Building an enabling policy environment for improving child health, development and wellbeing in Kosovo

A POLICY BRIEF BASED ON MICS 2014 FINDINGS
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‘...investment in early childhood is the most powerful investment a society can make, with returns over the life course many times the size of the original investment.’

(Irwin LG et al. 2007)
Prepared by: Prof. Dr. Giorgio Tamburlini

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All references to Kosovo* are made in the context of UN Security Council Resolution 1244 (1999)

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## Acronyms

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
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<tr>
<td>CAH</td>
<td>Child and Adolescent Health</td>
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<td>CHDW</td>
<td>Child Health Development and Wellbeing</td>
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<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
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<td>CRC</td>
<td>Convention for the Rights of Children</td>
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<td>CS</td>
<td>Cesarean Section</td>
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<tr>
<td>ECD</td>
<td>Early Child Development</td>
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<tr>
<td>ECE</td>
<td>Early Child Education</td>
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<td>FM</td>
<td>Family Medicine</td>
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<td>HI</td>
<td>Health Infrastructure</td>
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<td>HS</td>
<td>Health Sector</td>
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<td>HV</td>
<td>Home Visiting</td>
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<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>MICS</td>
<td>Multi Indicator Cluster Survey</td>
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<tr>
<td>MoEST</td>
<td>Ministry of Education Science and Technology</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>RMNCAH</td>
<td>Reproductive Maternal Newborn Child and Adolescent Health</td>
</tr>
<tr>
<td>SES</td>
<td>Socioeconomic Status</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

Data from MICS 2013-2014, combined with findings from recent studies and reports, show that Kosovo children face many challenges from conception through their early childhood years. Despite substantial and consistent progress, particularly in infant and child mortality, child health indicators in Kosovo are still among the poorest in the Region, pointing to gaps in both access and quality of care. Access to early education programmes is very low and development-focused family practices are poor, leading to low child development indexes. There is a widespread social acceptance of violent discipline methods and domestic violence. Among Roma, Ashkali and Egyptian communities there are still low immunization rates, high prevalence of stunting and gaps in birth registration. There are striking disparities based on socioeconomic and parental educational level for most health, nutrition and ECD/ECE indicators. All this translates, for many Kosovo’s children, into worse perspectives for health, cognitive, social and developmental outcomes with lifelong impact on chronic health conditions as well as on mental, behaviour and conduct disorders.

MICs data and other available information indicate the need for strengthened and equity focused action on all the main dimensions of Child Health Development and Wellbeing (CHDW): maternal, newborn and child health; early child development; early education and child social protection.

In the light of scientific evidence and global and regional commitments, policy directions are indicated to effectively address the challenges, thus providing an opportunity for Kosovo institutions, development partners and civil society organizations to strengthen and focus their action to improve CHDW. A package of 14 policy directions is proposed to address policy development and implementation gaps in health as well as in other sectors. The package implies a broadening of scope, from improving mortality rates and nutrition status to preventing disability and promoting health child development and social protection. This comprehensive and synergic package is based on continuum of care across prenatal and postnatal health, integrates actions in the dimensions of health, development and social protection, and calls for a coherent and joint effort to build a stronger enabling policy environment to improve child health development and wellbeing for all Kosovo’s children.

Based on human rights, health, economic and social development reasons, investing in children should be among the top policy priorities in Kosovo.
1. Purpose and background

1.1 A policy brief on investing in children

The purpose of this policy brief is to advocate for stronger and more focused investment in child health, development and wellbeing (CHDW).

Based on available data and primarily on MICS 2013-2014, key challenges in CHDW and their implications for Kosovo’s social and economic development are identified and discussed. In the light of scientific evidence and global and regional commitments, policy directions are indicated to effectively address these challenges, thus providing an opportunity for Kosovo institutions, development partners and civil society organizations to strengthen and focus their action to improve CHDW.

1.2 The case for investing in the early years

Over the last two decades, a robust and rapidly evolving body of research has pointed to the importance of the early years of a child’s life in impacting on healthy brain development, cognitive social and emotional functioning, together with a range of outcomes, from health to social adjustment, throughout the life course (Irwin et al. 2007, Jednorog et al. 2014, Leadsom et al. 2013). Evidence of Economic studies have shown that return of investment is maximized for interventions in the earliest years, from conception to the first years, with an average rate of return of up to 7 USD for every dollar spent to foster early childhood development (Carneiro and Heckmann, 2003).
the implications of what happens in the very first period of
life has primarily come from high income countries. Howev-
er, two recent series of reviews in the Lancet (Walker et al. 2011)
have documented the risks factors for subopti-
mal or poor child development in low and middle income
countries, as well as the protective factors and the benefits
of interventions aimed at reducing risk and promoting pro-
tective factors.

The resolution adopted by the UN General Assembly (no.
65/197. Rights of the Child, 30 March 2011)”Calls upon all
States to include, within the overall context of policies and
programs for all children within their jurisdiction, appropria-
te provisions for the realization of the rights of children in
early childhood, in particular: (a) To ensure that the rights of
the child are fully respected, especially in early childhood,
without discrimination on any grounds, including by adopt-
ting and/or continuing to implement regulations and mea-
ures that ensure the full realization of all their rights; (b) To
provide special support and assistance to children in early
childhood who are suffering from discrimination or living
under especially difficult circumstances, in order to ensure
their physical and psychological recovery and social inte-
gration and the full realization of their rights within an en-
vironment that encourages dignity and self-respect. (Con-
vention on the Rights of the Child. CRC/C/GC/7/Rev.1)
On this scientific, economic and human rights basis, there is growing consensus globally for investing in early childhood. Margaret Chan, WHO DG, highlighted the links between child survival and early child development, as mutually reinforcing goals: “Adverse experiences in early childhood increase poor social and health outcomes: low educational attainment, economic dependency, increased violence, crime, substance misuse, and depression, and a greater risk of non-communicable diseases, such as obesity, cardiovascular disease, and diabetes”. In 2013, the European Commission issued a recommendation (2013) on “Investing in children: breaking the cycle of disadvantage” which stresses the potential of early investments for reducing inequities: “Tackling disadvantage in early years is an important means of stepping up efforts to address poverty and social exclusion.

Reproductive, maternal and child health issues can be tackled effectively and in a sustainable way only by providing an enabling policy environment. In this respect, the UN Secretary-General launched the global strategy for women’s and children’s health Every Woman Every Child in 2010.
The strategy calls to focus on an integrated package of essential interventions and services; health systems strengthening; health workforce capacity building; and coordinated research and innovation. The WHO Regional Office for Europe developed in 2011 its new region-specific health policy – Health 2020 –to address the challenges related to attainment of better health and well-being for mothers and children. The emphasis of the European 2020 strategy is on shifting from single projects and from health sector only approaches to approaches which involve all sectors of society, all parts of government and, most importantly, people themselves. In 2012, Kosovo’s Minister of Health adhered to the global initiative Ending Preventable Child and Maternal Deaths: A Promise Renewed, aiming to stop women and children from dying of causes that are easily avoidable, which is particularly relevant for Roma, Ashkali and Egyptians communities.

The Regional Office for Europe responded to a call for the Ministries of Health of the 53 member states and issued in 2014 a Child and Adolescent Health (CAH) Strategy which points to early childhood as a priority area and emphasizes that “parenting capability and capacity (and that of other members of the family and other caregivers) is central to determining the health and well-being of children and adolescents from preconception on. Support for ensuring this requires action beyond the health sector and integrated services, with intensive contributions from sectors such as health, education, community development, welfare and finance, are crucial. A particular focus should be on including children in migrant or minority ethnic groups and children with disabilities”. (Investing in Children: the European strategy on child and adolescent health, WHO 2014). On the same line, the UNICEF Regional Office for CEE/CIS is also emphasizing a more comprehensive child health development and wellbeing approach and is stressing the importance of developing quality Home Visiting services based on such a comprehensive and integrated approach.
2. State of Kosovo’s children based on MICS 2013-2014: key points

The Multiple Indicator Cluster Survey (MICS) was carried out for the first time in Kosovo by the Kosovo Agency for Statistics (KAS). The Kosovo MICS surveys were structured in two separate surveys, which provides valuable information for children, women and men: one covering the main population and a separate survey for the Roma, Ashkali and Egyptian communities. The surveys provide statistically sound and internationally comparable data essential for developing evidence-based policies and programmes, and for monitoring progress toward goals and global commitments. The following sections provide an overview of the key findings.

2.1 Health & Nutrition

Based on MICS 2013-2014 data, the under-five mortality rate is 15, the infant mortality rate is 12, and the neonatal mortality rate is 9 per 1,000 live births (fig.1)

*Figure 1. MICS 2013 – 2014 child mortality rates*

According to the data reported from health facilities in (2014, the perinatal mortality rate (stillbirths and early neonatal deaths, ≥500 g) is 12 per 1,000 births in 2014, compared to 29.1 per 1,000 births (≥500 g) for all births in 2000 mainly due to an important reduction in early neonatal mortality rate from 14.8 to 3.66 per thousand (MoH, 2015).

These data are consistent with the MICS and show a steady and consistent decrease trend.
These positive trends are the result of a combination of factors. The main factor is the work done by Kosovo Institutions and international partners to improve access and quality of health care of pregnant mothers, newborns and children by introducing evidence based practices and providing opportunities for training, particularly for health professionals involved in providing care in the perinatal and early postnatal period.

However, mortality rates show striking inequities. Neonatal, infant and child mortality rates are about twice as much in the poorest quintiles (9, 13 and 19 per 1000 respectively) than in the richest (4, 7 and 9 per 1000). The Infant Mortality Rate among Roma, Ashkali and Egyptian children is, according to MICS, 41 per 1,000 live births, and under five mortality rate is 49 per 1,000 live births, both over three times higher than the average infant mortality rate in Kosovo.

The MICS show similar trends in immunization coverage, which is satisfactory on the whole, but still shows gaps and inequities. Coverage for DPT3 is 91 % for the poorest and 99% for the richest SES quintile. 79% of children 24-35 months old are fully immunized according to the Kosovo immunization schedule. However, only 30 percent of Roma, Ashkali and Egyptian children 24-35 months old are fully immunized.

Inequities are dramatic also in key nutrition indicators: the proportion of children who are stunted under age five is 1% of the children from the richest households and 9% from the poorest, while 14.6 % of Roma, Ashkali and Egyptian children under five year are stunted and 2.5% severely stunted.
The data regarding reproductive health also show a mix of progress and persisting gaps and inequities. Access to skilled attendance at birth is good, although there are persisting quality issues in obstetric and neonatal care, as shown by recent reports and assessments (Jeckai-te, 2011; Lazzerini 2014) and in antenatal care: according to MICS, about 8% of pregnant women do not receive the recommended 4 antenatal visits (23% among Roma, Ashkali and Egyptian population); 19% had not their blood pressure measured and blood and urine samples taken; and 9% of newborns did not receive a timely neonatal post-natal visit (23% among Roma, Ashkali and Egyptian population). The proportion of caesarean section shows increasing trend and too high (see figure).

*Figure 3. Percentage of births with caesarean section for period 2000 - 2014*

![Graph showing percentage of births with caesarean section from 2000 to 2014.](source: Ministry of Health, 2015)

Also matter of concern is the high proportion of women who are married or live in union before their 18th birthday, since early pregnancies and parenthood are at higher risk of both physical and mental health problems (WHO, 2015). According to MICS, early marriage regards 10% of Kosovo’s population. Among Roma, Ashkali and Egyptian the issue is even more worrying since 11% of young women married get married before age 15.

With respect to health status, there is lack of information about the prevalence, severity and type of disabilities, most of which are due to genetic abnormalities or to consequences of obstetric and perinatal complications and are preventable. Knowledge on prevalence of disabilities originating in the ante, peri and postnatal period is crucial to plan preventive actions, family support as well as rehabilitation services. As mortality declines and an increasing proportion of premature babies survives, it becomes essential to focus on the burden of disability (Vos et al., 2015).
2.2 Early Child Development and Early Learning

The Early Childhood Development (ECD) area shows a widespread situation of poor performance (see figure).

**Figure 4.** Percentage of children age 36-59 months attending early childhood education (from MICS 2013-2014)

Only 14% of children aged 36-59 months are attending an early childhood education (ECE) programme compared to an EU average of over 80%. Inequities are quite significant (attendance in urban areas is 23% versus 9% in rural) which can be explained also with availability of early education facilities but also with social norms, and information about the benefits of preschool education. Irrespectively of residence, only 6% of children whose mothers have lower secondary education level are attending ECE programmes compared to 37% of the richest households and 7% of the poorest, pointing to obstacles that are at the same time socioeconomic and cultural. The MICS provide some very interesting information on engagement of adults (especially fathers) in activities with children, as a prerequisite for optimal early development. Among these, the MICS describe the availability of children’s books, which is an internationally well recognized indicator of an enabling family environment for emergent literacy, and consequently of later literacy skills.
This indicator is alarmingly low in Kosovo: less than a third (31%) of under-five have three or more books at home, with huge differences: 65% among mothers with higher education and 10% among mothers with only primary education which reflect a quite similar pattern when related to socioeconomic status (10% among the poorest households and 67% among the richest).

Child development indexes are worryingly low, particularly for the cognitive dimension (literacy and numeracy): only 18% of children in Kosovo have a sufficient level of literacy and numeracy, with even lower indexes in Roma, Ashkali and Egyptian populations, where only 9% of children have a sufficient literacy and numeracy, with clear differences among those attending early childhood education (30%) and those not attending (5%). Overall, 17% of Kosovo’s children aged 36-59 months are not developmentally on track in at least three of the child development dimensions (cognitive, physical, social-emotional and learning). This percentage is even higher (23%) among Roma, Ashkali and Egyptians. Mother’s education and attendance to early childhood education are the main factors influencing child development indexes.

These data point to poor family practices with respect to an enabling cognitive environment and to a critical lack in both availability and quality of early childhood education, with implications on school readiness and school performance.

Data about access to primary and post-primary education are satisfactory, with 2% of lower secondary school age children out-of-school at the lower secondary level (6% among children whose mothers have no education). Rather than access, the issue may be the quality of education. However, we do not have for Kosovo information on quality of education which could be compared with European data, such as PISA and PIRLS surveys.

### 2.3 Child Protection

MICS data provides also information on issues related or having impact on child protection. For example, available data shows that there is still a problem in birth registration: the births of 12% of children were not registered. This percentage is 48% among Roma, Ashkali and Egyptians.
Data on child discipline are particularly worrying since 61% of children experienced psychological aggression or physical punishment during the preceding month. A minority (about 31% of children, and 19% among the Roma, Ashkali and Egyptian population) experienced only non-violent discipline, this percentage lowers to 19%. The attitude towards physical punishment is greater among families with lower educational level. Very worrying is the existence of a widespread attitude justifying domestic violence which varies – depending on the situations considered - between 33% and 42% among women and between 15% and 22% among men aged 15 to 49. Justification for domestic violence is higher among Roma, Ashkali and Egyptians. Overall, females justify domestic violence to a much greater extent than men and young men as much as older ones. The age and gender trends on violent discipline and domestic violence point to the need of addressing these issues since the early years and with a gender approach.

2.4 What the MICS findings add to what was previously known

The MICS confirms the improvement of all main mortality indicators which emerges from MoH data. Immunization rates are satisfactory for Kosovo wide, although there are still important gaps in Roma children. The prevalence of stunting, which occurs in almost 5% of Kosovo's children and in over 10% of Roma, Ashkali and Egyptian children is cause for concern, considering that stunting is associated with poorer child development and poorer health over the life course. Indicators of both mortality and immunization coverage indicate the existence of important inequities, with SES, education and ethnic origin as the main determinants of inequitable health outcomes.

Information provided by MICS on ECD and ECE is particularly worrying, indicating poor opportunities for overall development and poor cognitive development at an age where the plasticity of the brain is maximal and the negative impact on school performance and social outcomes later on is greater. Inequities are striking in both ECD in ECE and contribute to building development gaps among population groups. The 2013-2014 MICS shows the existence of social norm issues, such as pervasive attitude to violent discipline methods and in general to violence, that need to be addressed. The implications, ranging from social and gender based discrimination to intergenerational effects are well known and must be considered as a priority (WHO, 2013). Some of the social protection-related aspects are really worrying. Among all, is the fact that the proportion of young people who justify domestic violence against women is as high as among older men points to an urgent need to deal with the issue of violence since early childhood and with a gender approach at both family and community levels.

It is worth mentioning the information that MICS provide on access and use of media. In Kosovo, regular use of internet is 34% among the poorest SES quintile, 79% among the richest and 60% in Roma, Ashkali and Egyptian), and as expected is much higher in younger age groups. Only a very small part of the population (less than 5%) does not watch TV, with very marginal differences among population groups. This offers increasing opportunities for using the traditional as well as the digital media to reach out for all with information and communication about health, development and social protection issues.
2.5 Adjunctive information provided by other sources and information gaps

Recent assessments of the quality of maternal and newborn and paediatric care deserve a mention (Jeckaite, 2011; Lazzerini, 2014). They show the existence of gaps in safety, effectiveness and patient-centered care. Although the agenda of ensuring access to all essential health interventions is yet unfinished, particularly for ethnic minorities and poor families with low educational level, more attention should be paid on improving quality along the continuum of care starting from the pre-conception period and across pregnancy, birth, childhood and adolescence. Gaps in quality impact on mortality levels and even more on morbidity and complications, for both women and children. Studies on reproductive health-related morbidity and disabilities are needed to inform preventive plans and actions.

2.6 Kosovo data in the light of EU and regional data

In spite of substantial and consistent progress, child health indicators in Kosovo are still among the poorest in the Sub-Region and worse than in most neighbouring countries. With respect to ECE, the gap with European Union countries and neighbour countries is greater: the proportion of children attending preschool day care varies from 56% in Serbia to 24% in FYR of Macedonia and 17% in Albania, while the EU 27 average is almost 80% (see table). Birth registration is the lowest in the Sub-Region.

Table 1. Key CHDW indicators in Kosovo, neighbour countries and EU (sources Kosovo MICS* and SOWC 2013).

<table>
<thead>
<tr>
<th></th>
<th>Kosovo*</th>
<th>Albania°</th>
<th>Serbia°</th>
<th>FYR of Macedonia°</th>
<th>EU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant MR</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Under 5 MR</td>
<td>15</td>
<td>17</td>
<td>7</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>ECE 3-5 years</td>
<td>14%</td>
<td>17%</td>
<td>56%</td>
<td>24%</td>
<td>80% 1</td>
</tr>
<tr>
<td>Birth registration</td>
<td>88%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
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</tbody>
</table>

1 The European Union recommended attendance for the pre-primary school year is 100%, and for 0-3 years is 33%.
### 2.7. Implications of MICS data and key strategic challenges

The following table provides an overview of key facts emerging from the MICS 2013-2014 and from the other sources of information which have been mentioned. Four key areas are considered: health and nutrition, ECD and child protection and inequities. The implications for the whole Kosovo’s society of these facts and the related key strategic challenges are identified.

#### Table 2. Key facts, implications and challenges for CHDW in Kosovo

<table>
<thead>
<tr>
<th>Key facts</th>
<th>Implications for society</th>
<th>Key strategic challenges</th>
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<tbody>
<tr>
<td><strong>Health and nutrition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High perinatal and postnatal</td>
<td>Long term health, social and economic consequences of disabilities</td>
<td>1. Ensure free access to all essential preventive and treatment interventions along the continuum of care from conception to the first years</td>
</tr>
<tr>
<td>mortality rates</td>
<td>Persistent vaccine preventable diseases and lack of full protection in case of re-emerging epidemics</td>
<td>2. Improve quality of antenatal, perinatal and postnatal care</td>
</tr>
<tr>
<td>Widespread quality of care issues</td>
<td>Negative impact on child cognitive development</td>
<td>3. Improve vaccination coverage and nutrition particularly in Roma, Ashkali and Egyptian communities</td>
</tr>
<tr>
<td>Unknown burden of maternal and</td>
<td>Unnecessary costs for health system and households</td>
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<tr>
<td>neonatal morbidity and long term</td>
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<td>disability</td>
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<tr>
<td>Low immunization rates and</td>
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<tr>
<td>high prevalence of stunting,</td>
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<tr>
<td>particularly among Roma, Ashkali</td>
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<tr>
<td>and Egyptian communities</td>
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<td><strong>ECD</strong></td>
<td>Poor child cognitive and socio-relational child development</td>
<td>4. Scale up parenting support programs to improve child rearing practices, with special focus on early child development</td>
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<td>Very low access to ECE programmes</td>
<td>Reduced school readiness and performance, increased behaviour disorders</td>
<td>5. Increase provision of inclusive preschool education</td>
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<td>Poor development - focused family</td>
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<tr>
<td>practices</td>
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<tr>
<td><strong>Child protection</strong></td>
<td>Decreased social cohesion, increased societal and domestic</td>
<td>6. Ensure birth registration to all children</td>
</tr>
<tr>
<td>High proportion of non registered</td>
<td>violence, social and gender based discrimination intergenerational effects</td>
<td>7. Establish programs to promote child protection since the prenatal period, including focus on prevention of violent discipline methods</td>
</tr>
<tr>
<td>births</td>
<td></td>
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<tr>
<td>Persistence of social norm issues</td>
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<td>such as attitude to violent</td>
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<td>discipline methods and domestic</td>
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<tr>
<td>violence</td>
<td></td>
<td></td>
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<tr>
<td><strong>Inequities</strong></td>
<td>Social exclusion, increased costs for social services and in</td>
<td>8. Tackle inequities in health and development outcomes through both Health System (reach out and demand focused programs) and other sector policies</td>
</tr>
<tr>
<td>Large gaps between rich and poor,</td>
<td>general for remediation services</td>
<td></td>
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<td>educated for most health, nutrition</td>
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<td></td>
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<tr>
<td>and ECD/ECE indicators</td>
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3. Towards an enabling policy environment for Child Health Development and Wellbeing in Kosovo

The situation emerging from the MICS has its roots in the past, including pre-conflict times, is caused in part by adverse social and economic circumstances and in part by persistent difficulties in ensuring an enabling policy environment. Within the first group of factors, the multiple dimensions of poverty play a major role, as clearly shown by huge disparities in health, nutrition and ECD indicators by socio-economic status and mother’s education level and reported in MICS. Social exclusion also plays a role as shown by unacceptably poor health and development indicators among ethnic minorities, one of the prominent features of MICS data.

The following sections provide indications on priority actions in the health sector as well as in other relevant sectors.

Weaknesses and gaps in health, early education and social protection systems play undoubtedly a role in the situation emerging from the MICS. Policy development and implementation gaps must be addressed in all these sectors to improve the health development and wellbeing of all children in Kosovo.
3.1 Health sector policies

Although targeted by a many external donor-driven projects and technical support since the conflict, and maybe also due to overreliance on external aid, the health sector has for too long been the Cinderella among the public sector policies in Kosovo, and has been insufficiently funded.

Reforms have been introduced soon after the conflict as well as thematic strategies and action plans, and administrative instructions have been issued. However, they have either been introduced without adequate consideration of all the health system requirements, and above all sufficient funding, to make them effective or they have not been fully implemented. Two examples among the many. The Family Medicine concept has been introduced, as a cornerstone of health reform, without adequate supervisory, incentive and accountability systems, so that quality has improved too little and too slowly. FM still fails to intercept many pregnant women, and guidelines and protocols on child health and development are not adequately developed and implemented.

Decentralization, a globally shared concept, has been attempted, but municipalities and local health managers still lack the autonomy and the managerial capacity to support translation of policies and the development of the local health system. The diversity of situations across Kosovo in terms of local systems, with examples of good practice coexisting with gaps and inefficiencies, reflect the too wide spectrum of local capacity. The situation has changed recently, when health sector has been included among the five priorities of the new government. If accompanied by adequate budget allocation, governance and leadership, this may produce significant improvements in the near future.

The following sections identify the main health sector constraints and provide policy directions to address the key challenges to improve Child Health Development and Wellbeing in Kosovo.

3.1.1 Planning and supervision capacity of central MoH structures. Decentralization requires an increased capacity to provide local managers with guidance, standards and guidelines, local planning and managerial tools including accountability mechanisms. This complex range of tasks, together with the need to coordinate foreign aid and regulate a growing private sector, indicate the need to improve the capacity, in both quantitative and qualitative terms, of the understaffed central MoH departments, particularly to the Division for Mother, Child and Reproductive Health.

Policy direction §1. Strengthen the capacity of MoH structures and specifically of the Division for Mother, Child and Reproductive Health to improve its ability to promote and coordinate cross-department policies, ensure stewardship and supervision to programs, define standards and performance indicators, and give support to local managers.
3.1.2. Local managerial capacity. At municipal level, the Main Family Medicine Centre has a significant and central role, being responsible for hiring health personnel and health care administrators, in accordance with the guidelines and standards defined at central level.

Policy direction §2. Managerial capacity of all managers responsible for the administration of primary health care at local level needs to be improved. Selection of managers should be accurate and based on curricula. Reproductive maternal and child health should become the entry point for introducing managerial tools such as planning and monitoring frameworks.

3.1.3. Quality assurance & improvement. A lot has been done, with external support, to introduce quality management systems such as the MoH Strategy for Quality of Services, through WHO Beyond The Number (BTN) approaches and assessment tools in maternal and newborn and paediatric care, and supported by UNICEF implementation assessment of baby friendly standards. There is now the need to ensure implementation of the action plans and recommendations of the assessments, including the development of national guidelines and protocols, as indicated by the 2016-2020 health plan.

Policy direction §3. The quality management tools that have been introduced should be fully institutionalized, clinical guidelines and protocols developed as well as standards based on expansion of Baby Friendly Hospital Initiative to include all key maternal and child care. Relevant capacity at central and local level to implement quality approaches and protocols and monitor compliance to quality standards should be strengthened and used also for licensing and accreditation for the private health sector. Robson’s classification to monitor regularly indications for caesarean sections and promote appropriateness should be implemented.

3.1.4. Health System funding. Insufficient funding for the health sector is hampering the implementation of institutional and legal reforms and does not allow to tackle inequities caused by out-of-pocket expenditures mainly for medicines, use of diagnostic technology, and transportation. Co-payments and informal payments contribute to inequity. Although the Law on Health Insurance has been approved the MoH decided to align its implementation with the operationalization of the Health Insurance Fund in 2016. It would be important to include health insurance for families living in poverty and are not benefiting from the social assistance scheme.

Policy direction §4. Funding for the HS should be gradually increased within the public sector spending. Rational use of existing resources should be pursued through an accurate spending review in the health sector, giving priority to programs and investments that yield the greatest benefits for the population. Cost/benefits profiles of prestige investments in tertiary care areas should be carefully evaluated and priority given to funding for areas that address the highest burden of disease, including Primary health Care. Insurance schemes need to include in health basic package all essential ante, peri and postnatal interventions for all mothers and children.
3.1.5 Human resource. Kosovo has one of the lowest nurse to population ratio in Europe (3.5 per 1000 against a EU27 average of 7.9). Moreover, the role of nurses is still undervalued and their skills underutilized. Continuous professional development is lacking. Nursing skills are crucial particularly in PHC and community work for the MCH area, the elderly and disabled.

**Policy direction § 5.** A Human Resource plan should be developed taking into account the future need for health professionals and the need to increase the nurse to population ratio. Opportunities for Continuous Professional Development should be provided to municipal and health facility managers and to nurses, paying attention to the essential skills and knowledge to ensure timely delivery of equitable and quality PHC maternal and child health services in all targeted municipalities. Based on the Law on Chambers, professional board is established and encouraged to take the lead in promoting and strengthen the role of nurses in health promotion and reach out interventions, including home visiting.

3.1.6 Health Infrastructure and commodities. The renovation of Health Infrastructure (HI) has been targeted by government, municipal and donor’s projects. HI does not represent a major obstacle to the provision of quality care for reproductive, maternal and child health in Kosovo with the exception of some tertiary care specialized areas such as heart surgery, for which the benefit to cost of establishing centres in Kosovo rather than continuing the collaboration with foreign centres should be carefully evaluated. Priority should be given to ensure basic amenities such as energy, water included hot water and hygiene facilities in all health facilities and to provide essential medicines and diagnostics to the most vulnerable groups.

**Policy direction § 6.** Ensure the provision of provide essential medicines and diagnostics for ante, peri and postnatal interventions to the most vulnerable groups, irrespective of insurance status.

3.1.7 Health Information System (HIS). A crucial issue to allow for improved management and accountability at national and local level is the full functionality of the HIS. Lack of reliable data and/or insufficient technical capacity to analyse data undermine evidence based policy developments and result in inefficient management of health services.

**Policy direction §7.** The process for establishing a fully operational Health Information System should be speed up and investments made in capacity building. Data analysis and data based planning capacity needs to be improved at both central and local level, incorporated in medical and nursing curricula, and represent a priority content in the training and CPD of health managers. Morbidity data, particularly on perinatal adverse outcomes (congenital malformations, severe prematurity) should be collected prospectively by perinatal centres and included in HIS.
3.1.8 Service delivery. The family medicine system has been put as the heart of the PHC system in Kosovo, but is not fully operational in all municipalities and fails to respond to many tasks in RMNCAH. The lack of a full range of guidelines and protocols and insufficient compliance with the existing ones results in suboptimal service delivery. Large parts of the population bypass the FM system or prefer the specialist (e.g. paediatrician if existing within the FM Center) when existing in the system. Clear indications and mechanisms for referral between levels of care are lacking.

Policy direction §8. Revise indications for tasks to be performed at each level of care, and for referral. Improve tools and methods such as paper and computer-based records for appropriate referral and support with health insurance mechanisms.

3.1.9 Home visiting. The Ministry of Health has endorsed the Home Visiting package and road map and is currently supporting the home visiting services in selected municipalities, in collaboration with local authorities, other sectors and civil society organizations. HV is one of the most effective approaches to provide critical support to families and to link them with health, education and social services in the community to improve the outcome of pregnancies and the health and development of infants and young children through appropriate family practices.

Policy direction §9. Based on results of initiated HV programs and taking stock of international experience, the HV program should be scaled up and implemented by MoH in collaboration with municipalities and coordination with donors, in accordance to the recommended model in the Road Map and the family medicine system (UNICEF, 2014). The compliance of PHC professionals within the minimum working hours to be devoted to community work including HV, health promotion activities in community and schools and patient support groups should be monitored.

3.1.10 Communication for social mobilization and behaviour change. To achieve the best possible health status it is necessary to improve the health literacy of the population. This is even more true in Kosovo where insufficient awareness about the implications of health-related behaviours contribute to the large health divide and to gaps in equitable access to services and child rearing practices.

Policy direction §10. Health professionals need to have their communication capacities strengthened to engage in an open communication, not only providing services and information, but exploring the current knowledge of the population, their concerns and misunderstandings and proactively address them. The communication campaigns should complement this change by supporting families in adopting development focused practices. Technical support should be given by the relevant agencies and donors to the Health Promotion Unit or focal point within the National Institute of Public Health. A communication strategy, including media and materials for health professionals and users to improve health literacy and child-focused rearing practices, through the media, the social media and champions should be developed. Child and pregnancy health booklets should be revised with new evidence based information particularly on child development. The reasons for some negative or unhealthy practices and for not using community services by some excluded groups, and social norms behind practices should be addressed by specific research to provide information for evidence-based programming.
3.2 Other sector policies and inter-sector collaboration

Health is the product of multiple factors, well beyond the performance of the health system. Among the key challenges identified by the MICS, several, particularly those regarding child development and social protection, can be addressed effectively only with the active intervention of other sectors of the government and of society, by establishing and strengthening mechanisms for inter-sector collaboration at central and local level. The MICS findings indicate, among a general need for putting child health development and wellbeing among the top policy priorities of government’s initiative, a few clear priority issues to be addressed by sectors other than health.

3.2.1 Nutrition. Although improved over the years, thanks to 15 years of continuous efforts of the health sector supported by international agencies and donors is aligned with many other countries in Europe, the current prevalence of exclusive breastfeeding at 4 months is still below international recommendations. IYCF is insufficient as demonstrated by prevalence of stunting and requires increased efforts to avoid that the benefits of breastfeeding are lost due to early weaning and inappropriate feeding practices. Tin 2014 the MoH has endorsed the working group that drafted the Nutrition action plan 2014 – 2020, aiming at improving the nutritional status of the population with special focus on vulnerable groups. An amendment to legislation on breastfeeding is under promulgation to strengthen action in this area. The Ministry of Agriculture, Forestry and Rural Development, together with the National Institute of Public Health and private sector, with support from UNICEF, is engaged to ensure that flour is fortified with iron and folic acid to prevent birth anomalies and anaemia and contribute to better child health and development.

Policy direction § 11. Continue efforts by MoH with other line ministries and partners to implement and monitor legislation and policies, sustain breastfeeding promotion, including the compliance with the International Code, and fortify flour with iron and folic acid. Include appropriate IYCF in well child visits and home visits, with special attention paid to children belonging to Roma, Ashkali and Egyptian communities and to children from poor households.
3.2.2 Early childhood education and care. Pre-school education gives children substantial advantages in their later education. Parents and families have an important role in the child’s educational process. Despite this evidence, Kosovo has a very low preschool attendance rate and child rearing practices are generally poor. ECE services for 0-3 years are almost completely absent with some exceptions in urban areas while the recommended EU target is 33%. The Government of Kosovo is committed to the goals of Education for All that specifically aim to “expand and improve comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children” by supporting an integrated approach combining the process of early education, parenting practices and professional care. One-year pre-school is part of compulsory education under the new law and services for younger children include a combination of nutrition/health/education areas, including for children with disabilities. It is now urgent to fulfil this commitment and consider, in alignment with the global community, investments in ECD and ECE as the most strategic and cost effective to improve societal wellbeing and social inclusion.

Policy direction §12. A clear plan is needed for achieving 100% pre-school attendance and gradually increasing the provision of early education for children aged 0-3 to 33% (EU goal) and 3-5 to 66%. Early Learning Development Standards for Children age 0 – 6 need to be implemented as well as the Kosovo Education Strategic Plan, as crucial to ensure improved child development opportunities to all children and better health for the entire life course. Providing adequate care and services for younger children will require inter-sector collaboration, between the Ministry of Health (MoH), Ministry of Education, Science and Technology (MEST) and the Ministry of Labour and Social Welfare (MLSW), since health services are considered the best entry point for promoting appropriate, development-focused family practices. Promoting public-private partnerships with NGOs will also be crucial. A priority will be to develop a sustainable system of comprehensive teacher training with particular attention to preschool teachers and educators.

3.2.3 Social protection policies and parenting programmes. Birth registration, protection from the health, developmental and social consequences of poverty and social exclusion are fundamental rights of all children. MICS data also show that there is an urgent need to address negative social behaviours such as harsh discipline and domestic violence. Two approaches are equally necessary to fulfil these rights in the best interest of children and society. The first is to fight poverty by boosting economic growth, increase occupation and use the fiscal leverage to redistribute income. The second is to reduce the consequences of poverty by providing free and quality health and education services and supporting families in practices that promote child cognitive social and emotional development, early schooling, and prevent risk factors such as neglect and violence.

Policy direction §13. Current efforts should be strengthened to ensure birth registration, possibly linking it to benefits if accompanied by full immunization and adhesion to parenting programs starting during pregnancy. HV is a key response to many concerns regarding child wellbeing and social protection since it allows early prevention and identification of risk factors. Guidelines for incorporation of social protection issues in home visiting have been developed by UNICEF CEE/CIS and a recent WHO EURO document provided, based on experience from five member states, clues on how to incorporate ECD/SP in health systems (Tamburlini and Velea, 2014).
3.2.4. **Child friendly governance**. In a decentralized system, much can be done by dynamic local governments, particularly if supported by civil society. Child Friendly Governance, based on conceptual frameworks and indicators adopted in many countries and cities of Europe, and local initiatives such as “Gjakova fit for Children”, should be launched at central and local levels, promoting competition among municipalities, in building local alliances to support health, early education and social protection for all children, including those with disabilities.

**Policy direction §14.** Explore the possibility to launch a Child Friendly Governance competition, managed in cooperation between Government, International partners and Civil Society Organizations (CSO), to build awareness about the importance of investing in CHDW and to foster participation of civil society.
A combination of synergic policies

The lessons learnt from the global, regional and national contexts show that a combination of policies is necessary to address the key challenges outlined in chapter 1 (see table).

Table 3. Key challenges and enabling policy directions

<table>
<thead>
<tr>
<th>Key challenges for CHD&amp;W in Kosovo</th>
<th>Enabling Policy Directions*</th>
<th>Roles and responsibilities</th>
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<tbody>
<tr>
<td>1. Ensure universal free access to all essential preventive and treatment interventions along the continuum of care from conception to the first years</td>
<td>1, 4, 6, 8, 9, 10</td>
<td>MoH, Municipalities, Partners/Donors</td>
</tr>
<tr>
<td>2. Improve quality of antenatal, perinatal and postnatal care</td>
<td>1, 3, 5, 7</td>
<td>MoH, Municipalities, Partners/Donors</td>
</tr>
<tr>
<td>3. Improve vaccination coverage and nutrition particularly in more vulnerable groups, through outreach programmes</td>
<td>1, 2, 7-9, 10</td>
<td>MoH, Municipalities Partners/Donors</td>
</tr>
<tr>
<td>4. Scale up parenting support programs to improve child rearing practices, with special focus on early child development</td>
<td>1-2, 9-11, 12</td>
<td>MoH, MEST, MKSW, NGOs, Partners/Donors</td>
</tr>
<tr>
<td>5. Increase provision of preschool education</td>
<td>12</td>
<td>MEST, Municipalities, NGOs, Partners/Donors</td>
</tr>
<tr>
<td>6. Ensure birth registration to all children</td>
<td>9, 13-14</td>
<td>MoH, MLSW, Municipalities</td>
</tr>
<tr>
<td>7. Establish programs to promote child protection since the prenatal period, including focus on prevention of violent discipline methods</td>
<td>9-10, 13-14</td>
<td>MLSW, MoH, Municipalities</td>
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<tr>
<td>8. Tackle inequities in health and development outcomes through Health Sector (reach out and demand focused programs) and other sector policies</td>
<td>1, 4, 6-7, 9</td>
<td>MoH, MLSW, MEST Municipalities Partners/Donors</td>
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There is the possibility of taking advantage of synergies among different policies to achieve key objectives. For example, the overview shows the key role that a scaled up and well-functioning HV program (Policy Direction 9) can play in effectively addressing multiple challenges (1, 3, 4, 6, 7 and 8). Similarly, it shows how important is to develop capacity to use behaviour change strategies and tools, starting from social communication through a variety of media (Policy Direction 10) to address a variety of issues (1, 3-4, 6-7).

These recommendations are entirely consistent with recommendations emerging from global and regional strategies such as the need to use a health system approach, to promote multi-sector involvement, to move from demonstration to fully developed and institutionalized programs to improve governance based on accountability and monitoring framework.

**Overall, this package implies a broadening of scope, from improving mortality rates and nutrition outcomes to the prevention of disability, to health promotion to child development and social protection. This more comprehensive but still well focused approach based on a continuum of care and integration among different periods (pre and postnatal) and dimensions (health, development, wellbeing and social protection), is coherent with the evolution of needs and emerging CHD&W issues shown by MICS 2013 - 2014.**
3.4 Roles and responsibilities for effective partnership

The importance for Kosovo Institutions to engage in building effective partnership with civil society and NGOs to strengthen action and achieve results has been already emphasized. Evaluation of the Joint Programme showed advantages in having the three main UN Agencies dealing with RMNCAH issues collaborating in one comprehensive program. This model of joint partnership, adapted to include the key governmental, civil society, UN agencies and bilateral donors, depending on the area and the added value of each partner, should be followed to support the development and implementation of key policies, as outlined in the previous table. For each of the eight main challenges identified by this policy brief, key actors are tentatively identified and their roles and contributions, based on specific expertise, should be further defined in the MoH Sectorial Strategy 2015 – 2020 and multi-year action plans.

Time has come for a major shift of responsibility to Kosovo institutions, with technical support from UNICEF, WHO, other UN agencies, partners and donors, to move towards a coherent and joint effort to provide an enabling policy environment to improve CHD&W of children in Kosovo.
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