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Kosovo* Case Study

Preliminary Report

December 2019
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We are also grateful to Murat Sahin, Head of UNICEF in Kosovo, James Mugaju Deputy Head of Office and all Evaluation Reference Group (ERG) members who met the team and helped understand the local context as well as helped validate preliminary findings and offered valuable inputs informing the recommendations.

Also, we would like to thank individually all national stakeholders, home visiting nurses, community members and individuals who met the team and shared their wisdoms and informed this evaluation. Finally, our thanks go to Vjollca Caka, our national consultant, and our interpreters for their support during the visit to Kosovo. Without their help this work would have been not possible.
Preliminary Report

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PCA  Program Cooperation Agreement
PHC  Primary Health Care
QA   Quality Assurance
RBKO Raiffeisen Bank of Kosovo
RF   Results Framework
RO   Regional Office
ROAR Regional Office Annual Reports
SDC  Swiss Development Cooperation
SV   Site Visit
TAG  Technical Advisory Group
TOC  Theory of Change
ToMT Training of Master Trainers
TOR  Terms of Reference
ToT  Training of Trainers
UK   United Kingdom
UNEG United Nations Evaluation Group
UNSCR United Nations Security Council Resolution
UPHV Universal Progressive Home Visiting
Background

Population of Kosovo is 1.79 million and is the youngest in Europe, with an average age of 30 years. Kosovo is one of the poorest countries in Europe as economic growth since independence has not been sufficient to reduce the high rates of unemployment, provide formal jobs, or reverse the trend of large-scale outmigration. According to the 2017 Household Budget Survey (HBS) 18.0 % of Kosovo's population lives below the poverty line and 5.1 in extreme poverty. ¹

Overall child health and well-being indicators have improved since 2010, but in 2014 child mortality reveals deterioration, followed by widening equity gaps. Most health, nutrition and early childhood development and early childhood education reveal striking disparities based on ethnic or socio-economic background, and parental education level, which and require attention.

As a result of the health sector reforms of 2000 the patronage nursing, inherited from Federal Republic of Yugoslavia, was completely abolished in Kosovo, except in handful of Serbian municipalities. The nursing staff conducting patronage visits were transferred to newly formed family medicine center (FMC) were one doctor and two nurses bear responsibility for the delivery of PHC services to about 2,000 residents in the community. During this transitional period, numerous health system bottlenecks emerged that had negative impact on child health and wellbeing outcomes as well as contributed to widening equity gaps.

The political instability along with the weak institutional accountability negatively affected government's ability to deliver on policy promises. Neither central nor municipal governments were prepared to deliver equity-based services for children, including those requiring community outreach. ² Insufficient funding for health was not facilitating the translation of policy commitments into actions. ³ All of the aforementioned was compounded by complete lack of legislation or regulations for home visiting services. ⁴

While the family medicine system was put as the heart of the PHC system it was not fully operational in all municipalities and failing to respond to the needs of population, experiencing nursing and medical staff shortages. Furthermore, the role of nurses was undervalued, and their skills underutilized and requirements for continuous professional development was completely lacking. ⁵ As a result, the population coverage across the municipalities was variable and PHC seemed already strained.

Emergence of out-of-pocket payment as a means of accessing care allowed patients choose the level they wished to attend - without being referred - despite paying higher prices and all of this has led to the breakdown of the referral system between levels of care and in that undermined the concept of continuous care provision⁶ i.e. timely and appropriate referrals.

Accountability within the health sector suffered significantly due to inadequate HMIS and due to lack of culture and capacity among decision makers to hold the services accountable for the outcomes. Managerial capacity of all managers responsible for the administration of primary health care at local level needed significant improvement and reproductive, maternal and child health was seen as a potential entry point for introducing managerial tools such as planning and monitoring frameworks. ⁷

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² UNICEF Kosovo Office Annual Report 2012
⁴ In-depth interviews with policy makers and UNICEF staff
⁵ Tamburlini L., A Policy Brief Based on MICS 2014 Findings, UNICEF 2015
⁶ Based on information provided in Interviews with MSH
⁷ Tamburlini L., A Policy Brief Based on MICS 2014 Findings, UNICEF 2015
Heavy reliance on co-payments and informal payments when seeking care created significant financial access barriers and contributed to growing inequity. Furthermore, geographical access and transportation costs emerged as a barrier to accessing care. Large part of population (30%-60% in different regions), living more than 3 km away from medical facility, found difficult to cope with transportation costs thus making home visiting even more important.

Financial and geographical access barriers were further compounded by cultural and ethnical norms, where women in rural areas are not allowed to travel alone, where established norms and practices around breastfeeding or child upbringing are against the scientific evidence and where violence against the child i.e. punishment is an accepted norm in the society. Thus, there was a need to generate more demand by increasing the community understanding of the benefits offered by the home visiting.

Weak accountability for results (noted earlier) was also negatively affecting quality of delivered services, because quality was not perceived as a performance issue and there was no practice of either assessing or ensuring the quality of delivered services by the health system, including for home visiting.

**Evaluation Purpose, objectives, scope and methodology**

The evaluation of UNICEF’s support to UPHV introduction in Kosovo is an integral part of the Multi-Country Evaluation (MCE) of UNICEF’s contribution in promoting UPHV in the Europe and Central Asia (ECA) region. Kosovo was selected for in-depth evaluation out of 16 ECA countries and the report examines the extent to which UNICEF’s efforts to promote UPHV have contributed to addressing some of the critical health system-level bottlenecks in child survival, health, development and wellbeing. The evaluation report i) objectively reviews the theory of change and Kosovo context to assess the relevance of the UPHV in addressing young child survival, health and well-being needs; ii) examines extent to which the UPHV model was successfully applied in the targeted geographical areas, what results were attained and what were factors and constraints to implementation; iii) assesses UNICEF’s specific contribution, in terms of the roles the organization has played, towards addressing health system level bottlenecks while striving to improve coverage with evidence-based quality interventions; and iv) assesses extent to which the results achieved can inform the Government’s desire for national roll-out of UPHV services while considering the facilitating and impeding factors that may affect the scale up.

The evaluation is based on adapted Theory of Change (TOC). The TOC was adapted following Theory of Change developed by UNICEF regional office for Young Child Well Being. TOC was tested and operationalized for Kosovo context and helped the evaluation team examine the impact, relevance, effectiveness, efficiency and sustainability of the UNICEF supported UPHV interventions. A mix-method
evaluation methodology was used based on 72 document reviews, 55 in-depth interviews, three site visits and nine focus group discussions with nurses, pregnant women and mothers of children 0 to 3 years old coming from both general population and vulnerable groups. Both, qualitative and secondary quantitative data analysis, from the above sources was carried out to arrive at conclusions and formulate recommendations. Findings based on qualitative data were triangulated across different data sources and robustness ranking for the findings is provided in the annexes to this report.

The evaluation faced some limitations that impeded data collection process and affected the findings. Specifically, the absence of the impact and outcome level quantitative data restricted the evaluation to examine whether services contributed to long-term positive changes in wellbeing of children, particularly of those most vulnerable. This limitation to certain degree has been mitigated by ensuring the participation of the most vulnerable families in the evaluation process through appropriate data collection methods and tools and drawing conclusions mostly based on qualitative information collected.

**Key findings of the evaluation**

**Relevance:** UNICEF supported HV program, led by MoH, is fully aligned with national priorities and policies, are largely evidence based offering a comprehensive set of preventive services with intended linkages to other sectors. While they seem to be responsive to the needs of population, especially for Roma, Ashkali and Egyptian, the needs of poor and children with disabilities have not featured prominently. The interventions have been designed in a participatory manner addressing current needs of children and their families, particularly of Roma, Ashkali and Egyptian respecting gender and human rights issues UNICEF support to interventions, are considered appropriate with the potential of achieving desired results, only if two areas of the HV model are addressed. The first is the having nurses with the responsibility of delivering office as well as home-based services, that creates adverse incentives allowing them to choose between office vs home visits and the second is the frequency and timing of the prescribed home visits in the regulations. These topics are further elaborated in the recommendations section of the report.

**Effectiveness:** In summary, UNICEF was instrumental in addressing key system level bottlenecks albeit with variable results. Notably, the organization was extremely successful, in the environment where almost nothing existed, to advocate with institutions and provide technical assistance for the establishment of solid legislative and regulatory framework. However, supply and demand side bottlenecks were only partially addressed. Nevertheless, this partial achievement has its own objective explanations. Namely, on the supply side addressing structural factors affecting nurse supply is definitely beyond UNICEF's reach as it requires multi-sectoral and bold Government action. The nurse supply challenge, by far, is not unique to Kosovo and most countries around the globe face similar
Key findings of the evaluation

The evaluation faced some limitations that impeded data collection process and by far, is not unique to Kosovo and most countries around the globe face similar problems which has led WHO to propose Global strategy on human resources for health. Consequently, the evaluation team thinks, it would not be fair to expect from UNICEF to resolve this problem within the limits of HV program. Secondly, lack of transportation due to limited public funding of PHC is beyond UNICEF’s ability to tackle on a pilot or national scale. Thirdly, while UNICEF provided all other inputs required to facilitate HVN performance (e.g. bags, scales, etc.) the equipment gets outdated and not replaced by the facilities due to lack of funds and obviously affects sustainability.

Demand side bottleneck were also partially addressed. While work of the Red cross in communities and public awareness through social and regular media channels seems to have helped increase population awareness about immunization, breastfeeding and home visiting, this has not yet translated into effective demand (when measured by low number of home visits, although growing slowly). Focus Group Discussions (FGDs) conducted with beneficiaries helped evaluation team understand that changes in socio-cultural values are yet variable, which could also be a function of low coverage of families by Home Visiting Nurses (HVN). Finally, evaluation team thinks that quality bottleneck remains unaddressed due to interplay of low coverage and limited number of visits per newborn child which is only 1.4 per visited child.

Efficiency: The intervention to initiate HV was well coordinated with other projects and interventions as well as capitalized on already established structures and capacities by UNICEF allowing efficient use of available resources. To maximize possible results, sound partnerships with private sector were established and additional resources are being leveraged in support of HV system. Well documented evidence, generated with UNICEF’s financial support, informed design of the HV. Comprehensive M&E system has been developed and implemented, albeit the system requires further improvements and most importantly HV program requires mandates/demand from Government for better accountability for results against set performance targets.

Impact: The evaluation team, as stated in the MCE inception report, was not able to evaluate the impact of the program as it is at a very early stages of implementation. In Kosovo the evaluation team captured limited set of outputs (no outcomes or impact level data was yet available), which indicate on some potential future risks for the HV program if not addressed. Namely, challenges faced by HV program and arising from the health systems and the communities have to be timely addressed. E.g., while since 2016 the overall number of conducted home visits are growing, the current intervention coverage rates of both pregnant and children in the pilot municipalities are low and range between 10-26% of eligible population. Furthermore, municipalities are not revealing steady performance from a year to year, most likely revealing variable managerial capacity and/or variable accountability for achieved results.

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Presented program performance becomes even more dubious after averaging visits per individual (that was visited by a nurse). While coverage rates for pregnant women are extremely low, those that get visited do receive 1.44 visits on average instead of two prescribed by regulations. However, situation with children is more problematic. First, universal coverage of children with home visits faces problem, because only 16% of children 0-3-year-old are covered with home visits. Secondly, those that are visited by a nurse receive on average 1.5 visits instead of mandated five over initial three years of life. Thirdly, according to nurses and mothers most of these 1.5 visits occur during initial months after birth and consequently they are more medically focused without much elements related to child development, good parenting and/or risk identification, beyond medical risks. The positive development emerging from evaluation was the share of visits out of total home visits conducted to Roma, Ashkali and Egyptian families (N.B. both for pregnant and child, as the M&E system does not separate visits for a child or pregnant for these communities) was 8.2%, 6.0% and 8.6% from 2016 to 2018 respectively. These numbers indicate that HV reaches some vulnerable groups (not all), however with variable performance from a year to year. Furthermore, the evaluation team cannot ascertain if these levels should be regarded as satisfactory or if they should be higher, due to lack of municipal-level census data for these communities. Furthermore, no data was available to understand the delivery of services to poor or other vulnerable groups or across gender dimension. Consequently, the evaluation team is not in a position to conclude if inequities were reduced as a result of HV or if different population groups (including across the gender and poverty dimension) equally benefited from the program.

When looking at these outcomes numerous health system factors seem to be at play along with some socio-cultural believes that limit attainment of the results and require comprehensive response.

**Sustainability:** The evaluation team concludes that some critical factors (such as legal, institutional and financial mechanisms) positively affecting sustainability have been put in place by the program, however this is yet unfinished agenda and requires further fine-tuning. Also, there are broader structural and health system barriers, significantly bigger than HV, which needs attention and cross-governmental effort to enhance health sector performance and assure continuous supply of quality labor force. Finally, as the government works on PHC reforms/initiatives with UNICEF, the World Bank and Swiss Development Cooperation, it becomes important to exploit the window of opportunity and holistically consider the PHC model, its functions and staffing needs and embark on better coordinated route that will ensure greater sustainability of the system in a long-term perspective.

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15. Data supplied by UNICEF and describing nine municipalities out of fifteen, where comparable data over three-year period was available.
Lessons Learned

**Lesson 1:** Kosovo case study clearly demonstrates that sustained engagement with partners from government and other stakeholders through facilitation of national dialogue, high quality policy advice and technical assistance allowed for Government support for the institutionalization of system change. However, lack of focus on human resource supply when conducting health system analysis for the intervention design negatively affected potential sustainability of the HV model. Therefore, it is essential that UNICEF Kosovo office and for the government to ensure inclusion of the sustainability elements across all system building blocks in the design of the model. This approach would ensure longer-term sustainability of the HV model.

**Lesson 2:** Kosovo case study shows robust documentation of the approaches, steps, challenges and corrective measures taken by the project and lessons learned. Rigorous and continuous documentation certainly helped the evaluation team to understand the reforms as well as to validate its findings and compare with those found months/years ago. Albeit, only part of the evidence seems to have been effectively used by the government, when discussing or debating policy reforms for HV or when designing the model for service delivery and regulating it.

**Lesson 3:** Kosovo developed M&E system for the HV and diligently collected the information. However, the M&E system itself did not sufficiently capture relevant outcomes data for children and is rather concentrated on outputs only (presented in this report) which proves to be inadequate for monitoring HV program results or for augmenting accountability arrangements for the results in the health system. Seems for the Kosovo and UNICEF it is not only important to develop M&E and collect data regularly, but to be clear on how this data could help monitor the results; could help enhance accountability and most importantly facilitate the data-driven and action-oriented decision making on a home visitor and PHC provider level, before it reaches municipal or national level for further analysis.

Recommendations

Based on the findings the evaluation team recommends four key areas for future consideration and action each elaborated in more detail below. However, it has to be noted that these four areas should be seen as a closely inter-linked and mutually reinforcing and not as a silo group of recommended interventions.

**Model of Service Provision** itself touches upon three critical areas: *(a) appropriateness of current* one doctor two nurse model for achievement of HV aspirations considering implicit negative incentives which most likely leads to less than a home visit a day, while in other evaluated countries nurses conduct 5-6 visits a day. Furthermore, it is not clear how this model will play along with the SDC supported initiatives that are training same nurses for conducting home visits to chronic and lonely patients which further expands the requirements for the number of home visits. Therefore the need for home visits are expected to increase not only for HV but also for NCD management among chronic and
especially lonely elderly patients; (b) sufficiency of content of two visits to a pregnant women and five visits for a 0-3 child to timely detect risks and undertake timely preventive interventions or referrals and (c) how cross-sector cooperation and collaboration will be operationalized not only on the central level but on a local-community level. Finding solutions to the three issues would require on one hand more holistic consideration of basic package of services to be delivered by a reformed PHC which includes HV, NCD and other preventive and curative services; modality of facility based and community outreach service provision and its influence off staff time and staff requirements (number and qualification). Secondly, UNICEF, using current scientific evidence and accessible global expertise, could help government evaluate adequacy and sufficiency of the current content of the home visiting package for a pregnant and child 0-3-year-old to assure that the frequency and timing of the visits are sufficient to allow for timely risk identification and referral. And finally, there seems to be a need to discuss and agree on how the referrals within health sector and with other sectors would work on a community level and if these procedures and/or guidelines have to be mandated and regulated from a central level or facilitated through local – municipal level action.

Management for Results would also require set of concerted efforts. The first it would require demand and accountability for achieving set targets for HV that have to be established. Unless the targets are set ambitious enough and then demand for achieving these targets are placed on FMC managers and nurse coordinators it does not seems feasible for HV to deliver on universal part of HV. However, for this demand to be effective it would be essential to require family doctor and nurse to jointly plan for and deliver home visiting in a way that delivers the greatest benefit to a child and family. The second would be enabling managerial decision-making supported with adequate data system through well-designed and functioning HMIS (discussed later). And finally, there would be a need to enhance managerial capacity on a facility and municipality level with the knowledge and tools. Currently SDC is delivering management training to facility managers and maybe through better coordination and collaboration topics relevant to HV could be introduced in these trainings if circumstances permit. As for the management tools more details are provided below in the next section.

Money and resources seem to be critical for incentivizing home visits and also for creating more conducive working environment for home visitors. Namely, the government is considering performance-based payment for PHC. The evaluation team recommends considering home visits and achieved results as an element of the PHC performance measurement. In that monetary incentives, if introduced, would not be linked only to home visits but to also other results (e.g. immunization, chronic patient monitoring, etc.) that PHC team is expected to deliver. Furthermore, it would be essential to consider support with means of transportation and communication along with the necessary equipment/bags for home visitors, if the services have to be empowered.

Knowledge, Skills & Tool form the final bucket of recommendations and includes: (a) pushing knowledge and performance boundaries of nurses beyond medicalized approach and (b) supporting service provision with the digitalized home visitor checklists and other tools for service standardization as well as for information collection for HMIS. Overall, evaluation of service content described in paragraph 132 and demand for managing for results in paragraph 133 should naturally create environment where nurses are forced into practice that goes beyond purely medical visits and delivers on the progressive part of home visiting.
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visiting. However, this may require additional nudge as well as additional (refreshing and new modules) trainings which UNICEF and government should consider jointly. And finally, the HV should be seen as a means to collect the data of those, who do not reach the services, but are visited at home through universal home visiting. Therefore, the potential to maximize the value off the data HV collects (albeit currently on the paper), especially those that do not reach services, cannot be ignored. Therefore, the evaluation team thinks that to respond to SDG needs while capitalizing on the digital transformation of the 21st century, it is essential for UNICEF and countries to be more strategic when discussing M&E for HV.

Therefore, UNICEF and countries are recommended to consider digitalizing check-list (a) primarily as a tool which helps standardize nurse performance when conducting home visits to (b) generate critical data for improved case management for a child or mom, including for case referrals and secondly (c) as a means of freeing up time spent by nurses on administrative issues, compensating for labor shortages while allowing more time for higher number or for longer home visits and (d) generating critical information for M&E which can help improve facility level and municipal/national level management of services, conditioned power of artificial intelligence is well utilized for the data transformation/analysis into simple and informative management tools/dashboards for managers.
CHAPTER 1:
INTRODUCTION

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1.1 Context

Population of Kosovo is 1.79 million and is the youngest in Europe, with an average age of 30 years. According to the 2011 census the population is composed by Albanian nationals (91%), Serbs (3.4%) and other ethnic groups such as Turks, Bosnians, Roma, Ashkali and Egyptian, etc. By gender distribution there is a balance between male (50.4%) and female (49.6) population and the average life expectancy for women and men is 79.4 and 74.1 years respectively.16

Kosovo is a multi-party parliamentary republic with a Prime Minister of Kosovo being the head of government, and the President of Kosovo is the head of state. Kosovo is administratively divided into 38 municipalities. Post conflict fragility including lack of full international recognition continue to challenge economic and social prosperity. Over the years progress has been made in building a legal framework to safeguard the rights of ethnic and religious minorities. EU-facilitated dialogue between Kosovo and Serbia has led to several agreements, but their implementation remain challenging. While violent episodes are rare, the tensions between Kosovos Albanians and Kosovo-Serbs flare up occasionally. Till now Serbia continues to maintain administrative structures in four northern municipalities. Lack of an agreement at the higher political level continues to affect not only Kosovos membership in regional and international organizations but also further integration of the Serbian minority community into Kosovos political and economic system.17,18

Kosovo is one of the poorest countries in Europe as economic growth since independence has not been sufficient to reduce the high rates of unemployment, provide formal jobs, or reverse the trend of large-scale outmigration. According to the 2017 Household Budget Survey (HBS) 18.0 % of Kosovos population lives below the poverty line and 5.1 in extreme poverty.19

Kosovo experienced intense political struggles during 2016-2017 prior to the current coalition government was formed in 2017. The tensions between political parties and weakness of the previous government led to the governmental collapse and snap parliamentary elections. This was the third time in a row that the government collapsed, unable to tackle pressing issues such as unemployment, judiciary tensions and the border dispute with Serbia. The Parliamentary elections in June 2017 were followed by municipal elections in the fall of the same year during which public institutions were paralyzed.20

Soon after the new government came into the power with advocacy efforts of UNICEF Kosovo office the Home Visiting became the flagship program of the new leadership at the Ministry of Health.

1.2 Child health and wellbeing

There have been advances in healthcare provision in Kosovo in recent years, with improvements in the health outcomes of mothers and children. While national level indicators were improving urban/rural and ethnic disparities persisted indicating that many families and communities did not fully benefited from the right to health. Compared to the national estimates the range of maternal and child health indicators remain poorer among the Roma, Ashkali and Egyptian communities and access to quality healthcare services,
particularly community healthcare, was difficult for children with disabilities or developmental difficulties, and for socially vulnerable groups.\textsuperscript{21}

Child mortality rates fell progressively from late 1990s. According to Multiple Indicator Cluster Survey (MICS)\textsuperscript{(2013-2014)}\textsuperscript{22} under-five mortality fell from 47 per 1,000 live births during the 10-14 years period preceding the survey, to 15 per 1,000 live births during the most recent 5-year period (2008-2012). A similar pattern was observed for neonatal and infant mortality rates. According to the EUROSTAT Neonatal Mortality Rate reduction from 2000 onward was followed by the fluctuations since 2010.\textsuperscript{23} The Kosovo Agency of Statistics (KAS), that provides mortality indicators from 2010, demonstrates similar fluctuations for all three mortality rates\textsuperscript{24} (see Figure 1).

\textbf{Figure 1. Child Mortality}

\textbf{CHILD MORTALITY DYNAMICS}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{child_mortality.png}
\caption{Child Mortality}
\end{figure}

\textbf{Source: EUROSTAT; KAS}

\textbf{GENDER INEQUITIES}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{gender_inequities.png}
\caption{Gender Inequities}
\end{figure}

\textbf{Source: KAS}

\textsuperscript{21} UNICEF. 2017. Analysis on the Situation of Children with Disabilities in Kosovo.
\textsuperscript{22} The Kosovo* Agency of Statistics. 2014. 2013-2014 Kosovo* Multiple Indicator Cluster Survey. Prishtinë/Priština, Kosovo*.
Disparities based on ethnic or socio-economic background, and parental education level are striking for most health, nutrition and ECD/ECE indicators. As per MICS (2013-2014) the newborn, infant and under-5 mortality rates among Roma, Ashkali and Egyptian children are over three times higher than the average rates in Kosovo (see Figure 2). Children in rural areas have 1.5 higher probabilities of dying compared those living in urban areas (18 and 11 per 1,000 life births respectively). Low birth weight that carries a range of health risks is more prevalent among Roma, Ashkali and Egyptian children (9.7%) compared to the general population 5.4%.25

Significant inequities are observed in key nutrition indicators: In general population 4.3% of children under age five are moderately or severely stunted, while almost four-fold higher proportion (14.6%) is found among Roma, Ashkali and Egyptian children. There is a clear link between poverty and nutrition, as stunting is concentrated in the poorest quantile both in general population and among minority groups. Exclusive breastfeeding rate is 40% of children in rural areas have 1.5 higher probabilities of dying compared those living in urban areas (18 and 11 per 1,000 life births respectively). Low birth weight that carries a range of health risks is more prevalent among Roma, Ashkali and Egyptian children (9.7%) compared to the general population 5.4%.25

Figure 2 Child Health & Nutrition and ethnic inequities

ETHNIC INEQUITIES, mortality

![Graph showing ethnic inequities in mortality](source: MISC 2013-2014)

ETHNIC INEQUITIES, nutrition

![Graph showing ethnic inequities in nutrition](source: MISC 2013-2014)

Immunization coverage also differs by ethnic groups. According to the MICS (2013-2014) the percentage of children who received all the recommended vaccinations by their second birthday among general population is 84.5% compared to 38.5% among Roma, Ashkali and Egyptian children population.

Early Childhood Education (ECE) is important to ensure readiness of the child for school education and improved learning outcome. In Kosovo according to MICS (2013-2014), preschool attendance was 13.9% and 16.1% among 36-59 months old children in general population and ethnic minorities respectively. Socio-economic conditions and urban-rural residence appeared to be in positive correlation with preschool attendance.

Quality of home care such as engagements of adults in activities with children, presence of books in the home for the child, and the conditions of care is critical for the child's development. For 66.3% of children from general population and 40.7% of Roma Ashkali and Egyptian children aged 36-59 months an adult household member is engaged in four or more activities that promoted learning and school readiness. Fathers involvement in four and more activities with their children is extremely limited (about 6% in general population and 7% in ethnic minority groups). There are no gender differentials in terms of engagement of adults in activities with children.26

Presence of book is vital for later learning abilities. Only 31.1% of children under age-5 live in households at least three books for children are present, and this proportion is five times lower among Roma, Ashkali and Egyptian children. While no gender differentials are observed, urban children appear to have more access to books than those from rural households. Differences are also correlated with mother's education and households' economic status (66.7% among richest quintile compared to 9.7 % among poorest quintile).27

Children with disabilities in general and specifically children from the Roma, Ashkali and Egyptian communities are at high risk of abuse or neglect. The identification of children with disabilities is based on a medical rather than a social model. The legislation, that is under revision now, recognizes child disability only from age of one year, therefore children born with severe impairments and requiring immediate intervention are neglected by the system. At present accurate number of children with disabilities in Kosovo is unknown.28 Children with permanent disabilities receive cash support from the government but only after age of one.

Children have higher rates of poverty in Kosovo. In 2017, the overall poverty rate among children was 22.8 %, 4.8 percentage points higher than among the whole population and extreme poverty was 7.2 %, compared to 5.1 % among the whole population. The higher the number of children in the household, the higher the poverty rate.29 Social Assistance Scheme (SAS) is the only program targeted at poverty reduction. The SAS has strict eligibility criteria, therefore significant proportion of poor fall through the scheme. Another significant weakness is the lack of regular and automatic price indexation of SAS benefits. There is no particular program that targets children exclusively, however since 2015 families with children receive an additional small amount for every child to help maintain their health and nutrition.30 Families with un-registered children cannot acquire social assistance. Although significant improvements were observed during last years, Kosovo has the lowest birth registration rate in the region. According to MICS (2013-2014) data,

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27 ibid
28 UNICEF. 2017. Analysis on the Situation of Children with Disabilities in Kosovo
Kosovo has 931 PHC physicians, including both family doctors and general practitioners.

To address these gaps UNICEF Kosovo office in partnership with the Government, international and local partners advocated for and invested in the establishment of Home Visiting system which is family-centered, equitable, inclusive and offers innovative service.

UNICEF Regional Office for Eastern Europe and Central Asia, being the main supporters of HV for early childhood development in the region, commissioned multi-country evaluation of Universal Progressive Home Visiting for Young Children Well-being and Development in sixteen countries of the region. Thus, for the purposes of the multi-country exercise, Kosovo was selected as one of the case studies for more in-depth exploration.

1.3 Health System Bottlenecks

The reforms of the health sector that started in 2000 the patronage nursing system, inherited from Federal Republic of Yugoslavia, was completely abolished in Kosovo, except Serbian municipalities. The nursing staff conducting patronage visits were transferred to newly formed family medicine center (FMC) were one doctor and two nurses bear responsibility for the delivery of PHC services to about 2,000 residents in the community. During this transitional period, beyond this structural bottleneck, others also emerged and were well documented at the start of UNICEF’s HV program. These bottlenecks included:

Enabling Environment

The political instability along with the weak institutional accountability negatively affected government’s ability to deliver on policy promises. Along with the central government, municipalities were not well prepared to deliver equity-based services for children, including those requiring community outreach. All of this has led to limited responsiveness of central and local institutions to issues affecting the rights of children, adolescents and youth.

Insufficient funding for the health sector was not facilitating the translation of policy commitments into action for children and families. Health spending was not on the priority list of the government and within limited allocations to the health sector, secondary and tertiary care received higher priority over PHC and community outreach services.

Finally, insufficient funding made inequalities worse and limited access to healthcare for vulnerable groups. Insufficient funding was hampering the implementation of institutional and legal reforms and did not allow tackling inequities caused by out-of-pocket expenditures.

All of the aforementioned was further compounded by complete lack of legislation or regulations for home visiting.

Supply side bottlenecks

Kosovo has 931 PHC physicians, including both family doctors and general practitioners, for 1.9 million inhabitants. This averages 2040 inhabitants per PHC physician versus 2020 would require employing additional 300 physicians to meet populations’ needs.

around 88 % of children in Kosovo were reported as registered at birth, with 74 % possessing a birth certificate.

To address these gaps UNICEF Kosovo office in partnership with the Government, international and local partners advocated for and invested in the establishment of Home Visiting system which is family-centered, equitable, inclusive and offers innovative service.

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2020 would require employing additional 300 physicians to meet populations' needs. Furthermore, of the 910 general practitioners required under the new PHC model, only 552 were available according to WHO study of 2018. Furthermore, Kosovo has 2,183 nurses employed in PHC who often are the only staff available in remote family medicine centers where physicians only visit once or twice per week. Although many PHC nurses are employed, there are fewer than 2 nurses per physician working in the system, because the migration of nurses is a challenge. For example, Pristina family medicine center has 65 nurse and 35 doctor vacancies. In recent years, attention to the professional development of PHC nurses has increased and the Central Health Authorities organized training on communication skills and motivational counselling through a training-of-trainers approach for almost all PHC nurses. However, in Kosovo, fewer people than in other European countries are satisfied with their visits to PHC, and studies indicate that patients' expectations for PHC services in Kosovo have not been met. PHC capacity in terms of team composition, competencies and available equipment does not match the health needs and expectations of the population, which leads to decreasing prestige and bypassing of PHC services.

Emergence of out-of-pocket payment as a means of accessing care allowed patients choose the level they wished to attend - without being referred - despite paying higher prices and all of this has led to the breakdown of the referral system between levels of care and in that undermined the concept of continuous care provision i.e. timely and appropriate referrals.

Accountability within the health sector was suffering due to inadequate HMIS and due to lack of culture and capacity among decision makers to hold the services accountable for the outcomes. Lack of reliable data and/or insufficient technical capacity to analyze data undermined evidence-based policy developments and resulted in inefficient management of health services. Managerial capacity of all managers responsible for the administration of primary health care at local level needed significant improvement and reproductive, maternal and child health was seen as a potential entry point for introducing managerial tools such as planning and monitoring frameworks.

**Demand side bottlenecks**

Heavy reliance on co-payments and informal payments when seeking care created significant financial access barriers and contributed to growing inequity. Furthermore, geographical access and transportation costs emerged as a barrier to accessing care. Large part of population (30%-60% in different regions), living more than 3 km away from medical facility, found difficult to cope with transportation costs thus making home visiting even more important. Poor households were affected at most when trying to overcome physical and financial access barriers as majority of the poor population lives in rural areas and spend much larger share of their income on health-related transportation expenditure than elsewhere in the sub-region.

Financial and geographical access barriers were further compounded by cultural and ethnic norms and beliefs, where women are not allowed to travel alone, where established norms around breastfeeding or child upbringing are against the scientific evidence and where violence against the child i.e. punishment is an accepted norm in the society. Or where the proportion of young people who justify domestic violence against women is as high as among older men, which point 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.
Lack of community awareness and public sensitization about early childhood development issues and good parenting, along with lack of information about home visiting services and their value were negatively affecting demand for these services. There was a need to generate more demand by increasing the community understanding of the benefits afforded by the home visiting.

### Quality Related bottlenecks

Weak accountability for results (noted earlier) was also negatively affecting quality of delivered services. Thus, quality was not perceived as a performance issue and there was no practice of either assessing or ensuring the quality of delivered services by the health system, including for home visiting.

The staff shortages were compounded with the lack of a full range of MCH related guidelines and protocols and insufficient compliance with the existing ones resulting in suboptimal service provision. Consequently, large parts of the population bypassed the FMCs, which was a clear indication of lack of trust in the quality of PHC delivered services.

### 1.4 UPHV model and UNICEF’s support

#### Figure 3 UPHV Model

![UPHV Model Diagram]

49 Based on information provided in interviews with MOH and facility managers in municipalities.


Thanks to the advocacy efforts of UNICEF over past decade ECD emerged as an important priority on the government’s agenda across the sectors of education, health and social protection. This provided the space to re-start home visiting in Kosovo that was triggered by Istanbul conference, organized by the UNICEF regional office in 2013. The conference was followed by UNICEF commissioned initial assessment and culminated in a two-day conference on “support to early childhood development in Kosovo and the role of home visiting and outreach services”, which was co-organized by UNICEF, MoH, Ministry of Education, Science and Technology, (MEST) and Ministry of Labor and Social Welfare (MoLSW).

Hence, one of the UNICEF’s program priorities was to introduce and advance community-based services that are more family-centered. Consequently, home visiting (HV) was tasked to apply family-centered and gender-sensitive approaches when providing quality outreach and home-visiting services, especially to vulnerable children and pregnant women. Based on the reviewed documents and key informant interviews, UNICEF supported introduction of Universal and Enhanced components of HV model (see Figure 3) initially in five pilot municipalities, rolling out to 15 municipalities by the end of 2018. Currently UNICEF supports further rollout with the aim of in total involving 30 municipalities in HV before the end of 2020.

The overarching goal of the UNICEF’s support to strengthening HV pilot model during 2014-2018 was to assure that every child develops at full potential and no child is left behind. In the adapted TOC, the outputs originally set by UNICEF were relevant for the Kosovo program and grouped under two main objectives: i) improving early identification and support of children with health related problems, disabilities, at risk of developmental delays, abuse, neglect and abandonment; and ii) improving parental knowledge and practice about newborn care, child health, development and nurturing parenting practices by HV system (see Figure 4).

Achievement of this goal was not possible without addressing described health system bottlenecks and improving the quality and accountability of services, ensuring that they meet set standards, reach the most vulnerable, ensured access to needed ECD services within and outside the health sector and supported parents in providing adequate care.

Specifically, UNICEF identified the following activities to address each health system bottleneck:

**Enabling environment:** i) Development of mandates in the laws and strategies, and standards for home visiting services to enable operationalization of HV; ii) Design of the risk assessment tools (checklist) to allow for standardization of a nurse practice and early identification of the possible risks to child development by HVNs; iii) engaging, educating and facilitating coordination among different sectors to facilitate timely referrals from home visitors to other sectors/services. All these interventions were thought to enrich HV services with social and other aspects of care, ensure coordinated multisectoral response towards identified risks to child health, development and wellbeing.

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Every child is able to develop their full potential and no child is left behind

**OUTCOMES**
- Improved early identification and support of children with health related problems, at risk of developmental delays, with disabilities, at risk of abuse, neglect and abandonment and improved

**OUTPUTS**

**MoRES level 2**

- Improved parental knowledge and practice about newborn care, child health, development and nurturing parenting practices

**MoRES level 3**

- Enabling Environment
  - Drafting laws, secondary legislation and regulations in support of HV Development of HV operational standards and guidelines Development of HV training materials, Supporting development and implementation of fieldE system for EM facilitating coordination among different sectors for timely referrals Awareness rising of local authorities on a municipal level

- Supply
  - Training of nurses, social workers and educators and Awareness rising of facility managers/capacity strengthening

- Demand
  - Parental education through developing & disseminating material about “Better Parenting Initiative” with the help of red Cross, Increasing awareness using social and regular media channels, Leveraging partnership with private sector

- Quality
  - Achieve high coverage with home visits with adequate content of services, Enhance coordination between I-1V nurses, pediatricians, and other specialists in the health sector

**UNICEF CONTRIBUTION THROUGH CORE ROLES**

**Equity focused analysis of child survival, health development and wellbeing and health system level bottleneck analysis**

**Supply:** Capacity building of HV personnel was recognized as a priority support area to ensure provision of HV services by knowledgeable and adequately skilled and equipped personnel. Development of the HV training program and materials, training of master trainers and capacity building of Nurses, family doctors, social workers and educators has been prioritized. Also, investments were made in nursing bags and equipment and in selected municipalities in the means of transportation. Finally, for 2019-2020 UNICEF, with recommendations from the home visiting working group, plans to train health facility managers to facilitate further expansion of the model.

**Demand:** To improve parental knowledge in ECD related issues and cultivate nurturing parenting behavior the program focused on parents' access to knowledge and services focused on helping them adopt practices and behaviors fostering the early development of their children. It was believed awareness raising activities supported through Kosovo Red Cross in the communities and through social and regular media for general public will allow for the delivery of HV services in a more culturally sensitive manner.

**Quality:** Well established enabling environment, capacitated HV personnel along with improved parental knowledge and practices, adequate coverage of mothers and newborns with home visits and operationalized referral pathways within and outside health sector
Every child is able to develop their full potential and no child is left behind.

Equity focused analysis of child survival, health development and wellbeing.

UNICEF CONTRIBUTION THROUGH CORE ROLES

IMPACT

OUTCOMES

OUTPUTS

MoRes level 2

MoRes level 3

Improved early identification and support of children with health related problems, at risk of developmental delays, with disabilities, at risk of abuse, neglect and abandonment.

Enabling Environment

Drafting laws, secondary legislation and regulations in support of HV Development of HV operational standards and guidelines.

Development of HV training materials.

Supporting development and implementation of Itel&E system for FM Facilitating coordination among different sectors for timely referrals.

Awareness rising of local authorities on a municipal level.

Supply

Training of nurses, social workers and educators.

Awareness rising of facility managers/capacity strengthening.

Demand

Parental education through developing & disseminating material about “Better Parenting Initiative” with the help of red Cross.

Increasing awareness using social and regular media channels.

Leveraging partnership with private sector.

Quality

Achieve high coverage with home visits with adequate content of services.

Enhance coordination between IV nurses, pediatricians, and other specialists in the health sector.

Improved parental knowledge and practice about newborn care, child health, development and nurturing parenting practices.

Supply:

Capacity building of HV personnel was recognized as a priority support area to ensure provision of HV services by knowledgeable and adequately skilled and equipped personnel. Development of the HV training program and materials, training of master trainers and capacity building of Nurses, family doctors, social workers and educators has been prioritized. Also, investments were made in nursing bags and equipment and in selected municipalities in the means of transportation. Finally, for 2019-2020 UNICEF, with recommendations from the home visiting working group, plans to train health facility managers to facilitate further expansion of the model.

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Quality:

Well established enabling environment, capacitated HV personnel along with improved parental knowledge and practices, adequate coverage of mothers and newborns with home visits and operationalized referral pathways within and outside health sector.

Figure 4: Adapted Theory of Change
along with improved coordination were thought to contribute to better quality ECD services of all children, especially of most vulnerable.

Effective implementation of all planned activities was supposed to contribute to i) promotion of health, development and wellbeing in the family/local community; ii) Identification of risk factors and needs during pregnancy and the early years; iii) Connection of families with health care, social protection and other services in the community depending on family needs; iv) Early identification of difficulties in development and violent situations; v) Adequate references and interventions for families with special needs.  

UNICEF supported intervention intended to target the following beneficiaries in the targeted municipalities: i) **rights holders:** all pregnant, mothers/primary caregivers and children aged 0-3 years, family members. Vulnerable population: unemployed; disadvantaged and poor (those receiving social assistance); teenage and/or single parents; children with disabilities; Roma, Ashkali and Egyptian communities. ii) duty bearers: nurses and social workers and educators to acquire new knowledge, skills and job aids through training and provision of guidance on the service provision, coordination among HV professionals as well as with other services and provision of various job aids; iii) duty bearers: Ministry of Health, central and local institutions along with the local governments, municipal health and social sector authorities, health and other support service providers to effectively organize and manage services required for child survival, health and development; and finally iv) supporting and engaging NGOs for the dissemination of the information in the communities and in that fueling the demand for HV services.

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52 UNICEF 2017. Stocktaking on home visiting in Kosovo
CHAPTER 2:
EVALUATION PURPOSE, OBJECTIVES AND METHODOLOGY
The evaluation of UNICEF support towards enhancement of HV service in Kosovo is an integral part of the multi-country evaluation (MCE) that looks at UNICEF’s contribution in promoting HV in the Europe and Central Asia (ECA) region. Serbia, Armenia, Kosovo and North Macedonia were selected out of 16 ECA countries for in-depth evaluation, while other countries will undergo only desk review and phone interviews with the limited set of stakeholders. Thus, Kosovo case studies along with the multi-country evaluation report are intended to inform government’s and UNICEF’s future decisions about HV’s promotion and implementation in the EE&ECA region.

The evaluation of HV services in Kosovo examines the extent to which efforts of UNICEF Office to promote HV have contributed to addressing the noted health system-level bottlenecks in child survival, health, development and wellbeing. More specifically, the evaluation: i) reviews the theory of change for Kosovo context to assess the relevance of the HV model in addressing young child survival, health and well-being; ii) examines extent to which the HV model has been successfully applied in the targeted geographical areas and what are the results and explores success factors and identifies constraints to implementation; iii) assesses UNICEF’s specific contribution, in terms of the role the organization has played, towards addressing health system level bottlenecks and improving coverage with evidence-based quality interventions; and iv) assesses extent to which the results achieved to-date have/can support and inform the design of the Government programs for the delivery or scale-up of HV services at the national level and the factors that may facilitate or impede the scale up efforts.

Evaluation Scope and geographical coverage: The evaluation examined UNICEF’s support to enhancement of HV services in Kosovo over the period 2014-2018. Thematic scope of the evaluation focused on home-visiting services with its universal and enhanced components according to Figure 3, initially piloted in five municipalities and rolled out to 15 municipalities by the end of 2018.

Intended beneficiaries: The evaluation gives an important learning opportunity, both for UNICEF and its national partners, deriving lessons and evidence from the experience that can inform the scale up of good practices and UNICEF’s programming. The findings and recommendations of the HV evaluation will benefit multiple stakeholders. UNICEF Kosovo Office management responsible for designing UNICEF’s cooperation plan will use the Kosovo case study and MCE findings to inform UNICEF’s support to national government in the scale-up of the HV services. UNICEF staff, Health, ECD, Child Protection and Social Policy specialists will utilize the MCE findings and lessons learned for the advocacy and provision of ongoing support to national governments in streamlining the services included in the HV model, improving access of the most vulnerable children to quality home visiting services and further scale-up. It is expected that the findings and lessons learned stemming from this evaluation will help the government (in particular Ministries of Health, Ministries of Education, Ministries of Social Protection and municipalities) and their partners in formulating the national reform agenda and programs, as well as guiding the process of the HV national scale-up.
Evaluation Methodology: To meet the evaluation requirements the evaluation team adopted a theory-based approach, as appropriate for complex evaluation objects. The Evaluation Team (ET) adapted and contextualized the generic Theory of Change (TOC) illustratively converted into the Figure 4 on page 88. The TOC is based on a consensus in ECA region that the progressive realization of child rights and reduction of equity gaps is best achieved through changes in systems. The evaluation reviewed extent to which HV has been successfully applied in the targeted municipalities and resulted in required health system level changes. The latter was appraised along the MORES framework dimensions, such as creating enabling environment, development and implementation of conducive policies and legal framework, allocation and utilization of expenditures as well as effective management and coordination at national and sub-national level, and identification, prioritization and overcoming bottlenecks hampering availability, affordability, adequacy and use of home visiting services, both from supply and demand driven determinants.

Evaluation Criteria and Framework: According to the MCE Terms of Reference (TOR), the evaluation examined the impact, relevance, effectiveness, efficiency and sustainability following OECD DAC evaluation approach. These criteria were selected as: i) the standard international criteria for development evaluation, as suggested in OECD/DAC Manual, ii) appropriately geared to the purpose and objectives of the evaluation, and iii) appropriate for the learning emphasis of the study.

Evaluation phases, data collection methods, analysis and quality assurance: The evaluation methodology comprised a mix of three site visits in the pilot municipalities and observation, face-to-face in-depth interviews (IDI) with 55 individuals including government officials, representatives of health, social protection, service providers and non-government organizations (Annex 2: List of Key Informants), 9 FGDs with HVNs, pregnant women and mothers of children 0 to 3 years old (in total 74 individuals) and desk-based review of 72 documents containing qualitative and quantitative information informed the report.

The evaluation was implemented in three phases. In the first, desk review phase, ET conducted desk review and prepared detailed evaluation design which includes stakeholder mapping, design of the evaluation framework, selection of evaluation sites and beneficiaries, interview and focused group discussion guides, as well as a detailed plan for data collection. For filed based data collection the ET selected 3 intervention sites (Fushe Kosova, Dragash and Ferizaj). During site sampling the multistage purposive selection methodology has been applied (see details in Annex 3: Detailed evaluation methodology).

During the second phase June 30-July 13th, 2019, the evaluation team comprised of two international experts and one national expert organized a kick-off meeting and discussed evaluation methodology, time frame and deliverables with Kosovo Evaluation Reference Group (KERG) (see Annex 2: List of Key Informants); completed data collection at national level through IDIs, at some instances group interviews and FGDs in all selected sites. At the end of this phase, preliminary evaluation findings and recommendations based on the results of desk review and field data collection were presented to key stakeholders, initial reactions, suggestions, comments and follow up actions were discussed.

And during the last phase, the evaluation team analyzed collected data, prepared the draft evaluation report and submitted to UNICEF for formal review process.
The comments and suggestions provided by the Government and UNICEF will be addressed and incorporated into the final Evaluation Report. The final report will incorporate recommendations and comments from the Government, UNICEF and other Kosovo-based reviewers as appropriate. At the end of this phase, the second mission to Kosovo with the approximate duration of 2 days will be carried out by the evaluation team leader to present final findings and recommendations to the wide group of stakeholders.

Both, qualitative and secondary quantitative data analysis, from the above sources have been carried out to arrive at conclusions and formulate recommendations, presented in this report. Findings were triangulated across different sources to arrive at robust set of results. Qualitative data analysis entailed documentation, conceptualization, coding in Nvivo (qualitative analysis software), categorization and examining relationships. The quantitative data was derived from the secondary data obtained through the demonstration project administrative data and program/project related Monitoring and evaluation reports. Analytical methods for quantitative data included trend analysis, where possible.

Table 1: Number of participants for FGD and short interviews

<table>
<thead>
<tr>
<th>PHC</th>
<th>FGD participants</th>
<th>FGDS with home visiting nurses</th>
<th>FGDS with pregnant women</th>
<th>FGDS with parents</th>
<th>FGDS with Roma, Ashkali, Egyptian and other communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fushe Kosova</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>Dragash PHC</td>
<td>9</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Ferizaj PHC</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>14</td>
<td>23</td>
<td>12</td>
<td>74</td>
</tr>
</tbody>
</table>

To assure the quality of findings the evaluation team used: i) elements of multiple coding, with regular cross checks of coding strategies interpretation of data between local and international experts participating in the study; ii) used grounded theory for data analysis that helped mitigate the potential bias enshrined in the experts' prior theoretical viewpoint; iii) triangulation of data from different sources helped address the issue of internal validity by using more than one method of data collection to answer proposed evaluation questions; and iv) respondent validation, which involved cross checking interim and final evaluation findings with key informants enhanced the rigor of the evaluation results.

During the evaluation the MCE team ensured impartiality and independence at all stages of the process, which contributes to the credibility of the evaluation and to the avoidance of bias in the findings, analyses and conclusions.

Stakeholder Participation and Ethical issues:

The evaluation team ensured active participation of key stakeholders in all phases. The evaluation interviewed all key stakeholders. After completion of data collection in Kosovo, at the end of the mission, ET presented preliminary findings and recommendations to Kosovo Evaluation Reference Group (KERG) and solicited comments and suggestions. Initial draft of the report has been...
The comments and suggestions provided by the Government and UNICEF will be addressed and incorporated into the final Evaluation Report. The final report will incorporate recommendations and comments from the Government, UNICEF and other Kosovo-based reviewers as appropriate. At the end of this phase, the second mission to Kosovo with the approximate duration of 2 days will be carried out by the evaluation team leader to present final findings and recommendations to the wide group of stakeholders.

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<th>PHC Dragash</th>
<th>PHC Ferizaj</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGD with home visiting nurses</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>FGDs with pregnant women</td>
<td>6</td>
<td>4</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>FGDs with parents</td>
<td>12</td>
<td>11</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>FGDs with Roma, Ashkali, Egyptian and other communities</td>
<td>10</td>
<td>2</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>37</strong></td>
<td><strong>26</strong></td>
<td><strong>11</strong></td>
<td><strong>74</strong></td>
</tr>
</tbody>
</table>

To assure the quality of findings the evaluation team used: i) elements of multiple coding, with regular cross checks of coding strategies interpretation of data between local and international experts participating in the study; ii) used grounded theory\(^5\) for data analysis that helped mitigate the potential bias enshrined in the experts' prior theoretical viewpoint; iii) triangulation of data from different sources helped address the issue of internal validity by using more than one method of data collection to answer proposed evaluation questions; and iv) respondent validation, which involved cross checking interim and final evaluation findings with key informants enhanced the rigor of the evaluation results. During the evaluation the MCE team ensured impartiality and independence at all stages of the process, which contributes to the credibility of the evaluation and to the avoidance of bias in the findings, analyses and conclusions.

**Stakeholder Participation and Ethical issues:** The evaluation team ensured active participation of key stakeholders in all phases. The evaluation interviewed all key stakeholders. After completion of data collection in Kosovo, at the end of the mission, ET presented preliminary findings and recommendations to Kosovo Evaluation Reference Group (KERG) and solicited comments and suggestions. Initial draft of the report has been

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5 Thomas DR. (2018) Grounded theory. Chapter 22 in How to do Primary Care Research, edited by Goodyear-Smith F and Mach K.
shared for comments with UNICEF Office in Kosovo and KERG and feedback received will be reflected in the final report as appropriate.

The evaluation was guided by UNEG ethical guidelines for evaluation and applied the following approaches: i) the ET with the assistance from UNICEF filled in the ethical checklist and as a result no ethical clearance was required; ii) the team kept the evaluation procedures (FGDs and IDIs) as brief and convenient as possible to minimize disruptions in respondents work; iii) to ensure that potential participants can make informed decision, ET explained the purpose of evaluation and outcome, the process and duration of interview and/or FGD, confidentiality and data storage procedures and possibility to refrain from answering the questions posed in case key informant felt uncomfortable to respond; iv) key informants were interviewed face to face without presence of other individuals and their identities were not to be revealed and or statements attributed to a source; v) for FGDs, the ET applied grouping of participants to encourage open discussion around the evaluation questions by avoiding presence of their superiors and FGDs were held separately for each target beneficiary group; and vi) Information was analyzed, and findings reported accurately and impartially.

Evaluation Limitations and Mitigation Measures: The evaluation faced some limitations impeding data collection process and affecting the findings. Specifically, the absence of the impact and outcome level quantitative data restricted the evaluation examining whether services contributed to long-term positive changes in wellbeing of children, particularly of those most vulnerable. These limitations were mitigated to a certain degree by ensuring the participation of the most vulnerable families in the evaluation process, through appropriate data collection methods and tools and drawing conclusions mostly based on qualitative data collected.

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56 Thomas DR. (2018) Grounded theory. Chapter 22 in How to do Primary Care Research, edited by Goodyear-Smith F and Mash R.
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CHAPTER 3:
EVALUATION FINDINGS
This chapter presents the findings for each evaluation criteria: relevance, effectiveness, efficiency, sustainability and impact. The guiding questions included in the Annex 8: Evaluation ToR and refined during the inception phase are provided at the beginning of each section and referenced throughout the text. In each sub-chapter, the key findings are highlighted and form the basis for the conclusions.

3.1 Relevance

The evaluation team examined relevance of UNICEF supported interventions with the Government strategies, policies and programmatic interventions to address young child health, wellbeing and development in Kosovo. The information derived from document review, collected from key informant's and FGDs, after triangulation and validation, informed our opinion.

UNICEF’s supported interventions for HV services (objectives, strategies, activities, etc.), are well aligned with key national priorities reflected in the national development strategy (NDS) report 2016-2021 emphasizing importance of leaving no one behind by improving access to and quality of health services and providing greater financial protection through universal health insurance, as well as in the Strategy and Action Plan for Protection of Children’s Rights 2014-2018 and 2019-2023. The MoH recognizes the home visiting as a priority service within PHC, which is specified in the Government Program 2015-2018. Home visiting is seen as an effective approach to providing critical services to the population and especially to those facing challenges in accessing health care services. The importance of home visiting is also reflected in the Ministry of Finance document for 2019-2021 allocating slightly more funds to Family Medicine Centers (FMCs) from where home visiting is being delivered.

Evaluation questions for Relevance

- To what extent are the demonstration home visiting services (objectives, strategies, activities, etc.) aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion?
- To what extent the pilot home visiting services and approaches to delivery of support are: a) evidence-based; b) correspond and address actual needs of children, families and communities in the pilot region (and nationally, if scaled-up), especially the most vulnerable children and families; c) contributes to gender equality?
- Is the design of the model services and the activities appropriate for achieving the intended results and outcomes?
- Has the model service design and implementation been aligned with the Convention on the Rights of the child principles (non-discrimination, best interest of the child, the right to life, participation), gender mainstreaming and Human Rights Based Approach (HRBA) to programming? Did it contribute towards gender mainstreaming and HRBA?
- Were relevant partners involved in the program design, implementation and evaluation, including beneficiaries?

59 Final Stocktaking Report on Home Visiting in Kosovo, MoH/UNICEF compiled by Louise Aydinian, December 2017
The approaches for the delivery of HV services are well informed by the comprehensive assessments\(^{61,62}\), commissioned by UNICEF during 2013-2014 and are evidence based. UNICEF supported activities are primarily focused on four critical areas such as: (a) capacity building for nurses on ECD and home visiting; (b) defining the package of home visiting services through creating enabling environment and providing material inputs such as bags, scales, cars, etc.; and (c) increasing population awareness and in that demand for home visiting services through community focused interventions with the help of Red Cross and through social media campaigns and (d) advocating government to invest more resources in home visiting through mobilization of more budgetary resources and allocating it for PHC and for home visiting. Thus, the activities planned are relevant to address some important health system level bottlenecks identified during the initial phase of the program development.

The design of the model, as noted earlier, is Universal + Enhanced (see Figure 3 on page 26) and is largely responsive to the needs of children and their families, particularly of Roma, Ashkali and Egyptian and are gender sensitive attempting to respond to gender specific needs/behaviors observed within the communities. Albeit, focus on the poor or on children with disabilities are not prominent and explicit in the plans and in the reports produced by the government, with or without UNICEF support. Interventions under HV are aimed at ensuring that access for Roma, Ashkali and Egyptian children and their parents is secured for early childhood development and care services through the development of home-visiting nurse capacity and through training of social workers and establishment of closer functional linkages with home-visiting nurses.

Training material by its design is also evidence based and seems appropriate to achieve intended results and outcomes. The design of the package of HV services is informed by the most recent scientific evidence and is based on the UNICEF/ISSA modules on home visiting.\(^{63}\) HV model uses lifelong approach and attempts to provide a comprehensive package of services at different stages of child development (schematically presented in the Table 2). The current design of HV in Kosovo intends to provide preventive services by linking children and their families at risk to other services within and outside of the health sector, where possible. However, the model was not intended to assure fully cross-sectoral case management but was rather limited to universal and enhanced components of HV.

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While most aspects of the model seem appropriate and evidence based, two issues require further discussion: The first is organization of the service provision within family medicine center, where same nurse is responsible for the delivery of the office as well as home-based services. The model seems to create adverse incentives on a personal level for nurses by prioritizing office-based visits over home visits and in that adversely affecting number of home-visits conducted by a nurse per month ranging between 13-15 or less than a visit a day.65

The second issue relates to the frequency and timing of the visits. Namely, the model suggests two visits for a pregnant woman and five visits for a 0-3-year-old child. Out of these five visits three have to occur during first year of life and the remaining two during second and third year of life. Evaluation team questions sufficiency of three visits during first year after birth and one visit per year during age of two and three. Unless the number and timing of the home visits are closely linked with the child developmental milestones,
The second issue relates to the frequency and timing of the visits. Namely, the model emerged from FGDs and were confirmed by most participants, including nurse coordinators through IDIs and through their monthly reports to MoH.


While most aspects of the model seem appropriate and evidence-based, two issues require further discussion: The first is the having nurses with the appropriate with the potential of achieving desired results, only if two areas of the home visiting model are further discussed and addressed. The first is the engagement of specialists from different disciplines, including the social workers, psychologists, public health experts and educators in the design and delivery of trainings. Albeit, active involvement of end-users of the services in the design of the HV model did not feature prominently neither in the documents and nor during the interviews or FGDs.

Conclusion on Relevance: To conclude UNICEF supported home visiting intervention is fully aligned with national priorities and policies, are largely evidence based offering a comprehensive set of preventive services with the intent to enhance linkages with other sectors. While they seem to be responsive to the needs of population, especially for Roma, Ashkali and Egyptian, the needs of poor and children with disabilities have not featured prominently. The interventions have been designed in a participatory manner addressing current needs of children and their families, particularly of Roma, Ashkali and Egyptian respecting gender and human rights. UNICEF support to interventions, are considered appropriate with the potential of achieving desired results, only if two areas of the home visiting model are further discussed and addressed. The first is the having nurses with the

UNICEF engaged relevant partners in intervention design, implementation, and monitoring. UNICEF ensured effective participation of multi-sectorial stakeholders during the whole cycle of intervention planning and execution. In support of home visiting UNICEF managed to build broad-based partnership with national entities such as: Ministry of Health (MoH); Centre for Development of Family Medicine of Kosovo; Local Municipalities; Main Family Health Centers (MFHC); Center for Continued Nursing Education (CCNE); Ministry of Education, Science and Technology (MEST); Ministry of Labor and Social Welfare (MoLSW); National Institute of Public Health (NIPH); Kosovo Agency of Statistics (KAS). Besides, engaged with the international partners from donor and NGO community, which were critical for advancing home visiting agenda and generating broad-based support to the idea. UNICEF also promoted i) establishment of multidisciplinary working groups at the national level to support development of home visiting services in Kosovo; ii) engaging different sectors at the municipal level to improve coordination at the local level; iii) engagement of specialists from different disciplines, including the social workers, psychologists, public health experts and educators in the design and delivery of trainings. Albeit, active involvement of end-users of the services in the design of the HV model did not feature prominently neither in the documents and nor during the interviews or FGDs.

The evaluation confirmed intervention alignment with international instruments, standards and principles on HRBA & GE. Activities planned under the intervention aimed at supporting and empowering policy makers, capacity building of service providers and parents with information to take actions and achieve equitable development for all young children, and in particular young children of Roma, Ashkali and Egyptian ethnicity, whose health and developmental outcomes were lagging behind. HRBA and GE crosscutting issues were incorporated in key project components such as assessments, program documents, training materials, etc. Furthermore, increased use of evidence-based and innovative communication approaches as part of the home visiting were intended to address selected social norms and behaviors in relation to inclusion of children with disability, Roma, Ashkali and Egyptian children and violence against children and women. The intervention promoted the use of tools for early identification and follow up of developmental risks at age of 6 and 9 months. Activities with Roma, Ashkali and Egyptian families were also oriented towards the empowerment of women, bringing out changes in the stereotypes of traditional gender roles within the targeted communities. Additionally, the involvement of fathers in child development stimulation and nurturing parenting was claimed to be attempted, albeit yet without tangible outcomes.

66 Confirmed during FGDs with mothers and pregnant and IDIs with facility managers, nurses and other key informants.

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To address abovementioned bottlenecks (see section 1.3 above) UNICEF used its core roles of delivering office as well as home-based services, with described adverse incentives and the second is the frequency and timing of the prescribed home visits. These topics are further elaborated in the recommendations section of the report. Finally, for robustness of the presented findings please see Annex 3 on page 77.

### Effectiveness Evaluation Questions

- Were the objectives of UNICEF supported program(s) a) appropriate to address all relevant determinants (enabling environment, demand, quality and supply); b) realistic to address these determinants both through its direct intervention and by convening and advocating with partners c) Has the UNICEF supported program(s) contributed to achieving required changes as per the planned objectives?
- Has the UNICEF supported program(s) contributed to eliminating bottlenecks in ensuring coverage of UPHV services (creating enabling environment; Increasing availability of supply and qualified human resources; Ensuring financial accessibility; Changing knowledge and raising awareness about and demand for services; Ensuring quality of services)
- What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the service design and implementation, professional practices) were crucial for the achievement or failure to achieve the service objectives so far, especially reaching most vulnerable groups?
- How effective were capacity building activities targeting the staff of the demonstration services?

### 3.2 Effectiveness

This section of the report looks at UNICEF’s effectiveness by examining the contribution towards addressing all relevant determinants, eliminating bottlenecks and ensuring coverage of children and their families, particularly most vulnerable groups with necessary home visiting services.

The objectives of UNICEF supported interventions, described earlier in the report, were appropriate to address part of the identified bottlenecks. Namely: legal and regulatory shortcomings governing service provision by HVNs, advocacy to increase public funding for PHC, including for HVs, reducing access barriers with the help of community outreach, and especially for vulnerable, the knowledge and skills of home visitors, improving recording and reporting requirements and generating critical data about HVs, increasing parental awareness about ECD and home visiting. Most importantly UNICEF helped (TA & Policy Development) develop draft law on child protection (expected to undergo final reading in the Parliament) where Article 41 creates mandate for the health sector to deliver home visits to pregnant and children during the first three years of life, developing organizational setup, service standards and content for home visiting which defined mandates for two visits for a pregnant and five for the child during the first three years of life; developed organizational setup, service standards and content for home visiting (Advocacy & Technical Assistance), government developed regulations for the home visiting. Advocacy with the government rendered results that are prominently reflected when MoH assuming critical ownership and bringing social and educational sector along with UNICEF in its importance.

Nonetheless, some critical bottlenecks such as supply shortage of human resources (nurses) were not addressed. Notably challenges with nurse supply were of structural nature and beyond UNICEF's ability to resolve. These bottlenecks were largely determined by previous government's (before 2015). Thus, the objectives of UNICEF supported intervention were appropriate to address significant number of supply and demand side bottlenecks, but maybe on a pilot scale only and before being scaled-up to 15 municipalities.

To address abovementioned bottlenecks (see section 1.3 above) UNICEF used its core roles described in more detail below and also listed in the table.
Enabling Environment: Thanks to the program of work and advocacy efforts of UNICEF over past decade ECD has emerged as an important priority on the government’s agenda. Advocacy with the government rendered results that are prominently reflected when looking at the enabling environment for home visiting. Namely, with the help of UNICEF (Advocacy & Technical Assistance), government developed regulations for the home visiting which defined mandates for two visits for a pregnant and five for the child during the first three years of life; developed organizational setup, service standards and content for home visiting. Most importantly UNICEF helped (TA& Policy Development) develop draft law on child protection (expected to undergo final reading in the Parliament) where Article 41 creates mandate for the health sector to deliver home visits to pregnant and children under 0-3 and home visits to be used as a means of risk identification and referral to relevant sectors. While the law mandates for robust cross-sectoral collaboration, actual operationalization of this joint work on a community level is yet to come. Furthermore, UNICEF’s advocacy helped increase allocations for municipal PHC by annual 10% between 2017 and 2019 and further 5% annual growth is planned until 2021 in the medium-term budgetary framework.

It took long time and a lot of efforts to advocate for home visiting and convince the MoH in its importance.

MoH assuming critical ownership and bringing social and educational sector along with the institutional trust in UNICEF were critical factors that helped develop and adopt regulations.

Quote from a UNICEF KII

UNICEF provided continuous technical assistance and policy advice throughout program implementation for the development home visiting road map; A Policy Brief Based on MICS 2014 Findings; in costing and estimating budgetary requirements for home visiting; developing a policy paper informing policy choices of the Government.

Furthermore, UNICEF supported several comprehensive studies, workshops and conferences and facilitated knowledge generation and exchange e.g.: November 2013 UNICEF in collaboration with MoH, MEST and MoLSW organized a two-day conference on “support to early childhood development in Kosovo and the role of home visiting and outreach services”; produced case study documenting initial home visiting experiences.
A set of ECD training modules for nurses were adapted using UNICEF regional training materials and support from Albanian colleagues. Albeit these modules yet have not been institutionalized for pre-service training. There is only one public educational institution in Kosovo, where pre-service education of nurses will commence in 2020 and where the modules have already become part of the syllabus. In relative terms with other case-study countries the nurse education and licensing in Kosovo is significantly better organized. Namely, pre-service education programs (for both public and private establishments) undergo accreditation with the state accreditation agency, commission of which is composed of five international experts and three Kosovo nationals. Furthermore, nursing profession is subject of licensing (renewable every 4 year) by nursing chamber and relicensing requires accumulation 100 ECTS practical credits comparable to those in Europe. Therefore, most educational programs meet international standards, enabling trained nurses in Kosovo to be employed in European markets, with higher pay. Consequently, the nursing education had become an attractive business charging 1,200 Euro per annum per student compared to 100 Euro in public establishments. And many private schools emerged producing large number of nurses, albeit most of them for foreign markets. While overall requirement for educational programs are common, institutionalization of topics covering home visiting across the large number of schools presents challenge, that is comparable to the ones observed in other countries included in multi-country evaluation.

We were thinking how to facilitate introduction off HV trainings in a formal curriculum of pre-service and in-service educational institutions.

While for in-service training this was possible, albeit only on an elective basis, w do not think we will be able to easily introduce changes in the program of private educational establishments offering pre-service education.

UNICEF was and still is actively leading and contributing to the development of necessary recording and reporting forms for home visiting, supporting data collection exercise on a municipal and national level and helping with the data analysis. Furthermore, UNICEF’s contribution to the development of digital solutions for HMIS modules focused on home visiting remains critical for Kosovo. Finally, UNICEF commissioned qualitative assessment of home visiting in 2017 and commissioned stock taking for home visiting informing some policy decisions as well as this evaluation report (Monitoring & Evaluation). Evaluation team notes that UNICEF’s efforts in Kosovo in documenting implementation experiences and emerging learnings are commendable.

UNICEF placed emphasis on making the legal and regulatory frameworks operational through modelling and used the experiences of five pilot municipalities for scaling up to 15 municipalities with future plans before the end of 2020 to reach 30 municipalities (out of 38 in total). Modelling approach was also applied to piloting guidelines and tools for HV; standards, structure and content for the HV; Manual for the HV; Recording Forms; Home Visiting Check List; Software program on tablets; etc. (Modelling and testing innovations).

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75 European Credit Transfer and Accumulation System (ECTS): credits are a standard means for comparing the “volume of learning based on the defined learning outcomes and their associated workload” for higher education across the European Union and other collaborating European countries.

76 According to interviews with MoH and national Stakeholders.

77 We are short of nurses and the problem would become even more challenging when three nurses will retire over coming 18 months. It’s very hard to hire new nurses.


79 Ibid
Supply: While UNICEF was not in a position to influence nurse shortages in the system, training of HVNs and social workers in pilot municipalities were prioritized in its program of work (Capacity development). UNICEF in collaboration with CEE/CIS Regional Master Trainers from Albania supported the development of a training package on early child development for home visiting nurses. Initially 8 modules, available in Albanian language were selected and slightly modified to adjust to the local context. Master trainers were prepared with 5-day trainings. Additional two modules were added in 2018 and knowledge of 15 master trainers were further upgraded. Trainers came from different professional background such as nurses, psychologists, public health specialists, etc. Cascade training approach was used for master trainers to spread the knowledge to pilot municipalities initially. Two additional modules are under translation/ adaptation and will be introduced by end of 2019.

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Table 3: UPHV training modules

<table>
<thead>
<tr>
<th>Module</th>
<th>Implemented modules</th>
<th>Key Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module 1:</td>
<td>Early Childhood – A Time of Endless Opportunities</td>
<td>Explains the critical importance of the early years for child development and lifelong wellbeing, health, and achievement.</td>
</tr>
<tr>
<td>Module 2:</td>
<td>The New Role of the Home Visitor</td>
<td>Provides the vision for new and more comprehensive role for the home visitors. Explains the skills and support needed for this new role.</td>
</tr>
<tr>
<td>Module 7:</td>
<td>Parental Wellbeing</td>
<td>Explains the impact of perinatal mental illness on child development. Gives the home visitors information and tools to identify, support, and refer parents with perinatal mental health concerns.</td>
</tr>
<tr>
<td>Module 9:</td>
<td>Home Environment and Safety</td>
<td>Provides information about the most common unintentional injuries during the early years. Provides practical advice on reducing unintentional injuries</td>
</tr>
<tr>
<td>Module 10:</td>
<td>Caring and Empowering – Enhancing Communication Skills for Home Visiting Personnel</td>
<td>Provides an introduction to good communication practices. Gives concrete examples how home visitors can improve communications skills to engage families.</td>
</tr>
</tbody>
</table>
### Module 12: Children who Develop Differently

- **Key Contents:**
  - Explains why some children develop differently.
  - Emphasizes the importance of the family and family relationships when supporting children with developmental difficulties.
  - Explains about new approaches, i.e., “teaming around the child” and the “routines-based approach” to more effectively support this group of children and families.

### Module 13: Developmental Monitoring and Screening

- **Key Contents:**
  - The module is about early identification and interventions of children with disabilities.
  - Explains the concepts of developmental monitoring, screening, and assessment of children.
  - Provides information about basic monitoring tools that can be used in the home.
  - (was provided for coordinators)

### Module 14: Keeping Young Children Safe from Violence, Abuse and Neglect

- **Key Contents:**
  - Provides evidence on the impact of abuse, neglect and abandonment on child outcomes.
  - Explains the role of the home visitor with respect to prevention, identification of risk, referral and collaboration with other sectors to support vulnerable families.

### Module 15: Working with Other Services

- **Key Contents:**
  - Provides the rationale for collaborating with other sectors for the wellbeing of vulnerable young children and their families.
  - Supports the development of interdisciplinary collaboration.

### Module 17: Supervision, Supporting professionals and enhancing service quality

- **Key Contents:**
  - Prepares supervisors to sustain professional relationships with home visitors characterized by reflective practice, strength-based approaches, application of coaching skills and clear planning/record keeping.
  - (was provided for coordinators)

### Planned Modules

#### Module 5: Engaging Fathers

- **Key Contents:**
  - Provides evidence for the impact of positive father involvement on child development.
  - Shares tested approaches that home visitors can use to engage fathers.

#### Module 18: Gender Socialization and gender dynamics in families

- **Key Contents:**
  - Discuss the impact of gender inequality on children and parental well-being.
  - Prepares home visitor in breaking barriers to equal opportunities for boys and girls, and for modeling behavior based on respect and equity for future generations.
<table>
<thead>
<tr>
<th>Module</th>
<th>Key Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modules not implemented or planned at this stage</td>
<td></td>
</tr>
<tr>
<td><strong>Module 4:</strong> Falling in Love – Promoting Parent-Child Attachment</td>
<td>Emphasizes the importance of attachment for development. Provides information on how home visitors can support the development of secure attachments. Information cards on promotional interviewing with families and ways of building secure attachments at different stages of development.</td>
</tr>
<tr>
<td><strong>Module 6:</strong> The Art of Parenting: Love, Talk, Play, Read</td>
<td>Explains how loving, talking to, playing with, and reading to infants and young children affect their development. Provides basic information and tips on how to help parents in using these positive parenting skills.</td>
</tr>
<tr>
<td><strong>Module 8:</strong> Common Parenting Concerns</td>
<td>Addresses common parenting concerns related to sleeping, crying, toileting and the use of positive discipline that the home visitor will encounter in daily visits. Provides practical advice the home visitor can share with the caregivers.</td>
</tr>
<tr>
<td><strong>Module 11:</strong> Working Against Stigma and Discrimination – Promoting Equity, Inclusion, and Respect for Diversity</td>
<td>Shows how stereotypes, stigma and discrimination make the home visitor less effective when working with caregivers and families, particularly those that are often marginalized by society. Helps home visitors to reflect on their own biases and stereotypes in the context of life-long learning and self-improvement.</td>
</tr>
<tr>
<td><strong>Module 16:</strong> Responsive feeding</td>
<td>Describes responsive feeding. Provides practical advices to help parents notice the child's cues and respond appropriately. This assists to develop the foundations of a trusting relationship that supports the child's development.</td>
</tr>
</tbody>
</table>

Master trainers during October-December 2016 delivered the training to 200 individuals including health care providers, social workers and educators. And in 2017, 330 service providers were trained. Additionally, in 2018 trainings were cascaded for 170 nurses and social workers. All trainings were accompanied by pre and post-test to measure knowledge acquisition. According to the report 20% to 75% knowledge improvement was observed for various topics covered in the training (between pre and post test results). Furthermore, every year UNICEF supports MoH to organize meetings in three levels: (1) every three months meetings with home visiting working group (MFHC managers) at national level and at least one workshop with the same group depending on the program implementation phase. (2) two-day workshops with home visiting coordinators to strengthen their...
Through leveraging donor resources UNICEF equipped HVNs with the tablets (in two municipalities) and necessary equipment such as bags, scales and materials and checklists for identification of developmental risks. (Convening dynamic partnerships & leveraging resources). And UNICEF donated two cars for two municipalities to provide transportation support. However, during the evaluation in all visited facilities the home visiting nurses complained about lack of necessary equipment and the transportation, which was named as a most critical impediment especially in rural areas.

**Demand:** To increase demand for HVN services and parental awareness about ECD issues, UNICEF developed and implemented comprehensive communication strategy using Kosovo-wide approaches through traditional and social media, complemented with community-based approaches, with strong inter-personal communication and community mobilization elements. Kosovo wide approaches included video spots, TV debates, shows and programs and social media, which has 92% penetration in the Kosovo, albeit not much used by vulnerable groups and ethnic minorities. Community focused interventions were supported by development and distribution of materials, such as Better Parenting Leaflets disseminated by Red Cross in the pilot communities, engaging local media and organizing local events and through home visiting nurses and through support groups/peer-to-peer or/and meeting points. Messages for Roma, Ashkali and Egyptian communities about ECD and home-visiting were custom tailored to make relevant to their cultural specificity. And overall communication messages were focused on three priority areas: (a) promotion of immunization; (b) promotion of exclusive breastfeeding and (c) promotion of child stimulation, with focus on increasing fathers’ participation. When meeting with beneficiaries, the evaluation team observed high awareness about immunization and breastfeeding, but little and variable changes were noted with regards to fathers’ participation in child upbringing.

Home visiting program driving interlinkages between health and ECD help parents and children to address the needs they face. Live Facebook session with Minister and his wife, featured parents of two children with the challenges and joyful moments they faced when upbringing the children and the way home visiting could have been helpful during challenging moments. The session engaged around 30,000 parents/followers of the group. UNICEF supported the minister with key advocacy messages, data, recommendations and tips for good parenting.

**IDI Interview**

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85 UNICEF 2016 Communication Strategy - First 1000 Days of the Child’s Life
Through leveraging donor resources, UNICEF equipped HVNs with the tablets. 


Home visiting program driving interlinkages between health and ECD help parents.

Demand: breastfeeding, but little and variable changes were noted with regards to fathers’ beneficiaries, the evaluation team observed high awareness about immunization and child stimulation, with focus on increasing fathers’ participation.

Leteras much used by vulnerable groups and ethnic minorities. Community focused interventions and programs and social media, which has 92% penetration in Kosovo, albeit not Kosovo-wide approaches through traditional and social media, complemented with UNICEF developed and implemented comprehensive communication strategy using training of HVs, social workers and educators in pilot municipalities along with job aids and other inputs from UNICEF may have helped deliver relatively better quality HV services. However, this was mainly relevant to topics such as immunization and breastfeeding and not major quality improvements were noted for ECD issues.

To assist HVNs in application of new knowledge and skills into practice and improve the quality of home visits, UNICEF introduced external and internal supervision practices. External supervision was performed by external supervisors, from MoH and UNICEF. Internal supervision was performed by a nurse coordinator of the MFMC. Though stakeholders recognized supportive supervision as a critical function for continuous improvement of the quality, it has not been completely formalized and variable practices emerged across the visited facilities. Thus, the system yet lacks the vision for the system of supportive supervision, tools for effective supervision and adequate indicators to measure service quality.

There was a family where mother was hospitalized for several months and father for not mentally fit to take care of three children, including one six-month-old. Home visitors immediately alerted us [social services] and we had to take custody of children, wash them and their close and only return to family when mother was discharged and in a good health.

UNICEF’s work helped ECD emerge as an important priority on the government’s agenda across the sectors was well evidenced on a central level and confirmed through different sources of evidence. However, to fully realize the potential of HV cross sector collaboration has to occur on a community level, because timely identification of risks for a child and referral to respective services, especially outside the health sector, are essential elements of a quality HV program, even when only Universal and Enhanced elements of the model are being implemented (see Figure 3 on page page 26). The latter requires close operational interlinkages between health, social, education and other sectors, especially on a community level. Site visits, discussions with HVNs and social sector representatives revealed existing operational connections but triggered only by extreme cases (see text box) observed by home visitors. Relatively moderate cases, where child risks were timely detected and referred were not recalled and discussed in any of the meetings, most likely indicating on the need to further enhance capacity of HVNs to identify the risks and then establish operational linkages with other sectors for the referral. Based on the

FGD Participants

Quotes from Key informants from social services
The achievements in developing enabling environment for HV were significant, most likely because of two factors: (a) **continuous engagement of UNICEF on policy issues with the government** and (b) **timely and quality technical assistance**. UNICEF has played important role in both areas. Namely being next to the government and able to grasp the moment for engagement and support, seems to have been an important factor for UNICEF to better tailor its technical assistance to the needs of the national stakeholders, instead of working in a silo. As a result, the role of UNICEF was important in informing policy discussions/choices as well as program design and implementation. The evaluation team found UNICEF’s inputs to be of high quality, comprehensive, well contextualized and most importantly actively used by national stakeholders on a central level in the decision-making process and helped shape policies and regulations. UNICEF’s technical assistance provided for educational/training programs could not be underestimated as it helped equip nurses not only with the needed knowledge and skills, but also with necessary tools (such as home visiting check-list) that could be used to timely identify different risks for a child.

**Overall the developmental risk detection checklist** (for 6 months and 9 months old children) has proven to be an effective tool for home visitors. However, its operationalization, using paper forms/carerrier, imposes significant administrative burden on nurses. Ultimately filling in all required fields requires significantly higher time per family visit and lack of these forms in a digital format makes them useful only for case management and do not deliver greater benefits to the HV program, such as data driven decision making on a facility or municipality or national level, just to name a few. The work is underway to digitalize the checklists, but utility of digitalization needs deeper understanding to reap greater benefits from the investment.

**Nursing staff shortages** were frequently named by respondents at FMCs as a limiting factor for HV. Albeit sheer number of nursing staff without considering the daily workload is not sufficient to render informed judgement about sufficiency or insufficiency, as visited sited looked significantly underutilized. However, it is obvious that introduction of home visiting increased the demand on nursing staff time (a) to undertake home visits that, with travel time, may require on average 45-75 minutes for a visit in a low dense rural areas and (b) increased administrative burden by introducing additional recording and reporting forms. When this demand for time is compounded with the lack of means for transportation (an in that increasing travel time) the staff capacity would have finite ability to meet the needs of population, which obviously would negatively affect the number of visits conducted per

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day, and consequently outcomes of the HV. Therefore, without adequate consideration of the required nurse labor force and not only for home visiting but holistically for the delivery of a package of PHC services discussing adequacy of the staff seems impossible.

**Challenges linked to the home visiting model design** has revealed manifold influence on the success of HV in Kosovo and should be seen as a sequence of negative factors adversely affecting child health and wellbeing outcomes. Namely, evaluation team noted implicit tension between conducting home visits (at times under harsh weather conditions) vs. attending patients or administrative tasks in the office. The model seems to be at fault leading to low number of home visits per nurse per month and in that low coverage, compared to other countries in the region. Thus, whole notion of universality in home visits is undermined if coverage is only limited to 10-25% of eligible pregnant and children. Furthermore, less than a visit a day translates into a small number of visits per new-born averaging 1.4 in Kosovo, which mainly occurs during initial month or two during child’s life. Therefore, the visits are naturally more focused on medical issues and on breastfeeding and vaccination. Based on the scientific evidence odds of identifying child developmental delays, beyond medical and socio-economic problems, is rather low at this age and consequently potential for delivering knowledge about good parenting skills is also constrained. Finally, noted limited number of visits constraining nurse’s ability to identify children at risk, imposed limitations on building stronger and more durable collaboration with other sectors, such as social, education and etc.

**Financial access barriers** (e.g. even to access free of charge health or other services parents have to pay for transportation) hinders attainment of better results especially among Roma, Ashkali and Egyptian communities and among poor. Thus, using home visiting as a means of bringing more services for these population groups and in that slightly reducing financial access barriers needs to be further exploited.
To conclude, the evaluation team is of the opinion that scale-up, after the initial pilots, occurred without attaining maximum results i.e. at least achieving close to universal coverage with home visiting in pilot sites and at least testing more effectively the functioning of enhanced component of the HV model in a real life setting, which currently seems to be non-existent in the visited sites and most likely in other 12 municipalities involved with HV implementation.

Conclusion on Effectiveness: In summary, UNICEF was instrumental in addressing key system level bottlenecks albeit with variable results. Notably, the organization was extremely successful, in the environment where almost nothing existed, to address bottlenecks in enabling environment and establish solid legislative and regulatory framework in support of home visiting. However, supply and demand side bottlenecks were only partially addressed. Nevertheless, this partial achievement has its own objective

Table 4: Addressing Health System Bottlenecks

<table>
<thead>
<tr>
<th>Bottleneck</th>
<th>Fully addressed</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling Environment</td>
<td>Fully addressed</td>
<td>UNICEF was effective to put ECD on high policy agenda and facilitate development of enabling policy and regulatory framework.</td>
</tr>
<tr>
<td>Supply</td>
<td>Partially addressed</td>
<td>While capacity building of home visitors was heavily supported by UNICEF, notable staff shortages remain unaddressed. Furthermore, inadequate transportation, lack of communication means and necessary equipment for HVNs further constrain ability to deliver needed volume of services. Paper-based record keeping, and reporting practices increased demand on staff time and in that aggravated staff shortages for the provision of home visiting services. Finally, the current organizational model for HV provision may not provide incentives for high number of home visits. Thus, significant portion of supply-side bottlenecks yet remain unaddressed.</td>
</tr>
<tr>
<td>Demand</td>
<td>Partially addressed</td>
<td>Relatively good knowledge about breastfeeding and immunization were noted, without major shifts in better parenting and especially father's involvement in child upbringing. Demand for home visiting is growing (measured by number of home visits) but overall coverage remains low and not sufficient to deliver full benefits off UPHV.</td>
</tr>
<tr>
<td>Quality</td>
<td>Not addressed</td>
<td>The model of HV and current coverage levels do not allow maximizing the potential quality afforded by HV. Furthermore, the current M&amp;E system is inadequate to measure the quality of outcomes and outputs. A formalized quality improvement mechanism is still lacking.</td>
</tr>
</tbody>
</table>
3.3 Efficiency

**Efficiency Evaluation question**
- Where the demonstration services coordinated with other similar program interventions including of UNICEF? Was there any overlap of efforts?
- Was program implementation appropriately monitored and evaluated? How were the results used?
- Was program implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?

This section of the evaluation report examines whether UNICEF interventions were coordinated with other similar programs and implemented according to set timelines. It also examines extent to which the project implementation was appropriately monitored, and monitoring results informed future planning. Findings are presented to provide answers to the questions outlined for the given criterion in the Evaluation Framework (Annex 4) and the text box on the right.

**UNICEF’s support for enhancement of the HV services, were well coordinated with other programs supported by the organization.** Namely, home visiting was really mainstreamed in the UNICEF portfolio and across different parts of the office. Communications, social protection, social policy, education and health sectors were working jointly to deliver on the HV promise. Furthermore, UNICEF is a sole partner promoting HV in Kosovo and the organization seems influential to effectively coordinate with other programs and interventions implemented by the government and avoid duplication and overlap. Just to name few, close cooperation and coordination when developing child protection law was established with Ministry of Labor and Social Welfare and policy part of UNICEF. As noted
UNICEF was also successful in setting-up M&E system for home visiting program.

Cooperation with the UNICEF communications teams in Kosovo looked impressive, leading to development and implementation of comprehensive communication strategy described earlier. Furthermore, this collaboration has also led to fostering partnerships and leveraging resources from Raiffeisen Bank of Kosovo (RBKO) in support of Home Visiting Program. RBKO will provide financial support up to 20,000.00 EUR to generate demand across communities for the Home Visiting program. Through this support the number of children receiving integrated & quality services during the first 1,000 days of a child's life will be likely increased. RBKO also plans to make an in-kind donation of two or more cars for the Local Family Health Centers in selected municipalities to increase the coverage of the Home Visiting program from 20% to 50% of children being provided with integrated & quality services during the first 1,000 days of a child's life.

One initiative supported by Swiss Development Cooperation (SDC) and focused on managing non-communicable diseases on a PHC level was also noted by evaluation team. The program is being piloted in municipalities which is in part overlapping with UNICEF's program sites. SDC supported initiative also considers using home visitors to address the needs of chronic and elderly patients, especially those living alone in rural areas.

Evaluation team notes that SDC project is expected to further increase the workload of nurses in a PHC setting and especially for nurses undertaking home visits. In light of noted staffing challenges earlier, we assume that nurses maybe further stretched and possibly could negatively affect HV implementation i.e. further reduce number of home visits for pregnant and child, if SDC project incentives become more appealing for the PHC staff. Albeit, thus far close coordination and cooperation between UNICEF and SDC program has not been in place and unless demands imposed by HV and SDC supported programs are holistically discussed with the MoH under the umbrella of the PHC reforms, staff time shortages could be further aggravated on a PHC level and could possibly undermine achievement of objectives by both programs.

UNICEF was also successful in setting-up M&E system for home visiting program. Consequently, home visitor performance is closely monitored and reported on a monthly basis by HV coordinators using both paper-based and electronic reporting forms. Monitoring information is comprehensive capturing data about the home visits made to pregnant and child as well as to vulnerable groups and monitoring beneficiaries by gender breakdown and referrals made, albeit without separating the purpose and type of the referral for a child. Monthly reports from all facilities are compiled into a database by MoH, but with UNICEF's support for data compilation. Compared to other CCS countries for the MCE, Kosovo program seems to have relatively better organized M&E system which allows tracking some indicators routinely. Albeit the greatest limitation of the existing M&E

Quote from a Nurse Coordinator

I compile data across nurses on a monthly basis and submit to MoH. We only keep copies of reports for our records. This is how we use data in our facility....
UNICEF was also successful in setting-up M&E system for home visiting program. Cooperation with the UNICEF communications teams in Kosovo looked impressive, UNICEF Raiffeisen Bank Kosovo and UNICEF Partnership 90 UNICEF 2016 Communication Strategy - First 1000 Days of the Child’s Life

I compile data across nurses on a monthly basis and submit to MoH. We only keep referral for a child. Monthly reports from all facilities are compiled into a database by MoH, breakdown and referrals made, albeit without separating the purpose and type of the basis by HV coordinators using both paper-based and electronic reporting forms.

Almost all interventions were implemented according to schedule and no major challenges or delays were identified by the evaluation team.

Facility managers do not even know, in most instances, the data that is collected by a nurse coordinator and reported to MoH. They do not reveal huge interest in targets for their facility or performance of their staff.

We fully agree that our coverage targets are low compared to number of pregnant women and children 0-3-year-old in the targeted municipalities. However, we based our targets on the past years performance and never intended to be ambitious and reach close to 100% of beneficiaries.

And finally, as noted earlier in the report, beyond routine M&E UNICEF commissioned numerous studies examining various aspects of the HV program and informing national-level policy discussions (Monitoring & evaluation). While all these developments are positive, noted major weakness of the program seems to be lack of (or low coverage) targets and lack of accountability and complete lack of managing for specific results. Therefore, unless the accountability mechanisms from a facility to municipality and national level are introduced and demand for managing for results placed on nurses and facility managers, planned improvement in the overall M&E system may not be able to deliver on expected results.

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Conclusion on Efficiency: The intervention to strengthen HV was well coordinated with other projects and interventions as well as capitalized on already established structures and capacities allowing efficient use of available resources. To maximize possible results, sound partnerships with private sector were established and additional resources are being leveraged in support of HV system. Well documented evidence, generated with UNICEF’s financial support, informed design of the HV. Comprehensive M&E system has been developed and implemented, albeit the system requires further improvements and most importantly requires mandates for better accountability for results.

93 Confirmed through IDIs, document review and FGDs.
3.4 Impact

Impact Evaluation questions

- What factors favorably or adversely affected the outcomes of the services on families and children, including on the most vulnerable and influenced gender inequality?

- To what extent there were any positive or negative results in reducing inequalities (in child outcomes, access to and utilization of essential service, etc.)?

- Are different groups (based on ethnicity, socio-economic profile, urban-rural residence, children with special needs, gender, etc.) benefitting to the same extent of the services?

In this section of the Report, using TOC for HV, we are examining primarily the outputs of the HV initiative to understand the program success and/or failure and its potential influence on child health and wellbeing. Unfortunately, limited timespan and geographical scope of the HV implementation along with the lack of comprehensive data required for outcome-impact measurement, evaluation team is limited to discuss program outcomes or impact. Instead, the outputs of the program are being discussed and preliminary conclusions are being drawn around evaluation questions.

Figura 5 describes the number of home visits over 2016-2018 period as well as dynamics by municipalities. While overall number of home visits were growing from year to year (both for a child and pregnant women), municipal level performance reveals significant variability (see Figure 5), indicating that program is not producing consistent and stable outputs. Furthermore, although the overall number of visits (in all municipalities together) increased from 2016 to 2018, municipality-specific coverage of children with at least two visits are extremely low barely reaching 26% in best performing municipality – Mitrovice. 94

Presented program performance becomes even more dubious when average visits per individual (that was visited by a nurse) is evaluated see Figure 6. The figure indicates that while coverage rates for pregnant women are extremely low, those that get visited do receive 1.44 visits on average instead of two prescribed by regulations. However, situation with children is more problematic. First, universal coverage of children with home visits faces problem, because only 16% of children 0-3-year-old are covered with home visits. 95 Secondly, those that are visited by a nurse receive on average 1.5 visits instead of mandated five. Thirdly, according to nurses and mothers most of these 1.5 visits occur during initial months after birth and consequently they are more medically focused without much elements related to child development, good parenting and/or risk identification, beyond medical risks.

94 Data supplied by UNICEF and describing nine municipalities out of fifteen, where comparable data over three-year period was available
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96 Data supplied by UNICEF and describing nine municipalities out of 15, where comparable data over three-year period was available.
The positive development emerging from M&E systems was the share of visits out of total home visits conducted to Roma, Ashkali and Egyptian families (N.B. both for pregnant and child, as the M&E system does not separate visits for a child or pregnant for these communities) was 8.2%, 6.0% and 8.6% from 2016 to 2018 respectively. These numbers indicate that HV reaches some vulnerable groups (not all), however with variable performance from a year to year. Furthermore, the evaluation team cannot ascertain if these levels should be regarded as satisfactory or if they should be higher, due to lack of municipal-level census data for these communities. Furthermore, no data was available to understand the delivery of services to poor or other vulnerable groups or across gender dimension. Consequently, the evaluation team is not in a position to conclude if inequities were reduced as a result of HV or if different population groups (including across the gender and poverty dimension) equally benefited from the program.

Figure 6 Average number of visits delivered by a home visiting nurse

<table>
<thead>
<tr>
<th>Year</th>
<th>Pregnant Reach</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1.01</td>
<td>1.00</td>
</tr>
<tr>
<td>2017</td>
<td>1.44</td>
<td>1.41</td>
</tr>
<tr>
<td>2018</td>
<td>1.51</td>
<td>1.44</td>
</tr>
<tr>
<td></td>
<td>2.00</td>
<td></td>
</tr>
</tbody>
</table>

Available evidence through desk-review, IDIs and FGDs allows to identify systemic factors that explain poor program outcome i.e. low coverage and small number of visits per beneficiary. Interplay of these factors are presented in Figure 7 and include following:

Inadequate information exchange between levels of care, namely PHC facilities face challenges obtaining information about pregnancy and/or delivery which significantly constrains their ability to identify close to 100% of beneficiaries, eligible for home visiting. Factors for inadequate information exchange are diverse, such as (a) population prefers to seek better quality antenatal (ANC) or delivery services either from a private provider and/or from a clinic in a neighboring municipality; (b) some PHC facilities may not have obstetrician to deliver ANC or delivery services, such as in Dragash, where OB&Gyn has been absent for almost three years; (c) there is no mandate in the system to notify PHC facility about a pregnant or new-born based on their actual residence. As a consequence, home visitors are trying to find different ways to collect this information, albeit not always being successful. Mechanisms for the data collection could be pregnant women presenting for a lab analysis to the PHC, word of mouth in the community, establishing informal...
Inadequate information exchange between levels of care, namely PHC facilities face Available evidence through desk-review, IDIs and FGDs allows to identify systemic factors

Figure 6 Average visit per visited individual

58 108 107

Figure 7 Systemic Reasons for Low Coverage

Systemic Reasons for Low Coverage

<table>
<thead>
<tr>
<th>Reason</th>
<th>Critical Bottlenecks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakdown in information exchange between ANC clinics/Maternities and HVs</td>
<td>Indentify 100% of pregnant &amp; newborns</td>
</tr>
<tr>
<td>Recording legal residence vs. actual address of mother and newborn residence</td>
<td>Lost due to lack of address or internal migration</td>
</tr>
<tr>
<td>Inadequate staffing, lack of transport means and poor working conditions (i.e. lack of uniforms and equipment)</td>
<td>HVs ability to reach household (time, sufficient human resources, transportation)</td>
</tr>
<tr>
<td>Cultural values not allowing external person into household</td>
<td>Cultural acceptance of a person into home</td>
</tr>
<tr>
<td>Stigma about certain population groups deter HVs from entering household</td>
<td>Willingness of HV to enter the community or household (stigma)</td>
</tr>
</tbody>
</table>

Even, when the residence of a pregnant or child is identified, the challenges with time, transportation, or willingness to undertake home visit vs. office work, etc. (described earlier) kick in and further reduce the number of women and children visited by HVNs.

If all abovementioned factors are conducive, there are also two additional factors that come into a game one being household's willingness to let a nurse in a home environment and the second willingness of a home visitor to enter a home alone. Numerous cases how cultural values and perceptions negatively affect home visitor performance were noted by FGD participants such as fear to reveal home environment to an external person, fear of community being seen a visiting nurse – women entering the house alone, which frequently triggers the need for two nurses jointly to visit a child or mother, fear of being exposed to a risk if nobody but male greets the home visitor without mother and child being at home, etc.. Thus, interplay of the described factors eventually leads to very low coverage rates and requires closer consideration and multi-prong response on the part of the government and UNICEF.
Conclusion on Impact
As expected, and described in the MCE inception report, the evaluation team was only able to capture limited set of outputs, but sufficient enough to identify some potential future risks for the HV program not being able to deliver the impact, unless major challenges for the program, in the health systems and in the community are timely addressed. When looking at the program in Kosovo, numerous health system factors seem to be at play along with some socio-cultural believes that limit attainment of the results and require comprehensive response.

3.5 Sustainability

Sustainability Evaluation Questions
• Are legal, institutional and financial mechanisms established to ensure sustainability of the home visiting services? Are conditions established to ensure quality of the services (service standards, training, supervision mechanisms, etc.)?
• What are the key factors that can positively or negatively influence the long-term financial sustainability of services?
• Have UNICEF developed the UPHV models scaled-up, incorporated into national policies and/or systems?
• What were the critical elements which could make the UPHV program sustainable (or which could impede sustainability)?
• Are other partners supporting UPHV service program initiated with support from UNICEF?

This section of the evaluation report examines the prospects of sustainability for HV services. Namely, assesses what are enabling factors contributing to sustainability and challenges that may have negative impact. Findings are presented to provide answers to the questions outlined for the given criterion in the EF (Annex 4: Evaluation Framework) and text box on the right.

While we have noted program limitations earlier, some factors are expected to positively impact sustainability and eventual scalability of the HV in Kosovo. Namely, the government took the steps to legislate home visiting (see paragraph 72 on page 43) and most importantly include the service in the basic benefit package so it could be funded out of state budget. The government is already taking steps to facilitate national scale-up and is thinking to assure greater sustainability by allocating additional financial resources (about 10 Euro per visit) in the state budget, hopefully starting from 2020. When these additional resources materialize prospects for sustainability could become greater.

While, the model of HV in Kosovo is yet fully integrated within the Family Medicine Centers (FMCs) composed of one doctor and two nurses, with all the challenges noted earlier. The roles and responsibilities of nurses and home-visiting practice standards are reflected in the administrative instructions (i.e. secondary legislation) assuring durable institutionalization in the family medicine practice. However, this model comes with limitations and therefore
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While, the model of HV in Kosovo is yet fully integrated within the Family Medicine Centers (FMCs) composed of one doctor and two nurses, with all the challenges noted earlier. The roles and responsibilities of nurses and home-visiting practice standards are reflected in the administrative instructions (i.e. secondary legislation) assuring durable institutionalization in the family medicine practice. However, this model comes with limitations and therefore the discussions to separate HV and appoint dedicated nurse are taking place in Kosovo since early days of HV initiation, albeit final decision is to keep a flexible model, depending on a location of FMC. Considering the fact that service organization implies a set of challenges and may be determining factor for a low coverage the government needs to give close consideration to the model revision/enhancement.

Current accountability arrangement within the health systems and the ones for HV, including M&E, do not seem to be conducive to drive the program to sustainable levels of service provision, unless managing for results is enhanced and PHC teams, facility managers and municipal heads are held accountable for achieving results.

Organization of nursing education is another structural barrier negatively affecting continuous labor force supply of home visitors and in that medium to long-term sustainability. While UNICEF facilitated adoption of HV training materials by a nursing school and pre and in-service training modules were accredited, there is no guarantee that private nursing schools in Kosovo will use these modules in their programs. Consequently, supply of adequately trained nursing staff understanding ECD and HV related issues is expected to face challenges, unless UNICEF identifies other mechanisms which could support long-term development/education of nursing staff in a more sustainable manner. Furthermore, HV related topics that were included in the continuous professional development (CPD) for nurses are elective, the CPD courses are only partially funded by the government/employer, and participants are expected to also pay out-of-pocket, which emerges as a financial access barrier for underpaid nursing staff. Therefore, elective nature of courses on one hand and financial access barriers on the other become structural impediments for sustainable delivery of HV trainings through CPD channel.
Attractiveness of Nursing Profession among young generation seems to be diminishing and supply of nurses is decreasing below replenishment levels. All interviewed policy makers, PHC facility heads and nurses in the FGDs confirmed that it is hard to fill a job opening for a nurse. One reason being undifferentiated low salary for a nurse undertaking home visit or working in the office. Nursing labor force is aging and imposes medium to long-term challenges for the sector. While numerous factors could be at play when individuals are not attracted to the profession all interviewed noted that experienced nurses are leaving for private sector or abroad and young mostly enter a nursing school to find a job in better paid European countries. Therefore, as noted earlier, continuous nurse supply for the sector is a bigger sustainability issue for Kosovo going far beyond the home visiting services and affecting whole health care system, which requires more holistic consideration of these issues by the government.

Based on the obtained evidence, UNICEF seems to be a sole supporter to the government in the area of HV. However, the World Bank and SDC are also helping the government with PHC reforms, which are not directly contributing to home-visiting but having the direct impact on how home visiting will develop in Kosovo, what will be the demands placed on nursing staff, especially when conducting home visits, how staffing issues will be addressed and how the overall family medicine based PHC model would look like and how it would be funded. All of this creates some threats for HV sustainability but also opens the room for collaboration and closer coordination with partners to maximize the impact of investments.

Conclusion on Sustainability

The evaluation team concludes that some critical factors (such as legal, institutional and financial mechanisms) positively affecting sustainability have been put in place by the program, however this is yet unfinished agenda and requires further fine-tuning. Also, there are broader structural and health system barriers, significantly bigger than HV, which needs attention and cross-governmental effort to enhance health sector performance and assure continuous supply of quality labor force. Finally, as the government works on PHC reforms/initiatives with UNICEF, the World Bank and SDC, it becomes important to exploit the window of opportunity and holistically consider the PHC model, its functions and staffing needs and embark on the route that will assure greater sustainability of the system in a long-term perspective.
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4.1 Conclusions

Throughout in the report the evaluation team provided summary statement for each OECD criteria. In this section we have pulled all those summary statements to provide all conclusions in one place to a reader.

Relevance: UNICEF supported HV intervention is fully aligned with national priorities and policies, are largely evidence based offering a comprehensive set of preventive services and linkages to other sectors. While they seem to be responsive to the needs of population, especially for Roma, Ashkali and Egyptian, the needs of poor and children with disabilities have not featured prominently. The interventions have been designed in a participatory manner addressing current needs of children and their families, particularly of Roma, Ashkali and Egyptian respecting gender and human rights. UNICEF support to interventions, are considered appropriate with the potential of achieving desired results, only if two areas of the HV model are further discussed and addressed. The first is the having nurses with the responsibility of delivering office as well as home-based services, with described adverse incentives and the second is the frequency and timing of the prescribed home visits.

Effectiveness: In summary, UNICEF was instrumental in addressing key system level bottlenecks albeit with variable results. Notably, the organization was extremely successful, in the environment where almost nothing existed, to address bottlenecks in enabling environment and establish solid legislative and regulatory framework in support of home visiting. However, supply and demand side bottlenecks were only partially addressed. Nevertheless, this partial achievement has its own objective explanations. Namely, on the supply side addressing structural factors affecting nurse supply is definitely beyond UNICEF’s reach as it requires multi-sectoral and bold Government action. The challenge, by far, is not unique to Kosovo and most countries around the globe face similar problems which has led WHO to propose Global strategy on human resources for health. Consequently, the evaluation team thinks, it would not be fair to expect from UNICEF program to resolve this problem within the limits of HV program. Secondly, lack of transportation due to limited public funding of PHC is beyond UNICEF’s ability to tackle on a pilot or national scale. Thirdly, while UNICEF provided all other inputs required to facilitate HVN performance (e.g. bags, scales, etc.) the equipment gets outdated and not replaced by the facilities due to lack of funds and obviously affects sustainability, discussed later.

Demand side bottleneck were also partially addressed. While work of the Red cross in communities and public awareness through social and regular media channels seems to have helped increase population awareness about immunization, breastfeeding and home visiting, this has not yet translated into effective demand (when measured by low number of home visits, although growing slowly). FGDs conducted with beneficiaries helped evaluation team understand that changes in socio-cultural values are yet variable, which could also be a function of low coverage of families by HVNs. Finally, evaluation team thinks that quality bottleneck remains unaddressed due to interplay of low coverage and limited number of visits per newborn child thoroughly elaborated in the report.

Efficiency: The intervention to strengthen progressive component of HV was well coordinated with other projects and interventions as well as capitalized on already established structures and capacities allowing efficient use of available resources. To

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98 WHO 2016. Global strategy on human resources for health. workforce 2030
maximize possible results, sound partnerships with private sector were established and additional resources are being leveraged in support of the HV system. Well documented evidence, generated with UNICEF’s financial support, informed design of the HV. Comprehensive M&E system has been developed and implemented, albeit the system requires further improvements and most importantly HV program requires mandates for better accountability for results.

**Impact:** as described in the MCE inception report, the evaluation team was only able to capture limited set of outputs, but sufficient enough to identify some potential risks for the HV program not being able to deliver the impact, unless major challenges for the program, in the health systems and in the community are timely addressed. When looking at the program in Kosovo, numerous health system factors seem to be at play along with some socio-cultural values that limit attainment of the results and require comprehensive response.

**Sustainability:** The evaluation team concludes that some critical factors (such as legal, institutional and financial mechanisms) positively affecting sustainability have been put in place by the program, however this is yet unfinished agenda and requires further fine-tuning. Also, there are broader structural and health system barriers, significantly bigger than HV, which needs attention and cross-governmental effort to enhance health sector performance and assure continuous supply of quality labor force. Finally, as the government works on the PHC reforms/initiatives with UNICEF, the World Bank and SDC, it becomes important to exploit the window of opportunity and holistically consider the PHC model, its functions and staffing needs and embark on the route that will assure greater sustainability of the system in a long-term perspective.

### 4.2 Lessons Learned

**Lesson 1:** Kosovo case study clearly demonstrates that sustained engagement with partners from government and other stakeholders through facilitation of national dialogue, high quality policy advice and technical assistance allowed for Government support for the institutionalization of system change. However, lack of focus on human resource supply when conducting health system analysis for the intervention design negatively affected potential sustainability of the HV model. Therefore, it is essential that UNICEF Kosovo office and for the government to ensure inclusion of the sustainability elements across all system building blocks in the design of the model. This approach would ensure longer-term sustainability of the HV model.

**Lesson 2:** Kosovo case study showed one of the best documentations of the approaches, steps, challenges and corrective measures taken by the project and lessons learned. Rigorous and continuous documentation certainly helped the evaluation team to understand the reforms as well as to validate its findings and compare with those found months/years ago. Thus, it seems necessary for other countries to review the degree of documentation in Kosovo and follow similar approach. Albeit, only part of the evidence seems to have been effectively used by the government, when discussing or debating policy reforms for HV or when designing the model for service delivery and regulating it. Therefore, similar experiences have to be avoided and more active use of the evidence by the government has to be facilitated.
Lesson 3: Kosovo developed M&E system for the HV program and diligently collected the information. However, when the M&E system itself is not focused on capturing outcomes for children and is rather concentrated on outputs only (presented in this report) the system would prove inadequate for monitoring HV program results or for augmenting accountability arrangements for the results within the government and in the health system. Therefore, just developing M&E system and collecting data regularly, would not be sufficient unless the designers of the system are clear on how this data could help monitor the results; could help enhance accountability and most importantly facilitate the data-driven and action-oriented decision making on a home visitor and PHC provider level, before it reaches municipal or national level for further analysis.

4.3 Recommendations

Based on the findings the evaluation team recommends four key areas for future consideration and action (see Figure 8) each elaborated in more detail below. However, it has to be noted that these four areas should be seen as a closely inter-linked and mutually reinforcing and not as a silo group of recommended interventions.

Figure 8 Four Key areas for consideration

Model of Service Provision itself touches upon three critical areas: (a) appropriateness of current one doctor two nurse model for achievement of HV aspirations considering implicit negative incentives described in the report and also how this model will play along with the SDC-supported initiatives if the requirements for the number of home visits are expected to increase not only for HV but also for NCD management among chronic and especially lonely elderly patients; (b) sufficiency of content of two visits to a pregnant woman and five visits for a 0-3 child to timely detect developmental delays and risks and undertake timely preventive interventions or referrals and finally when model moves to fully progressive component of HV (c) how cross-sector cooperation and collaboration will be operationalized not only on the central level but on a local-community level. Finding solutions to the three issues would require on one hand more holistic consideration of basic package of services to be delivered by a reformed PHC which includes UPHV, NCD and other preventive and curative services; modality of facility based and community outreach service provision and its influence off staff time and staff requirements (number and qualification). Secondly, UNICEF, using current scientific evidence and accessible global expertise, could help government evaluate adequacy and sufficiency of the current content.
of the home visiting package for a pregnant and child 0-3-year-old to assure that the frequency and timing of the visits are sufficient to allow for timely risk identification and referral. And finally, there seems to be a need to discuss and agree on how the referrals within health sector and with other sectors would work on a community level and if these procedures and/or guidelines have to be mandated and regulated from a central level or facilitated through local – municipal level action.
Management for Results would also require set of concerted efforts. The first it would require demand and accountability for achieving set targets for HV that have to be established. Unless the targets are set ambitious enough and then demand for achieving these targets are placed on FMC managers and nurse coordinators it does not seems feasible for HV to deliver on universal part of HV. However, for this demand to be effective it would be essential to require family doctor and nurse to jointly plan for and deliver home visits by a nurse in a way that delivers the greatest benefit to a child and family by following the philosophy of HV. The second would be enabling managerial decision-making supported with adequate data system through well-designed and functioning HMIS (discussed later). And finally, there would be a need to enhance managerial capacity on a facility and municipality level with the knowledge and management tools. Currently SDC is delivering management training to facility managers and maybe through better coordination and collaboration topics relevant to HV could be introduced in these trainings if circumstances permit. As for the management tools more details are provided below in the next section.

Money and resources seem to be critical for incentivizing home visits and also for creating more conducive working environment for home visitors. Namely, the government is considering performance-based payment for PHC. The evaluation team recommends considering home visits and achieved results as an element of the PHC performance measurement. In that monetary incentives, if introduced, would not be linked only to home visits but to also other results (e.g. immunization, chronic patient monitoring, etc.) that PHC team is expected to deliver. Furthermore, it would be essential to consider support with transportation and means of communication along with the necessary equipment/bags for home visitors, if the services have to be empowered.

Knowledge, Skills & Tool forms the final bucket of recommendations and includes: (a) pushing knowledge and performance boundaries of nurses beyond medicalized approach and (b) supporting service provision with the digitalized home visitor checklists and other tools for service standardization as well as for information collection for HMIS. Overall, evaluation of service content described in paragraph 132 and demand for managing for results in paragraph 133 should naturally create environment where nurses are forced into practice that goes beyond purely medical visits and delivers on the progressive part of home visiting. However, this may require additional nudge as well as additional (refreshing and new modules) trainings which UNICEF and government should consider jointly. And finally, the UPHV should be seen as a means to collect the data of those, who are invisible to the system, but are identified through universal home visits. Therefore, the potential to maximize the value of the data UPHV collects (albeit currently on the paper), especially those that do not reach services, cannot be ignored. Therefore, the evaluation team thinks that to respond to SDGs, while capitalizing on the digital transformation of the 21st century, it is essential for UNICEF and countries to be more strategic when discussing M&E for UPHV.

Therefore, UNICEF and countries are recommended to consider digitalizing check-list (a) primarily as a tool which helps standardize nurse performance when conducting home visits to (b) generate critical data for improved case management for a child or mom, including for case management and referrals and secondly (c) as a means of freeing up time spent by nurses on administrative issues, compensating for labor shortages while allowing more time for higher number or for longer home visits and (d) generating critical information for M&E which can help improve facility level and municipal/national level management of services, conditioned power of artificial intelligence is well utilized for the data transformation/analysis into simple and informative management tools/dashboards for managers.
UNICEF and countries are recommended to consider digitalizing check-lists for managers.

Data transformation/analysis into simple and informative management tools/dashboards can help improve facility level and municipal/national level information for M&E, allowing for more time for higher number of home visits and generating critical data for improved case management for a child or mom. As a means of freeing up time spent by nurses on administrative issues, this can compensate for labor shortages while allowing for case management and referrals. Additionally, digitalized home visitor checklists can support service provision with the UPHV, NCD, and other preventive and curative services.

Money and resources seem to be critical for incentivizing home visits and also for creating a feasible for HV to deliver on universal part of HV. However, for this demand to be effective, it requires demand and accountability for achieving set targets for HV that have to be established. Unless the targets are ambitious enough and then demand for achieving set outcomes along other PHC performance measures/indicators.

Table 5

<table>
<thead>
<tr>
<th>Recommendations to the government</th>
<th>Suggested Timeline</th>
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<tbody>
<tr>
<td>Consider holistically content of the basic benefit package to be delivered by a reformed PHC which includes UPHV, NCD and other preventive and curative services</td>
<td>Short-term</td>
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<tr>
<td>Clearly define the model of PHC service organization and especially how (by whom) the home visiting services are being delivered for UPHV as well as for NCD services and other preventive and curative services</td>
<td>Short-term</td>
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<tr>
<td>Discuss and agree on how the referrals within health sector and with other sectors would work on a community level and if these procedures and/or guidelines have to be mandated and regulated from a central level or facilitated through local – municipal level action.</td>
<td>Medium-term</td>
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<tr>
<td>Establish clear and ambitious targets, at least in the sub-set of municipalities, and enforce accountability for achieving these targets</td>
<td>Short-term</td>
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<tr>
<td>Enable managerial decision-making on a facility level by integrating HV monitoring in the HMIS system for PHC.</td>
<td>Medium-term</td>
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<tr>
<td>Working with SDC enhance managerial capacity on a facility and municipality level with the new knowledge and management tools.</td>
<td>Medium-term</td>
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<tr>
<td>When introducing performance-based payment for PHC services, assure inclusion of HV program targets-outcomes along other PHC performance measures/indicators</td>
<td>Medium-term</td>
</tr>
<tr>
<td>Consider funding adequately necessary inputs (equipment, bags, etc.) and means of transportation for a PHC facility to also benefit HV function for UPHV and/or for NCD or for other preventive services as well</td>
<td>Medium to Long Term</td>
</tr>
<tr>
<td>Critically evaluate the nursing needs for the reformed PHC and assure adequate nursing supply-attraction to the sector</td>
<td>Long-term</td>
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### Recommendations to the government

#### Recommendations to UNICEF

<table>
<thead>
<tr>
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<tr>
<td>Using available scientific evidence, help government evaluate adequacy and sufficiency of the current content of the home visiting package for a pregnant and child 0-3-year-old to assure that the frequency and timing of the visits are sufficient to allow for timely identification of developmental delays and other risks and timely referral.</td>
<td>Short-term</td>
</tr>
<tr>
<td>Support government develop the digitalized check-list for UPHV, which would not only help a nurse in case management, but that would also generate the necessary data for UPHV program management on a facility, municipality and national level and that would be fully integrated with the emerging HMIS system for PHC.</td>
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</tr>
<tr>
<td>Support government with refresher or additional trainings that nurses may require</td>
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</tbody>
</table>
Recommendations to the government

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Support government develop the digitalized check-list for UPHV, which would not only help a nurse in case management, but that would also generate the necessary data for UPHV program management on a facility, municipality and national level and that would be fully integrated with the emerging HMIS system for PHC.

Support government with refresher or additional trainings that nurses may require.

Recommendations to UNICEF

ANNEXES
Annex 1: List of Documents Reviewed

1. Draft Law on Child Protection
2. European Credit Transfer and Accumulation System (ECTS) credits are a standard means for comparing the “volume of learning based on the defined learning outcomes and their associated workload” for higher education across the European Union and other collaborating European countries.
5. February - April 2018
16. Monitoring Results for Equity System, UNICEF
19. Program interventions, UNICEF’s Program guidance for early childhood development, 2017
29. UNICEF 2017: Capacity Development for Health Care Professionals Providing Home Visits, Kosovo 2016/2017
30. UNICEF 2018 Training Health Professionals to Support Families in Improving Health, Development and Child Protection
31. UNICEF 2018. Leaving no child behind in health sector in Kosovo: Concept Note
32. UNICEF Kosovo Office Annual Report 2012
33. UNICEF Kosovo Office Annual Report 2017
34. UNICEF proposal 2018. Strengthen family-centered health system to reach vulnerable children and mothers.
35. UNICEF Raiffeisen Bank Kosovo and UNICEF Partnership
36. UNICEF. 2017. Analysis on the Situation of Children with Disabilities in Kosovo
### Annex 2: List of Key Informants

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Office/Position</th>
<th>Organization/Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murat Sahin</td>
<td>Head of Office</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>James Mugaju</td>
<td>Deputy Head of Office</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Agron Gashi</td>
<td>Health and Nutrition Officer</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Dafina Mucaj</td>
<td>Local Consultant on Home Visiting</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Afrim Ibrahimi</td>
<td>Child Protection Officer</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Dren Rexha</td>
<td>Social Policy Specialist</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Teuta Halimi</td>
<td>Child Rights Monitoring Specialist</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Kozeta Imami</td>
<td>ECD Officer</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Dafina Zuna</td>
<td>Communication assistant and C4D</td>
<td>UNICEF Kosovo Office</td>
</tr>
<tr>
<td>Qendresa Ibra-Zariqi</td>
<td>Senior Child Rights Protection Officer</td>
<td>Prime Minister Office /Office for Good Governance (OGG)</td>
</tr>
<tr>
<td>Alban Morina</td>
<td>Chief of Primary Health Care Division/Chair of home visiting working group</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Merita Vuthaj</td>
<td>Chief of Division for Mother and Child Health</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Arsim Qavdarbasha</td>
<td>Acting Director for Health Services</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Avdi Lokaj</td>
<td>Chief of Budgeting and Finances</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Zenel Hisenaj</td>
<td>Senior Administrator of HIS</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Fatmir Plakiqi</td>
<td>Health Insurance Fund</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Fetije Huruglica</td>
<td>Chief of Nursing Division</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Merita Berisha</td>
<td>Director of Department for Social Medicine</td>
<td>National Institute for Public Health</td>
</tr>
<tr>
<td>Valbona Zhqei</td>
<td>Trainer on Home Visiting</td>
<td>National Institute for Public Health (NIPH)</td>
</tr>
<tr>
<td>Ema Skeja</td>
<td>Trainer on Home Visiting</td>
<td>Center for Mental Health</td>
</tr>
<tr>
<td>Elvana Podvorica</td>
<td>Trainer on Home Visiting</td>
<td>Faculty of Medicine, Department of Nursery and Midwives in Pristina (QKUK)</td>
</tr>
<tr>
<td>Lutfi Bislimi</td>
<td>Child Protection Officer</td>
<td>Ministry of Labour and Social Welfare</td>
</tr>
<tr>
<td>Imrane Ramadani</td>
<td>ECD Officer</td>
<td>Ministry of Education, Science and Technology</td>
</tr>
<tr>
<td>Laberie Luzha</td>
<td>Head of Division for Pre-school education</td>
<td>Ministry of Education Science and Technology</td>
</tr>
<tr>
<td>Avni Kastrati</td>
<td>Director of Social Statistics</td>
<td>Statistical Office of Kosovo</td>
</tr>
<tr>
<td>Fevzi Sylejmani</td>
<td>Director of CSW in Dragash</td>
<td>Ministry of Education Science and Technology</td>
</tr>
<tr>
<td>Vjolca Kadolli</td>
<td>Director of Main Family Health Center Mitrovica</td>
<td>Main Family Health Center Mitrovica</td>
</tr>
<tr>
<td>Osman Maxhera</td>
<td>Director of Main Family Center in Fushe Kosova Municipality</td>
<td>Main Family Health Center Fushe Kosova</td>
</tr>
</tbody>
</table>

*Note: The list includes various key informants from different organizations and positions, such as government offices, UNICEF, and other specialized roles related to public health, social services, and child protection.*
<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Title</th>
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<tbody>
<tr>
<td>Mirnije Gojnovci</td>
<td>Main Family Center Fushe Kosova</td>
</tr>
<tr>
<td></td>
<td>Home Visiting Coordinator in Fushe Kosova municipality</td>
</tr>
<tr>
<td>Jakup Dumani</td>
<td>Municipal Directorate of Health and Social Wellbeing Fushe Kosova</td>
</tr>
<tr>
<td></td>
<td>Director of and Social Wellbeing in Fushe Kosova municipality</td>
</tr>
<tr>
<td>Ganimete Rexhepi</td>
<td>Municipal Directorate of Health and Social Wellbeing Fushe Kosova</td>
</tr>
<tr>
<td></td>
<td>Senior Health Officer</td>
</tr>
<tr>
<td>Abaz Xhikolli</td>
<td>Center for Social Work in Fushe Kosova (CSW)</td>
</tr>
<tr>
<td></td>
<td>Director of CSW</td>
</tr>
<tr>
<td>Bari Bislimi</td>
<td>CSW Fushe Kosova</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
</tr>
<tr>
<td>Zoran Kitic</td>
<td>Municipal Division for minority, repatriates and returnees in Fushe Kosova</td>
</tr>
<tr>
<td></td>
<td>Senior Officer of minority issues</td>
</tr>
<tr>
<td>Agim Jashari</td>
<td>FAKOS NGO</td>
</tr>
<tr>
<td></td>
<td>Officer on Children with disabilities issues</td>
</tr>
<tr>
<td>Ramadan Jashari</td>
<td>Main Family Health Center Dragash</td>
</tr>
<tr>
<td></td>
<td>Director of Main Family Health Center</td>
</tr>
<tr>
<td>Behar Brenolli</td>
<td>Municipal Directorate for Health and Social Wellbeing in Dragash municipality</td>
</tr>
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<td></td>
<td>Director of Directorate</td>
</tr>
<tr>
<td>Nexhibe Berisha</td>
<td>Main Family Health Center Dragash</td>
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<td>Home Visiting Coordinator</td>
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<tr>
<td>Ibrahim Gashi</td>
<td>CSW in Dragash</td>
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<tr>
<td></td>
<td>Director of CSW</td>
</tr>
<tr>
<td>Lindita Kozmaqi</td>
<td>Municipality of Dragash</td>
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<tr>
<td></td>
<td>Officer for Gender Equality and child rights</td>
</tr>
<tr>
<td>Mrika Aliu</td>
<td>Action for Mother and Child (AMC)-NGO</td>
</tr>
<tr>
<td></td>
<td>Executive Director</td>
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<tr>
<td>Albiona Meka</td>
<td>Action for Mother and Child (AMC)-NGO</td>
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<tr>
<td></td>
<td>Main Coordinator for Home Visiting Programe</td>
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<tr>
<td>Afrim Maliqi</td>
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<td>Durim Gashi</td>
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<tr>
<td>Qamile Ramadani</td>
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<td></td>
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<tr>
<td>Ahmet Kryeziu</td>
<td>Save the Children – NGO</td>
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<td>Kanarina Shehu</td>
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<td>Rrita Limaj</td>
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<tr>
<td>Nadire Imeri</td>
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<tr>
<td>Kefsere Vata</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Mimoza Eminie</td>
<td>Main Family Health Center in Ferizaj</td>
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<tr>
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<td>Vigan Behluli</td>
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<td>Consultant</td>
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<tr>
<td>Anne Dostert</td>
<td>Luxemburg Embassy</td>
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<td></td>
<td>Head of Luxemburg Embassy in Kosovo</td>
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</tbody>
</table>
Kosovo UPHV Evaluation Reference Group Members

Chair: Uran Ismaili, Minister of Health
Co-chair: Murat Shahin, UNICEF Kosovo Head Office

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naim Bardiqi</td>
<td>General Secretary, Ministry of Health</td>
</tr>
<tr>
<td>Albana Morina</td>
<td>Head of Division for Primary Health Care, Ministry of Health</td>
</tr>
<tr>
<td>Merita Vuthaj</td>
<td>Head of Division for Mother and Child Care, Ministry of Health Director of Mother and Child Care Division</td>
</tr>
<tr>
<td>Donika Bajrami</td>
<td>Advisor to Minister of Health on Primary Health Care, Ministry of Health</td>
</tr>
<tr>
<td>Osman Maxhera</td>
<td>Director, Main Family Health Centre, Fushe Kosove</td>
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<tr>
<td>Erseka Hasanaj</td>
<td>Director, Health Directorate, Mitrovica</td>
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<tr>
<td>Kefsere Vata</td>
<td>Nurse and Home Visiting Coordinator, Main Family Health Centre, Ferizaj</td>
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<td>Public Health Specialist, National Institute of Public Health</td>
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<tr>
<td>Merita Shala</td>
<td>Professor/Home visiting national trainer, Faculty of Education</td>
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<tr>
<td>Mrika Aliu</td>
<td>Executive Director, Action for Mother and Child</td>
</tr>
<tr>
<td>Imrane Ramadani</td>
<td>ECD officer, Ministry of Education, Science and Technology</td>
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<tr>
<td>Lutfi Bislimi</td>
<td>Child Protection Officer, Ministry of Labour and Social Welfare</td>
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<tr>
<td>Ardita Tahirukaj</td>
<td>Head of Office, World Health Organisation</td>
</tr>
<tr>
<td>Qamile Ramadani</td>
<td>Project Coordinator, Accessible Quality Healthcare</td>
</tr>
<tr>
<td>Qendresa Ibra Zariqi</td>
<td>Child Rights Senior Officer, Office of Good Governance, Prime Minister’s Office</td>
</tr>
<tr>
<td>Hyrije Salihu</td>
<td>Beneficiary of home visiting programme, Fushe Kosova</td>
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</table>
Annex 3: Detailed evaluation methodology

Conceptual Framework: The MCE adopted a theory-based approach that has proven to be helpful for complex evaluation objects. As a conceptual framework, the evaluation was guided by the Theory of Change (TOC) illustrated in Figure 4. The TOC has been adapted based on the TOC of the draft regional strategy towards “Young Child Health and Well-Being” and will be tested throughout the evaluation and adjusted if needed. Testing of the TOC will take place through analysis of UPHV interventions and service models along with UNICEF’s contribution in reducing health system level bottlenecks.

As the TOC is based on a consensus in the ECA Region that progressive realization of child rights and reduction of equity gaps is best achieved through changes in systems, the evaluation reviewed the extent to which the UPHV model has been successfully applied and has resulted in required health system level changes facilitating better child outcomes, especially for marginalized children.

The reconstructed TOC helps to map system level barriers that inhibit effective delivery of UPHV services onto MoRES determinants (e.g. enabling environment, supply related issues or demand barriers affecting the quality and the coverage with the services). The proposed TOC implies that UNICEF’s contribution towards reducing these (MoRES Level 2) bottlenecks would lead to health system level changes that determine quality and coverage with the UPHV (MoRES Level 3), especially for the most vulnerable children.

Reconstructed Theory of Change

**IMPACT**

- Every child is able to develop their full potential and no child is left behind

**OUTCOMES**

- Improved early identification and support of children with health related problems, disabilities, at risk of developmental delays, abuse, neglect and abandonment
- Improved parental knowledge and practice about newborn care, child health, development and nurturing practices

**OUTPUTS**

- **Enabling Environment**
  - Development of HV operational standards
  - Design of standard risk assessment tools
  - Development and enforcement of Domination mechanisms and multi-sectoral coordination protocols/ procedures to facilitate timely referrals to other sectors/services and establishing linkages with support services established and referral pathways enforced

- **Supply**
  - Development of HV training materials
  - Training of master trainers
  - Capacity budding of Pediatricians, nurses and Roma Health Mediators

- **Demand**
  - Outreach HV services and times using campaigns (e.g. for vaccinations) to reduce informational, geographic, financial and cultural access barriers to services
  - Strengthening HV /RHM linkages to deliver
  - HV services in a more culturally sensitive way

- **Quality**
  - Enhance multisectoral coordination and collaboration at local levels
  - Enhance coordination between RHM, HV nurses and Pediatricians, as well as within the health sector

**UNICEF CONTRIBUTION THROUGH CORE ROLES**

- Equity focused analysis of child survival, health development and wellbeing and health system level bottleneck analysis

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100 In the report we use the term “Coverage” instead of “Effective Coverage” required by MoRES framework due to the limitations described later in the report and also issues discussed in the evaluability section.
The overall goal of the UNICEF’s support to strengthening UPHV pilot model during 2014-2018 was to assure that every child develops at full potential and no child is left behind. In the reconstructed TOC, the outputs originally set by UNICEF were grouped under two main reconstructed objectives (Annex 2: Reconstructed Intervention Objectives): i) improving early identification and support of children with health related problems, disabilities, at risk of developmental delays, abuse, neglect and abandonment; and ii) improving parental knowledge and practice about newborn care, child health, development and nurturing parenting practices by UPHV system.

Achievement of this goal was not possible without addressing described health system bottlenecks and improving the quality and accountability of pre- and post-natal care services, ensuring that they meet set standards, reach the most vulnerable, ensure access to needed ECD services within and outside the health sector and support parents in providing adequate care.101

Specifically, UNICEF identified the following activities to address each health system bottleneck:

- **Enabling environment**: i) Development of operational standards for home visiting services enabling operationalization of new approaches of UPHV progressive component; ii) Design of the risk assessment tools to allow for standardization of a nurse practice and early identification of the possible risks to child development by HVNs; iii) operationalization of coordination mechanisms and multisectoral coordination protocols/procedures to facilitate timely referrals to other sectors/services. All these interventions were thought to enrich UPHV services with social and other aspects of care, ensure coordinated multisectoral response towards identified risks to child health, development and wellbeing.

- **Supply**: Capacity building of HV personnel was recognized as a priority support area to ensure provision of UPHV services by knowledgeable and adequately skilled and equipped personnel. Development of the UPHV training program and materials, training of master trainers and capacity building of HVNs, pediatricians and RHMs, has been prioritized.

- **Demand**: To improve parental knowledge in ECD related issues and cultivate nurturing parenting behavior, the program focused on parent’s access to knowledge and services concentrated on helping them adopt practices and behaviors fostering the early development of their children, especially those facing multiple deprivations through periodic campaigns. It was believed that strengthening HVN and RHM linkages will allow for the delivery of UPHV services in a more culturally sensitive way.
  - Quality: Well established enabling environment, incapacitated HV personnel along with improved parental knowledge and practices, adequate coverage of mothers and newborns with home visits and operationalized referral pathways within and outside health sector along with improved coordination were thought to contribute to better quality ECD services of all children, especially of most vulnerable.

**Evaluation Purpose, objectives and scope**

**Purpose**: The Right of Every Young Child to Comprehensive Development and Wellbeing initiative was launched by the UNICEF ECARO in 2012 in order to address inequities in the health, development, care and protection of young children in the region and was informed by the findings of the multi-country evaluation in the region.102,103 The study suggested that the health sector did provide some level of universal home visiting services to families of expectant mothers, newborns and young children in most countries in the region. These services were often provided by a patronage nurses. However, the quality of home visiting services was reportedly low and too narrowly focused on medical and basic health conditions. In addition, providers lacked the knowledge, skills, and tools for early identification of risks and needs, including children with developmental difficulties, and children maltreated or exposed to violence, and for assisting families to secure early intervention and other needed social services.104 Based on these reviews, a regional consensus-building conference in Ankara, Turkey in 2012 laid the foundations for the introduction of UPHV model105 in the region.

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Countries adopted different UPHV implementation strategies. The 2017 Regional Stocktaking Report\textsuperscript{106} and Evaluability Assessment indicated that the application of the UPHV approaches, with a couple of exceptions, is being delivered through modeling and piloting, and that a number of countries are now considering the scale up of UPHV services. Later in 2019, UNICEF will develop a number of new country cooperation agreements (Country Program Documents). This indicates that the timing is right to undertake the MCE that could clarify what results have been achieved to date, what contribution has UNICEF made, what needs to be adjusted and how best to support scaling up of UPHV services over the coming years.

**Objectives:** The evaluation of UNICEF’s support to UPHV introduction in Kosovo is an integral part of the Multi-Country Evaluation (MCE) of UNICEF’s contribution in promoting UPHV in the Europe and Central Asia (ECA) region. Kosovo was selected for in-depth evaluation out of 16 ECA countries and examines the extent to which UNICEF’s efforts to promote UPHV have contributed to addressing some of the critical health system-level bottlenecks in child survival, health, development and wellbeing.

The evaluation in Kosovo:

1. objectively reviews the theory of change and Kosovo context to assess the relevance of the UPHV in addressing young child survival, health and well-being needs;
2. examines extent to which the UPHV model was successfully applied in the targeted geographical areas, what results were attained and what were factors and constraints to implementation;
3. assesses UNICEF’s specific contribution, in terms of the roles the organization has played, towards addressing health system level bottlenecks while striving to improve coverage with evidence-based quality interventions; and
4. assesses extent to which the results achieved can inform the Government’s desire for national roll-out of UPHV services while considering the facilitating and impeding factors that may affect the scale up.

**The geographic scope:** The UPHV model has been initially piloted initially in five municipalities, rolling out to 15 municipalities by the end of 2018. Currently UNICEF supports further rollout with the aim of in total involving 30 municipalities in HV before the end of 2020.

**Equity scope:** Considering the primary importance of UPHV as an entry point into the family with the aim of reducing observed equity gaps and enhancing child health, development and well-being within the groups left behind, the MCE looks at program outputs and outcomes through an equity lens (i.e. examining by income, ethnic, disability, gender, urban/rural, etc.) where available data permits such analysis, and/or where trend data is available over the evaluation period to detect any changes in equity related outputs/outcomes that may have occurred. Furthermore, the MCE focuses its attention on evaluating whether UNICEF supported interventions were equity conscious, i.e. whether they looked at equity challenges during the intervention planning process, and whether they adequately highlighted the need to address the equity issues upfront rather than as an afterthought. It also evaluates whether the interventions delivered were appropriate to tackle the inequities, and whether continuous monitoring of equity issues was carried out.

**Health system level changes:** The ToR of this evaluation explicitly requests the assessment of the health system level changes (especially influencing health system bottlenecks) that possibly facilitated and/or hampered attainment of planned results. It is well known that effective public health interventions can only have a measurable impact when implemented at a “sufficient” scale.\textsuperscript{107} Therefore, due to the specificity of

\[\text{106 Ibid 13}\]
the UPHV model in Kosovo, the health system level impacts that may have affected child's outcomes (health, development and well-being) are measured either on a national and/or regional/oblast level.

Evaluation timeline: Since UPHV in the region only started in 2013/14, as noted earlier, the time period for the evaluation in Kosovo examines at UNICEF's contribution during 2014-2018.

Intended users of the evaluation report: The MCE will have multiple users who will benefit from the findings and recommendations of the UPHV evaluation, including the following:

a) UNICEF Kosovo Office management responsible for designing UNICEF's cooperation plans in the region will use the MCE findings to inform UNICEF's support to national governments in the scale-up of the UPHV services;

b) Among other UNICEF staff, Health, ECD, Child Protection and Social Policy specialists will utilize the MCE findings and lessons learned for the advocacy and provision of ongoing support to national governments in streamlining the services included in the UPHV model, improving access of the most vulnerable children to quality home visiting services and further scale-up;

c) It is expected that the findings and lessons learned stemming from the MCE will help governments (in particular Ministries of Health and Social Protection) and their partners in formulating national reform agenda and programs, as well as guiding the process of the UPHV national scale-up.

d) UNICEF technical networks working on young child health and well-being initiatives will also gain knowledge from the MCE.

Evaluation approach and methodology

Effective implementation of all planned activities was supposed to contribute to i) improving early identification and support of children with health related problems, disabilities, at risk of developmental delays, abuse, neglect and abandonment; and ii) improving parental knowledge and practice about newborn care, child health, development and nurturing parenting practices by UPHV system.

UNICEF supported intervention intended to target the following beneficiaries: i) Children 0-3 years of age and their families, including Roma. Albeit focus on urban/rural poor was not explicit in the program documents; ii) Pediatricians, HVNs and RHMs to acquire new knowledge, skills and job aids through training and provision of guidance on the service provision, coordination among HV professionals as well as with other services and provision of various job aids; iii) Ministry of Health, Republican and Municipal Public Health Institutes along with local governments, municipal health and social sector authorities, health and other support service providers to effectively organize and manage services required for child survival, health and development; and finally iv) supporting and enhancing NGO capacities for improved monitoring of rights realization for Roma children.

Evaluation criteria and framework: The proposed approach to the MCE rests on a thorough desk review of literature from UNICEF’s regional and country offices, which included regional strategies (including in a draft form) and guidance notes as well as country plans, reports and other documents. Furthermore, the approach is also informed by an evaluability assessment commissioned by ECARO before embarking on the MCE.

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According to the Terms of Reference (TOR), the evaluation examines the impact, relevance, effectiveness, efficiency and sustainability of the UPHV intervention. The evaluation utilizes the OECD DAC evaluation approach. Evaluation criteria were selected as: i) the standard international criteria for development evaluation, as reflected in OECD/DAC Manual; ii) appropriately geared to the purpose and objectives of the evaluation; and iii) appropriate for the learning emphasis of the study.

Evaluation Criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Relevance</td>
<td>Relevance is understood as the extent to which the UPHV model was relevant at the time of conceptualization and remains relevant and suited to the current priorities and policies and to the current population needs, particularly on most vulnerable.</td>
</tr>
<tr>
<td>Impact</td>
<td>Impact is defined as positive and/or negative, primary and secondary long-term effects/impact on target group of beneficiaries produced in the course of program implementation, directly or indirectly, intended or unintended.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Effectiveness will be measured as the extent to which the UPHV has been effective in attaining its objectives.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Efficiency is understood as the extent to which the demonstration project has been administered efficiently in terms of how well inputs and activities were converted into results (outputs).</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Sustainability is understood as the extent to which the benefits from the UPHV intervention are likely to continue after the end of the program, and the extent to which measures have been put in place with a view to ensuring the medium to long-term ownership of rights holders and commitment by duty-bearers and their national and international development partners.</td>
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The evaluation responds to the evaluation questions per each criterion as outlined in the TOR, although specific evaluation questions have been refined/modified based on the findings of the evaluability assessment (see MCE Inception Report). Out of the original 29 questions stipulated in the TOR, the MCE has decreased the number of questions to 19 by combining some similar questions under one question and removing those questions to which the MCE will not be able to respond due to the absence of necessary data. Furthermore, some questions have been more detailed to ensure the coverage of important issues. Revisions and changes introduced to questions formulated in the TOR are summarized in the Table 6. More details are provided in Annex 11.

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### Table 6: Summary of revisions/changes introduced in questions provided by TOR

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Question IDs</th>
<th>Revision/changes</th>
<th>Explanation</th>
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<tr>
<td>Relevance</td>
<td>Q1, Q2, Q3, Q4, Q5</td>
<td>No changes introduced</td>
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<tr>
<td>Impact</td>
<td>Q6 and Q7</td>
<td>Dropped</td>
<td>Due to the lack of impact level data and absence of convention for indicators necessary for measuring the impact, MCE will not be able to answer this question</td>
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<tr>
<td></td>
<td>Q8</td>
<td>Reformulated</td>
<td>As MCE will not be able to examine impact the question was reformulated</td>
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<tr>
<td></td>
<td>Q9</td>
<td>Reformulated</td>
<td>The question was reformulated to allow extent to which there were positive or negative results in reducing inequalities and whether different groups (based on ethnicity, socio-economic profile, urban-rural residence, children with special needs, etc.) benefiting to the same extent of the services?</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Q10 &amp; Q11</td>
<td>Combined</td>
<td>These questions were combined to allow more accurate assessment whether UNICEF supported programs identified critical determinants and health bottlenecks, program objectives were appropriate and realistic to address identified determinants and bottlenecks</td>
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<tr>
<td></td>
<td>Q12</td>
<td>Reformulated</td>
<td>Allowing more clarity</td>
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<tr>
<td></td>
<td>Q13, Q14, Q15</td>
<td>Dropped</td>
<td>These questions are reflected and covered under Q9 and Q8</td>
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<td></td>
<td>Q16, Q17</td>
<td>No change</td>
<td></td>
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<tr>
<td>Efficiency</td>
<td>Q18, Q19, Q20</td>
<td>Dropped</td>
<td>Due to lack of financial data (reflected in Stock Taking Report and in the Evaluability report) these questions were dropped</td>
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<tr>
<td></td>
<td>Q21, Q22, Q23</td>
<td>No change</td>
<td></td>
</tr>
<tr>
<td>Sustainability</td>
<td>Q24, Q27</td>
<td>Reformulated</td>
<td>Allowing more clarity</td>
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<tr>
<td></td>
<td>Q29</td>
<td>Dropped</td>
<td>This question has been considered as the overarching conclusion of the MCE. Therefore, instead of keeping it as an evaluation question, ET suggests this question to be answered in the recommendation section of the MCE report.</td>
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</table>
Evaluation Framework: To answer all evaluation questions, a detailed Evaluation Framework (EF) has been developed (Annex 6). The EF structures questions as indicators, which can be measured or assessed during the evaluation. It also identifies the sources of information, the methods the evaluation will apply, the range of documents to be reviewed, key informants to interview for each question and data analysis methods.

The MCE also integrates Human Rights (HRB) and equity (EQ) based dimensions into all evaluation criteria/questions identified. The evaluation questions are informed by i) the UNEG guidance on how to integrate Human Rights HRB & EQ considerations in assessments\textsuperscript{110}; and ii) UNICEF’s equity-based assessment.\textsuperscript{111} The questions will examine to what extent UPHV services benefited right-holders, including a wide range of program beneficiaries, and strengthened the capacities of duty bearers and other key players to fulfill their obligations and responsibilities.

Apart from the EF, specific UPHV program/project Results Framework (RF) was used to demonstrate how program/project activities eventually resulted in achieving its objectives. In collaboration with the UNICEF Regional Office and Country Office teams, the MCE team collected and carefully assessed the data provided in the RF. Where possible, these data were used to establish causal relationships between results and interventions. Based on the findings, along each of the above-mentioned criteria, the evaluation team draw conclusions, provides recommendations and addresses broader questions on lessons learned.

Data Collection Methods: A variety of qualitative and quantitative methods have been used to achieve the evaluation objectives and to respond to the specific evaluation questions. The evaluation methodology encompasses a mix of desk-review (DR) – a review of existing reports, documents and secondary quantitative data analysis – in-depth interviews (IDI), site visits (SV) and observation, focus group discussions (FGD) and short exit interviews. The data collection methods to be used per evaluation criteria are presented in the Annex 6. A more detailed description of each data collection method is outlined below.

Document Review (DR): The MCE team will conduct a comprehensive review of key UNICEF documents (strategies, frame works, previous reviews, Kosovo Programme Document and Kosovo Office Annual Reports), partner documents and Kosovo specific documents (national policy documents, and documents describing UPHV design and implementation progress, etc.) see Annex 3: List of Documents Reviewed.

Secondary Quantitative Data: As part of the desk review, the MCE collected and analyzed available secondary quantitative data, including UNICEF budget expenditure data. The quantitative data from routine statistics and data obtained through Kosovo specific studies; program/project related operational research and operational databases etc. Where available, the quantitative data sources were complemented by national administrative data arising from existing health information or other systems.

Site Visits (SV): The MCE team selected 4 sites for the site visits. These sites have been sampled using the multistage sampling methodology. Parameters used for sampling comprised of population size of children up to 3 years old, the share of poor and vulnerable people, share of ethnic minorities, annual birth rate and coverage of children and their families by the intervention. Ranking of each indicator was performed on the scale 0-5. In the first stage, all districts per each province were listed by their geographical location representing different parts of Kosovo and clustered by size of children population under the age three. The highest score “4” was attributed to the districts where the share of 0-3 years old children represented above 40 percent of total population. On the next stages municipalities were mapped against share of poor and vulnerable children and coverage of children and their families by the demonstration home visiting services. At the end the total ranking scores were calculated and 3 municipalities were selected for the site visits. During the site visits, the MCE team collected qualitative information through in-depth interviews with key informants and through focus group discussions with home visitors and direct beneficiaries.

\textsuperscript{110} Integrating Human Rights and Gender Equality in Assessment–Towards UNEG Guidance, UNEG, 2011
\textsuperscript{111} How to design and manage Equity – focused assessments, UNICEF, 2011
In Depth Interviews (IDI): IDIs with various key stakeholders and individuals have been an important source of evidence for many of the evaluation questions. IDIs helped the evaluation to:

- Understand the range of contextual and operational challenges of demonstration project and its opportunities;
- Continue analysis started by desk review for deeper analysis;
- Generate findings and lessons learned;
- Explore the implementation of different strategies/interventions where applicable; and
- Identify different results/pathways of contribution where feasible.

The evaluation in total interviewed 49 individuals at national, provincial, municipal and facility levels. Prior to visiting key informants IDI interview topic guides were developed based on the Evaluation Framework to help ensure systematic coverage of questions and issues (Annex 7). The interview topics were selected around the evaluation questions but grouped and targeted according to the organization and/or individual to be interviewed.

Focus Group Discussions: The ET selected FDGs as another method for data collection as this method is particularly suited for obtaining several perspectives from providers and beneficiaries (right holders and duty bearers). Based on the discussions and agreement with UNICEF CO, FDGs were conducted in each sampled site for four type of participants outlined in the Table 1 on page 85. In total 9 FDGs were carried out covering 74 participants from different groups of beneficiaries. FDGs aided to obtain in-depth rich data on the reasons and consequences of the current situation, on the bottlenecks faced by beneficiaries, as well as on the demand and needs of the community regarding additional services.

Home visitors and pregnant women and mothers of children 0 to 3 years old who used UPHV were randomly selected from the PHC Centre's staff and user's rosters. During sampling of FGD participants, ET ensured equal participation of different ethnic groups, particularly of Roma and those with rural/urban residence. FGD guides have been designed per each type of FGD participants (Annex 8) and used during the FGDs.

Data analysis, triangulation and quality assurance: Both, qualitative and secondary quantitative data analysis was carried out to arrive at conclusions and formulate recommendations.

Qualitative data analysis: Findings based on qualitative data were triangulated across key informants and compared with available documentary evidence. Data analysis will entail documentation, conceptualization, coding in Nvivo (qualitative analysis software), categorizing, as well as examining relationships. The analysis was also be amended through elements of the “grounded approach” using inductive analysis. This combined approach allowed capturing the complex environment. For qualitative information judgment scores were assigned to evaluation questions where applicable (Annex 6).

Quantitative data analysis: The quantitative data were derived from the routine statistics and secondary data obtained through Kosovo administrative data; program/project related operational research.

Data Verification – As stated above, the evaluation team reviewed data from various sources to answer main questions of the evaluation. Responses from each data source were compared in order to identify discrepancies. For treating response variations, the team established a protocol for “treating discrepancies in the data”. In case of variation among the data collected, the evaluation ranked the reliability of the data by information source.

Quality Assurance: A number of techniques were applied during the evaluation to assure quality: (a) elements of multiple coding, with regular cross-checks of coding strategies interpretation of data between local and international experts participating in the study. This represented one of core activities of the weekly meetings and online conferences during the evaluation phase when the data was collected through in-depth interviews and focus group discussions; (b) using “grounded theory” for data analysis, which
helped to mitigate the potential bias enshrined in the experts’ prior theoretical viewpoint; (c) triangulation from different sources of data collected during the evaluations, which was useful to address the issue of internal validity by using more than one method of data collection to answer the proposed evaluation questions; (d) respondent validation, which will involve cross-checking interim and draft evaluation findings with key informant respondents.

To account for the data quality and to assess the strength of assessment conclusions, MCE used the “robustness scoring” approach for each finding. Consequently, four scores (A to D) were used in this process. Assignment of the score depends on an assessment of the combination of the following two criteria: a) the extent to which qualitative and/or quantitative evidence generated from different sources point to the same conclusion; and b) the quality of the individual data and/or source of evidence (e.g., as determined by sample size, reliability/ completeness of data, etc.). Table 7 shows detailed description for “robustness score” assignment. Filled-in Robustness ranking for Kosovo evaluation can be found in Annex.

**Table 7: Robustness Ranking for Assessment Findings**

<table>
<thead>
<tr>
<th>RANKING</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence (i.e., there is very good triangulation); and/or the evidence source(s) is/are of relatively high quality and reliable to draw a conclusion (i.e., there are no major data quality or reliability issues).</td>
</tr>
<tr>
<td>B</td>
<td>There is a good degree of triangulation across evidence, but there is less or ‘less good’ quality evidence available. Alternatively, there is limited triangulation and not very good quality evidence, but at least two different sources of evidence are present.</td>
</tr>
<tr>
<td>C</td>
<td>Limited triangulation, and/or only one evidence source that is not regarded as being of a good quality.</td>
</tr>
<tr>
<td>D</td>
<td>There is no triangulation and/or evidence is limited to a single source and is relatively weak; or the quality of supporting data/ information for that evidence source is incomplete or unreliable.</td>
</tr>
</tbody>
</table>

**Evaluation Phases**

A phased approach was applied for this assignment, including a sequence of activities with specific deliverables in each of the phases that were agreed with UNICEF and the key stakeholders. Progress to the next step was built upon the consensus achieved at the previous step. The evaluation was implemented in three phases, as described in the MCE Inception Report and depicted schematically below in

**Phase 1: Desk review.** In this phase the MCE team collected all available regional, Kosovo specific and UPHV program related documents with the help of UNICEF ECARO and Kosovo office, and through CIF’s outreach and web search. The MCE also conducted an evaluability assessment by reviewing the documents and the available secondary quantitative data.

The team also held extensive consultations with UNICEF ECARO and selected members of the Regional Evaluation Reference Group (ERG). During the face to face inception meeting organized in early February in Geneva, the team discussed and clarified the methodology and scope of the evaluation; jointly selected case study countries based on agreed sampling criteria; aligned expectations on MCE deliverables and timelines; and clarified the roles and responsibilities of independent regional experts to be assigned by UNICEF, as well as the regional and Kosovo evaluation reference groups.
**Figure 9: Evaluation phases, activities and deliverables**

<table>
<thead>
<tr>
<th>Desk Review Phase</th>
<th>Field Data Collection Phase</th>
<th>Data Analysis &amp; Reporting Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>• Collection of program and country specific documents for desk review</td>
<td>• Preparation for country missions</td>
<td>• Country specific data analysis &amp; triangulation</td>
</tr>
<tr>
<td>• Desk review and production of country specific desk review findings</td>
<td>• Missions to the countries</td>
<td>• Development of Draft Country case studies (Country specific Evaluation Reports)</td>
</tr>
<tr>
<td>• Design of evaluation methodology, evaluation framework, data collection tools and stakeholder map for each country under evaluation</td>
<td>• Field data collection through IDIs, FGDs and site visits</td>
<td>• Development of First Draft of Evaluation Report</td>
</tr>
<tr>
<td>• Development of Inception report Submission of Inception report to UNICEF ECARO</td>
<td>• Stakeholder De-briefing on preliminary evaluation findings and recommendation</td>
<td>• Incorporation of comments received from UNICEF and key stakeholders into the Final Evaluation Report</td>
</tr>
<tr>
<td>• When applicable comments will be addressed in the final Inception report</td>
<td></td>
<td>• Prepare Power Point Presentation on key findings and recommendation of the evaluation</td>
</tr>
<tr>
<td>• Obtaining clearance from UNICEF ECARO</td>
<td></td>
<td>• Visit UNICEF ECARO and sampled countries to present findings</td>
</tr>
</tbody>
</table>

**TASKS**

- Inception report including desk review findings, evaluation methodology, evaluation framework, data collection tools, country selection, evaluation schedule and country mission agenda

**OUTPUTS**

- Data collected during the country missions
- De-briefing presentation on preliminary findings and recommendations prepared
- Country Case Studies
- Final Evaluation Report
- Power point presentation

Furthermore, the MCE team also held an inception meeting with the four countries sampled for in-depth evaluation and discussed the objectives of the MCE, timelines for data collection and validation workshops, and the support required from the UNICEF offices.

Based on the discussions and evaluability assessment, the MCE team adjusted the evaluation methodology including the EF, data sources, data collection methods, tools, sampling methodology, the stakeholder map, and implementation schedule.
Key Deliverable: Inception Report including: detailed evaluation methodology; data collection tools; sampling methodology; list of key Informants for interviews; implementation timelines and milestones.

At the end of the inception phase, the MCE team prepared and submitted an Inception report (the current report) to UNICEF ECARO for review. UNICEF ECARO will solicit comments from all participating offices, Evaluation Reference Groups, and Quality Assurance Group and will furnish consolidated comments to the MCE team to inform the final version of the Inception report.

Phase 2: Data Collection Phase. This phase of the evaluation was devoted to data collection through the proposed data sources. Specifically, as part of the data collection, the MCE team organized remote and face to face interviews (RI) with about 50 Key Informants (KI). The identified key informants were UNICEF CO UPHV Focal Points; representatives from the Ministry of Health responsible for Maternal and Child Health and/or Primary Health Care, representatives from the Ministry of Social affairs (where applicable) and development partners supporting UPHV.

Key Deliverable: Country case studies – UPHV evaluation report; Final MCE Report, and Power Point Presentation on MCE key findings and recommendations

Phase 3: Data Analysis and Reporting Phase. In this phase, the MCE team completed thorough data analysis and triangulation, and prepared Country Case Study (CCS) report, which will be submitted to UNICEF ECARO/Regional Reference Group and UNICEF Offices for validation. The consolidated comments and suggestion received from UNICEF ECARO as well as external quality assurance team will be integrated into the final CCS Report, as deemed appropriate. In this phase, the MCE Team Leader will travel to Kosovo and present findings and recommendations to key stakeholders.
# Annex 4: Evaluation Framework

<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>RELEVANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1</strong></td>
<td>To what extent are the demonstration home visiting services (objectives, strategies, activities, etc.) aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion?</td>
</tr>
<tr>
<td><strong>Q2</strong></td>
<td>To what extent the pilot home visiting services and approaches to delivery of support are: evidence-based and correspond and address actual needs of children, families and communities in the pilot region (and nationally, if scaled-up), especially the most vulnerable children and families? Contributes to gender equality?</td>
</tr>
<tr>
<td><strong>Q3</strong></td>
<td>Is the design of the model services and the activities appropriate for achieving the intended results and outcomes?</td>
</tr>
<tr>
<td><strong>Q4</strong></td>
<td>Has the model service design and implementation been aligned with the Convention on the Rights of the child principles (non-discrimination, best interest of the child, the right to life, participation), gender mainstreaming and Human Rights Based Approach (HRBA) to programming? Did it contribute towards gender mainstreaming and HRBA</td>
</tr>
<tr>
<td><strong>Q5</strong></td>
<td>Were relevant partners involved in the program design, implementation and evaluation, including beneficiaries?</td>
</tr>
<tr>
<td>Judgement criterion/instruction</td>
<td>Data collection methods</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>DR</td>
</tr>
</tbody>
</table>

**Indicator:** The UPHV is fully aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion

Qualitative judgment: Fully/Partially/No

**Indicator:** Pilot home visiting services and approaches to delivery of support are:

- evidence-based,
- correspond and address actual needs of children, families and communities in the pilot region (and nationally, if scaled-up), especially the most vulnerable children and families and is gender responsive contributes to gender equality.

Qualitative judgment: Yes/No

**Indicator:** The design of the model services and the activities are appropriate for achieving the intended results and outcomes (particularly of most vulnerable, disadvantaged, gender responsive, etc.)

Qualitative judgment: Fully/Partially/No

**Indicator:** Model service design and implementation been aligned with the Convention on the Rights of the child principles, Gender mainstreaming and Human Rights Based Approach (HRBA) to programming and contribute towards Gender mainstreaming and HRBA

Qualitative judgment: Fully/Partially/No

**Indicator:** Relevant partners, including beneficiaries, particularly women, were involved in the program design, implementation and evaluation

Qualitative judgment: Fully/Partially/No
### EFFECTIVENESS

<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q6</strong></td>
<td>Were the objectives of UNICEF supported program(s) appropriate to address all relevant determinants (enabling environment, demand, quality and supply)? Were the objectives of UNICEF supported program(s) realistic to address these determinants both through its direct intervention and by convening and advocating with partners?</td>
</tr>
<tr>
<td><strong>Q7</strong></td>
<td>Has the UNICEF supported program(s) in the respective countries contributed to eliminating bottlenecks in ensuring coverage of UPHV services (creating enabling environment; Increasing availability of supply and qualified human resources; Ensuring financial accessibility; Changing knowledge and raising awareness about and demand for services; Ensuring quality of services)</td>
</tr>
<tr>
<td><strong>Q8</strong></td>
<td>What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the service design and implementation, professional practices) were crucial for the achievement or failure to achieve the service objectives so far, especially reaching most vulnerable groups? How effective were the capacity building activities targeting the staff of the demonstration services</td>
</tr>
</tbody>
</table>
a. **Indicator:** objectives of UNICEF supported program(s) were appropriate to address all relevant determinants (enabling environment, demand, quality and supply).

**Qualitative judgment:** Yes/No (for each determinant)

b. **Indicator:** objectives of UNICEF supported program(s) were realistic to address all relevant determinants both through its direct intervention and by convening and advocating with partners.

**Qualitative judgment:** Yes/No

c. **Indicator:** UNICEF supported program(s) contributed to achieving required changes as per the planned objectives.

**Qualitative judgment:** Yes/No

**Indicator:** UNICEF supported program(s) in the respective countries contributed to eliminating bottlenecks

**Qualitative judgment:** Fully/Partially/No (for each of 4 MoRES determinants)

Qualitative judgment will stem from the analysis of progress/trends of outcome level indicators as country UPHV program Results Framework. These indicators will help measure whether bottlenecks in a place (pilot region) have been reduced. However, to evaluate what was UNICEF's contribution we will use contribution score (described in section 3.3.2) for each determinant to establish plausible contribution

List of key benefits for children and families in target population (disaggregated by gender, rural/urban residence, ethnicity, wealth, etc.). Key potential benefits will initially be identified through the document review and validated through IDIs and FGDs
<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q9</strong></td>
<td></td>
</tr>
<tr>
<td>How effective were the capacity building activities targeting the staff of the demonstration services</td>
<td></td>
</tr>
<tr>
<td><strong>Q10</strong></td>
<td></td>
</tr>
<tr>
<td>Were the demonstration services coordinated with other similar program interventions, including of UNICEF? Was there any overlap of efforts?</td>
<td></td>
</tr>
<tr>
<td><strong>Q11</strong></td>
<td></td>
</tr>
<tr>
<td>Was program implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?</td>
<td></td>
</tr>
<tr>
<td>Indicator: Capacity building activities targeting the staff of the demonstration services were effective</td>
<td>Qualitative judgment: Yes/No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>share of home visitors applying the received knowledge into practice / or changes in home visitor skills (benchmark skills: provide case management for CDD; use of standardized tools; counsel caregivers for child development; identify child abuse/neglect; assess social-emotional risk) share of the trained home visitors staff retained at the moment of the evaluation Share of women trained in home visiting Quantitative data obtained for these two quantitative indicators from the MoRES (post-training tests, monitoring reports, home visiting report analysis, wherever available) will be triangulated with qualitative findings from the FGDs and SVs.</td>
<td><strong>Dr</strong> <strong>Idi</strong> <strong>Fgd</strong> <strong>SV</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator: The demonstration services were coordinated with other similar program interventions, including of UNICEF and there was no overlap of efforts</th>
<th>Qualitative judgment: Fully/Partially/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Partially&quot; would imply for example the case when programs were coordinated with other UNICEF programs, but not with other partners'</td>
<td><strong>Dr</strong> <strong>Idi</strong> <strong>Fgd</strong> <strong>SV</strong></td>
</tr>
</tbody>
</table>

<p>| Indicator: programs implemented according to initial timeline by country | Qualitative judgment: Yes/No (for each country) |</p>
<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was program implementation appropriately monitored and evaluated? How were the results used?</td>
<td>Qualitative</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>

**IMPACT**

<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What factors favorably or adversely affected the outcomes of the services on families and children, including on the most vulnerable and influenced gender inequality?</td>
<td>Qualitative</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To what extent there were any positive or negative results in reducing inequalities (in child outcomes, access to and utilization of essential service, etc.)? Are different groups (based on ethnicity, socio-economic profile, urban-rural residence, children with special needs, gender, etc.) benefitting to the same extent of the services?</td>
<td>Qualitative</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>

**SUSTAINABILITY**

<table>
<thead>
<tr>
<th>Criterion/Question</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are legal, institutional and financial mechanisms established to ensure sustainability of the home visiting services? Are conditions established to ensure quality of the services (service standards, training, supervision mechanisms, etc.)?</td>
<td>Qualitative</td>
<td>Qualitative</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Indicator 1: The program implementation was appropriately monitored and evaluated. Monitoring indicators are disaggregated by gender, rural/urban residence, ethnicity, vulnerability and wealth groups, etc.</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative judgment: Yes/No (for each country)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Indicator 2: Share of M&E recommendations implemented |
|---|---|---|

This analysis will be primarily qualitative and based on the data obtained from IDIs, FGDs, review of country specific studies, reports and surveys

<table>
<thead>
<tr>
<th>Indicator 1: legal, institutional and financial mechanisms established to ensure sustainability of the home visiting services</th>
<th>Data collection methods</th>
<th>Data Analysis Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative judgment: Yes/No (for each country)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| Indicator 2: conditions established to ensure quality of the services (service standards, training, supervision mechanisms, etc.) |
|---|---|---|
| Qualitative judgment: Yes/No (for each country) |</p>
<table>
<thead>
<tr>
<th>Q16</th>
<th>What are the key factors that can positively or negatively influence the long-term financial sustainability of the services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q17</td>
<td>Have UNICEF developed the UPHV models scaled-up, incorporated into national policies and/or systems?</td>
</tr>
<tr>
<td>Q18</td>
<td>What were the critical elements which could make the UPHV program sustainable (or which could impede sustainability)?</td>
</tr>
<tr>
<td>Q19</td>
<td>Are other partners supporting UPHV service program initiated with support from UNICEF?</td>
</tr>
<tr>
<td>Indicator: Description of the critical elements identified by the MCE and validated through DR, IDI, and FGDs</td>
<td>DR</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Indicator: Share of pilots scaled-up (a) at regional level; (b) at national level, through incorporation into national policies and/or systems by country by year</th>
<th>DR</th>
<th>IDI</th>
<th>FGD</th>
<th>SV</th>
<th>Qualitative</th>
<th>Quantitative</th>
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</table>

<table>
<thead>
<tr>
<th>Indicator: Description of the critical elements identified by the MCE and validated with key stakeholders</th>
<th>DR</th>
<th>IDI</th>
<th>FGD</th>
<th>SV</th>
<th>Qualitative</th>
<th>Quantitative</th>
</tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator: Other partners supporting UPHV service program initiated with support from UNICEF</th>
<th>DR</th>
<th>IDI</th>
<th>FGD</th>
<th>SV</th>
<th>Qualitative</th>
<th>Quantitative</th>
</tr>
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</tbody>
</table>

**Qualitative judgment: Yes/No (for each country)**
Annex 5: In-depth Interview Guide

Speak to the respondent:

Good morning/afternoon/evening. My name is -----------. I am a researcher carrying out a study on the evaluation of the Universal Progressive Home Visiting for young children wellbeing and development in your region. The findings of the given evaluation will help to identify both the positive outcomes and the remaining challenges and inform future government actions.

The interview will take about an hour. I am kindly asking for your permission if I can record our conversation. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Your name will not be associated to responses.

Remember, you do not have to talk about anything you do not want to, and you may end the interview at any time you wish. Therefore, I sincerely request your cooperation in responding to the following questions. However, at any time during the course of the interview, you are free to terminate the interview. Are there any questions about what I have just explained?

Hand over Informed Consent Form. Allow the respondent to read it carefully and sign if agrees to take part in the interview.

Are you willing to participate in this interview?
   Yes: Proceed with questions
   No: Thank you. Terminate the interview.

Start asking questions.

Questions for IDIs for each stakeholder to be interviewed will be selected from the Evaluation Framework prior to the interview. Schematically information to be collected through IDIs is presented in Table 8.

<table>
<thead>
<tr>
<th>Key Informants</th>
<th>Evaluation questions to be asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF ECARO Focal point for ECD</td>
<td>Q12, Q14, Q15, Q16, Q18, Q19</td>
</tr>
<tr>
<td>UNICEF ECARO Focal point for C4D</td>
<td>Q12, Q14, Q15, Q16, Q18, Q19</td>
</tr>
<tr>
<td>UNICEF ECARO Focal point for Health</td>
<td>Q12, Q14, Q15, Q16, Q18, Q19</td>
</tr>
<tr>
<td>Former UNICEF ECARO Advisor for Health</td>
<td>Q12, Q14, Q15, Q16, Q18, Q19</td>
</tr>
<tr>
<td>UNICEF ECARO Focal point for Child Protection</td>
<td>Q12, Q14, Q15, Q16, Q18, Q19</td>
</tr>
<tr>
<td>National and International experts who supported countries in design/implementation of UPHV model</td>
<td>Q1, Q2, Q3, Q4, Q5, Q6, Q7, Q9, Q10, Q12, Q16, Q18</td>
</tr>
</tbody>
</table>
### Key Informants

<table>
<thead>
<tr>
<th>Key Informants</th>
<th>Evaluation questions to be asked</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF CO Focal Point for UPHV</td>
<td>Q1, Q2, Q3, Q4, Q5, Q6, Q7, Q9, Q10, Q12, Q13, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>MOH representatives</td>
<td>Q1, Q2, Q3, Q4, Q5, Q6, Q7, Q9, Q10, Q11, Q13, Q14, Q15, Q16, Q17, Q19</td>
</tr>
<tr>
<td>MOSP representative(s) responsible for vulnerability assessment and social benefits/programs</td>
<td>Q1, Q3, Q5, Q6, Q7, Q8, Q10, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>Sub-national Government Authorities</td>
<td>Q2, Q3, Q5, Q6, Q7, Q8, Q9, Q10, Q14, Q16, Q18, Q19</td>
</tr>
<tr>
<td>Sub-national Health Authorities</td>
<td>Q2, Q5, Q6, Q7, Q9, Q10, Q11, Q12, Q14, Q15, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>Sub-national Social Protection Authorities</td>
<td>Q2, Q5, Q6, Q7, Q9, Q10, Q12, Q14, Q15, Q16, Q19</td>
</tr>
<tr>
<td>Sub-national Child Protection Authorities</td>
<td>Q2, Q5, Q6, Q7, Q9, Q10, Q12, Q14, Q15, Q16, Q19</td>
</tr>
<tr>
<td>Facility Manager/Chief Nurse/GPs</td>
<td>Q3, Q6, Q7, Q9, Q10, Q11, Q13, Q14, Q15, Q16, Q17, Q18</td>
</tr>
<tr>
<td>Social service/Early Intervention/Disability/ECD service providers</td>
<td>Q2, Q4, Q5, Q6, Q7, Q10, Q12, Q15, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>Civil Society Organizations active in the areas of child protection, deinstitutionalization, disability, etc. as applicable</td>
<td>Q1, Q2, Q3, Q4, Q5, Q6, Q9, Q10, Q12, Q15, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>Selected Development Partners active in the fields of PHC reform, MCH, Human Resource Development and planning, Health Financing, Social Protection, ECD/ECE, etc.</td>
<td>Q1, Q2, Q3, Q4, Q5, Q6, Q9, Q10, Q12, Q15, Q16, Q17, Q18, Q19</td>
</tr>
<tr>
<td>Medical/Health statistical offices</td>
<td>Q7, Q8, Q14</td>
</tr>
<tr>
<td>Research/Academia/Training institutions</td>
<td>Q2, Q3, Q5, Q6, Q9, Q10, Q11, Q12, Q16, Q18</td>
</tr>
</tbody>
</table>
Annex 6: Focus Group Discussion Guides

Annex 6.1 Focus Group Discussion with home visitors

Introduce yourself: My name is representing Curatio International Foundation.

Introduction to the objectives of the research: UNICEF ECARO has contracted us to evaluate the demonstration home visiting services in the region, including in your place. The findings of the given evaluation will help to identify both the positive outcomes and the remaining challenges and inform future actions to streamline the UPHV service package in a way to better meet your needs.

A brief introduction to the rules of focus groups

• The FGD will last for 60-90 minutes
• Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no negative consequences on you.
• Your names will not be asked and recoded. Names will not be associated with responses. Everything said and done is confidential and will not be used outside the room except for the purposes of this research. We will not tell your home visitor anything about what you say;
• FGDs will be tape-recorded to allow us to have a complete notes. Records will be transcribed later and together with records will be kept in a secure place with limited access to non-authorized individuals for another 12 months.
• You are also requested to keep the information you get from other participants during the discussion in confidence.
• You do not have to talk about anything you do not want to, and you may end your participation in discussion at any time
• Every statement is right;
• Please do not hesitate to disagree with someone else, but we ask that any disagreements be respectful and civil;
• But do not all talk at once

Ask questions

I would like to begin our discussion with some general questions about home visiting services

What do you personally see as the most important aspect of your work? What do you feel proud of in your work?

In your opinion to what extent the home visiting services are important for and relevant to the needs of the most vulnerable children and families?

To what extent have you been equipped with necessary knowledge and practical skills to do your job?

Probe for:

• How did you learn to do your job?
• Did you receive formal training?
• Did this happen before or after you were hired in your current position?
• How effective were these trainings?
• What do you feel you still need training in?
Could you please explain to what extent you have all supplies required for the delivery of quality home visiting services?

Probe for:
- Transport or transportation costs
- Home visitors “BAG” with all necessary equipment and materials
- Identification card
- Medical forms for recording home visit results
- Cell-phone or tablet for communication and data entry
- Information materials
- Etc.

How much supervision do you get and how useful supervision is? Who can they go to for help if they have a very challenging family?

Probe for:
- Which entities from which level
- Frequency of supervision visits
- Administrative or clinical supervision (paper work, caseload, etc. or difficult cases, case management, observation)
- Average duration of supervision mission
- Provision of feedback by supervisors
- Supervision performed on an individual or group bases
- Time for reflection and problem solving allowed by supervision
- Usefulness of supervisory visits

Who do you see as the needs of most vulnerable groups of children, their families, pregnant women and mothers? Have you been able to reach out to these groups? What are the barriers for this happening (or happening more)? What strategies have worked or been more successful?

What are key factors that impede provision of effective home visiting services? What makes it more challenging to do your job well? Please give examples.

Probe for:
- Difficulty to locate families at identified address
- Lack of transport and difficulty to travel to remote areas
- Absence of partner/father at home during the home visiting restricting promotion of partner involvement in stimulation of child development
- Strong cultural/religious believes
- Absence/lack of information materials for distribution
- Absence of clear guidance on particular case management
- Insufficient competencies to deal with cases of domestic violence of women and children, postdelivery depression and/or mental health issues in the family
- Other

In your opinion, would it be possible to achieve the same results with less resources? If yes, please give examples. If no, explain why.

Please explain how the quality of your services are monitored. How do you keep track of what you do? How do you or your supervisor know that you are doing a good job and providing services as expected? Where does this information go? What are the follow-up actions, if any? Please give concrete examples

How would you assess your workload? On average how many home visits do you undertake per day? What is the share of the working time you spend on paper work vs. home visits? Please explain and give examples.
Are you satisfied with your work?
Probes:
• What do you like best about your job?
• What could you change, if possible?
• What more do you need to do your job well and feel satisfied with your work?
• Do you see your work as stressful?
• IF YES, What makes is stressful
• IF YES: How do you cope with the stress? Who can you go to for help?
• Do you think most home visitors feel the same way as you?
• Is there a lot of turn-over in this position?
• IF YES: What makes people leave?
• IF NO: What keeps people working in this role?

What are your further needs?
Is there anything I haven't asked about that you would like to tell me related to the topics we have discussed?
Bring the discussion to the closure.

Annex 6.2 Focus Group Discussion with current pregnant women who used UPHV services

Introduce yourself: My name is ----------------- representing Curatio International Foundation.

Introduction to the objectives of the research: UNICEF ECARO has contracted us to evaluate the home visiting services in the region, including in your place. The findings of the given evaluation will help to identify remaining weaknesses and inform future actions to streamline the home visiting service package in a way to better meet your needs.

A brief introduction to the rules of focus groups
• The FGD will last for 60-90 minutes
• Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no negative consequences on you.
• Your names will not be asked and recorded. Names will not be associated with responses. Everything said and done is confidential and will not be used outside the room except for the purposes of this research. We will not tell your home visitor anything about what you say;
• FGDs will be tape-recorded to allow us to have a complete notes. Records will be transcribed later and together with records will be kept in a secure place with limited access to non-authorized individuals for another 12 months.
• You are also requested to keep the information you get from other participants during the discussion in confidence.
• You do not have to talk about anything you do not want to, and you may end your participation in discussion at any time.
• Every statement is right;
• Please do not hesitate to disagree with someone else, but we ask that any disagreements be respectful and civil;
• But do not all talk at once
Ask questions
I would like to begin our discussion with some general questions about home visiting services

Do you already have children?
If yes how old are they?
If no, in which month of pregnancy are you?

Have you ever been visited by home visitors during your pregnancy? If yes, how many times and at what age of pregnancy? How did the home visitors identify themselves (e.g., as nurses, doctors, other kind of provider)?

How is your pregnancy going? What type of questions the home visitor asked to find out whether there are any health or medical concerns you have about your pregnancy?

Please describe (give examples) what type of services they provided during the home visits.
Probe for:
• CHECKED if the house was clean
• Measured the blood pressure (e.g. someone wrapped a wide cloth around your arm, above the elbow; you felt a squeezing pressure in your arm; pressure was released after a couple of minutes)
• Advised about nutrition and weight gain
• Explained importance of regular antenatal visits
• Explained how to plan and get ready for the baby
• Discussed preparation for labour and birth, including information about coping with pain in labour and the birth plan
• Explained how to recognize active labor
• Discussed care of the new baby including breastfeeding
• Made appointment for next antenatal visit
• Asked about domestic violence
• Discussed other family needs and provided referrals to other services when needed

Could you tell what were the most important things you learned from the home visitor? Please explain extent to which you think home visitors were or were not helpful in provision of guidance, information, counselling and in referring you to other services when needed.
Probe:
• Explained importance of personal and home hygiene
• Explained how to exercise during the pregnancy and how to eat healthy
• Explained about the negative impact of smoking, alcohol and substance use
• Other issues related to pregnancy, labor, newborn care, breastfeeding, etc.
• Gave you enough opportunity to ask questions you wanted
• Spent enough time with you (by standard 60-90 minutes)
• Got to know you as a person (or made an effort to connect with you)
• Tried to engage other members of your family (such as your partner or own parent)

Do you know of examples when home visitors helped you access other services?
Probe for:
• Helped to access social protection offices
• Helped to get social benefits
• Helped your child to be admitted to kindergarten or a preschool program (if the women has other children)
• Helped you find services for dealing with violence in your home
• Helped to get health care, including antenatal care
• Helped find counseling or mental health services
• Referred the child with developmental disorders to early intervention services (if the women have other children)
• Helped women and/or a child being violated to access respective services
• Referred the women with postdelivery depression to the doctor and/or psychologist
• Other

In your opinion how the home visiting services meet needs of all women regardless of wealth, residence, ethnicity, education background? Please specify

Overall, how would you rate the quality of home visiting services on a scale “0 to 5” where “5” is highly satisfactory and “0” not satisfactory
Probe:
• IF SCORE OF 5: What about the home visiting services makes you so highly satisfied?
• IF SCORE OF 1 or 2: What could the home visitor do differently to make you rate it more highly?
Would you advise and recommend other pregnant women to use it?
If there was one thing you could change about the home visiting services available in your community to pregnant women, what would it be?
Is there anything I haven't asked about that you would like to tell me related to the topics we have discussed?

Bring the discussion to the closure

Annex 6.3 Focus Group Discussion with mothers of children between 0-3 years old who received home visiting services, including the most vulnerable

Introduction: My name is ------- representing Curatio International Foundation.

Introduction to the objectives of the research: UNICEF ECARO has contracted us to evaluate the home visiting services in the region, including in Kosovo. The findings of the given evaluation will help to identify remaining weaknesses and inform future actions to streamline the home visiting service package in a way to better meet your needs.

A brief introduction to the rules of focus groups
• The FGD will last for 60-90 minutes
• Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no negative consequences on you.
• Your names will not be asked and recoded. Names will not be associated with responses. Everything said and done is confidential and will not be used outside the room except for the purposes of this research. We will not tell your home visitor anything about what you say;
• FGDs will be tape-recorded to allow us to have a complete notes. Records will be transcribed later and together with records will be kept in a secure place with limited access to non-authorized individuals for another 12 months.
• You are also requested to keep the information you get from other participants during the discussion in confidence.
• You do not have to talk about anything you do not want to, and you may end your participation in discussion at any time
• Every statement is right;
• Please do not hesitate to disagree with someone else, but we ask that any disagreements be respectful and civil;
• But do not all talk at once
Ask questions
How many children do you have and what is their age?

Have you ever been visited by home visitors after your child was born? If yes, how many times and at which ages? How did the home visitors identify themselves (e.g., as nurses, doctors, other kind of provider)? Did this person also visit you while you were pregnant?

What type of questions does the home visitor usually ask to find out whether there are any concerns you have about your child?

Please describe (give examples) what type of services they usually provide during the home visits. What do they do when they are visiting with you?

How home visitors engage your partners during the home visiting? Please give examples

Could you tell what were the most important things you learned from the home visitor?

Can you provide examples when home visitors helped you to access other services? Please give examples of services you received with the help of home visitors

Probe for:
• Helped to access social services in the community (including services for children with disabilities and developmental difficulties)
• Helped to get social benefits
• Helped the child to be admitted to a kindergarten or preschool program, or to child care
• Helped you find needed services for family violence
• Helped the child/the mother get access to health care services, including mental health services
• Other

Please explain extent to which you think home visitors were or were not helpful in provision of guidance, information, counselling and in referring you to other services when needed.

Probe:
• Explained importance of personal and home hygiene
• Explained how to eat healthy
• Explained about the negative impact of smoking, alcohol and substance use on family and child health
• Other issues related to r newborn care, breastfeeding, sleep, etc.
• Gave you enough opportunity to ask questions you wanted
• Spent enough time with you (by standard 60-90 minutes)
• Got to know you as a person (or made an effort to connect with you)
• Tried to engage other members of your family (such as your partner or grand parent)

Overall, how would you rate the quality of home visiting services on a scale “0 to 5” where “5” is highly satisfactory and “0” not satisfactory

Probe:
IF SCORE OF 5: What about the home visiting services makes you so highly satisfied?
IF SCORE OF 1 or 2: What could the home visitor do differently to make you rate it more highly?

Would you advise and recommend other families with young children to use Home Visiting Services?

If there was one thing you could change about the home visiting services available in your community, what would it be?

Is there anything I haven't asked about that you would like to tell me related to the topics we have discussed?

Bring the discussion to the closure
## Annex 7: Robustness rating of the findings

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Evaluation Finding</th>
<th>Robustness Score</th>
<th>Justification</th>
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</thead>
<tbody>
<tr>
<td>To what extent are the demonstration home visiting services (objectives, strategies, activities, etc.) aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion?</td>
<td>UPHV intervention by its design is fully aligned with national priorities and policies</td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
</tr>
<tr>
<td>To what extent the pilot home visiting services and approaches to delivery of support are: a) evidence-based; b) correspond and address actual needs of children, families and communities in the pilot region (and nationally, if scaled-up), especially the most vulnerable children and families; c) contributes to gender equality?</td>
<td>UPHV package of services are evidence based and attempt to deliver a comprehensive set of important services as well as linking the most risky and vulnerable children and their families to health, social, education and other services. They are focused on the identified needs, especially among Roma, Ashkali and Egyptian communities, however, focus on other vulnerable groups such as poor or child with disabilities does not feature prominently. The interventions are planned the way to contribute to gender equality.</td>
<td>A</td>
<td>The finding with regards to evidence-based services addressing current needs of children and their families, particularly some vulnerable groups and not all, are consistently supported by the full range of evidence sources, including quantitative analysis and qualitative evidence.</td>
</tr>
<tr>
<td>Is the design of the model services and the activities appropriate for achieving the intended results and outcomes?</td>
<td>UNICEF supported interventions, address most of identified system level bottlenecks, to achieve stated objectives and seem appropriate to achieve intended results and outcomes. However, the evaluation team notes two concerns: the first one relates to the organization of the service delivery under the family medicine center, where nurses are responsible to</td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
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<td>Evaluation Question</td>
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<tr>
<td>To what extent are the demonstration home visiting services (objectives, strategies, activities, etc.) aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion?</td>
<td>deliver office as well as home-based services, which may create adverse incentives to increase the number of home visits conducted and in that may lead to low coverage rates. The second concern of the evaluation team relates to the frequency and timing of the home visits, provided in the government regulations, which may not be sufficient to timely identify primarily developmental risks and refer a child and family to the respective services.</td>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources</td>
</tr>
<tr>
<td>Overall the service design and implementation are well aligned with the Convention on the Rights of the child principles (non-discrimination, best interest of the child, the right to life, participation), gender mainstreaming and Human Rights Based Approach (HRBA) to programming? Did it contribute towards gender mainstreaming and HRBA?</td>
<td></td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
</tr>
<tr>
<td>Were relevant partners involved in the program design, implementation and evaluation, including beneficiaries?</td>
<td>The design and implementation of the intervention encompasses wide range of inputs and contributions from various stakeholders.</td>
<td>A</td>
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Preliminary Report
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<th>Evaluation Question</th>
<th>Evaluation Finding</th>
<th>Robustness Score</th>
<th>Justification</th>
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<tbody>
<tr>
<td><strong>EFFECTIVENESS</strong></td>
<td>Were the objectives of UNICEF supported program(s) a) appropriate to address all relevant determinants (enabling environment, demand, quality and supply); b) realistic to address these determinants both through its direct intervention and by convening and advocating with partners c) Has the UNICEF supported program(s) contributed to achieving required changes as per the planned objectives?</td>
<td>B</td>
<td>There is a good degree of triangulation across evidence sources, plausibly informing ToC for this evaluation. However, there is lack of data from non-intervention sites limiting association of observed changes to the intervention with high degree of confidence</td>
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<td></td>
<td>UNICEF supported program objectives were appropriate to address most of the identified bottlenecks (except the ones that would remain out of UNICEF reach) at the start of the program. However, noted limitations of the care delivery model along with the premature scale-up seems to have stretched UNICEF’s limited financial and human resources and some of the program shortcomings were neither spotted and nor considered and addressed. Consequently, achievement of the required changes per planned objectives seems to be at risk, unless course corrections are taken by UNICEF CO in Kosovo.</td>
<td></td>
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<td>Evaluation Question</td>
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<td>What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the service design and implementation, professional practices) were crucial for the achievement or failure to achieve the service objectives so far, especially reaching most vulnerable groups?</td>
<td>UNICEF’s continuous engagement with the Government and timely delivery of quality technical assistance seems to have been facilitating factors in enacting legislation, developing regulations and shaping government policies. On the other hand, nursing staff shortages and challenges linked to home visiting model design across with financial access barriers have negatively affected service coverage rates, including for vulnerable groups.</td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
</tr>
<tr>
<td>How effective were the capacity building activities targeting the staff of demonstration services?</td>
<td>While UNICEF delivered trainings have certainly improved nurse knowledge around the topics covered in the training, site visits, interviews with the nurses and beneficiaries confirmed that this knowledge, especially related to ECD and good parenting issues have not yet fully translated into nurse behavior/practice.</td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
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</table>

**EFFICIENCY**

Where the demonstration services coordinated with other similar program interventions including of UNICEF? Was there any overlap of efforts?

The intervention to strengthen progressive component of UPHV was well coordinated with other projects and interventions as well as capitalized on already established structures and capacities allowing efficient use of available resources. To maximize possible results, sound partnerships with private sector were established and additional resources are being leveraged in support of UPHV system.

A The finding is consistently supported by the full range of evidence sources
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<tr>
<td>Was program implementation appropriately monitored and evaluated? How were the results used?</td>
<td>Well documented evidence generated with UNICEF’s financial support informed design of the UPHV. Comprehensive M&amp;E system has been developed and implemented, albeit the system requires further improvements and most importantly UPHV program requires mandates for better accountability for results.</td>
<td>A</td>
<td>There is a good degree of triangulation across all sources of qualitative evidence</td>
</tr>
<tr>
<td>Was program implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?</td>
<td>The intervention was implemented in a timely manner without any significant delays</td>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources</td>
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**IMAPCT**

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<th>Evaluation Question</th>
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<tr>
<td>What factors favorably or adversely affected the outcomes of the services on families and children, including on the most vulnerable and influenced gender inequality?</td>
<td>Detailed list of the factors negatively affecting program outcomes are thoroughly described in Figura 7 on page 59 and explained in paragraphs 108 through 111</td>
<td>B</td>
<td>There is a good degree of triangulation across evidence, which plausibly informs ToC for this evaluation. However, there is lack of data from non-intervention sites limiting attribution of observed changes to the intervention with high degree of confidence</td>
</tr>
<tr>
<td>To what extent there were any positive or negative results in reducing inequalities (in child outcomes, access to and utilization of essential service, etc.)?</td>
<td>Evaluation team noted that around 8% of total home visits are being made to Roma, Ashkali and Egyptian community. However, the team cannot ascertain if these levels should be regarded as satisfactory or if they should be higher. Furthermore, no data was available to understand the delivery of services to poor or other vulnerable groups or across gender dimension.</td>
<td>C</td>
<td>Limited triangulation, and/or only one evidence source that is not regarded as being of high reliability.</td>
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<tr>
<td>Evaluation Question</td>
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<tr>
<td>Are different groups (based on ethnicity, socio-economic profile, urban-rural residence, children with special needs, gender, etc.) benefitting to the same extent of the services?</td>
<td>The evaluation team is not in a position to conclude if inequities were reduced as a result of UPHV or if different population groups (including across the gender and poverty dimension) equally benefited from the program.</td>
<td>C</td>
<td>Limited triangulation, and/or only one evidence source that is not regarded as being of high reliability.</td>
</tr>
<tr>
<td><strong>SUSTAINABILITY</strong></td>
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<tr>
<td>Are legal, institutional and financial mechanisms established to ensure sustainability of the home visiting services? Are conditions established to ensure quality of the services (service standards, training, supervision mechanisms, etc.)?</td>
<td>While some legal and regulatory mechanisms have been put in place, yet they are not sufficient to assure sustainability in a medium to long-term perspective and further efforts are required to achieve sustainability.</td>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources.</td>
</tr>
<tr>
<td>What are the key factors that can positively or negatively influence the long-term financial sustainability of services?</td>
<td>Some positive factors have been identified, however structural and health sector related factors, described earlier in this section are expected to negatively affect sustainability of the UPHV initiative, unless are adequately addressed by the government.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have UNICEF developed the UPHV models scaled-up, incorporated into national policies and/or systems?</td>
<td>Yes, most of the work supported by UNICEF are incorporated in the national policies, laws, regulations and systems. However, the evaluation noted certain limitations which require further action.</td>
<td></td>
<td>The finding is consistently supported by the full range of evidence sources.</td>
</tr>
</tbody>
</table>
### Evaluation ToR

**Multi-country evaluation of the Universal Progressive Home Visiting for Young Children Well-being and Development in the Europe and Central Asia Region (ECAR)**

Request for Proposal 2018-ECARO-181225

Institutional Service Contract  
(October 2018)

### 1. Overview

This Terms of Reference is developed for a Multi-Country Evaluation (MCE), which will look at the extent to which UNICEF efforts to promote Universal Progressive Home Visiting (UPHV) in countries in Europe and Central Asia region (ECAR) have contributed to addressing some of the critical health system-level bottlenecks in child survival, health, development and wellbeing. The evaluation will examine UNICEF’s contribution to system level changes and the transformation of nationally developed models and approaches (supply and demand driven), over the period 2014-2018. It will aim to inform important health reform processes that are taking place in countries in the region, and to support UNICEF and governments in their strategies and emerging plans for national scale up of UPHV services across the region. As UNICEF work in this area has been undertaken with different levels of intensity, with variable levels of funding, and with emphasis on different parts of the system, depending on the country, the evaluation will be seen as both formative and summative in nature - the overall evaluation bringing an understanding of the richness and diversity of approaches in different settings and environment.

All countries in the region who have implemented Universal Progressive Home Visiting (UPHV) programmes over the period 2014-2018 will be considered as within the scope of the evaluation. Country case studies (CCS) will be selected by the evaluation team to represent the diversity of contexts in which UPHV is being used as a strategic intervention. Detailed selection criteria and the selection of countries to

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### Evaluation ToR

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<tbody>
<tr>
<td>What were the critical elements which could make the UPHV program sustainable (or which could impede sustainability)?</td>
<td>See responses to Q16</td>
<td>A</td>
<td>The finding is consistently supported by the full range of evidence sources</td>
</tr>
<tr>
<td>Are other partners supporting UPHV service program initiated with support from UNICEF?</td>
<td>UNICEF seems to be a sole supporter to the government in the area of UPHV. The World Bank and SDC are also helping the government with PHC reforms that creates room for collaboration to maximize the sustainability of investments.</td>
<td>B</td>
<td>There is a good degree of triangulation across evidence sources, but there is less or 'less good' quality evidence available in support of this conclusion.</td>
</tr>
</tbody>
</table>

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**Note:** The universal progressive approach, also known as 'proportionate universalism', is a blended universal and targeted approach which proposes to shift the whole population gradient towards greater equity. In this model, all families receive health home visiting services, which are used in part to identify families in need of more enhanced or intensive services.

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**Annex 8: Evaluation ToR**
be included in the MCE case studies will be determined by the evaluation team during the Inception phase. Selection of these countries will not only document evidence of programme achievements and lessons learned, but will show feasibility of a range of interventions applied in different health, socio-economic and political context.

The MCE UPHV will consider all standard evaluation criteria (relevance, effectiveness, efficiency, impact, sustainability). The goal of the UNICEF effort has been to strengthen the health home-visiting sub-system to enable it to support families of young children beyond physical health and with an additional focus on reaching the most vulnerable. At the time of the development of this Terms of Reference it is not clear if sufficient evidence will be available to systematically examine the contribution of UPHV to changes at the level of the child. Beyond the evaluation, it is recognized that measuring child development and wellbeing is a methodological challenge. UNICEF, as a custodian agency for the Early Child Development (ECD) related Sustainable Development Goal (SDG) indicator 4.2.1 (Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being) is currently working with a group of inter-agency experts on the development of an Early Childhood Development Index.

From a formative perspective, the evaluation will allow the gathering of information to understand strength, weaknesses, opportunities, lessons learned and innovations (e.g. what could have been and what have been done differently?) in order to improve and sharpen further equity based inclusive service provision for young children.

The multi-country evaluation, as a process and generating knowledge products, will be used to promote sharing of experiences within the ECA region, to accelerate dialogue with partners and donors related to further programming of universal progressive home visiting as part of national health systems, and most importantly, results of the planned multi-country evaluation will inform the design of new Government programmes and UNICEF support towards improvements in child health and wellbeing, putting those most frequently left behind first. In the ECA region this includes children with disabilities, Roma children, children living in rural and impoverished communities and girl (and sometimes boy) children.

2. Universal Progressive Home-Visiting

Context and Background
The Right of Every Young Child to Comprehensive Development and Wellbeing initiative (founded on, inter alia, Convention on the Rights of the Child, Article 6) was launched by the UNICEF Europe and Central Asia Regional Office as part of the Regional Knowledge and Leadership Agenda in 2012 with the objective to address inequities in the health, development, care and protection of young children in the region. Global evidence from neuroscience and child development research has underlined the critical importance of the early years, as well as a significant knowledge and practice gap of policy makers, practitioners, and families. One mechanism of service delivery that was identified as having great potential to address these inequities is Universal Progressive Home Visiting (UPHV), home visiting that has typically been an outgrowth of health care services.\(^\text{114}\) UPHV provides a means of reducing user barriers such as poor access to health and social services, both in terms of outreach/supply and uptake/demand. The UPHV approach ensures equity, enabling outreach to the most disadvantaged and marginalised children and providing them with targeted services based on their needs.

Health-based home visitors (nurses) have a valued status with families and can also assist families with referrals and advocate for them with other services. Based on findings from a multi-country review\(^\text{3}\), several single country assessments, and a regional survey (2011-2013), it was determined that in view of high coverage of health services in the ECA region, the health sector through its existing home visiting services provided one of the best entry points for reaching specific population groups, including the most

\(^{114}\) Although home visiting crosses service systems and home visitors can come from other professions (most notably social work), ECARO has focused primarily on home visiting that is part of health systems.
marginalized, to promote comprehensive young child well-being and development (including responsive feeding and health), and cognitive and psychosocial development to create a strong foundation for lifelong health, wellbeing and achievement.

A multi-country review of the region (Davidson, 2011) suggested that the health sector did provide some level of universal home visiting services to families of expectant mothers, newborns and young children in most countries in the region. These services were often provided by a community (or patronage) nurse. Overall, however, the quality of home visiting services was reported to be low and too narrowly focused on medical and basic health conditions with an emphasis on basic weight- and growth-monitoring and addressing issues of illness and sickness at the expense of a more holistic and preventative view of child development and well-being that incorporated larger concepts of the family's ecology. In addition, a lack of resources in some countries post-transition for government services in general and MCH (Maternal and Child Health) services in particular led to further erosion of quality, and some other countries abolished home visiting completely as part of health sector reform.

In 2012, a regional consensus-building health conference in Ankara, Turkey resulted in a recommendation towards the development and introduction of a mixed model of home visiting, based on research on the social determinants of health. The model consists of a well-defined package of universal services for all families and enhanced support for families with identified needs. As described in the model approach, the universal progressive system would involve a) additional visits by the home visitor and, as needed, referral to more specialized services in the health and other sectors; b) an increased focus on more holistic elements of child health and well-being, including a focus on family health and what is now being called nurturing care and c) a teaming of professionals from different sectors around the child and family for integrated case management.

UNICEF works in 21 countries in the European and Central Asia (ECA) region. The table below lists the countries which initially participated in the regional roll-out of UPHV through their participation in a regional Steering Group - as well as those engaged more recently. Ministries of Health have been the main sectoral partner with whom UNICEF has worked on UPHV. These 16 countries represent the most active UNICEF country participants in the region-wide modelling initiative and will serve as the primary focus of the evaluation. Three countries (Albania, Azerbaijan, and Ukraine) also have home visiting services in particular led to further erosion of quality, and some other countries abolished home visiting completely as part of health sector reform.

<table>
<thead>
<tr>
<th>Early participating countries</th>
<th>Later participating countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia and Herzegovina</td>
<td>Belarus</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Georgia</td>
</tr>
<tr>
<td>Croatia</td>
<td>Kazakhstan</td>
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<tr>
<td>Kosovo (UNSCR1244)</td>
<td>Kyrgyzstan</td>
</tr>
<tr>
<td>The former Yugoslav Republic of Macedonia</td>
<td>Moldova</td>
</tr>
<tr>
<td>Romania</td>
<td>Uzbekistan</td>
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<tr>
<td>Serbia</td>
<td>Montenegro</td>
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<tr>
<td>Turkmenistan</td>
<td>Tajikistan</td>
</tr>
</tbody>
</table>

117 It should be noted that UPHV has not been applied in any humanitarian/emergency context in the ECA region (which are specifically in Turkey and Ukraine).
118 United Nations Security Council Resolution 1244
At a regional level the UNICEF Regional Office has supported the enabling environment for UPHV – establishing coordination and exchange mechanisms, developing guidance and training materials, and providing technical advice to Country Offices. An expert “Technical Advisory Group” or TAG, was established in 2013 to provide technical guidance and a resource pool of multi-disciplinary experts to support in country activities and research. with approximately 30 international experts who represented a range in knowledge of home visiting, child development, child protection, multi-sectoral collaboration, health sector reform, financing, public health, and monitoring and evaluation.

The ECA region is the only region where UNICEF has applied a UPHV approach. The UPHV approach in ECA builds on a legacy of universal health coverage and universal home visiting.

Theory of Change – UPHV’s contribution to Young Child Survival, Health, Development and Well-Being In December 2016, UNICEF prepared draft regional strategy towards “Young Child Health and Well-Being”. The Theory of Change in this draft document serves as a regional framework for operationalizing the new UNICEF Strategic Plan (2018-2022) and Health Strategy (2016-2030). As is detailed in the Theory of Change (ToC) for Young Child Health and Well-being (see below), it was hypothesized that improvement in home visiting services will lead to consequent positive changes in family support for young child development. These changes, in turn, can support improvement in indicators of child well-being and ultimately reductions in equity gaps among marginalized and vulnerable populations. It is important to note, however, that Home Visiting is only one service component contributing to the two outcomes and impacts for young children. Further information on the strategy, results, identified system level bottlenecks, UNICEF interventions can be found in the Regional Strategy document.

The Regional Strategy document notes that although progress has been made in reducing child mortality, strong inequalities remain. There are different ways that home visiting intersects with this outcome, including provision of quality care during pregnancy and the neonatal period, and promoting of breastfeeding and other positive nutrition practices. However, to ensure child survival and health growth and development, the Regional Agenda promotes programmatic focus on two main priority program areas:
**Figure 1. ECA Regional Theory of Change for YCHW.**

**Impact**
- Equitable realization of child rights: including survival, health, development and wellbeing
- Ensure every child has access to quality health, nutrition, and development services
- Ensure every child grows up receiving nurturing and responsive care in a safe and stimulating home environment

**System level Outcomes**
- Equity-focused maternal and child care and development is politically prioritized and implemented, that ensure that children’s holistic needs are addressed and enable families to provide young children with nurturing care
- Services stimulating child health and well-being, integrated into programmes across various sectors, including maternal health, child survival and health, nutrition, rehabilitation, early learning, social protection (families participating in a cash transfer programme, prevention of violence and abuse), mental health, and services for families with developmentally disabled children
- Effective multi-sectorial coordination and collaboration ensured comprehensive young child health and wellbeing
- Adequate resource allocation, equity-focused budgeting and efficient use of resources is widely practiced by all relevant sectors
- Data collection and management systems to identify and support children most in need institutionalized and effectively function

**Enabling Environment**
- Supply
  - Child Development services is integrated into health and all relevant sectors and access to such services ensured to all children and their families including those most vulnerable and CWDs
  - Essential commodities, supplies and professional human resources are available at all level of service provision to all children including those most vulnerable
- Quality
  - Quality practices institutionalized at all levels of service provision
- Demand
  - Financial access to services at all levels ensured to all children including those most vulnerable and CWDs
  - Culturally sensitive service standards as well as culturally innovative and transformative interventions are institutionalized and widely practiced
  - Caregivers have knowledge and apply positive child care and development practices

**Advocacy (independent voice)**
- Technical Assistance and Policy development
- Convening dynamic partnerships and leveraging
- Monitoring & Evaluation
- KnovAedge generation and child rights monitoring
- Capacity development of government and civil society
- Modeling and testing innovations

**UNICEF CONTRIBUTION**

**Enablers:** Effective human capacity, Fininancial resources, stewardship and governance
Strengthening of Primary Health Care with the emphasis on provision of outreach services through enhancement of home visiting services for pregnant women and families with children under three years. The antenatal period is a crucial time for skilled health care. Early identification of pregnant women and regular, high-quality monitoring throughout pregnancy is an important step towards delivering a healthy baby. In the ECA region, the health care system through primary health facility and home visiting/patronage nursing, reaches the vast majority of pregnant women and families of young children with such services as antenatal care, delivery by trained health care providers, well-child care, immunization, growth monitoring and management of common childhood illnesses. However, in many cases, content of the services is not yet informed by the global evidence on what is important for positive delivery outcome and child development during the critical first one thousand days.

Prioritizing interventions targeted at labour, birth and first week of life. Quality care during and after childbirth is a matter of life and death. The single most important factor in the decline of maternal and newborn deaths worldwide is access to quality care for mothers and new-borns. The interventions needed to save women and new-born girls and boys from dying of preventable causes are simple, affordable and based on evidence. This body of knowledge is outlined in Every New-born Action Plan, which highlights a series of high-impact interventions that address the needs of women and new-borns across the continuum of care, with an emphasis on care around the time of birth.

It is clear that home visiting has the potential to be a prime service delivery mechanism. Despite concerns that home visits in the region continue to be largely focused on physical health, they are seen in the Strategy as a “largely untapped opportunity and excellent entry point” to support nurturing and developmentally-enhancing care, and to address inequities by outreach to under-served populations.

UNICEF UPHV activities and their implementation in the region have been summarized and reviewed in the recent Home Visiting Stocktaking Report 2018. A non-exhaustive list of some of these interventions include:

- Assessing the situation and defining goals for the UPHV Services
- Generating political commitment, advocacy, building public awareness and demand around the benefits of home visiting,
- Defining the service delivery models in different country contexts and supporting the development of institutional structures.
- Modelling of the new types of services
- Strengthening human resources through the provisions of training materials and training
- Facilitating international study visits, continuous education programmes at in-service level, established pre-service curricular, internal supervision
- Management costing and financing of new UPHV services
- Supply, including patronage bags, equipment, smartphones
- Optimizing the workload through utilizing IT solutions (mobile application)
- Strengthening multispectral approach by providing the trainings to the staff of different agencies and NGOs, establishing the referral algorithms
- Monitoring and documenting
- Developing of data collection tool to monitor the quality of the services (Lot Quality Assurance Sampling)
- Evaluation of UPHV models/services.

Financial Investment in UPHV services.
It is not possible to estimate the overall UNICEF budget expenditures allocated towards the development of UPHV services in ECAR. In most of the participating countries, budgets allocated under the programmes for strengthening young child development and wellbeing include activities beyond home visiting. The evaluability assessment undertaken in preparation for this multi-country evaluation indicates quite modest financial investments and quite significant variation e.g. for the period 2012-2017 of USD 882,726
The objectives are formulated so as to address the 5 OECD/DAC standard evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. Almost all COs in ECA region are, in 2018, supporting home visiting reforms to include early childhood case studies, representing the diversity of contexts in which UPHV is being used as a strategic intervention. An extensive document review will be developed by the evaluation team to support the selection of country contexts in which UPHV is being implemented. The role and contribution of the Regional Office (and HQ if ECA RO) to support the final selection of countries for the country case studies, representing the diversity of contexts in which UPHV is being implemented. The selection criteria, based on the extensive document review will be refined in consultation with UNICEF. Moreover, as a number of countries are now discussing scale up and UNICEF will begin developing a number of new country cooperation agreements (Country Programme Documents) in 2019, the timing is right to undertake an evaluation that is both summative and formative to understand what results have been achieved through UPHV to date, what contribution UNICEF has made, what needs to be adjusted and how best to promote scaled up services over the coming years.

3. Purpose of the Multi-Country Evaluation

The purpose of the evaluation being commissioned is, in part, to provide a summary account of UNICEF’s results to date in promoting Universal Progressive Home Visiting in the region – taking into consideration considerable variability across countries. The evaluation will also be an important learning opportunity, both for UNICEF and its partners, deriving lessons from the experience and existing evidence that can inform the scale up of good practices beyond the current countries (table 1) and inform UNICEF programming at all levels.

The 2017 Regional Stocktaking Report and Evaluability Assessment (EA) indicate that the application of the UPHV approaches, with a couple of exceptions, has been delivered through modelling and piloting. Some countries have already scaled up the model, such as Armenia, where services are provided at scale. Moreover, as a number of countries are now discussing scale up and UNICEF will begin developing a number of new country cooperation agreements (Country Programme Documents) in 2019, the timing is right to undertake an evaluation that is both summative and formative to understand what results have been achieved through UPHV to date, what contribution UNICEF has made, what needs to be adjusted and how best to promote scaled up services over the coming years.

4. Objectives of the Multi-Country Evaluation

i) Objectively review the theory of change and country context to assess the relevance of the UPHV model in addressing young child survival, health and well-being.

ii) Assess the extent to which the UPHV model has been successfully applied in the targeted countries and with what results. To understand the success factors and constraints to implementation of UPHV in the context of specific country histories and systems.

iii) Assess UNICEF’s specific contribution, in terms of the roles the organization has played, towards addressing health system level bottlenecks and improving effective coverage with evidence-based interventions.

iv) Assess the extent to which the results achieved to-date have/can support and inform the design of new Government programmes for the delivery of UPHV services at national level in ECA countries – and the factors that may facilitate or impede scale up

The evaluation will be conducted applying equity and gender based analysis, taking into consideration potential influence of external factors and social determinants of health. Specific attention will be paid to understanding the extent to which UPHV extends the reach of Government social services to be inclusive of households and children typically left behind.

5. Evaluation Scope

All countries in ECA region which have supported the establishment of universal progressive home visiting services over the period 2014-2018 will be considered to be within the evaluation scope.

Four country case studies (CCS) will be selected. Detailed and rigorous selection criteria, based on the extensive document review will be developed by the evaluation team to support the selection of country case studies, representing the diversity of contexts in which UPHV is being used as a strategic intervention. Almost all COs in ECA region are, in 2018, supporting home visiting reforms to include early childhood

119 The objectives are formulated so as to address the 5 OECD/DAC standard evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability. https://www.oecd.org/development/evaluation/qualitystandards.pdf

Kosovo* Case Study
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The following proposed CCS selection criteria should be considered by the evaluation team:

- Starting point of engagement (engagement in Canadian Public Health Association analysis in 2011, participation in regional conference in 2012, participation in the earlier TAG meetings as of 2013)
- The start year of UNICEF support to a country UPHV program
- Sustained engagement through time (years of active program support to Home Visiting)
- UNICEF resources allocated for UPHV program
- Availability of data/data systems
- Self-assessment of program maturity for an evaluation
- Program scaled up
- Plans to scale up Home Visiting program within the next year
- Geography (coverage of ECA sub-regions)

The selection criteria, based on the extensive document review will be refined in consultation with UNICEF ECA R0 to support the final selection of countries for the country case studies, representing the diversity of contexts in which UPHV is being implemented. The role and contribution of the Regional Office (and HQ if relevant) will also be considered within the scope of the Multi-Country Evaluation.


The evaluation will respond to the following evaluation questions:

**Relevance**

1. To what extent are the demonstration home visiting services (objectives, strategies, activities, etc.) aligned with the government policies priorities/policies/reforms agendas in the areas of maternal and child health, early childhood development, child care and social inclusion?

2. To what extent the pilot home visiting services and approaches to delivery of support are evidence-based, correspond and address actual needs of children, families and communities in the region and nationally, especially the most vulnerable children and families?

3. Is the design of the model services and the activities appropriate for achieving the intended results and outcomes?

4. Has the model service design and implementation been aligned with the Convention on the Rights of the child principles (non-discrimination, best interest of the child, the right to life, participation), gender mainstreaming and Human Rights Based Approach (HRBA) to programming? Did it contribute towards gender mainstreaming and HRBA?

5. Were relevant partners involved in the programme design, implementation and evaluation, including beneficiaries?

**Impact**

1. To what extent did the services contribute to long-term positive changes in caregiving practices and wellbeing of children? Are there any differences in terms of the impact on the most vulnerable children and families?

2. To what extent and in which areas (parenting practices related to nutrition, safety, early childhood development, child protection and prevention of abandonment, improving parental knowledge) the services had significant impact? Are there any sub-group differences?

3. What factors favourably or adversely affected the impact of the services on families and children, including on the most vulnerable?

4. What worked and what did not work to reduce inequities (in child outcomes, access to and utilization of essential service, etc.)? What are reasons for this?

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4. What worked and what did not work to reduce inequities (in child outcomes, access to and utilization of essential service, etc.)? What are reasons for this?
Effectiveness:
1. Has the UNICEF supported programme(s) contributed to achieving required changes as per the planned objectives? Are objectives realistic?
2. Was UNICEF able to ensure that all relevant determinants at (enabling environment, demand, quality and supply) were tackled both through its direct intervention and by convening and advocating with partners?
3. Has the UNICEF supported programme(s) in the respective countries contributed to eliminating bottlenecks in ensuring effective coverage of UPHV services i. Increasing availability of supply and qualified human resources; ii. Ensuring financial accessibility; iii. Changing knowledge and raising awareness about and demand for services; iv. Ensuring quality of services;
4. Was the equity gap in coverage with UPHV services reduced? To what extent the target groups have been reached? Could the interventions reach out to the most vulnerable groups of children and pregnant women disaggregated by place of residence, wealth, gender and ethnicity?
5. What are the key benefits for children and families who received support from the services? Are different groups (based on ethnicity, socio-economic profile, urban-rural residence, children with special needs, etc.) benefitting to the same extent of the services?
6. What factors affected the effectiveness of the services and their impact on families and children? What factors affected the effectiveness in relation to the most vulnerable groups?
7. What factors (e.g. political, social, gender and cultural, social norms, systemic, or related to the service design and implementation, professional practices) were crucial for the achievement or failure to achieve the service objectives so far?
8. How effective were the capacity building activities targeting the staff of the demonstration services?

Efficiency:
1. Has allocation of resources for UNICEF supported programmes been done in the most cost-benefit manner?
2. Have UNICEF budgets and resources (human, financial and technical) been adequately used on addressing priority bottlenecks? In other words, could we have the same programme results will less resources? (economic and technical efficiency)
3. Were key activities cost-efficient in regard to the achieved outputs?
4. Were the demonstration services coordinated with other similar programme interventions, including of UNICEF? Was there any overlap of efforts?
5. Was programme implemented according to initial timeline? Were there any delays in implementation and what were the reasons for that?
6. Was programme implementation appropriately monitored and evaluated? How were the results used?

Sustainability:
1. Are legal, institutional and financial mechanisms established to ensure sustainability of the home visiting services? Are conditions established to ensure quality of the services (service standards, training, supervision mechanisms, etc.)?
2. What are the key factors that can positively or negatively influence the long-term financial sustainability of the services?
3. Have UNICEF developed UPHV models scaled-up, incorporated into national policies and/or systems?
4. What were the critical elements which made the programme sustainable (or which did not make it sustainable)?
5. Are other partners supporting UPHV service programmes initiated with support from UNICEF?
6. What conditions need to be put in place to ensure the provision of quality home visiting service and results for children, in terms of resources (human, financial, material), human resource development, institutional linkages within the health care system and with other sectors, etc.?
Evaluation questions will be reduced and refined by the evaluation team after the during the desk review phase and in consultation with the Reference Group and partners and stakeholders form the participating countries – to focus on the questions that, if well answered, have the greatest potential to impact on future programming.

7. Dissemination and Use

- The main audiences for the multi-country evaluation are:
  - UNICEF management responsible for designing and approving UNICEF programmes in the region (note that a reference group for the MCE will be established comprising country, regional, global representation of key stakeholders interested in UPHV).
  - Government partners (in particular MoH) who are designing and overseeing UPHV programmes.
  - UNICEF technical networks working on young child health and well-being initiatives.

The results of the evaluation will be first validated internally and with all partner governments. Final results will be presented and discussed at a conference with the participation of all partner governments. The evaluation report and individual country reports will be placed in the public domain – together with a management response to follow up on recommendations.

8. Methodology and Technical Approach

The evaluative framework will be constructed on the TOC provided and lean heavily on the good practices promoted in the Home Visiting Resource Manual, developed by the Regional Office in 2015.

The methodology will include the following elements and stages:

**Desk Review** of existing documentation, the stocktaking and EA reports, evaluation reports, all relevant UNICEF project and programme documents, researches and studies; government strategies and policy documents, primary and secondary data reports and perform initial validation of resources and final definition of the scope for the evaluation;

- Based on the desk review, the consultants will develop an Inception Report that includes:
- A summary of initial findings against the evaluation questions derived from the desk review;
- clear criteria for selecting the 4 case study countries, representing the diversity of contexts in which UPHV is being used as a strategic intervention;
- recommended methodological approach to this assignment, which takes into account the difference in the stages of development of UPHV in the selected countries, including elements of both formative and summative evaluation approaches
- draft data collection instruments and the identification of any ethical considerations, if relevant.
- Reduced and refined evaluation questions, responding to the specificities of the context and supported by detailed evaluation matrix.
- propose country case study mission plans and any necessary revisions in the budget for the evaluation;
- propose a structure for the individual country case study reports and of the Final Synthesis Evaluation Report

**Country missions** in each of the 4 selected case studies (2 weeks per case studies) to collect additional data and evidence (each mission will comprise one international expert, one regional expert (paid by UNICEF) and one national expert). The evaluation team will meet with the country level reference group, gather additional evidence, conduct key informant interviews, including with key stakeholders and partners, draft and present an initial analysis before the end of the mission (deliverable: 2-5 page aide memoire or ppt presentation).
Evaluation team members will sign a no conflict of interest attestation.

The following limitations to the evaluation are anticipated:

- countries are at different stage of implementation on and development with regards to the HV model, which may negatively impact comparability between countries
- unavailability and poor quality of data and evidence, for impact and outcome level;

To address some of these limitations, the evaluation will use information provided through the Evaluability assessment on availability, scope and quality of data and validate key determinants of inequity and trends at impact and outcome level. At a next stage the evaluation approach will be further narrowed down, examining all and country specific programme interventions and their impact, including UNICEF's specific role. Detailed in-country evaluation framework should be developed to allow comparability of programme approaches across the countries.

The evaluation should follow UN Evaluation Group Norms and Standards – including ensuring that the planned evaluation fully addresses any ethical issues. The consultants should also adhere to UNICEF's Evaluation Policy, to UNEG's ethical guidelines for UN evaluations and to UNICEF Reporting Standards. Evaluation team members will sign a no conflict of interest attestation.
### 9. Expected Deliverables, Timeframe and Reporting requirements

The TL will report to the UNICEF ECA Regional M&E Advisor and be the main focal point within the evaluation team for all communications. Once the documents are prepared and delivered, UNICEF shall hold the Intellectual property right of the documents and the related materials.

<table>
<thead>
<tr>
<th>Expected Outputs:</th>
<th>Required Completion Date:</th>
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<tbody>
<tr>
<td>A. Inception Report (30-40 pages), including the Desk Review, outlining the main evaluation issues that will be addressed, the relevant evaluation questions and the proposed and final methodology that has been agreed upon between UNICEF ECARO before the evaluation is set to begin. All tools will be annexed to the report. The IR will be subject to an external quality review.</td>
<td>40 days after the start of the assignment</td>
</tr>
<tr>
<td>B. Selected Countries Evaluation reports (20 pages each) – providing a case study for each of the selected countries for the MCE. The reports will be shared with the regional reference group as well with the respective Country Offices.</td>
<td>4 months after completion of deliverable A</td>
</tr>
<tr>
<td>C. Draft Evaluation Report (including an Executive Summary and Annexes): The report will be shared with all participating countries to ensure that the evaluation meets UNICEF expectations as stipulated in the Evaluation Terms of Reference. The draft report will be subjected to an external quality assurance review.</td>
<td>1 month after completion of deliverable B</td>
</tr>
<tr>
<td>D. Final Synthesis Evaluation Report including Executive Summary (40-60 pages) (excluding the Executive Summary and Annexes)</td>
<td>Within 2 months after completion of deliverable C</td>
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<tr>
<td>E. Power point presentation (20-30 slides) to communicate the main findings, conclusions and recommendations of the evaluation. It is anticipated that the TL will present the final report at a date to be agreed between UNICEF and the consultant.</td>
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Report writing, terminology, publication and citation guidelines of UNICEF should be followed. Necessary guidelines will be provided by UNICEF. All documents produced should be child-sensitive, and in line with the Convention on the Rights of the Child and other legal documents on human rights. All deliverables will be submitted in English, the content of which should be well structured, coherent and evidence-based.
10. Location and Duration

The evaluation will take place over a 12-month period of October, 2018-October, 2019 and will be remunerated against the deliverables to be indicated in the TOR.

International consultants will be home based with travels to the selected case study countries. National consultants will be selected and appointed by the consulting company for each of the case study countries. They will only be required to do in-country travels, if need be.

Proposed Workplan.

<table>
<thead>
<tr>
<th>Activity</th>
<th>2018</th>
<th>2019</th>
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<tbody>
<tr>
<td>ToR final draft</td>
<td></td>
<td></td>
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<tr>
<td>Call for tender issued</td>
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<tr>
<td>Evaluation Institute/team identified</td>
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<tr>
<td>Evaluation Institute/team contracted</td>
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<tr>
<td>Evaluation Reference Group established</td>
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<td></td>
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<tr>
<td>Draft and Final Inception report produced</td>
<td></td>
<td>09/10</td>
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<tr>
<td>Evaluation Design and Instruments validated</td>
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<tr>
<td>Field work conducted in 3-5 countries</td>
<td>09/10</td>
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<tr>
<td>Separate country reports and draft synthesis report submitted</td>
<td>09/10</td>
<td></td>
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<tr>
<td>Presentation of Findings and Conclusions (Validation Workshop)</td>
<td>09/10</td>
<td></td>
</tr>
<tr>
<td>Final report submitted</td>
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<td>09/10</td>
</tr>
</tbody>
</table>
Travel Requirements for the Assignment

The Evaluation team will be required to complete two country mission in each of the selected countries for the Case studies (up to 4 countries). The total duration of the country missions should be up to 2 weeks. The first mission should be attended by two of the international experts from the team and the nationally selected consultant. Second mission should be attended only by the Team Leader (TL) accompanied by the national consultant.

The international evaluation team should plan to participate in an evaluation launch mission to Geneva (UNICEF Regional Office). The team leader and potentially other team members will participate in a final one day international conference, where all evaluation results are presented and discussed. The venue and place of the conference (in the ECA region) will be discussed and agreed between UNICEF and the evaluation team. The conference will be organized and funded by UNICEF.

Travel and daily subsistence allowances will be as per the rules and regulations of the contracted evaluation company.

Any additional specific information regarding the time schedule, procedures, benefits, travel arrangements and other logistical issues will be discussed with the successful candidate evaluation company.

11. Qualification requirements

The evaluation will be carried out by a team of 2-3 international consultants (including the Team Leader) and one national expert in each of the case study countries (to be recruited by the company). In addition, UNICEF will bring into the team one or two independent regional experts (remuneration by UNICEF). The TL will be involved in the selection of all team (international and national experts) members. All consultants should have substantive expertise in leading or conducting evaluations and should not have any conflict of interest with respect to UNICEF and/or national UPHV programmes and activities.

The team will include members who together form an appropriate balance of expertise and practical knowledge in the following areas:
- Public health
- Health Economist
- Health system management specialist
- Early Childhood development
- Social Policy

National consultants should experts in national health system reforms. Complied responding to the tender should plan to hire interpreters separately as necessary.
As a general guide, the level of effort and duration of the evaluation suggest that the Team Leader should be allocated a total of 70 days and team member should be allocated 40 days (depending on the distribution of work and missions across the team).

12. Roles and Responsibilities

Common tasks and duties for all team members
1. All team members are requested to refer attentively to the documentation made available in the evaluation shared folder, including the ToR, context information and information on and preparatory analysis of UNICEF's interventions.
2. All team members are requested to familiarize themselves with UNICEF's global normative products in the substantive areas for which they are responsible. These are available on the UNICEF website www.unicef.org.
3. Complementary to the evaluation ToR, the evaluation team leader will prepare a number of orienting documents and tools (including an evaluation matrix) in discussion with the evaluation team. These documents should be read by all team members and will be used as a framework for guiding the questions to be asked and data to be gathered during the evaluation.

4. All team members will contribute to concise written reports a) at the end of the desk review phase and prior to the start of the field mission (3-5 pages), b) at the end of the field work as contribution to the preliminary debriefing session, and c) for the draft evaluation reports for each country. Team members will also contribute to the revision of the final synthesis draft evaluation report, reviewing the report in its entirety and making suggestions.

Roles and Responsibility – Team Leader

The Team Leader has the overall responsibility for the Multi-country evaluation of the Universal Progressive Home Visiting for Young Children Well-being and Development in the ECA Region looking at the relevance, effectiveness, efficiency, impact and sustainability of UNICEF’s and other key interventions for adolescents. Specifically, the tasks of the TL include:

- Guide the extensive desk review of existing information on the context, national policies and priorities and UNICEF’s work, including all relevant programme and project documents and reports, previous studies, research and evaluations
- Develop and provide detailed methodological guidance for the team and coaching them in the tools and approach to be used for data gathering and analysis. The guidance will be shaped by UNICEF’s Monitoring Results for Equity Systems framework and inquiries into UNICEF performance organized around core roles;
- Facilitate meetings/interviews with national counterparts and development partners;
- Provide guidance in preparing evaluation deliverables;
- Follow the methodology described in the ToR, prepare check-lists as appropriate and consult with the Team Members as necessary on methodological issues;
- Coordinate with the evaluation team to consolidate inputs from evaluation team and ensure timely delivery of evaluation products;
- Manage the evaluation work plan, respecting deadlines for specific activities and inputs described in the work plan;
- Maintain a high level of communication with the other team members;
- Review all relevant documentation related to the UNICEF support for UPHV, including inter alia secondary information available in-country such as statistics, studies and surveys related to children and programmatic areas as well as project documents and progress reports, baseline studies, other technical reports, etc;
- Take part in at least 2 of the case studies evaluation missions;
- Conduct interviews with a range of key stakeholders and informants;
- Visit accessible field programmes sites and interview field staff and ultimate beneficiaries, as appropriate and feasible;
- Assess UNICEF’s, work government and other partners’ contribution and comparative advantage in the context of existing policies, plans and emerging issues;
- Contribute to the team’s analysis and discussion of evaluation questions and issues common to the whole team;
- Lead the consolidation of the teams' inputs for the debriefing session(s) and in the presentation of the draft findings to stakeholders
- Submit the Inception Report upon completion of the Desk Review phase, the mission (field visit) an aide memoire/ppts upon completion of the Field Missions, the Draft and Final country evaluation reports (ERs) and final synthesis report, and the power point presentation on the main findings and recommendations emerging from the evaluation.

Note that the IR and ERs will be subject to an external quality assurance review prior to being cleared by UNICEF as final deliverables.
13. Evaluation criteria

Interested companies are requested to submit their technical and financial proposals by 9 November 2018.

After the opening, each proposal will be assessed first on its technical merits and subsequently on its price. The proposal with the best overall value, composed of technical merit and price, will be recommended for approval. UNICEF will set up an evaluation panel composed of technical and procurement staff and their conclusions will be forwarded to the internal UNICEF Contracts Review Committee, or other relevant approving authority.

The evaluation panel will first evaluate each response for compliance with the requirements of the request for proposal (RFP) procedure of UNICEF. Responses deemed not to meet all of the mandatory requirements will be considered non-compliant and rejected at this stage without further consideration. Failure to comply with any of the terms and conditions contained in this RFP, including provision of all required information, may result in a response or proposal being disqualified from further consideration.

All bidders’ proposals will be reviewed by 30 October, 2018. It is expected that the contract with the selected bidder will be signed not later than 10 November.

The overall weighting between technical and price evaluation will be as follows: The technical component will account for 70% of the total points allocated and the financial component will account for 30% of the total points allocated.

The assessed technical score must be equal to or exceed 42 of the total 70 points allocated to the technical evaluation in order to be considered technically compliant and for consideration in the financial evaluation.

The proposals will be evaluated against the following technical criteria:

<table>
<thead>
<tr>
<th>Item</th>
<th>Technical Evaluation Criteria</th>
<th>Max. Points Obtainable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Overall Response</strong> e.g. the understanding of the assignment by the proposer and the alignment of the proposal submitted with the ToR</td>
<td>10</td>
</tr>
<tr>
<td>1.1</td>
<td>Completeness of response</td>
<td>5</td>
</tr>
<tr>
<td>1.2</td>
<td>Overall concord between RFP requirement and proposal</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td><strong>Company and Personnel</strong></td>
<td>25</td>
</tr>
<tr>
<td>2.1</td>
<td>Range and depth of organizational experience with similar projects</td>
<td>4</td>
</tr>
<tr>
<td>2.2</td>
<td>Samples of previous work</td>
<td>3</td>
</tr>
<tr>
<td>2.3</td>
<td>Number of customers, size of projects, number of staff per project</td>
<td>3</td>
</tr>
<tr>
<td>2.4</td>
<td>Client references</td>
<td>7</td>
</tr>
<tr>
<td>2.5</td>
<td>Key personnel: relevant experience and qualifications of the proposed team for the assignment</td>
<td>8</td>
</tr>
</tbody>
</table>
### Technical Evaluation Criteria

<table>
<thead>
<tr>
<th>Item</th>
<th>Technical Evaluation Criteria</th>
<th>Max. Points Obtainable</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Proposed Methodology and Approach e.g. Work plan showing detail sampling methods, project implementation plan in line with the project</td>
<td>35</td>
</tr>
<tr>
<td>3.1</td>
<td>Proposed work plan and approach of implementation of the tasks as per the ToR</td>
<td>15</td>
</tr>
<tr>
<td>3.2</td>
<td>Implementation strategies, monitoring and evaluation, quality control mechanism</td>
<td>10</td>
</tr>
<tr>
<td>3.3</td>
<td>Technologies used - compatibility with UNICEF</td>
<td>5</td>
</tr>
<tr>
<td>3.4</td>
<td>Innovative approach</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Total Technical Scores</strong></td>
<td><strong>70</strong></td>
</tr>
</tbody>
</table>

#### 14. Administrative Issues

The bidders are requested to provide an all-inclusive cost in the financial proposal. In all cost implications bidders, should factor the cost of the required service/assignment. Estimated cost for travel should be included in the financial proposal. Travel cost shall be calculated based on economy class travel, regardless of the length of travel. Costs for accommodation, meals and incidentals shall not exceed applicable daily subsistence allowance (DSA) rates, as promulgated by the International Civil Service Commission (ICSC). Unexpected travels shall also be treated as above.

#### 15. Management of the Evaluation

The multi-country evaluation will be managed by the ECAR M&E Regional Advisor. A regional Reference Group will be established to guide and oversee the implementation of the Multi-Country Evaluation. The RG will include representatives of UNICEF Office of Evaluation, UNICEF Programme Division, ECA RO (Early Childhood Development and Health Section and Deputy Regional Director) and the Deputy Representatives of the case study countries.

The Regional Advisor on Monitoring and Evaluation will be the key focal point for the Evaluation Institution/Team. At CO level, this role will be assumed by the M&E Specialist.

The M&E Section in the Regional Office will manage the evaluation and provide support to the evaluation team throughout the process.

#### 16. Payment Schedule

All payment terms will be indicated in the institutional contract upon selection of the successful company.

- 30% of the payment is due after the deliverable of final Inception report.
- 30% of the payment is due after the submissions of approved individual evaluation reports for the selected case study countries and
- 30% of the payment is due after the submission of the final synthesis evaluation report.
- 10% of the payment is due after the integration of any final comments and corrections to the final synthesis evaluation report.
Inception reports, individual evaluation reports and final synthesis evaluation report will be considered final after satisfactory review by the external review facility and the approval of the Reference Group.

17. Evaluation Ethics
All UNICEF Programme and project evaluations are to be conducted in accordance with the principles outlined in the UNEG ‘Ethical Guidelines for Evaluation’ and the UNEG Code of Conduct for Evaluation in the UN System. Both documents can be found at the following link: http://www.uneval.org/search/index.jsp?q=ethical+guidelines.

Annex 1: Bibliography
3. Case Study 6, HEALTH HOME VISITING TO SUPPORT EARLY CHILDHOOD DEVELOPMENT IN THE CEE/CIS REGION; BETTINA SCHWETHELM AND DEEPA GROVER (UNICEF Regional Office For Central and Eastern Europe/Commonwealth of Independent States)
4. UNICEF’s Programme Guidance for Early Childhood Development; UNICEF Programme Division, 2017