End-of-Project Evaluation of the Joint Programme

“IMPROVING HEALTH OF WOMEN AND CHILDREN OF KOSOVO 2007-2010.”

as implemented by UNFPA, UNICEF AND WHO

Prishtina, Kosovo

Final Draft

End-of-Project Evaluation Report

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<table>
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AIHA</td>
<td>American International Health Alliance</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>KDHS</td>
<td>Demographic, Social and Reproductive Health Survey in Kosovo</td>
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<td>EC</td>
<td>European Commission</td>
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<td>FP</td>
<td>Family planning</td>
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<td>HIV</td>
<td>Human Immune-Deficiency Virus</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<td>IHWC</td>
<td>Improving Health of Women and Children in Kosovo</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IVF</td>
<td>In Vitro Fertilization</td>
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<td>JP</td>
<td>Joint Program for IHWC</td>
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<td>KAP</td>
<td>Knowledge Attitudes and Practices</td>
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<td>KOGA</td>
<td>Kosovo Obstetrical Gynaecology Association</td>
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<td>KOPF</td>
<td>Kosovo Population Foundation</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MoH</td>
<td>Ministry of Health.</td>
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<td>RAE</td>
<td>Roma Ashkali Egyptian</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RRs</td>
<td>Reproductive Rights</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United National Children’s Fund</td>
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<td>UNMIK</td>
<td>United Nations Mission In Kosovo</td>
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<td>WHO</td>
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Executive Summary

Overview: The Joint Programme (JP) for Improving the Health of Women and Children of Kosovo was funded by the Luxembourg government to form a unique collaboration by three Kosovo-based UN agencies (UNFPA, UNICEF and WHO) to support government initiatives to strengthen the health care system, improve the quality of mother and child health care services and achieve the United Nations Millennium Development Goals 4 (reduce child mortality) and 5 (improve maternal health). The JP budget of 2,311,200 euros was to be implemented over a period of 3 years beginning in 2007 and was given a one-year no-cost extension. The project was developed to address five major MCH and RH related outcomes to be achieved through a series of outputs and project activities. Now that many of the components have been implemented, this end-of-project evaluation assesses the JP impact on mothers’ and children’s health in Kosovo. It attempts to document lessons learned for decision making on the continuation of the intervention and its approaches.

Methods and Analytic Framework: Per the inception report for the evaluation, the methodology was developed based on the evaluation terms of reference (TOR) and initial meetings with relevant staff and JP participants within the Ministry of Health (MoH), implementing partners and civil society. A desk review was conducted to address all outcome areas with an assessment of the respective outputs and activities within each outcome guided by seven core criteria: relevance, effectiveness, efficiency, sustainability, long-term impact, gender, and joint program management. Interviews were conducted in the local language with more than 42 stakeholders in Dragash, Fushë Kosovë, Mitrovicë, Prishtinë, Prizren and Skenderaj. Semi-structured questionnaires were used for training follow-up interviews with a total of 16 respondents (doctors, nurses and peer educators); 15 client exit interviews were conducted with antenatal, family planning (FP), and post-partum patients at regional hospital and municipal level maternal and child health facilities in the six locations.

The evaluation was limited in time and resources and it was not feasible to employ quantitative research methods (i.e. to collect statistically representative samples). Therefore the evaluation is inherently qualitative in nature, with the goal of using purposive, non-random samples to ensure a wide coverage of project activities. Due to the short time permitted to plan the evaluation and limitations due to the summer holidays, the response rates for certain interview categories was lower than desired.

The analytical framework for the evaluation follows a logic model approach. The evaluation employs a simple but plausible model where project activities are performed to achieve outputs that result in the desired outcomes.

Findings: One of the JP characteristics is its complexity; it attempts to cover a wide range of areas pertinent to the improvement of the health status of women and children in Kosovo. Each of the five main outcomes has from one to four outputs. For each of 13 outputs, plans were made for up to eight specific activities, a total of 49 planned activities in all. Based on objective assessment of available evidence, this evaluation has concluded that four out of the 13 proposed output objectives were fully achieved; while there was very substantial progress within most of the remaining nine outputs, they did not fully achieve the stated output objectives. A large majority of the planned activities were carried out; 42 of the 49 planned activities were fully implemented. Most planned activities were highly relevant and several activities were highly effective. Based on a triangulation of findings from the desk review, stakeholder interviews, exit interviews and training follow-up interviews, all but six of the proposed activities were considered highly relevant to the initial and current context of MCH and RH in Kosovo. For many of the activities, however, even those that were fully implemented and highly relevant, due to the lack of baseline and follow-up data, it was not feasible to determine if they
were effective or not. Nonetheless, using the available data more than a quarter of the activities was considered highly effective.

**Conclusions based on seven core criteria:**

**Relevance:** Overall, despite changes in the country context, the JP remains extremely relevant to Kosovo’s MCH and RH challenges.

**Effectiveness:** Overall, despite the successful implementation of many of the proposed activities, the objectives were fully achieved for only 4 of the 13 outputs. This does not mean that the JP was an ineffective project; it was highly effective in implementing a wide range of planned activities. The JP was simply too ambitious with regard to the number of outputs and activities and had set unrealistic output targets.

**Efficiency: Administrative** - There were initial delays in releasing funds and establishing a joint working agreement. There were also delays in implementing activities that reflect the fact that the UN agencies responsible for the project are understaffed and simply could not undertake the numerous multiple activities simultaneously. **Financial** - Most of the activities appear to have been implemented within reasonable cost levels. The evaluation found evidence that the UN agencies made strong efforts to assure financial accountability on the part of local implementing agencies. The evaluation was, however, able to assess the financial efficiency of many of the project activities because of limitations of the financial data available from the three implementing partners; their centralized global reporting systems made it difficult to track activity budget lines in detail.

**Sustainability:** Many of the activities and outputs will not be continued when the JP funding ends. The evaluation nonetheless found an increased willingness for the Kosovo MOH to consider greater financial and management responsibility for important JP supported activities.

**Long-term Impact:** JP activities have potential for long-term impact, especially with the expanded regulatory framework and strategic planning. This potential will only be achieved if there is sustained follow-up to ensure adherence to the protocols and guidelines, especially by the MCH and RH Office.

**Gender:** Most of the JP activities were found to be neutral, but there were examples of activities that were transformative, encouraging change toward greater equality for women.

**Joint Program Management:** The large majority of stakeholders interviewed agreed that there were advantages to having three major UN Agencies combined into the administration of one program. In terms of day-to-day management of projects, however, some implementing agencies expressed the opinion that the multiple UN agency partnership did not make any real difference; they interacted with only one UN agency for their respective activities.

**Recommendations:**

**Future Program Design:**

- **Support innovation, not just ongoing well-established programs.** The JP has tended to support a portfolio of programs that were well-established and jointly funded from multiple sources. While joint funding can help achieve greater impact, priority should be given to the design of carefully focused innovative programs to address the most urgent problems contributing to maternal and child mortality and morbidity.

- **Discourage “one-off” training and support a health systems approach.** The JP has re-energized important training packages for MCH and FP service delivery programs, but these training efforts urgently need to be combined with a systematic follow-up and sustained systems approach with innovative mentorship.

- **The private sector must be genuinely involved to have impact on ANC and obstetric care.** The Primary Health Care Strategy, which relies on Family Medicine Doctors and Nurses, is
necessary but not sufficient to improve MCH and RH outcomes in Kosovo. For future joint programs, the mandate of the UN agencies must be expanded to accommodate the full integration of the private sector within the widest possible range of activities.

- **Narrow the focus.** Any future JP should prioritize a limited number of MCH RH issues, as outlined in the *Recommended Focus Areas* below, so as to work at a scale that is adequate to have an impact.
- **Establish plausible achievable targets based on available data.** Future JP project activities should develop realistic targets based on the best available baseline data and ensure that comparable follow-up data are collected in time to measure activity impact.
- **Use mass media at a scale that can have impact.** If behavior change communication strategies are employed for a MCH and RH problem, they should only be attempted with sufficient resources to use media effectively, especially TV. The positive experience of the relatively well funded BPI using TV should be used as a model for future programs.

**Recommended focus areas: Unwanted pregnancy and unsafe abortion**

- **Develop and fully fund a major coordinated campaign to increase the use of effective contraception to reduce unwanted pregnancy and reduce the demand for abortion services.** Assuming the results from the 2009 KDHS are valid, Kosovo has experienced a decrease in use of effective contraception and an increase in unwanted pregnancy that has resulted in an increase in abortions in the private sector. A major program initiative needs to address this urgent problem.
- **Improve the quality of care for abortion services in the private sector.** Based on the recent successful precedent in regulating In Vitro Fertilization (IVF), the private sector should be constructively engaged to regulate the quality of care and follow-up for all legal abortion services.

**Recommended focus areas: Perinatal and Maternal Health**

- **Follow-up quickly and forcefully to address proximate causes of maternal and perinatal Mortality.** JP supported efforts to improve perinatal care and audit maternity hospitals have identified key proximate causes of maternal and perinatal mortality. Failure to follow-up with effective interventions, both short and long-term, will result in needless maternal and perinatal morbidity and mortality.
- **Support measures to consistently implement maternal death audits.** High priority needs to be given to implementing and institutionalizing rigorous audit procedures, such WHO’s *Beyond the Numbers.*
- **Establish intensive long-term (five-year) ongoing technical collaboration with international centers of excellence in Pediatrics and Obstetrics.** Collaborate to ensure a five-year continuity of technical exchange that addresses the microsystems within each maternal health care setting.

**Project Management**

- **Employ a compelling logical framework.** Develop a plausible and practical logic model to guide future program monitoring and evaluation. Ensure that all targets are realistic and feasible to measure at baseline and at the end of the project.
- **Prioritize and effectively implement Monitoring and Evaluation.** Allocate at least 5% of the budget for monitoring and evaluation staff and related resources to develop and implement a monitoring and evaluation plan that leverages existing data sets to the maximum possible extent and identifies and fills important data gaps, such as unmet need for contraception, as quickly as feasible during the project cycle.
- **Increase the meaningful involvement of key government and private stakeholders.** While the JP has clearly demonstrated effective collaboration with a wide range of stakeholders, future projects should build on that success to ensure that key private and public health institutions, such as the NIPH and KOGA, are consulted at the earliest possible stages of project design and development.
- **Increase coordination and cooperation with other ongoing programs.** The JP could seek ways for more interaction and coordination with other programs that address health of mothers and children, such as the EC and AIHA.
Section 1. Introduction

Initial and current context

The 2007 context: At the time of the Joint Programme for Improving the Health of Women and Children project was initiated there was an urgent need to address continuing poor performance in the health sector on multiple indicators. In addition to serious public health problems, health status was adversely affected by the high prevalence of post-war-related trauma and environmental hazards. There were serious barriers to health care access, including the cost of care and drugs, and informal payments for access. Minority groups, the elderly and rural populations faced particular difficulty. Poor maternal health was of special concern due to inadequate antenatal care, resulting in infections, hypertension as well as unsafe abortions. At the time the Joint Programme (JP) began, the Maternal Mortality Ratio (MMR) was considered the highest among neighboring countries and facility-based data estimates, despite their limitations, permitted an estimate of the MMR at 21 per 100,000 births. The infant mortality rate (IMR) was estimated at 44 per 1,000 live births and the Under-5 mortality rate was estimated at 69 per 1,000 live births, with the caveat that the data were very limited and must be interpreted with caution. Persistent high infant mortality was attributed in part to substandard delivery and post natal care with a low proportion of exclusive breastfeeding. Immunization coverage, which had improved substantially from the immediate postwar period, was still inadequate. With a very young population age distribution (50% under age 25) there was an urgent need for health education and outreach. Compared to other European countries, contraceptive prevalence was low, with only 35% currently using contraception. The decade of ethnic conflict in the 90s had resulted in a shortage of skilled Albanian health clinicians, who wished to return to actively participate in health sector. Underlying all of these problems was a limited health care budget with serious imbalances.

Current Context: Kosovo still compares unfavorably in the region (Albania, Bosnia and Serbia), with higher estimated maternal death ratio, lower life expectancy and higher infant mortality (Qosaj and Berisha, 2010). According to the 2010 UNDP Human Development Report for Kosovo, the health care system is poorly financed, contributing to poor health outcomes and inequalities, with a large portion of the cost of health care passed on to the patients; the cost of drugs, which are usually born by the patient’s out of pocket payments, is a major barrier to health care. But, despite a chronic problem of gaps in the available data for economic, education, health indices, there are some favorable trends. Based on data from the 2009 Demographic, Social and Reproductive Health Survey in Kosovo (KDHS), for example, the proportion of households making over 300 Euros per month almost doubled from 19.2% in 2003 to 36.2% in 2009. Despite extremely high unemployment, Kosovo had the highest GDP growth rate of any South Eastern European nation in 2009 (Qosaj and Berisha 2010). There has also been a significant improvement in the proportion completing primary school, especially for young women (KDHS 2009).

The role of the private sector: Kosovo is witnessing a transition from a centralized state-owned health system to a more decentralized mixed system with government and private sector facilities. As of 2009, the MOH list of licensed private health care institutions reached at total of 783 private health

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facilities and 341 pharmacies. While of unknown quality and scope, this number of private sector institutions exceeds the current number of MOH primary health care facilities: 33 Main Family Medicine Centres (MFMC) 156 Family Medicine Centres and 236 Health Punctas (Qosaj and Berisha 2010, page 60 and 61). Despite the lack of official data on private practices, it appears that Kosovo patients use private practices to have a choice on their clinician, to reduce waiting times and to avoid under-the-table payments. A significant portion of private services include maternal health care consultations, ultrasounds, PAP smears, abortions, hysterectomy, normal deliveries and Caesarean sections. While it is required that private services are licensed, the MOH has limited regulatory role for standard setting and monitoring quality of care (Qosaj and Berisha 2010).

**Possible improvements in infant and child mortality:** Despite well founded concerns about the limited available data, there are signs of a decline in perinatal mortality, which serves as a proxy for infant mortality (Qosaj and Berisha, 2010 page 34). Recent data from the KDHS also suggest that IMR and under-five mortality may have declined. The 2009 KDHS survey found for the period 2005-2009 an infant mortality rate of 9.5 per 1000 and an under-five mortality rate estimate of 11.2 deaths under age 5 per 1000 live births.

**Fertility and contraception trends:** The results from the 2009 KDHS suggest that there has been a substantial decline in fertility in the past decade. The total fertility rate for Kosovo declined from 2.9 children per woman in 2002 to 2.0 in 2009, a reduction of nearly one child per woman. While there were no questions on fertility preferences in the 2009 KDHS, there is some evidence of unwanted pregnancy. Women who were currently pregnant were asked if they wanted to become pregnant at the time they did. Less than two-thirds (64%) said they wanted to be pregnant this time, 10 percent would have preferred to wait till later while 3 percent said the pregnancy was not intended at all. Importantly 24 percent did not give a definite answer.

While more than two-thirds (69%) of married women reported ever using a method of family planning in 2009, only 28% reported ever use of a modern method (defined as pill, IUD, Injectable, Foam/Gel, Condom, or sterilization). Withdrawal continues to be the dominant method of contraception in Kosovo. Of the 35.2% of women reporting that they were currently using a contraception use in 2009, a large majority rely on withdrawal. It was by far the most common reported current method (25.2% of married women reported withdrawal as their current method) accounting for over 70 percent of all current methods in use in 2009 (25.2/35.2=71.6%). There has been a decline in the proportion of married women reporting modern method use since 2003, only 15 percent of married women reported current use of a modern method in 2009 as compared to 22.6% in 2003. These trends in contraception use have been attributed in part to a reduction in donor involvement in reproductive health since 2003. While withdrawal has been demonstrated to have contraceptive efficacy with perfect use, in general it is considered one of the least effective methods3 (http://www.contraceptivetechology.org/table.html). There are clearly advantages to shifting Kosovo’s contraceptive method mix toward more effective methods.

**Maternal Mortality:** There continue to be important concerns for maternal mortality. Following an alarming surge in Maternal deaths in 2008 (8 deaths, MMR 28.4) and 2009 (12 deaths, MMR 43.1), the number of reported maternal deaths dropped to two cases in 2010. (MOH. Perinatal Situation in

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Kosovo for 2000-2010). The above results do not include home and private sector facilities; there may be under-reporting or misclassification of cause of maternal deaths.

**Section 2. Statement of goals and objectives of the evaluation**

After four years since the beginning of the JP project, now that many of the components of the JP have been implemented, it is essential to measure, monitor and evaluate the impact that the project has had on mothers’ and children’s health in Kosovo. It is important to document the lessons learned for future programs for decision making on the continuation of the intervention and its approaches. The evaluation will be designed to inform the stakeholders concerning the progress that has been achieved as well as the areas where progress has not been achieved. The results from the evaluation will guide future stakeholder decisions and interventions and to ensure that they are appropriate for Kosovo.

The evaluation will assess the extent to which the outputs and outcomes of the project have been met. The final evaluation report, including the evaluators’ recommendations, will aim to be a practical tool to identify which best practices could be used and recommend improvements in the overall approach for the improvement of the health of women and children in the future. The final report will be designed to be relevant for a wide range of stakeholders, including Kosovo Ministries, civil society, public- and private-sector health care providers, local non-government agencies (NGOs), UN agencies and donors, to make informed choices toward interventions in the Kosovo health sector. The report will recommend which components of the JP should be removed, maintained, modified or added in the upcoming projects.

**Section 3. Scope of the Evaluation**

The evaluation covers the entire programme period (September 2007 to date) to assess the changes that occurred in Kosovo during and due to its implementation. A particular challenge in this process is the lack of data management systems to measure impacts on the health sector. In this context, in order to ensure utility and applicability to the needs of the implementing UN agencies and other key stakeholders, the evaluation will consistently apply a set of seven criteria to assess each of the outcomes, outputs and activities for the program: relevance, effectiveness, efficiency, sustainability, long-term impact, gender, and joint program management. These criteria are defined in detail in the evaluation inception report.

**Analytical Framework:** As shown in the simplified logic model framework in Figure 1 below, the project was developed to address five main outcomes: (1) improve access and quality of health services for women and children with special emphasis on pregnant women and newborn children, (2) reduce vulnerability from reproductive health risk factors, (3) change community practices in areas of reproductive health, child health and development, (4) reduce and prevent child morbidity and mortality from major preventable diseases and (5) improve provision of quality health services for women and children by health workers. These five major outcomes were to be achieved by a series of 13 outputs, also shown in Figure 1. This evaluation applies the above mentioned seven core criteria to each of the five outcomes, with specific attention to the numerous specific activities within each of the respective 13 outputs within each of the five outcomes.
Figure 1. Simplified Logic Model for Joint Project IHWC - Kosovo

**Outcome 1: Improved access and quality of health services for pregnant women and newborn children.**

Output A. 90% of pregnant women having access to and utilizing qualitative antenatal care.
Output B. Over 95% of deliveries occurring at maternal and child friendly health care facilities.
Output C. Micronutrient deficiency among pregnant women reduced by 50%.

Program activities lead to outputs

**Outcome 2. Improved access and quality of women and child health services.**

Output A. Strengthened management of health services.
Output B. Morbidity and mortality rates from cervical and breast cancer reduced by 30%.

Program activities lead to outputs

**Outcome 3. Reduce vulnerability from reproductive health risk factors**

Output A. Reduction in number of unwanted pregnancies.
Output B. Reduction in smoking and other psychoactive substances rate among pregnant women.
Output C. Reduction in rate of RTI/STI and prevalence of HIV/AIDS.
Output D. Increased knowledge and improved skills of health workers on RH issues

Program activities lead to outputs

**Outcome 4. Changed and improved practices of community in the area of reproductive and child health.**

Output A. Increased access and utilization of quality RH and child health and development services.

Program activities lead to outputs

**Outcome 5. Reduction and prevention of child morbidity and mortality from major preventable diseases.**

Output A. 95% of children fully immunized with major EPI Antigens.
Output B. Reduced child morbidity and mortality rates from ARI and Diarrhea.
Output C. Micronutrient deficiencies among children reduced by 50%.

Program activities lead to outputs
Section 4. Methods

This section presents a brief summary of the methods used and sequence of events, from inception report to intensive two weeks of interviews and site visits. For details of the methodology, please see the original inception report.

**Stakeholder Involvement**: Meetings were held with all key stakeholders, including MOH, civil society organizations, NGOs, donor community as well as all implementing agencies. A meeting was arranged with representatives of beneficiary client groups, including women’s health advocates, members of the minority communities, and youth representatives. The objective of these meetings was to ensure an opportunity for stakeholders to participate in the design, data collection, analysis and development of recommendations.

**Desk Review and synthesis by the Five Outcomes per Outcome/output Matrices**: A desk review was conducted to address each of the above mentioned five outcome areas with an assessment of the respective outputs and activities within each outcome. The desk review was based on a wide range of project documents and data sources, guided by the above mentioned seven core criteria.

**Stakeholder Interviews with semi structured questionnaire based on evaluation criteria**: As shown in list of persons contacted in Annex 2, interviews were conducted more than 42 stakeholders in Dragash, FushëKosovë, Mitrovicë, Prishtinë, Prizren and Skenderaj. A copy of the questionnaire is found in Annex 5.

**Training Follow-up Assessment**: A basic sampling frame was developed from all training events sponsored by the JP. A systematic random sample was to be taken to choose training participants (medical doctors, nurses and peer educators) in major training category areas (antenatal care, safe motherhood, family planning, management of pregnancy, neonatal resuscitation, use of colposcopes, management etc.). Using this approach, a total of 16 trainees were then identified at the above mentioned six locations. A semi-structured questionnaire (See Annex 5) was developed to assess the extent to which trainees are a) still working in the MOH System versus Private Sector, b) are using the skills they learned, c) estimated number of clients they serve per year. As needed, interviews were conducted in the local language with the assistance of the co-evaluator.

**Client exit Interviews**: Using a qualitative semi-structured interview questionnaire (See Annex 5), 15 client exit interviews were conducted with antenatal, family planning (FP), and post-partum patients at regional hospital and municipal level maternal and child health facilities in the six locations. These interviews assessed patient satisfaction with health service delivery, counseling services, anti-smoking protocols, and FP.

**Limitations and possible biases of the evaluation**: There are several important limitations in the methods used in this evaluation. First, the evaluation was limited in time and resources and it was not feasible to employ statistically representative quantitative research methods (i.e. to collect statistically representative samples). Due to the small sample sizes the evaluation is inherently qualitative in nature. While there was an opportunity for a randomization process for the training follow-up assessment, due to difficulties in logistics, the randomization process was largely abandoned and the interviewees were selected on a pragmatic and purposive basis; those interviewed are not truly representative of the target population. Due to the very short time frame permitted to plan the
evaluation and the poor timing due to the summer holidays, the response rates for certain interview categories was lower than desired; key informants were away and could not be reached. There are possible biases in the selection of respondents due to the requirement to select regions on a purposive non-random basis. There was also a potential bias in selection of interviewees by members of UNFPA project staff who assisted with evaluation logistics; however, the two evaluators had the final say as to which persons were interviewed and were not limited to interviewing only persons recommended by these staff. The choice of regions was informed in part by a quantitative and qualitative scale for municipalities developed by UNDP, selecting the locations that were rated as having the greatest needs for social and economic development. To avoid the possibility of implementing agency bias all interviews were conducted by the evaluation team without any collaborating agency staff present.

As anticipated the inception report, in view of the critical need to ensure that an adequate number of stakeholder interviews were completed in each of the six locations, it was not possible to complete the desired number of training follow-up interviews and exit interviews. Despite the relatively small numbers trainees and clients interviewed, the evaluation team nonetheless found the results from the 31 interviews to be extremely helpful, providing important insights on the process and follow-up to training, as well as the viewpoints of the most important constituents of the JP, the health care clients.

Confidentially and Informed Consent: The evaluation team observed all of the precautions that were outlined in the methodology section of the inception report, including signed and witnessed informed consent for client exit interviews and proper storage of completed data collection instruments.

Section 5. Findings

This section of the evaluation report addresses the results of the JP evaluation based on the above-mentioned seven evaluation criteria. The findings are first discussed in Section 5-a at a macro level, giving the overall assessment of achievement of the goals and objectives of the JP, including Kosovo’s progress toward MDG4 and MDG5. The findings are then presented in Section 5-b at a detailed level for each activity within the outputs within each of the five outcomes.

Section 5-a. Macro Overview - Achievement of Output Results for the Five Main Outcomes

As discussed in the analytical framework above and as shown in Figure 2 and Table 1 below, the JP is quite a complex project. The overall structure consisted of the five major outcomes, each with from one to four outputs. For each of the 13 outputs there were anywhere from one to eight specific activities, a total of 49 planned activities in all. The large majority of activities were carried out; over 85 percent, or 42 of the 49 planned activities, were fully implemented. For various reasons, seven of the planned activities were not implemented or were only partly implemented.

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4 In this detailed section, the report attempts to address as many as possible of the specific questions outlined in Section 3, pages 5 through 8, of the terms of reference.

5 Due to re-programming, in the course of the implementation, some of the activities had to be abolished, others are still ongoing.
Achievement of Output Objectives: As shown in Figure 2 and Table 1, based on objective assessment of available evidence, this evaluation has concluded that four out of the 13 proposed output objectives were achieved. The explanations for how these results were determined for each output are presented below in Section 5-b with the detailed discussion for each outcome. For each of the 13 outputs a matrix was prepared summarizing evaluation findings for each activity using the seven core criteria. These 13 matrices are attached in Annex 1.

The fact that only four of the thirteen output objectives were achieved does not mean that the JP was unsuccessful. There was substantial progress toward achievement of the objectives for the remaining 9 outputs. The targets for the 13 proposed outputs were extremely ambitious; in some cases they were clearly not achievable within a four-year time frame. Nonetheless, a great deal of progress was made toward achieving them. For many of the outputs, despite not achieving the stated objective, many of the proposed activities were successfully implemented and made important contributions to the MCH and RH status of Kosovo.

Most planned activities were highly relevant and several activities were highly effective: As shown in Table 1, based on a triangulation of findings from the desk review, stakeholder interviews, exit interviews and training follow-up interviews, all but 6 of the proposed activities were considered highly relevant to the initial and current context of MCH and RH in Kosovo. For many of the activities, however, even those that were fully implemented and highly relevant, due to the lack of baseline and follow-up data, it was not feasible to determine if they were effective or not. Nonetheless, using the available data more than a quarter of the activities was considered highly effective. The explanations for how these results were determined for each activity are presented below in the detailed discussion in Section 5-b for each outcome.
Figure 2. Achievement of Output Results for the Five Main Outcomes of the Joint Programme

Outcome 1: Improved access and quality of health services for pregnant women and newborn children.
• Output 1. 90% of pregnant women having access to and utilizing qualitative antenatal care: Not Achieved. Using the simple measure of 4 or more ANC visits, there is evidence for progress, but the data fail to demonstrate that the 90% target has been achieved.
• Output 2. Over 95% of deliveries occurring at maternal and child friendly health care facilities. Achieved. Plausible that it has been achieved at the general level of “occurring at a birth friendly certified hospital”.
• Output 3. Micronutrient deficiency among pregnant women reduced by 50%. Not Achieved. Despite Kosovo’s clear success in overcoming iodine deficiency through salt iodization, based on a comparison of the results from two definitive studies, UNICEF 2001 and UNICEF, NIPH 2010, there is no evidence of a 50% reduction in micronutrient deficiency among pregnant women.

Outcome 2. Improved access and quality of women and child health services.
• Output 1. Strengthened management of health services. Achieved: Clear successes, some setbacks.
• Output 2. Morbidity and mortality rates from cervical and breast cancer reduced by 30%. Not achieved. Despite the implementation of most of the activities as planned and the likelihood that this output will have long term impact, the evaluation found no evidence that this target has been achieved.

Outcome 3. Reduce vulnerability from reproductive health risk factors
• Output 1. Reduction in number of unwanted pregnancies. Not achieved. Programs in three of the four activities are promising but seriously underfunded compared to the scope of the problem; they were not sufficiently coordinated to leverage other partner UN Agency resources, i.e. social mobilization expertise.
• Output 2. Reduction in smoking and other psychoactive substances rate among pregnant women. Not achieved. The evaluation was unable to find evidence for any reduction in the rate of smoking among pregnant women. This output developed a definitive baseline on smoking among pregnant ANC clients that should be extremely useful in developing anti-smoking strategies.
• Output 3. Reduction in rate of RTI/STI and prevalence of HIV/AIDS. Not achieved. The evaluation was unable to find evidence that this output has achieved its target. Due to limited reporting on these types of infections, there are no available measures for the rates and prevalence of RTI/STI that can be assessed over the time of the evaluation. While some of the individual activities had merit, none appear to have been sufficient in scope to achieve a significant impact toward this output.
• Output 4. Increased knowledge and improved skills of health workers on RH issues. Achieved. This output has been highly successful on multiple capacity building activities training key staff in priority areas.

Outcome 4. Changed and improved practices of community in the area of reproductive and child health.
• Output 1. Increased access and utilization of quality RH and child health and development services. Achieved. This output has clearly demonstrated some impressive results. Two of the activities were implemented at a scale that is plausible for an increase access and use of quality services.

Outcome 5. Reduction and prevention of child morbidity and mortality from major preventable diseases.
• Output 1. 95% of children fully immunized with major EPI Antigens. Not Achieved. Despite clear improvement on all four indicators for BCG, DPT3, OPV3 and MMR, the percentage of children fully immunized has not reached 95%.
• Output 2. Reduced child morbidity and mortality rates from ARI and Diarrhea. Not achieved. While all four of the activities for this output have been implemented forcefully and effectively, the evaluation was unable to find evidence that this output has reduced child morbidity and mortality rates from ARI and Diarrhea. It is plausible that these activities will have a favorable impact in the future.
• Output 3. Micronutrient deficiencies among children reduced by 50%. Not achieved. The anemia rate among children <5 the target for output 3 has not have been significantly reduced. Nonetheless, there were successful activities to provide professional and technical support for formulation and implementation of measures for reducing micronutrient deficiencies among children.
Achievement of MDG4 and MDG5: The JP proposal was consciously designed to address the key indicators that will contribute to success in meeting Millennium Development Goals 4 and 5 (See the footnote below for the basic MDG4 and 5 definitions\(^6\) UNICEF, UNFPA, WHO 2007). In order to evaluate the JP, it is important to critically assess the extent to which these two MDGs may have been achieved. Unfortunately, this is a difficult undertaking in that, for understandable reasons given the extreme turmoil in Kosovo, Yugoslavia in 1990, there appears to be no consensus on the 1990 baseline indicators for Kosovo’s under five mortality rate (U5MR) or maternal mortality ratio (MMR). There is a lack of accurate health information data for Kosovo and there may be under reporting of infant and maternal mortality. The 1990 baseline estimates are not mentioned in the JP proposal, and, despite extensive discussions of the MDG 4 and 5, are not available on any of the three implementing agency websites.

As shown in Table 2 below, depending on the data used and the assumptions made concerning the estimates for the key indicators in 1990, a case could be made that, as of 2010, both of these MDGs may have been achieved. For the MDG4, the recent results from the 2009 Kosovo Demographic and Health Survey contains estimates of infant mortality rates (IMRs) and U5MRs by five-year intervals that suggest a decline by more than two-thirds since 1990 (SOK September 2011)\(^7\).

A case can also be made that the MMR has declined by more than three-quarters since 1990. This case is based on the 1990 regional estimate and confidence intervals for Central Europe’s MMR, which serve as a conservative proxy for maternal mortality in Kosovo, Yugoslavia in 1990. This is a conservative estimate in that the conditions in Kosovo in 1990 were extremely grave. Maternal mortality may well have been much higher. Based on the current estimated MMR for 2010, Table 2

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\(^6\) MDG4a Target 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Under-five mortality rate (U5MR) – Probability of dying between birth and exactly five years of age, expressed per 1,000 live births. MMR: MDG 5 target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Maternal mortality ratio – Annual number of deaths of women from pregnancy-related causes per 100,000 live births.

\(^7\) The JP UN agencies have urged caution in the use of the 2009 KDHS results, expressing reservations about the accuracy of the mortality estimates for IMR and U5MR.
shows a decline in more than three quarters from 1990. Because of the relatively small number of live births in Kosovo in 2010, (a total of 27,645), the MMR is extremely sensitive to the number of maternal deaths. To actually maintain the achievement the MDG5 would require that there be no more than two maternal deaths each year. There is concern that, due to underreporting, the actual MMR may be higher that the official 2010 ratio.

<table>
<thead>
<tr>
<th>Table 2: Has Kosova Achieved the MDG 4 and MDG 5?</th>
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<tr>
<td><strong>MDG 4 Goal: Reduce U5MR by two-thirds between 1990 and 2015</strong></td>
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<td>Year</td>
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<td>1990-94</td>
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<td>2005-05</td>
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<td><strong>Percent Decline</strong></td>
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* Estimates from DKHS for 2009 SOK September 2011 Table 5.4 on page 58.

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<thead>
<tr>
<th><strong>MDG 5 Goal: Reduce MMR by 75% between 1990 and 2015</strong></th>
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<tr>
<td>Year</td>
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<td>1990 MMR</td>
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<td>2010 MMR</td>
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<td><strong>Percent Decline</strong></td>
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**Ministry of Health, Perinatal situation in Kosovo for 2000-2010, Prishtina, Kosovo, March 2011

The missing MDG: While there has been progress toward achieving MDGs 4 and 5, there is a third closely related MDG, which was developed only just before the formulation of the JP. Ideally, it should have been addressed explicitly in the original JP proposal. This is the MDG Target 5b: “To achieve, by 2015, universal access to reproductive health.” Per the UNFPA, “The new Target of achieving universal access to RH by 2015, introduced by the former UN Secretary-General in 2006, recognizes the centrality of RH in addressing core issues of the MDGs. …it offers a great opportunity to give appropriate attention to unmet need for contraception.” (UNFPA, accessed August 2011).

This relatively new component of MDG5 has four indicators, two of which (1 and 3) were explicitly mentioned in the JP proposal: 1) Contraceptive prevalence rate, 2) Adolescent birth rate, 3) Antenatal care coverage (at least one visit and at least four visits, and 4) Unmet need for family planning. This last indicator, unmet need for family planning, is especially important. According to UNFPA, “Unmet need for Family Planning (FP) measures the gap between the proportion of women who desire contraception to limit or space their births and those who are currently using it, based on a target coverage rate of 100% of women who have a demand/need for contraception. Monitoring this indicator is crucial for tracking achievement of MDG 5, given the strong evidence of the large health and poverty reduction benefits that can be reaped from addressing unmet need for FP.” Unfortunately, during the time the JP was implemented, the 2009 Kosova DHS questionnaire did not collect the required data to measure unmet need. This is a serious gap and should be explicitly addressed in the upcoming UNICEF supported multiple indicator cluster survey (MIC).
Section 5-b: Detailed Assessment of Outputs and Activities for each of the five Outcomes

Outcome 1: Improved access and quality of health services for pregnant women and newborn children.

Output 1: 90% of pregnant women having access to and utilizing qualitative antenatal care.

Overall Finding: Using the simple measure of 4 or more ANC visits, there is evidence for progress, but available data fail to demonstrate that the 90% target has been achieved. Data from 383 respondents at 24 Kosova maternities and birthing centers in 2003 found 72% had 4 or more ANC visits (UNICEF 2003). Data from 2008 from a sample of 1,000 women found 78.1% report 4+ visits versus target of 90% (UNICEF 2009). In 2008, the highest level achieved was in Prishtina at 80.8%. Given that these most recent data are from 2008, and as the project went on until 2011, the picture may have improved. Despite MOH commitment to Family Medicine, the large majority of ANC care is provided by OB/Gyns: 100% in 2003, and 98.5% in 2008. A trend toward private sector has been observed: in 2008, only 28.7% of ANC services were in public sector, the remaining 71.3% in the private sector (UNICEF 2009).

Output Activities: The evaluation found evidence for substantial and well-coordinated interventions for all of the three activities for this output.

Activity 1: Support health education of women about importance of qualitative antenatal visits (UNICEF 20,000 euros allocated, fully expended). The two projects supported by UNICEF, the Better Parenting Initiative and the Family Health Education Program implemented by Kosova Red Cross, have both clearly addressed Activity 1, Support health education of women about the importance of qualitative antenatal visits.

Activity 2: Train health workers in providing evidenced based antenatal care (WHO 45,000 euros allocated, fully expended). This activity included WHO supported training of health care workers in providing evidenced based antenatal care and was plausible intervention. Training follow-up interviews with participants in the five-day Evidence Based Medicine course revealed some problems in the design of the course. For example, two participants who were interviewed felt that they were not given sufficient advance information to prepare, the content of the course was at times too technical, that they were not able to apply the material, and that the location of the course in Prishtina was a severe constraint on their participation.

Activity 3: Adopt, print and disseminate booklets on “Child Health and Pregnancy Care”. (UNICEF 55,000 euros allocated, fully expended; WHO 10,000 euros allocated, fully expended). This activity, a combined WHO UNICEF effort to support the adoption, printing and dissemination of booklets, “Child Health” and “Pregnancy Care” represent a substantial level of well-considered and coordinated effort on this ongoing activity with plausible coverage and potential for impact. There is evidence of...

8 All financial data presented in this report are estimates as of July 2011; they are not precise due to limitations in the agencies’ centralized global reporting systems. For some activities additional funding was available from other sources. Funds for activities that were not implemented were reprogrammed.


10 The JP supported an intensive national assessment, consultation and revision for the two booklets after their first two years of use. This was done using a questionnaire that was completed by clinicians at a wide range of maternity care settings. Interestingly, there did not appear to be an attempt to consult with a key group of end users, the mothers who are expected to keep the booklets. Over 290 questionnaires were completed and consultation meetings were organized in seven municipalities. Based on these consultations some limited revisions (including insertion of WHO Child Growth Charts) were made and 30,000 copies of the revised booklets were printed and delivered to the MOH for distribution in 2009. In addition, this consultation provided...
high estimated coverage for Child Booklet (90%) from recent February unpublished data (Hasani 2011 unpublished); lower coverage for the Pregnant woman booklets(60%) (UNICEF 2009). The recent 2010 Evaluation of Immunization Services found that possession of a vaccination card is very much related with the possession of the Child Health Booklet that children get after they were born. It is important to note that three of these programs, BPI, Family Health Education, and the Child Health and Pregnancy Care Booklets, were well established before the JP began and might have continued without the support from the JP. The MOH has made plans to continue to print booklets from 2011, which is a good example of potential for sustainability.

There were five indicators for Output 1:

- **Percentage of antenatal care coverage:** Increase from 72% in 2003 to 78% in 2008, using the WHO standard recommendation of four visits (UNICEF 2009).
- **Reduction in pre-term deliveries:** The evaluation did not obtain data on trends in preterm birth rate (less than 37 weeks of gestation). In any case, it does not seem plausible that any of the three activities, even if they were fully implemented, would result in any significant impact on rate of pre-term deliveries.
- **No of health workers trained in providing qualitative antenatal care:** The two training courses designated as part of this activity included 17 senior health workers were trained in Evidence Based Medicine for five days and 399 health workers who received a one-day course primarily oriented to the dissemination of Pregnancy and Child Care Booklets.
- **Increasing percentage of women expressing satisfaction with quality of antenatal care:** Levels of patient satisfaction reported in two UNICEF surveys were high, but there was no trend toward an increase. The 2003 UNICEF study found overall satisfaction rate to be quite high: only 3% were not satisfied, 97% either satisfied or somewhat satisfied. Results for the 2008 UNICEF study used alternate measures of satisfaction that are not comparable.
- **Number of booklets printed and distributed:** 30,000 printed and delivered to the MOH for distribution (Per the 2009 Annual Report).

**Outcome 1 Output 2: Over 95% of deliveries occurring at maternal and child friendly health care facilities.**

**Overall Finding:** It is very plausible that Output 2 has been achieved and that over 95% of deliveries occur in hospitals that are certified to be “Baby Friendly”. The reporting in the JP Annual Performance Reports was inadequate to justify this claim, however. Three of the five planned activities for this output were fully implemented, two were only partially implemented.

**Activity 1: Carry out certification and monitor continual compliance of all maternities as Baby friendly hospitals/institutions** (UNICEF 15,000 Euros allocated, 79% expended). UNICEF has continued a highly developed program to audit and certify maternities. Based on reports, interviews and site visits at a non-representative sample of maternities, it appears that as of 2010 all of Kosovo’s MOH maternities are maternal and child friendly in so far as they were currently certified to be “Baby Friendly.” UNICEF estimated in 2008 that 90% of all Kosovo births take place at 18 birth friendly certified maternities; it is plausible that they have achieved 95% coverage as of 2010 when all MOH institutions were certified. The evaluation team did not verify compliance with “Baby Friendly” certification and, based on key informant interviews, there is an expectation that some maternities may lose their certification in the coming year based on ongoing or planned assessments. Post-training interviews indicated there was strong support for the UNICEF trainings on infant feeding and breastfeeding, which is one of the standards for compliance with BFHI. This finding comes with the

the impetus for the development of an Administrative Instruction for Mandatory Use of the Pregnant and Child Health Booklet by all health professionals (WHO, Lulaj, S. 2007).
caveat that non-maternal and child friendly health care was observed during some site visits (e.g. mothers required to pay for all of their consumables etc.). This activity is another example of a well-established program that would likely have continued without JP support.

**Activities 2 and 3: Train health workers in Management of Pregnancy and Childbirth package** (WHO 45,000 euros allocated, 67% expended); **Training the health workers on neonatal resuscitation** (WHO 15,000 euros allocated, 100% expended). Through WHO, trainings were conducted in 2008 for more than 160 doctors and nurses in two key areas related to this output. The American Academy for Pediatrics Neonatal Resuscitation Program (two one-day trainings for 64 doctors and nurses from 6 regional hospitals). This is a highly relevant training course with important implications for the reduction of perinatal mortality. A one-week long training was conducted for 49 doctors and 49 nurses in five regional FMC in the WHO Integrated Management of Pregnancy, Childbirth, Postpartum and Newborn care (IMPAC). It was unclear if there was follow-up to this training. The underlying issue remains that this training strategy is designed for primary health care and was conducted for family medicine specialists in a context where the majority of ANC and Post-partum care is done in the private sector by Ob/Gyns.

**Activities 4 and 5: Carry out Needs Assessment of maternity wards of regional hospitals** (UNFPA USD 2,163 allocated, fully expended); **Support provision of essential equipment to maternity wards of regional hospitals** (UNFPA USD 14,445 allocated, fully expended). UNFPA conducted an assessment of basic maternity and neonatology care equipment needs with the intent of purchasing essential equipment for maternity wards of regional hospitals. Because the assessment report over-specified a great deal of non-essential and otherwise inappropriate equipment, the results from this assessment could not be used. Funds for equipment purchases were reprogramed for other activities. UNFPA did ultimately make some fairly modest equipment purchases subsequently, for example hospital beds for UCCK maternity.

**There were eleven indicators for this output.**

- MMR: The evaluation found some basis for expecting that the JP will contribute to reduction in MMR over time.
- Perinatal Mortality Rate (PMR): Has declined, but the evaluation found no compelling evidence of a reduction attributable to the JP. But there is clear relevance of the JP activities in this output toward effective intervention, Neonatal Resuscitation, which has clearly reduced PMR at the UCCK.
- IMR: No compelling evidence of a reduction attributable to JP.
- Percent of deliveries in health facilities: A high percentage of deliveries took place in health facilities before the JP began and there was no direct evidence of an increase attributable to the JP. Per the UNICEF 2009 ANC report, page 9, the UNICEF 2001 Micro-Nutrient Study found 96% of women gave birth in health institutions with professional care.
- Number of health workers trained in superior skills in pregnancy and birth management: At minimum 98.
- Needs assessment (for equipment needs) carried out: Yes, a needs assessment was carried out; but UNFPA concluded it was not satisfactory.
- Kinds of equipment provided in hospitals and regional health facilities: A limited number of purchased made, for example hospital beds for UCCK.
- No of institutions certified as “Baby friendly”: 21 = 100% of MOH Maternities.
- No of baby friendly hospitals maintaining compliance after one year: Ongoing process - 18 were recertified in 2010.
- No of health workers trained on neonatal resuscitation: Total of 100: 36 in 2007, 64 in 2009.

**Outcome 1 Output 3: Micronutrient deficiency among pregnant women reduced by 50%.**

**Overall Finding:** Based on a comparison of two national studies, UNICEF 2001 and UNICEF, NIPH 2010, there is no evidence of a 50% reduction in micronutrient deficiency among pregnant women.
The Kosovo Micronutrient Survey of 2001 found 14% anemia among women of reproductive age, while the 2010 UNICEF, NIPH study, among pregnant women, found a prevalence of 23%, indicating a moderate public health problem of anemia (Section 6.2 in UNICEF, NIPH 2010). The achievement of a reduction by 50% was probably beyond the timeline for this four year project. For example, a draft action plan for flour fortification, dated January 2009, anticipated a 30% reduction in iron deficiency anemia (IDA) would take five years to achieve (Johnson Trip Report 2009).

**Activity 1: Situation Analysis on prevalence of micronutrient deficient among pregnant women**

(UNICEF euros 20,000 allocated, fully expended). A definitive study was conducted by UNICEF and NIPH in 2010, was partially supported by the Joint Project. The impact of this activity was somewhat reduced due a) lack of comparable baseline data and b) delay of fielding the study until toward the end of project. Nonetheless, the results of this study are clearly beneficial and have been used effectively for advocacy for food fortification.

**Activity 2: Supplementation of Iron and Folic Acid to the pregnant women**

(UNICEF euros 45,000 allocated, only 3% expended). Very little of this activity could be implemented. Per the 2008 annual progress report, 200,000 tablets of Iron and Folic Acid were procured for distribution by Ministry of Health to health facilities. Ultimately, the procurement of tablets created many difficulties and, after prolonged discussion, this initiative was discontinued and funds allocated for the tablets were reprogrammed to support other project activities.

There were three indicators for this output:

- **Situation Analysis Conducted:** Yes.
- **Number of Folic Acid/Iron tablets distributed among pregnant women:** Not applicable, as this program activity was discontinued.
- **Prevalence or percentage of pregnant women using Iron and Folic Acid.** No evidence of an increase was found. Based on the results from the 2008 ANC Study supported by UNICEF, 18.4% used folic acid and 26.7% used iron supplements (UNICEF 2009 page 27). The 2010 UNICEF NIPH study found 16% use of iron supplements in 2010 (144 out of 900 pregnant women, based on UNICEF, NIPH 2010 page 22).

**Outcome 2 Improved access and quality of women and child health services**

**Output 1 Strengthened management of health services**

**Overview on achievement of Output 1:** There were mixed results for the eight diverse activities implemented for this Output. The JP supported ANC situation analysis clearly met its objectives and the ongoing support to the series on the perinatal situation in Kosovo is very pertinent. The JP has made strong progress with Technical and Professional Assistance to MCH and RH Office within the MOH and the JP has clearly succeeded in provided pertinent training for appropriate health care staff. But the long-term problem remains of a high proportion of ANC and OB care which is entirely outside the MOH. Problems persist in expanding the role of Family Medical Doctors for ANC; only a small increase in FM doctors reported providing ANC in 2009 UNICEF study. Efforts to promote Youth Friendly Health Services failed to gain MOH support and have been delayed until 2011. Many of the other activities within Output 1 are relatively small and uncoordinated, with little likelihood of impact. An intense focus on one narrower health management issue would have been preferable.

**Activity 1 Situation Analysis of MCH Situation**

(UNICEF 25,000 euros allocated. Fully expended).

The survey, “Antenatal Care in Kosovo: Quality and Access” provides extremely important and essential baseline data for the project. Given the delays in starting the project in 2007, it is actually quite remarkable that the study was fielded in August 2008. The survey was based on a household sample of women of reproductive age who gave birth in the past five years. The absence of comparable data from the earlier 2003 UNICEF study, which used an alternate sample design at
maternity sites, means it is difficult to develop any time trends. If repeated using a comparable methodology and data collection instrument, the 2008 study will permit tracking key indicators over time, such as indicators of quality of interaction with providers and type of care received. The absence of a JP Monitoring and Evaluation Plan resulted in missed opportunities to ensure that the survey was designed to capture comparable repeated indicators to permit measurement of change over time. In addition to the ANC study, it is important to acknowledge JP support for the excellent series, “Perinatal Situation in Kosovo,” which has a long tradition of combined UNICEF, WHO and UNFPA support. This series is a vitally important exercise that provides a model for the collection of vital statistics; it a huge opportunity to improve reporting on MCH and RH related statistics. This series collects some data from private sector facilities. This is an important precedent that should be used as a basis for expanding data collection from the private sector. As with several other JP supported activities, this series was ongoing and well established prior to the JP. This series may require continued donor support in the future.

**Activity 2 Provide Technical and Professional Support for MCHRH Office in MOH** (UNICEF 22,000 euros allocated. Fully expended; WHO 15,000 euros allocated, Fully expended). (UNFPA euros 2,163 euros allocated, Fully expended). This activity has been consistently implemented, with considerable success despite significant problems of turnover in senior MOH leadership as well as the resignation of the MCHRH Officer in October 2009 due in part to problematic MOH policies. The support activities have included advocacy for the MCRH Office position within the MOH, transport and phone costs for the MCRH Office, technical support for drafting and finalizing strategic, health policies, and Administrative Instructions pertaining to MCH such as breastfeeding and abortion under special circumstances, support for and participation in bimonthly coordination meetings, and site monitoring visits. There is potential for sustainability with the recently proposed MOH 600,000 euro funding for the MCRH Office for a period of three years. Especially important is the development of a Mother, Child, Adolescent and Reproductive Health Strategy, which was completed in July 2011, has been submitted for endorsement to the Permanent Secretary. During interviews with senior stakeholders there were concerns that the MCRH Office should take a more active role in policy determination and not be constrained to merely serve as a secretariat for MCH issues.

**Activity 3. Conduct workshops/training for HCWs to improve management and administrative skills** (UNFPA 25,953 euros allocated fully expended). Over the course of this project a great deal of training has been carried out, much of it pertaining to improved management and administrative skills. There were over 600 participants in training events that ranged from a large symposium for Kosovo Midwives, 13 3-day trainings on Quality Assurance, and a senior level two-day stakeholder conference. The two-day stakeholder conference was designed to review the Joint Program, increase technical and professional support for the MCRH Office and improve quality of MCH care services within PHC/FM and establish coordination mechanisms for planned project activities. This two-day stakeholder conference, implemented through WHO, was an extremely thoughtful effort to re-invigorate the Joint Program, which due to administrative issues in the MOH had reached a low rate of implementation. The conference called for 1) a more integrated approach between JP interventions and health systems to improve implementation at the country level and 2) strengthened leading role of the MOH, stronger and closer collaborating between governments and other actors at the national level. It is likely that this stakeholder conference, by making concrete recommendations to improve the role of the MCHRH Office had a significant impact. It reflects a clear responsiveness to need for change in the face of problems within the MOH.

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11 According to an agreement with the MoH, the MCRH officer is supported for transport and phone cost, not salary.
Activity 4. Strengthen capacity of family doctors and family nurses (UNICEF 10,000 euros allocated, 90% expended. WHO 20,000 Euros allocated 75% expended). This activity consists primarily of trainings for FM Doctors and FM Nurses conducted in collaboration with the Center for Development of Family Medicine. These programs appear to be somewhat theoretical and may not have succeeded in increasing the percentage of women seeking health care from PHC/CM. The available documentation is sparse and does not provide any evidence for in-depth training that would have an impact on service delivery. During an interview with a representative of the CDFM the evaluation team was impressed with an emphasis on tracking activities, such as training events, but gained no compelling evidence of ongoing progress in providing leadership to expand the role of FM for MCH and RH care services.

Activity 5. Support improved quality of hospital based pediatric care WHO 40,000 euros allocated. Approx. 80% expended. Clearly the project has done much in this regard, but the evaluation identified only one reference regarding activities in this category and it was already cited by WHO for Outcome 1, Activity 1. Per the 2008 Annual Report, 700 copies of the Albanian translated version of a pocket book, “Hospital care for children” were disseminated at six one-day workshops conducted for pediatricians and pediatric nurses from the staff of the five regional hospitals in Prizren, Gjakova, Peja, Mitrovica and Gjilan and Pediatric Clinic in UCC Pristine. The objectives of these workshops were: 1. Promotion and distribution of the pocket book “Hospital care for children”; 2. Explanation and determining of responsibilities of different health care providers and levels on fulfilling child health and pregnancy booklets according to the endorsed administrative instructions; 3. Reinforcing referral system for mother and child health care and 4. Identifying possible topics for EBM guidelines/protocols development. The workshop was designed in part to reinforce the use of the Child Health and Pregnancy Care Booklets. It also identified topics for proposed EBM protocols, guidelines are under development and a CD-ROM of the pocket book for hospital care for children will be published by the end of September 2011. This training for just one day appears to be fairly superficial and of itself would not be likely to improve quality of care. It does appear to have served an important function to reinforce the use of the Child Health and Pregnancy Care Booklets as well as disseminate the pocket book on Hospital Care for Children.

Activity 6. Develop protocols for youth and women friendly services (UNFPA 9,934 euros allocated, 50% expended). Clearly the JP project has done much in this regard, but progress has been slow due to reluctance on the part of the MOH to pursue this strategy. The WHO supported a workshop to facilitate a training of trainers workshop (4 days for 27 people) on the Orientation Programme for Adolescent Health and Development in Kosovo in November 2010. There were two main Objectives: 1. Organize and facilitate the four day training of trainers workshop on the Orientation Programme (OP) for Adolescent Health and Development 2. Field-test the revised modules on Adolescent Development and Mental Health and test the addition of an extracurricular session for introducing the Adolescent health Job Aid and Programming for Adolescent Friendly Health Services (AFHS). This training will be used in future in at least one pilot venue.

Activity 7. Strengthen youth centers in regions and facilitate referrals of health facilities (UNICEF 42,000 euros allocated; 50% expended). UNFPA 615 euros allocated, fully expended. There has been concerted effort by all partners on projects related to youth friendly services. For example, per the Annual Report for 2008, a specialized NGO from Macedonia conducted a two-day training on youth friendly health services. It was focused on standards and criteria of youth friendly services which will strengthen abilities of the service providers to respond to young people more effectively and with greater sensitivity and to become more aware of the changes they need to do in their work and with young people. The training was attended by 7 family medicine doctors, 1 gynaecologist, 10
representatives of NGO, 3 youth peer educators, and 2 UNFPA staff. This activity was postponed due to unclear institutional arrangements. There were problems in getting the MOH to be receptive to the idea of a strategy targeting just the youth segment of the population. “The Ministry of Health has not been fully supportive of these endeavors because of a lack of conviction of the usefulness of the curriculum and the need for adolescent friendly health services. One possible reason is the perceived competition with the family medicine approach that is being implemented in the country” (Bloem Trip Report 2010). Apart from the data on TOT course participants for Peer Educators, there is little concrete information on the impact of these programs. They have focused in large part on HIV prevention.

Activity 8. Support access to quality MCH services for RAE and other vulnerable groups
(UNICEF 45,000 euros allocated, two thirds expended; WHO 30,000 euros allocated, fully expended).
UNFPA 22,264 allocated, fully expended. This activity consists of a series of small, but generally high quality projects have been supported by the JP, implemented by all three partners, WHO, UNICEF and UNFPA. Most of the reported activity appears to be very pertinent, but one series of activities, related to Prison Health, may not have been as relevant to the scope of the JP. The prison health activities are justified by the UN agencies on the basis of women’s health. One project, initiated by UNFPA, was discontinued due to a lack of accountability with the implementing NGO.

There were nine indicators nine for the above eight activities:
Activity 1. Situation analysis conducted: Yes.
Activity 2. Guidelines, policy documents, technical recommendations, strategy documents. The JP, especially through the WHO, has clearly played an important role in assisting in formulation of guidelines and policies.
Activity 3. No of training courses and workshops conducted. 15 training events with 600 participants.
Activity 4. No of training and workshops conducted. 10 training events with over 300 participants.
Activity 5. No of hospital users expressing satisfaction with pediatric care: The evaluation did not obtain data to measure this indicator.
Activity 6. Developed protocols for youth and women friendly services. For reasons explained above, this has only been partially implemented; it is under development with activities planned for later in 2011.
Activity 7. Increased number of youth and women expressing satisfaction with health service delivery. The evaluation was not able to locate a consistent set of comparable data over time. One representative survey on ANC collected data for a single aggregate measure of satisfaction. No data were available on youth satisfaction with health services.
Activity 7. Increased activities of youth centers and increase in referrals. No data were located for this indicator.
Activity 8. Increased utilization of health facilities by minority groups/RAE community: It is plausible that the work supported by JP through three agencies has increased minority population use of health facilities. The projects tend to be somewhat small-scale and, apart from ensuring that they worked in different locations, not did not appear to the evaluators to be coordinated in terms of strategies and approaches.

Outcome 2 Improved access and quality of women and child health services
Output 2 Morbidity and mortality rates from cervical and breast cancer reduced by 30%
Overview on achievement of Output 2 Target: Despite the implementation of most of the activities as planned, and the likelihood that this output will have long-term impact, there is no evidence that this target has been achieved during the four years of the project. Actually four targets are implied: a
reduction in four rates by 30%: morbidity and mortality for cervical cancer, morbidity and mortality for breast cancer). There are currently no reliable data to permit estimates of morbidity and mortality rates from cervical and breast cancer in Kosovo. It is therefore not feasible to measure changes in these four rates over time. There are no estimates given for these rates and no apparent justification for the choice of a 30% reduction for these rates. While important progress has been made on four of the five activities, even if there were reliable data, the level of activity is probably insufficient to have made a measurable impact. The situation analysis was high quality and ground-breaking; it helped provide impetus for follow-through on several activities, including activities that were not anticipated, such as training for palliative care. Understandably, Activity 2, for social mobilization, was not implemented. It was a low priority due to the finding that social mobilization was premature until capacity was increased.

Activity 1. Conduct situation analysis on breast and cervical cancer (UNFPA euros 14,400 allocated, fully expended). A very comprehensive and in-depth situation analysis was carried out with a wide range of findings and recommendations (Knowles and Packer 2008). Many of its key recommendations were followed up. One key recommendation, for a subsequent in-depth Needs Assessment that would include an Options Appraisal, has not been implemented. The report stressed the near absence of data and estimated that a large portion of cervical and breast cancer cases went undiagnosed. It cited inappropriate treatment and follow up. It stressed that the current treatment capacity not able to absorb a campaign to increase awareness and therefore it was important to increase capacity first. The report cited the trend toward self-referral, by-passing PHC and the need for consistent guidelines. The report described that UCCK as being overwhelmed, the NIPH as underutilized and cited the lack of palliative care. Key Follow-up: 1) A key recommendation was for a subsequent in-depth Needs assessment that would include an Options appraisal (this was not implemented). 2) It also recommended colposcopy training for two Ob/gyns from each region and six from the Tertiary unit in Pristina (see below). 3) In response to the finding of an absence of palliative care, The Centre for Continuing Nursing Education incorporated a Palliative Care module into its learning curricula and WHO supported the translation of a book, “Palliative care for cancer and other patients” into Albanian.

Activity 2. Conduct social mobilization for routine and regular assessments to reduce incidence of breast and cervical cancer (UNFPA no funds allocated). As outlined above, the recommendation from the assessment was that a social mobilization campaign would be premature until capacity was increase. Nonetheless, per the 2010 Annual report, UNFPA and WHO jointly supported a breast cancer awareness project implemented by the Balkan Breast Cancer Initiative in collaboration with Radiology Mammography International.

Activity 3. Financially support procurement of Colposcopes for Regional hospitals. (UNFPA Euros 45,406, fully expended). Per the 2009 Annual Performance report, UNFPA procured three colposcopes and three microscopes that were donated to the GYN/Ob Clinic, The Women’s Wellness Center, in the Main Family Medicine Center, and the Pathology Institute in Pristina as well as the Regional Hospital in Peja. There were complaints from some senior informants that the type of colposcopes purchased was not state-of-the-art. UNFPA had to procure them through Copenhagen.

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12 Given the gravity and urgency of the findings of the situation analysis, it was surprising that more of the recommendations were not translated into action. In one instance, followup was stopped by the MOH. all three agencies advocated for hiring a professional staff (graduated pathologist was identified and was willing to work) at the laboratory of Obs’Gyn Clinic. The process was initiated, but stopped at MoH level. The lack of implementation of recommendations may also reflect the diversity of JP project activities, with many competing demands for project staff.
and, despite efforts to get input from the recipients, was not able to get exactly what they wanted. This is a chronic problem of recipients wanting the most up-to-date state-of-the-art equipment, which is often prohibitively expensive.

**Activity 4. Provide training to health workers in utilization of Colposcopes.** (UNFPA Euros 9,900 allocated, 43% expended). As the situation analysis recommended, UNFPA supported colposcopy training for two Ob Gyns from each region and six from the Tertiary unit in Pristina. This was implemented (See UNFPA – Mission Report on workshop on Colposcopy training). The evaluation team interviewed two training participants. At the Tertiary level the training was felt to be definitely hands on, using animal tongues, which have very similar characteristics to the morphology of human cervical tissue. In contrast, an Ob/Gyn at the region who felt it was not been “hands on” enough and that there had been not been enough follow-up.

**Activity 5. Establishment of population registers for malignant diseases.** (WHO Euros 10,000 55% expended). Per the 2009 Annual report, at the request of the MCHRH Office, WHO translated two important guidelines into Albanian: “Comprehensive cervical cancer control- A guide to essential practice” and “National cancer control programmes – Policies and managerial Guidelines.” They were to be printed and disseminated to key stakeholders. This is part of the process of the planned establishment of a National Cancer Control Program. This is a good example of the benefit of having a key normative agency as part of the JP. Per the 2010 Annual Report, in June 2010 the JP sponsored Kosovo participants at a Regional Workshop on National Cancer Control Programmes, held in Tirana. Per the 2010 Annual Report, In close collaboration with the NIPH of Kosovo, as well as the Institute of Public Health in FYR of Macedonia, WHO is creating an electronic data-base of cancer registrations; in July 2011 the JP supported an assessment visit by an expert group from the ICRI in Lyon.

There were six indicators for the five activities:
Activity 1. Situation analysis conducted: Yes.
Activity 2. Increase in number of women going in for regular screenings for breast and cervical cancer detection. The evaluation did not obtain data for this indicator.
Activity 3. Reduction in incidence of breast and cervical cancer. The evaluation did not obtain data for this indicator.
Activity 4. No of colposcopes procured. Three.
Activity 4. Percentage of health workers trained in using colposcopes. While it was not clear what the proper denominator should be, the effort to train two OB/Gyns from multiple regions seems to be an appropriate initial response.
Activity 5. Register is functioning. No. Work began in 2010 and it may be nearing the start-up phase later this year.

**Outcome 3 Reduced vulnerability from reproductive health risk factors.**

Output 1 Overall Findings on “Reduction in number of unwanted pregnancies”: The output target has not been achieved. Programs in three of the four activities are promising but seriously underfunded compared to the scope of the problem; they were not sufficiently coordinated to leverage other partner UN Agency resources, especially UNICEF social mobilization expertise. Activity 3 has not been implemented. Recent available data suggest that is unlikely that the number of unwanted pregnancies has decreased (SOK, September 2011). In fact, based on findings from the recent 2009 KDHS, it is plausible that there has been an increase in abortions in the private sector. The 2009 KDHS indicates that, compared with the 2003 KDHS, there has been a decline in the use of modern contraception from 22.6% in 2003 to 15% in 2009, accompanied by an increase in reliance on withdrawal, while total fertility has declined by an average of almost one child (average decline of .9)(
Women who were currently pregnant were asked if they wanted to become pregnant at the time they did. Less than two-thirds (64%) said they wanted to be pregnant this time (SOK September 2011). Rates of condom use at last intercourse among youth are substantial (55% (UNKT 2008)) but urgently need to be increased. Acceptability and access to hormonal methods (OCs and EC) need to be expanded. Social marketing currently reaches only some 200 out of 341 MOH licensed private pharmacies and needs collaborating UN Agency and MOH support to diversify its portfolio and dramatically increase visibility for modern contraception use among both married and unmarried couples.

Activity 1. Support conduct of community awareness campaigned on safe sex practices (UNFPA $56,700 allocated, 96% expended). Very thoughtful and imaginative work has been done by committed agencies working with youth and minority communities. Unfortunately, the numbers reached, over 200 community sessions reaching more than 7000 participants in two years (as reported in Annual Reports for 2008 and 2009), are well below what is needed to have an impact for the entire country. Some of these agencies have a decade of experience and are diversifying their funding base with prospects for continued activities. Apart from pre- and post- training surveys the evaluation team was unable to obtain any data to assess impact on knowledge attitudes and practice.

Activity 2. Jointly plan with NGOs activities to conduct and strengthen peer education system. UNFPA Support conduct of community awareness campaigned on safe sex practices (UNFPA $53,522, 87% expended). A variety of projects have been implemented by a core group of committed local agencies working with youth using innovative interactive methods. The numbers reached over the past three years (as reported in Annual Reports for 2008, 2009, 2010), are well below what is needed to have an impact for the entire country. Internet site visits, after some encouraging results appear to have atrophied from a high of 31.5 thousand reported visits to less than 5,000. Some of these agencies have a decade of experience and are diversifying their funding base with prospects for continued activities. Apart from results comparing standard pre- and post-training surveys, the evaluation team was unable to obtain any data to assess impact on knowledge attitudes and practice.

Activity 3. Provide counseling services for high risk groups (sex workers). (UNFPA No funds allocated). UNFPA determined that this activity was not feasible and therefore it was not implemented.

Activity 4. Strengthen distribution of contraceptives through social marketing. (UNFPA $117,450 allocated, 100% expended). A spin off from PSI, the UNFPA supported KOPF social marketing program has been in continuous operation for over 8 years and currently sells over 680,000 condoms a year through some 200 pharmacies. Under the JP, UNFPA has provided technical assistance (TA) for KOPF on at least two occasions, the latter being an intense 5-day intervention to address essential management functions for social marketing. Based on the recommendations of the second TA visit, market research was conducted in 2010 using quantitative and qualitative methods. A national sample of over 1,000, size proportional to region, half men and women, two thirds below age 25 20% married, high percent with college (43.15). It concluded that condoms were the most prevalent form of contraception, that the current market price of 50 euro cents was acceptable, and that trends appear to be toward increased condom use. Of this sample, 46.6% reported condom use at last intercourse, compared to a 2008 youth study that found 55% of youth report condom use at last intercourse (UNKT 2008). Despite this TA, KOPF has not been able to reach financial independence. This appears to be due to two main factors, overall sales are less than needed to generate sufficient revenue (Meyer 2008, 2009), and efforts to diversify products (OCs and EC) has met serious difficulty. The UN and donor community should accept the reality that SM will require continued support for the foreseeable future. The UN agencies should use their combined influence to assist KOPF to a) overcome difficult regulatory hurdles to permit introduction of key additional

13 According to UNFPA, KOPF may be on track to reach financial independence. This year, they are planning to procure two million condoms from their own revenues (from condoms purchased by UNFPA).
contraceptive products, especially EC and OCs b) re-energize promotion of family planning as a maternal health initiative using the combined resources of all three agencies.

There were six Indicators for the four activities in Output 1:

**Activity 1. Number of campaigns planned and conducted:** Slightly more than 200 community sessions reaching more than 7000 participants in two years. This is probably insufficient intensity of effort compared to actual need. The overall funding is well below what would be required to have impact.

**Activity 2. Percentage of Medical Terminations of Pregnancy (MTP) among young unmarried women. No data available to assess this indicator.** According to Basha and Hutter 2006, in 2002 UNFPA estimated 5 abortions for every 100 live births, based on general hospital data, which does not report private sector data. The 2006 study stressed that, while abortion is relatively acceptable among married women, it is much more sensitive for unmarried. Per the 2009 KDHS, 7.9% of women who were ever pregnant report having had an abortion on request (SOK, September 2011).

**Activity 3. No of joint programmes and activities planned and conducted:** Per data in Annual Report the numbers reported are too low have any measureable impact. (This is the same issue as the indicator of Activity 1 above).

**Activity 4. No of counseling sessions for high risk groups (sex workers). Not applicable.** As explained above, UNFPA determined that this proposed activity was not feasible and it was not implemented.

**Activity 5. Contraceptives distributed:** During the period from 2007 through mid 2011, the UNFPA supported social marketing program sold a total of 3,193,000 condoms and gave away 106,000 condoms, the equivalent of an average of 740,000 condoms sold and given away each year. Data for other methods distributed were not available\(^\text{14}\). During the period between 2007 and 2010, UNFPA used JP funds to purchase just 20,000 pregnancy tests and 10,000 injectable contraceptives with an equivalent number of non-reusable syringes. During the same period, using UNFPA core funds as well as funds from the German Government, UNFPA purchased 3.5 million condoms for social marketing, and provided the MOH with 2.5 million condoms, 70,000 pregnancy tests, 30,000 emergency contraceptives, 100,000 cycles of oral contraceptives, and 15,000 injectable contraceptives with an equivalent number of non-reusable syringes.

**Activity 6. Contraceptive prevalence rate.** As shown in Table 3 below, assuming that the KDHS for 2003 and 2009 used comparable data collection methods, contraceptive prevalence has only increased slightly in the interval between 2003 and 2009, from 54.9% to 58.%. Most importantly, the profile of methods in use has lower efficacy, with an increase in withdrawal and a decline in modern method use, especially the IUD and the Pill.

<table>
<thead>
<tr>
<th>Method</th>
<th>1999</th>
<th>2003</th>
<th>2009*</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td>7.5%</td>
<td>11.5%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Pill</td>
<td>4.6%</td>
<td>4.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Condom</td>
<td>1.8%</td>
<td>4.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>0.1%</td>
<td>1.1%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Vaginal Methods</td>
<td>0.3%</td>
<td>0.8%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Traditional</td>
<td>17.4%</td>
<td>32.3%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Total</td>
<td>32.2%</td>
<td>54.9%</td>
<td>58.8%</td>
</tr>
</tbody>
</table>

*Ignores 0.3% use of injectable.

\(^{14}\) The LMIS used by MoH has changed in 2010 and when MoH was asked to give data on contraceptive distribution, UNFPA was told that data can not be retrieved from the old system. The pharmaceutical department was contacted several times to seek possibilities to get this data from hard copy reports (if they exist). UNFPA is not currently in a position to monitor distribution of contraceptives and avoid stock outs in all public health facilities. Contraceptives are part of the essential drug list, and are distributed with other drugs based on the request from the health institutions (pull system).
Outcome 3  Reduced vulnerability from reproductive health risk factors.

Output 2 Reduction in smoking and other psychoactive substances rate among pregnant women:

Overall Findings: While there is no evidence of any reduction in the rate of smoking among pregnant women, and while it comes late in the JP project cycle, this output has achieved a definitive baseline on smoking among pregnant ANC clients that should be extremely useful in developing anti-smoking strategies. It also provides useful data on a number of related issues such as gender based violence and the impact of caregiver counseling on success rates in stopping smoking. Data from the evaluation of the BPI suggests, given a commitment to use sustained TV campaign, there is potential for social mobilization to reduce smoking during pregnancy. A key issue is that, by focusing exclusively on FM Doctors and Nurses, the JP relegates the intervention to just 7% of the at risk population of ACC clients, of whom perhaps half (56.4% of 7%= 3.5%) actually receive anti-smoking counseling (based on data from the JP supported smoking study). For social mobilization activity, assuming adequate resources, it is clearly desirable to follow UNICEF’s model to work at a scale with TV media that can have impact. The reality is that, despite the high cost, TV is the main channel of information dissemination and must be used effectively. For example, a 2005 UNICEF study found that 74.8% of ANC couples said they would recommend TV as the best place to distribute information. While costly, or alternatively requiring extensive negotiations to obtain free of charge airing, TV appears to be one of the best options for impact for BCC.

Activity 1. Conduct baseline survey about prevalence of smoking and other psychoactive substances among pregnant women (WHO 15,000 Euros allocated. Fully expended). Work began on this survey in Sept 2009. The delay in fielding this study is understandable, but unfortunate as it undercut the potential for follow-up on the findings during the JP. The delay also rules out measuring change over time during the course of the JP. Nonetheless, this study is an excellent resource with extremely useful findings that should permit effected smoking cessation programs. The main result was to confirm that smoking during pregnancy is a serious problem in Kosovo: 20.9% of respondents smoked during pregnancy; 56.6% had received smoking counseling and there was significant, albeit bi-variate, evidence that caregiver counseling reduces smoking, for both active and passive smoking. The study collected additional information on key related ANC indicators, including

- Only 7% of the ANC clients interviewed were served in Primary Health sector, the rest in private sector.
- Patient Satisfaction was high on four indicators (waiting time, time with caregiver, advice received, respect showed) at above 80%.
- Almost two thirds were counseled on breastfeeding and 98.5% were planning on breastfeeding.
- Over half (55.4%) had a pregnancy booklet (55.4%), and 71% percent said they had been given child booklet for their previous child.
- Over 1/4th, 27.8%, said that they made a pre-pregnancy visit.

Activity 2. Conduct awareness- raising media campaigns about ill-effects of smoking and other psychoactive substances during pregnancy (WHO 15,000 Euros allocated. 55% expended). The evaluation team was not able to locate specific materials related to this activity, but it was clear that this issue has been addressed in a variety of JP supported activities, including the work of PEN, the Kosovo Red Cross and the BPI.
Activity 3. Conduct counseling for pregnant women at health centres (WHO 15,000 Euros allocated. 41% expended). Pregnancy and safe delivery are addressed by the better parenting initiative in materials that are distributed through health facilities and other channels. As noted above, unfortunately, the reliance on Family Medical Doctors and Nurses dramatically restricts access to ANC clients. As explained above, based on the recent findings of the WHO ANC smoking study, only 3.5% of ANC clients actually receive anti-smoking counseling from Family Medical staff in MOH facilities.

Output 2 had four Indicators for three activities (4)

Activity 1. Survey planned, conducted and results analyzed. Yes.
Activity 2. Campaigns against smoking and other substances media support therefore. The evaluation team was not above to quantify this. It was noted that various programs such as PEN, Red Cross, and BPI address this issue.
Activity 3. Number of pregnant women counseled. No data were located for this indicator. Per the discussion above, the number if likely to be quite small. Using a PHC approach, with only 7% of ANC clients seen within MOH HP sector, of which say 56.6% get anti-smoking counseling, would mean that only 3.5% of eligible clients are being served by FM Doctors and Nurses implementing antisomoking counseling.
Activity 4. Number of women expressing satisfaction with counseling services. The evaluation team was not able to find data on this specific indicator. Based on other findings, the percentage satisfied with counseling services is probably quite high. There were measures of Patient Satisfaction in the Tobacco ANC study on four indicators (waiting time, time with caregiver, advice received, respect showed) and all were above 80%. Again, per the above indicator for Activity 3, the actual number counseled by FM Doctors and Nurses is likely to be very small.

Outcome 3 Reduced vulnerability from reproductive health risk factors.

Output 3 Reduction in rate of RTI/STI and prevalence of HIV/AIDS

Overall Findings: The evaluation did not find any evidence that this output has achieved its target. Due to limited reporting on these types of infections, there are no available measures for the rates and prevalence of RTI/STI that can be assessed over the time of the evaluation. Kosovo’s HIV/AIDS prevalence is estimated at <1 percent among those at higher risk of exposure and the requirements for a sample size sufficient to detect a reduction in such a low HIV prevalence would be entirely beyond the resources available in the JP (Qosaj and Berisha, 2010). While some of the individual activities had merit, none appear to have been sufficient in scope to achieve a significant impact toward this output. Assuming adequate baseline data were collected, a strategic coordination among the diverse activities toward a more narrow focus on certain attitudes and practices might have made a measurable difference. While a great deal of concerted effort was made for a national IEC campaign, there were few if any clearly defined objectives for knowledge, attitudes and behaviors, no baseline, and no follow-up survey to assess impact. If focused more narrowly on one activity or specific RTI/STI in one area, with a pre- and post- survey some impact might have been made in knowledge and attitudes, and perhaps behavior. Alternatively, the entire focus of this output could have been on improving reporting of STIs and this might have made a significant difference.

Activity 1. Plan and conduct a Kosovo-Wide IEC on Family Planning and BCC on STI/HIV/AIDS prevention (UNFPA $29,154 allocated, 53% expended). Very extensive IEC activities were implemented using multiple media, but the evaluation team found no evidence of strategic coordination and/or any well thought out objectives with any theory-based model for combining two what are very different areas of behavior, FP and STI prevention. Ideally the campaign should have used a more narrow focus, just on FP or just on STIs, and collaborated with
UNICEF to ensure adequate monitoring and evaluation. Multiple agencies hired to do diverse activities with inadequate overall monitoring of knowledge, attitudes and behaviours.

**Activity 2. Support updating of different protocols on RTI/STI/HIV and conduct training programmes for health workers on the same** (WHO 30,000 Euros allocated. Fully expended; UNFPA $10,000 allocated, 10% expended). Per the 2008 Annual Progress Report and Friends of Health, Final narrative report on Training for Physicians for surveillance, reporting, health education tools, management and prevention measures of RTI/STI, Prishtina, Kosovo, November 2008, WHO supported 7 one-day trainings at seven regional public health institutes devoted to efforts to improve RTI/STI surveillance reporting and prevention. A total of 166 participants (FM Doctors, Ob/Gyns, public health nurses, infectious disease specialists, urologists and dermatologists and others) with an “ad hoc” agenda to conduct in-depth discussions of the poor level of STI reporting. Based on the available documentation, this training was not likely to have had much impact. There was no evidence of follow-up. In addition to this training, WHO supported multiple activities: translation of guidelines, “Sexually Transmitted Infections and other Infections of Reproductive Tract,” translated in Albanian, The First International Symposium on STI (including HIV/AIDS) epidemiologic situation in Kosovo, 5&6 June 2008, Pristina, the development of the Kosovo AIDS Strategy 2009-2013, supporting the participation in the “Fourth Annual Conference on HIV Treatment Adherence” in Miami Fl, USA from 05-07 April 2009” and technical support to Ministry of Health to finish report on HIV/AIDS and TB Global Fund Project – 3 – 30 march 2011, Pristina. In 2011, UNFPA supported CDFM (through KHF) to develop an STI training curriculum, which will be used for the trainings of FM Doctors and nurses as a part of their CPD. The curriculum is in a process of revision and a ToT, facilitated by international consultant, will be organized in autumn 2011.

**Activity 3. Enhance knowledge and awareness about RTI/STI through social mobilization activities** (UNFPA $14,400 allocated. 28% expended). Per the three Annual Progress Reports for 2008, 2009, 2010, there is only brief reference to community based education sessions held by Red Cross Kosovo and minority community NGOs. For example, in 2008, there were 2,661 participants, mainly females who attended courses on prevention of STIs. Apart from standard pre- and post-training survey results, no evidence was provided to support any claim to impact.

**Activity 4. Support conduct of campaign/activities on the occasion of World AIDS Day (WAD).** (WHO 15,000 Euros allocated. Fully expended). Per annual reports for 2007, 2008, 2009 and 2010, there have been a variety of WAD activities which vary in intensity, are somewhat anecdotal and inconsistent in their approach. The 2007 WAD was supported by WHO, which funded the design and publishing of AIDS Day promotion spots on three local TV stations, leaflets and posters in local languages. The 2008 program was focused more narrowly, just in Gjilan. This may have enhanced its utility be being focused on just one city. While the WAD activities were diverse and imaginative, using multiple youth and theater agencies to produce plays and youth focused street events, there is very little basis for expecting any impact from these events on the output target (and there was no attempt to evaluate the impact of these activities). These types of activities are typically supported by like-minded agencies on a pro-bono basis. These activities were included in the activity planning for the JP from the beginning, but it was not clear to the evaluation team why these types of one-day annual campaign activities should have been funded through the JP.

**Outcome 3 had six Indicators for four activities (6)**

Activity 1. Campaign planned and conducted. Yes.
Activity 5. IEC material printed and disseminated. Considerable quantities were produced. See footnote below.15

Activity 6. Campaigns/activities planned and conducted. Major IEC campaigns carried out for three consecutive years with multiple activities, especially 2008 and 2009.

Output 4 Increased knowledge and improved skills of health workers on RH issues

Overall Findings: This output has been highly successful implementing multiple capacity building activities to train key staff on important priority areas. This output demonstrates how the JP was responsive to negative trends in maternal mortality in 2008 and 2009. In addition to developing a robust sequence of training events that should reduce the risk of maternal deaths, the WHO implemented training activities to reinforce promising interventions that have shown progress in reduction of perinatal mortality in Kosovo. This output demonstrates the important benefits of multi-UN Agency collaboration in implementing a MCH and RH project in collaboration with the MOH. While the UNFPA has successfully updated and rolled out a new family planning curriculum, there is a dilemma in investing heavily in FP training almost exclusively for FM Doctors and FM Nurses, who are not the only caregivers for FP services; there may be significant potential for FP service delivery in the private sector.

Activity 1. Establish clinical training team on Safe Motherhood (WHO 15,000 Euros allocated. 95% expended). Recognizing that there had been insufficient supervision or follow-up visits following courses in Kosovo on Promoting Effective Perinatal Care, Emergency Obstetric Care (EOC) and Essential Newborn Care and Breast Feeding between 2001 and 2004, in 20010 WHO supported an intensive training on “Effective Perinatal Care(EPC) ” using a newly updated WHO Euro/JSE/USAID training package. The training objectives were: train perinatal caregivers (Ob, neonatologists, midwives and nurses) based on WHO Europe standards and elaborate plans of actions for OB/Gyns, Midwives, and Anesthesiologists. There were 31 participants (10 Ob/Gyns, 6 neonatologists, 8 midwives, 6 neonatal nurses, 1 anesthesiologist). The two-week program was both theoretical and hand-on and generated a large number of extremely pertinent and urgent recommendations for improvement of Midwifery and obstetric care and Neonatal Care EPC. Some of the staff trained in this session were selected to be assessors for the assessment of EPC and MCH care at regional Kosovo hospitals.

Based in part on the above activities, a second intervention, an assessment of safety and quality of hospital care for mothers and newborn babies, was supported by UNFPA and WHO from 7 to 18 March 201116. This assessment employed both international and national assessors, trained in the use of a locally adapted assessment tool, to assess four hospitals. The results were extremely compelling: for 8 out of 13 criteria, one or more hospitals were found to, “need substantial improvement (in order) to reach standard care without significant health hazards.” There are plans to repeat the assessments at

2008: Popular Biweekly women’s magazine. Kosovarja- 26 articles, 10,000 copies for every issue. Articles on RH 87,000 brochures on FP distributed to 22 MFHCs, 4 Regional Hospitals and UCCK.
2009: Popular Biweekly women’s mag. Kosovarja 19 articles, 10,000 copies for every issues. Articles on RH STI, condom, EC. Estimated 580,000 copies or 580,000 families w access (NB: contradicts 2008 report of 10,000 copies per issue=190,000). Ad for Love-Plus in daily newspaper, “Kohaditore” 100 times from 15 Sept to 31 Dec 2009. Total of 250,000 brochures on FP, info posters on contraceptive availability, pregnancy calculators, and STI brochures distributed to 22 MFHCs, 4 Regional Hospitals and UCCK by IPH, CDFM, and UNFPA.
each hospital following training interventions as well as plans for additional hospital assessments. During evaluation interviews, this process was greeted supportively, as a basis to learn what works and does not. One clinician expressed satisfaction that the assessments were constructive and not entirely critical. For example, her hospital had been documented to be in compliance with current evidenced based practice, for example in not using general anesthesia for C-sections. A key concern based on interviews was impatience on the part of hospital staff for follow-up training based on the audits. Based on these findings there is an urgent need for follow up and expansion of the audit process. The audits offer hope for an ongoing sustainable method for improving quality of care that has potential to significantly reduce both MM and PM. **It is extremely important to act quickly and comprehensively in response to the findings of these audits; until concerted follow-up action is taken, there are significant health hazards to women giving birth in these hospitals.**

**Activity 2. Build a core group of specialists trained in Safe Motherhood Initiative (SMI) (WHO 30,000 Euros allocated. Fully expended).** This activity is essentially the same as Activity 1. In addition to the important capacity building activities mentioned above, WHO has supported a range of pertinent activities. This includes support and KOGA clinical protocols and ALARM course, printing of the Obstetric and Neonatology Guidelines prepared by KOGA experts and approved by Ministry of Health and Translation of “Alarm International Program - AIP” into Albanian.

**Activity 3. Support conduct of RH skills improvement training/workshops for health workers.** (WHO 30,000 Euros allocated. 95% expended, UNFPA 60,000, 40% expended). This activity is essentially the same as Activity 1. In addition to the important capacity building activities mentioned above, WHO has supported a range of pertinent activities. This includes support and KOGA clinical protocols and ALARM course, printing of the Obstetric and Neonatology Guidelines prepared by KOGA experts and approved by Ministry of Health and Translation of “Alarm International Program - AIP” into Albanian. The JP also supported training for nurses; 214 nurses were trained to support family doctors to manage common childhood illnesses and counsel families on better child care, development and safe motherhood as part of continuing nursing education in 2008 and 186 nurses in 2010.

**Activity 4. Train service providers on modern Family Planning** (UNFPA allocated $216,619\(^{17}\), 95% expended). UNFPA has facilitated a well-grounded and systematic update of the national FP training curriculum. In 2008 and 2009 KHF trained over 1,100 Family Medicine Doctors and Nurses in FP using a somewhat out-of-date 1997 John Snow Inc. curriculum that was initially used in Albania. Based on a Technical assessment on FP training needs in 2009, UNFPA, in collaboration with MOH, KHF, and CDFM supported a complete update of the FP training curriculum based on materials from the WHO (UNFPA has translated the four key WHO “pillar” FP resource documents into Albanian). A four-day workshop consolidated the update of the curriculum. Subsequently a three day training of 20 master FP trainers in the use of this updated curriculum was carried out in October 2010. The training was then rolled out throughout the regions (in collaboration with the CDFM). The emphasis is on training FM working within PHC in collaboration with the CDFM. Per the 2010 Annual report, the role of the CDFM trainers “gave the trainers responsibility for quality of work and ownership.” Based on evaluation follow-up interviews, there was strong enthusiasm for the updated FP course. One FM Doctor described being much more confident in providing FP services. Previously he referred clients to the local Ob/Gyns, now he felt confident in his skills to provide the services himself. The overall impression in reviewing reports is that the process was very thorough and

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\(^{17}\) This amount of $217,000 is the largest single line item in the UNFPA budget for the JP, followed by $117,000 in support for strengthening distribution of contraceptives through social marketing.
efficient, with a strong sense of urgency to implement the update quickly; it was very thorough with a strong emphasis on monitoring and follow up. The main problem for quality assurance is the lack of infrastructure to ensure the follow-up actually happens.

As mentioned above in the discussion of Output 3, in 2010 UNFPA sponsored an in-depth assessment of Kosovo’s contraceptive LMIS system, which made several compelling recommendations. Recent events have overtaken some of the study’s findings with the launching of a new electronic inventory system for all MOH essential drugs. This may obviate the need for a special focus on contraceptive LMIS. Currently a parallel system is in place with KHF preparing a six month meeting of regional FP staff to compile a status report on contraceptive use and stock outs. Per 2010 report, “Due to the lack of data from the HMIS, UNFPA through KHF is collecting information regarding FP services, contraceptive use, contraceptive distribution, and their availability (stock outs) in the FMC and the regional hospitals.” The results from the KHF 6 month assessment can and should be compared with the new electronic system. The Director of MOH Department of Pharmaceuticals, Dr. Bekim Fusha, has agreed to provide data for FP commodities from the new electronic MIS for comparison.

Restriction on access to EC: A key finding of the LMIS study was the restriction on access to EC. According to Dr. Koo’s 2009 LMIS assessment,” EC for the moment is available only on medical prescription signed by a doctor. This raises an important accessibility issue for women living in remote rural areas where health services are provided at Ambulantas that have a doctor present only two or three days per week. This issue was raised with MOH as well as CDFM. There was some willingness to revisit this, if UNFPA provide a document presenting accessibility to ECs in other European countries

Outcome 4  Four Indicators for four activities (4)
Activity 1. Clinical team established. A team of local national auditors was established.
Activity 2. No of trainings conducted. 2 WHO trainings.
Activity 3. No of health workers trained. 31
Activity 4. No of service providers trained in modern FP methods. Over 845 have been trained using the two FP curricula. According to KHF, a total of 614 doctors and nurses were trained using the older FP curriculum in 2008 and 2009. Subsequently, following an initial 3-day TOT with 20 participants, a total of 227 doctors and nurses have been trained using the new FP curriculum, more will be trained this year. A total of 181 doctors have been trained using the new FP curriculum. Assuming that these trainings focused only on the 465 FM doctors and FM residents working throughout the MOH, this is the equivalent of 39% of this cadre, a significant portion.

Outcome 4 Changed and improved practices of community in the area of reproductive and child health.

Output 1 Increased access and utilization of quality RH and child health and development services.

Overall Results: This output has demonstrated impressive results despite the fact that only two of the four proposed activities, 2 and 3, were implemented at a scale sufficient to increase access and use of quality RH and Child Health Development services. Of these two activities, the Better Parenting

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18 Dr. Koo’s report recommended that, “A document presenting the accessibility of ECs in European countries should be prepared and handed over to the MOH and DCFM as a basis for continue discussion about liberalizing access to ECs.” It appears that UNFPA followed-up on this with discussions among doctors and nurses at the Family Medical Association, but there was ultimately no decision to remove medical barriers for EC. This law needs to be changed as soon as possible.
Initiative (BPI) stands out for having been convincingly evaluated with a representative sample of ANC couples. The evaluation results demonstrate that the BPI has achieved significant coverage among Kosovo’s ANC clients, with respondents claiming that BPI materials have influenced their behaviors related to MCH issues. One key caveat is that the BPI was a well-developed ongoing project that was already established before the JP and had already been demonstrated to be effective in reaching ANC clients based on a prior representative assessment survey. BPI has been supported with other sources of donor support and there is a chance it would have continued without support from the JP. Other programs, such as the UNICEF-supported Kosovo Red Cross Family Education Program and UNFPA supported projects for members of minority communities have great plausibility for having impact, but as yet have not been demonstrated to have any impact based on any rigorous evaluation.

Activity 1. Conduct KAPB survey on RH, child health and development (WHO 30,000 euros allocated. 0% expended). This activity was not implemented because UNICEF had completed the Antenatal Care survey and the Evaluation of the Better Parenting Initiative, which overlapped a great deal with this proposed study. The funds were reprogrammed for other activities. This is an example of good coordination among implementing agencies.

Activity 2. Conduct social mobilization campaigns on reproductive health, child health and development, especially for RAE Community (UNICEF 20,000 euros allocated. 62,600 euros expended (313% above planned budget); UNFPA $42,400, 93% expended). This activity has reached a significant portion of the respective target populations, especially the BPI, which has been definitively assessed. The success of UNICEF’s social mobilization is a combination of ongoing experience and working at a sufficient scale to get sufficient major media coverage and material distributed to actually reach a significant portion of ANC clients. One important concern is that the results from the BPI evaluation indicate that, while respondents report that their behavior is influenced by BPI materials and programs, there are no prospective data to confirm this. Also, a key caveat is that the BPI was a well-developed ongoing project that was already established before the JP was launched and had already been demonstrated to be effective in reaching ANC clients based on a prior representative assessment. The BPI is supported with other sources of donor support. Hence, there is a chance it would have continued without support from the JP. While data support impact at the level of knowledge and attitudes, there are no data to support behavioral impact. Despite commendable efforts on the part of UNFPA supported projects oriented toward minority communities, such as Health For All, at the time of this evaluation there were no rigorous data supporting the claim of any significant impact.

Activity 3. Conduct training of nurses, volunteers and community members for counseling on better parenting and maternal health (UNICEF 30,000 euros allocated. 44% expended). This activity refers to the Kosovo Red Cross Family Health Education Program, which has 127 trained volunteers from 26 Red Cross branches conducting trainings in health facilities, schools and homes. Four thousand (4,000) participants in these trainings are estimated by the Kosova Red Cross to reach 25,000 persons indirectly. A key caveat, as with the BPI, is that this is a very well-developed ongoing project that was already established well before the JP and had already been demonstrated to be effective in reaching a large number clients based on a prior representative assessment. It is also supported with other sources of donor support. Hence there is a chance that it would have continued without support from the JP.

19 As explained above, the funds from procurement of iron and folic acid are allocated and utilized for social mobilization campaign. The reprogramming of the budget line from iron and folic acid was presented to the steering committee.
without support from the JP. In addition, in 2008, 214 nurses were trained to support family doctors and to manage common childhood illnesses and to counsel families on better child care, development and safe motherhood as part of continuing nursing education. In 2010, an estimated 186 nurses were trained on skills and knowledge on the management of the most common childhood illnesses, on advising parents for better child care, development, safe motherhood and infant and young child feeding. Hence, there is a chance it would have continued without support from the JP. Unlike the BPI, however, this project has never been evaluated to see if it has any impact on behaviors up until very recently. Unfortunately the data for the study were not yet available for this evaluation.

**Activity 4. Provide post-partum/post abortion family planning services at health facilities.**
(UNFPA financial data not available). Only training was provided with no follow-up to ensure the establishment of FP services. According to the original project proposal\(^{20}\), this project activity was developed with very high expectations. By the end of the project a minimum of 25,000 women who give birth at a hospital or had an abortion were to receive education and information on FP and/or a package of brochures on different methods of contraception. This was to be achieved by training midwives on counseling skills and contraceptive technology. The training was to be organized in the regional hospitals. Master trainers trained in a previous project were to facilitate the training of 100 midwives in seven regions all over Kosova. “Educated midwives on counseling skills and contraceptive technology will provide information’s to women regarding modern FP methods during they stay in hospital after delivery or after abortion or before discharge from hospital. In the same time each women who delivers or had an abortion in the public health facilities will receive a package of IEC material on modern FP methods. Unfortunately, per 2008 Annual Progress Report, See page 12 the project did not succeed beyond training 67 midwives of the Univ. Gyn/Ob Clinic, who attended a 3-day course on counseling skills for FP for post-partum and for those who had an abortion. The evaluation team contacted KHF to see if there was any follow-up to assess the number of PP and PA FP clients served as a result of this program only to be informed, “Regarding this activity relevant institutions did not report about midwives work following training”. This is a conspicuous example of the overall approach to training, which is to assume the implementing agencies work is completed when the training is over. In fact, the work begins when the training is over to ensure that there are new activities on the basis of the training.

**Outcome 4 Four Indicators for four activities (4)**

Activity 1. KAPB Survey conducted and results published. No KAPB Survey was done by WHO. Instead, an alternate survey was carried out by UNICEF.

Activity 2. No of campaigns conducted and activities undertaken. Very Substantial. In addition to the major BPI national media campaign, over three years there were 550 sessions by Kosovo Red Cross and UNFPA with over 14,500 participants.

Activity 3. IEC material printed and disseminated. Very substantial: Over three years from 2008 through 2010, 45,000 BPI leaflets and 30,000 pregnancy and child booklets.

Activity 4. Number of people trained: 67 midwives of the Univ. Gyn/Ob Clinic attended a 3 day course on counseling skills for FP for post-partum and for those who had an abortion.

Activity 5. Number of post-partum and post-abortion FP services. There were no data to show any increase in these service due to these activities.

**Outcome 5 Reduction and prevention of child morbidity and mortality from major preventable diseases**

\(^{20}\)See: Kosova Health Foundation UNFPA 30-Month PROJECT PROPOSAL Improving Women and Children’s health in Kosovo Submitted December 10, 2007.
Output: 1. 95% of children fully immunized with major EPI Antigens

Comments on Output: Despite clear improvement on all four indicators for BCG, DPT3, OPV3 and MMR, the percentage of children fully immunized has not reached 95%. In 2004, fully immunized children were defined as having three doses of DPT and OPV, and one dose of BCG during the first 12 months of age. In 2010, fully vaccinated children are defined as having three doses of DPT, OPV, hepatitis B and one dose of BCG. Based on the lot quality technique (for card and history as reported by parents), the proportion fully immunized increased from 78% in 2004 to 83 percent in 2010. HepB3 is currently estimated at 99% coverage. The biggest challenge remains to increase MMR coverage from 78 to 95%. There is concern that immunization coverage of Roma, Ashkalia and Egyptian children may be lower than the national average, due to many issues, such as displacement, and lack of records.

Activity 1. Support and strengthen quality delivery of immunization plus services (UNICEF 30,000 Euros allocated, 60% expended. WHO 15,000 Euros allocated, 24% expended). UNICEF has supported Kosovo EPI program continuously. The MOH has purchased EPI antigens through UNICEF since 2003. UNICEF has supported the implementation of the cold chain, hygienic disposal of used materials and other programs to improve performance of the EPI vaccination teams. The National Institute of Public Health was supported with provision of cold chain equipment strengthening the cold chain and ensuring delivery of quality immunization services.

Activity 2. Increase immunization coverage by strengthening immunization services for most vulnerable groups (UNICEF, 20,000 euros allocated, 69% expended. WHO 10,000 euros allocated, no funds expended). Per the 2007 Annual report, UNICEF advocated within the Institute of Health Protection in Mitrovica/North aiming to strengthen immunization services for Serian and Roma/Ashkalia and Egyptian communities. Per the 2008 report, UNICEF plans to work with the Regional Health Institutes in 2009 to reach and vaccinate children of underserved RAE communities. In 2009 UNICEF assisted the NIPF in vaccine supply forecasting and trained 120 health workers on EPI skills, including introduction of Haemophilus Influenza Vaccine. In collaboration with FMCs, EPI field teams identified an estimated 1,100 partially or not vaccinated children of RAE communities and registered them to be immunized during regular services. In 2010 UNICEF supported the NIPH in the implementation of “the evaluation of the quality of immunization services using lot quality technique (LQT). The result show an overall improvement in all four immunization coverage rates between 2004 and 2010.

There were two indicators for this output:

| Indicators: Card | Card & History
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<tr>
<td>Activity 1 and 2: BCG Coverage</td>
<td>85</td>
</tr>
<tr>
<td>Activity 1 and 2: DPT3 Coverage</td>
<td>81</td>
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<tr>
<td>Activity 1 and 2: OPV3 Coverage</td>
<td>82</td>
</tr>
<tr>
<td>Activity 1 and 2: MMR Coverage</td>
<td>66</td>
</tr>
<tr>
<td>Fully vaccinated</td>
<td>82</td>
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</table>

Activity 2: Immunization coverage of children of vulnerable groups. As of 2010, an estimated 81.4% of RAE children Kosovo-wide were fully vaccinated. This approaches the proportion fully vaccinated for the entire population of Kosovo. Anecdotally, immunization coverage for RAE children is considered lower. Therefore, UNICEF is planning to continue to support the NIPH to implement additional supplementary immunization activities for RAE and other poorest groups.

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21This estimate is based on 2010 data for over 5,000 minority children in 16 areas of Kosovo. Of 5,042 children, 4,106 were reported to be fully immunized (81.4%). This result should be interpreted with caution.
Outcome 5. Reduction and prevention of child morbidity and mortality from major preventable diseases

Output: 2 Reduced Child morbidity and mortality rates from ARI and Diarrhea

Overall result for this output: While there was no available evidence that this output has reduced child morbidity and mortality rates from ARI and Diarrhea, all four of the activities for this output have been implemented forcefully and effectively. It is plausible that they will have a favourable impact on the prevention and treatment of these two important childhood diseases.

Activity 1. Support training of health workers on breastfeeding management (UNICEF 20,000 euros allocated, 67% expended). This activity has been consistently implemented in a highly coordinated fashion, reinforcing the baby friendly campaign and promoting the breast feeding law. In order to become a baby friendly institution, hospitals are required to train health workers on breastfeeding management. Trainings were focusing mostly health workers in maternities. From 2008, trainings focused on Infant and Young Child Feeding in primary health care. Follow-up after the training on IYCF are planned for 2012. Based on site visits, there was clear health care provider enthusiasm for the training. Despite the fact that most training follow-up interviews did not report receiving any follow-up, it is heartening to see a very clear commitment and compelling protocol in place for systematic follow-up visits for the training for the Infant and Young Child Feeding Counseling. This constitutes a best practice and appears to be extremely well integrated with a wide range of MOH and UN partner agencies.

Activity 2. Conduct training for health workers on adequate management of childhood illness (UNICEF 21,000 euros allocated, 154% expended. WHO 45,000 euros allocated, 89% expended). WHO and UNICEF Kosovo have done extensive work collaboratively for over ten years to develop and improve the IMCI strategy. Under the JP program WHO has implemented a wide range of pertinent trainings, assessments, translation of key guidelines and documents and supported participation in international training and conferences for capacity building. Most importantly, the JP has been used effectively by WHO to reassess the IMCI program and, based in large part on the extremely serious problems found in the March 2009 Report on follow-up visits of Integrated Management for Childhood Illnesses (IMCI), has generated a commitment for a major effort to revitalize the program. As with the important recent WHO supported work by Jeckaite et al. to assess the safety and quality of hospital care for mother and newborns, the problems have been identified, but the solutions will require long-term systemic approaches that need support. This constitutes a best practice and reflects resourcefulness on the part of WHO to use the JP to respond to emerging issues.

Activity 3. Support adoption and implementation of orientation program on child adolescent health for health professionals. WHO 20,000 euros allocated, 77% expended. WHO has supported a variety of capacity building activities for child adolescent health; including training in adolescent medicine and a November 2010 TOT course for an Orientation Programme on Adolescent Health for Health Care Providers. Twenty three participants were certified to help in the fall of 2011 to support two pilot centers for development of Youth Friendly Health Services. This is positive progress despite difficult interactions with some health institutions that have not supported the piloting of Youth Friendly Services.

Activity 4. Support translation, adoption, printing and dissemination of professional literature on child health (WHO 25,000 euros allocated, 108% expended). WHO has used the JP resources effectively to generate a wide range of useful profession resource documents in Albanian, ranging from a CD version of the Pocket Book on Hospital care for Children, training videos for new WHO Child Grown Standards and the WHO-UNICEF “Infant and young child feeding counseling.”
Five Indicators for four activities:

**Activity 1. Exclusive breastfeeding rate.** Only one estimate was available, so it was not feasible to assess progress. According to UNICEF, based on an assessment of maternities, early initiation of breastfeeding has been estimated at 95% (Reference citation not available).

**Activity 1. Infant and under 5 mortality rate.** There is evidence from the 2009 KDHS of a decline between the five-year periods of 2000-2004 and 2005-2009, which slightly proceeds the time of this project. The evaluation was not able to obtain precise estimates that would plausibly document a reduction in the infant and under 5 mortality rates as a result from this intervention over the time period from 2007 to 2011.

From Table 5.4 KDHS SOK September 2011 page 58.

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<tr>
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<th>IMR</th>
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<tr>
<td>2000-2004:</td>
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<tr>
<td>2005-2009:</td>
<td>9.5</td>
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**Activity 2. Number of health care workers trained.** 3 trainings, 106 trained.

**Activity 3. Development and adoption of Child and Adolescent Health Strategy.** It was finalized in July 2011 and it is expected that it will be approved and signed by Minister of Health, Fall of 2011.

**Activity 4. Material on child health printed, translated and disseminated.** Numerous items in Albanian: CD version of the Pocket Book on Hospital care for Children, training videos for new WHO Child Grown Standards and the WHO-UNICEF “Infant and young child feeding counseling.”

**Outcome 5. Reduction and prevention of child morbidity and mortality from major preventable diseases.**

**Output 3: Micronutrient deficiencies among children reduced by 50%.**

**Achievement of output 3:** While it is clear that UNICEF has succeeded in some activities to provide professional and technical support for formulation and measures for reducing micronutrient deficiencies among women and children, on the basis of the anemia rate among children <5 the target for output 3 has not have been achieved. According to a 2002 UNICEF nutrition survey report, in 2001 among Kosovo children <5 the rate of mild and moderate anemia was 18.2 (14.4-22.0). Based on the finding from the 2010 report for the 2009 UNICEF, NIPH Nutritional Survey of Pregnant Women and School Children in Kosovo, the anemia prevalence in all the children of Kosovo was about the same at 15.7%, indicating a mild public health problem of anemia among school children. The underlying cause is iron deficiency. Given that current JP supported interventions have not had much time to work, future studies may reveal a reduction. Based on the 2010 UNICEF report Kosovo has now overcome iodine deficiency, the current practice of iodized salt in Kosovo is ensuring adequate iodine nutrition status not only in school aged children but also among pregnant women who are the most vulnerable group. Kosovo meets WHO and UNICEF standards for iodine. This was the first time measurements were made of pregnant women and documenting this is a significant accomplishment.

**Activity 1. Provide professional and technical support for formulation and measures for reducing micronutrient deficiencies among children** (UNICEF 20,000 euros allocated, 146%
expended, WHO 20,000 euros allocated, 0% expended). This activity has been implemented at multiple levels, most importantly through UNICEF advocacy with key stakeholders (Min of Ag, Forestry and Rural Dev, PM advisor for Health, MOH, NIPH, Flour Miller Association, miller, media and others to support flour fortification with folic acid and iron) toward the passage of a new law on mandatory flour fortification. In addition, UNICEF hired a short term consultant to develop a work plan for flour fortification and UNICEF used JP funds to partially fund a key baseline nutritional study that has demonstrated Kosovo’s success in fortifying salt with iodine and provided strong evidence in support of the need for flour fortification. UNICEF supported trainings of health workers on Infant and Young Child Feeding and translation of a training package with the objective to contribute in reduction of micronutrient deficiencies.

**Indicators**

**Formulation of measures/policies by MOH for reducing micronutrient deficiencies.**

UNICEF has succeeded in advocacy for a law on flour fortification as well other nutritional policies. In 2009, UNICEF supported the working group to prepare the draft Law for Flour fortification. The Law was submitted by the working group to the Ministry of Agriculture for further procedures. The Law on Flour Fortification is currently in Draft Legislative Strategy for 2011; it is anticipated that the Law for Flour Fortification will be enacted later this year.

**Section 6: Good practices and learning elements**

The evaluation found several instances of JP supported program activities that stood out as best practices. The following examples were found to be especially noteworthy:

- The combined efforts of the three UN Agencies to provide capacity building support and appoint the MCRH Officer to the Mother and Child Health and Reproductive Health Office was an excellent example of sustainable capacity building for the MOH.
- The UNFPA supported revision of the Family Planning Training curriculum was an excellent example of adapting training needs to reflect current best practices in reproductive health.
- The WHO supported trainings for Effective Perinatal Care and the joint WHO and UNFPA auditing maternity hospitals stood out as a timely response to an acute need to improve quality of care toward reducing perinatal and maternal mortality.
- The WHO supported Stakeholder Conference demonstrated a remarkable transparency, openness and commitment to ensure that the JP was more responsive to the MCH and RH needs of Kosovo.
- The UNICEF supported training of health workers on breastfeeding management, especially in the context of successful certification of all maternities, appears to have had a favorable impact and has a very thoughtfully designed protocol for training follow-up.

Several other activities stood out for high quality, including:

- the UNICEF supported BPI social mobilization activity, a program that appears to be working at a scale sufficient to have an impact, and the Kosovo Red Cross Family Education Project, which has demonstrated a strong track record for extensive coverage,
- the UNFPA supported NGO, Health For All, working with minority community members, and

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22 UNICEF activities to reduce micronutrient deficiency are also supported with other funding sources.
• several of the data collection efforts, especially the UNFPA supported situation analysis on breast and cervical cancer, the UNICEF supported situation analysis on prevalence of micronutrient deficiency, and antenatal care, the WHO supported study on use of tobacco and other psychoactive substances among pregnant women.

Section 7. Conclusions based on seven evaluation criteria

Relevance: Overall, despite changes in the country context, the JP remains extremely relevant to Kosovo’s MCH and RH challenges. Given the recent favorable trends in MOH management, as well as the commitment of the Kosovo Government to work toward greater compatibility with European Union standards for health care, the JP is more relevant than before. There were highly relevant activities in virtually all outputs for the five outcomes. Some of the most relevant activities are those where the JP made a conscious effort to change course in response to a surge in reported maternal deaths. For example, concrete actions were taken to improve the quality of care for maternal and neonatal health, in particular the recent progress toward institutionalization of audits of maternity hospitals and the planned follow-up for these audits. One important threat to the relevance of the JP has been the intensive focus on the Family Medicine cadre of health care providers, which misses the opportunity to engage a large portion of the MCH clients who are served by the private sector health care system. While it is acknowledged that the MoH has placed a priority on the Family medicine, which is considered as cornerstone of the health sector reform, the JP should not ignore the fact that large portion of MCH clients are served by the private sector.

Effectiveness: Overall, despite the successful implementation of many of the proposed activities, the overall JP was of limited effectiveness in achieving its stated objectives for the 13 outputs. The overall objectives were achieved for only 4 of the 13 outputs. This does not mean that the JP was an ineffective project; the JP was highly successful in multiple areas and implemented 85% of the planned activities. It simply reflects that reality that the JP was too ambitious, the targets for many of the outputs were not realistic, and it should have focused more resources intensively on fewer outcomes and outputs.

Efficiency:

Administrative efficiency: There were initial delays in releasing funds and establishing a joint working agreement. There were also delays in implementing activities that reflect the fact that the UN agencies responsible for the project are understaffed and simply could not undertake the multiple activities simultaneously. This in turn resulted in the delay in time-sensitive baseline data collection, which seriously hindered the JP’s ability to design program strategies and measure impact. There was a tendency to contract multiple activities to a small core of implementing partners (UNICEF and UNFPA both contracted with KHF for diverse activities under single project proposals). This was administratively expedient, but may have reduced oversight and accountability.

Financial efficiency: Most of the activities appear to have been implemented within reasonable cost levels. The evaluation found evidence that the UN agencies made strong efforts to assure financial accountability on the part of local implementing agencies. The evaluation was not, however, able to assess the financial efficiency of many of the project activities because of the imprecision of the financial data provided. Despite the fact that the utilization of the budgets was monitored, changes of budget lines were reported to steering committee and financial reporting proceeded as per rules and regulations, the financial reporting in the Annual Progress Reports for JP were found to be quite
general and superficial. This is due in part to the agencies’s global centralized financial systems. Because of these systems, the three implementing UN agencies were not able to maintain a very precise record on their expenditures by activity and output. There should have been stronger financial oversight of the project on an annual basis to ensure that it was feasible to accurately track allocations of funding for specific outputs.

**Sustainability:** Many of the activities and outputs will not be continued when the JP funding ends. But there were several instances where the evaluation found an increased willingness for the Kosovo MOH to at least consider assuming greater financial and management responsibility for important components of JP supported activities. Examples of potentially sustainable activities include the proposed MOH funding for the office of MCH RH, the printing and dissemination of booklets for pregnant women and child health, possible MOH support for the Family Health Education Project, the Better Parenting Initiative (BPI), and the new development of a rapid electronic Pharmacy Logistics Management Information System (LMIS). More importantly, while financial sustainability is critical, the JP has made important contributions in the development and implementation of important health guidelines, policies and regulations that will continue, some for at least for the next five years, before they need to be updated.

**Long-term Impact:** JP activities have potential for long-term impact, especially with the expanded regulatory framework and strategic planning. This potential will only be achieved if there is sustained follow-up to ensure adherence to the protocols and guidelines.

**Gender:** Most of the JP activities were found to be neutral, but there were examples of activities that felt to be transformative, encouraging change toward greater equality for women. Examples include the inclusion of gender in WHO supported trainings, a focus on empowerment of women to insist on condom use as part of social mobilization activities, and the inclusion of gender based violence in the analysis of smoking and substance abuse. The evaluation found no instances of reinforcement of negative gender stereotyping.

**Joint Program Management:** The large majority of stakeholders interviewed agreed that there was an advantage to having three major UN Agencies combined into the administration of one program. The main advantages cited were coordination, avoiding duplication of effort, and the strategic application of each agencies comparative advantage as the need arose (for example WHO on normative issues, UNFPA on RH matters and UNICEF on national advocacy and social mobilization). A key opinion was the advantage of three UN agencies speaking with one voice on policy and program issues. This was often cited as an important asset when the MOH needed support on difficult policy decisions.

In some instances, such as overcoming MoH policy and management obstacles for the JP, the three UN agencies may have missed the opportunity to speak more forcefully on some issues. Specific examples include the issue of social marketing of EC and OCs, the issue of Youth Friendly Services, and the promotion of post-partum and post-abortion family planning.

For many implementing agencies, however, there was an opinion that multiple UN agency partnership implementation did not actually make any real difference. Given their day-to-day administrative management was in relation to just the one UN agency, the agency that holds their contract, the fact that two other agencies were part of the JP made no difference to them.

The three UN partners have very different levels of funding and staffing. As a result, at times they were not able to participate equally on all activities. UNICEF, having a much larger budget, is often
able to co-fund projects at a more fully scaled-up level, such as the BPI. Pooling funds in this way permits a more comprehensive approach. With a larger staff, for example having a full time M&E expert, UNICEF is more capable of following through on certain activities that are beyond the reach of the other partners, such as the implementation of adequate baseline and follow-up data collection. The UNFPA devoted a major share of one of its key staff members to the overall JP management. This was important, but it may have meant that other UNFPA priority activities were neglected during the course of the JP, such ensuring a continuous availability of contraceptive supplies through MOH system. Before the JP, UNFPA had funding from the German Government to monitor contraceptive supplies and ensure that stock outs were kept to a minimum. Currently UNFPA is unable help ensure the continuous availability of contraceptives in all public health facilities despite that fact that they are on the essential drug list and managed and distributed by MoH.

**Joint Programme Successes:** In summary, the JP was successful in the following areas:

- Most activities were completed for each of the specific outputs.
- Targets were achieved for four of the 13 outputs.
- There was clear evidence that the JP responded appropriately and effectively to changing circumstances and constraints.
- There is clear evidence of progress with MCH and RH Office, as well as a clear indication of support of (input on) policy development and implementation.
- On balance, there is very strong stakeholder support for overall joint project approach and multiple agency mechanism.
- There is clear evidence of comparative advantage with three implementing partners.
- A number of activities have potential to be sustained after implementation (especially the ones targeting human resources capacity development).

**Joint Programme Problems:** The JP experienced difficulties in the following areas:

- The proposal was too ambitious, some proposed outcomes and outputs not really achievable (by intervention itself); the JP was spread too thin over too many activities.
- Some social mobilization activities were not strategically focused, lacked well defined behavioral objectives and were not implemented at an adequate scale.
- Overly pragmatic contracting in clusters of activities to one agency reduces accountability. A future JP should give agencies larger projects with narrower focus.
- No monitoring and evaluation plan was developed. Many important baseline surveys were delayed until middle or end of project.
- Some UN Agencies were understaffed to implement multiple activities, hence delays in implementation.
- While the evaluation found that strong efforts had been made to be inclusive of the full range of stakeholders, nonetheless during some interviews concerns were raised over insufficient stakeholder consultation during initial project formulation. This may reflect the political turmoil that prevailed at the time the JP was developed.
- Bridging the gaps between a) the MOH versus the private sector; b) Family Medicine and Specialties.
- Key reservations on training: most were well received, but, despite excellent protocols for follow-up for WHO IMCI as well as UNICEF nutrition feeding training, it appears that often there was no follow-up.
Nature of interventions: Many were a continuation of prior initiatives; it is plausible that some would have been continued even if not funded (e.g. BPI, PEN and Red Cross TOT)

Constraints: Some of the project activities encountered severe obstacles and constraints. Some were overcome, but some were not and more effort should have been made to overcome them.

Section 8. Recommendations

Future Program Design:

- **Support innovation, not just ongoing well established programs.** The JP supported a portfolio of programs that were well-established and jointly funded from multiple sources. These programs, such as BPI and Family Health Education, would likely have continued without JP support. While these programs have merit and joint funding helps increase impact, future JP activities should focus on activities that would otherwise not be developed\(^\text{23}\).

- **Discourage one-off training and support a health systems approach.** The JP has succeeded in facilitating a reassessment and re-energized three important training packages for MCH and FP service delivery programs: Effective Perinatal Care, Integrated Management of Childhood Illness, and FP Training. All three of these training efforts urgently need to be combined with a sustained systems approach that encourages each MCH RH health care facility to participate in a long-term iterative process of participatory self-assessment and health care improvement\(^\text{24}\). This systems approach should use innovative mentoring and coaching techniques, preferably with long-term (five-years) institutional ties to international centers of excellence in perinatology and obstetrics.

- **The Family Medical Strategy is necessary but not sufficient for MCH and RH.** The current training strategy was designed to be in line with MoH priorities and understandably focuses on FM Doctors and FM Nurses; while they are necessary they are not sufficient to improve MCH and RH outcomes in Kosovo. The private sector must be genuinely involved to have impact on ANC and obstetric care. The current UN Agency mandate to work with MoH needs to be expanded to the private sector, especially given that most health workers practicing in the public arena are also practicing in the private sector due to low incomes. Therefore, future JP funded programs must reach out beyond the Family Medical Model to constructively engage the private sector and specialties. A common theme has emerged from virtually all of the baseline and follow-up assessments (ANC, Tobacco ANC, BPI) that the Private Sector is the main provider of ANC and Ob Care. New strategies are needed that recognize that the Family Medical approach currently misses the majority of key client constituents for MCH and RH. FM Doctors and FM Nurses need structural support to overcome the current status quo where “child clients tend to belong to the pediatricians” and the “ANC and FP clients belong to the OB/Gyns”.

\(^{23}\) Examples of innovative approaches that might be considered include: 1. As an alternative to training, provide fellowships at relevant international institutions for carefully selected change makers within the health system. This would include follow up grant support to help ensure changes can be implemented as well as long-term coaching and support of senior health care leaders. 2. Develop a small grants system for institutions to give the leadership opportunity to manage changes to improve processes. 3. Encourage applied research through a system of research grants system for the improvement of MCH and RH. 4. Identify and provide long-term support to individual clinicians through grants to improve health care systems. 5. Work with private sector through medical professional association to support continuing education programs.

\(^{24}\) For a compelling example of a systems approach see Homan et al. 2009.
• **Avoid bundling of programs.** A pattern was observed where one UN agency would contract with one implementing agency to carry out multiple and somewhat unrelated activities. This is expedient, but may be put the implementing agency in a difficult situation of being overburdened on multiple tasks. It is hard to hold the implementing agency accountable for performance when so many activities are underway at one time.

• **Narrow the focus.** Any future JP should prioritize a limited number of MCH RH issues so as to work at a scale that is adequate to have an impact (See the *Recommended Focus Areas* below).

• **Work at a scale that will address a specific MCH and RH problem with sufficient resources to use the media effectively, especially TV.** The positive experience of the relatively well funded BPI should be used as a model for future programs, but with the caveat that the focus should be kept sufficiently narrow to permit rigorous monitoring of changes in KAPB over time. It is acknowledged that TV is an expensive media, but if BCC programs are to be effective, this high cost must be accepted and budgeted.

*Recommended Focus Areas - Unwanted pregnancy and unsafe abortion:*

• **Develop and fully fund a major coordinated campaign to reduce unwanted pregnancy.** Assuming the results from the 2009 KDH are valid, Kosovo has experienced an increase in unwanted pregnancy that has resulted in an increase in abortions in the private sector. Improved data are needed on unmet need for family planning in order to help design a campaign to encourage the use of more effective methods of contraception; simultaneously improve contraceptive logistics within the MOH and assist the social marketing program to diversify its products to include OC and ECs.

• **Improve the quality of care for abortion services in the private sector.** Based on the recent successful precedent set by the establishment of a private sector regulatory framework for In Vitro Fertilization (IVF), the private sector should be constructively engaged to regulate the provision of abortion services and to create incentives to encourage private sector post-abortion family planning services. FIGO should be involved through the FIGO Reduction of Unsafe Abortion Initiative.

• **Focus the combined expertise of all three UN Agencies more effectively on RH issues.** Specific examples include UNICEF support for social mobilization to reduce unwanted pregnancy and nationally representative population data in the next MICS. It is especially important to compensate for some of the gaps in the recent 2009 KDHs especially to collect data that permits a measurement of unmet need for family planning.

*Recommended Focus Areas - Perinatal and Maternal Health:*

• **Urgent follow-up is needed to address proximate causes of Maternal and Perinatal Mortality.** Thanks to the recent JP supported efforts to improve training for Effective Perinatal Care and the auditing of Maternity Hospitals, some of the proximate causes of Maternal (basic hygiene and other remediable practices) and Perinatal Mortality (failure to cross-train staff on neonatal resuscitation) have been identified. But a great deal more work remains to be done to ensure consistent follow-up to these recent audits and to then expand the audit process to other hospitals. Failure to act quickly and forcefully may result in needless and tragic maternal and perinatal morbidity and mortality.
• **Support measures to consistently implement maternal death audits.** High priority needs to be given to institutionalizing rigorous audit procedures, such as training for the WHO *Beyond the Numbers* methodology. This is a highly sensitive area that requires delicate negotiations with all stakeholders in the public and private sector, but it needs to be prioritized for rapid implementation.

• **Establish intensive long-term (five-year) ongoing technical collaboration with international centers of excellence in Pediatrics and Obstetrics.** Design this collaboration to ensure a five-year continuity of technical exchange that addresses the microsystems within each maternal health care setting. This approach is far more likely to succeed than hundreds of one-time trainings.

**Project Management:**

• **Employ a compelling logical framework.** Develop a plausible and practical logic model to guide future program monitoring and evaluation. Ensure that all targets are realistic and feasible to measure at baseline and at the end of the project.

• **Prioritize and effectively implement Monitoring and Evaluation.** Allocate at least 5% of the budget for monitoring and evaluation staff and related resources to develop and implement a monitoring and evaluation plan that leverages existing data sets to the maximum possible extent and identifies and fills important data gaps, such as unmet need for contraception, as quickly as feasible during the project cycle.

• **Increase the meaningful involvement of key government and private stakeholders.** While the JP has clearly demonstrated effective collaboration with a wide range of stakeholders, future projects should build on that success to ensure that key private and public health institutions, such as the NIPH and KOGA, are consulted at the earliest possible stages of project design and development.

• **Increase coordination and cooperation with other ongoing programs.** The JP could seek ways for more interaction and coordination with other programs that address health of mothers and children, such as the EC and AIHA.
Annexes (Please note: These six annexes are attached in separate zip-files.)

Annex 1. Evaluation Criteria Matrices for each of the 13 Joint Program Outputs
Annex 2. List of persons interviewed (respecting confidentiality criteria)
Annex 3. List of sites visited
Annex 4. References
Annex 5. Data-collection instruments
Annex 6. Terms of Reference