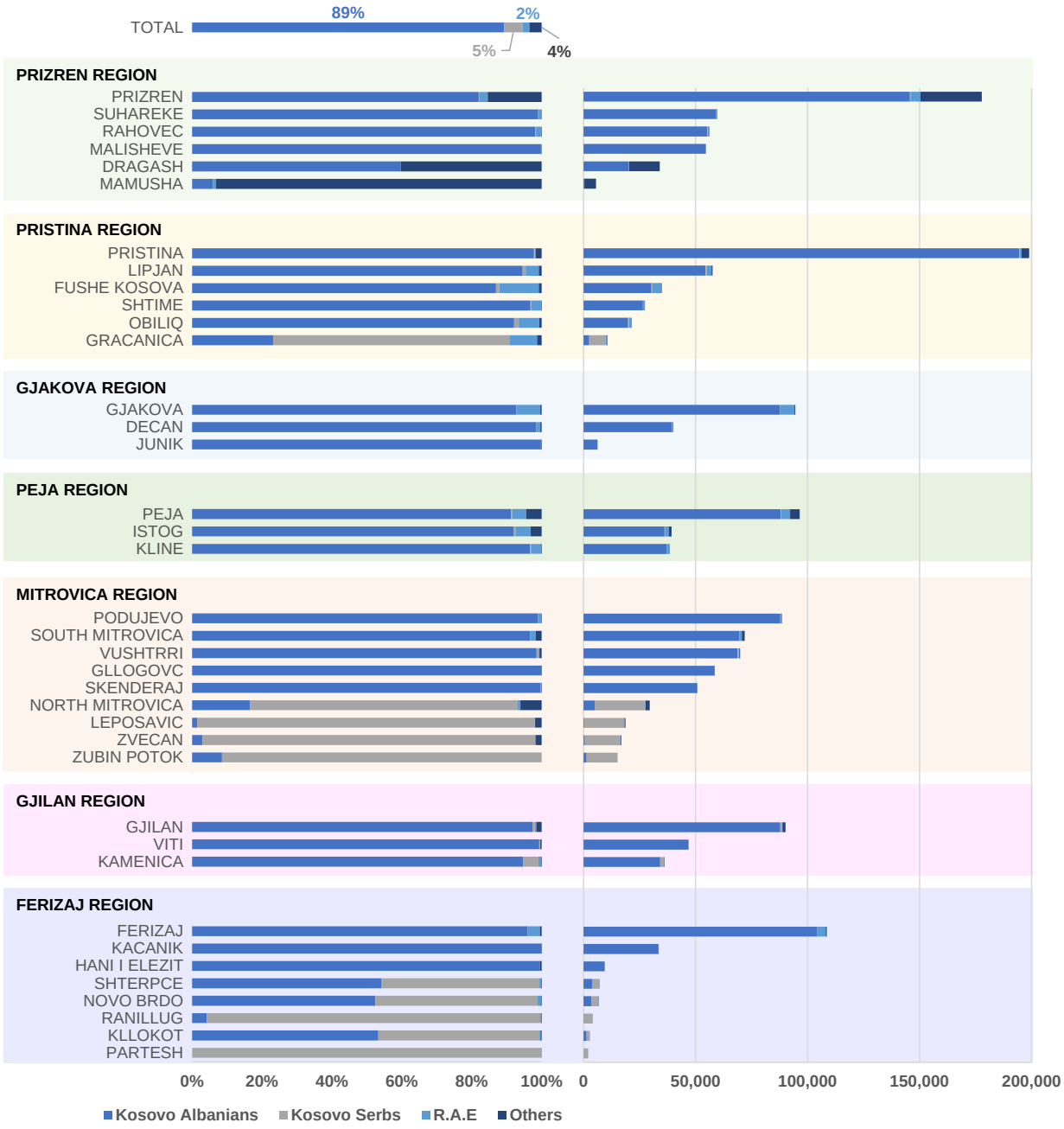
Kosovo is divided into 7 districts, an increase in the number of districts by two following an administrative reform suggested by the United Nations Interim Administration Mission (hereinafter, UNMIK) in 2000. The districts are further subdivided into 38 municipalities. The largest and most populous district is Pristina, including the capital city Pristina.

The major ethnic groups in Kosovo are Albanians (89%), followed by Serbs (5%) and other ethnic groups, including Bosniaks and Turks (4%), and Romani, Ashkali and Egyptian (RAE, 2%). Both Albanian and Serbian are official languages of Kosovo. Islam is the most widely practiced religion in Kosovo (Albanians), followed by Easter Orthodox Christianity (Serbians)

Kosovo is a partially recognized state in Southeastern Europe. The United Nations Interim Administration Mission (hereinafter, UNMIK) was established in 1999 and in 2008 the Assemble of Kosovo adopted the declaration of independence. International recognition of Kosovo, since its declaration of independence from Serbia in February 2008 following the conflicts in the 1990s, has been mixed. The number of states that recognize Kosovo's independence (approximately 100 states, as of September 2020) have risen to nearly 100 and the country expressed its willingness to join various intergovernmental organizations, such as the United Nations and the EU. Kosovo joined the World Bank and the International Monetary Fund (hereinafter, IMF) in 2009 and also established diplomatic relations with Japan.

Source: The Survey Team created based on Ezilon.com (https://www.ezilon.com/maps/europe/kosovo-maps.html)

Figure A-1: Map of Kosovo



Source: Municipal Profiles 2018 (OSCE, 2018)

Figure A-2: Ethnic Composition by Municipalities

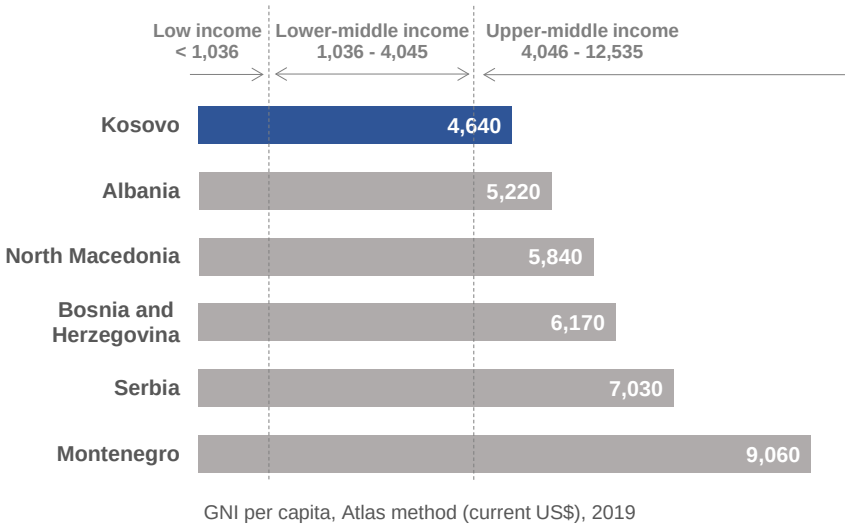
A.1.2 Economy and Industry

This section explores the economic situation of Kosovo, its industry and the economic sectors by studying major macroeconomic indicators and other social indicators including employment and poverty levels.

A.1.2.1 National income level and economic growth

The per capita gross national income (GNI per capita, Atlas method) in 2019 stood at 4,640 dollars in Kosovo which was lowest among its neighbors (Figure A-3). Kosovo was upgraded from lower-middle income to upper-

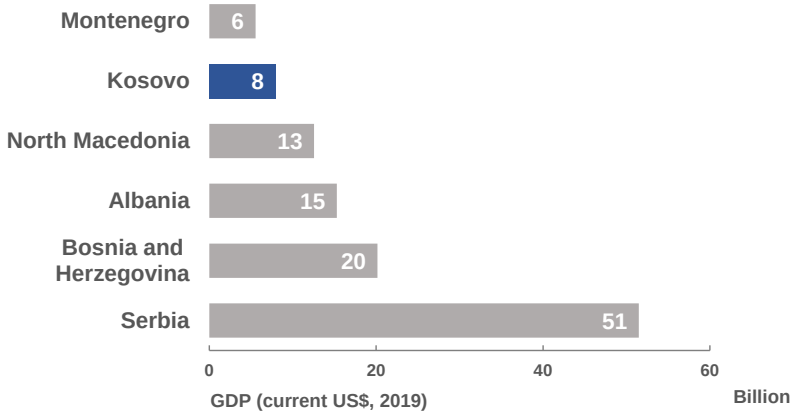
middle income country in the World Bank's country classifications by income level in July 2019 and the living standard of the people is gradually improving. Regardless the economic development achieved, GNI per capita, in PPP terms (purchasing power parity) (2019) remains at one fourth of the EU average, thus challenging further comparative economic growth.



Source: World Development Indicators

Figure A-3: GNI per Capita (2019, Atlas method, current US$)

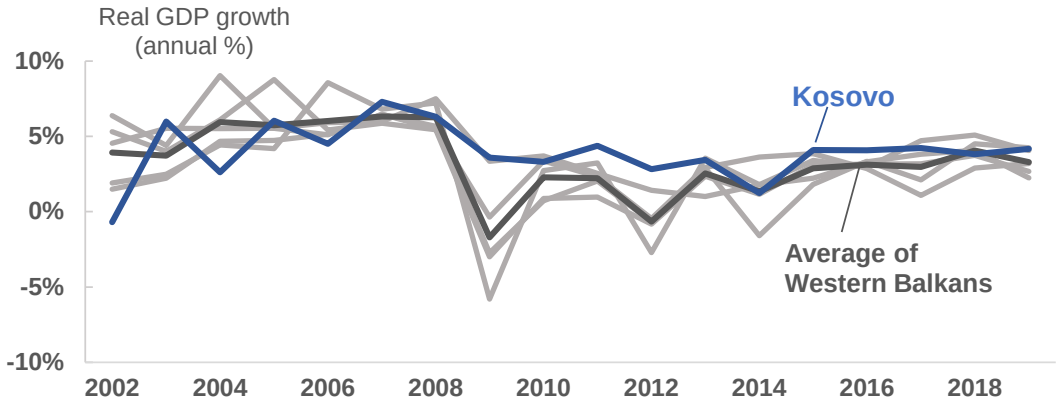
The Gross Domestic Product (GDP) value of Kosovo was worth approximately 8 billion US dollars (approximately 840 billion yen) in 2019, the second smallest in the Western Balkans (Figure A-4). As a comparison the Gross Prefectural Domestic Product of Tottori Prefecture, that is the smallest among Japanese prefectures was 1.8967 trillion yen (FY 2017), thus the GDP of Kosovo is less than half of Tottori Prefecture. In addition, summing up the GDPs of the six Western Balkans countries (Kosovo, Albania, Bosnia and Herzegovina, Montenegro, North Macedonia and Serbia), the regional GDP, representing a regional population of cc. 17.6 million people would total at approximately 112.9 billion dollars (approximately 11.8545 trillion yen; approximately equivalent to the Gross Prefectural Domestic Product of Hiroshima Prefecture [11.7908 trillion yen, FY 2017])



Source: World Development Indicators

Figure A-4: Gross Domestic Product (GDP) (2019, current US$)

In terms of economic growth, GDP growth of Kosovo averaged 3.9% between 2002-2019 which was moderately above the average GDP growth rates of the Western Balkans region (Figure A-5). In addition, Kosovo and Albania suffered little by the global financial crisis in 2008. It is thought that this stability was not because these two countries remained firm during the financial crisis, but rather it was due to the following two factors: on the one hand the economy of these countries was not so strongly connected to the global market due to their low export dependency (described below) and on the other hand their consumption-led economic structure was strongly supported by cash remittances from migrant workers.

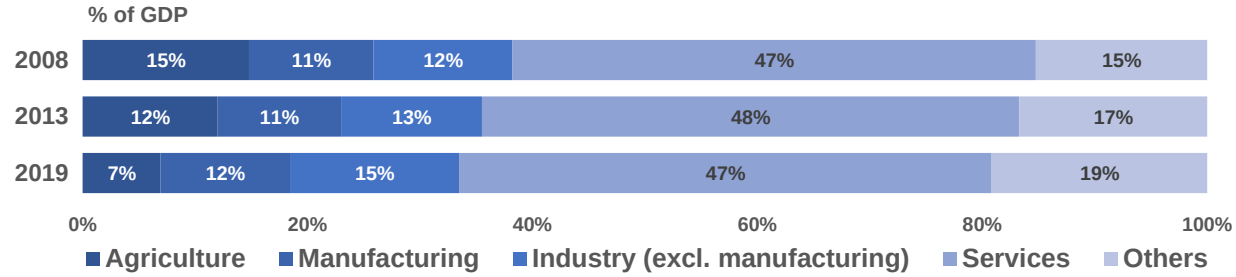


Source: World Development Indicators

Figure A-5: Real GDP growth

A.1.2.2 Industrial structure

The last decades has not shown large scale structural changes in the industrial structure of Kosovo. Figure A-6 shows changes in the share of economic sectors in GDP in the country. From 2008 through 2019, while the ratio of agriculture, forestry, and fisheries contributing to GDP gradually decreased from 15% to 7%, the ratio of industry and services have little increase.

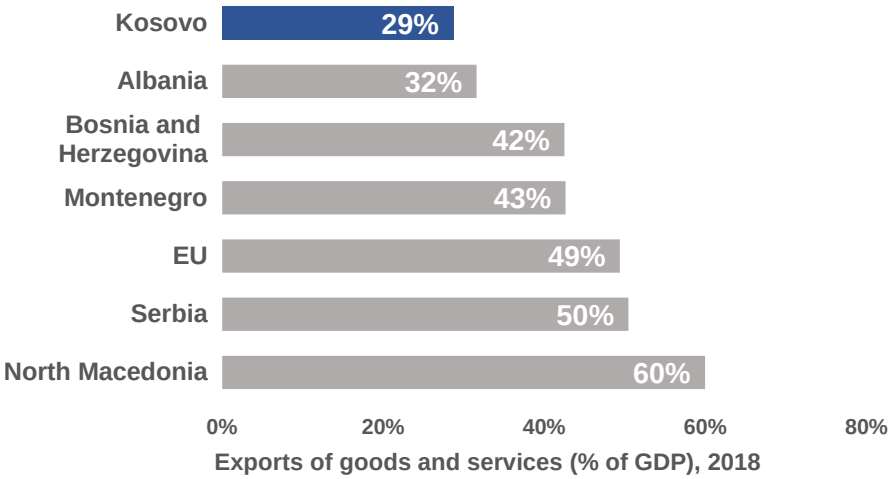


Source: World Development Indicators

Figure A-6: Industrial Structure as Percent of GDP

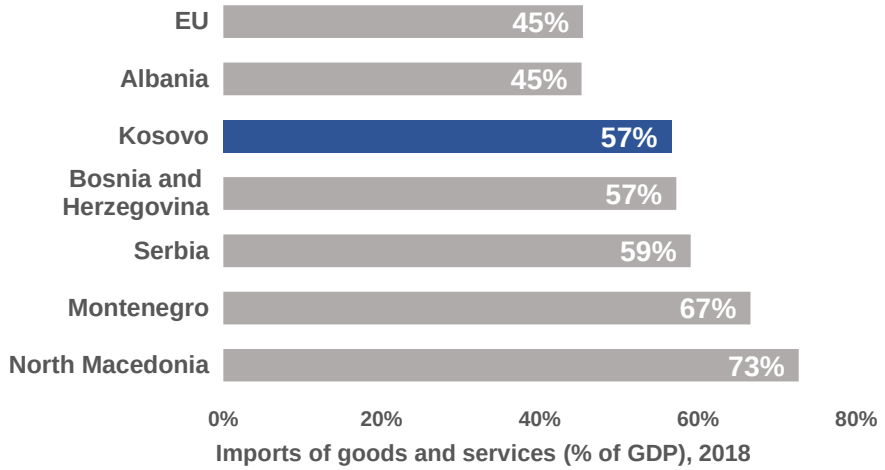
A.1.2.3. Trade

The trade balance of Kosovo suggests that the growth of major industries may be insufficient to counterbalance imported goods and services. Figure A-7 shows the value of export of goods and services as percent of GDP (export dependence). There is a global understanding that the higher the export dependency of a country the more advanced its economy is. Export dependency ratio of Kosovo was 29% in 2018, being the lowest level among the Western Balkans countries. On the other hand, imports of goods and services (% of GDP) was reported the second lowest after Albania among Western Balkans states (Figure A-8). All six Western Balkans states recorded a trade deficit, and Kosovo ranked highest in this respect (% of GDP). Trade deficit has been present for a long period of time (See Figure A-9 for the past 10 years).



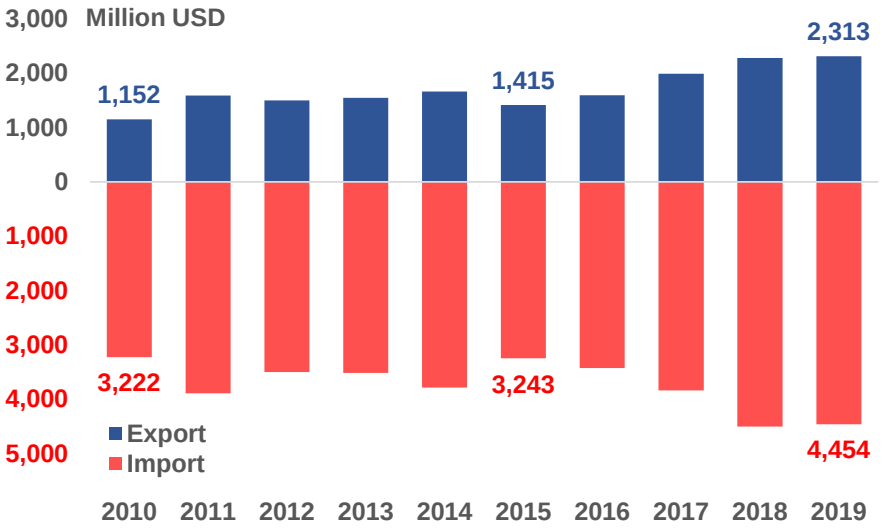
Source: World Development Indicators

Figure A-7: Export of Goods and Services as Percent of GDP (export dependence) (2018)



Source: World Development Indicators

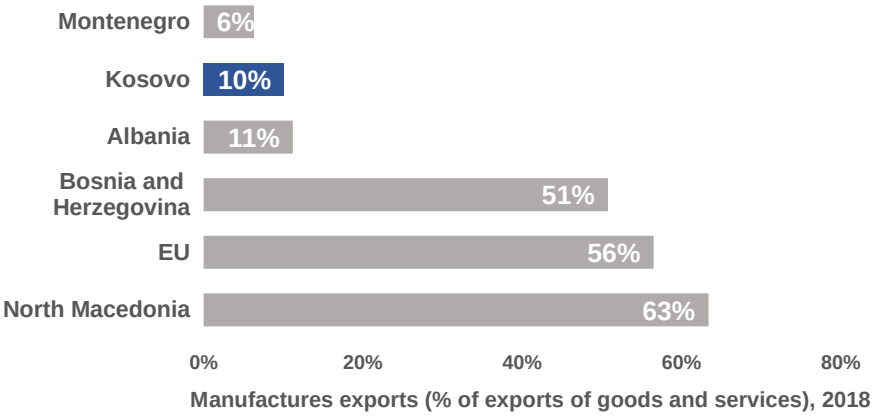
Figure A-8: Import of Goods and Services as Percent of GDP (2018)



Source: World Development Indicators

Figure A-9: Trend of Export and Import of Goods and Services

Figure A-10 shows the share of manufactured products in exports of goods and services (% of manufactured products in total exports). This ratio is thought to be an indicator of industrialization and generally tends to increase with industrialization. In 2018 ratio of manufactured export was 10% in Kosovo, comparable to those of Montenegro and Albania.

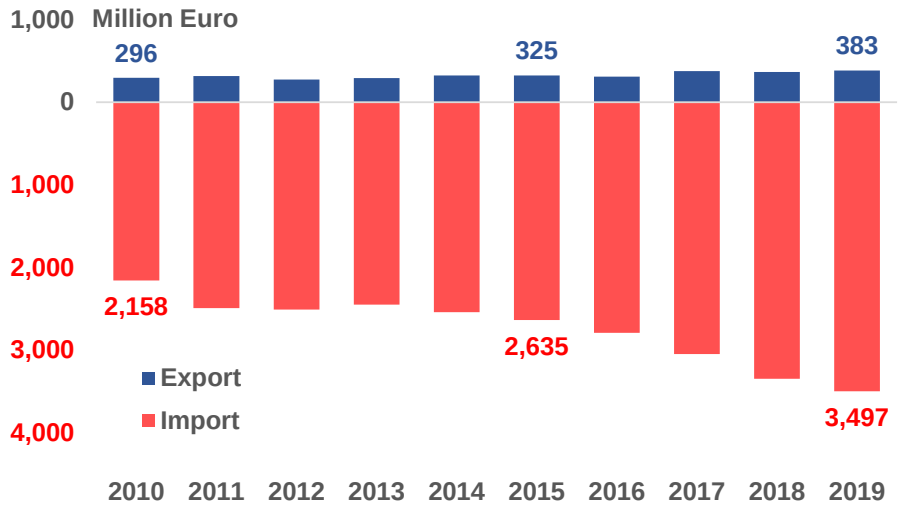


Source: World Development Indicators

Figure A-10: Ratio of Manufactured Exports in Exports of Goods and Services (2018)

Figure A-12 shows the changes in trade in goods in Kosovo for the past 10 years, while

Table A-1 and Table A-2 show the changes in the top 5 items of merchandise exports and merchandise imports, respectively. During this period the annual growth rate of merchandise exports remained at 3%. In addition, although its amount tends to decrease, steel has accounted for more than half of merchandise exports in 2010 and it still ranked first in export of goods even in 2019. In terms of other items, the exports of plastic products and the like tend to increase, but none of these items have reached the scale that is considered to be a major export item. On the other hand, the scale of imports is larger than that of exports, and the amount is growing at an annual rate of 6%.



Source: Kosovo Agency of Statistics

Figure A-11: Changes in Merchandise Trade

Table A-1: Top 5 Items of Merchandise Export

(Unit: Million EUR)

	2010		2015		2019	
	Item	Amount	Item	Amount	Item	Amount
1	Iron and steel	159	Iron and steel	116	Iron and steel	75
2	Ores, slag and ash	28	Mineral fuels, mineral oils	23	Plastics	48
3	Copper	12	Plastics	19	Articles of iron or steel	34
4	Mineral fuels, mineral oils	11	Articles of iron or steel	19	Beverages, spirits, and vinegar	29
5	Raw hides and skins	10	Ores, slag and ash	16	Ores, slag and ash	22
Total		296		325		384

Source: Kosovo Agency of Statistics

Table A-2: Top 5 Items of Merchandise Import

(Unit: Million EUR)

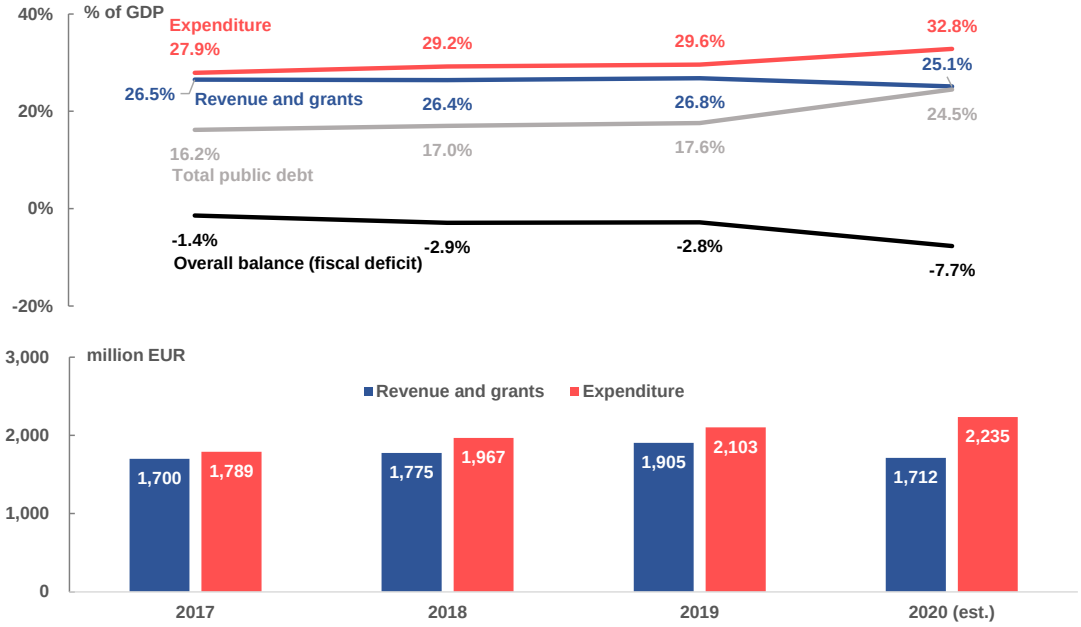
	2010		2015		2019	
	Item	Amount	Item	Amount	Item	Amount
1	Mineral fuels, mineral oils	339	Mineral fuels, mineral oils	337	Mineral fuels, mineral oils	453
2	Nuclear reactors, boilers, machinery, and mechanical appliances	188	Nuclear reactors, boilers, machinery, and mechanical appliances	178	Vehicles other than railway or tramway	315
3	Vehicles other than railway or tramway	140	Vehicles other than railway or tramway	164	Nuclear reactors, boilers, machinery, and mechanical appliances	269
	Electrical machinery and equipment	111	Plastics	139	Iron and steel	208
5	Iron and steel	101	Electrical machinery and equipment	132	Plastics	189
Total		2,158		2,635		3,497

Source: Kosovo Agency of Statistics

Changes in industrial and trade structure should be analyzed in more detail. However, it is clear from the presented previous data that the ratio of exports (as % to GDP) is low, and its growth rate is slow. From this analysis it seems probable that in Kosovo, import substitution has not been progressing adequately not only for heavy industrial products, such as capital goods and consumer durables, but neither for nondurable consumer goods, nor light industrial products. Kosovo has a private consumption-led economic structure that is dependent on cash remittances from migrant workers.

A.1.2.4 Finance

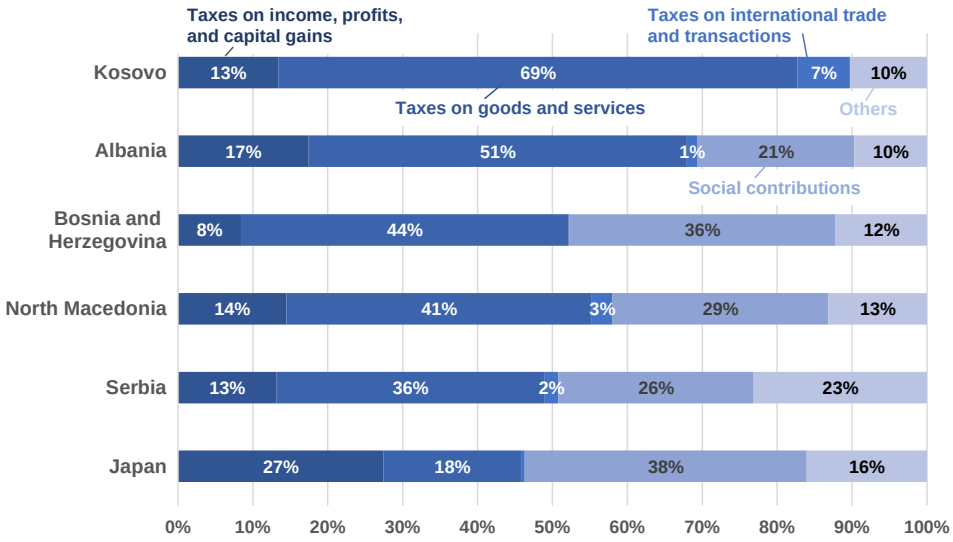
Figure A-12 shows changes in basic fiscal data: in government gross revenue and expenditure (lower section of the figure) as well as the fiscal balance and level of public debt (as % of GDP) (upper section of the figure). The fiscal deficit of Kosovo has been growing in recent years and it is expected to soar to 7.7% of GDP due to a significant decrease in tax revenues caused and large-scale financial support measures necessitated by the COVID-19 pandemic.



Source: Staff Report for the 2020 Article IV Consultation (IMF, 2021)

Figure A-12: Basic Fiscal Data

Figure A-13 shows the comparative revenue breakdown of Western Balkans states in 2019 (Note that Montenegro is excluded since its data were not obtained, as EU average data were neither obtained. Instead, data from Japan are included as reference). Revenues from sales taxes (including VAT) within the Kosovo government budget stands as high as 69%, while revenues from social insurance premium are 0%. There is a need to closely investigate the whether the administrative underpinnings are appropriate to perform the management of insured persons and the collection of premiums in Kosovo.

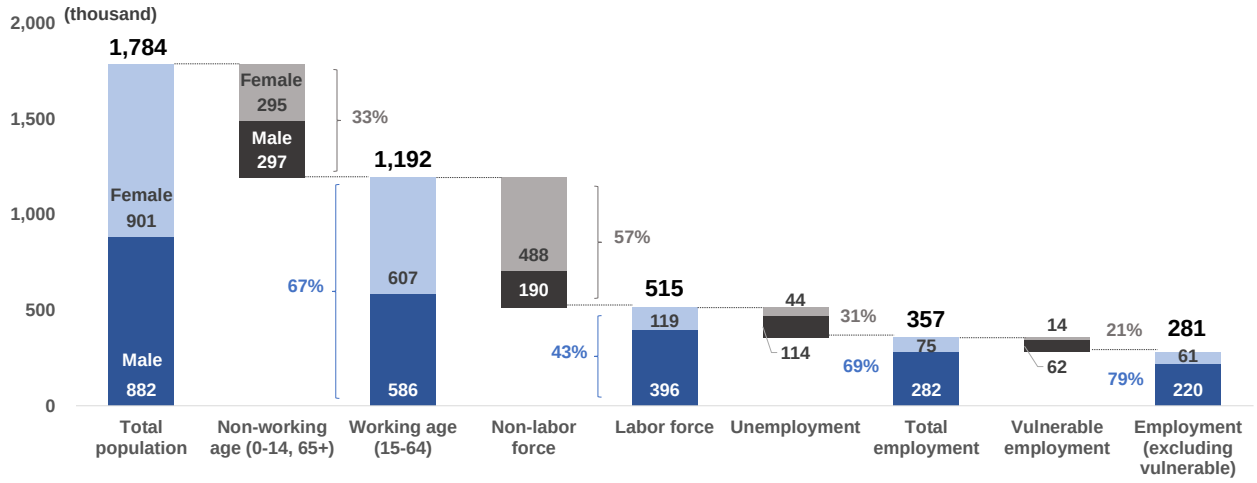


Source: Government Finance Statistics (IMF)

Figure A-13: Comparative Revenue Breakdown of Western Balkans (2019)

A.1.2.5 Employment

The employment status also needs to be examined since it is closely related to economic and industrial development of a country. Figure A-14 shows basic demographic data including total population, working age population, labor force population, the number of employed people and employment rate in Kosovo in 2017.



Source: Kosovo Agency of Statistics

Figure A-14: Population of Working age, Labor force, Employment (2017)

The total population of Kosovo in 2017 was 1.784 million people (882,000 men and 901,000 women), out of which 1.192 million people (586,000 men and 607,000 women) 67% of total population belonged to the working age group. Only 515,000 people, 43% of working age population were active (labor force population). The remaining 57%, 678,000 people were economically inactive. Within the economically active population, only 357,000 people are employed, thus unemployment rate was as high as 31%. Employed people were also encountering insecurity: 21% of them were in unstable forms of employment[64], while 70% of the were in temporary employment.

As a comparison the percentage of active population within the active age population (between 15 and 64 years old), thus the level of labor market participation rate in other countries are as follows: 80% in Japan 74% in the EU; 73% OECD average; 67% Croatia; and 66%. in North Macedonia.

Thus, Kosovo's employment rate at 43% is extremely low and it is even worse for women. Although women's social status is advancing in the country, there are many factors behind this low level of employment activity: on the one hand the number of women who go from the Balkans to Western European countries to seek employment and work opportunity has been increasing in recent years, while on the other hand also patriarchal traditions affect women's life choices.

Although statistical definitions and standards used by the Kosovo Agency of Statistics to survey the labor force

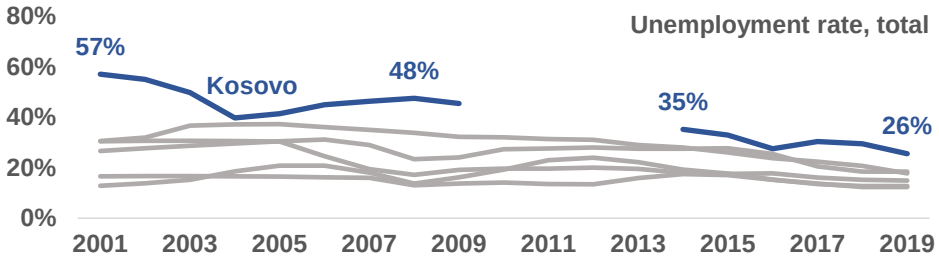
[64] Sole proprietors and family workers who contribute to their family business

population could also add to these numbers, even after reviewing definitions and revising upward the labor force population, it will be quite unlikely that this revision will lead to an upward revision of the number of employed persons (it is quite unlikely that persons who were counted as the non-labor force population were actually employed persons, and most of them may probably be counted as an unemployed person). In other words, the potential unemployment rate may rather be higher than the reported 31%.

In addition, the size of the working age population is decreasing at an accelerated rate because of the work related outmigration to foreign countries. As described above, the large amount of cash remittance from migrant workers (more than 10% as a percentage of GDP) suggests that the international labor movement is progressing, also due to the fact that no major industries are growing. As a consequence, no industries are growing because there is a lack of skilled labor due to the outmigration. This downward spiral may be a hindrance to Kosovo's economic growth[65].

In Kosovo, with a low level of active labor market participation, the percentage of persons who are in temporary and other unstable forms of employment is high. This uncertainty coupled with an industrial infrastructure only modestly supporting economic growth leads to reduced ability of people to contribute to insurance premiums, who are struggling to make ends meet. Thus, even if they are imposed, it may be actually impossible to collect insurance premiums.

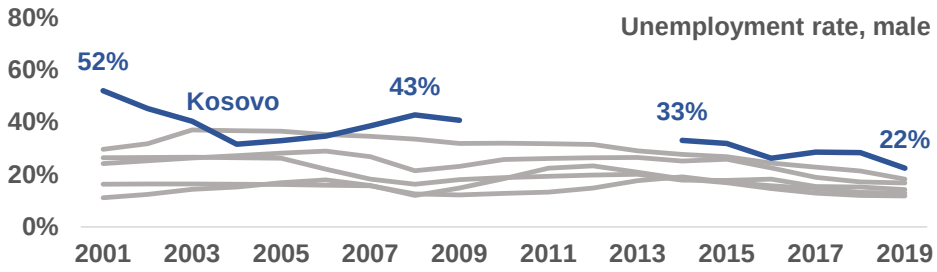
Focusing on unemployment in more detail Figure A-15, Figure A-16 and Figure A-17 present changes in the unemployment rate of Kosovo compared with those of other Western Balkans countries. Although there are some missing data, the unemployment rate of Kosovo has been gradually decreasing for the past 10 years. Nevertheless, this ratio remains among the worst in the region. In particular, the unemployment rate of women in Kosovo is outstandingly high.



Source: World Development Indicators

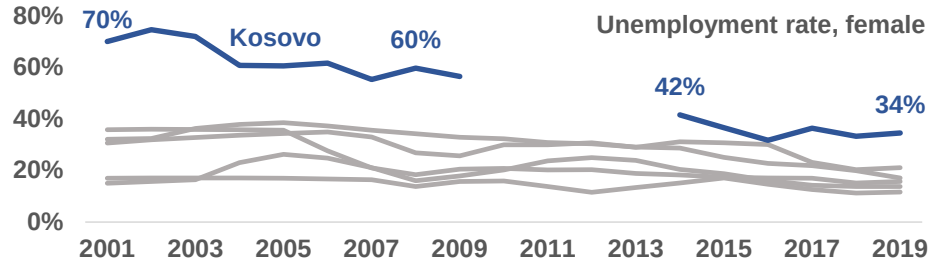
Figure A-15: Changes in Unemployment Rate (total)

[65] Economic growth is extremely important as a fundamental factor to achieve universal health coverage. When Japan established a universal health insurance system in 1961, labor supply was abundant, e.g., the first baby boomers entered the working age population. Thus, high economic growth began around 1955, and "doubling national income plan" formulated in 1960 (the plan to double national income per capita in 10 years) was also achieved a few years ahead of schedule. Fortunately, Japan experienced such a remarkable economic growth. This promoted the achievement of universal health insurance system (UHC by the social insurance system) (Shimazaki, 2014).



Source: World Development Indicators

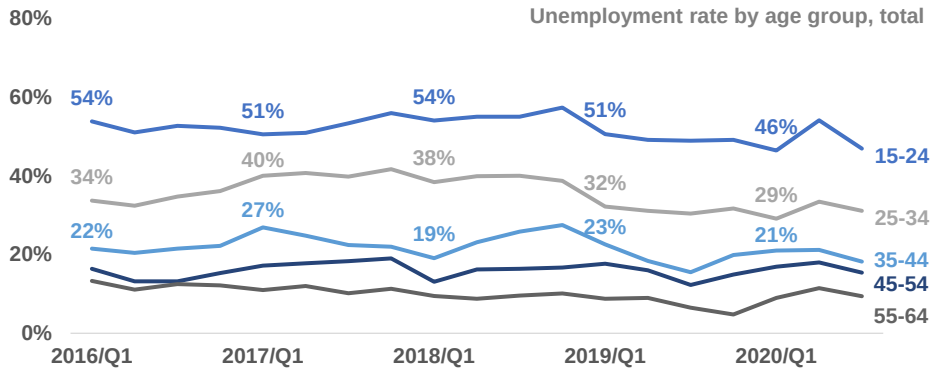
Figure A-16: Changes in Unemployment Rate (male)



Source: World Development Indicators

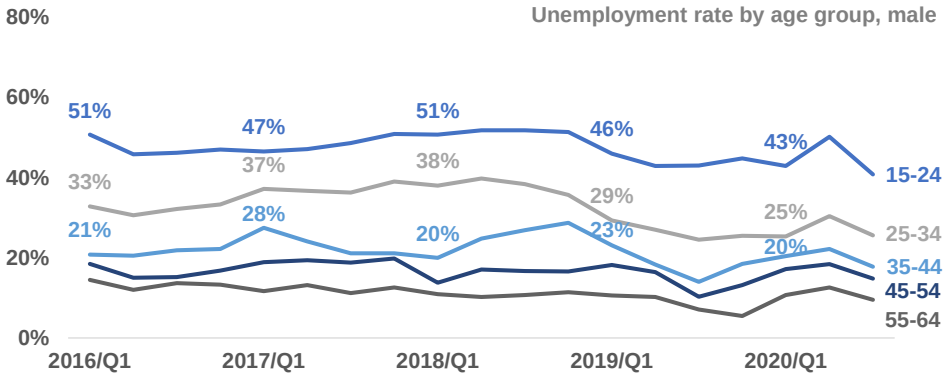
Figure A-17: Changes in Unemployment Rate (female)

Figure A-18, Figure A-19 and Figure A-20 show the changes in the unemployment rate by age group in Kosovo between 2016 and 2020. It is worth noting the high levels of youth unemployment. In particular, the unemployment rate among women aged between 15 and 24 years soars around 60% in recent years, which is extremely high.



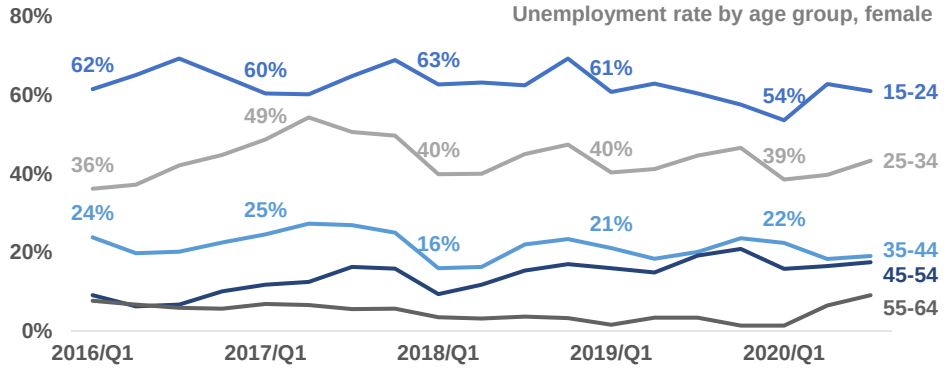
Source: Kosovo Agency of Statistics

Figure A-18: Changes in Unemployment Rate (by age group, total)



Source: Kosovo Agency of Statistics

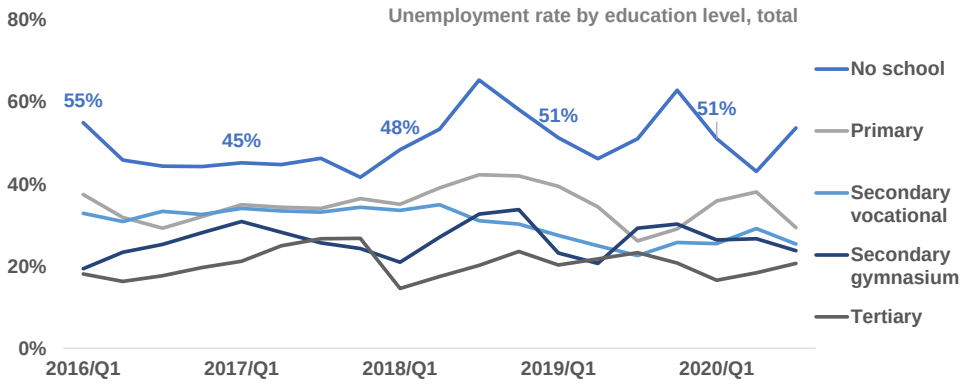
Figure A-19: Changes in Unemployment Rate (by age group, male)



Source: Kosovo Agency of Statistics

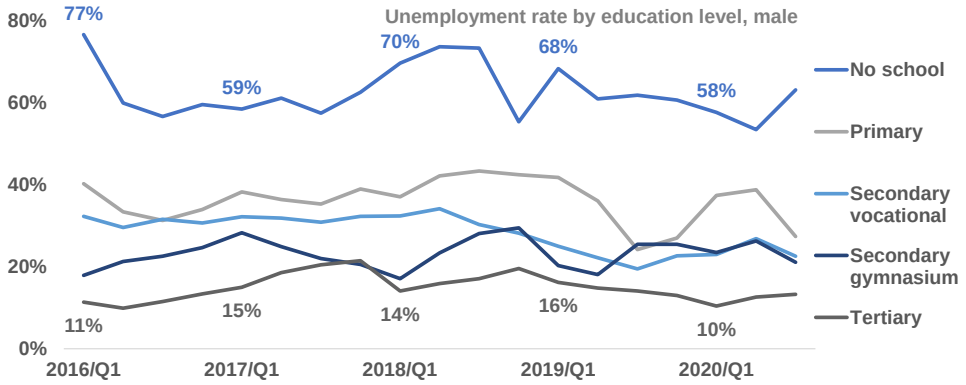
Figure A-20: Changes in Unemployment Rate (by age group, female)

Figure A-21 shows the changes in the unemployment rate by education level between 2016 and 2020. On the whole, a higher education level is associated with a lower unemployment rate, which relation is an expected outcome. On the other hand, in the case of women, the relation between education levels and unemployment rates is not necessarily unequivocal. In addition, although the Survey Team cannot draw conclusions due to limited available data, the Survey Team presume that the unemployment rate may also be affected by seasonal factors, e.g., the unemployment rate tends to increase sharply in the fourth quarter among women who cannot complete their primary education.



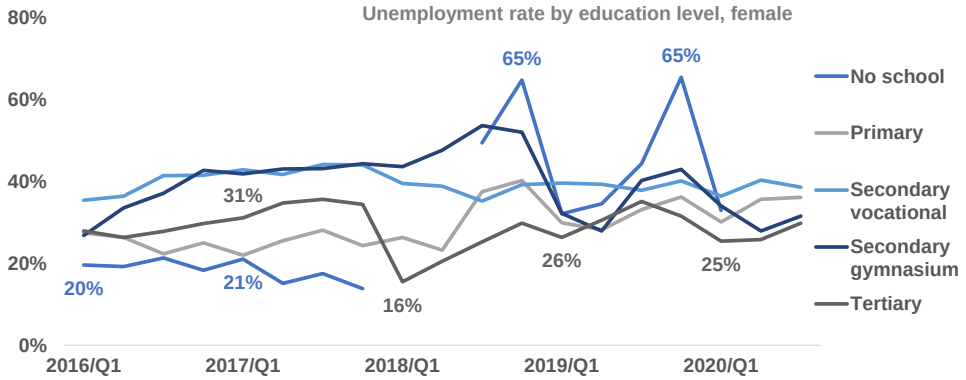
Source: Kosovo Agency of Statistics

Figure A-21: Changes in Unemployment Rate (by education level, total)



Source: Kosovo Agency of Statistics

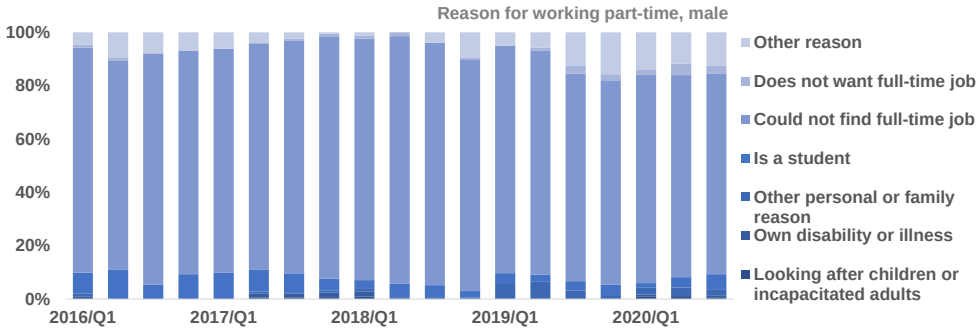
Figure A-22: Changes in Unemployment Rate (by education level, male)



Source: Kosovo Agency of Statistics

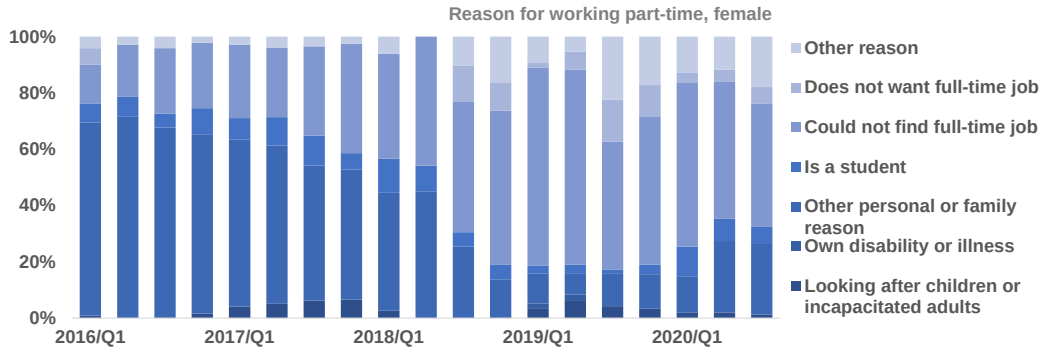
Figure A-23: Changes in Unemployment Rate (by education level, female)

Figure A-24 and Figure A-25 show reasons and decisions why people opt for part-time employment. From the figures it is clear that for most men, the reason for choosing part time employment is a lack of full-time employment opportunity, thus they choose part time jobs as a necessity. Whereas women have more diverse reasons for their decisions, including "other personal or family reasons" and "other reason".



Source: Kosovo Agency of Statistics

Figure A-24: Reasons why People Opt for Part-time Employment (male)

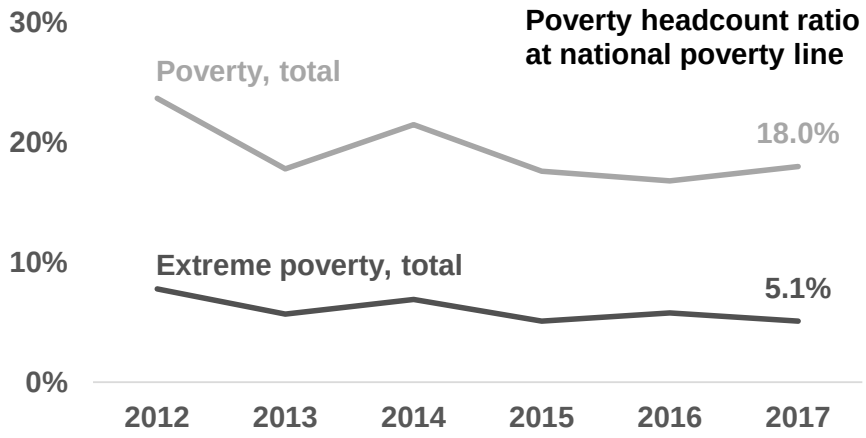


Source: Kosovo Agency of Statistics

Figure A-25: Reasons why People Opt for Part-time Employment (female)

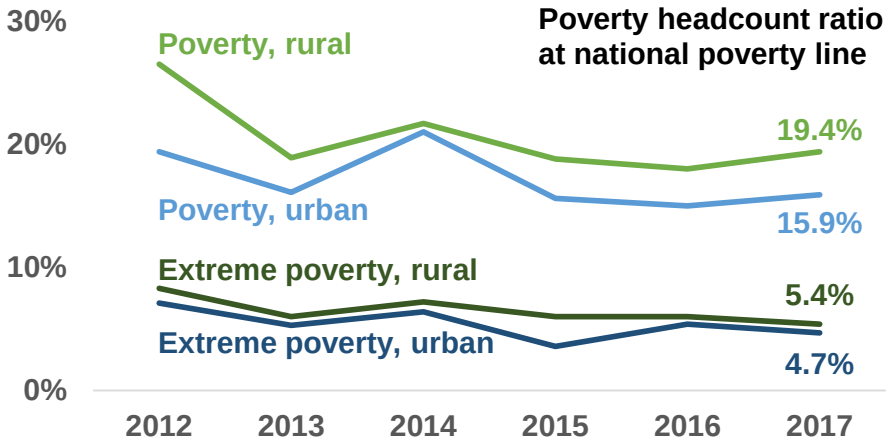
A.1.2.6 Poverty

Kosovo is one of the poorest countries in Europe. Absolute poverty (a condition where income or expenditure is below a certain level to purchase the minimum required food and other necessities) has been a challenge in Kosovo. In this analysis the Survey Team uses poverty indicators based on the national poverty line established/set by the Government of Kosovo based on the Household Budget Survey. Figure A-26 shows changes in the poverty rate published by the Kosovo Agency of Statistics. Nationally approximately 18% of the people (approximately 1 in 5 people) lived below the poverty line (1.85 EUR per day), and approximately 5% (approximately 1 in 20 people) lived below the extreme poverty line (1.31 EUR per day) in 2017. In both standards, the poverty rate in rural areas is higher than that in urban areas, and the gap between urban and rural areas has been growing.



Source: Kosovo Agency of Statistics

Figure A-26: Changes in Poverty Rate (national level)

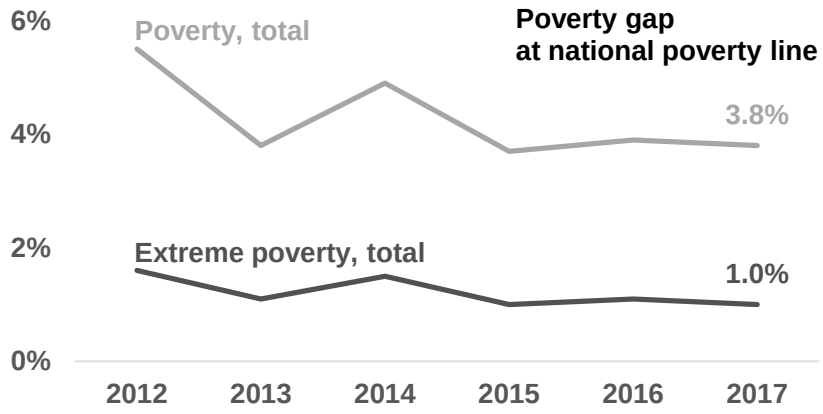


Source: Kosovo Agency of Statistics

Figure A-27: Changes in Poverty Rate (by urban and rural)

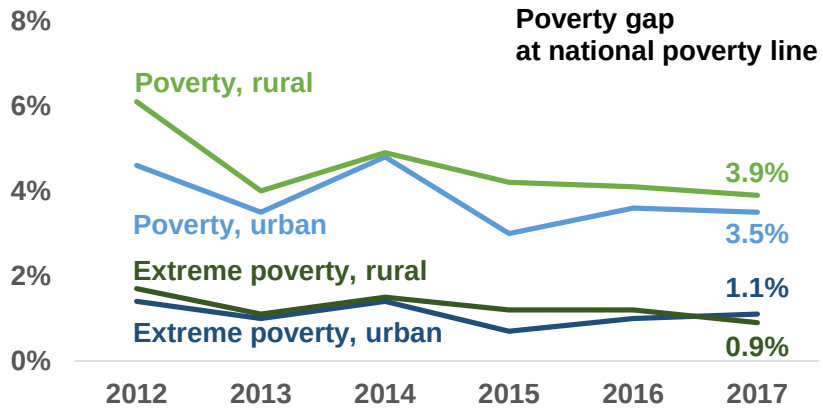
Figure A-28 shows changes in the poverty gap at national poverty line and extreme poverty line, published by the Kosovo Agency of Statistics. While the poverty rate shows the number of people living in poverty, the poverty gap index explains the "depth" of poverty. It is defined as the average poverty gap in the population as a proportion of the poverty line, thus measuring the extent to which individuals fall below the poverty line (the poverty gaps) as a proportion of the poverty line. The poverty gap indexes are useful indicators to support policy making focusing on the poorest people who could left out of support if only the sheer numbers of poor people were taken into consideration.

Disparity between urban and rural areas also shown in the poverty gap. However, there is a slight ray of hope since the poverty gap as a proportion of the extreme poverty line was slightly closing according to 2017 data. The reasons such as the social, economic transformations influencing the poverty gap should continuously be studied and analyzed.



Source: Kosovo Agency of Statistics

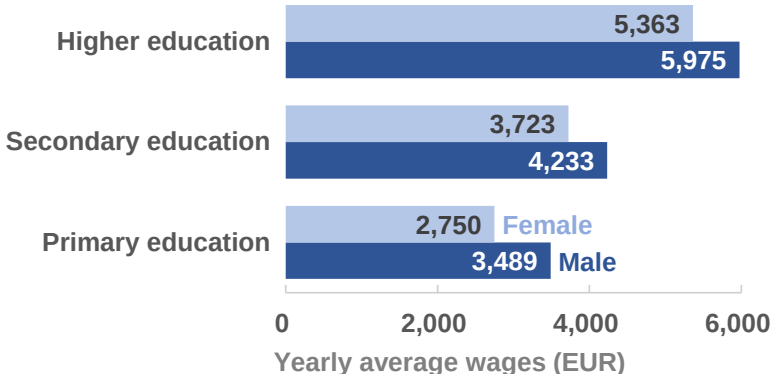
Figure A-28: Changes in Poverty Gap (national level)



Source: Kosovo Agency of Statistics

Figure A-29: Changes in Poverty Gap (by urban and rural)

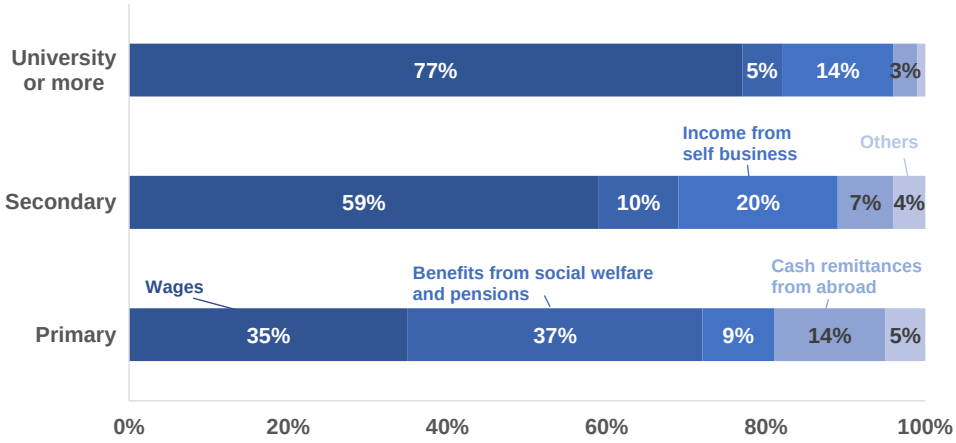
Life chances and income levels are not only affected by the geographical areas people live, i.e., urban or rural areas but also by educational attainment. Figure A-30 shows the average annual income by education level and by gender in 2017. For both men and women, a higher education level is associated with a higher average annual income. However, the average annual income of women is lower than that of men in each education level. The wage gap is closing as educational level rises, or put it otherwise: the lower the educational attainment, the bigger the gender wage gap is, thus the gender wage gap at higher education level is 11%, for those with secondary education it is 14% and for those with only primary education it is 27%.



Source: Kosovo Agency of Statistics

Figure A-30: Average Annual Income (2017, by education level and by gender)

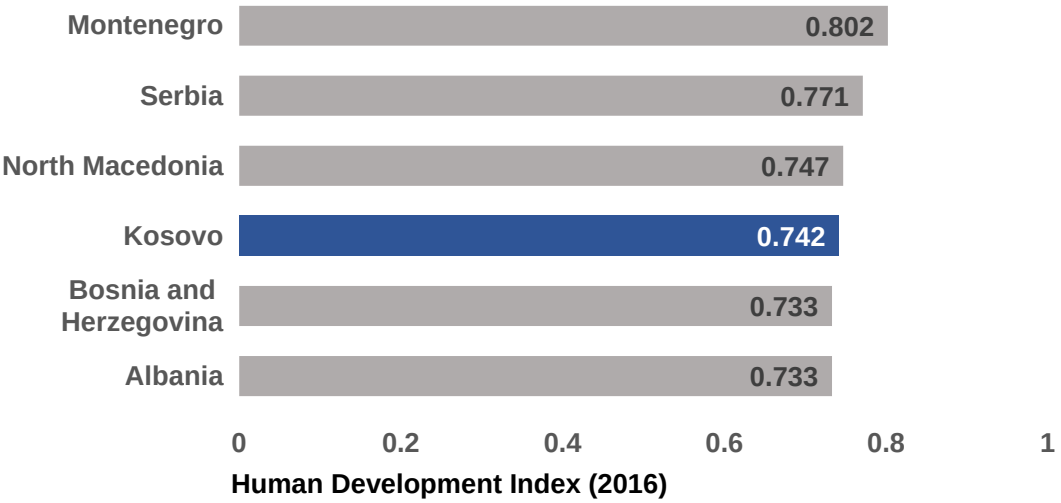
Figure A-31 shows main sources of income by education level. The tendency in this regard is that people with higher educational attainment tend to rely more on wages and salaries as their main source of income. The percentage of income from wages and salaries is 80% for those who received University education or higher, a little over 50% for those who received secondary education, and around 20% for those who received only primary education. Within this it is an important to note that for 30% of those people with only primary education their main source of income is benefits from social welfare or pensions and 15% of them are dependent on cash remittances from abroad, which is also considerable.



Source: Kosovo Agency of Statistics

Figure A-31: Main Sources of Income (2017, by education level)

It is also important to consider the Human Development Index (hereinafter, HDI) which is a composite measure of average achievement in key dimensions of human development (1. average life-expectancy, 2. education [enrollment rate, adult literacy rate], and 3. living standards [real GDP per capita]). This is to counterbalance sole monetary considerations. Figure A-32 shows the HDI of Kosovo and other Western Balkans states in 2016. The HDI is classified into the following four categories according to the standards of the United Nations Development Program (UNDP): low HDI countries (less than 0.550), medium HDI countries (0.550 to 0.699), high HDI countries (0.770 to 0.799), and very high HDI countries (0.800 or higher). Kosovo and most of the other Western Balkans states fall under high HDI countries, while Montenegro classifies as very high HDI country.

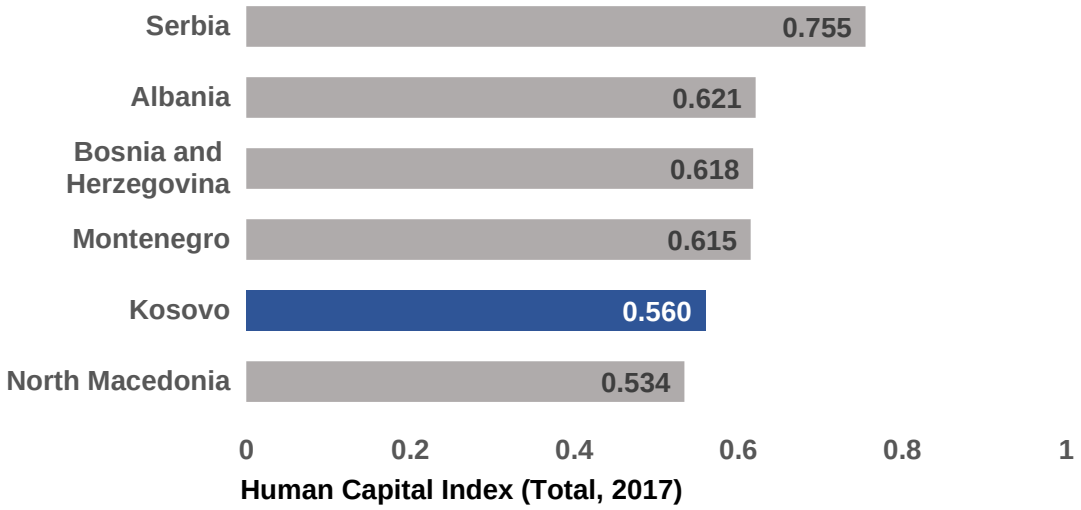


Source: UNDP

Figure A-32: Human Development Index (2016)

Another composite indicator is the Human Capital Index (hereinafter, HCI). Figure A-33 provides a regional comparison of the Human Capital Index (hereinafter, HCI) published by the World Bank in 2018. The HCI is an index based on the composition of three dimensions (1. child survival rate, 2. education and knowledge [quantity and quality of education], and 3. health and hygiene [nutritional conditions of children and adult survival rate])

and has values between 0 and 1 similar to that of HDI indicator. The HCI database provides data at the country level for amount of human capital that a child born today can expect to attain by age 18, given the risks of poor health and poor education that prevail in the country where she lives. The index assesses learning and employment outcomes across 5 distinct age groups on a scale from 0 to 1. For example, if a country's HCI is 0.6, it means that children in that country can display only 60% of their productivity capital, compared with an ideal situation where education and health care are sufficiently provided. The HCI of North Macedonia is the lowest while that of Kosovo is the second lowest among the Western Balkans states.



Source: World Development Indicators

Figure A-33: Human Capital Index 2017

A.1.3 Overview of Political Situation

This section briefly gives an overview of Kosovo's politics. To investigate health care related policy and administration issues as well as support and cooperation mechanisms in this field, it is also important to carefully analyze not only economic but also political and historical circumstances.

Firstly, the Survey Team gives a historical overview of Kosovo in the following table. Kosovo and other Western Balkans states have a country- and region-specific history as follows: 1) the influence of Islam through the Ottoman Empire which ruled and governed the region for more than 400 years from the middle ages to the modern ages; 2) the influence of the Yugoslav period, from the establishment of Yugoslavia from the end of World War II, represented by socialism and collectivism; and 3) the influence of the Kosovo War in the late 1990s.

Table A-3: Summary History of Kosovo

Year/Month	Summary history
1389	Serbia loses to Ottoman Turkey in the Battle of Kosovo.
1913	Serbia recaptures Kosovo after victory over Turkey in the Balkan Wars.
1945	Socialist Federal Republic of Yugoslavia (consisting of six republics) is established.
1974	With the revision of the Yugoslav constitution, Kosovo gained significant autonomy.
1981	Riots broke out by ethnic Albanians demanding that the autonomous province of Kosovo be elevated to the status of a republic.
1989	Conflict between Albanian and Serb populations deepen, and Kosovo's autonomy is drastically reduced.
1990	Albanian residents organize an armed group, the Kosovo Liberation Army (KLA), and begin armed struggle.

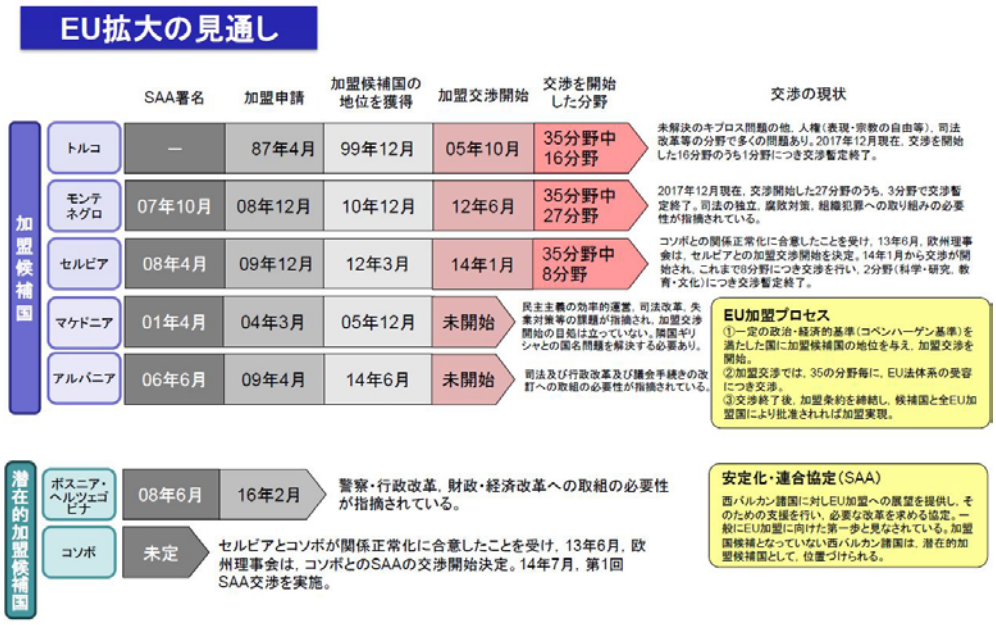
Year/Month	Summary history
1998	The security situation in Kosovo and the humanitarian situation of the population deteriorated rapidly as Serbia launched a KLA sweep.
1999 Mar	In response to the start of NATO airstrikes, Serbia intensifies its KLA mopping-up operations (Kosovo conflict).
1999 Jun	NATO air strikes end with the withdrawal of Serbian security forces from Kosovo. Interim administration by the United Nations (UNMIK) begins.
2002 Apr	The United Nations (UNMIK) begins its "standards before status" policy.
2008 Feb	On the 17th, the Kosovo Assembly declared the independence of the "Republic of Kosovo".

Source: Ministry of Foreign Affairs of Japan

Regarding Kosovo's internal politics, it is characterized by frequent changes of government evidenced by the five parliamentary elections (in 2010, 2014, 2017, 2019, and 2021) held following the declaration of independence in 2008. For example, after the June 2017 general elections, a coalition government was formed from four political parties (Democratic Party of Kosovo [PKD], Alliance for the Future of Kosovo [AAK], and Social Democratic Initiative [NISMA]), but the prime minister who was summoned by the Kosovo special court announced his resignation in July 2019, and new parliamentary election was held in October 2019. Afterwards a coalition government dominated by the Self-determination Movement (LVV) and the Democratic League of Kosovo (LDK) was launched in February 2020, but a non-confidence motion against the cabinet was passed by the parliament as soon as in March 2020 initiated by the inner opposition of the ruling parties and a new government dominated by the LDK was born in June 2020. However, the constitutional court judged the parliamentary vote on the formation of the new cabinet invalid, and therefore once again parliamentary election was held in February 2021, and Kurti's second government was launched in March 2021. This political sequence of events was described to demonstrate critical external factor inhibiting the progress of policy making, project implementation and cooperation with intergovernmental and donor organizations. During hearings with the World Bank and other donors such as LuxDev, it was commented that the consistency and sustainability of policies were not maintained, and the construction and operation of aid projects had been greatly affected by these political turmoil. It is said that Kurti's second government reaching single-party majority in the parliament with its Self-determination Movement (LVV) that has a good chance to become the first government to remain in office until the end of its term.

To add to the political instability of the country, the reconciliation and harmony with the Serb minority of Kosovo, which largely opposes the declaration of independence also constitutes a challenge, which also affects the political and administrative management related to health care. For example, Serbia does not recognize Kosovo as an independent state and the Serbian Government offers health services for Serbian residents in North Kosovo. Thus, the health care provision system is complex in Kosovo.

The diplomatic challenges ahead of Kosovo are to increase the number of states that recognize Kosovo's independence (stands at nearly 100 states, as of September 2020) and to achieve the accession to various international organizations, such as the United Nations, and the EU in the future. Kosovo is recognized by the EU as a potential candidate for accession. The process towards EU accession of Kosovo and neighboring countries are shown in the following diagram (the Stabilization and Association Agreement [SAA] between Kosovo and the EU came into effect in April 2016). It is said that Kosovo faces major challenges ensuring environmental protection standards and the harmonization of social security for migrant workers.



Source: Ministry of Foreign Affairs of Japan (November 2018)

Figure A-34: Progress of EU Accession of Kosovo and Other Neighboring Countries

A.1.4 National Development Strategy

A.1.4.1 National Development Strategy 2016-2021

Kosovo has adopted the National Development Strategy 2016-2021 (hereinafter, NDS 2016-2021) in which national development directions are laid down. In the NDS 2016-2021, priority sectors were defined including infrastructures, energy supply and generation, governance, human resources development, and the improvement of business environment. Within this document little attention was given to the health sector. For example, the NDS 2016-2021 limits itself to the strengthening of health facilities and utilization of HIS (HIS) as strategic goals of the health sector, with many other important areas, such as health insurance coverage and tertiary health institutions are being left out. When the NDS was formulated in 2015, 7 years had just passed since the independence declaration. Therefore, this suggests the background of those days that economic growth and its environmental improvement, and human resources development were recognized as more important.

Table A-4: Priority Sectors in National Development Strategy 2016-2021

Priority sectors	Description
1 Human resources	Improvement of pre-school education, linkage between education and employment, etc.
2 Governance and Law	Evidence-based policy making, etc.
3 Industrial development	Promotion of small and medium enterprises, utilization of resources, etc.
4 Infrastructure development	Development of power infrastructure, etc.
5 Implementation of the National Development Plan	-

Source: National Development Strategy 2016-2021, GOK

A.1.4.2 Next National Development Strategy

The next National Development Strategy is being prepared by the Office of the Prime Minister and should be finalized in 2021. As described in the previous subsection, the health sector is not well represented within the present NDS 2016-2021. However recent events, such as the COVID-19 pandemic from early 2020, made politicians acknowledge the importance of public health measures and the fight against infectious diseases. Thus, according to hearings with the MOH, it is highly likely that the health sector will get a higher importance in the coming Next National Development strategy.

At the same time, the results of the existing NDS 2016-2021 are being evaluated, and its evaluation report is planned to be compiled in the near future.

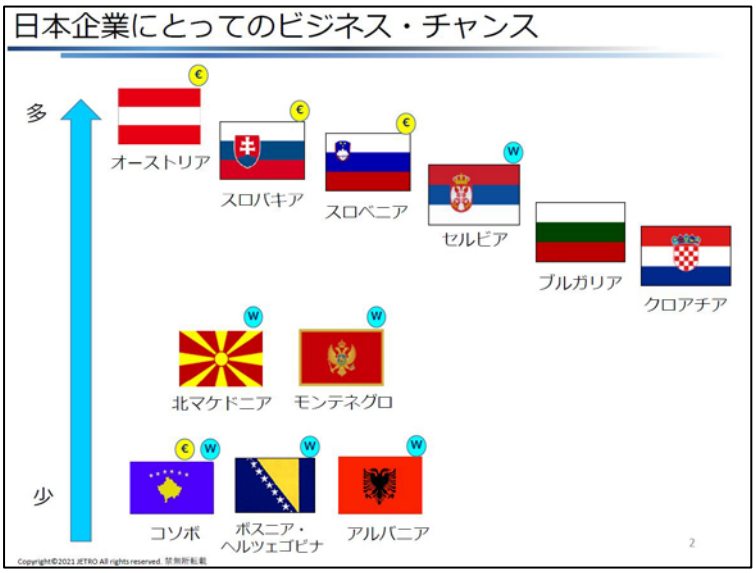
A.1.5 Political and Economic Relations with Japan

Japan has provided humanitarian and restoration assistance to Kosovo through international organizations since 1998 when the situation in Kosovo deteriorated. Japan began full-scale cooperation with Kosovo after the establishment of diplomatic relations in 2009 and has provided grant aid, technical cooperation projects and organized training courses, in the fields of environmental infrastructures, management skills, administrative capacities, and human resource development to contribute to the stabilization of economic and social infrastructures toward a sustainable state.

In January 2018, the former Prime Minister Abe announced the Western Balkan Cooperation Initiative and stated that Japan will support economic and social reforms of the Western Balkans countries which are aiming at joining the EU and will enhance Japan's cooperation in the Western Balkan area. As a result, a Japanese Embassy/Kenkin Chuzaikan Jimusho was established in Kosovo in January 2020. In December 2020, Ms. Mari Yamashita, a Japanese woman, was appointed as the Representative of the United Nations Secretary-General and the Director of the UN Office in Belgrade, the United Nations Interim Administration Mission in Kosovo (UNMIK) and has been engaged in the supervision of peacekeeping support operations.

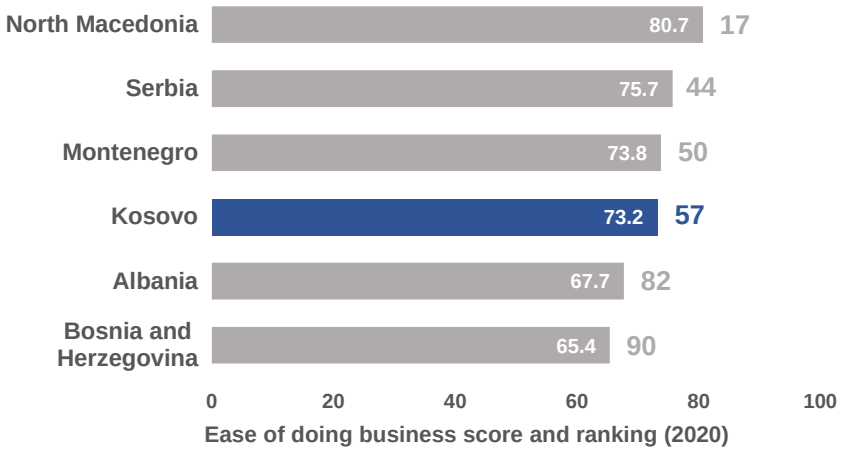
On the other hand, it cannot be said that the economic relation between Japan and Kosovo is strong. At present, there are only two Japanese companies operating in Kosovo, Hirano mushroom LLC (mushroom cultivation) and Japan Tobacco Inc. (tobacco sales).

Although some Japanese medical device manufacturers perform sales activities in Kosovo or in the neighboring countries through agencies, most of the previous sales results covered equipment purchase as non-project grant aid, and the situation in Kosovo is still not favorable for businesses to be positively developed.



Source: JETRO Wein office (March 2021)

Figure A-35: Business Opportunity in Kosovo and Neighboring Countries for Japanese Companies



Source: Doing Business 2020

Figure A-36: Score and Rank of Ease of Doing Business

Appendix 2:
Health Services at Primary Health Facilities

Table A-5: Health Promotion Services Provided by Primary Health Facilities

Health promotion services including information, communication and education in primary health care
1. Activity in health education and promotion in PHC
2. Cooperation with the health education sector for the implementation of the health promotion calendar
3. Establishment and facilitation of cross-sectoral cooperation
4. Creating a supportive environment for the development of public policies focusing on health
5. Implementation of communication activities to increase knowledge and community awareness on the benefits and lifestyle choices as well as promoting healthy social attitudes
6. Community Empowerment
1. Implementation of the Extended Immunization Program
2. Reporting of vaccination side effects; regular registration and reporting of vaccinations (including coverage monitoring
3. Provision of vaccination services in MFMC, MFC, FMA and community
4. Provision of activities about information, education and counseling on immunization
5. Other immunization according to the recommendations of NIPHK
6. Preventive care and patient/family education on the prevention of accidents and infectious diseases
7. Preventing, capturing and managing cases of violence or abuse
8. Prevention and management of STI and HIV AIDS infections
9. Prevention and control of reproductive tract and GI cancers
10. Preventive care for the elderly
Health services for children and teenagers in Primary Health Care
1. Activities related to promotion, communication, and education
2. Implementation of the Expanded Program Immunization
3. Management of most common childhood diseases
4. Prevention, management and treatment of the child case of violence and abuse
5. Check-ups of children before vaccination,
6. Check-up visit before registration in preschool and school institutions.
7. Check-up visits of children with special needs.
8. Check-up visits of school children
9. Application of preventive measures within td oral health.
10. Community services
Health services for women and reproductive health in Primary Health Care
1. Activities related to promotion, communication, and education
2. Care for safe motherhood
3. Family Planning
4. Prevention and management of reproductive tract infections, STI and HIV/AIDS
5. Prevention and control of reproductive tract cancers
6. Menopausal women care
7. Care for women with gynecological problems
Preventive oral health services in Primary Health Care
1. Dental visits
2. Dental check-ups
3. Systematic dental visits with data processing
4. Appointed visits: To take preventive and therapeutic measures based on the findings of the systematic visit. Completion of documentation
5. Preventive visit: Based on anamnesis from the patient or parent and the examination, the risk factors for diseases are evaluated or identified, and the prevention measures and activities for the elimination of the risk factors are defined. Completion of documentation
6. Visits are made at certain periods of time (age):
7. Curative services:

Source: Administrative Instruction 04/2020 Primary Health Car

Table A-6: Diagnosis Services Available at Primary Health Facilities

Blood biochemistry	MFMC	FMC	FMA
1. Glycaemia	✓	✓	✓
2. Urea-creatinine	✓	✓	
3. Bilirubin- total	✓	✓	
4. Bilirubin- direct	✓	✓	
5. AST	✓	✓	
6. ALT	✓	✓	
7. Cholesterol	✓	✓	
8. Triglycerides	✓	✓	
Urine			
1. General analysis	✓	✓	✓
2. Occult Blood in Urine	✓	✓	✓
3. Appearance, color, odor, pH, specification	✓	✓	✓
4. Protein, glucose, ketones, blood, esterase of stom	✓	✓	
5. Microscopic examination of sedimented urine	✓	✓	
6. Pregnancy test	✓	✓	
7. ASTO	✓	✓	
8. CRP	✓	✓	
9. Rheumatic Factors	✓	✓	
10. T3･T4･TSH	✓	✓	
11. Glucosed hemoglobin	✓	✓	
12. Fat fractions	✓	✓	
1. Sedimentation	✓	✓	
2. Red blood cell count	✓	✓	
3. Hematocrit	✓	✓	
4. Hemoglobin	✓	✓	
5. White blood cell count	✓	✓	
6. Thrombocyte count	✓	✓	
7. Bleeding time	✓		
8. Clotting time	✓		
9. Fe	✓		
10. Electrolyte	✓		
11. Glycemia (glucometer)	✓	✓	
12. Hemoglobin (comparator of Lovebond)			✓
13. Glucose strip test	✓	✓	✓
14. IgG/ IgM test against SARS-CoV-2	✓		
15. Rapid diagnostic test for SARS -CoV-2	✓	✓	

Source: the Survey Team corrects the contents of table based on Administrative instruction 04/2020.Some of the contents may be classified differently, but the original text published in Administrative instruction 04/2020 is used.

Appendix 3:
Patient's Satisfaction of Health Facilities

1. Breakdown of Heath Facility Users

According to the response from secondary and tertiary health facilities during the subcontracted survey, three health facilities answered that over 90 percent of the patients received health services with free of charge as shown in Table A-7.

Surveys conducted by the Swiss AQH Project and UNDP also show the patients attributes of health facilities. The Quality of Care Study 2018 surveys primary health facilities in 38 cities, and includes multiple facilities such as family medicine centers and family medicine clinics in addition to the main family medicine centers classified as primary health facilities. There are cities, but here the Survey Team has basically focused on the patients who visited the main family medicine center. About half (42%) of the patients of primary health facilities are pensioners, unemployed people, low income people etc. who are considered to use service with free of charge.

In addition, the secondary and tertiary health facilities and two Serbian hospitals (Gracanica and north Mitrovica) also receives the unemployed and pensioners accounting for less than half (43%) which is similar share of the primary health facilities. From these results, it can be seen that the majority of patients of public health facilities are free service users.

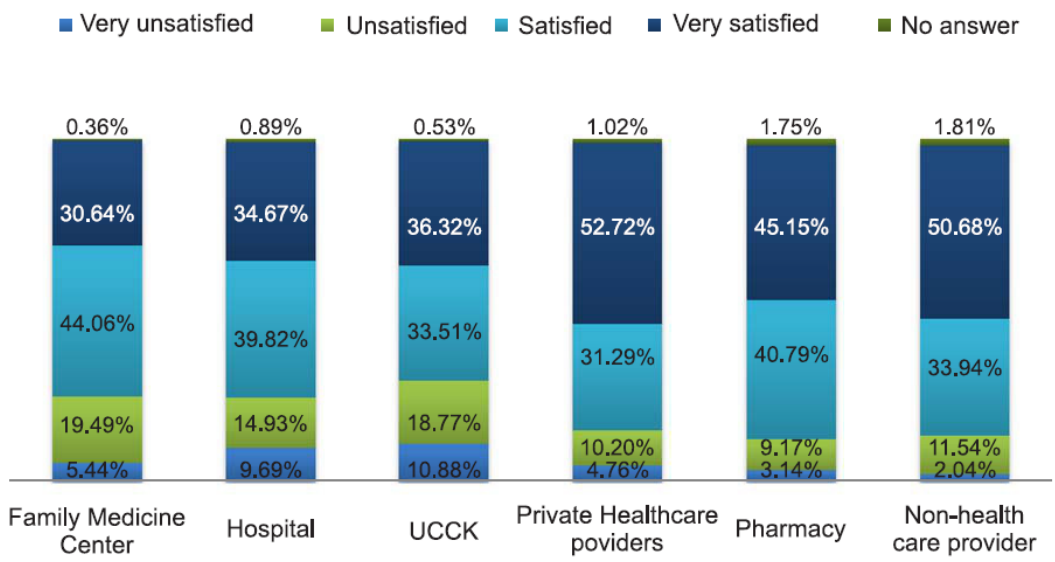
Table A-7: Ratio of Patients using Health Service for Free of Charge (secondary and tertiary health facilities)

UCCK	Ferizaj	Gjakova	Gjilan	Mitrovica	Peja	Prizren	Vushtrri
80%	No answer	No answer	96%	95%	No answer	No answer	No answer

Source: Survey Team compiles the results of questionnaires to each health facility

2. Satisfaction of People

The MOSAIC survey conducts satisfaction surveys on public primary health facilities and hospitals (considered as secondary and tertiary health facilities) and public health services. On the other hand, UNDP's ACTION PAPER ON HEALTHCARE IN KOSOVO conducts satisfaction surveys on public health facilities (primary, secondary, and tertiary), private health facilities, and pharmacies. Comparing the results of both surveys, they match that their satisfaction with secondary and tertiary health facilities is slightly lower than that with primary health facilities. Looking at Figure A-37, there are slightly large number of patients who are dissatisfied with the services of secondary and tertiary health facilities, and private health facilities are more satisfied with their services than those of public health facilities.



Source: ACTION PAPER ON HEALTHCARE IN KOSOVO, 2013, UNDP, USAID

Figure A-37: Result of Satisfaction Survey of Health Sector

3. Needs of People regarding Health Services

In the Community Health Needs Assessment Survey conducted by the Swiss AQH Project, it conducts focus group discussions with community representatives, stakeholders (city staff, MFMCs, health facility personnel), and residents including socially vulnerable people and summarizes health-related issues. In addition, a group discussion conducted in the Knowledge, Attitudes, Practices and Behavior: Non-Communicable Diseases survey also raised opinions on the services of public health facilities. The opinions commonly raised in multiple, or all cities surveyed are as follows.

- Since there are no essential medicines in health facilities and they cannot be distributed free of charge, they have to buy medicines at their own expense.
- There are times when a doctor is absent.
- The condition of facilities and device is poor.
- Awareness-raising activities and health examinations have not been conducted.
- There is no health insurance system.

In addition, as opinions expressing the situation of the people, "I could not pay the high medical expenses (800 euros) for diabetes and I had no choice but to visit to have treatment in the neighboring country where the medical expenses are low.", "I often have to stop the treatment," and "because I don't have the money to buy medicine, I sometimes beg on the road and manage to pay for medicine (ethnic minority)."

Appendix 4:
Result of Focus Group Discussion

In the study, focus group discussions were conducted with five target groups in order to collect information on differences in the utilization of health services by socio-economic strata and to ascertain whether there are people left from health services. The target groups and discussion topics are shown in Table 9-8.

Table A-8: Participants of FGDs and Discussion Theme

	Participants	Discussion Theme
FGD1	Ethnic minority(Gorani, Bosnian, Roma, Serb)：6 people	Experience of visiting a doctor, thoughts on public health facilities, thoughts on private health facilities, and lifestyle.
FGD2	Ethnic minority (Ashkali, Egypthian, Turk)：7 people	Experience of visiting a doctor, thoughts on public health facilities, thoughts on private health facilities, and lifestyle.
FGD3	Unemployed youth (under 30 years old)：6 people	Experience of visiting a doctor, thoughts on public health facilities, thoughts on private health facilities, and lifestyle.
FGD4	Labour in informal sector：5 people	Experience of visiting a doctor, thoughts on public health facilities, thoughts on private health facilities, and lifestyle.
FGD5	Women hove under 2 years old child(ren)：6 women	Experience of antenatal care, thoughts on public health facilities, thoughts on private health facilities, and lifestyle.

Source: Survey team

Access to health services by each socio-economic stratum is described in 5.4, and the main statements regarding points other than access to health services are to be summarized here.

1. Thoughts on Public Health Service

The main statements made by FGDs' participants regarding access to health care services are shown in Table A-9. Summarizing the remarks, it can be seen that the majority of the FGDs' participants use public health services despite their dissatisfaction with unfriendly, unhygienic, and long waiting time. In addition, it was found that they use public health services first, and if they are not satisfied with the contents of the medical consultation, they change to visit private health facilities.

Table A-9: Main Statements Regarding Public Health Service

Participants	Main statements by participants
Ethnic minority (Gorani, Bosnian, Roma, Serb)	・I have been getting checked at FMC about 3-4 times a month for hypertension. ・A few years ago, I had surgery at a general hospital for cholecystitis. It was an appropriate service. ・At a public health facility, the doctor asked for money in addition to the service fee. If I didn't pay, they wouldn't let me have the examination. ・At a public health facility, I had to buy medicine (which is supposed to be free), it was difficult to make appointments, and some doctors had bad attitudes and not giving me consultations.
Ethnic minority (Ashkali, Egypthian, Turk)	・My mother is diabetic and has been treated at FMC for 9 years. ・If I has symptoms such as high blood pressure or diarrhea, I goes to a public health facility. ・Public health facilities have long waiting times, but the good thing is that they provide free medicines.
Unemployed youth (under 30 years old)	・I went to the emergency counter at a public health facility, but the doctor was not available, and I was passed around. ・I don't trust MFMC because they give me expired medicines. ・I feel that the doctors at the public health facilities are kind, but the device and other facilities are inadequate. ・The FMC near my house is only open 3 days a week, in which case I have to go to a remote MFMC.

	・ I go to a public health facility first, and if I cannot get appropriate services, I go to a private health facility.
Labour in informal sector	・ When I visited a public health facility for an emergency, it was suggested to switch to seeing a doctor in the private sector. ・ Sometimes, doctors are not available at the MFMC, even during business hours. ・ I used to go to the FMC to get injections, but they did not have any injecting medicine and I had to buy it myself at the pharmacy. ・ I had to wait for a long time at a public health facility even when I went to see the doctor under urgent circumstances. ・ Public health facilities have long waiting time, but the service fee is low.
Women hove under 2 years old child(ren)	・ Private health facilities are cleaner and more hygienic than public health facilities. ・ I was treated unkindly when I visited there before. If you don't have connections in a public health facility, you are at a disadvantage in terms of waiting time.

2. Thoughts on Private Health Service

The main statements regarding access to private health services by FGDs' participants are shown in Table A -10. Residents visit public health facilities when they have already been diagnosed with a certain disease, such as diabetes or hypertension, and have a set of medications. On the other hand, when patients themselves judge that their symptoms are severe or complicated and require detailed and advanced examination, they tend to use private health facilities rather than public health facilities.

Table A-10: Main Statements Regarding Private Health Service

Participants	Main statements by participants
Ethnic minority (Gorani, Bosnian, Roma, Serb)	・ In the private sector, I can make an appointment quickly and the doctors are kind. ・ There are no private health facilities nearby, so I go to a public healthcare facility. ・ I usually use the public healthcare facility nearby, but if my symptoms are serious, I use the private healthcare facility.
Ethnic minority (Ashkali, Egypthian, Turk)	・ If I feel that I have a headache or other symptoms that require a detailed examination, I will go to a private medical facility with high medical technology to have an examination. ・ I like the private facilities because the waiting time is short, and the medical personnel are kind. However, the fees for private facilities are very high.
Unemployed youth (under 30 years old)	・ I would be taking blood tests, etc. in the private sector. ・ At the private health facility, they carefully explained my condition, what would happen in two years, treatment methods and the effects of medication.
Labour in informal sector	・ Private health facilities are more reliable and provide better quality services. ・ I have never used a private health facility because I have the impression that private facilities are only for profit. ・ Private health facilities charge high fees for their services.
Women hove under 2 years old child(ren)	・ The all family members are using private health facilities. They are hygienic and the services are of high quality. ・ There was a time when my family member was transferred to a public health facility when he was receiving medical treatment at a private health facility and went into a critical situation. I think that the private health facility did not want to take responsibility.

3. Thoughts on Maternal and Child Health Service

Among the FGDs' participants, the main statements about maternal and child health services by women with children under the age of two are shown in Table A-11. All participants had monthly checkups and most of the

checkups were conducted at private health facilities. One participant said that she gave birth of her first child at a public health facility and had a bad impression of the services and unkindness of the medical staff, so she gave birth of her second child at a private health facility. There were also a few respondents who used private health facilities for tests during pregnancy, but delivered their children at less expensive public health facilities and received postnatal care again at the same private health facilities they used during pregnancy.

Table A-11: Main Statements Regarding Private Health Service

Participants	Main statements by participants
Women hove under 2 years old child(ren)	・ During my pregnancy, I had monthly checkups. ・ Most of the checkups were done at private health facilities. ・ When I had blood tests and urine tests at a private facility, I was recommended to go back to a public facility to reconfirm the contents of the tests and I had tests at a public facility. ・ I used a private health facility for medical checkups and a public health facility for delivery due to cost considerations. The service I received at the public facility was poor and I was treated unkindly. ・ After delivering the baby at the public healthcare facility, I suffered from severe pain for two days until a doctor, who I knew, intervened and took care of me. ・ When I gave birth at a public health facility 7 years ago, it was unsanitary and unfriendly, but when I gave birth again two years ago, the situation had changed, and they were kind to me. ・ My husband told me to visit a private health facility, so I use the private one. ・ I received postnatal care at a private health facility because of the short waiting time, high quality of service, and hygiene.

Appendix 5:
Photos of Health Facilities

University Clinical Center of Kosovo

	
Orthopedic clinic	Waiting room
	
Consultation room	Operation room
	
Poster explaining about mask to prevent COVID-19	Patient receiving consultation
	
Educating poster of public health	

General Hospital - Ferizaj

	
Entrance of hospital	Operation room
	
In-patient bed	Waiting room
	
Consultation room	Patient receiving consultation
	
Warehouse of medicines	Ambulance car

General Hospital - Gjakova

	
External appearance of hospital	Operation room
	
Poster for food safety practice	Medical refrigerator
	
Inside of ambulance car	Laboratory
	
Warehouse of medicines	

General Hospital - Gjilan

	
External appearance of hospital	Entrance
	
Waiting space	Operation room
	
Entrance for emergency	Reception
	
Warehouse of medicines	Ambulance car

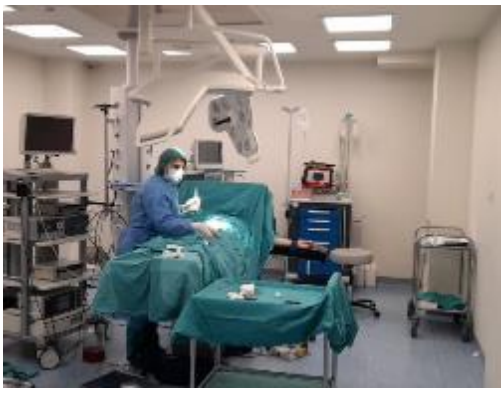
General Hospital - Mitrovica

	
External appearance of hospital and signature board	Hemodialysis center
	
Waiting space	In-patient bed
	
Laboratory	Medicine and documents' file
	
Warehouse of medicines	

General Hospital - Prizren

	
Entrance	Reception
	
CT	Patient receiving treatment
	
Medicine in warehouse	

General Hospital - Vushtrri

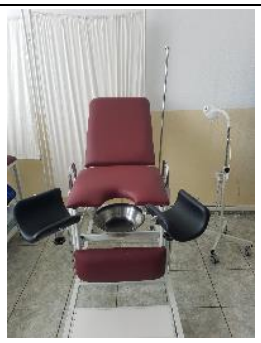
	
External appearance of hospital	Waiting room
	
Laboratory	Patient receiving consultation
	
Medicine in warehouse	Operation room
	
Ambulance car	

Primary health and medical facilities

MFMC Decan



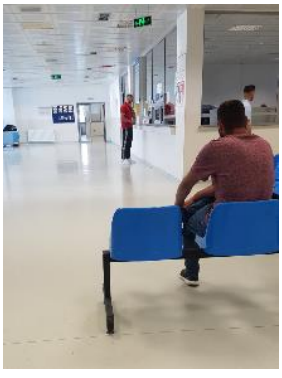
MFMC Fushe Kosova


MFMC Hani i Elezit



MFMC Skenderaj


Appendix 6:
COVID-19 Vaccination Campaign

1. Background

(1) Relevance to the Survey

The Survey was conducted to to contribute to building resilient health systems towards UHC in Kosovo (see Part 1, Chapter 1 for the background and purpose of the Survey). Considering the social and economic impact of COVID-19 on Kosovo, through the Survey, it was decided to conduct a public awareness campaign to prevent the spread of COVID-19 infection, aiming for quick and short-term benefits.

(2) Needs assessment

In order to examine specific contents of awareness-raising and public relations activities that contribute to the prevention of the spread of COVID-19, a needs assessment was conducted based on existing information and data as well as through discussions with the Ministry of Health and other related parties. In the discussions with the relevant parties, the JICA Survey Team exchanged opinions in both directions with the aim of implementing more effective activities, including the introduction of Japanese knowledge and experiences such as the results of various surveys and examples of the use of awareness-raising and public relations tools and nudges to promote the avoidance of three Cs (closed spaces, crowded places and close-contact settings) and hand disinfection.

As a result of the needs assessment, it was found that Kosovo was facing issues related to the promotion of vaccination, which is said to be a last resort for the containment of COVID-19, such as the fact that the start date of vaccination was the slowest in Europe and that there was a tendency for the public to be less willing to be vaccinated than in other countries. In February 2021, the Kosovo National Deployment and Vaccination Plan for COVID-19 Vaccines (hereinafter referred to as the "Initial Plan"), which was developed by the Government of Kosovo, including the NIPH and the Ministry of Health, with the support of WHO and other international organizations, included seven activities related to vaccination promotion. However, it was recognized that additional support from international organizations would be necessary to implement these activities, and there were high expectations from government agencies for cooperation in this field.

Based on the above-mentioned needs assessment and discussions with JICA, it was decided to implement a communication campaign to encourage COVID-19 vaccination (hereinafter referred to as the “Campaign”) as an awareness-raising and public relations activity to contribute to the prevention of the spread of COVID-19.

(3) Situation Analysis

In order to consider and formulate a basic policy for the Campaign, the JICA Survey Team analyzed the situation regarding COVID-19 vaccination in Kosovo through existing literature and interviews with relevant organizations.

In terms of supply, despite the slow start, according to the Ministry of Health, donations from international organizations such as COVAX, the EU, Norway, Croatia, and other countries, as well as purchases from the government budget, have progressed steadily. As of August 2021, the Government of Kosovo was on track to secure sufficient quantities of vaccine to achieve the target vaccination rate of 70% set in the Initial Plan. The maximum number of doses that can be administered per day is approximately 17,000 (to be increased to approximately 22,000 from October 2021), and there are only two types of vaccines in use: those manufactured

by AstraZeneca and Pfizer.

As for the demand side, as mentioned above, a major issue was the low willingness of the people to be vaccinated. The Initial Plan by the Government of Kosovo was to classify the target population according to priority and proceed with the vaccination in a phased manner, but the vaccination speed continued to be slow due to the fact that some healthcare workers, who are the priority vaccination target, refused to be vaccinated with AstraZeneca's vaccine. As a result, the government was forced to take various measures to speed up daily vaccinations, such as changing the initial phased manner to cover all citizens aged 18 and above at once from late July 2021. Even during the period from the end of July to September 2021, when the largest wave of infection spread, there was little change in people's perception and behavior toward COVID-19 or their willingness to be vaccinated. As of October 6, the number of people who had completed two doses of vaccination was about 30% of the population (about 570,000 people). By early November 2021, just prior to the implementation of the Campaign, the percentage of people who had completed two doses of vaccination had risen to about 45% of the population, but the number of daily doses of vaccination administered had begun to decrease, with the goal of achieving 70% still ongoing. Under these circumstances, the Government of Kosovo recognized the need to strengthen the supply system, including the introduction of mobile vaccination vehicles, and to further encourage vaccination in order to increase the speed of vaccination again, and expectations for support from other donors remained high.

In the field of vaccination promotion, WHO and UNICEF are the main donors actively providing support. WHO provides comprehensive support from planning to evaluation and monitoring of vaccination projects in Kosovo, and also conducts a survey on people's perceptions and behaviors called "Behavioural Insights on COVID-19 in Kosovo" (BI Survey). According to the results of the BI Survey (the fifth round, conducted in June 2021), people could be classified into five clusters based on their perceptions and behavioral tendencies regarding the risk of COVID-19 infection and vaccination. These clusters are “Deniers”, “Undecided”, “High risk concerned”, “Low risk concerned”, “Acceptors”. The characteristics of each cluster are described as follows:

Table A6-1: Characteristics of each cluster

Cluster	% of the total population	Major characteristics
Deniers	18%	“I don’t believe COVID exists. The media has made it all up and blown it out of proportion. I don’t want to hear anything about COVID or vaccines ever again.”
Undecided	14%	“I’m at low risk and I’m not sure about these vaccines, but I might get vaccinated anyway.”
High risk concerned	32%	“I’m afraid I could get this virus, but I have a lot of concerns about the vaccines. I believe they can help stop the pandemic, but I want to be convinced they’re safe and effective.”
Low risk concerned	31%	“Even though I’m at low risk, I’d get vaccinated to end the pandemic. I still have concerns about the vaccines, though.”
Acceptors	5%	“I’m at low risk, but I’ll get vaccinated. I’m not worried about the vaccines. I just want to get back to normal life.”

Source: Prepared by the Survey Team based on WHO’s BI Survey

UNICEF has started implementing outreach activities related to the prevention of the spread of COVID-19

infection and vaccination for about three years since July 2021, with funding of about one million USD from USAID. Specifically, UNICEF is conducting social listening to collect and analyze people's conversations about COVID-19 on social media and communication activities by holding meetings and visiting homes in targeted communities (including areas where ethnic minorities live). The Campaign by JICA Survey Team was carried out after a series of discussions with other donors who have been carrying out similar activities in this field in advance, and an agreement was reached to closely share information and exchange opinions in order to avoid duplication of activities with each other.

2. Objectives

Based on the situation analysis described above, the JICA Survey Team conducted the Campaign on COVID-19 vaccination promotion with the following two objectives.

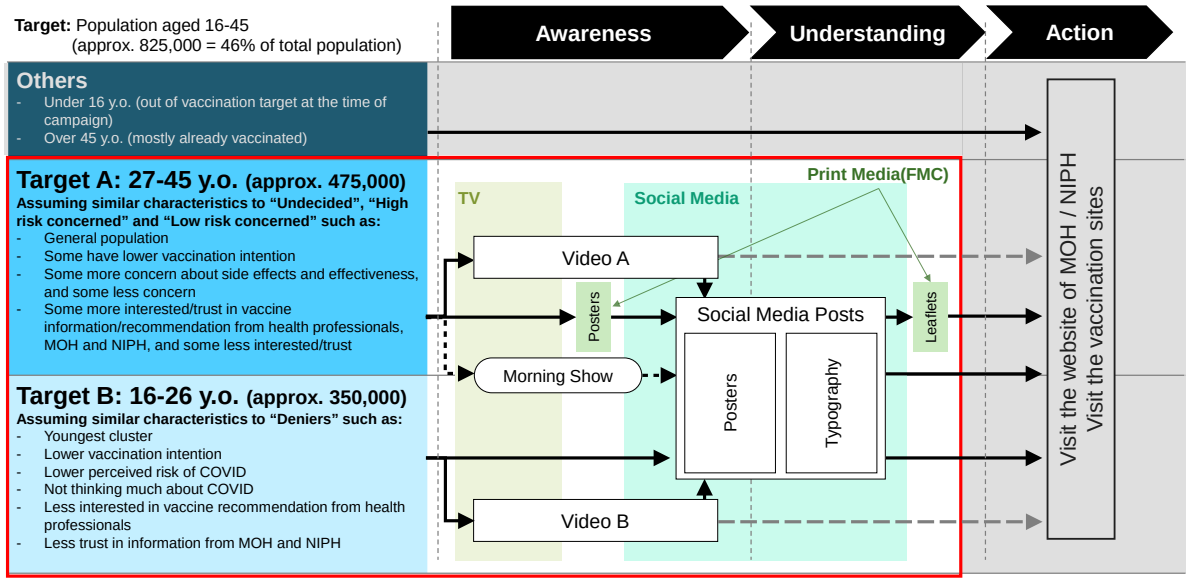
- To raise awareness in COVID-19 vaccination, especially among those who have low interest and intention to be vaccinated.
- To further increase attention in COVID-19 vaccination and promote correct understanding of its effects and safety, targeting those who have a certain level of interest and intention to be vaccinated, but have concerns about the effects and safety.

The achievement of the above two objectives will in turn lead to people's willingness to be vaccinated and actually take action to be vaccinated, which would be expected to contribute to the early realization of the national target vaccination rate.

3. Methodology

(1) Framework of the Campaign

The framework of the Campaign is shown in the figure below.



Source: The Survey Team

Figure A6-1: Frameworkd of the Campaign

For the Campaign, the JICA Survey Team divided the target audience into two categories, and created, distributed, and distributed promotion tools to each of them, while referring to the cluster classification in the BI survey and data on vaccination status from the Ministry of Health.

The first target is the age group of 27-45 years old (hereinafter referred to as "Target A"). It is assumed that most of the people in Target A have characteristics similar to "Undecided", "High risk concerned", and "Low risk concerned" in the BI survey. The reason why those who are older than middle age is not included is because the percentage of those who have received at least one dose of vaccine was already over 90% among those aged 50 and above as of the beginning of October 2021, so we judged that the effect of the Campaign would be small.

The second target is young people between the ages of 16 and 26 (hereinafter referred to as "Target B"). We assumed that this group would have many of the same characteristics as the "Deniers" in the BI survey. In addition to the demographic characteristics of being mainly young, the "Deniers" in the BI survey were the least vaccinated, and had distinctive cognitive and behavioral characteristics such as not believing in the existence of COVID-19, believing that COVID-19 has already ended, and not wanting to hear about COVID-19 or the vaccine. Therefore, we thought it would be effective to create and distribute a communication tool (video) with a different content and message from that of Target A above.

(2) Tools

The tools created for the Campaign are as follows:

① Video A (Judo Team)

<table>
<tr><td colspan="2"> 
</td></tr>
<tr><td>Target</td><td>• Mainly Target A</td></tr>
<tr><td>Contants</td><td>• A video featuring high-profile and influential figures to encourage vaccination. The video features four people, including women's judo gold medal winners at the Tokyo 2020 Olympics, Distria Krasniqi (48kg) and Nora Gjakova (57kg), as well as nationally popular Majlinda Kelmendi (Rio 2016 Olympic gold medalist) and their coach Driton Toni Kuka. Driton. They appeared on stage to call for vaccinations under the motif of "be part of the winning team.
• Three different lengths (56 seconds, 45 seconds, and 16 seconds) and three types of subtitles for each length: "no subtitles," "Albanian subtitles," and "Serbian subtitles," for a total of nine 3×3 versions were created.</td></tr>
<tr><td>Media</td><td>• TV (RTK (Radio Television Kosovo)
➢ RTK 1 (Albanian language)
➢ RTK 2 (Serb language)</td></tr>
</table>

	• Social media ➢ MOH's Facebook, YouTube, Instagram, Twitter ➢ RTK' Facebook

② Video B (Youngsters)

Target	• Mainly Target B
Conttents	• The video conveys the message that vaccination is important to restore a safe normal life. The video features people of the same generation as the target audience (i.e. 16-26 y.o.), and encourages people to get vaccinated and get back to their normal, enjoyable lives, such as school, shopping, sports, and travel. • Seven versions (one 59-second long version and six 16-second short versions), each with three types of subtitles: "no subtitles," "Albanian subtitles," and "Serbian subtitles," for a total of 21 versions (7 x 3) were created.
Media	• TV (RTK (Radio Television Kosovo) ➢ RTK 1 (Albanian language) ➢ RTK 2 (Serb language) • Social media ➢ MOH's Facebook, YouTube, Instagram, Twitter ➢ RTK' Facebook

③ Social media posts (Judo Team)

Target	• Taget A and Target B
Contents	• Cutouts of a scene from Video A. It is aimed to increase the recall rate of the Campaign, by using these posts together with the video.
Media	• Social media ➢ MOH's Facebook, YouTube, Instagram, Twitter

④ Social media posts (Typography)

Target	• Taget A and Target B
Contents	• In order to promote understanding of the efficacy of vaccines, the content of the posts provides information based on scientific data in an easy-to-understand manner. The content was selected and specified by the Ministry of Health based on information released by the ECDC (European Centre for Disease Control and Prevention). The four types of content created are as follows. 1. 2 doses of vaccine reduce the risk of hospitalization due to Delta variant by 94%. 2. 2 doses of vaccine are 95% effective in preventing the onset of disease 3. Vaccine is effective against any mutant variants* 4. Vaccines manufactured by AstraZeneca and Pfizer are both WHO approved. * As for "3. Vaccine is effective against any mutant variants", we stopped posting it since Omicron was placed as a variant of concern on November 26.
Media	• Social media ➢ MOH's Facebook, YouTube, Instagram, Twitter

⑤ Posters and Leaflets

Target	• Mainly Target A
Contents	• Posters (2,000 copies) ➢ A cutout of a scene from Video A with size of 50 cm x 70 cm. The photo of Coach Driton Toni Kuka, which was predicted to have the highest publicity impact as a result of the focus group discussion, was used. We aimed to increase the recall rate of the Campaign by using it together with TV and social media. • Leaflets (20,000 copies)

	➢ The leaflets have a relatively detailed description of the characteristics of the vaccine, including efficacy, safety, and other features. Based on the results of interviews with stakeholders and focus group discussions, there was a high need for the creation of a communication tool with the detailed information compiled by a highly trusted public institution such as the Ministry of Health, which has yet to be distributed at the time of the Campaign.
Media	• Posting and distribution at FMCs (Family Medicine Center)

(3) Media

The media that the tools created for the Campaign are described below.

① TV

- Broadcasted spot commercials at RTK 1 (Albanian language) and RTK 2 (Serb language)[66].
- In addition, with the cooperation of RTK, a 20-minute live interview session on the Campaign was held during RTK's morning show on Saturday, December 4, 2021. Dr. Faik Hoti, Head of Public Communication Department, Ministry of Health, Mr. Mitsunori Ogasawara, Charge d'Affaires and Counsellor, Embassy of Japan in Kosovo, and Ms. Vlora Basha, representative of Index Kosova (local subcontractor) appeared on the program.

② Social media

- Distributed through the Ministry of Health's Facebook, Instagram, YouTube, and Twitter accounts.
- Distributed through the RTK's Facebook account.

③ FMC

- Distributed to FMCs nationwide under the direction of the Ministry of Health. Posters were displayed in the waiting rooms of FMCs and other places where patients (visitors) could easily see them, and the leaflets were handed out by doctors to patients or placed in waiting rooms so that patients could freely take them home.

(4) Work plan of the Campaign

The work plan of the Campaign is shown in the figure below.

[66] At the time of planning the Campaign, it was assumed that social media would be used as the main media since the advertising fee for TV commercial broadcast was too expensive to be covered within the budget. On the other hand, with the support of the Law and Justice Team, Governance Group, Governance and Peacebuilding Department of JICA and the experts of the JICA Project for Capacity Building of RTK Phase 2, the JICA Survey Team could approach RTK to collaborate with the Campaign. They agreed with the purpose of the Campaign and agreed to cooperate in the broadcasting of TV commercials free of charge.

Campaign activities	2021				2022
	September	October	November	December	January
i) Planning					
Desk research - secondary data analysis					
Communication strategy development					
Social media strategy development (including designs and posts)					
Pre-campaign evaluation survey					
ii) Development of creatives					
Concept development of video materials					
Design of printed materials (posters, leaflets)					
Pre-testing of materials (videos, prints, posts, etc.)					
Finalization of printed materials and social media materials					
Development and production of videos					
Printing of materials (posters, leaflets)					
iii) Media buying					
Media planning and optimization					
iv) Placement of advertisement					
Campaign deployment and monitoring (TV, social media and FMC)					
v) Evaluation and reporting					
Post-campaign evaluation survey					
Final report					

Source: The Survey Team

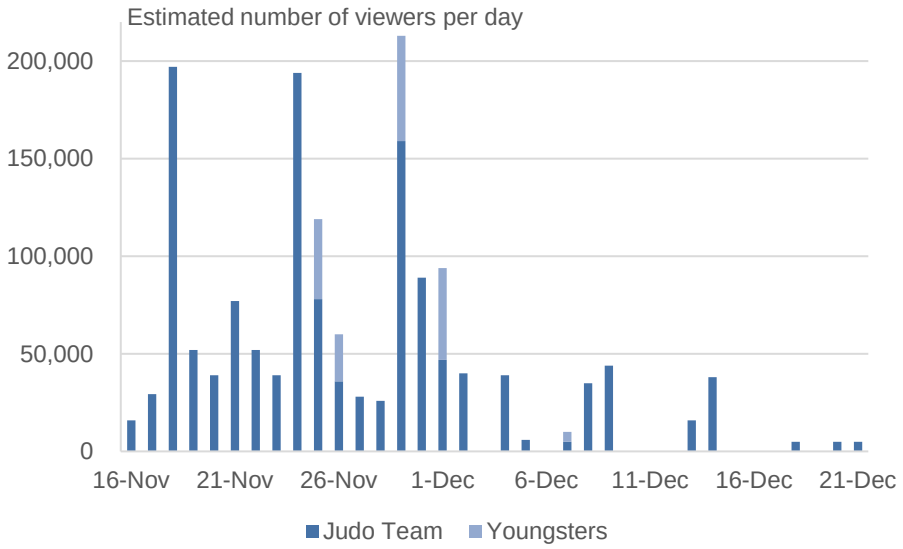
Figure A6-2: Work plan of the Campaign

4. Results of the Campaign implementation and lessons learned

(1) Indicators

① Number of viewers of TV commercials

During the Campaign, RTK 1 and RTK 2 broadcast a total of about 150 spot commercials: about 140 for Video A (Judo Team) and about 10 for Video B (Youngsters). In the first half of the campaign period (the second half of November), RTK cooperated with us in setting up five days when the commercials were aired at least 10 times a day, including times with relatively high viewership, and the total estimated number of viewers was about 1.57 million.



Source: The Survey Team

Figure A6-3: Estimated number of viewers of TV CM

② Number of social media viewers

The table below shows various indicators for viewing Video A (Judo Team) and Video B (Youngsters) on social

media. “Impression” is the number of times the video has been displayed (e.g., if the video is displayed twice to the same user on different dates, it is counted two times. This includes cases where the playback time is less than 3 seconds.), “3 second video view” is the number of times the video was played for more than 3 seconds, “Reach” is the number of users who saw the video at least once, and “Frequency” is the average number of times the video was displayed to one user (Impression / Reach).

Video A reached approximately 70% of the social media users in Target A (27-45 years old), and Video B reached approximately 90% of the social media users in Target B (16-26 years old). When social media posts (Judo Team and Typography) are added to the videos, Impression of the Campaign was approximately 8.2 million and Reach was approximately 1.07 million.

Table A6-2: Indicators of video views on socia media

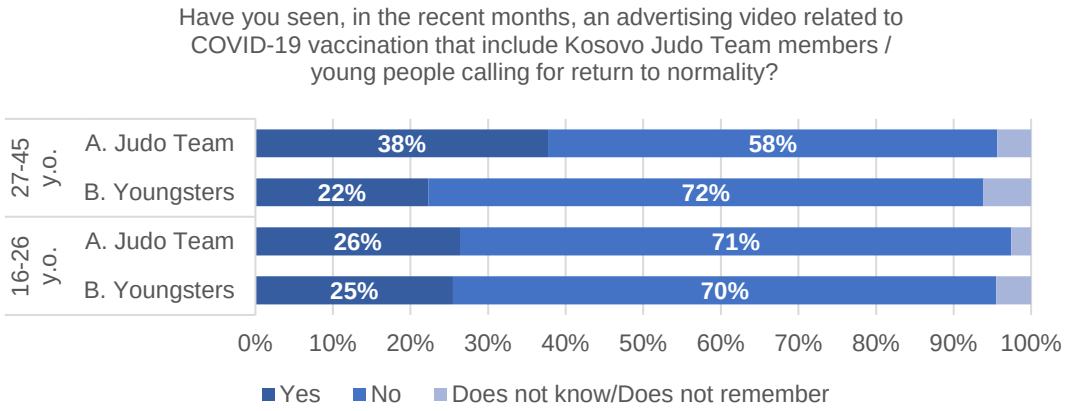
	Impression	3-sec view	Reach*	Frequency
Video A (Judo Team)	2,865,355	636,932	326,995 (70%)	8.75
Video B (Youngsters)	4,097,035	844,492	340,840 (89%)	12.02

Source: The Survey Team

*The values in parentheses for Reach are calculated as a percentage of the estimated number of social media users aged 27-45 (Target A) for Video A, and as a percentage of the estimated number of social media users aged 16-26 (Target B) for Video B.

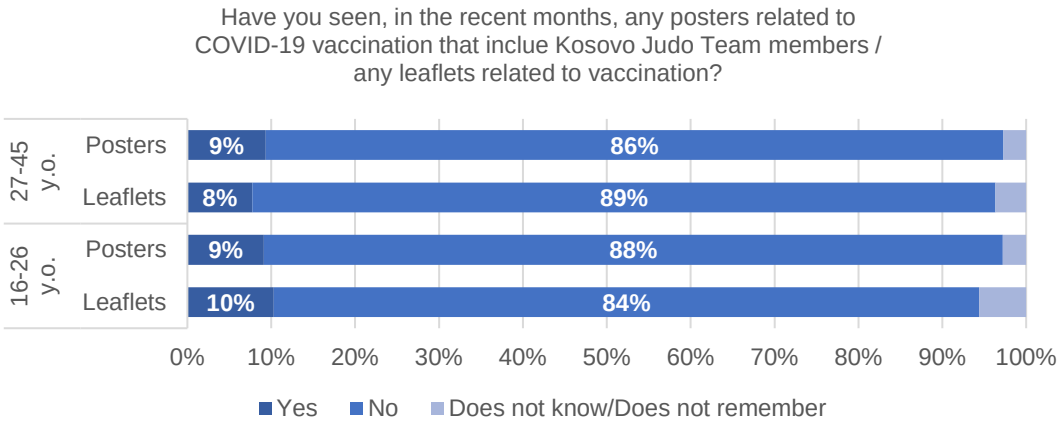
③ Advertising recall rate

After the implementation of the Campaign, a questionnaire survey was conducted from December 20 to 26, 2021, among 1,000 randomly selected people aged 16 or older. Figure A6-4 shows the percentage of respondents who had seen Video A (Judo Team) and Video B (Youngsters), and Figure A6-5 shows the percentage of respondents who had seen the posters and leaflets. In Target A (27-45 years old), 38% of respondents have seen Video A (Judo Team), and in Target B (16-26 years old), 25% of respondents have seen Video B (Youngsters). On the other hand, as for posters and leaflets, about 1 in 10 respondents in both Target A and Target B had seen them.



Source: The Survey Team

Figure A6-4: Percentage of respondents who had seen the videos



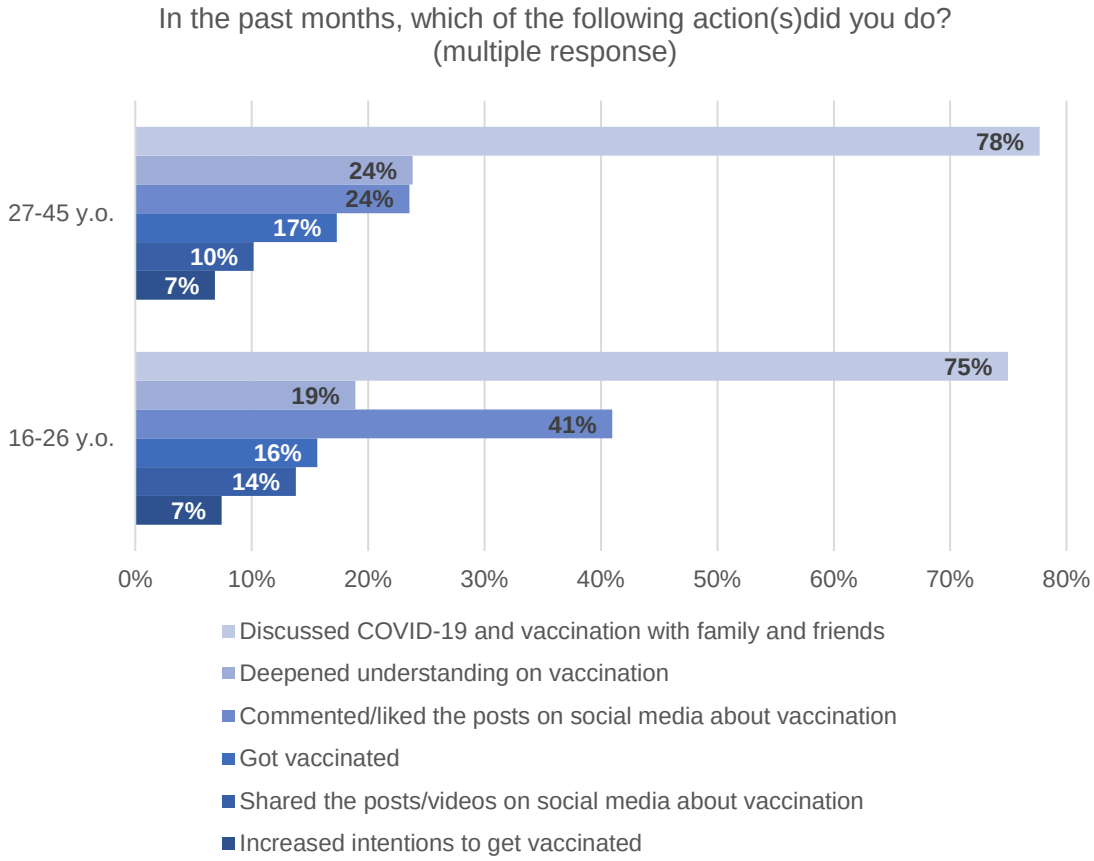
Source: The Survey Team

Figure A6-5: Percentage of respondents who had seen the posters or leaflets

④ Increased awareness and understanding

Engagement (the total number of likes, shares, comments, etc.) for the entire Campaign was approximately 1.49 million. Considering the fact that the total Reach for the Campaign was approximately 1.07 million people as mentioned above, this means that on average, people who actually saw the ads took actions such as like, share, and comment 1.4 times, which means that there was a certain level of response. Although there were some negative comments, such as criticism and sarcasm, the Public Communication Department of the Ministry of Health confirmed and judged that the effect of the advertisement was to increase interest in vaccination itself through discussion among people, and decided to leave those comments undeleted.

The figure below shows the results of a questionnaire survey on the perceptions and behaviors of those who responded that they had seen one or more of the communication tools of the Campaign. For both Target A (27-45 years old) and Target B (16-26 years old), more than 75% of the respondents who had seen the Campaign said that they had discussed COVID-19 and vaccination with their family and friends. In addition, 24% of the respondents in Target A and 19% in Target B said that their understanding of vaccination had deepened. Although the cause-effect relationship is unclear due to various factors other than the Campaign, 16-17% of the respondents who saw the Campaign actually took action to get vaccinated, and 7% of the respondents said that their intention to get vaccinated increased.



Source: The Survey Team

Figure A6-6: Perceptions and behaviors of those who saw tools of the Campaign

Dr. Faik Hoti, Head of Public Communication Department, Ministry of Health, and Dr. Edita Haxhiu, Chief of the NIPH Vaccination Project, who also serves as Chairperson of the COVID-19 Vaccination Committee, expressed their satisfaction with the results of the Campaign.

(2) Lessons learned

① Necessity of Strengthening the public communications capacity of government agencies such as the Ministry of Health

- In this Campaign, the creation of communication tools itself was largely based on inputs from the Japanese side (experts and local subcontract, etc.), but in the formulation of the basic policy and the distribution of the created tools, existing information, data and mechanisms were utilized to a great extent. And it was confirmed that a certain level of effect could be obtained. From another perspective, the JICA Survey Team felt that although there is a foundation for effective communication, government agencies such as the Ministry of Health may face some difficulties to fully utilize it at present. In addition to the current COVID-19 vaccination recommendation, the health sector is expected to face many situations in which effective public communication is required, such as prevention of non-communicable diseases, health promotion, and promotion of

public understanding when a health insurance system is introduced in the future. It is considered important to strengthen the capacity of government agencies to plan and implement effective public communication, while also cooperating with donors.

② Effective use of various media

- In the Campaign, TV commercials were aired with the cooperation of RTK. The results of the questionnaire survey confirmed that the videos of the Campaign have been seen through TV not only by the 27-45 age group, but also by more than half of the 16-26 age group. Even with the rapid spread of social media today, TV can still have an influence on a wide range of generations. In the future, it would be desirable to continue to consider the possibility of cooperation in government public communication with content that contributes to the public interest, while fully respecting RTK's philosophy of delivering accurate, neutral, and fair broadcasting and its independence.

- The Campaign received a great response on social media. On the other hand, a wide variety of comments, including negative ones, could be seen, and the increase in vaccination intentions seemed to be limited compared to the growing interest and understanding of vaccination. In addition, it was not easy to monitor these randome comments with human eyes and make timely decisions and actions. In the future, it would be desirable to understand the characteristics and difficulties of social media, and to effectively utilize social media while introducing social listening and other techniques.

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