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EDITORIAL



Asst. Prof. Dr. Ardita Baraku
Executive Director
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Health of Kosovo

Non-communicable diseases – a shared responsibility for health

For the National Institute of Public Health of Kosovo (NIPHK), addressing noncommunicable diseases (NCDs) means maintaining a continuous commitment to prevention, health promotion, surveillance and control, as well as early intervention at every stage of life. Raising awareness of NCD risk factors can delay the onset of these diseases or their complications, thereby increasing both life expectancy and quality of life. Prevention, however, is not the responsibility of NIPHK alone; it is the result of cooperation among individuals, communities and institutions in many different forms.

This edition of Shëndeti magazine is dedicated to NCDs as both a reflection of and testimony to the efforts of various national and international institutions to prevent and control them and to strengthen institutional and individual surveillance. Its purpose is to offer the broadest and most comprehensive possible overview of this issue by bringing together data, experiences and perspectives that can support sound and timely decisions for the health of the population.

This special issue of Shëndeti was prepared in cooperation with the Integrated Health Services (IHS) project through two initiatives that approach NCDs from different perspectives. The first brought together journalists and experts from public health institutions to make health information easier to understand and more visible in public discussion. The interviews, expert articles and journalistic investigations included in this edition demonstrate what can be achieved when professional expertise and the work of the media come together around a shared responsibility: keeping citizens informed.

The second initiative, the Leadership Course on Noncommunicable Diseases, was developed jointly by the University of Prishtina, the IHS project and NIPHK as part of the 2026 Prishtina International

Summer University (PISU). The course gave participants the opportunity to work with evidence, policies and concrete public health challenges, while developing the skills needed to think and act in response to NCDs. The inclusion of both initiatives in Shëndeti reflects the value of long-term cooperation among institutions, professionals, academia and the media: it helps ensure that knowledge does not remain confined to the pages of a publication but is applied in decision-making, communication and the protection of population health.

The publication brings together articles reflecting the perspectives of public health professionals, clinical health professionals, policymakers, academic staff, civil society and the media. Readers will be able to learn about health workforce planning; the use of health statistics in policymaking; successful interventions to reduce NCDs; the importance of public information, education and communication; the early prevention of vascular diseases; hospital care and care pathways for patients with chronic conditions; and the role of nurses in humanising health care.

The articles vary in format and approach. Together, they seek to make the challenges and consequences of NCDs more accessible to the wider public, while also highlighting opportunities to strengthen leadership capacity for designing and implementing the most appropriate NCD measures.

As Editor-in-Chief of Shëndeti, I believe that this edition is further evidence of NIPHK's commitment to its vision of 'A healthy population, in a healthy environment, in a healthy state.' This vision guides us towards shared responsibility, in which prevention, cooperation, knowledge and action form the foundation of a healthier and more productive society.

Non-communicable diseases in Kosovo: an epidemiological perspective and public health challenges

Noncommunicable diseases (NCDs) constitute one of the most significant public health challenges globally and in Kosovo.



Asst. Prof. Dr. Albiona Rashiti
National Institute of Public
Health of Kosovo

This group primarily includes cardiovascular diseases, diabetes mellitus, chronic respiratory diseases, chronic kidney diseases, mental disorders and malignant neoplasms (1,2). These diseases directly affect mortality, disability, life expectancy, quality of life and the economic sustainability of families and health systems, highlighting the close relationship between NCDs, social inequalities and the capacity of health systems to provide prevention, diagnosis, treatment and long-term care.

Noncommunicable diseases were responsible for at least 43 million deaths globally in 2021. Of these, approximately 18 million were classified as premature deaths, occurring before the age of 70, while 82% of premature NCD deaths occurred in low- and middle-income countries (2).

The purpose of this article is to present an integrated assessment of the epidemiological situation of noncommunicable diseases and malignant neoplasms in Kosovo.

By interpreting these data, the article seeks to identify Kosovo's epidemiological and public health priorities, strengthen the use of evidence in health planning, and underscore the need for coordinated measures in primary prevention, organised screening, early diagnosis, integrated clinical management, cancer care and standardised epidemiological surveillance.

This analysis is based on reports submitted by health institutions.

Under Administrative Instruction No. 11/2013 on the Health Information System and the Reporting of Health Statistics, every health institution in Kosovo is required to report NCD cases using designated reporting forms (3). The completion of these forms is governed by the Manual for Reporting Cases of Widespread Chronic Noncommunicable Diseases.

Reports are submitted to the Department of Health Statistics at the National Institute of Public Health of Kosovo (NIPHK), where the data are collected and processed to produce the Health Statistics Yearbook: Report on Widespread Noncommunicable Diseases (4). The Department of Epidemiology subsequently analyses these reports.

The data are anonymous and confidential and are presented only as numerical values. They are disaggregated by sex, age, place of residence and type of disease according to the ICD-10 classification, and compared across the years 2023-2025.

According to NIPHK's Analytical Report on NCDs in Kosovo (5), the number of registered cases increased by 5.5% between 2023 and 2024, from 41,258 to 43,539. This may be attributable to population ageing, longer survival with chronic

diseases and improved diagnosis. The demographic profile shows that more than 70% of cases occurred among people aged 60 years and over, increasing from 28,569 to 30,633, possibly as a result of multimorbidity. Women accounted for the majority of cases (61.1% in 2023 and 59.8% in 2024), which may be associated with longer life expectancy and greater use of health services.



Noncommunicable diseases were responsible for at least 43 million deaths globally in 2021. Of these, approximately 18 million were classified as premature deaths, occurring before the age of 70, while 82% of premature NCD deaths occurred in low- and middle-income countries (2).

The purpose of this article is to present an integrated assessment of the epidemiological situation of noncommunicable diseases and malignant neoplasms in Kosovo.

Arterial hypertension remains the leading diagnosis, accounting for approximately 50% of cases, and increased by 4.7%, from 20,472 to 21,425 cases. Type 2 diabetes recorded the highest increase, at 20.6%, rising from 9,723 to 11,729 cases; this may be influenced by obesity, diet and physical inactivity. Both conditions remain major risk factors for complications affecting multiple organs. Meanwhile, acute myocardial infarction increased to 2,366 cases,

71.8% of them among men; chronic kidney failure rose by 48.4%, reaching 1,043 cases; and chronic bronchitis reached 1,164 cases.

T Malignant neoplasms increased by 3.6% between 2024 and 2025, from 3,644 to 3,775 cases, and were concentrated among people over 50 years of age. Breast cancer was the most common cancer among women, with 592 cases in 2025. In the overall population, cancers of the digestive organs remained the most frequent, with 685 cases in 2025, followed by skin and lung cancers; lung cancer predominated among men.

The analysis confirms that NCDs represent the principal health challenge in Kosovo. They have a direct impact on life expectancy, quality of life, disability, mortality, economic productivity, the burden on the health system and families, and the country's overall development.

The rise in NCD cases should serve as a signal for evidence-based action to strengthen health promotion, prevention and disease management through appropriate measures across the life course.

Achieving Sustainable Development Goal target 3.4, which calls for a reduction in premature mortality from NCDs, requires political commitment, sustainable financing, stronger primary health care and a dynamic surveillance system (6). Only an integrated, intersectoral and person-centred approach focused on prevention can sustainably reduce the burden of NCDs in Kosovo.

The institutional response should be based on a proactive and integrated model that promotes healthy lifestyles and the avoidance of risk factors. To enable the early detection of NCDs and prevent complications, health professionals should conduct systematic screening. Once a condition is diagnosed, timely and appropriate disease management should become a continuing shared commitment among the health professional, the individual and the family.

To address factors beyond the health system and strengthen intersectoral cooperation, every other sector should, within its own mandate, contribute to creating the conditions needed to protect and improve population health. Such interventions form part of global policies that emphasise the influence of the environment and other living organisms on human health.

Investing in health today safeguards our future. Preventing NCDs is a shared responsibility that depends directly on the decisions we make every day. Active interventions at individual, societal, institutional and governmental levels are essential to ensuring long-term well-being and the effective prevention of these diseases across the population.

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When health journalism becomes part of public health

In Kosovo, health journalism is not, and should not be treated as, an editorial luxury, as in many cases it constitutes an important part of the public health infrastructure itself.

Getoarbë Mulliqi
Association of Journalists
of Kosovo



The quality of information citizens receive about diseases, prevention, treatment, patients' rights, and the functioning of healthcare institutions directly influences how they understand risks, make decisions about their health, and hold the healthcare system accountable. Strengthening journalism in this field is therefore much more than an investment in a specialised area of the media.

However, this role is being fulfilled in an increasingly challenging environment for specialised journalism. For many years, print newspaper newsrooms employed journalists who consistently covered specific areas such as the economy, justice, education, culture, and health. It was precisely through this long-term specialisation that they developed networks of sources, became familiar with institutions, learned the relevant terminology, and acquired a level of expertise that cannot be developed in just a few days or through occasional reporting. The disappearance of printed daily newspapers and the almost complete shift of the media market towards online platforms have fundamentally transformed this model, placing newsrooms and journalists under pressure to work at a much faster pace, compete constantly for attention, and produce as much content as possible in as little time as possible.

In this environment, many journalists no longer have the opportunity to focus exclusively on one field because the same journalist may report on politics, the economy, education, or justice within a single day, only to encounter, a few hours later, a complex health-related topic that requires an understanding of terminology, data, context, and the potential consequences that inaccurate wording may have for the public. This is not due to a lack of commitment or professionalism on the part of journalists, but rather reflects a media landscape that has changed rapidly and often forces them to become generalists in areas that require more time and specialisation.

It was precisely in response to this situation that the Association of Journalists of Kosovo (AGK) recognised the need, starting in 2023, to create more opportunities for journalists wishing to deepen their knowledge of health reporting. The AGK cannot replace newsrooms, nor does it seek to do so. However, it can create opportunities for journalists to acquire new knowledge, establish contacts with professional sources, engage more closely with experts from various fields, and develop the tools and skills that the demands of their daily work often prevent them from building and sustaining over time.

This has been one of the key benefits of the collaboration with the Integrated Health Services (IHS) Project, a partnership that developed gradually but was built around a very clear idea: if we want

citizens to receive better health information, we must also invest in the capacity of the journalists who seek out, verify, understand, and communicate that information to the public. For this reason, the joint activities were not designed merely as isolated training sessions, but as efforts to build more sustainable relationships between journalists, healthcare professionals, institutions, and patient representatives.

The initial steps focused on establishing direct dialogue between journalists and healthcare professionals, giving journalists the opportunity not only to acquire new knowledge but also to establish reliable contacts, both locally and internationally, whom they could approach even after an activity had ended.

This aspect is particularly important in health journalism, as the quality of reporting often depends on a journalist's ability to identify the right sources, ask the right questions, and determine whether the information received is complete, accurate, and explained in an understandable way. The collaboration subsequently expanded to include capacity-building activities on reporting about diabetes and related topics, as well as the Award for Responsible Reporting on Diabetes. The significance of this initiative was not simply in recognising one or more stories, but in the criteria used to evaluate them: medical accuracy, the use of data and expert knowledge, research, originality, and ethical responsibility. Through this approach, the aim was to convey a broader message: health reporting should not be limited to reproducing a statement, press release, or statistic taken out of context, but requires preparation, verification, and a heightened sense of responsibility.

In the subsequent phases of the collaboration, the focus broadened to include patients' rights, the psychological and legal aspects of reporting, and how patients' experiences can be incorporated into a story without reducing them to victimisation or sensationalism. The roundtable discussion, "The Power of the Reporting Angle", brought together journalists, healthcare professionals, institutions, and patients' rights representatives, highlighting that quality journalism in this field depends not only on access to information, but also on the ability to understand it, place it in context, and, where necessary, challenge it.

In 2026, the initiative "Beyond the Headlines: Journalism, Non-Communicable Diseases and the Stories That Matter" took this approach a step further by connecting journalists directly with experts from various fields and engaging them in solutions-oriented reporting, gender perspectives, the use of data, and one of the greatest challenges in health journalism: translating scientific and medical



The disappearance of printed daily newspapers and the almost complete shift of the media market towards online platforms have fundamentally transformed this model, placing newsrooms and journalists under pressure to work at a much faster pace, compete constantly for attention, and produce as much content as possible in as little time as possible.

language into information that the public can understand, without compromising its accuracy or significance.

For the AGK, this is the essence of such a partnership. A journalist does not need to be an epidemiologist to interview an epidemiologist, nor a cardiologist to report on cardiovascular diseases. However, journalists must understand the subject well enough to know what questions to ask, what data to seek, and how to distinguish evidence from opinion, fact from exaggeration, and useful information from sensationalism. At the same time, collaboration with healthcare professionals must not bring journalists so close to institutions that they lose their critical distance. The aim is not for journalists to become spokespersons for the healthcare system, but rather to be better equipped to question it, challenge it, and hold it accountable.

For this reason, the AGK is particularly pleased that this commitment has extended beyond training activities to include other forms of professional support and recognition.

In addition to the Award for Responsible Reporting on Diabetes, health reporting has also been included in the AGK's Annual Journalism

Awards through the Best Health Reporting category. For us, this is a clear way of demonstrating that this field matters and that journalists who invest time in understanding a medical record, a statistic, a systemic problem, or a patient's experience deserve to be supported and recognised.

Despite the challenges facing the media market, Kosovo still has journalists, shows/programmes, and platforms dedicated exclusively to health, as well as professionals who have invested years in developing knowledge, sources, and credibility in this field. For precisely this reason, in a media environment where speed is rewarded almost every minute, mechanisms must also be established to reward depth, accuracy, and investigative reporting because journalism that requires more time should not be seen as an obstacle to the pace of news production, but as an investment in the quality of information available to the public.

Ultimately, the beneficiaries of this investment are not only journalists, newsrooms, or the healthcare system, but above all, citizens who, after reading or watching a news report, gain a better understanding of the warning signs of a disease, become more aware of their rights as patients, and receive more accurate information about prevention, treatment, and health risks. Families also benefit by learning more about diabetes, hypertension, and cardiovascular diseases, as does the wider public, which becomes better equipped to distinguish between claims circulating on social media and professionally verified information. At the same time, the healthcare system itself benefits because, when engaging with better-informed journalists, it faces more precise questions, more substantive requests for information, and greater demands for transparency and accountability. This is why the success of the collaboration between the AGK and the IHS Project will not be measured by the number of seminars, photographs, or certificates, but by the quality of the questions journalists ask institutions, the way statistics are explained rather than merely published, and the stories in which patients are treated as individuals with a voice, dignity, and rights.

In this process, the AGK is working to build bridges between journalists, experts, and reliable sources of information, providing media professionals with additional tools to develop specialised expertise in an environment that continually pushes them towards generalist reporting. If these bridges lead to better-prepared journalists, more open institutions, and better-informed citizens, then health journalism will no longer remain merely a field of reporting, but will become an active part of how society understands, advocates for, and protects public health.

OP-ED

From statistics to health: when numbers save lives

Health is not determined solely by individual choices. It is also influenced by the conditions in which we live, learn, and work.



Asst. Prof. Dr. Ardita Baraku
Executive Director
National Institute of Public
Health of Kosovo

In public health, statistics are more than just numbers presented in tables, graphs, or annual reports. They reflect the health status of the population, reveal the factors that put it at risk, and guide decisions that directly affect the lives of citizens.

The fact that approximately one in three adults in Kosovo lives with arterial hypertension is not merely a statistic. It represents thousands of citizens at increased risk of myocardial infarction and stroke. It represents families who may face the premature loss of a loved one, a healthcare system burdened by chronic diseases, and an economy that loses productivity due to work incapacity and premature death.

Health is the result of interactions between biological factors, individual behaviour, the environment in which we live, and the functioning of the healthcare system. In this model, statistics serve as the link between these factors. They tell us how many people develop diseases, why they become ill, who is most at risk, and which interventions are effective. For this reason, statistics are not the end point of analysis; they are the starting point for action.

At the Individual Level: Statistics as a Guide to Healthy Choices

At the individual level, statistics are a tool that helps every citizen understand their personal health risks and make informed decisions about their health.

For example, epidemiological evidence highlights the risk of arterial hypertension. It shows that age, excess body weight, excessive salt intake, physical inactivity, and smoking are not merely associated with unhealthy lifestyles, but are established risk factors for hypertension and its complications.

Similarly, research shows that a healthy diet, regular physical activity, maintaining a healthy body weight, smoking cessation, and regular blood pressure monitoring significantly reduce the risk of heart attack, stroke, and other cardiovascular complications.

When people understand that the risk is real but also preventable, they are more likely to change their behaviour. This is the power of statistics: they help turn information into awareness, and awareness into action.

At this level, the role of the National Institute of Public Health of Kosovo (NIPHK) is to generate and communicate reliable evidence, promote health education, and support health promotion programmes. Building on this evidence, primary healthcare professionals use it to support early detection and provide motivational counselling to help individuals self-manage their risk factors.

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At the Community Level: Statistics as a Driving Force for Mobilisation

Health is not determined solely by individual choices. It is also influenced by the conditions in which we live, learn, and work.

Statistics help identify municipalities and population groups that bear the greatest burden of cardiovascular diseases or associated risk factors. This allows interventions to be planned and targeted where the need is greatest.

If data indicate a high prevalence of hypertension, obesity, or physical inactivity in a particular community, the response cannot be limited to treating patients alone. It must also include creating an environment in which a healthy lifestyle becomes the most natural choice.

This involves promoting healthy eating and physical activity in schools, organising preventive health screenings in workplaces, developing community programmes for walking, sports, and recreation, creating public spaces that encourage physical activity, and strengthening the role of families in fostering healthy habits.

At this level, statistics become a tool for mobilisation. They help municipalities, schools, civil society organisations, and the media foster a shared culture of prevention, in which taking care of health is no longer the responsibility of the healthcare system alone, but becomes a social norm.

At the Institutional Level: Statistics as a Basis for Decision-Making

Healthcare institutions plan their services on the basis of evidence, and providing such evidence is one of the key functions of the NIPHK.

Through national surveys, registries, epidemiological surveillance, and research, the NIPHK generates evidence on the burden of disease, trends, and risk factors, providing the scientific basis for health programmes.

For example, if statistics show that more than half of the cases of NCDs remain undiagnosed or are diagnosed late, screening should become an institutional priority. If evidence indicates that a significant proportion of patients do not achieve adequate blood pressure control, clinical guidelines, systematic patient follow-up, and ongoing patient education need to be improved.

Similarly, epidemiological trends enable institutions to plan more efficiently for essential medicines, medical equipment, human resources, and the financing of healthcare services. Furthermore, the success of the healthcare system is measured not only by the number of patients treated, but also by the number of conditions and complications prevented through early detection and effective control of risk factors.

At the National Level: Statistics as the Foundation of Public Policy

The control of NCDs is not the responsibility of the health sector alone. It requires collaboration across all sectors and health-oriented public policies.

Statistics guide decision-making on measures such as urban planning that promotes walking and cycling, and national screening programmes. Without reliable data, these policies would be based on assumptions rather than the actual needs of the population.

For this reason, the World Health Organization (WHO) has identified a package of highly cost-effective interventions known as the WHO Best Buys,

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If we aim to reduce the burden of NCDs in Kosovo, we must change the way we view statistics.

which are particularly recommended for low- and middle-income countries. These include measures such as tobacco control, reducing salt intake, promoting physical activity, limiting alcohol consumption, and strengthening primary healthcare. Their implementation is based on statistical evidence and an understanding of the actual burden of NCDs in each country.

If we aim to reduce the burden of NCDs in Kosovo, we must change the way we view statistics. They are not merely numbers published in annual reports; they are evidence, warning signals, and guides for action. At the individual level, they help citizens make informed decisions. At the community level, they mobilise society to build a culture of prevention. At the institutional level, they guide health planning and policies. At the national level, they become the foundation for policies that protect the health of the population and support the country's development.

Only when numbers are translated into action do statistics fulfil their most important mission: saving lives!



RESEARCH

Data that save lives: how they are collected, interpreted and used in public health

A number recorded on a medical form may seem like a routine piece of data. However, in the public health system, it may represent much more: a new diagnosis, a patient in need of treatment, a population group at risk, or a health problem that requires intervention by institutions.



Jehona Hulaj
Telegrafi

In public health, statistics are not merely the outcome of an administrative process. They are part of a chain that begins with the patient, continues through data collection and reporting, moves on to analysis and interpretation, and, if used appropriately, ultimately leads to decision-making and interventions.

This is particularly important for non-communicable diseases (NCDs), which, according to the Manual of the NIPHK, prepared by Assist. Prof. Dr. Sanije Hoxha-Gashi, Dr. Mirëllinda Hoxha-Hatashi, and Assist. Prof. Dr. Rina Hoxha, represent a major public health problem and can be prevented through the control of risk factors, early diagnosis, and prompt treatment.

In Kosovo, according to data from the Kosovo Agency of Statistics (KAS), diseases of the circulatory system were the leading cause of death in 2020, accounting for 50.8% of deaths, followed by malignant neoplasms at 14.9% and diseases of the respiratory system at 7.2%. Meanwhile, according to the 2021 report on NCDs, arterial hypertension accounted for the largest proportion of reported cases, at 44.6%, followed by non-insulin-dependent diabetes mellitus at 35.4%.

But the question for public health is not simply how many cases we have. It is also how we know this, what the data tell us, and what we do with them

The First Data Point Begins with the Patient

The process of generating health statistics begins at the healthcare institution where the patient is diagnosed or treated. The Manual of the NIPHK defines the Non-Communicable Diseases Registry as a process of systematically collecting information on individuals diagnosed with these diseases, and emphasises that its value depends on the quality of the data and their use in research and planning.

The reporting form for mass non-communicable diseases is completed by a physician for every patient with an NCD who has been examined, diagnosed, or treated during the year. The form includes information on the healthcare institution, level of care, age, sex, place of residence, occupation, date of initial diagnosis, diagnosis, and stage of the disease.

In this way, a piece of data recorded during a medical consultation can become part of a much broader picture of population health.

Who Collects and Manages the Data?

Data collection does not end with the completion of the form. Every physician who diagnoses or treats cases of NCDs is required to report them, while data collection must be carried out by trained personnel.

The non-communicable diseases registrar plays a particularly important role in this process. The registrar is responsible for managing the information and must ensure that the data are accurate, complete, and submitted in a timely manner.

Administrative Instruction No. 11/2013 defines the procedures for the flow and collection of data and the use of official reporting forms. In cases where irregularities or inadequate or delayed reporting are identified, the document provides for institutional intervention.



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Primary Care: Where Data Meets the Community

This importance is particularly evident in Primary Health Care. In its response to Telegrafi, the Ministry of Health describes Primary Health Care as the level of care closest to citizens.

“Primary Health Care is the first and closest point of contact between citizens and the healthcare system and, for this reason, plays a crucial role in the prevention, early detection, and long-term management of non-communicable diseases,” the Ministry stated in its response.

Data generated during the provision of healthcare services can reveal not only how many patients have been diagnosed, but also the needs of a community.

“Data generated during the provision of healthcare services, including information on hypertension, diabetes, cardiovascular diseases, risk factors,

vaccination status, examination results, and patient follow-up, can be used to better understand the health needs of the population,” the Ministry of Health notes.

According to the Ministry of Health (MoH), such data should be used beyond reporting. They should serve as a basis for clinical decision-making, the organisation of services, the identification of at-risk groups, and the planning of preventive interventions.

Analysis can help identify increases in cases of hypertension or diabetes, individuals who do not undergo regular check-ups, and patients who require more frequent monitoring.

However, this requires reliable data.

“It is essential that data are accurate, standardised, complete, and recorded regularly,” the MoH further emphasises in its response.

Data Do Not Speak for Themselves

Having data does not automatically mean that the problem has been understood. In an earlier interview with Telegrafi, Dr. Ardita Baraku explained that an increase in reported cases of NCDs may indicate an actual rise in new cases, but it may also reflect improvements in access to healthcare services, diagnostic capacity, or statistical reporting.

This distinction is crucial. An increase in cases may signal a growing problem, but it may also indicate that the system is becoming better at identifying patients who previously remained undiagnosed.

Therefore, an increase in cases should not automatically be interpreted as a deterioration in the population's health status. Incidence measures new cases, prevalence reflects the burden of disease in the population, while mortality helps assess outcomes and the effectiveness of interventions.

When Statistics Become a Signal for Action

It is precisely at this point that data must move beyond describing the problem and lead to interventions. The Ministry of Health emphasises that, for example, if cardiovascular risk factors increase in a community, the response should not be limited to patients who have already been diagnosed.

“Measures such as intensifying preventive check-ups, systematically measuring blood pressure and other risk factors, providing counselling on nutrition and physical activity, identifying individuals at risk at an early stage, and ensuring more regular follow-up of patients with chronic diseases should be considered,” the MoH stated to Telegrafi.

The same logic applies to screening. The process should therefore follow this sequence: data, analysis,

risk identification, intervention, and monitoring of results.

From Numbers to Decisions: When Statistics Show Where Intervention Is Needed

According to the NIPHK Manual, data enable the analysis of incidence and prevalence, the identification of areas where NCDs occur, the determination of areas requiring intervention, and the monitoring of disease control programmes.

In the OpEd “From Statistics to Health: When Numbers Save Lives”, Dr. Ardita Baraku argues that statistics are not the end point of analysis, but the starting point for action.

At the individual level, they help citizens understand their risks; at the community level, they indicate where interventions are needed; at the institutional level, they support the planning of services and resources; while at the national level, they can guide public policies.

The Ministry of Health also considers the link between Primary Health Care data and national policymaking to be important. According to the Ministry, Primary Health Care is where the healthcare system has the most direct contact with the population.

Therefore, data from this level can provide highly valuable information about the actual needs of citizens.

These data can influence priorities, resource allocation, workforce planning, and preventive programmes.

“A continuous cycle must be established: data from the field, data analysis, policymaking, intervention, measurement of results, and policy improvement,” the Ministry of Health states.

From Evidence to Practice

Data are not the only essential element. Clinical guidelines are also important. Clinical guidelines and protocols are crucial because they establish common standards for the prevention, diagnosis, treatment, and follow-up of patients. However, guidelines alone are not sufficient.

According to the MoH, they must be accompanied by continuous training for healthcare professionals, a sustainable supply of medicines and equipment, functional data systems, and monitoring of their implementation in practice.

Examples of how data are used for tobacco control, healthy eating, and cancer screening planning also demonstrate how statistics can move beyond reports and inform public policy.



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“A continuous cycle must be established: data from the field, data analysis, policymaking, intervention, measurement of results, and policy improvement,” the Ministry of Health states.

From Statistics to Patients: When a Number Becomes a Decision

Four years ago, a woman identified as E.H. visited a Main Family Medicine Centre (MFMC) because she felt something was wrong with her health. Her blood glucose level was measured at 24 mmol/L. She was referred from the MFMC to the University Clinical Centre of Kosovo (UCCK), where she was diagnosed with type 1 diabetes at the Endocrinology Clinic, and insulin treatment was initiated immediately. A single measurement is not a national statistic. However, this case illustrates the basic process: measurement,

identification of the problem, referral, diagnosis, and treatment.

At the population level, thousands of data points can reveal where problems exist, which groups are most at risk, and where interventions should be focused.

The Challenge Is to Make the System Proactive

A proactive system needs more than just additional data. It needs accurate, standardised data that can be used in a timely manner.

The path must be clear: data collection, quality control, analysis, interpretation, decision-making, intervention, and monitoring.

A piece of data collected at an MFMC can lead to early diagnosis; thousands of data points can reveal a trend; a correctly interpreted trend can indicate a risk factor; an identified risk factor can lead to a preventive policy; and a policy that is implemented and monitored can improve health outcomes.

This is why, as Baraku argues in her OpEd, statistics should be viewed as evidence, warning signals, and guides for action.

The Ministry of Health also recognises the need to shift from a reactive model to a preventive one.

In public health, the goal is not merely to know how many people are ill. The goal is to understand why they are ill, who is at risk, where interventions are needed, and what can be done to reduce the number of people affected in the future.

Because it is only when numbers are translated into action that statistics begin to save lives.

[Data that save lives: How they are collected, interpreted and used in public health - Telegra](#)

OP-ED

Stroke doesn't wait: why every minute can save a life

In Kosovo, stroke remains one of the leading causes of death and long-term disability. Although significant progress has been made with the introduction of thrombolysis and thrombectomy for the treatment of acute stroke, many patients still do not arrive in time to benefit from these treatments.



Dren Boshnjaku
Neurologist
Neurology Clinic

One Minute That Changes a Life.

A 58-year-old man suddenly finds himself unable to move his right arm and has difficulty speaking and walking. His wife thinks, “It will pass.” His son first takes him to the family doctor. Several hours later, he arrives at the Neurology Clinic, but the window for effective treatment has already closed.

This is not an isolated case. It is a reality that occurs almost every day. The paradox is that modern medicine now offers treatments that can save brain tissue and significantly reduce disability, but their effectiveness depends on one factor that can never be recovered: time.

Stroke Is Not the Only Problem – Delay Is a Problem Too.

In Kosovo, stroke remains one of the leading causes of death and long-term disability. Although significant progress has been made with the introduction of thrombolysis and thrombectomy for the treatment of acute stroke, many patients still do not arrive in time to benefit from these treatments.

The reason is not always a lack of capacity within healthcare services. Often, the problem begins much earlier: at home. Many people do not recognise the early signs and symptoms of stroke, wait for them to resolve on their own, or seek help in the wrong place. Every hour lost reduces the chances of a good recovery.

The science is clear: time is brain. For every minute that an artery in the brain remains blocked

The Most Dangerous Myth: “I’ll Wait a Little Longer”

The most common misconception we encounter is the belief that the signs and symptoms will disappear on their own. Many patients wait because the weakness seems mild, their speech improves, or the dizziness subsides after a few minutes.

In reality, even symptoms that last only a short time can be a warning sign of a much more severe stroke. Every delay can mean permanent loss of speech, mobility, memory, or independence in activities of daily living.

Therefore, recognising the signs and symptoms is just as important as the treatment itself.

Why Does This Concern Every One of Us?

Stroke does not affect only the patient. It changes the life of an entire family. A person who was working, caring for their family, and living independently just yesterday may suddenly need assistance with even the most basic activities of daily living.

The cost is not measured solely by the number of days spent in hospital. It is also measured in years of rehabilitation, lost productivity, and the emotional and economic burden placed on families and the healthcare system.

The good news is that most cases can be prevented. Hypertension, diabetes, smoking, high cholesterol, obesity, and physical inactivity are risk factors that can be controlled. This means that many strokes are not inevitable.

What Should We Do?

First, we need to invest more in public education. Every family should recognise the main signs and symptoms of stroke and know that the only appropriate response is to call 194 immediately.

Second, information and awareness-raising campaigns must be continuous, rather than limited to World Stroke Day. Schools, the media, healthcare institutions, and civil society organisations must work together to increase public awareness and knowledge.

Third, prevention must begin long before the disease occurs. Regular blood pressure monitoring, physical activity, a healthy diet, smoking cessation, and diabetes management are among the most important investments individuals can make in their own health.

Every Minute Matters

In the fight against stroke, modern treatments and new medicines alone are not enough to secure victory. Success begins with preventing risk factors and empowering citizens to recognise the signs and symptoms of stroke, seek immediate medical attention, and understand that time is not merely something measured by the clock – time is brain, time is independence, and very often, time is life.

<https://agk-ks.org/lajmet/stroku-nuk-pret-pse-cdo-minute-mund-te-shpetoje-nje-jete/>

RESEARCH

A race against time

One summer morning, D.RR., a 52-year-old man, noticed that he could not lift his right arm. His family members noticed that he was having difficulty speaking clearly. Both were among the most common symptoms of stroke, but neither he nor his family recognised them. Initially, they thought it was due to fatigue or low blood pressure. However, as time passed, his condition did not improve. On the contrary, his symptoms continued to worsen. Only then, he recalls, did they rush to the Emergency Centre.



Vlerë Mehmeti
Journalist

Following medical examinations, D.R.R. was diagnosed with a stroke. Doctors explained that he had lost some of the valuable time during which more effective treatment could have been provided. He had to undergo rehabilitation for months, as he experienced difficulties moving his right arm and speaking.

This is not an isolated case. Doctors say they encounter patients every day who arrive at hospital after the window for treatment has closed.

Stroke: A Medical Emergency Where Every Minute Counts

Stroke is a medical emergency that occurs when the blood supply to part of the brain is interrupted or when a blood vessel in the brain ruptures. As a result, brain cells are damaged within minutes, potentially causing serious consequences such as paralysis, difficulty speaking, or loss of other vital functions. Stroke is the second leading cause of death worldwide and the leading cause of physical disability.



Neurologist Dren Boshnjaku explains that stroke is considered a “silent attack”, not only because silent cerebral infarctions (strokes without noticeable symptoms) can occur, but also because of the lack of public information and awareness about the warning signs and the need for an urgent response.

According to Dr. Dren Boshnjaku, recognising the symptoms and controlling risk factors are the most

important steps in preventing the consequences of stroke.

“Warning signs that should not be ignored include weakness or numbness of the face, arm, or leg on one side of the body, speech difficulties, vision problems, and loss of balance or coordination. Other symptoms requiring attention include vertigo, double vision, and difficulty articulating words. Ten modifiable risk factors (hypertension, physical inactivity, abnormal blood lipid levels, diet, abdominal obesity, psychosocial factors, smoking, cardiac causes, alcohol consumption, and diabetes) account for more than 90% of the global risk of stroke,” Boshnjaku explains.

“The appropriate response in such cases is to call the emergency number, 194, immediately. Do not wait for the signs or symptoms to disappear. Even if they improve, they may indicate a transient ischaemic attack (TIA), which can be a warning sign of a more severe stroke,” Boshnjaku urges.

At the Neurology Clinic of the UCKK, where stroke patients are treated, healthcare professionals say that delays in recognising symptoms and seeking medical assistance remain among the greatest barriers to successful treatment.

According to Edmond Komoni, Director of the Neurology Clinic, stroke is the most common condition requiring hospitalisation at the clinic, accounting for approximately 50% of all hospital admissions. Around 1,000 stroke patients are treated each year.

“Unfortunately, very few patients arrive within the optimal time window for intravenous thrombolysis, which is 3–4.5 hours. The greatest delays occur because family members are slow to recognise that the patient may be experiencing a stroke. It often happens that a patient wakes up in the morning with signs of stroke, such as paralysis or difficulty speaking, which means that the stroke occurred during sleep, several hours earlier. These are known as wake-up strokes,” Komoni explains.

During 2025, 59 patients with acute ischaemic stroke were treated with intravenous thrombolysis at the Neurology Clinic, while a further 34 patients received this treatment by mid-2026. According to him, the treatment of acute stroke is based on two main methods.

“Intravenous thrombolysis is the first method, involving the administration of alteplase, a medication used to dissolve the thromboembolus and restore blood flow to the affected area of the brain. This treatment must be administered within a maximum of 3–4.5 hours from the onset of symptoms. Mechanical thrombectomy is the second method, in which specialised catheters are advanced through the blood vessels to reach the thrombus and attempt to remove the blockage mechanically. This therapeutic procedure is performed in collaboration with neurointerventional radiologists,” he explains.

Beyond the number of cases, the consequences remain severe. According to neurologist Boshnjaku, approximately 2,700 stroke patients were treated at the Neurology Clinic and general hospitals during 2024. He emphasises that the consequences are long-term.

“Long-term complications are common. Cognitive impairment affects 54–65% of survivors, while fatigue, depression, and anxiety remain common problems even years after a stroke. Rehabilitation should begin as early as possible and significantly improves the ability to perform self-care activities, motor function, and functional independence. Within 90 days of a stroke, 10% of patients under the age of 55 and 30% of those over 65 develop new moderate or severe disabilities. Around 70% of patients with severe stroke die or are left with significant disabilities within five years,” Boshnjaku stated.

Nevertheless, according to him, most cases can be prevented.

“The final message is simple: stroke is not necessarily fatal – it is preventable and treatable,” he says.

Time Determines the Patient’s Outcome

If a patient meets the criteria and arrives within the appropriate time window, they may benefit from intravenous thrombolysis, which must be administered within 3–4.5 hours of symptom onset. In certain cases, mechanical thrombectomy is also performed. However, according to doctors, the main problem is not the time spent at the clinic.

They say that most patients do not arrive within the optimal treatment window. Often, two to three hours are spent on assessment at the Emergency Centre alone, while the greatest delay, according to them, occurs before the patient seeks medical assistance. Neurologist Dren Boshnjaku says that the main reasons for these delays are a lack of awareness of the signs of stroke, a failure to recognise the need for emergency medical attention, and the fact that many citizens initially consult their family doctor instead of calling emergency services immediately.

“The main reasons for delays include a lack of awareness that stroke is a medical emergency, failure to recognise the signs and symptoms, visiting a family doctor instead of calling emergency services, and fear or denial of the situation,” Boshnjaku explains.

In addition to treatment, Boshnjaku believes that raising public awareness remains one of the most effective ways to reduce the consequences of stroke. According to him, investing in public information costs far less than treating and rehabilitating patients who are left with long-term disabilities.

“Media campaigns are a powerful and very low-cost means of raising awareness of risk factors, the signs and symptoms of stroke, helping in prevention and its adequate treatment. Recommended strategies include public campaigns using the acronym 2FSK, educational programmes in schools, training family doctors and primary healthcare nurses to screen for risk factors and respond to stroke alarm signs, and involving faith communities, community centres, and local media in informing and raising public awareness,” Boshnjaku explains.

The Links in the Healthcare System and the Importance of Coordination

At the primary care level, every patient with a suspected stroke is considered an emergency case.

According to the Directorate of Health of the Municipality of Prishtina, family medicine teams and emergency services immediately identify the symptoms, carry out an initial assessment in accordance with international guidelines, stabilise the patient, and arrange urgent transport to the Emergency Clinic at the UCCK.

In 2025, according to reports from this institution, primary healthcare services recorded 31 cases of stroke, while seven cases had been registered by June 2026.

“Recognising the warning signs is extremely important. If a person suddenly cannot smile normally, experiences weakness in their arms or legs, or has difficulty speaking clearly, do not wait for the symptoms to disappear. Call emergency services (194) immediately. When it comes to stroke, time is critical. The sooner treatment begins, the greater the chances of recovery and avoiding long-term disabilities,” primary health care physicians emphasise.



In 2025, according to reports from this institution, primary care services recorded 31 cases of stroke, while seven cases had been registered by June 2026.



Thrombectomy: A 24-Hour Service, but Not Without Challenges

For patients who meet the eligibility criteria, mechanical thrombectomy represents one of the most advanced treatments for ischaemic stroke (a stroke caused by a blockage in a blood vessel).

The Radiology Clinic reports that this service is available 24 hours a day, 365 days a year. However, the institution acknowledges that, since February 2026, there have been disruptions in the supply of consumables required to perform the procedure due to budgetary delays.

This is also reflected in the number of procedures performed.

In 2025, 19 mechanical thrombectomies were performed, while in 2026, only one procedure had been carried out by the time the clinic provided its response.

According to the clinic, in addition to supply issues, challenges include a shortage of dedicated staff and the need for continuous investment in equipment and infrastructure.

“I Thought It Would Pass”

D.RR., whose name has been changed to protect his privacy, says he had never imagined that numbness in his hand and difficulty speaking could be signs of a stroke.

“At first, I thought my hand had gone numb because I was tired. I couldn’t pronounce words properly, but I believed it would pass. My family also thought we should wait a little,” he recalls.

It was only when his symptoms failed to improve that he went to hospital.

“When the doctors explained that every minute mattered, I realised how much time I had lost. Fortunately, I received treatment, and today I can walk and speak normally, but rehabilitation took several months.”

He now advises anyone experiencing similar symptoms not to wait even a minute.

“If I had known then what I know today, I would have called emergency services immediately.”

OP-ED

From communication to behaviour change

The COVID-19 pandemic taught us a lesson that must not be forgotten: being scientifically correct is not enough if facts do not translate into action. Information must be clear, understandable, credible, and delivered at the right time. Even the best recommendation loses its value if people do not understand, trust, or follow it. This lesson is equally valuable in the fight against chronic non-communicable diseases.



Dr. Faik Hoti
Public Health Specialist
NIPHK

Chronic non-communicable diseases, including cardiovascular diseases, diabetes, cancer, and chronic lung diseases, currently represent the greatest public health burden in Kosovo. They are not transmitted from person to person but are closely linked to harmful behaviours that become part of our everyday lives. Smoking, unhealthy eating, physical inactivity, alcohol consumption, and chronic stress are major risk factors. The good news is that most of these factors can be modified. The bad news, however, is that changing behaviour is much more difficult than changing a law or adopting a strategy.

Every day in Kosovo, people die from diseases that, in many cases, could have been prevented. Yet we continue to invest far more in treating the consequences than in changing the behaviours



A message such as ‘Live healthily’ is too general. By contrast, messages such as ‘Walk for at least 30 minutes every day’, ‘Quit smoking today’, or ‘Check your blood pressure, even when you feel well’ are specific, practical, and actionable.

that cause them. This is the greatest paradox of public health.

Therefore, the question today is not only what we know about these diseases, but also how we communicate about them. In public health, it is not those who have the facts who succeed, but those who manage to translate them into new, preventive behaviours.

The COVID-19 pandemic taught us a lesson that must not be forgotten: being scientifically correct is not enough if facts do not translate into action. Information must be clear, understandable, credible, and delivered at the right time. Even the best recommendation loses its value if citizens do not understand, trust, or follow it. This lesson is equally valuable in the fight against chronic non-communicable diseases.

In public health, everything begins with communication.

However, one of the greatest misconceptions is that health communication serves only to inform. In fact, information is merely the beginning. Most smokers know that smoking harms their health. Most people know that physical activity is beneficial and that diets high in salt, fat, and sugar increase the risk of disease. Nevertheless, having this information alone is not enough to change their behaviour. Change requires something more: trust, motivation, and a sense that action is achievable. This is precisely where the distinction lies between a message that informs and one that changes behaviour. A message such as “Live healthily” is too general. By contrast, messages such as “Walk for at least 30 minutes every day”, “Quit smoking today”, or “Check your blood pressure, even when you feel well” are specific, practical, and actionable. The simpler the message, the more likely it is to translate into action. An effective message does not cost as much as building a hospital, yet it can prevent thousands of citizens from needing one.

In Kosovo, we have seen that communication can deliver results. The history of tobacco control in Kosovo demonstrates this. The Law on Tobacco Control, health warnings on cigarette packaging, and awareness-raising campaigns have contributed to a gradual decline in the social acceptability of smoking, particularly in family settings. However, challenges remain, especially with the spread of electronic

cigarettes among young people, creating a new form of addiction often disguised as fashion or modern technology, as well as the lack of full compliance with the law in public spaces. Breast cancer awareness campaigns have also contributed to earlier detection of the disease and improved treatment opportunities.

Another equally serious threat is disinformation. In the age of social media, citizens are exposed daily to “medical advice” from non-professionals, conspiracy theories, and claims without scientific evidence. Unfortunately, false information often spreads faster than facts. This not only creates confusion but also undermines trust in healthcare institutions and experts. When institutions remain silent or delay communicating, the gap is filled by voices that do not serve public health. Unfortunately, Kosovo has also seen public figures promoting conspiracy theories and scientifically unfounded claims, amplified by television channels and digital platforms, often without the necessary professional scrutiny. It is clear that the fight against disinformation cannot be won through censorship, but through the continuous engagement of institutions, transparency, integrity, and professional communication.

However, communication cannot remain the responsibility of healthcare institutions alone. It must become a collaborative effort involving healthcare professionals, journalists, the education system, communities, and citizens themselves. Professional journalism has an irreplaceable role in this process. At a time when sensationalism often attracts more clicks than facts, accurate and responsible health reporting is a public service in the truest sense of the term. A verified news report can prevent more harm than delayed treatment. Investigative journalism and critical examination of shortcomings in the healthcare system, inadequate policies, or practices that endanger health can also make an important contribution.

Equally important is ensuring that communication efforts are not limited to occasional campaigns. Behaviour change does not happen within a week or a month. It requires repetition, consistency, and continuous evaluation of impact. Institutions must invest in long-term communication strategies tailored to different age groups and communities.

Ultimately, the fight against chronic diseases will not be won solely in health centres, clinics, or hospitals. It will be won much earlier: in families, schools, the media, workplaces, and public spaces. It will be won when communication aims not only to inform, but also to persuade, motivate, and change behaviour.

A clear message can encourage someone to have their blood pressure checked for the first time, quit smoking, walk more, or adopt a healthier lifestyle. These decisions may seem small, but they are the ones that will change tomorrow’s statistics. Because in public health, words are not merely a means of providing information. They are a tool for prevention.

RESEARCH

When information is not enough: is health communication changing citizens' behaviour in Kosovo?

Globally, chronic non-communicable diseases are responsible for approximately 74 per cent of all deaths. The World Health Organization estimates that a significant proportion of these deaths can be prevented through the reduction of risk factors, early interventions, and public health policies.

Qëndresë Uka Matoshi
Nacionale



Every year, thousands of people in Kosovo are diagnosed with cancer, cardiovascular diseases, diabetes, and chronic lung diseases. Many seek medical attention only when their disease has progressed, even though part of the burden of these diseases could be reduced through prevention, early detection, and timely treatment.

Globally, chronic non-communicable diseases are responsible for approximately 74 per cent of all deaths. The World Health Organization estimates that a significant proportion of these deaths can be prevented through the reduction of risk factors, early interventions, and public health policies.

In Kosovo, healthcare institutions also organise campaigns, publish statistics, and share messages about prevention and medical check-ups.

But the question remains: is providing information to citizens enough? Do public health messages explain not only why people should undergo check-ups, but also when, where, and how they should act?

This research examines how institutions, healthcare professionals, and the media communicate about chronic non-communicable diseases and whether this communication succeeds in translating information into action.

Because in public health, citizens need more than simply knowing what a disease is. They also need to know what they can do today to prevent it or detect it early.

“Communicate Clearly and Simply”

In the year she thought her battle was over, Professor Lindita Rugova received news that no one wants to hear: her breast cancer had returned. For the second time, her life became a cycle of tests, treatments, and waiting. But this time, she was not fighting only for herself. She was also fighting for her two children and for a message she wanted to share with other women: time matters.

“When I was first diagnosed, I thought I had won the battle forever. The recurrence of the disease taught me that taking care of your health never ends.”

According to her, health communication must be clear, understandable, and tailored to people’s needs.

“Messages must be clear and simple. People need to be invited to information sessions, while professionals should provide them with the necessary explanations. Communication should be tailored to the patient, their age, level of education, and needs.”

Rugova believes that motivational messages are also important.

“I have been living with cancer for 15 years, and I continue to live with it. I am stronger than a rock, and it will not defeat me.”

But her story also raises another question: if information about prevention is available, why are so many cases still diagnosed late?

Data Exist, but Are They Being Translated into Action?

According to the latest available data from Kosovo’s healthcare institutions, thousands of new cancer cases are registered every year.

The National Institute of Public Health of Kosovo (NIPHK) report on malignant diseases for the period January–December 2025 shows that 3,775 new cancer cases were registered in Kosovo during 2025. In the previous year, 2024, a total of 3,644 cases were registered.

Cancer, cardiovascular diseases, diabetes, and chronic lung diseases are closely linked to risk factors such as tobacco use, unhealthy diets, physical inactivity, and alcohol consumption.

Healthcare institutions and international partners organise campaigns on prevention, medical check-ups, and early detection of diseases. However, public communication often intensifies during international awareness days or months.

During the rest of the year, public attention often fades. This is one of the main weaknesses of health communication: chronic diseases are present throughout the year, while communication about them is often seasonal.

On social media, prevention messages are frequently concentrated around specific international awareness days. In the media, attention is more often directed towards medicine shortages, problems within the healthcare system, tragic cases, or new developments. These issues are important. However, health reporting cannot be limited to moments when the system fails.

Citizens also need to know:

- At what age they should undergo a medical check-up;
- Where they can seek assistance;
- How often they should have a check-up;
- Which signs they should not ignore; and
- What practical steps they can take.

A message such as “Get checked” is important, but often insufficient.

From “Get Checked” to “Here’s What You Need to Do”

Health communication experts say that a campaign should not be measured solely by the number of posts, videos, or organised activities. The key question is: has anything changed in citizens’ behaviour?

According to communications expert Teuta Berisha, health communication should be a



continuous process that builds trust and encourages the development of new habits.

“Effective communication is not measured by the number of posts or campaigns, but by the change it brings about in people’s behaviour. When messages appear only during awareness months, they risk being perceived as calendar events.”

“Citizens need to understand what they should do, when they should act, and why that action is important for their health.”

Such a message is much more specific: “Have regular check-ups”, compared with: “Contact the Family Medicine Centre, ask about the health check-up recommended for your age, and book an appointment.”

Behaviour change requires repetition, credibility, and concrete guidance.

What Do Citizens Say?

For citizens, the problem is not always a lack of information.

A.B., 53, from Prishtina, says that she mainly receives information about cancer from television and online news portals.

“I usually hear about cancer when someone dies. Very rarely do I hear what I should do to prevent it.”

L.R., 37, from Prizren, believes that personal stories have a greater impact than statistics.

“When you hear about a woman who has survived cancer and is now living a normal life, you believe it more than when you see a poster with numbers.”

E.H., 61, from Mitrovica, also believes that the language used in communication matters.

“When only medical terms are used, many people do not understand the message. People need simple, understandable language.”

These statements are not representative of the general population. However, they illustrate a recurring concern: citizens do not necessarily need more information, but rather information that guides them towards concrete action.

This is the difference between simply providing information and communicating effectively.

“The Patient Must Come Before the Symptoms”

According to Dr. Ilir Kurtishi, Director of the Oncology Clinic at the University Clinical Centre of Kosovo, public communication about cancer has improved, but there is still room for further progress.

“Information is important, but the main objective should be to change citizens’ behaviour by motivating them to undergo regular check-ups and not ignore warning signs.”

“Pink October has played a very important role in raising public awareness, but cancer does not follow a calendar. Education and the promotion of prevention must continue throughout the year.”

Dr. Kurtishi calls for greater coordination between healthcare institutions, the media, and professionals. “Communication must be based on scientific evidence, avoid creating fear and spreading misinformation, and promote trust in the healthcare system and the importance of regular medical check-ups.”

For family physician Dr. Qerim Haxholli, communication about prevention must begin before patients develop symptoms.

“The family doctor is the first point of contact with the healthcare system. When citizens are well informed, they do not seek medical care only when they are ill. They also come to make sure they are healthy.”

“Instead of simply telling people to ‘get checked’, we need to explain at what age, which check-ups they need, how often, and where they can have them. When the message is specific, citizens are much more likely to respond.”

Fear Can Attract Attention. Hope Encourages Action.

According to psychologist Dr. Mimoza Shahini, one of the main challenges in health communication is the gap between what people know and what they actually do.

“Knowing that they should have a medical check-up does not necessarily mean that a person will take action.”

Delaying check-ups may be associated with fear of a diagnosis, negative experiences with the healthcare system, lack of time, costs, or the absence of a culture of regular medical check-ups.

According to Dr. Shahini, messages based solely on fear can be counterproductive.

“When fear becomes overwhelming and individuals feel they have no control over the situation, or are not offered a concrete solution, fear can lead to avoidance, denial, or psychological paralysis.”

“Communication that motivates people to take action must be simple, clear, positive, and adapted to the individual’s circumstances. People are more likely to act when they feel capable, supported, and confident that their actions can lead to positive outcomes.”

Public Communication Must Be Part of Prevention

Dr. Faik Hoti, Public Health Specialist at the NIPHK, says that the fight against chronic non-communicable diseases must begin long before patients are admitted to hospital.

“The question today is not only what we know about these diseases, but how we communicate about them. In public health, success does not belong to those who merely possess the facts, but to those who manage to translate them into new, preventive behaviours.”

According to him, many citizens know that smoking harms their health, that physical activity is important, and that regular check-ups can help with the early detection of certain diseases. However, information alone is not enough unless it builds trust, motivation, and the belief that change is possible.

“A message such as ‘Live healthily’ is too general. A message that tells citizens what they need to do, when they should act, and why it matters is much more likely to translate into action.”

According to Dr. Hoti, communication must be a shared responsibility.

“Communication cannot remain the sole responsibility of healthcare institutions. It must become an alliance between healthcare professionals, journalists, the education system, communities, and citizens.” As he argues, “In public health, words are not merely a means of providing information; they are a tool for prevention.”

How Does the Media Report on Health?

Media coverage of health issues often intensifies when there is a new development: a shortage of medicines, a patient protest, a problem within the healthcare system, or a tragic case.

Prevention, however, requires a different approach.

An analysis of media content and communication on digital platforms should examine not only how frequently health topics are covered, but also what kind of information is provided to citizens.

One of the most common shortcomings is that articles focus on describing the problem without answering practical questions:

- What should citizens do?
- When should they have a health check-up?
- Where can they access services?
- Who can they turn to for professional advice?

Journalist Alban Selimi argues that healthcare should not make the news only when the system fails.

“Journalism also has a preventive role. By reporting more frequently on risk factors, preventive check-ups, and success stories, the media can genuinely influence how citizens take care of their health.”

“If we focus only on crises, citizens remain informed about the problem, but not about the solution. Health reporting should help people understand what they can do today to prevent disease tomorrow.”

The story of a woman whose cancer was detected at an early stage may not attract as many clicks as a tragic story. However, it may have a far greater impact on another woman’s decision to undergo a screening examination.

In this sense, the media are not merely watchdogs of the healthcare system. They must also be part of prevention efforts.

What Does Science Say About Communication That Changes Behaviour?

Research in health communication shows that people do not change their behaviour simply because they hear a fact. They need to understand the risk, believe that taking action will be beneficial, know how to take that action, and not face barriers that make it impossible.

This is why a message such as “Have a mammogram” is less useful than one that provides citizens with concrete guidance, such as: “Find out which recommendations apply to your age and risk level, contact the relevant service, and seek professional advice about the screening you need.” Such communication does more than raise awareness. It connects information with action.

International studies show that cancer prevention and early detection require not only services and infrastructure, but also the active participation of citizens.

Studies by the International Agency for Research on Cancer (IARC) show that up to 40% of cancer cases could be prevented by reducing risk factors and investing in early diagnosis. However, the



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benefits of screening can only be realised if citizens actively participate in screening programmes. This participation cannot be achieved through infrastructure or modern equipment alone, but also requires continuous, personalised, and credible communication.

This is precisely where communication becomes part of public health policy.

What Can Kosovo Learn from Other Countries?

The experience of European countries shows that the most effective communication does not rely solely on occasional campaigns.

In Slovenia, the national screening programmes DORA for breast cancer, ZORA for cervical cancer, and SVIT for colorectal cancer are supported by continuous communication and clear guidance for citizens.

Citizens do not receive only general information about the importance of medical check-ups. They receive invitations, notifications, and guidance on how to participate in the relevant programmes.

In Croatia, communication about prevention programmes is supported by cooperation between healthcare institutions, public health institutes, family doctors, and the media.

The main lesson for Kosovo is clear: communication should not be the responsibility of a single institution.

It should be coordinated between the Ministry of Health, the NIPHK, the HUCSK, municipalities, family doctors, the media, and patient organisations.

The Problem Is Not Just a Lack of Information

This research shows that Kosovo has a wealth of information, statistics, campaigns, and activities concerning chronic non-communicable diseases.

However, the gap between information and action remains significant.

Messages are often general: “Get checked.” “Take preventive measures.” “Take care of your health.”

These messages are accurate, but not always sufficient.

Citizens need messages that answer the questions: What should I do? When should I do it? Where should I go? And why should I act now?

The interviews and experts’ experiences point to a common conclusion: the most effective communication is continuous, credible, understandable, and action-oriented.

Real-life stories can create an emotional connection. Experts can provide credibility. The media can bring information to the public. Institutions must provide accurate guidance and accessible services. And citizens must be at the centre of this communication.



The main lesson for Kosovo is clear: communication should not be the responsibility of a single institution.

What Needs to Change?

The findings of this research point to several recommendations:

- Develop a national approach to communication on chronic non-communicable diseases, ensuring continuous communication throughout the year.
- Ensure that every message includes a specific call to action: what citizens should do, when, and where.
- Strengthen coordination between the Ministry of Health, the NIPHK, the HUCSK, municipalities, Family Medicine Centres, patient organisations, and the media.
- Strengthen the role of family doctors as accessible and trusted sources of information.
- Make greater use of real patient stories, always respecting patients' privacy, dignity, and consent.
- Encourage the media to report more on prevention, risk factors, medical check-ups, services, and solutions, alongside critical reporting on problems within the healthcare system.
- Strengthen digital communication through short videos, infographics, and easy-to-understand messages.
- Measure the impact of campaigns not only by the number of posts or views, but also by changes in citizens' behaviour.

The Right Word Said at the Right Time

Lindita Rugova's story shows that timing matters.

The words of doctors and psychologists demonstrate that the way we talk about health can influence how people respond to it.

The experience of journalists shows that the media can do more than simply report on problems after they occur.

And public health experience shows that prevention cannot be built through a single campaign.

It is built every day: in families, schools, Family Medicine Centres, the media, and on social media.

In every setting where citizens receive information that may influence their decisions.

The fight against chronic non-communicable diseases is not won solely in hospitals, clinics, and laboratories. It begins much earlier; in the way society communicates about health.

When a citizen decides to quit smoking, become more physically active, seek medical advice, or participate in an appropriate prevention programme, they may be responding to a message that has convinced them that their actions matter.

Therefore, public communication is not merely a tool for disseminating information.

When built on facts, trust, and empathy, it becomes part of prevention.

And sometimes, a word spoken at the right time can be the first step towards a decision that changes a life.



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OP-ED

The role of nurses in humanizing healthcare

In healthcare, not everything that matters can be measured through laboratory tests, parameters, or clinical outcomes.

Fekrije Hasani
Senior Health Expert
IHS



There are moments when a patient needs someone to explain once again something they have not understood. There are moments when fear is not expressed in words but is evident in silence,

in the way a patient repeats the same question or seeks reassurance from the person beside them.

In most cases, nurses are the ones who notice these signs. Nurses are among the healthcare professionals who spend the most time with patients. They monitor patients' conditions, carry out procedures and administer treatments, but they also listen to questions, concerns and fears that patients may not always feel able to raise with their doctor during a consultation.

This is precisely where the humanization of healthcare begins: in the ability to look beyond the diagnosis and see the person living with it.

In healthcare practice, it is easy for a patient to become, unintentionally, a medical record or a room number, a diagnosis or simply another task to be completed. The pace of work, responsibilities and number of patients make this risk even greater.

However, a patient whom we see as just one case among many may be experiencing one of the most difficult days of their life.

Therefore, patient-centred care cannot be limited to asking, "What treatment does this patient need?" We must also ask, "What matters to this person? What concerns them? What do they not understand?"

Communication is not merely a matter of courtesy. It is an integral part of professional care. A clear explanation can reduce fear and improve the patient experience. Listening can reveal a concern that the patient has struggled to express and help us understand their needs, while building a relationship based on trust. Involving patients in decision-making can restore some of their sense of control at a time when illness has taken it away.

The same applies to dignity.

Dignity is preserved in things that may sometimes seem small: the way we address patients, how we respect their privacy, how we explain a procedure to them, and whether we speak with them or merely about them.

Humanizing healthcare, however, is not just about being kind. It requires partnership. Modern healthcare should not be something that nurses "do for patients", but something that is developed together with them.

Patient-centred care requires patients to be listened to, informed and involved in decisions about their health. Nurses play a particularly important role in this process by advocating for patients' needs, choices and dignity within the healthcare team.

However, patient-centred care cannot depend solely on the goodwill of nurses. Even the most dedicated healthcare professional may struggle to provide compassionate care when working under

pressure, facing a heavy workload and having insufficient time for communication.

Therefore, alongside clinical skills, institutions that support this approach are also needed. Continuing education, communication skills and a culture that considers listening to and informing patients an integral part of care are equally important.

Technology, equipment and protocols are essential for providing quality care, but they cannot replace human connection.

A nurse cannot always change the course of an illness. However, they can profoundly influence how a person experiences their illness and treatment.

Humanizing healthcare begins with the way we see the patient. If we see them only as a diagnosis, care risks becoming merely technical. If we see them as a person with physical, emotional and social needs, care takes on a different dimension.

Therefore, empowering nurses is not merely a professional matter. It is essential for a healthcare system that strives to be of higher quality, more equitable and more patient-centred.

Ultimately, patients may not remember every procedure they underwent, but they will remember how they felt when they needed care the most.

And that is precisely where the strength of nurses lies: in caring not only for the illness, but also for the person living with it.

The Care Patients Remember

When a person is admitted to hospital, the care they receive involves more than just diagnosis, laboratory tests, treatment or medical procedures. At times when illness leaves a patient feeling uncertain, frightened or dependent on the help of others, the way they are spoken to, whether someone listens to their concerns and whether they feel they are treated with dignity also matter.

Nurses play a particularly important role in this aspect of healthcare. They are among the healthcare professionals who spend the most time with patients, closely monitoring them throughout their treatment. They are often the people patients turn to when they have a question, a fear or a need they may struggle to express during a brief consultation.

For Fekrije Hasani, Senior Health Expert at the Integrated Health Services (IHS) Project, it is precisely this close contact with patients that places nurses in a key position to make healthcare more humane.

"There are moments when a patient needs someone to explain once again something they have not understood. There are moments when fear is not expressed in words but is evident in silence, in the way a patient repeats the same question or seeks reassurance from the person beside them," says Hasani.

This relationship becomes particularly important when patients face prolonged treatments, serious diagnoses or uncertainty about their health. In such cases, nursing care goes beyond simply administering treatment or carrying out procedures. It involves communication, listening and building trust.

“This is precisely where the humanization of healthcare begins: in the ability to look beyond the diagnosis and see the person living with it,” emphasizes the health expert.

Close Contact with Patients as Part of Care

Astrit Hajdini, a nurse at the Oncology Clinic, has been practising nursing since 2010. He has spent most of his career caring for oncology patients, whose treatment is often accompanied by significant emotional strain and numerous challenges.

“I chose nursing because I have always felt a desire to be there for people during the most difficult moments of their lives. Working in healthcare, particularly in oncology, requires not only professional knowledge but also compassion, patience and emotional support for patients and their families,” explains Hajdini.

In a ward where patients face serious diagnoses and prolonged treatments, the relationship they develop with healthcare staff can influence how they cope with treatment.

“Nurses play a key role in humanizing healthcare, especially at the Oncology Clinic. In addition to treatment and professional care, patients need moral support, warm communication and hope. Often, a kind word or a compassionate approach can make a significant difference to a patient’s emotional well-being,” says the oncology nurse.

Hasani links this role to the way communication with patients is established. According to her, communication should not be seen as a mere formality, but as an integral part of professional care.

“Communication is not merely a matter of courtesy. It is an integral part of professional care,” emphasizes Hasani.

Clear communication can help patients better understand their condition and treatment, while listening can reveal concerns that may not emerge during a medical procedure.

Involving patients in decision-making, meanwhile, can restore some of their sense of control at a time when illness may have significantly limited it.

A Relationship That Can Influence Treatment

Nurses’ experiences show that this relationship goes beyond communication alone.

Hajdini recalls a patient who felt frightened and emotionally exhausted by chemotherapy treatment. Through close communication, moral support and continuous care, the patient gradually began to gain more confidence and strength to continue treatment.

According to Hajdini, at one point the patient told the doctor: “If Astrit is not at work, I will not come in for my next treatment.”

The nurse considers this statement one of the most meaningful expressions of appreciation in his career. “For me, this was one of the greatest acknowledgements I have received as a nurse,” he says.

Fetije Huruglica, former Head of the Nursing Division at the Ministry of Health, also has extensive experience working with patients. She began her career in 1975 at the Internal Medicine Clinic, in the Cardiology Department.

As Fetije recalls, on her first day at work, her father accompanied her to the entrance of the clinic and gave her a piece of advice that Huruglica says she has remembered throughout her career.



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“On my first day, my father accompanied me to the entrance of the clinic where I was about to start working. He told me, ‘I need to tell you something: you are now going to work with people who are ill, who are struggling and in pain. You must always greet them with a smile.’ I asked him, ‘But what if I don’t feel like smiling because I’m tired?’ He replied, ‘You must leave your tiredness behind and speak to them with kindness,’” recalls Huruglica.

According to her account, Huruglica was not yet 18 when she began working as a nurse. In 1979, she moved to Benghazi, Libya, where she worked in cardiology for seven years. After returning to Kosovo, she resumed working at the Internal Medicine Clinic and later worked with humanitarian organizations during the war, providing healthcare services to the displaced population.

Reflecting on the working conditions at the time, the former nurse says: “As I mentioned at the beginning, despite the limited working conditions we had back then, we nurses managed to provide care, warmth and hope to our patients,” she recalls.

How Much Scope Is There for Personalized Care?

Today, the nursing profession in Kosovo operates within a framework of licensing and professional education.

According to data from the Kosovo Chamber of Nurses, Midwives and Other Healthcare Professionals (OIK), there are currently 22,210 licensed nurses, while 10,978 have completed the relicensing process.

Approximately 7,800 nurses are employed in the public sector.

However, OIK does not have complete and detailed data on the distribution of the remaining nurses between the private sector and other healthcare institutions.

OIK considers patient-centred care one of the fundamental principles of quality nursing practice.

This includes not only clinical care but also respect for patients’ dignity, privacy, autonomy and their right to be informed and participate in decision-making.

In practice, however, the consistent implementation of this approach faces challenges. Among the challenges identified by OIK are heavy workloads, insufficient staffing relative to patients’ needs, limited time for individual communication, administrative burdens and the need for continuous professional development.

These factors can make it more difficult to provide personalized care, particularly in situations requiring intensive care and rapid intervention.

Hasani emphasizes that the humanization of healthcare cannot depend solely on the personal dedication of nurses.

“Patient-centred care cannot depend solely on the goodwill of nurses. Even the most dedicated healthcare professional may struggle to provide compassionate care when working under pressure, facing a heavy workload and having insufficient time for communication,” says the expert.

For Hasani, compassionate care requires institutional support, continuing education and working conditions that allow nurses the time and space to address patients’ needs.

Professional Education and Communication

OIK data show that 458 continuing professional education programmes have been accredited over the past three years. As part of these activities, OIK has issued 47,074 electronic certificates, while accredited institutions have issued 53,398 physical certificates, bringing the total to 100,472 certificates.



OIK clarifies that the number of certificates does not necessarily represent the number of unique individuals, as a nurse may have participated in several activities.

The programmes cover topics related to patient care and safety, infection prevention and control, medical emergencies, safe administration of treatment, care for patients with various conditions, as well as communication, ethics and professional responsibility. According to OIK, patient-centred care, nurse-patient communication and respect for patients' rights, dignity and individual needs are included in continuing professional education activities.

Clear and professional communication helps patients understand their health condition, medical procedures and treatment. Good communication also helps identify patients' needs, concerns and expectations at an earlier stage.

For Hasani, patient-centred care begins precisely with the way patients are viewed.

“In healthcare practice, it is easy for a patient to become, unintentionally, a medical record or a room number, a diagnosis or simply another task to be completed,” emphasizes Hasani.

She stresses that the question should not be limited to what treatment a patient needs.

“Patient-centred care cannot be limited to asking, ‘What treatment does this patient need?’ We must also ask, ‘What matters to this person? What concerns them? What do they not understand?’” adds the expert.

A Profession That Retains Its Core Values Despite Change

Huruglica's experience shows that nursing in Kosovo has undergone significant changes, from the limited working conditions in the early years of her career to the development of professional education and new nursing structures.

In 2001, the Nursing Office was established within the former UNMIK-led Department of Health Services, with the aim of developing a nursing strategy for Kosovo and promoting professional advancement through training. With the support of international experts, the first cohort of the Nursing and Midwifery programme began their studies at the Faculty of Medicine of the University of Prishtina in the 2003/2004 academic year.

Today, alongside professional development, the challenge remains to ensure that standards of care are reflected in patients' everyday experiences.

For Hajdini, dedication and empathy should be an integral part of every nurse's work, particularly in wards where patients face serious illnesses.

“I would advise young nurses to practise this profession with dedication, empathy and responsibility. In oncology, patients need not only treatment but also emotional and compassionate support.



My message, based on my 47 years of experience as a nurse, both in clinical practice and in nursing administration, has always been the same. I have said at many meetings that if I were given another life, I would still choose to become a nurse,” says the former Head of the Nursing Division.

Never forget that sometimes even a smile or a kind word can make a significant difference to a patient,” advises Hajdini.

After 47 years in the profession, Huruglica says that if she had the opportunity to choose again, she would make the same decision.

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She adds, “Patients never forget the care and compassion you show them during the difficult moments in their lives when they turn to us for help.”

Ultimately, humanizing healthcare does not require nurses to choose between professionalism and compassion. Both are essential parts of care. Clinical knowledge, procedures and treatments are necessary, but the way patients are listened to, informed and treated shapes an important part of their experience.

“Nursing is not just a profession, but also a humanitarian mission that every person who chooses to become a nurse should embrace,” concludes Huruglica.

In a healthcare system where the demand for care is high and healthcare professionals often have limited time, the challenge is not only to provide the right treatment, but also to ensure that patients remain at the centre of the process. This is where one of the most important roles of nurses lies: caring for the illness without forgetting the person living with it.

RESEARCH

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Bubulina Peni
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In a healthcare system where the demand for care is high and healthcare professionals often have limited time, the challenge is not only to provide the right treatment, but also to ensure that patients remain at the centre of the process. This is where one of the most important roles of nurses lies: caring for the illness without forgetting the person living with it.

This article was produced as part of the activity "Beyond the Headlines: Journalism, Non-Communicable Diseases and the Stories That Matter", a partnership between the Association of Journalists of Kosovo (AGK) and the Integrated Health Services (IHS) Project. IHS is a joint initiative of the Ministry of Health and the Swiss Agency for Development and Cooperation in Kosovo. The content of the interview does not necessarily reflect the views of IHS or AGK.

OP-ED

Education and empowerment of patients with diabetes, **key to fewer hospitalizations**

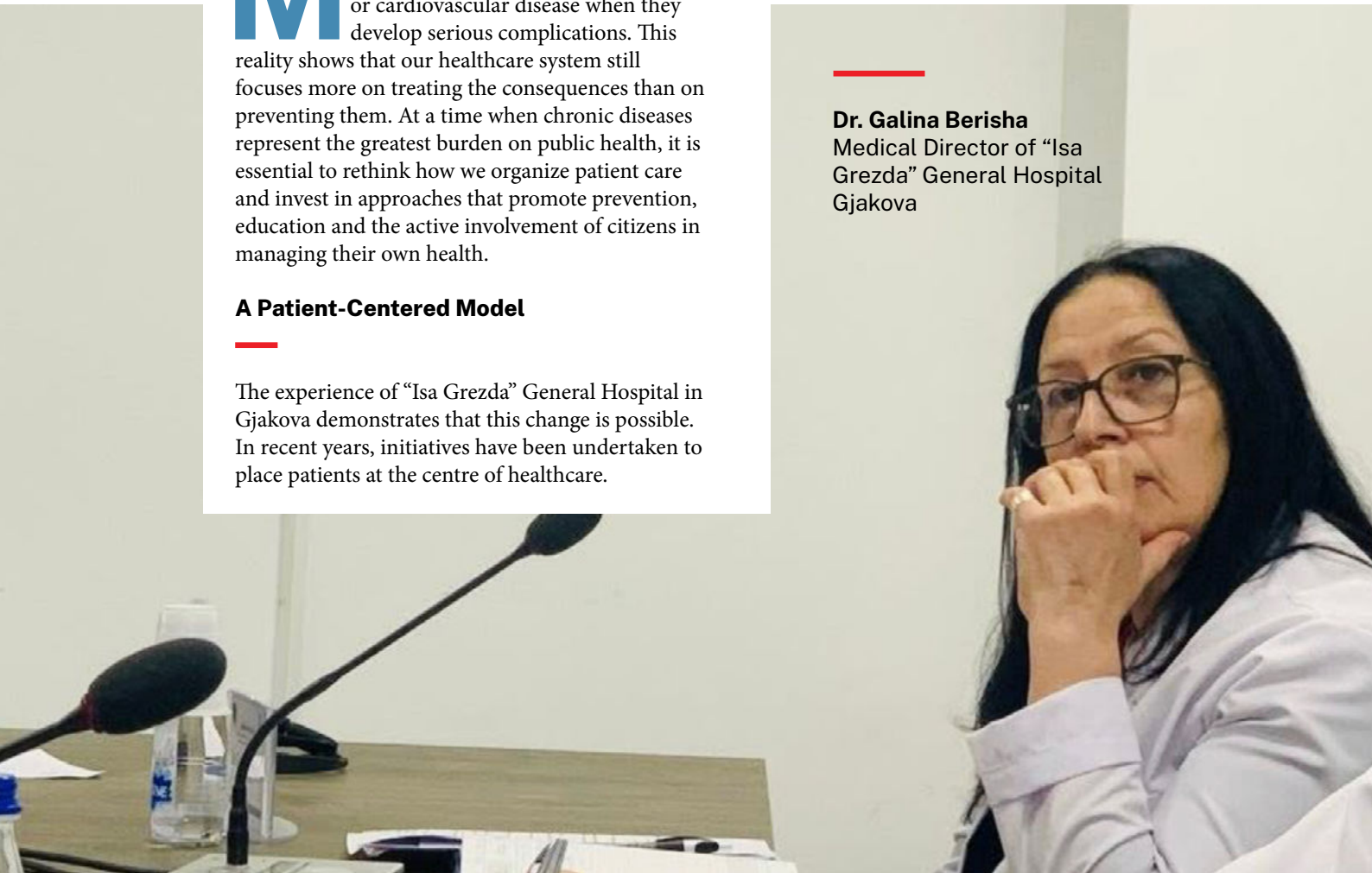
Many patients in Kosovo only discover that they have diabetes, arterial hypertension or cardiovascular disease when they develop serious complications.

Many patients in Kosovo only discover that they have diabetes, arterial hypertension or cardiovascular disease when they develop serious complications. This reality shows that our healthcare system still focuses more on treating the consequences than on preventing them. At a time when chronic diseases represent the greatest burden on public health, it is essential to rethink how we organize patient care and invest in approaches that promote prevention, education and the active involvement of citizens in managing their own health.

A Patient-Centered Model

The experience of “Isa Grezda” General Hospital in Gjakova demonstrates that this change is possible. In recent years, initiatives have been undertaken to place patients at the centre of healthcare.

Dr. Galina Berisha
Medical Director of “Isa Grezda” General Hospital
Gjakova



The multifunctional reception area, health resource centres for patients with chronic diseases, health education activities, early screening and the promotion of continuous monitoring have created a model in which patients are no longer merely recipients of services, but active partners in managing their own health.

The value of this model has also been recognized internationally. It was presented at the European Conference of the Health Promoting Hospitals (HPH) Network in Malmö, demonstrating that local experience can offer solutions of interest and value to the international healthcare community.

Beyond the Myth That Medications Are the Only Solution

There is still a belief that diabetes and hypertension are treated primarily with medications. In reality, medication is only one part of managing these conditions. Without continuous education, regular check-ups, a healthy diet, physical activity and good communication with healthcare professionals, the risk of complications remains high.

Many patients are not fully aware of the damage these conditions can cause to the eyes, heart, kidneys, brain and blood vessels. For this reason, screening, counselling and health education are just as important as medical treatment. The earlier risks are identified, the greater the chances of preventing complications and preserving patients' quality of life.

Why this model matters

The results so far show that when patients receive clear information and continuous support, they become more involved in decisions about their health, adhere more closely to their treatment and work more closely with healthcare staff. The health resource centres established at Gjakova Hospital, more structured communication and guidance provided through the multifunctional reception desk have contributed to raising patient awareness and improving continuity of care.

As healthcare professionals, we often measure success by the number of patients treated. However, true success is also measured by the number of complications we manage to prevent. This is precisely where the value of investing in health promotion and patient empowerment lies. It is not an additional cost to the healthcare system, but a long-term investment in its quality and sustainability.



Citizens do not simply receive general information about the importance of check-ups. They receive invitations, notifications and guidance on how to participate in the relevant programmes.

What Should Kosovo Do Next?

The experience of Gjakova should serve as a model for other healthcare institutions in Kosovo. There is a need to expand screening programmes, establish health resource centres for patients with chronic diseases in all hospitals, strengthen health education, develop forms of remote monitoring and continuously invest in training healthcare professionals in communication and patient-centred care.

Healthcare should not end when a patient leaves the hospital. It should continue through ongoing support, counselling and follow-up, with the aim of helping patients live longer and enjoy a better quality of life.

Conclusion

Chronic diseases will not disappear, but the way we manage them can change fundamentally. The most important lesson from the experience of Gjakova Hospital is that transformation does not necessarily begin with expensive technology or major infrastructure investments, but with a new culture of care in which patients are informed, listened to and empowered.

Only by shifting from treating complications to prevention, education and partnership with patients can we build a more efficient, more compassionate and more sustainable healthcare system for Kosovo.

This is the most valuable investment in the health of future generations.

[Arbreshë Uka, “Education and Empowerment of Patients with Diabetes, Key to Fewer Hospitalizations”, available at: <https://klankosova.tv/edukimi-dhe-fuqizimi-i-pacienteve-me-diabet-celes-per-me-pak-hospitalizime>]

RESEARCH

Education and empowerment of patients with diabetes, **key to fewer hospitalizations**

According to European protocols, endocrinologists should educate patients and inform them that every patient with diabetes must see an ophthalmologist and a nephrologist at least once a year.

A portrait of a woman with long dark hair, wearing a light blue blazer, sitting in front of a yellow and black patterned background. A white geometric structure is visible on the left.

Arbreshë Uka
Klan Kosova

Neki Popaj from Fortesë, Rahovec, was diagnosed with diabetes, a chronic disease, nearly a decade ago. Due to a lack of adequate information,

the 61-year-old says he has been unable to manage his condition properly and was recently hospitalized because of high blood glucose levels.

During his nearly 10 years of living with diabetes, he received hospital treatment for the first time at Gjakova General Hospital, where he stayed for more than 10 days.

“I’ve had diabetes for almost 10 years. Until now, I’ve been taking medication, and now, thanks to the doctors, they’ve even saved my life. I was in a very, very bad condition! My blood sugar went up to 40, but now I’m feeling much better and have started to stabilize,” the patient recounts.

The patient says that throughout these years, he has never received proper guidance from the doctors he has consulted. Popaj emphasizes that the lack of proper patient education led to complications from diabetes over time, as he experienced this summer.



Chronic diseases will not disappear, but the way we manage them can change fundamentally.

“No, I didn’t know these things before, and no one had informed me until I came here to the hospital,” says patient Neki Popaj.

However, the 61-year-old is now leaving the hospital feeling much more empowered and aware of how to manage his diabetes. Neki Popaj explains that he received guidance from healthcare professionals, specifically the hospital’s endocrinologists, through the hospital-based diabetes management health resource centre.

He expresses his gratitude and appreciation to the staff, both for the treatment he received and for the education that will help prevent many other complications associated with diabetes.

“They explained everything to me and gave me all the information I needed. They told me what to eat, what to drink and when. They gave me a lot of advice, and I’m feeling much better now.”

He now also understands that diabetes can damage other vital organs and that he needs to undergo

regular check-ups with specialists in other medical fields.

They advised me that I should also have my eyes and kidneys checked because of diabetes, and overall, I couldn’t be feeling better. “Patients are always better off when they follow their doctor’s advice. Otherwise, their health deteriorates.”

This hospital-based health resource centre, with its pleasant and comfortable environment, unlike the typical infrastructure of older hospital facilities, has been made possible through the partnership and support of the Integrated Health Services (IHS) Project.

The service began operating almost a year ago.

In this room within the hospital, hospitalized patients with diabetes attend educational sessions and practical training on managing their condition. Patients have also expressed pleasant surprise at this new approach.

“Usually, three or four patients gather here. We provide education on nutrition, correct insulin administration and the use of other medications. We also perform diabetic foot examinations and discuss physical activity and various other topics related to diabetes management,” explains endocrinologist Blerina Sylka Avdiaj.

Patients also receive practical training, particularly on measuring blood glucose levels at home. Until now, a lack of proper information has led some patients to repeatedly prick the same finger, causing wounds that have been difficult to heal.

“In addition to the educational sessions, we also raise their awareness through practical training, particularly on blood glucose monitoring. Patients often believe they should prick only one finger because they think blood sugar cannot be measured accurately using other fingers. As a result, they develop recurring wounds that are difficult to heal,” explains endocrinologist Blerina Sylka Avdiaj.

It is important to emphasize that diabetes affects vital organs, and Gjakova Hospital aims to focus on prevention and education so that patients gain knowledge and take the initiative to attend check-ups with other specialists.

Diabetes can also lead to vision loss and kidney damage, which, in severe cases, may require dialysis.

According to European protocols, endocrinologists should educate patients and inform them that every patient with diabetes must see an ophthalmologist and a nephrologist at least once a year.

“It is essential to visit an ophthalmologist and a nephrologist once a year. Pregnant women and patients with complications need more frequent check-ups, every six months or even every three months.

Diabetes is a disease that requires a multidisciplinary approach to assessment.

“We have had many such cases where patients have undergone limb amputations, ended up requiring



We have had many cases where patients went to the beach, walked barefoot on the sand and suffered burns, which in the most severe cases led to foot amputations. They often cover their feet with sand, believing it is beneficial to their health, and do not notice how hot it is. As a result, they suffer severe burns.

dialysis or lost their sight. This has happened not only because of how their condition was managed, but also because they were unaware that they needed to consult specialists in these different medical fields,” says endocrinologist Blerina Sylka Avdiaj.

However, this is not the only hospital health resource centre. A separate space is dedicated entirely to outpatients with diabetes. This outpatient health resource centre also began operating almost a year ago. The initiative was implemented at Gjakova General Hospital with the financial, professional and logistical support of the Integrated Health Services (IHS) Project. “Our first contact with patients with diabetes takes place at the specialist outpatient clinics. We see many patients there, but there are only two endocrinologists, so our time is limited. We simply do not have enough time to dedicate 30 minutes to each patient. That is why we inform patients about the counselling sessions and gather on Mondays and Thursdays for educational sessions and other activities,” says endocrinologist Blerina Sylka Avdiaj. Patients are very happy to come here. For them, the sessions also provide a form of psychological support, in addition to what they learn about nutrition, education, prevention and diabetes management.

“Patients are eager to participate, and up to 10 people attend. Once they come for the first time, they want to come back because the sessions are held in groups and they can share their experiences with one another. It is also a form of psychological therapy for them. The round table and kitchen make the environment feel even more welcoming. We spend about two hours together here, but if it were up to the

patients, we would stay all day, which unfortunately is not possible,” says Sylka Avdiaj.

Female patients are more interested in raising their awareness than male patients.

Meanwhile, this health resource centre provides education not only to patients but also to their family members. They attend together and learn from doctors how to respond if their family member with diabetes experiences a significant drop or rise in blood glucose levels.

Beyond this, even I, as a health journalist, learned something new that I had not encountered before. Patients with diabetes need to be particularly careful at the beach and should never walk barefoot on the sand. The consequences can be serious. “During the summer, patients need to take extra precautions, and we advise them to stay well hydrated because of the high temperatures. We also advise patients going to the seaside to take care of their feet, because people here tend to enjoy walking barefoot on the sand. However, for patients with diabetes, this can lead to serious complications.

“We have had many cases where patients went to the beach, walked barefoot on the sand and suffered burns, which in the most severe cases led to foot amputations. They often cover their feet with sand, believing it is beneficial to their health, and do not notice how hot it is. As a result, they suffer severe burns,” she explains. When endocrinologist Blerina Sylka Avdiaj shares this information with patients with diabetes and their family members, they recall similar incidents, although they had not previously been aware of this vital information.

“They are surprised when we explain this to them. Family members also recall similar experiences but had not understood why they happened. The same thing happens when patients are exposed to low temperatures. They feel cold and repeatedly use hot objects or move closer to heating sources, without realizing how hot they are, which can eventually cause burns,” she says.

The reason is that they have significantly reduced sensitivity to both hot and cold temperatures, as well as reduced sensitivity to pain, because diabetes damages the nerve fibres in their feet.

To prevent patients from developing such complications, Gjakova General Hospital offers examinations of the feet and nerve fibres through its electromyoneurography (EMNG) unit, another investment supported by the IHS Project.

“When patients complain of numbness, tingling and unpleasant sensations in their feet, we first assess whether they need an EMNG examination, which is performed by a neurologist. EMNG assesses the physiological function of nerve fibres, both motor and sensory, and helps determine whether the patient has nerve damage, particularly in the peripheral nerves of the feet. This type of examination and timely referral can delay the development of diabetic

foot complications or prevent existing diabetic foot problems from worsening.

Initially, patients did not have a clear understanding of this type of examination, and we continued referring them for it. They, in turn, informed their family members and friends, which contributed to an increase in demand," says the endocrinologist.

According to the data, 377 electromyoneurography (EMNG) examinations and 280 body mass index (BMI) measurements were performed between July of last year and July 2026.

Support from the IHS Project and the implementation of an online application for remote diabetes monitoring have helped save the life of a young patient.

Due to stigma, a young patient with type 1 diabetes had refused medical check-ups and avoided in-person contact. As a result, he had repeatedly been admitted to hospital in a serious condition.

"We have a programme called 'Monitoring,' an application that allows us to monitor patients remotely. We currently have six patients enrolled. It has proven very successful because of the confidentiality it provides, particularly for one young patient with type 1 diabetes. He had consistently avoided medical appointments because he did not want others to see him or find out that he had diabetes. Only his family knows about his condition.

Because of the stigma, he had been admitted to our hospital several times in a serious condition. This application has helped him greatly," says endocrinologist Blerina Sylka Avdiaj.

According to healthcare professionals, this application and the two health resource centres established a year ago have already shown noticeable results, contributing to a decline in hospitalizations. Compared with previous years, patients with severe diabetes-related complications now require hospital treatment much less frequently.

"Hospitalizations have started to decline, meaning that fewer patients with diabetes now require hospital treatment. In previous years, we frequently had patients with type 1 diabetes admitted in serious acute conditions, whereas we have not had a single such case for several months now, which is good news. There has also been a significant decrease in the number of patients with diabetes experiencing complications, such as diabetic foot complications or eye damage," says endocrinologist Blerina Sylka Avdiaj. Since 2024, Gjakova General Hospital has been a member of the Health Promoting Hospitals (HPH) Network. Following this step, doctors say their work is no longer limited to diagnosing and treating patients, but also includes health promotion, identifying health risks and providing counselling. The hospital also aims to introduce diabetic foot screening in the near future. Nurses have already received training in Slovenia for this purpose. This, too, has been made possible through the support

of the IHS Project, with the aim of ensuring that all components of care are fully functional, placing patients at the centre and empowering them.

"We underwent two weeks of training in Ljubljana, Slovenia, on diabetic foot screening. This examination involves assessing the feet, checking blood circulation, identifying wounds and taking foot measurements. Diabetic foot screening helps prevent or delay the need for amputation," says Butrint Stavileci, a nurse at the EMNG unit.

There is a need to increase the number of endocrinologists. All this work, including their responsibilities at the specialist outpatient clinic and patient care in the Internal Medicine Department, is carried out by just two endocrinologists. Until recently, there was only one.



EMNG assesses the physiological function of nerve fibers, both motor and sensory, and helps determine whether the patient has nerve damage, particularly in the peripheral nerves of the feet. This type of examination and timely referral can delay the development of diabetic foot complications or prevent existing diabetic foot problems from worsening. Initially, patients did not have a clear understanding of this type of examination, and we continued referring them for it. They, in turn, informed their family members and friends, which contributed to an increase in demand," says the endocrinologist. According to the data, 377 electromyoneurography (EMNG) examinations and 280 body mass index (BMI) measurements were performed between July of last year and July 2026.

OP-ED

Prevention costs less than treatment: using WHO's “Best Buys” for non-communicable diseases

Promoting healthy eating is equally important. WHO recommends measures such as reducing salt in foods, limiting unhealthy fats and raising awareness among individuals about making healthier choices.

Prof.Dr. Merita Berisha
Director of Education
and Science
Director of the Department
of Social Medicine
National Institute of
Public Health of Kosovo



Non-communicable diseases, such as cardiovascular diseases, diabetes, cancer and chronic obstructive pulmonary disease, are among the leading causes of death worldwide. Faced with the ever-increasing costs of treatment and the burden these diseases place on individuals and the healthcare system, the answer is clear: we must invest more in prevention. Prevention costs less, saves more lives and offers long-term benefits for society as a whole. For this reason, the World Health Organization's (WHO) “Best Buys” should be at the centre of health policies. These low-cost, highly effective interventions, which can prevent thousands of cases of disease and premature deaths, do not require expensive technology or unaffordable investments; they require institutional commitment and public awareness.

In my opinion, wider implementation of these measures, at both the individual and population levels, should be a priority for every society seeking to improve public health.

One of WHO's key recommendations is to reduce tobacco consumption through higher taxes, restrictions on advertising and the creation of smoke-free environments. Tobacco remains a major risk factor for many chronic diseases. Investing in policies that reduce tobacco use costs far less than the long-term treatment of patients with lung cancer, heart disease or other smoking-related conditions.

Promoting healthy eating is equally important. WHO recommends measures such as reducing salt in foods, limiting unhealthy fats and raising awareness among individuals about making healthier choices. An unhealthy diet is one of the leading causes of overweight, obesity, hypertension and diabetes. It is essential to create conditions that help people eat more healthily and prevent disease or delay the onset of complications.

Another WHO “Best Buy” is promoting physical activity. Sedentary lifestyles have become part of everyday life for many people, particularly young people. Creating spaces for walking, cycling and sports activities does not require excessive investment, yet brings significant public health benefits. A more physically active population is less likely to develop chronic diseases and has a greater chance of enjoying a long and productive life.



The number of cases treated for chronic diseases in Kosovo is increasing. Experts are calling for greater investment in prevention and more effective implementation of existing policies.

Some may argue that implementing these measures requires funding and institutional commitment that not every country can afford. For example, tax measures require coordination between institutions and across countries to achieve the desired results. However, the initial costs of prevention are far lower than the long-term costs of treatment, rehabilitation and lost productivity among people affected by illness. In this sense, prevention is an investment rather than an expense, and its value extends far beyond financial savings.

Non-communicable diseases cannot be completely eliminated, but their impact can be significantly reduced. WHO's “Best Buy” interventions offer a clear, affordable and proven approach to preventing diseases before they require costly treatment. The prevention and control of NCDs require continuous teamwork and a commitment to pursuing not only WHO's motto, “Health for All”, but also “Health in All Policies”. If we aim to build a healthier society and a more sustainable healthcare system, we must act now.

<https://agk-ks.org/lajmet/parandalimi-kushton-mepak-se-trajtimi-shfrytezimi-i-best-buy-te-obsh-se-per-semundjet-kronike-jo-ngjitese/>

[Albulena Bytyqi, “Chronic Diseases on the Rise, Prevention Remains a Challenge in Kosovo”, an article presenting data, institutional perspectives and citizens' experiences regarding the implementation in Kosovo of the “Best Buy” interventions recommended by the World Health Organization (WHO), available at: <https://www.rtklive.com/sq/news-single.php?ID=731499>]

RESEARCH

Chronic diseases on the rise, **prevention remains a challenge in Kosovo**

Non-communicable diseases continue to be among the greatest public health challenges in Kosovo. Cardiovascular diseases, diabetes, cancer and chronic respiratory diseases account for a significant proportion of the burden of morbidity and mortality. The main risk factors include tobacco use, unhealthy diets, physical inactivity and alcohol consumption.

Albulena Bytyqi
Radio Kosova



The number of cases treated for chronic diseases in Kosovo is increasing.

Experts are calling for greater investment in prevention and more effective implementation of existing policies. This investigative report presents official data, institutional perspectives and citizens’ experiences regarding the implementation in Kosovo of the “Best Buy” interventions recommended by the WHO.

Chronic non-communicable diseases continue to be among the greatest public health challenges in Kosovo. Cardiovascular diseases, diabetes, cancer and chronic respiratory diseases account for a significant proportion of the burden of morbidity and mortality. The main risk factors include tobacco use, unhealthy diets, physical inactivity and alcohol consumption.

To address this challenge, the World Health Organization (WHO) has developed a set of interventions known as “Best Buys”, which are considered among the most cost-effective measures for preventing non-communicable diseases.

What Are the “Best Buy” Interventions?

In response to the continued rise in chronic non-communicable diseases globally, the WHO has identified a package of interventions known as “Best Buys”, which are based on scientific evidence and offer the greatest impact on improving public health at a relatively low cost.

These measures focus on reducing the main risk factors through tobacco and alcohol control, promoting healthy eating, increasing physical activity, early diagnosis and strengthening primary healthcare.

Their aim is not only to treat diseases but also to prevent their onset, while reducing the financial burden on the healthcare system and improving citizens’ quality of life. For this reason, the “Best Buy” interventions are now considered an international standard for developing preventive public health policies.

Reality in Kosovo

Official data show that the number of cases treated for chronic diseases increased from 41,258 in 2023 to 43,539 in 2024. Luljeta Selimi, Senior Health Statistics Officer at the Kosovo Agency of Statistics (KAS), says that the 65–69 and 70–74 age groups remain the most affected, while arterial hypertension and diabetes mellitus continue to be the most common diagnoses.

These statistics show that the burden of non-communicable diseases continues to grow, making prevention a necessity for the healthcare system.

Treatment remains indispensable, but investments in early diagnosis and preventive measures are essential to curb the growing burden of these diseases.



Official data show that the number of cases treated for chronic diseases increased from 41,258 in 2023 to 43,539 in 2024.

Policies Exist, but Implementation Remains as the Main Challenge

Although Kosovo has established an important legal and strategic framework for the prevention of non-communicable diseases, interviews conducted for this investigative report show that the main challenge is no longer the lack of policies, but their implementation in practice. Institutions, experts and civil society organizations agree that progress has been made in developing strategies and legislation, but their impact remains limited due to insufficient funding, limited institutional capacities and oversight that is not always effective.

NIPHK: Prevention Requires Greater Investment

According to Prof. Dr. Merita Koçinaj-Berisha, Director of the Department of Social Medicine at the National Institute of Public Health of Kosovo (NIPHK), the “Best Buy” interventions are based on scientific evidence and aim to address the main risk factors at both individual and population levels. However, their implementation in Kosovo remains partial due to limited financial and human resources, insufficient capacity for preventive care and difficulties in changing citizens’ behaviours. She emphasizes that, despite the positive results of the Tobacco Control Law, greater investment is needed in preventive programmes and the promotion of healthy lifestyles.

Ministry of Health: Strategies Are in Place, but Funding Remains a Challenge

Dr. Merita Vuthaj, Director of the Department of Health Services and Public Health at the Ministry of Health, believes that Kosovo has taken significant steps towards implementing the World Health Organization's recommendations for the prevention of non-communicable diseases.

According to her, the adoption of the *Health Sector Strategy 2025–2030 and the Action Plan for Non-Communicable Diseases*, together with screening programmes and initiatives promoting physical activity, healthy eating and smoking cessation, form the foundation of preventive health policies.

However, she emphasizes that the lack of a dedicated budget for prevention programmes remains one of the main challenges to the full implementation of these policies.

One of the most significant examples of the gap between legislation and practice remains the Tobacco Control Law. Shkumbin Spahija, Executive Director of the Kosovo Advocacy and Development Centre (KADC), believes that Kosovo has one of the most advanced laws in the region, but its implementation is inconsistent. According to him, the lack of regular inspections, inconsistent enforcement and non-compliance with legal provisions in some public spaces demonstrate that improvements in legislation must also be accompanied by stricter enforcement.

He recommends increased oversight, stronger inspection mechanisms and the expansion of smoking cessation programmes.



One of the most significant examples of the gap between legislation and practice remains the Law on Tobacco Control.

WHO: Prevention Requires Long-Term Commitment

According to Dr. Isme Humolli from the World Health Organization Office in Kosovo, the challenges facing the country are not unique, as most countries encounter difficulties in changing behaviours that affect public health. She emphasizes that tobacco control, the promotion of physical activity, healthy eating and reducing alcohol consumption remain the main pillars of prevention and require sustained institutional commitment.

An additional perspective is offered by Prof. Dr. Suzanne Suggs, Professor of Social Marketing at the Università della Svizzera italiana (USI) in Lugano, Switzerland, and an expert in public health communication. According to her, the success of the “Best Buys” interventions is measured not only by the adoption of laws and strategies, but also by





institutions' ability to communicate effectively with citizens. She emphasizes that health education, public awareness and collaboration among institutions, healthcare professionals, the media and communities are essential to making prevention part of everyday culture.

Overall, the interviews convey a common message: Kosovo does not lack strategies or legislation. The real challenge remains the consistent implementation of policies, securing the necessary funding and making long-term investments in prevention so that the “Best Buys” interventions deliver tangible improvements to citizens' health.

Citizens: Greater Awareness, but Practical Barriers Remain

Interviews conducted with citizens show that awareness of the risks associated with tobacco use, unhealthy eating and physical inactivity has increased in recent years. Most respondents stated that they are aware of the importance of a healthy lifestyle and are making efforts to take better care of their health. However, according to respondents, putting these recommendations into practice remains challenging.



Interviews conducted with citizens show that awareness of the risks associated with tobacco use, unhealthy eating and physical inactivity has increased in recent years.

They emphasized that high prices of healthy foods, a lack of suitable spaces for physical activity, the fast pace of life and continued smoking in some public places make it difficult to change everyday habits.

Dren Gashi, a resident of Prishtina, believes that information on the importance of prevention has improved, but people still need more practical support from institutions to adopt healthier habits. Meanwhile, Njomza Thaçi, a resident of Prizren, emphasises that promoting healthy living must be accompanied by concrete investments in sports

infrastructure, health education and policies that make healthy choices easier for everyone.

Overall, people believe that institutions should invest more in health education, promoting preventive activities and creating conditions that support healthier lifestyles.

When Illness Changes Your Life

Statistics and public policies show the scale of the burden of non-communicable diseases, but behind every number is a human story. One such story is that of G.M. from Malisheva, who has lived with a chronic condition for years. For him, the diagnosis meant more than medical treatment: it changed his lifestyle, daily routine and family life.

He says it was only when he faced the illness himself that he understood the importance of regular check-ups and prevention. In his view, better information and timely preventive check-ups could have prevented, or at least eased, many of the difficulties he faces today.

His story shows that treatment remains essential, but cannot replace prevention. Every investment in early diagnosis, health education and reducing risk factors means fewer patients, lower costs for the health system and a better quality of life for people. G.M.'s experience is therefore not an isolated case; it reflects the reality faced by many people living with chronic conditions in Kosovo.

Analysis

The statistics, interviews and documents reviewed point to a clear conclusion:

Kosovo has established a legal and strategic framework for preventing non-communicable diseases, but putting it into practice remains the main challenge. Strategies and action plans align with World Health Organization recommendations, yet their impact remains limited by insufficient funding, constraints in institutional capacity and oversight that is not always effective.

The Law on Tobacco Control is the clearest example of this gap. Although considered one of the most advanced in the region, its enforcement remains uneven. At the same time, insufficient investment in prevention programmes and health education makes it harder to change behaviours associated with the main risk factors.

The interviews also reveal broad agreement among institutions and experts on the direction Kosovo should take. The challenge is not to develop new policies, but to fully implement those already in place. This requires better institutional coordination, more funding for prevention and active public involvement in promoting healthy lifestyles.

Conclusion

The investigation shows that Kosovo has made progress in aligning its policies with international recommendations for preventing non-communicable diseases. However, the success of “Best Buys” interventions will be measured not by the number of strategies or laws adopted, but by their impact on people's lives.

Achieving this requires greater investment in prevention, stronger primary health care, more effective oversight of law enforcement and ongoing communication with the public. Through cooperation among institutions, healthcare professionals, the media and communities, “Best Buys” interventions can move from policies on paper to tangible public health outcomes.

Ultimately, the question is no longer whether Kosovo has the policies needed to prevent non-communicable diseases. The challenge is to implement them consistently, so that prevention becomes a priority rather than a response that comes only after illness has changed people's lives.

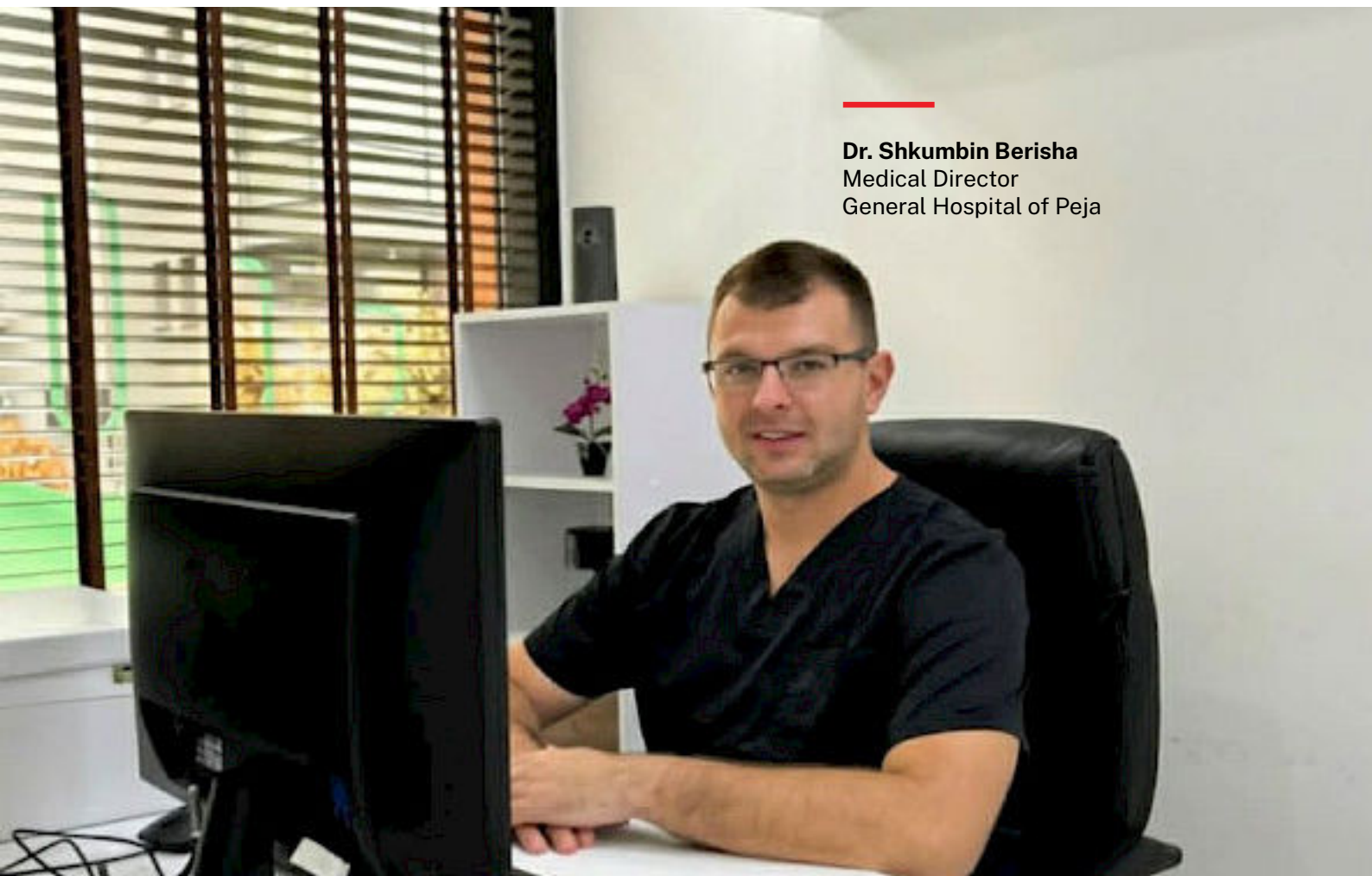


Taken together, the interviews convey a shared message: Kosovo has no shortage of strategies or legislation.

OP-ED

Patients with chronic conditions need continuity of care

Hospitals must continue to improve conditions for diagnosis and treatment. We have highly skilled specialists and healthcare professionals in these areas, providing a strong foundation. This calls for better coordination among professionals caring for the same patient, clear discharge instructions, and better communication with primary care and the services where the patient will continue treatment.



Dr. Shkumbin Berisha
Medical Director
General Hospital of Peja

For a patient living with a chronic condition, coming to hospital is more than just another visit. They bring with them years of living with hypertension, diabetes, heart disease or other health problems, sometimes several at once. They may come because their condition has suddenly worsened, but the care they receive, from admission to returning home, also shapes what happens afterwards.

That is why it is not enough to ask whether the patient has been treated and stabilised; we must also consider what awaits them after discharge.

A Journey That Neither Begins nor Ends in Hospital

As the average age of the population rises and chronic diseases emerge at increasingly younger ages, we as healthcare professionals see patients who need long-term care every day.

Their journey may begin with a family physician, at a specialist outpatient clinic or in the emergency department.

In hospital, it continues with assessment, examinations, diagnosis, specialist consultations and treatment. But an equally important part begins after the patient leaves: treatment at home, regular check-ups, diet, physical activity and monitoring of their condition.

In practice, the connections between these stages can make all the difference. When each part of the system knows what has happened before and what needs to happen next, the patient has a better chance of keeping their condition under control and avoiding complications.

Discharge from hospital does not mean care has ended

In hospital, our main focus is naturally on the problem that brought the patient there. We need to diagnose it, treat it and stabilise the patient. But with chronic conditions, this is only part of the work.

When the patient leaves, what happens next must be as clear as possible. Have they understood the diagnosis? Do they know how to take their medication? When is their next check-up due? Do they recognise the warning signs that mean they should seek help again?

These may seem like simple matters, but they are very important to patients and their families. If instructions are not understood or care does not continue as it should, a problem that could have been managed early may bring the patient back to hospital.

Discharge from hospital should therefore be seen as a transition to the next stage of care, rather than its end.

Patients Need to Understand the Condition They Live With

As healthcare professionals, we work with diagnoses, tests, treatments and protocols. Patients, meanwhile, have to live with their condition every day.

A person with diabetes makes daily decisions about food and treatment. Someone with hypertension may have no symptoms, even when their blood pressure is not under control. A patient with heart disease needs to know when a change in their condition requires attention.

That is why communication with patients is part of treatment. Giving them a medical report and a list of medicines is not enough. We must make sure, as far as possible, that they understand their condition and their role in looking after their health.

Families can also be important partners in this, especially for older patients or those living with several conditions at once.

What Can We Do Better?

Hospitals must continue to improve conditions for diagnosis and treatment. We have highly skilled specialists and healthcare professionals in these areas, providing a strong foundation. Hospitals must continue to improve conditions for diagnosis and treatment. We have highly skilled specialists and healthcare professionals in these areas, providing a strong foundation. This calls for better coordination among professionals caring for the same patient, clear discharge instructions, and better communication with primary care and the services where the patient will continue treatment.

At the same time, we should not wait for the condition to worsen before taking action. Prevention must begin much earlier. Education on healthy eating, physical activity, regular check-ups and early identification of risk factors are among the best ways to reduce the burden of chronic diseases.

Behind every diagnosis is a person who wants to return to their family, work and everyday life. That is why our success means more than a patient leaving hospital in better health. It means they leave knowing what to do next, with a clear pathway for continuing care. For patients living with chronic conditions, the hospital door should not be the place where care starts all over again each time their condition worsens: <https://agk-ks.org/lajmet/pacienti-kronik-ka-nevoje-per-vazhdimesi-te-kujdesit/>

[Majlinda Bytyqi, "Beyond the diagnosis of chronic diseases in Kosovo: When care begins with listening to the patient", at the following link: <https://gazetashneta.net/pertej-diagnozes-se-semundjeve-kronike-ne-kosove-kur-kujdesi-nis-me-degjimin-e-pacientit/>]

RESEARCH

Beyond the diagnosis of chronic diseases in Kosovo: when care begins with listening to the patient



Majlinda Bytyçi
Gazeta Shneta

Non-communicable diseases are long-term health conditions that require ongoing care and treatment, such as diabetes, hypertension and heart disease. In Peja, care for a patient with a chronic condition does not end when their condition is stabilised in hospital. Before returning home, patients need to feel confident about how to take their medication, what to eat, how to monitor their blood glucose and blood pressure, and when to seek medical help again. At Peja General Hospital, this support is provided by the health resource centre.

At the age of 24, after giving birth, Arjana Gashi developed high blood pressure. For the past 16 years, hypertension has been part of her daily life. At Peja General Hospital, she is one of the patients whose care journey goes beyond receiving medication. From the Emergency Department to the Internal Medicine Ward, from ongoing monitoring to advice on diet and lifestyle, patients are prepared for the moment when they leave hospital and manage their condition at home. In this process, the health resource centre for patients with diabetes and hypertension aims to bridge hospital treatment and everyday life.

“I first went to the Emergency Department, then I was admitted to the Internal Medicine Ward. They came every day to monitor my condition and measure my blood pressure,” Gashi recalls.

She says she developed hypertension at the age of 24, after giving birth. At first, she found it difficult to accept that high blood pressure would become part of her life.

“I thought it would go away after I gave birth to my second child, but it didn’t,” she says.

One difficulty Gashi experienced was that a rise in her blood pressure did not always come with noticeable symptoms.

“The hardest part is when my blood pressure goes up, because I don’t realise it straight away. I never notice it, and I haven’t felt dizzy either. Once, while chatting, I checked it just out of curiosity, and it turned out to be high,” she explains.

For patients like Arjana, managing a chronic condition cannot be confined to the hospital. She needs to learn to understand her condition, follow her prescribed treatment, look after her diet and know what to do when she returns home.

“Treatment has helped me manage my condition. I’ve come to terms with it. When I was younger, I took it very hard, but as I’ve grown older, I’ve started taking better care of myself,” Gashi says.

For Arjana, hypertension is part of everyday life. For Qazim Shala, the journey began differently.

He says he discovered he had diabetes around three years ago; until then, he had not known he had the condition. He went to hospital because of pain in his hands and feet. After his blood glucose was checked, he learned that it was high.

“The doctor told me I needed to stay in hospital because my blood sugar was very high,” Shala recalls.

At the time of the interview, he had been in hospital for four days and said his blood glucose had reached 15.2.

During his stay, his blood glucose was checked several times a day, and he also received dietary advice.

This included avoiding sugary fizzy drinks, which can raise blood glucose levels.

Zekë Berisha, meanwhile, has lived with diabetes for 16–17 years. He remembers the first signs: thirst, a dry mouth and sweating. For him, diabetes now also involves other complications and long periods in hospital.

When Care Begins with Listening to the Patient

Non-communicable diseases, such as diabetes, hypertension and heart disease, require ongoing care even after hospital treatment.

For patients, the challenge often begins when they return to everyday life.



Non-communicable diseases, such as diabetes, hypertension and heart disease, require ongoing care even after hospital treatment. For patients, the challenge often begins when they return to everyday life.



This is where one of the most important parts of the care journey comes in: the health resource centre, where patients gain the knowledge and support they need to manage their condition better at home.

Arita Muzliaj, the nurse who leads the health resource centre within the Internal Medicine Ward, explains that patients receive advice on diabetes, hypertension and the complications associated with these conditions.

“The role of the health resource centre is to educate patients with diabetes about their lifestyle. They learn about diet, taking their medication and administering insulin,” Muzliaj explains.

Counselling takes place during the patient’s stay on the ward. Patients who are able to move around can get counselling at the health resource centre, while nurses visit those with limited mobility in their rooms.

According to Muzliaj, patients in the Internal Medicine Ward are mainly older people and often have more than one condition.

“Patients have other conditions alongside diabetes. Most are in the final stage of life, while the others are managing their conditions,” she says

For this reason, patient education is seen as an important part of care. “Patients who have not been adequately educated or lack information about their condition are, of course, more likely to experience serious complications. Education does a great deal to improve their quality of life,” Muzliaj explains.

But what do patients learn before returning home? Counselling begins with the basics of daily life: diet, medication and lifestyle.

“The foundation is diet and eating habits. Avoiding fats, being careful about what you eat when you have diabetes, avoiding sugars, white bread and foods made with white flour, anything that harms the patient or worsens their condition,” Muzliaj says.

But counselling goes beyond diet. Patients also receive advice on physical activity, walking, weight, smoking and alcohol.

For patients with diabetes and hypertension, this advice also addresses how the two conditions can affect each other.

“These conditions can worsen each other’s complications. If someone has diabetes and does not manage their hypertension, the hypertension makes their diabetes worse. If someone has hypertension and does not watch their diet, their blood pressure becomes harder to control,” Muzliaj explains.

Patients are therefore not simply treated for high blood glucose or blood pressure; they receive advice on managing their overall health.

One of the most important moments in the health resource centre’s work comes before discharge.

Muzliaj explains that patients are first asked about their lifestyle and habits before admission. Counselling then progresses gradually during their hospital stay.

“I usually ask them during their stay. Patients here tend to stay longer, not just for a day or two. In the first few days, I prefer to ask what their lifestyle was like before they were admitted, and then we begin offering advice,” she says.

The Day Before Discharge, Patients Also Complete a Questionnaire

“The day before discharge, I use a questionnaire to find out what patients have understood during their stay and how well they can put that information into practice at home,” Muzliaj says.

The aim is therefore not only for patients to know which medication to take, but also to understand how to manage their condition in everyday life.

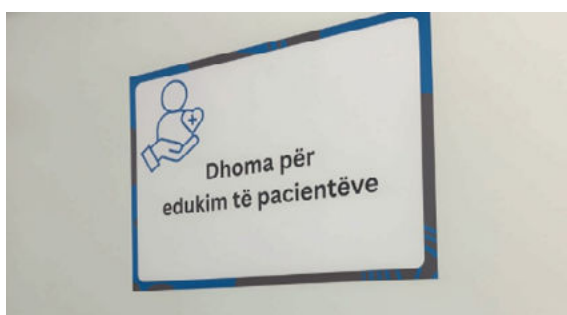
Meanwhile, endocrinologist and internist Teuta Mulla Goga describes the journey from another perspective: the clinical process.

“The journey usually begins in the Emergency Department, where the examination starts based on the symptoms the patient reports,” she explains.

If a patient’s readings indicate a blood glucose crisis or other abnormal values, they may be admitted to the Internal Medicine Ward or another appropriate ward.

According to her, Peja General Hospital has 18 internists across various specialties, including endocrinologists, cardiologists, gastroenterologists and nephrologists.

After admission, patients with diabetes are examined by an endocrinologist, and their blood glucose is monitored several times a day, depending on the clinical indication. As the patient’s clinical condition improves and their readings begin to return to normal, the team assesses whether the treatment is working.



“As the patient’s clinical condition improves and their readings begin to fall and return to normal, their earlier symptoms start to ease. We can see that the condition is improving: the patient feels better, and their laboratory results are closer to the normal range,” she says.

According to Mulla Goga, the health resource centre plays an important role in the care journey of patients with diabetes. “The health resource centre is very important for patients with diabetes because, during their hospital stay, they can attend the educational sessions the nurse holds at a scheduled time each day,” she says.

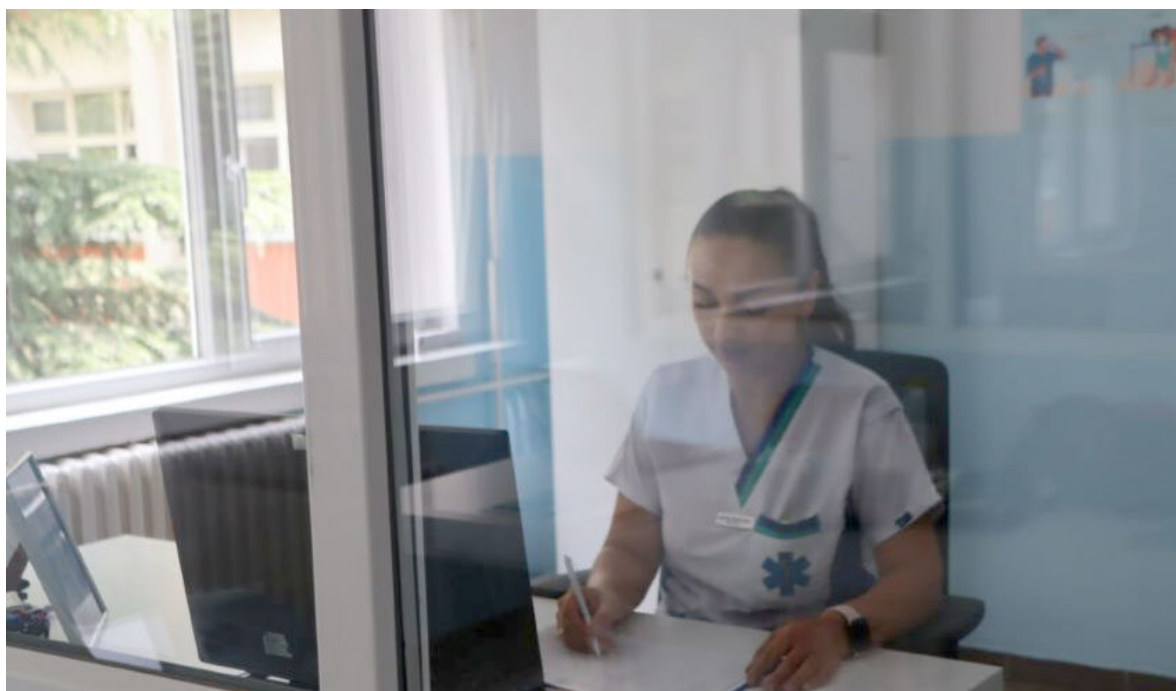
Chronic diseases require ongoing care and awareness

The experiences of patients in Peja are part of a challenge that extends beyond any single hospital or country.

According to the World Health Organization (WHO), non-communicable diseases, including cardiovascular diseases, cancer, chronic respiratory diseases and diabetes, are among the world’s leading health problems.

In 2021, these diseases caused at least 43 million deaths, accounting for around 75% of global deaths unrelated to pandemics.

WHO notes that these diseases are generally long-term and are linked to a combination of genetic, physiological, environmental and behavioural factors.



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According to her, Peja General Hospital has 18 internists across various specialties, including endocrinologists, cardiologists, gastroenterologists and nephrologists.

Factors such as tobacco use, physical inactivity, unhealthy diets and harmful alcohol use increase the risk.

In the European Region, around 1.8 million deaths from non-communicable diseases each year could be prevented or avoided through prevention and timely treatment, according to a 2025 WHO report. This makes care beyond diagnosis all the more important.

Meanwhile, according to data obtained by Gazeta Shneta, around 500 people received advice from the health resource centre within the Internal Medicine Ward at Peja General Hospital in 2026, compared with around 842 patients in 2025.

The health resource centre, however, currently operates mainly within the Internal Medicine Ward.

According to Muzliaj, the service also sees outpatients, including people who have recently started insulin and need guidance on how to use it.

However, it is not yet fully operational within the specialist outpatient clinic, as originally planned.

This shows that the care journey for a patient with a chronic condition involves more than a visit to the doctor. It requires a series of connected steps: diagnosis, treatment, education, self-management, follow-up and a return to the community.

Endocrinologist Mulla Goga emphasises the importance of continuing treatment. “The message is that everyone living with diabetes should take their medication as prescribed. Even if their blood glucose and blood pressure return to normal, they must continue treatment, because those improvements are the result of the treatment,” she says.

For Arjana, high blood pressure is now part of life. For Qazim, diabetes is a condition he learned to live with only after being diagnosed. For Zekë, years of living with diabetes have also brought complications requiring lengthy hospital treatment.

Three different stories, with one thing in common: care cannot be limited to the days spent in hospital.

Beyond tests, insulin, medication and monitoring, what patients learn about continuing their care at home also matters: understanding their condition, knowing their body and recognising when to seek help. Leaving hospital is not the end of care. It is the beginning of a daily life in which patients need to feel informed, supported and confident in managing their condition.

RESEARCH

Investing in people is the best thing we can do for public health in our country



Human resources are among a country's most valuable assets, particularly in the health sector. Fatmir Hoxha, a trainer and human resources expert, believes that “investing in the people who keep the health system running is the best investment we can make in public health in our country”.

Merita Miftari
Gazeta Express

Without motivated, well-trained and valued professionals, investment in infrastructure cannot guarantee quality healthcare services. Fatmir Hoxha points out that the World Health Organization (WHO) considers the health workforce the backbone of every functioning health system and emphasises the importance of workforce planning, recruitment, development and retention.

“Modern human resource management is no longer limited to contracts, personnel files or hiring procedures. Today, it encompasses workforce planning, competency-based recruitment, professional development, performance management, motivation, employee wellbeing, leadership and building an organisational culture directly aligned with the institution’s objectives,” Hoxha emphasises.

Hoxha explains that “a hospital or Main Family Medicine Centre (MFMC) cannot perform well simply because it has a certain number of staff”.

He emphasises that “it needs the right professionals, deployed according to actual needs, with opportunities for professional development and an efficient organisation of work”.

Good Management Directly Affects Patients

Good management directly affects service quality and patient care.

Hoxha emphasises that “well-trained, motivated and organised staff deliver higher-quality services, make fewer errors, communicate better and provide a better experience for patients”.

“For this reason, spending on human resources should be seen as a long-term investment in the institution’s performance and sustainability,” he adds.

Hoxha also discusses the role of managers and leaders in creating a working environment where employees perform well and continue to develop.

According to him, “leaders play a decisive role. Even when an institution has highly skilled staff, results can be poor if leadership is weak”.

Hoxha therefore emphasises that “a modern manager must be more than an administrator; they must also be a leader, communicator, mentor and someone who supports the team”.

Public institutions, however, often operate with limited resources. So, “which practices can improve performance without requiring substantial additional resources?”

Hoxha says that “not every improvement requires a large budget”.

“Often, the problem lies in how existing resources are managed,” he explains.

“Public institutions can achieve a great deal through relatively simple measures: regular communication with staff, constructive feedback, mentoring, recognition of good work, better scheduling, redistribution of tasks and using data to understand the actual workload,” he continues.

“For example, in a clinic or MFMC, before immediately requesting more staff, it is worth assessing whether schedules, patient flow and the distribution of tasks are organised as effectively as possible.

Another low-cost measure with a high impact is truly listening to employees: an institution that asks staff about the main problems and then takes

concrete action builds greater trust and engagement. So, even with budget constraints, management can improve significantly if institutions shift from thinking ‘we don’t have the resources’ to asking ‘how can we make better use of the resources we have?’” Hoxha says.

Kosovo Faces the Challenge of Healthcare Professionals Leaving the Country

Retaining healthcare professionals in Kosovo remains a challenge, particularly because of working conditions, salaries and opportunities for professional development.

Hoxha emphasises that “one of Kosovo’s greatest challenges remains keeping healthcare professionals in the system”.

“The migration of doctors, nurses and other professionals is more than the loss of a staff member; it is the loss of years of investment in education and training,” he says.

“Alongside recruiting new professionals, we must also focus on creating conditions that encourage existing staff to stay: real opportunities for career progression and professional development, better management, suitable working conditions, fair performance appraisal and an institutional culture that respects professionals,” Hoxha explains.

Compared with developed European countries, he says, “Kosovo still has room to improve its use of data for workforce planning, forecasting needs for specific professions and specialties, and staff retention policies. But European countries face similar problems: the relevant institutions report significant shortages of doctors and nurses in many countries across Europe”.

“The difference is that more developed systems have more advanced mechanisms for workforce planning, professional development and staff retention,” he says.

Finally, Hoxha emphasises that “Kosovo’s goal should be to build a system where healthcare professionals are seen as the institution’s greatest asset, rather than just a number on the payroll”. The World Health Organization (WHO) recognises health workers as the backbone of every functioning and resilient health system, and among its most valuable resources for ensuring quality healthcare services. WHO also stresses the importance of investing in the health workforce, including training, employment and retention.

From good policies to good practices: why leadership training in non-communicable diseases matters for Kosovo

Dr. Jana Gerold
Project Leader
Swiss TPH



Kosovo has invested seriously in drafting sound health policy: national strategies and technical guidance on non-communicable diseases are, by regional standards, well designed. Yet the distance between a well-written policy and what actually happens in a clinic or municipality remains wide, and closing that distance depends on people, not paperwork. This July, Kosovo

ran its first Non-Communicable Disease Leadership Course, a pilot built specifically to train (future) professionals who can carry good policy through to implementation. Why did this particular gap need its own course, and what does closing it actually require?

The course grew out of a straightforward diagnosis shared by the Integrated Health Services project, the University of Prishtina and the National Institute of Public Health of Kosovo: the country's NCD strategies are not the weak link. What is missing is a critical mass of professionals equipped to negotiate financing, coordinate institutions and keep a signed strategy moving once the initial momentum around its adoption fades. Rather than adding another technical curriculum, the course set out to build leadership capacity for that specific, unglamorous work — the kind that rarely appears in a strategy document but determines whether it survives contact with budgets, staff turnover and competing institutional priorities. Participants worked through real Kosovo case areas, concerning tobacco control, alcohol consumption, nutrition, and physical activity.

What distinguished this course from a conventional public health training was its deliberate focus on the mechanics of follow-through rather than technical content alone. Participants were pushed to think in terms a strategy document rarely spells out: who has to agree to a budget line, which municipal office actually owns a referral pathway, what happens to a pilot once donor financing ends. Pairing Kosovo-based faculty with colleagues from the region and Switzerland added a comparative dimension to this work, letting participants test where Kosovo's own well-written policies were losing traction against systems that had faced, and in some cases solved, similar coordination problems. This is the core argument for specialized leadership courses of this kind: strengthening a patient-centred care ecosystem



The course emerged from a clear observation, shared by the Integrated Health Services (IHS) project, the University of Pristina, and the National Institute of Public Health of Kosovo: the country's strategies for chronic non-communicable diseases are not the weak link.

is less a matter of writing better strategies than of building enough people, across enough institutions, who know how to keep an agreed strategy alive.

Switzerland's own experience with non-communicable disease policy illustrates the point. Its National Strategy for the Prevention of Non-Communicable Diseases, adopted in 2016, was never meant to be a finished document: it is jointly steered by federal and cantonal authorities, formally reviewed and adjusted, and in 2024 extended to 2028 while a successor approach is developed. What keeps that strategy relevant is not the original text but a standing institutional habit of monitoring it, renegotiating priorities between levels of government, and treating implementation gaps as something to be managed continuously rather than solved once. Kosovo faces a structurally different context, but the underlying lesson travels: a good NCD policy needs a permanent constituency of people whose job is to keep checking whether it is actually happening, escalate where it is not, and adjust course when circumstances change. That is precisely the kind of leadership Kosovo's own NCD leadership training now aims to cultivate, one course at a time.

For patients, this distinction is not abstract. Cardiovascular disease, diabetes, chronic respiratory disease and cancer already account for the great majority of deaths and health spending in Kosovo, and the people living with them experience the health system through whether a tobacco-control measure is enforced, a referral pathway works, or a prevention programme survives past its pilot phase - not through

the wording of a strategy. A country with strong strategies but weak follow-through leaves patients exposed to exactly the coordination failures those strategies were meant to prevent. Training leaders who can hold institutions to their own commitments is therefore not a supplement to patient-centred care; it is one of its preconditions.

The next step is less about running a bigger course than about giving its lessons somewhere to go. NIPHK, IHS and the University of Prishtina should consider how graduates of this pilot are actually deployed - into the committees, working groups and monitoring functions where Kosovo's NCD strategies are negotiated and reviewed - rather than treating the course as a credential in itself. Institutionalizing a standing capacity for policy follow-through, closer to how Switzerland's federal-cantonal structures continuously revisit their own NCD strategy, would do more for patient-centred care in Kosovo than any single additional training cohort.

Kosovo does not lack good policy on non-communicable diseases; it lacks enough people whose job is to make sure that policy keeps happening. That, more than any new strategy document, is what a patient-centred care ecosystem in Kosovo now needs most.

Box 1: The course grew out of a straightforward diagnosis shared by the Integrated Health Services project, the University of Prishtina and the National Institute of Public Health of Kosovo: the country's NCD strategies are not the weak link.

Strengthening leadership capacity for noncommunicable diseases: experiences from the Prishtina International Summer University

Prof.Dr. Merita Berisha

Director for Education and Science

Director, Department of Social Medicine

National Institute of Public Health of Kosovo



Noncommunicable diseases (NCDs) pose a significant public health challenge in Kosovo, contributing to greater morbidity, premature mortality and demand for health services [1]. Addressing this burden requires not only clinical and preventive interventions, but also strong leadership capacity at every level of the health system [1,2]. Developing leadership competencies among health professionals and other stakeholders is essential for strategic planning, intersectoral coordination, resource management and policy implementation [1,4]. According to the World Health Organization (WHO), a prepared and competent workforce is essential to reducing premature mortality from NCDs and strengthening universal health coverage [1,2].

At the initiative of, and through cooperation among, the National Institute of Public Health of Kosovo (NIPHK), the Integrated Health Services (IHS) project, Swiss TPH and the University of Prishtina (UP), relevant documents and the needs of the target group were analysed to develop an NCD leadership module. The process included reviewing key documents and identifying the needs of the target group, which informed the content, learning objectives and relevant competencies for undergraduate and postgraduate programmes aimed at addressing public health challenges and managing NCDs. Teaching materials, practical exercises, simulations, presentations and assessment tools were prepared for the module's implementation. Learning activities included discussion, peer review and reflection on the political and institutional context, policy implementation, health equity, economic impacts, multisectoral cooperation, leadership, change management, communication and strategic advocacy. The course was held at the UP Faculty of Medicine from 6 to 17 July 2026 as one of the activities of the Prishtina International Summer University (PISU).

Over the two weeks, the course enabled participants from different fields in Kosovo, together with one participant from Albania and one based in Geneva, to gain new knowledge, exchange experiences and develop concrete projects through active participation and interactive work. The course provided an integrated platform for developing knowledge and competencies in NCD leadership and management, with particular emphasis on implementing the cost-effective interventions recommended by WHO and known as the 'Best Buys'. Participants exchanged experiences, analysed NCD management challenges and developed concrete initiatives for implementing priority measures. Through participatory methods, group work and practical exercises, they identified interventions suited to the local context, connecting scientific evidence with strategic planning and decision-making. Contributions from national

and international lecturers helped participants develop competencies in leadership, intersectoral coordination and the management of change processes for a more effective response to NCDs.

Divided into four groups, participants worked in multidisciplinary teams to analyse policy challenges and develop practical solutions related to the four high-impact WHO interventions for NCDs that formed the core of the course: tobacco control, unhealthy diets and obesity, harmful use of alcohol, and physical inactivity. They strengthened their ability to approach health policy in a more structured, evidence-based and multidisciplinary manner.

More specifically, the projects focused on population-level interventions, including legislation, taxation, regulation, public campaigns and environmental changes. These included tobacco taxes, higher excise duties on alcoholic beverages, restrictions on the advertising and availability of alcohol and tobacco, and stronger enforcement of the relevant laws.

Participants also examined individual-level interventions, such as clinical services, counselling, screening, treatment and patient support, with a focus on promoting healthy diets and integrating the promotion of physical activity into primary health care.

On the final day, each team presented its policy analysis and advocacy proposals for NCDs, adapted to the local context, before an assessment panel. The presentations demonstrated the technical knowledge and leadership skills developed over the two weeks.



Over the two weeks, the course enabled participants from different fields in Kosovo, together with one participant from Albania and one based in Geneva, to gain new knowledge, exchange experiences and develop concrete projects through active participation and interactive work.

Participants gave positive feedback, describing the course as well structured, interdisciplinary, evidence-based and actively participatory.

The relevance of this course is closely linked to the implementation of the Health Sector Strategy 2025-2030 [5], which aims to improve population health, increase the quality and safety of services, ensure equitable access and strengthen the health system. The Strategy places particular emphasis on the prevention and control of NCDs, the promotion of healthy diets and physical activity, and the reduction of risk factors, including tobacco and alcohol use. Analysis of data reported by all levels of health care to the National Institute of Public Health of Kosovo for 2023 and 2024 shows a considerable increase in registered cases [6].

Effective NCD management requires a systemic approach encompassing institutional capacity, intersectoral coordination, strategic planning and the use of data for decision-making. Within this framework, developing the leadership competencies of health professionals is essential to strengthening the institutional response. The course sought to build skills in systematic problem analysis, priority-setting, strategy design and implementation, and the leadership of change processes and performance improvement.

The experience of these two weeks demonstrated that the course has sufficient value and potential to be continued, institutionalised and expanded further.

Such a course - innovative in the region, well structured and relevant - can help health professionals and experts from other fields develop a more results-oriented, evidence-based and change-focused approach. These competencies will support better use of resources and mobilise professionals to translate national NCD priorities into concrete, measurable interventions at institutional and community levels.

Experts from the partner institutions are working to prepare the module for delivery at doctoral level during the planned UP Winter School. Work is also under way on an application to include it in next year's Prishtina International Summer University, where participants from Kosovo as well as from a range of international universities would be able to take part.

Investment in leadership development is not only an investment in the individual development of professionals; it is also an intervention that strengthens the capacity of the health system. Effective leadership is essential to coordinating levels of care, empowering multidisciplinary teams, improving service quality and directing policy towards prevention, early diagnosis and the long-term management of chronic noncommunicable diseases.



Such a course - innovative in the region, well structured and relevant - can help health professionals and experts from other fields develop a more results-oriented, evidence-based and change-focused approach.

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Getting ready for Kosovo's first **NCD** **leadership course**

Before the first participant entered the classroom, months of coordination were needed to turn an ambitious course proposal into a workable ten-day programme.



Linda Baleta
Integrated Health
Services Project

Agreeing on the course framework

Preparing the Non-Communicable Disease Leadership Course began with discussions among the Integrated Health Services project, the University of Prishtina and the National Institute of Public Health of Kosovo. The course was envisaged as a practical, multidisciplinary approach, grounded in Kosovo's NCD policy challenges sitting in the global NCD context. The Prishtina International Summer University provided the academic setting: a two-week programme from 6 to 17 July 2026 at the Faculty of Medicine.

The course was developed within the Memorandum of Understanding between Swiss TPH and the University of Prishtina. Responsibilities were shared from the beginning. The University of Prishtina and the Faculty of Medicine provided the academic and hosting framework; NIPHK contributed national public health expertise; and IHS contributed international multi-disciplinary expertise, supported the technical preparation, coordination and financing. Prof. Dr. Merita Berisha served as local coordinator and the central link between the institutional and academic sides of the process.

Building a programme that could work in practice

Once the dates and institutional framework were agreed, the next task was to translate the course objectives into a coherent programme. We worked backwards from the output expected on the final day: each participant group would need to present a complete policy proposal. The curriculum therefore had to guide the groups step by step from defining an NCD problem to assessing policy options, stakeholders, evidence, costs, equity, implementation, monitoring and advocacy.

This resulted in ten connected modules rather than ten separate lectures. Each day required a module title, learning objectives, faculty input, a practical assignment and a group output that could be carried forward and built upon the following day. Detailed daily agendas were then developed around a common rhythm: presentation, exercise, coffee break, reporting back and wrap-up. The sessions were scheduled from 14:00 to 17:30. Because the course would be delivered entirely in English, language capacity also had to be considered when selecting lecturers and participants, preparing materials and communicating with participants.

Coordinating a multidisciplinary faculty

Faculty coordination was one of the most demanding tasks. For most modules, a Kosovo faculty member was paired with a colleague from Albania, North Macedonia or Switzerland, combining knowledge of Kosovo's health system with expertise in political science, leadership, economics, implementation and communication. This required aligning schedules, expectations and materials across institutions and countries.

Lecturers received the overall programme and guidance on how their sessions connected with the Policy Workbook. Presentations had to leave enough time for application, while exercises needed to be realistic for Kosovo and achievable within one afternoon. Case-study instructions, worksheets and presentation requirements were reviewed and aligned so that groups would not have to start again each day. This preparatory work was essential to maintaining continuity across a course taught by a large and varied faculty.



The course was envisaged as a practical, multidisciplinary approach, grounded in Kosovo's NCD policy challenges sitting in the global NCD context.

Recruiting and preparing the participants

A public call for applications opened on 12 May 2026. Rather than relying only on CVs, we used an essay competition to assess how applicants analysed a real policy issue. Candidates examined Kosovo's tobacco-control policies in relation to the WHO Framework Convention on Tobacco Control, identified implementation gaps and proposed feasible measures. Applications also included a CV, proof of study or graduation and a brief biography.

The submission deadline was 24 June, allowing time for review before results were announced on the last week of June. The assessment considered

understanding of the NCD challenge, clarity of problem definition, feasibility, originality and writing quality. Twenty-two candidates were admitted and 14 enrolled. Once participation was confirmed, communication covered the English-language format, course dates and timetable, attendance expectations, required preparatory reading and the collaborative nature of the work.

Preparing the learning materials

The practical methodology required its own set of materials. Four case areas were prepared: tobacco control, harmful alcohol use, unhealthy diets and obesity, and physical activity. A Group Policy Workbook gave every team the same analytical pathway and created a place to record decisions and revise them as the course progressed. An evaluation rubric clarified what would be expected in the final presentations.

The preparation also included the course programme, ten daily agendas, faculty presentations, exercises, readings and case materials. Files were checked against the timetable and organized by day. Evaluation forms were prepared for Days 3, 5 and 10 so that logistical or learning problems could be identified before the course ended.

Putting the logistics around the learning

Academic preparation was only one part of making the course possible. The team also had to coordinate the teaching room, daily access, presentation equipment, breaks, participant communication and changes in faculty availability. Contact lists and schedules needed to remain current, particularly because national and international lecturers were contributing on different days. Each agenda had to match the room arrangements, teaching materials and expected group task for that afternoon.

Attendance procedures were important because participants could miss no more than two teaching days if they were to receive a certificate. Although the pilot was not part of the University credit system, participation requirements still needed to be communicated clearly and documented consistently. The organizers also planned the final presentation session, review panel, peer feedback and certificate process. These details may sound administrative, but they protected the academic integrity of the pilot and gave participants a clear understanding of what successful completion required.



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Ready for the first day

By 6 July, the visible elements were in place: a classroom, a programme, confirmed participants, paired faculty, daily agendas and the first set of exercises. Behind them stood months of emails, revisions, scheduling decisions, document preparation and coordination among institutions. From the project side, the main lesson was simple: a practical course depends as much on the connections between its parts as on the quality of each individual lecture.

The pilot also showed where preparation can improve. Future editions should begin faculty coordination earlier, distribute readings and case materials well in advance, agree assessment criteria before the course and build more flexibility into the timetable. Consolidating all materials into a single course package is therefore not only documentation of what was done; it is part of preparing the next edition more efficiently and coherently.

Presentations by participants in the NCD Leadership Course

Four priority areas for the prevention of chronic noncommunicable diseases



Group: Tobacco Control

The tobacco control group focused on increasing excise tax, one of WHO’s “Best Buy” interventions for reducing tobacco consumption. Considering the prevalence of smoking and the relatively affordable price of tobacco products in Kosovo, the group proposed gradual increases in excise tax,

with regular adjustments for inflation, to make tobacco less affordable, particularly for young people. The presentation emphasised that this measure requires cooperation between finance and health institutions, alongside monitoring of sales, consumption and policy implementation.



Group: Healthy Eating

The healthy eating group proposed a national communication campaign for behaviour change, drawing on WHO-recommended interventions to promote a healthy diet. Messages would be tailored to families, young people and lower-income groups, focusing on achievable actions such as reducing sugary drink consump-

tion and salt intake, reading food labels and choosing healthier foods. The group emphasised that communication should be practical and non-stigmatising, while school food standards, food labelling and the affordability of healthy foods would help people translate these messages into everyday choices.





Group: Physical Activity

The physical activity group proposed integrating physical activity assessments and brief counselling into routine primary care visits, using existing services to support patients in changing their behaviour. Under the proposal, clinical guidelines and training for doctors and nurses would make this counselling easier to implement. The

group linked this intervention within health services to public campaigns, education in schools and the creation of safer spaces for walking and cycling. This approach combines individual support with community conditions that make it easier for people to be active.

Group: Harmful Use of Alcohol

The harmful use of alcohol group selected an increase in excise tax as its main proposed measure for Kosovo, in line with WHO’s “Best Buy” interventions aimed at reducing affordability and consumption. Particular attention was given to young people and heavy episodic drinking. The group proposed com-

binning pricing policy with restrictions on advertising and the hours and locations of sale, stronger enforcement of drink-driving regulations, and screening and brief counselling in primary care. It suggested measuring results through data on sales, consumption patterns and health-related harms.



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