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ORIGINAL ARTICLE

Kosovo-Serbs' experiences of seeking healthcare in a post-conflict and ethnically segregated health system

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Abstract
Objective To examine the experiences of Kosovo-Serbs who seek healthcare in the formal Kosovo health system.
Methods Eleven semi-structured interviews were carried out with Kosovo-Serbs who live in one of the following mono-ethnic enclaves: Gorazhdevc/Goraždevac, Videje/Vidanje, Klinë/Klina and Viti/Vitina. A phenomenological approach was used to collect and analyze data.
Results The analysis shows the critical role of the depth of the relationship with Kosovo-Albanian doctors in the Kosovo-Serbs' experience of seeking care in the formal sector. The patient–doctor relationship is the result of two processes—longitudinal care and consultation experiences. Four elements, i.e., knowledge, trust, closeness and regard were identified as key aspects contributing to the depth of the relationship between Kosovo-Serb patients and Kosovo-Albanian doctors.
Conclusions Fear, anxiety and language differences are still important barriers to Kosovo-Serbs' access to formal health care. These barriers are partly overcome as interviewees establish and develop relationships to Kosovo-Albanian doctors based on reciprocal knowledge, trust, closeness, and regard. Hereby, Kosovo-Serb patients and Kosovo-Albanian doctors contribute to blur the lines the ethnically divided health system and transcend the legacy of war.

Keywords Kosovo · Health access · Post-conflict · Ethnic disparities · Health promotion

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Introduction

In the wake of the inter-ethnic conflict that shattered Kosovo from 1989 to 1999, many Kosovo-Serbs either fled to Serbia, to the northern part of Kosovo or into isolated mono-ethnic enclaves in Kosovo. The war left Kosovo with an ethnically segregated health system (Shuey et al. 2003; Bloom et al. 2007). Ethnic disparities in health and access to healthcare are well documented by several observers (WHO 2001; Campbell et al. 2003; Doctors of the World 2004; Buwa and Vuori 2006). Barriers to access healthcare in the formal system include interethnic relations affected by distrust, (Bloom and Sondorp 2006) and fear related to security and freedom of movement which limit Kosovo-Serbs from seeking care outside the mono-ethnic enclaves (Wang et al. 2010). The health system is composed of a formal sector administered by the Ministry of Health and an informal sector, supported by the Serbian government in Belgrade. Most Kosovo-Serbs avoid seeking care in the formal healthcare system and use instead the informal primary healthcare services in the enclaves, staffed by Kosovo-Serb healthcare workers (Raka 2009). The informal sector also provides care at secondary and tertiary levels at the hospital in Mitrovica, which is financially supported by the Serbian Government in Belgrade (Doctors of the World 2004). The hospital staff and patients are exclusively Kosovo-Serb (Physicians for Human Rights Report 2009).

This study contributes to already existing knowledge by examining the perspective of Kosovo-Serbs, who readily seek care in the formal health system, notwithstanding the barriers evidenced by previous research. No study has, to the best of our knowledge, examined the rationale, which underpins Kosovo-Serbs' use of the formal health system or identified mechanisms of access from the perspective of

the Kosovo-Serb population. Therefore, it is unknown how Kosovo-Serbs who readily use the formal health system experience their encounter with Kosovo-Albanian doctors and by which components they characterize the doctor–patient relationship. The analysis of Kosovo-Serbs' experiences in the formal health sector provides important information about the values Kosovo-Serbs ascribe to their encounters and relationships with Kosovo-Albanian doctors. Such information is vital to identify facilitators of access that may be "real" for Kosovo-Serbs, but invisible to the eye of health policy-makers. The insight provided by such approach may help to identify processes and factors that facilitate Kosovo-Serbs' use of formal healthcare, which in turn may guide the efforts to improve equal healthcare access. The objective of this study was therefore to explore how Kosovo-Serbs experience their encounter with the formal healthcare system, hereunder the aspects by which they define their relationship to the Kosovo-Albanian health provider.

Methods

A qualitative study design was employed to explore Kosovo-Serbs' experiences of the formal healthcare system. Eleven semi-structured interviews were conducted in November, 2010. The study used a phenomenological approach to collect and analyze data as it has the potential to provide thick descriptions and explore the lived experiences of the concerned individuals (Bryman and Burgess 1999). This approach was appropriate given the study context (Swift et al. 2007) and the study's central question: *what is the meaning, structure and essence of Kosovo-Serbs lived experience of the formal healthcare system in Kosovo?*

Data collection

The interviews were carried out by this article's first author, a Kosovo-Albanian, bilingual in Serbian and Albanian. Seven interviewees were carried out in Serbian, whereas four interviewees preferred being interviewed in Albanian. The length of interviews varies between 45 and 90 min. All interviews were audio recorded, transcribed verbatim and translated into English. Interviewees were recruited through a snowball technique, whereby all interviewees were asked to refer the interviewer to another Kosovo-Serb with recent experiences of the Kosovo health system. Interviews were conducted in the mono-ethnic Kosovo-Serb enclaves of Goraždevac/Goroazhdevc (4), Vidanje/Videje (4), Kline/Klina (2) and Viti/Vitina (1).

Eight men and three women were interviewed. Their ages ranged from 27 to 61 years. Six interviewees were married and had children; four were single and one widowed with three children. Educational attainment varies between completion of elementary school (2), completion of high school (5), completion of nursing school (1) and a university degree (1). The occupations held include journalist, nurse, NGO field officer, community representative, priest, radio technician, small-scale farmer and housewife. One interviewee was unemployed.

Diverse aspects of Kosovo-Serbs' experiences with formal healthcare were captured through questions relative to: (a) conditions and circumstances of deciding formal health system use (b) use of the formal health system (c) encounters with formal healthcare system doctors (d) formal/informal barriers and facilitators in the formal healthcare system.

Analysis

The authors analyzed the data following a general inductive data analysis format of coding, clustering in categories and thematizing (Giorgi 1985). Interview transcripts were read through several times to identify statements relevant to the research questions. The identified statements served to create meaning units, which in turn were clustered into categories. Themes were then created by looking across categories. Throughout each step of the analytical process, the authors discussed the interpretation of data. The analysis draws on the phenomenological approach, characterized by its attention to structure and meaning of human experience in relation to particular phenomena (Giorgi 2005). The essence of lived experience, the structure and meaning of human experience, is captured through the detailed description and interpretation of how interviewees perceive and make sense of phenomena.

The analysis was inspired by the conceptual framework outlined by Ridd et al. (2009), which suggests distinguishing between dynamic factors that develop or maintain the doctor–patient relationship and the characteristics that constitute an ongoing depth of a relationship. Based on a systematic review and thematic synthesis of qualitative studies on the doctor–patient relationship, Ridd et al. found that doctor–patient relationships are enhanced by two processes, i.e. longitudinal care and consultation experiences. These two processes result in the depth of the doctor–patient relationship, which is composed of four elements: knowledge, trust, loyalty and regard.

Results

Kosovo-Serbs, who seek care in the post-conflict and ethnically segregated health system, experience an improvement of the security situation and inter-ethnic relations. To

interviewees, physical access to formal healthcare is eased. However, interviewees also confront a range of barriers including language differences, their fear of being the object of revenge and anxiety of being discriminated against. These barriers are overcome as interviewees establish and develop relationships to their Kosovo-Albanian doctors. By strengthening doctor–patient relationships based on reciprocal knowledge, trust, closeness, and regard, interviewees blur the lines of an ethnically segregated health system and hereby transcend the legacy of war.

Improvement of security situation and inter-ethnic relations The general improvement of the security situation and inter-ethnic relations is the first feature by which interviewees describe the context in which they seek formal healthcare:

> "Well, at the beginning it was a problem being Serb! People, who knew we were Serbs, looked down at us. It wasn't comfortable at all. Now we go out to town, we go for a drink and eat and we do things we always used to do". (Zoran)

The improved situation, which is apparent in the freedom of movement and the normalization of everyday life, has eased the use of public places, transport, and institutions:

> "When I talk to people now, I see that many have started to go and see the Albanian doctor, go to town, to buy medicines and things like that". (Marko)

Interviewees emphasized that they are less fearful of being attacked or harmed in public places or institutions. Several mentioned that they no longer perceive the need to be escorted by the KFOR when they leave the Kosovo-Serb enclaves:

> "Some years ago it was different: people were more scared that they would be attacked on their way to town or harmed by Albanian doctors". (Marko)

Interviewees also describe being better received by the employees of the formal health institutions as compared to the immediate post-war time. The need to be accompanied by a facilitator when seeking care in the formal health sector, established after the war as a safeguard against discrimination, is perceived as obsolete:

> "It was very difficult, especially in the years just after the war. I felt that no-one paid me any attention. Now things have changed. I can go alone, without asking for anyone's assistance". (Nenad)

While interviewees experience an improved physical access to formal healthcare, seeking care outside the enclaves still entails the fear of being the object of revenge and anxiety of being discriminated against.

Fear of revenge and discrimination The fear of being the object of revenge and anxiety about being discriminated against constitute an important barrier to seeking formal healthcare. All interviewees describe first- or second-hand experiences of discrimination:

> "The first time I went to Pec Hospital, I was not treated very well. I was so ill and couldn't stand on my legs. They made me wait for hours in the waiting room. I left and decided never to return. It was a waste of time". (Stefan)

Some providers change attitudes depending on the presence of Kosovo-Albanian patients:

> "Inside the doctor's room everything is fine, the doctors behave normally, but when you're outside in the waiting room, I have noticed that they try to pay us less attention just because other people could say something; they could call those doctors traitors. Kosovo-Albanian doctors don't like to receive Kosovo-Serb patients in the presence of Kosovo-Albanian patients". (Nikola)

The importance of fear is evidenced by an interviewee who did not have any first-hand experiences of discrimination. Yet, he feared being the object of revenge:

> "Honestly speaking, there is still some fear inside of me. I haven't managed to overcome the fear, although I had only good experiences, especially with the older Kosovo-Albanian doctors. Really, I do not know why it is like this. Maybe I have not been able to fight against this wall of fear that is created in my mind or maybe it is because what I hear from people talking about their negative experiences". (Marko)

Interviewees experience the general security situation and inter-ethnic relations to have improved. The physical access to the formal healthcare institutions, located outside the enclaves is eased. However, interviewees also identify their fear of being the object of revenge and anxiety about being discriminated against as barriers to seek care in the formal system. Therefore, it is important to understand how Kosovo-Serbs experience seeking care in the formal system and how they overcome the barriers encountered. The analysis now turns to describe the processes through which interviewees establish and develop relationships with Kosovo-Albanian doctors.

Longitudinal care Seeing the same doctor is the first process by which interviewees establish and develop a patient–doctor relationship. Interviewees emphasize that despite the ethnically fragmented environment, they seek the care of Kosovo-Albanian doctors who trained and practiced prior to the war. Kosovo-Albanian doctors are still highly valued and trusted and readily consulted for

their “expertise”, “professionalism”, for their experience and their familiarity with Kosovo-Serb patients. This is apparent in that interviewees deliberately seek to consult the same Kosovo-Albanian doctor with whom they personally or someone from the community has established a relationship prior to the war:

> “We have seen the same doctor for many years: me, my wife, our children, my parents, my uncle. We always see Dr. Burim, a Kosovo-Albanian. Before the war, he worked with Serbian doctors. I have trust in that doctor, he knows us and he knows our situation very well. He knows everything about me”. (Alexandar)

Longitudinal care is important, but cannot guarantee the maintenance and development of the patient–doctor relationship by itself. The quality of the consultation experiences is as important in determining the maintenance and development of the patient–doctor relationship.

Consultation experiences is the second process by which interviewees establish and develop an in-depth patient–doctor relationship. The doctor’s sociability and communicative skills are critical for the consultation experience:

> “He is calm and polite. There’s always a long queue in front of his office because he is good doctor and nice with patients. People appreciate that very much”. (Aleksandar)

Interviewees define the quality of the consultation experience by various aspects. Some particularly value the “welcome ritual”, when the doctor takes time to greet properly, small-talk about general issues, asking of news from family and common friends. Taking time to ask questions and answering the patient’s questions is another aspect by which interviewees describe the quality of the consultation experience. The provider’s sensitivity and gentleness together with allocating time to establish the diagnosis, taking the patient’s medical history and explaining the diagnosis and treatment in words that are easily understandable to the patient are highly valued:

> “He showed interest in helping and was ready to answer all my questions, even questions about health problems that worried me”. (Ana)

To other interviewees, quality of consultation experiences is about being treated first as a human being then as a patient:

> “I have been treated very, very well: first of all as a human being and then as a patient”. (Ivana)

Consultation experiences are also defined by the doctor’s proficiency in Serbian and his non-discriminatory attitude.

The doctor’s language skills in Serbian are an important feature of the consultation experience, because communication issues caused by linguistic diversity are indeed a barrier to healthcare access:

> “What if my doctor could not speak my language and I cannot speak his language. How could I explain my problem to him?” (Bojan)

For Kosovo-Serbs access to formal healthcare, the language issue is highly relevant. The younger generations of Kosovars who grew up during the war, when inter-ethnic tensions were at their highest, were discouraged to learn the languages of other ethnic communities. Young Kosovo-Serbs, seeking care in the formal sector, are likely to encounter young Kosovo-Albanian providers with whom they are unable to communicate for lack of sharing each other languages:

> “When I went to the hospital, it was very difficult to find somebody who could help me. I tried talking to a nurse but she couldn’t understand what I was asking for, so I just left”. (Danilo)

Some interviewees only consult Serb-speaking providers. Others are accompanied by a translator, usually a friend. Using a friend as translator is, however, problematic as the privacy of the consultation is compromised. Therefore, the quality of the consultation experience is also defined by the health providers’ proficiency in Serbian.

A non-discriminatory attitude of the provider interviewees defines the quality of the consultation experiences by the provider’s non-discriminatory attitude. Interviewees referred to patients’ rights and the Hippocratic Oath, which require doctors to treat all patients equally:

> “My doctor knows how to respect people and he is also aware that it is the right of everybody to seek care in the hospital no matter their ethnicity. That is why people prefer him; he doesn’t mind that we are Serbs”. (Ivana)

The doctor’s non-discriminatory attitude is also important as interviewees seek the advice of other patients before consulting a Kosovo-Albanian doctor:

> “I knew that he is a good doctor because of what I have heard from other people. I was comfortable before going. All doctors should behave like him: treat all patients the same way, whether the patient is Serb or Albanian”. (Bojan)

Interviewees’ relationships to Kosovo-Albanian doctor are enhanced through the process of longitudinal care, seeing the same doctors as before the war. However, the development of the patient–doctor relationship equally relies on the quality of the consultation experiences, which by interviewees are defined by the doctor’s consultation skills, proficiency in Serbian and non-discriminatory attitude. These two processes result in the depth of the patient–

doctor relationship, which encompasses four components, i.e. knowledge, closeness, trust, and regard.

Knowledge Mutual patient–doctor knowledge is a particularly important aspect of the relationship. Mutual knowledge is perceived as a safe-guard against being the object of revenge or discrimination:

> "If I go to see a doctor who doesn't know me; it might be that he lost someone in the family or he is young so he does not care about me. He will consider me as a criminal, as someone who killed during the war. This makes me feel really bad, but I keep working, living my life as I used to do always; talking to people and trying to avoid what other people might think about me". (Nikola)

Another man explained his choice seeking care at a particular hospital:

> "There is no problem with Klina Hospital because people know each other. I, myself am lucky because my wife knows all the doctors here and they know her. So whenever I need somebody, my wife will accompany me. So we do not have any problems". (Stefan)

Trust in the quality and efficacy of the diagnosis and prescribed treatment is a very important feature of the doctor–patient relationship. For some interviewees trust and knowledge are closely related. To these interviewees trust is embedded in the number of years a doctor has been practising in the Kosovo-Serb community. The doctor whose diagnosis and treatment can be trusted is the doctor with many years of medical practising during the pre-war period and familiarity in treating Kosovo-Serb patients. Doctors with whom the community has established a close relationship anchored in the period prior to the war are perceived as highly trustworthy:

> "Look, since the birth of my first child. I stress, since the birth of my first child and up till today, I only go to the institutions in Klina and they are all Albanian doctors! My trust in those doctors has not changed at all. My trust is the same as in pre-war times. It was always the Albanian doctors who looked after my children, Always! Nothing has changed as far as I am concerned". (Nikola)

Trust in the doctor seems to rely partly on his medical experience, partly on his "knowing" the patient from before the war:

> "He is one of the most experienced doctors in this region. My husband knows him very well from before the war. I was very ill some months ago. I am not sure that Serbian doctors in Mitrovica would have paid me the same attention". (Ivana)

Trust is closely related to the doctor's medical experience and experience with treating Kosovo-Serbs. Trust is also granted to the doctor who takes his/her patient seriously.

Closeness Trust is related to the sense of closeness, i.e., familiarity and similarities. A trusting relationship is based on the perception of sharing a personal history, i.e., familiarity and being similar with respect to socio-cultural heritage, values and language. The importance of closeness, i.e., familiarity and similarity for a trusting relationship are apparent in that interviewees readily consult the Kosovo-Albanian doctors who share a personal history with a Kosovo-Serb:

> "I was born and raised in Klina. Before the war started, Dr Agim was my neighbour. We went to school together. He was my close friend and I know him very well. This gives me a sense of safety, like in the pre-war times. You know, when Serbian and Albanian people used to live in harmony together". (Nikola)

Closeness may also be established through work relations established prior to the war. A nurse who worked with Kosovo-Albanian doctors prior to the war, now assists Kosovo-Serbs to access the formal health sector. Her husband explains:

> "She used to work in the hospital of Klina for many years. Up till 1999, when she stopped working. It was the time when the war started and everything changed. She helps other people in the village. They often ask her to assist them. They feel more comfortable if she goes with them because she knows the doctors and she speaks Albanian". (Stefan)

Regard This last aspect by which interviewees define the depth of the patient–doctor relationship is affective. This aspect goes beyond knowledge and trust and relates to closeness. This aspect is about comfort and liking and encompasses dimensions of the patient–doctor relationship which can be likened to a friendship:

> "He is very friendly. We had a long conversation after the consultation. We talked about everyday life problems. It's always interesting to talk to him. You know, he always offers me a drink". (Alexandar)

Other interviewees described this particular aspect of the patient–doctor relationships by words such as "gentleness", "respectful", "friendliness", "kindness" and "caring", "sensitivity".

Kosovo-Serbs, who seek healthcare in the post-conflict and ethnically segregated health system, overcome obstacles to access by establishing and developing relationships with Kosovo-Albanian doctors. These relationships are

enhanced by two processes, i.e., longitudinal care and consultation experiences, which in turn result in depth of the patient–doctor relationship. In the present study, the depth of the relationship is composed by reciprocal knowledge, trust, closeness and regard.

Discussion

This study shows that to interviewees, the security situation and inter-ethnic relations have improved, which in turn has eased their physical access to the formal healthcare system. Yet, interviewees continue to encounter barriers including language, fear of being the object of revenge and anxiety about discrimination. These barriers are partly overcome as interviewees establish and develop doctor–patient relationships based on reciprocal knowledge, trust, closeness, and regard. By strengthening their relationships to Kosovo-Albanian doctors, interviewees contribute to blur the lines of a so far, ethnically divided health system and transcend the legacy of war. Previous research has shown that healthcare may be a connector of communities even in inter-ethnic conflict (Cherny 2007). It has also been documented that the quality of patient-provider relationships relies on communication and consultation skills rather than ethnic concordance between provider and patient (Adegbembo et al. 2006; Street et al. 2008).

The patient–doctor relationship cannot be understood in isolation from the context in which it is developed. Previous literature has documented how in post-conflict settings patient-provider relations are affected by feelings of fear and distrust (Bloom and Sondorp 2006; Cherny 2007).

Longitudinal care is an important aspect in the patient–doctor relationship. Interviewees seek care from Kosovo-Albanian doctors who trained and practiced in the pre-war period and with whom interviewees have established a close relationship. However, longitudinal care does not guarantee the development of the relationship by itself. Pandhi et al. (2007) argue that consultation experiences are equally important in determining both the maintenance and the development of the patient–doctor relationship.

Interviewees define the quality of consultation experiences by the doctor's consultation skills, proficiency in Serbian and non-discriminatory attitude. Previous studies suggest similar characteristics as critical to the consultation experiences (Beach et al. 2006; Lings et al. 2003; Scheppers et al. 2006; Trachtenberg et al. 2005). Interviewees identified being met first as a person then as a patient as important for the quality of the consultation experience. Previous research suggests that whatever the context, communication is an important factor in the patient–doctor relation (Tarrant et al. 2003).

Trust is identified as another important element in the doctor–patient relationship. This is well-documented by previous research (Goold and Klipp 2002; Hall et al. 2002; Mainous et al. 2003). Trust seems strongly related to closeness, i.e. the sense of *familiarity and similarities*. Interviewees' trust in the quality of diagnosis and treatment is related to longitudinal care and consultation experiences. Trust is rooted in the doctor's knowledge of Kosovo-Serb patients' personal histories, sharing the same language, experience of working together and sharing personal histories. Previous research has identified familiarity with the provider as an important factor in the doctor–patient relationship (Gabel et al. 1993).

Experiences shared by friends or relatives influence Kosovo-Serbs' opinions about a particular Kosovo-Albanian doctor. Kosovo-Serbs' experiences with the formal health sector are also influenced by practical factors, i.e., being able to communicate in the same language. This is particularly an issue for the younger generation of Serbs. Previous literature has documented language-related communication issues (Collins et al. 2002; De Alba and Sweningson 2006; Flores 2005; Weinick et al. 2000).

Strengths and limitations

The recruitment of participants was made possible by the Kosovo-Albanian interviewer's in-depth knowledge about the history of Kosovo-Serbs living in the enclaves, her language skills and contacts, established through previous experience with Kosovo-Serb patients in a Kosovo hospital. However, the interviewer being Kosovo-Albanian, participants may have been less critical about the formal health system than they would have been had the interviewer been Kosovo-Serb. The recruitment of interviewees was limited to certain enclaves and only participants who know one another or the interviewer were included.

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