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AN INVESTIGATION INTO THE HEALTH OF A REPRESENTATIVE SAMPLE OF ADULTS IN KOSOVO

INVESTIGATORS
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This study was conducted while the investigators were employed by the ***International Medical Corps***. in Kosovo.

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ABSTRACT

Objective: The purpose of this descriptive study was to investigate the health attitudes, behaviours and needs of Kosovars following the conflict in 1999 as the region was moving from an emergency into a post emergency development stage of health care.

Methods: The methodology triangulated qualitative and quantitative information and data (focus group interviews, demographic data and observations) to describe the health of a representative sample of 87 Kosovars in the Podujevo municipality of Kosovo.

Results: *Participants were found to be physically and emotionally healthy, evidenced by coping abilities including individual, family and community function, the ability to engage in short-term planning and productive daily activities pertaining to rebuilding lives. There were eight health themes that arose from the narratives with the environment and access to health care identified as priorities by participants. While it was reported that the assistance of NGO's was invaluable in resettlement and rebuilding, a darker side was uncovered in that the approximately 60,000 ex-patriots in the region added to the existing serious environmental woes. Further, in a region where prostitution, substance abuse, homelessness and criminal activity hardly existed before the conflict, an alarming increase was taking place, adding to the distress of Kosovars who were attempting to regain a life of peace and stability.*

Conclusion: *It can only be hoped that the benefits accrued to Kosovars by international aid (protection, guidance, stability) will outweigh the serious costs to their environment, health, and culture. If the intelligence, endurance, motivation and problem solving skills demonstrated by participants in this study can be extrapolated to Kosovars in general, then there exists, a strong base on which to restructure the health care system, maintain health, and thereby ensure a positive future for the region.*

INTRODUCTION

The armed conflict in Kosovo ended with NATO's intervention in June 1999. Following what had been an emergency refugee situation in the region for almost a year, a traumatized population entered a period of intense planning, rebuilding, and adjustment, assisted by hundreds of non-government organizations (NGO's) all under the coordination of the United Nations Mission in Kosovo (UNMIK).

In September 1999, the UNMIK Joint Civil Commission (Health) released a document of proposed policy guidelines for Kosovo (*1*). That report raised important questions pertaining to the causes of morbidity, mortality and resources needed to rebuild the health care system. Subsequently, many health studies were carried out by NGO's that pertained to these and a variety of other health issues (*2, 3, 4, 5*). However, these studies were often in the form of quick answer surveys conducted by investigators who spent only a short time in Kosovo, with the result that knowledge of the region and culture were sketchy at best. Further, while health surveys can elicit some particular objective data, individuals are not provided with opportunities to freely express their unique perspectives (*6, 7*). Indeed, it is these very perspectives that lead to a fuller understanding of evolving life experiences that may enhance or hinder health and by extension the health care system (effectiveness, resources, and sustainability) (8,9,10). Hence, combining subjective information and objective data is crucial for a broader and deeper understanding of culture and health (*11, 12).*

GOAL AND OBJECTIVES OF THE STUDY

Goal: To establish knowledge pertaining to the health beliefs, behaviours and needs of people in ten communities in the Podujevo municipality of Kosovo.

Objectives:
1. To conduct focus group narrative interviews.
2. To collect demographic data via questionnaire.
3. To record observations pertaining to personal characteristics and environment.

STUDY BACKGROUND

The investigators spent an average of four days per week in the field over a six month period, observing and developing professional and personal relationships with Kosovars and NGO workers. Health beliefs, behaviours and needs were noted while collaborating with staff of ambulantas (outpatient clinics) and mobile clinics in rural mountain areas, with community members during community education forums, and while assessing the health of individual and family referrals made by local residents, officials and/or NGO personnel. These activities and collaborations revealed information that was contrary to the findings of many survey studies previously carried out in Kosovo, in that most families were coping with meeting their sustenance needs, rebuilding, and resolving losses and trauma. In short, adequate biopsychosocial health was evident across the age spectrum in homes, in schools and at the workplace. Since Kosovars were pondering different options to rebuild their health care system, obtaining information that would investigate these observations in more detail, would be a useful addition to previous survey findings. Hence, the rationale for this study was to add individual narrative to existing survey findings and contribute to effective, resourceful and sustainable heath care planning (*13, 14*).

STUDY MILIEU

Kosovo is a mountainous region in the Balkans. Its exterior borders are Macedonia to the south, Serbia to the north and east and Montenegro to the west. The municipality of Podujevo is 40

kilometres north of Pristina. It's interior borders are Serbia to the east and north, Pristina to the south and Mitrovica and Vushtrri to the west. The population of this area is approximately 120,000 people with almost 2/3 of this number residing in rural areas. Since the recent conflict the municipality is now almost exclusively Albanian with a few enclaves of Romas and a small number of Serbians. Most of the rural roads are unpaved and are little more than mud tracks through the countryside and the mountains. Kosovars living in the remote mountain areas rarely have reliable transport and residents who seek health care rely on each other through sharing whatever vehicles are available such as tractors, late model cars or horse drawn carts. The infrastructure in the municipality had been crumbling, over approximately the past decade, due to a deteriorating economic situation that became critical in the aftermath of the conflict (*6, 14*). For example, there are few amenities such as working telephone lines, snow removal and postal service, electricity is sporadic and heating fuel and petrol can be difficult to obtain.

METHODOLOGY

INFORMATION COLLECTION AND ANALYSIS

Recruiting and Selection

Locations for focus groups were selected to represent areas to the north, south, east, west and central parts of the municipality of Podujevo. Volunteers were recruited by distributing an information sheet in Albanian to ambulantas and community stores that outlined the nature of the study. Participant selection consisted of the first 8-10 volunteers, 18 years or older, in the belief that a random sample would more effectively highlight health similarities and differences within and between the volunteers.

Ethical Considerations

Each participant was required to sign a letter of consent prior to the initiation of the first interview. This letter was in Albanian and contained information pertaining to the purpose of the study, the time commitment, the structure of the interviews, confidentiality, the role of the interviewer and how information from the study would be disseminated.

Narrative Interview

The primary investigator did not speak Albanian hence the interviews were carried out by Albanian research assistants, a physician and a medical student, who were mentored in interviewing techniques by prior to the initiation of the study. On a rotating basis one research assistant conducted the interview while the other, along with the primary investigator, were in charge of the audio-tape and observing personal characteristics, the environment, and dynamics within the group and between participants and the interviewer.

Before beginning each interview, the setting (ambulanta, school or community center) was organized in that participants were seated around a table that held a snack and beverage. They were thanked for agreeing to take part in the study, asked to read the consent form and encouraged to ask questions prior to signing the consent. The narrative interview began with the interviewer posing an open-ended question pertaining to health: ***"What thoughts and feelings do you experience when you hear or think of the word, 'health?'*** The interviewer's role was to act as a catalyst to empower participants to freely express their thoughts and feelings while observations pertaining to personal and cultural characteristics and group dynamics were noted.

Content analysis of the resulting taped information focused on in-depth analysis and comparisons of responses within and between focus groups. Specifically, analysis included: i)

reading, transcription, and editing of the audio-tapes; ii) adding observations and field notes; iii) re-reading the transcript until meanings and key concepts began to emerge; iv) coding prominent topics; v) categorizing the codes and, vii) developing and interpreting themes.

Questionnaire

The demographic questionnaire contained twelve multiple choice and short answer questions that pertained to personal issues such as age, marital status, education, employment, etc. (Fig. 1).

SAMPLE DEMOGRAPHIC QUESTIONS

Please answer the following questions by circling or writing in your answers.

1. What is your date of birth? Month…….. Day……. Year…….
2. Where were your born? ……..
3. Are you married? Y N
4. Do you have children? Y N
   If yes, how many? ……
5. What is your education? Primary Secondary Post Secondary Technical
6. What is your occupation? ……
7. Are you currently employed? Y N

If no, when was your last date of employment? Month……. Day……. Year…….

8. How many kilometers are there between your home and your ambulanta? ……..
9. How many people are residing in your home? Adults……. Children……

FIG. 1

While participants completed the questionnaires, the research assistants were readily available in order to answer questions or provide assistance wherever necessary. Upon completion, each questionnaire was checked to ensure completeness, and data were cleaned, edited and entered into an EPI Info statistical program.

Participant Time Commitment

The time required of each participant who volunteered for the study was 2.5 hours. The narrative interview and questionnaire required a total of 1.5 hours to complete. The remaining time was used for introductions, explanations, and terminating the interview process.

Triangulation

Findings were triangulated (narratives, observations, questionnaire responses) only after all information and data had been gathered and analyzed separately (Fig. 2).

TRIANGULATION MODEL

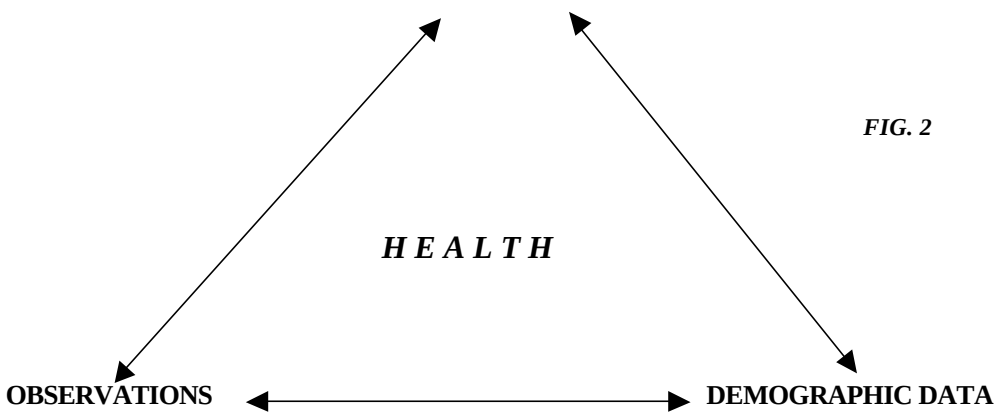


FIG. 2

Piloting the Study

A small pilot study was conducted prior to the initiation of the full study in order to test the above methodology.

FINDINGS

Investigator Observations

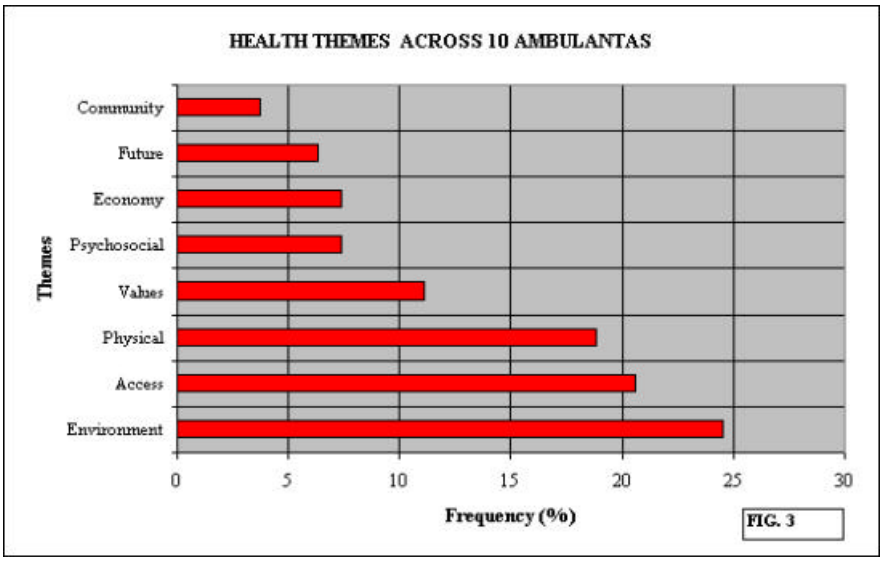
Most groups numbered 7 – 10 participants, many of which were young adults. Interviews were carried out during late autumn and winter when heating materials were in short supply and locations were unheated, necessitating the wearing of outer clothing by everyone (coats, hats, and gloves). In spite of this challenge to group dynamics, participants were courteous, answering questions and expressing their views with humour, intensity and passion. A small number of participants indicated difficulty reading the questions.

Number of Participants and Frequency of Responses

The number of participants interviewed across ten ambulanta areas totaled 87. Of this number over half were male with the result that overall, male participation was generally higher in relation to females.

Themes

Eight themes emerged from the narrative group interviews. While these themes are presented and discussed in a chronological manner, they emerged randomly as participants verbally as participants verbally moved between time perspectives, emphasizing health issues over their life times (Fig. 3). Over 50% cited that health was dependent on a) the environment**,** b**)** access to health care, and c) physical health. Other themes pertained to values, psychosocial, economic, future, and community issues.



Gender and Frequencies

Taking into account the higher number of males overall there was only a slight difference between males and females pertaining to the conditions perceived to be important to maintaining health. Two exceptions to this pattern were responses pertaining to community and access to health

services where there were substantial spreads between gender responses with males expressing more concern.

Health is Environment

This health belief comprised approximately one-quarter of total participant responses and was defined within individual and community health contexts of sanitation, quality food, air, and water, intact, warm, dry, spacious housing, and safety.

> *"**During the war my house was destroyed. When it rains, water comes into the room, there is a bad smell and the air is very wet. All of this affects my family's and my health. The war influenced conditions. The large numbers of bombs left over in the environment are very dangerous. We are now living in hard conditions without electricity, running water. Many wells are not clean and a big problem is the drinking water. The water is not clean or drinkable. Cleanliness in our environment is not at an acceptable level. Good food and clean air are necessary. If we want to be healthy we need better living conditions."***

The importance of community responsibility to protect and maintain a clean and safe environment was also cited.

> ***"We are not organized to clean our village. There is no designated place for garbage disposal and no means to remove garbage. We must keep the environment clean for living and for growing quality food. Hygiene of the village influences health. We need to take care of the environment in which we live. These efforts will lead to better health."***

Health is Access

This health belief comprised approximately twenty percent of total responses and was defined within a broad range of concerns pertaining to the health care system. While a small number of participants offered positive responses such as, *"**The service (in the ambulanta) is okay and the staff is very good and professional**,"* concerns pertinent to caregivers, medications, ambulanta, equipment, health promotion, and transport (availability, knowledge, expertise, proximity) were identified as difficulties that often prevented people from having their health care needs met. The responsibility of caregivers to provide quality health care was referred to with frequency.

> ***"I would suggest that there be a doctor here five days a week because this ambulanta covers 10 villages. We also need more specialists. The care is not so good because those who are here do not function properly. The ambulanta must be organized to prevent illness. I would suggest that we have more lectures to expand our knowledge about maintaining health."***

Many participants were appalled at the scarcity and/or lack of services and passed on anecdotes about someone they knew, friend or relative, who was not receiving care due to insufficient resources and access to an ambulanta (distance, cost, transport) was also cited.

> *"**Economic conditions influence health. If we cannot find medication in the ambulanta then we have to buy it. We cannot supply our family with what they need. In mountain areas there is a lack of transport. We have to calculate travel expenses but we have few opportunities for transport and we wait. People must walk in bad weather and their condition then is worsened."***

Health is Physical

This theme was defined within broad contexts that were believed to impact on physical health including, cleanliness, nutrition (quality and quantity), exercise/fitness/mobility, adequate rest, age, eyesight, and dental factors. Also linked with this theme were religious beliefs and illness prevention.

> *"**Hygiene is the most important aspect of health. But that is now difficult because since the war we do not have money to buy washing machine, soap for washing clothes or our bodies. These things affect our health. We need to advise sick people to be more careful when sneezing or coughing which requires a cloth or handkerchief, and to wash their hands. In this way, diseases are not transmitted. Transmission of diseases can be prevented by advising children to keep clean. Hygiene must begin at the individual level through family and community, then health is increased. The***

people who come to the mosque for praying must be clean. If somebody does not respect hygiene, he does not respect health and at the same time does not respect God."

Health is Values

Life values that were considered as important touchstones in order to maintain health and a good quality of life were as follows.

"Health provides the base for all other things and it includes personal, family, environment and hygiene. Everything loses value if you do not have health it is a big treasure. A person who has problems with health has a difficult time to achieve and reach goals in any field of life."

Health is Psychosocial

Less than 10% of participants identified this theme but those who did linked it to physical health, family, community, and the conflict.

"The word 'health' means not only the absence of diseases but also psychological health. If our psychic state is not calm then our health cannot be good. If one family member is suffering a problem with mental health everyone is affected. We have cases of children who have problems with dreams. They are frightened and get up in the night. These problems are common after the war. I would suggest that better organization of the village in psychosocial aspects should be done. This will influence and make health conditions better."

Health is Economic

This theme was identified by less than 10% of participants who linked economics to health at the personal, family, community and regional levels. Finances necessary to meet the needs pertaining to biopsychosocial health and overall quality of life such as, nutrition, clothing, hygiene, humanitarian assistance, rebuilding, health care, and employment were seen as crucial to health.

"***Health depends on financial conditions. If we are in good economic conditions we are in a position to fill our needs for food, clothes, sleep. Health is better. With a better standard of living we would have more opportunities to protect our health and to prevent disease. Work is needed. With work we will achieve all things. We will build houses, schools, ambulantas. If everyone has a job and a salary we are in a position to make health better. Better organization of economic health should be done where people can work and raise the living standard. This will make health conditions better."***

Health is the Future

Future health was cited by approximately six percent of participants and included illness prevention behaviours that would result in better future health including lifestyle, (exercising, substance use (alcohol and tobacco), cleanliness, nutrition) and maintaining a balance between physical and mental health.

"For myself, to be healthy, I have a routine. I get up early, work, take a rest, try to keep hygiene at a good level and walk outside every day. We need to be aware of how to protect the health that we have (with) sports activities, nutrition, rest and sleep. Children need to be vaccinated regularly. Parents need to educate children. In time a base is laid for future health. We need to take care of our health even when we have good health. I think we have to be more vigilant."

Health is Community

Fewer than 5% of participants cited the importance of community support and the importance of intact, organized communities that possess the capability to mobilize around health issues. However, an awareness of the link between the conflict and health risks was evident.

"A good community is necessary for good health. Good communication between the school and the ambulanta is very important for health in the community. We have many burned houses and many people have moved out of the region. If no one takes care this community will become deserted. Aids has now knocked on our door. We have many people from abroad in our country. Everyone needs to be careful with whom they have sexual contact and to protect themselves with condoms."

Summary

The narrative findings illustrated participants' primary concerns about health. These concerns spanned a broad range of micro and macro issues. The ability to link individual health needs to family, community, municipality, and region is indicative of knowledge that enables participants to logically recognize, analyze, problem solve and understand the strengths on which a new health care system can be restructured.

TRIANGULATION

Since health was defined as a process of ongoing and seamless life experiences and events, participant's subjective accounts were considered the primary vehicle with which to obtain health descriptions. While providing individual descriptions and meanings of experiences, the narrative simultaneously illustrated how a common history and culture can serve as a backdrop to each participant's unique reality. Participants' narratives of life events revealed patterns and unifying features that represented experiences, associated meanings, personal characteristics, well-being and gave rise to prominent themes. Investigator observations pertaining to personal and group characteristics and environments occurred at several different junctures and levels across all focus groups. The demographic data and investigator observations added a dimension that fleshed out and augmented the narrative, thereby increasing validation and confidence in interpreting findings.

Number, Gender, and Ages of Participants

Participants represented a mainly young cohort with an overall mean of 32 years and the mean age ratio of males to females was 35:25 years (Table 1).

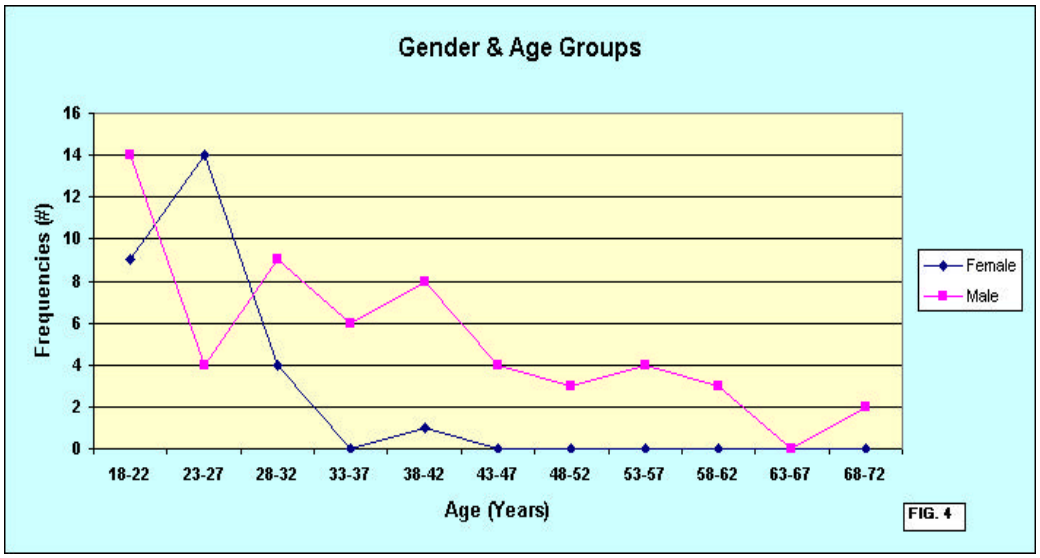
DEMOGRAPHIC QUESTIONNAIRE
(AGE AND GENDER)

Total Sample	**n**	**x**
Ages 18 – 70 years	87	32
By Gender		
Female – ages 18 – 39 years	28	25
Male - ages 18 – 70 years	59	35

TABLE 1

While there were a larger number of males and their ages spanned a broader range, it is noteworthy that in the age grouping 23-27, the number of males dropped appreciably while female numbers were highest (Fig. 4).

The higher number of male volunteers and age distribution requires closer scrutiny. Four of the ten communities closest to the borders of Serbia were quite heavily damaged during the conflict causing women to migrate to safer villages in the interior. ***"Our objective was to survive. We walked from village to village for many days. We had to risk our lives to go to other villages."*** Due to a damaged infrastructure (homes, schools and ambulantas) and the fast approaching winter many women, including those who had lost a male breadwinner in the conflict, remained in the host communities until conditions had



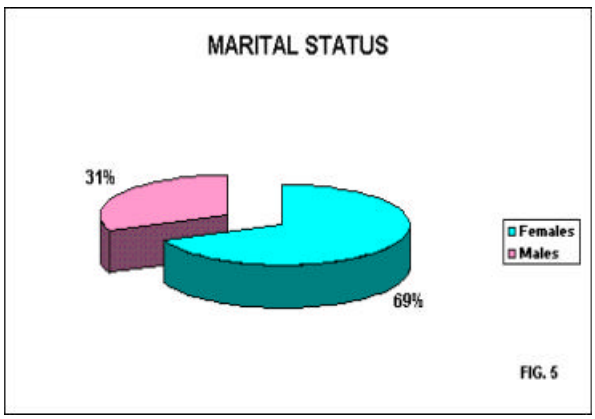
stabilized in their home villages. However, a fifth village that is within a kilometer of the Serbian border is an exception to the above explanation in that the focus group contained more women than men. This village is in an extremely isolated and densely forested mountain area from which internal migration would not have been a simple option for women hence, refuge was sought within the immediate environment. Further, the proximity of this village to the Serbian border resulted in many men being taken prisoner or killed during the conflict. Subsequently, due to the distance from large centers coupled with the lack of transportation, resources, and the size of families, those women who lost a spouse and/or breadwinner would have experienced much difficulty relocating during or post-conflict.

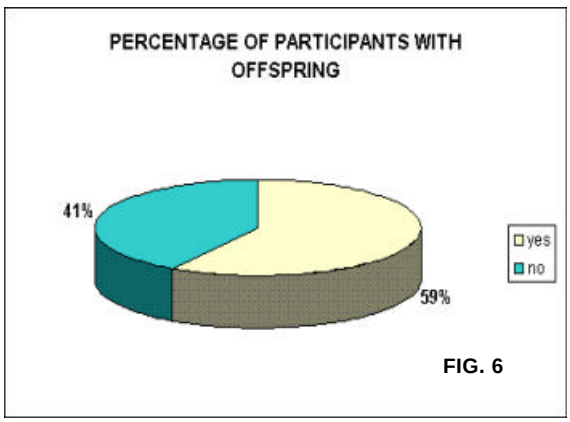
Two of the remaining five groups were located close to Podujevo city (a former KLA stronghold) and contained a higher number of females than males. Many women who were from three outlying villages that had experienced a great deal of damage had fled to the two communities referred to above to seek refuge. ***"We had many burned houses (and) a number of the population moved out of the region."*** Since their home villages were undergoing a great deal of rebuilding it is likely that these women did not intend to return until their communities had been made habitable once more.

The implications of these findings pertaining to gender are important to follow up in subsequent studies as effective planning of health care resources will have to be tailored according to each community's evolving and fluid needs, one of which will be gender.

Marital Status and Offspring

While 49% of participants were married, the percentage of married females exceeded that of males by over half (Fig. 5).

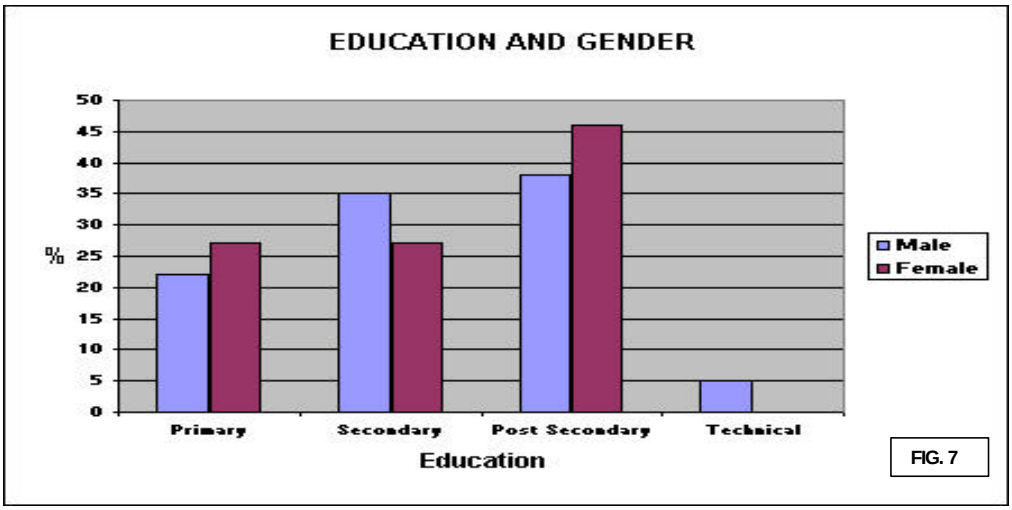




Fifty-nine percent of married/cohabiting participants had offspring with an overall mean for the number of children at 4.5 (Fig. 6). These findings combined with the relatively young age of the cohort, illustrates that participants married early and began families soon after. Pre conflict, large, extended families were a cultural norm, and childcare was built into the household, reducing the physical, financial, and emotional aspects of caring for children appreciably. Hence, there was little reason to delay beginning a family whether or not one or both parents were employed. However, given the current post conflict situation, including the reduced number of eligible males between the ages of 23-27, and economic difficulties, the challenges presented by rebuilding lives and homes might result in later marriages and/or fewer or later pregnancies, significantly altering marriage and childbearing patterns in the future.

Education

Educational levels of participants are illustrated in Fig. 7.

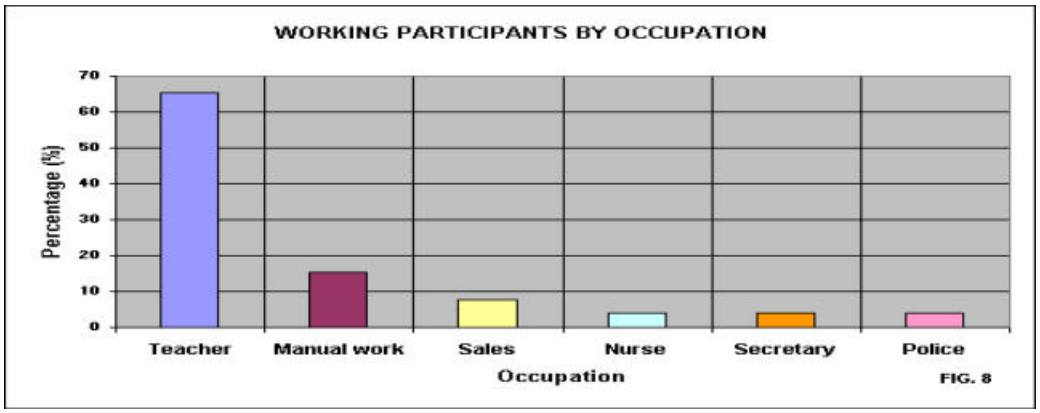


Noteworthy in these findings is that genders are separated by less than 10% at the primary, secondary and post-secondary levels. The importance of post-secondary university and technical educations has profound implications for rebuilding the infrastructure of the region, as the socio-economic structure depends on international investment that in turn will require many skills and specialized education. Hence, those individuals who have acquired these attributes at post-secondary levels will possess the necessary flexibility to cope with the current upheaval and at the same time, achieve personal and professional growth (*15*). It is no accident that participants who had difficulty completing the written questionnaire were those who had not completed secondary school. Future investment in the region will lie in offering opportunities to upgrade the knowledge and skills of Kosovars who are still at an employable age.

Economic Factors

Sixty percent of participants reported being unemployed. The occupations of participants who reported employment are illustrated in Fig. 8.

Those in service occupations (medicine, teaching) reported working long hours and receiving wages that were barely enough to provide their families with sustenance. As a group, they presented as confident and devoted to their vocation, were leaders in their communities and garnered a great deal of respect. It is this combination of strength, leadership and service to the community that will contribute to successful rebuilding of the region in the future.



Participant information pertaining to the importance of personal, community and regional finances revealed knowledge of the interconnections between the micro and macro economic realities. For example, the importance of financial resources in order to maintain personal self-esteem and health necessary for successful rebuilding of the communities and the region is apparent in the dialogues. While participants believe that the assistance of NGO's is necessary, there is a realization that this aid is short-term, and that opportunities for employment would be a better long-term solution for rebuilding. However, even though participants possess an adequate understanding of the importance of financial resources and employment at both micro and macro levels, given the current unstable economic and socio-political situation in the region, there will be a need for an advisory body to assist and guide communities on how this can best be achieved as well as to engage in future capacity building strategies.

Questions that were poorly answered pertained to last employment, household income, and breadwinner. It is probable that pre-conflict, the deteriorating infrastructure had begun to affect the employment situation within the municipality. Kosovars are task oriented, place much value on employment, achievement and a professional role within their daily lives. The steadily growing unemployment resulting from a deteriorating economy exacerbated by the conflict, resulted in sketchy employment histories that participants might have found difficult to explain and indeed, might have even caused them to experience feelings of shame and embarrassment.

Family Systems

The average number of people cohabiting in the same dwelling was 6 – 8, including adults (parents, grandparents, aunts, uncles) and children. It is this pattern of cohabitation that might impact negatively on future health. That is, while the Kosovar family system and lifestyle was, prior to the conflict, conducive to extended family living there are now challenges to sustain this system (food, clothing, health care, etc.). Further, the necessity of living within a crowded environment while family homes are rebuilt and/or repaired, and the accompanying the health hazards now present in the environment (air, water, food quality, lack of clean water, soap, heat, the presence of landmines, questionable refrigeration and sanitation) exacerbated by unemployment, lead to a situation that presents serious health risks both physical and emotional over time (*15*).

The gender mortality rate among participants' parents indicated that overall, there was approximately a 20% higher death rate among the male parents of participants, peaking at 44 years and continuing to be high into elder years. One reason for this higher mortality can be attributed to lung disease. Prior to the conflict, Kosovo had few if any regulations pertaining to environmental work protection for employees. Further, most Albanian men consume between 1 – 2 packets of cigarettes per day. It has been shown that lung disease is related to both unregulated and heavy industrialized employment situations as well as lifestyle (smoking) (*4*). A second reason for the

higher male mortality was related to violence including taking part in or being victimized by circumstances related to the conflict.

The overall lower mortality rate among participant's mothers, was likely a result of the lifestyle of that generation who remained at home tending to children, elders, and duties related to nurturing of families. It has been shown in the literature that women who work in the home are generally subject to more flexibility and less stress, resulting in better health (*17*). Contributing to this situation is the cultural nature of extended family living that includes abstinence from smoking tobacco and shared women's work by mothers, grandmothers, aunts, daughters and older children.

Access to Health Care

The largest percentage of participants reported that the distance from their homes to their ambulantas ranged from under 1 to 2 kilometres (91%) with the remainder reporting traveling distances ranging from 3 – 8 kilometres, indicating that most participants fell within the UNMIK mandate. However, given the absence of reliable transport, poor road conditions and lack of finances to pay for what public transport was available, this finding has to be scrutinized carefully. For example, the lack of transport combined with cold weather, resulted in mainly those participants who lived in close proximity who volunteered for this study, an indication that there are likely many more Kosovars who would have difficulty reaching the ambulanta than is shown in these findings. While rural areas tend to be universally under serviced, the post conflict problems exacerbate this dilemma to a greater extent for Kosovars in this period due to a severely damaged infrastructure. Much more detailed research needs to be carried out in order to determine the number of people who lack transport and as a result, do not have ready access to health care due to lack of resources.

Participants defined good health as a result or outcome of the following; availability, knowledge and skills of caregivers, emergency transport, access to ambulantas, specialists, medicine, and last but not least, financial stability. While there was somewhat of an emphasis placed on the importance of health education and illness prevention, participants believed it to be largely the responsibility of professional caregivers both to relay information and to ensure compliance. Sheldon (*2*) found that in Kosovo, males read and/or absorb more information pertaining to health, and that both genders obtain close to 40% of their health information from the ambulanta or primary health care setting. Findings in this study were comparative in that the majority of participants believed that the appropriate place to obtain health information was from their ambulanta.

Males were found to be much more concerned about health access issues in general and health promotion in particular, most likely due to their roles as breadwinners and heads of large, extended families (5). However, given the current post-conflict employment situation, a decision pertaining to any kind of fee-for-service will have to be modified, deferred or delayed until employment for most people becomes a reality (6). Hence, a dual focus on availability of health services and ability to pay, are important considerations in future planning.

Environment

Most participants linked environmental deterioration to the conflict. While this analysis is essentially correct, it stops short of identifying another important issue that has contributed to the current environmental problems. For example, the deterioration of water and air quality and living conditions in general began 10 years earlier, as the economic system in Yugoslavia began to seriously falter, leading to unemployment on a large scale and resulting in weakened government regulations, health and social health programs (5, 6, 14). Hence, the breaking down of the infrastructure that contributed to the deterioration of the environment was already taking place and affecting the health of Kosovars prior to the conflict. The increasing numbers of lung and stomach diseases reported might be linked to unregulated air pollution, heavy smoking habits, lax food inspection, poor water

quality and a decreasing lack of resources to protect health, reduce risks and treat disease. However, the lack of regulations pertaining to the environment, the number of military and NGO personnel in the region, and the upkeep of large families with limited resources, makes even basic preventive health practices extremely difficult if not impossible to implement.

Participants are cognizant of the effects of the environment on health and in the current transition period a willingness to assume responsibility was frequently verbalized. This willingness however, will need to be tempered with education pertaining to what can be realistically accomplished with scarce resources at the micro level (improved living conditions, sanitation) and what cannot (food, air, and water quality, industry, coal and wood burning, and large scale sanitation). Contributing to further environmental deterioration is a large international presence through increased traffic, an overtaxed sanitation disposal system, and a drain on resources (electricity, heating). Hence, improving living conditions will be a formidable task due to the length of time the environment has been deteriorating in addition to present ongoing stresses. It is probable that if more financial and personal resources and support were available, participants would invest a great deal into the environment. However, it will be difficult if not impossible to effectively improve the environment at any level if people are unemployed and regulatory bodies are not in place. Barring these important first steps, the deterioration of the environment will continue to occur unabated and to take an increasing toll on health.

Primary Health

Participants identified ways in which risks to health can be reduced through preventive practices, but their distress pertaining to issues over which they had little/no control such as, the lack of qualified practitioners, clean water, money to meet the costs of soap, and lack of laundry facilities is palpable in the dialogues. While participants indicated an awareness of the importance of hygiene and sanitation as primary building blocks on which health risks are reduced, they lacked the necessary resources and as a result, expended a great deal of emotional and physical energy in order to simply maintain an acceptable quality of life from day to day (*18, 19*).

Studies have shown that if primary health care is the touchstone of a health care system, then maintenance and/or improvement of health, and significant savings of resources both personal and financial can result (20, 21). Hence, rebuilding and restructuring a resourceful and sustainable health care system must have, at its base, an effective primary health care system. Accomplishing this goal would necessitate the rebuilding of accessible ambulantas with adequate staffing and resources. For example, reliable, clean water, electricity, heat, transport, and the need to build confidence in the skills of primary care nurses and physicians is crucial. Addressing these issues would necessitate appropriate resources in order to make services readily available and to educate caretakers in health promotion techniques, so that unnecessary and expensive referrals would be avoided. Finally, there must be a special effort to encourage women to become involved in any planning as women are the primary caretakers of families.

Psychosocial Health

While many participants identified living conditions that would pose risks and/or lead to physical illness, only a small number considered the possible debilitating effects of emotional issues such as, stress and trauma, on health. Even in cases where headache, disturbed sleep, and anxiety were cited as life difficulties, often a solely physical explanation was offered (quality of water, air, food, lack of heat, etc.). Psychosocial health not being identified as a higher priority raises two questions first, whether Kosovars have considered psychosocial issues a part of health over time or second, whether individuals are too focussed in the current period, on the tasks of rebuilding. For example, the many tasks of resettling that are depleting the energy of participants includes, ensuring

intact housing, regrouping families, seeking job opportunities, supplying households with food and personal needs, rebuilding communities, all within an environment with serious infrastructure problems including lack of and/or limited communications, fuel, electricity, water, petrol, etc. Given these multiple challenges, it is possible that participants are only able to concentrate on their immediate physical health thereby delaying coming to terms with psychosocial issues until resettling is complete. It is at that time that difficulties may begin to emerge and require some attention from the health care system. A desire on the part of some participants, albeit a small minority, to heal wounds associated with the conflict, to reduce stress, deal with trauma, and to maintain balance and stability, is an indication that some participants possess insight pertaining to the importance of effective psychosocial function on overall health, and knowledge that pertains to healthy function for the individual, family and community. It is precisely this insight and knowledge that can be utilized when and if psychosocial issues become a more important focus of health in the future.

Community Mobilization

Mobilizing community resources is a difficult process at this time as families, communities, educational and social systems have been seriously disrupted by the conflict, forcing many to become internal or external refugees. The resulting ongoing community upheavals, due to the regrouping of families and rebuilding of homes makes community mobilization difficult. However, the emphasis placed on group cohesion in the dialogues by participants, through the frequent use of the communal word "we", as opposed to "I", is indicative of pre-conflict community cohesion, stability and mutual support. This communal "we" reveals a value within the culture that is accustomed to looking beyond individual, immediate needs and to both give and receive support from within their communities. This will be one of the most important strengths to nurture in rebuilding, mobilizing and regaining community equilibrium.

Summary

Triangulating qualitative, subjective information pertaining to life experiences and health derived from the narrative interviews and quantitative, objective data from the questionnaire and observations, illuminated different layers and dimensions of experience and health. When combined, this information completed a comprehensive picture of how the experiences of conflict and upheaval influenced the health and well-being of participants.

CONCLUSION

The purpose of this study was to conduct a descriptive investigation of the health of Kosovars in ten communities in the Podujevo municipality of Kosovo. Data obtained from short-term surveys conducted in Kosovo, primarily carried out by investigators who spent only a brief time in the country, indicated that Kosovars were suffering both physical ill health and associated debilitating effects of trauma related to the recent conflict. However, based on this investigation including in depth observations and interactions with Kosovars over a prolonged period, it was evident that there were many biopsychosocial health strengths in the population at large. There was no doubt that people were still struggling with the effects of a conflict that had driven many from their communities and region, destroyed their homes and uprooted families, leading to numerous losses both personal and material. There was evidence however, that most were experiencing adequate physical health and coping effectively and constructively. That is, short term goals had been set to rebuild families, communities, homes and the region, and Kosovars were progressing steadily toward meeting these goals. It was these observations, at odds with the findings of completed surveys that lead the investigators to carry out a study that would identify and clarify the health strengths that Kosovars possessed.

Narrative information was chosen as the central research tool in order to reveal longitudinal sequences of individual experience that embraced life before, during and after the conflict, while at the same time capturing individual meaning, context and perspective. The use of narrative lead to a participant centered agenda, challenged received wisdom and generated many new ideas. It is this kind information that is useful in resourceful, effective and sustainable future policy planning.

Partnering with Kosovars in order to recruit participants and identify a suitable place for interviews was a useful strategy as residents of communities felt and indeed were part of the total process. This made the research process a richer and more rewarding experience for all. Sharing food and a beverage was not only culturally correct, but symbolic of the equality and equity between participants and investigators. Finally, working with two Albanian research assistants enabled the primary investigator to develop a fuller and deeper understanding of cultural mores that added confidence to the task of interpreting findings. These findings spanned a broad range of micro and macro health issues that pointed to participant's knowledge of and ability to analyze, problem solve and reach an understanding of the ways in which an effective health care system could be successfully restructured. These findings would not have been possible without having spent a prolonged period in the country and/or with the use of survey data alone.

In an environment of stability and peace, healthy behaviours can be chosen at a micro level but the larger macro issues are all dependent on funding at the regional, municipal and community levels. However, community development, organization, mobilization and ultimately health, are all dependent on such funding. A common thread that ran through all of the narratives was the use of "we" in reference to family, community, and region demonstrating a priority that can translate into strength in future successful rebuilding and development. The mainly young cohort of participants possessed reasonable educational preparation for employment within a profession or a trade, however, the important steps of electing a national governing body for the region, expanding educational opportunities, foreign investment, increased employment opportunities and community stabilization and mobilization, are all crucial components that are necessary for the maintenance of existing health.

Unemployment beginning in the mid-late 1980's, that left thousands of young, healthy and educated people jobless, was a precipitating factor that lead to frustration that began as peaceful demonstrations and over time resulted in open conflict and thousands of deaths. These findings indicated that two deeply held values are embodied in successful employment. Unless opportunities to rebuild new lives in the post conflict stage are made available, it is feasible that tensions may again flare, and the opportunity for this region to find peace will be seriously compromised and/or eluded (23, 24). Indeed, this situation is now taking place as international aid and military organizations attempt to control brushfire demonstrations, disputes and clashes. Exacerbating this potentially explosive situation is the reduced quality of life that has prevailed post-conflict, including a contaminated environment, sporadic electricity and heat, a need to depend on humanitarian organizations, and high unemployment. All of these factors lead to a deterioration of health at all levels over time. It has been well established that there is a link between poverty and ill-health, morbidity and mortality (22). For example, tuberculosis, a disease often associated with poverty, has been on the rise in Kosovo.

A further challenge pertains to the preservation of the extended family, a deep cultural value held by Kosovars. Most participants' parents will be over 65 years of age within the next ten years or so meaning that extended family households could include children, grandchildren, parents, grandparents, indeed, even great-grandparents, an impossible task that will fall to younger family members unless reasonable employment is made available. The importance of employment and financial resources were identified as the first steps toward empowerment and establishment of a strong link to good biopsychosocial health and the ability to assume personal and financial

responsibility for family and loved ones. Cultural beliefs and behaviours pertaining to the family cohesiveness must be recognized in the restructuring period, coupled with expanding employment opportunities in order to ensure that Kosovars can meet their responsibilities and achieve some measure of stability and life success.

Availability, knowledge and skills of caregivers, emergency transport, access to ambulantas, medicine, and equipment were all identified as crucial to maintaining good health. It has been shown that primary health care, if successfully implemented and practiced, can result in improved personal health and financial savings. Hence, encouraging people to take responsibility for some aspects of their health is paramount and provides a base on which a future sustainable health care system can be structured. A strategy that promotes a strong primary health care system coupled with accessibility, capacity building and renewed confidence in caregivers will have to take priority in future planning.

It is important to determine if participants are delaying coming to terms with the trauma associated with the conflict and if so, then future health planning will have to include resources pertaining to meeting the needs that emerge at that time. The immediate health care needs and tasks of resettling are many and resources are few, hence while health was generally perceived in the short term, it is likely that an ongoing uncertainty made the future difficult if not impossible to contemplate. It may well be that as resettlement progresses, and until a government is formed and investment in the region becomes a reality, Kosovars will continue to restrict their hopes and dreams to the immediate present.

In sum, this study has shown that participants are physically and emotionally healthy in that, they are carrying on with productive day-to-day function including, rebuilding homes, planting crops, caring for and sending children back to schools, and regrouping families. It was not the intent to underplay or minimize the suffering that Kosovars have endured. With the assistance and co-ordination of aid programs, the immediate emergency period has been transcended relatively smoothly and moved into a post emergency development stage. In this process there has been a cross-cultural exchange of information pertaining to health, social, economic, and political issues that has elicited new understandings on the part of host Kosovars and their international guests. At the same time, capacity building in the forms of new knowledge and skills have been passed on that will assist Kosovars to build a robust and peaceful future. However, this situation presents as a double-edged sword. For example, sexually transmitted diseases and prostitution (forced and voluntary) are rampant, as is the criminal element consisting of many factions. Further, lifestyle changes such as smoking, drug and alcohol use by both genders and pregnancies among young, unmarried women will all have profound effects on the culture. Subtle attitude changes pertaining to gender roles, marriage, child-rearing, extended family living, diet, etc., are also taking place accompanied by changes in health behaviours that will result in a very different biopsychosocial health picture and needs in the near future. These are rapidly growing problems that hardly existed before the conflict and the influx of an international presence. It can only be hoped that the benefits accrued to Kosovars by international organizations (protection, guidance, stability) will outweigh the above costs to their culture and way of life.

Policies pertinent to the rebuilding/restructuring of the health care system will have to pay attention to the prevailing attitudes, health behaviours and gender roles within communities and the region through in depth, scientifically rigorous studies with a strong emphasis on narrative. This study has shown that before, during and post conflict, Kosovars exhibited health, intelligence, endurance and motivation. It is these strengths that need to be nurtured in this period of rebuilding in order to form a strong base for maintenance and improvement of health and by extension, the health and future of the region.

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