



THE UNIVERSAL PROGRESSIVE HOME-VISITING PROGRAMME MATURITY MODEL ASSESSMENT SUMMARY OF THE REPORT WITH RECOMMENDATIONS



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Summary

Home-visiting services are an important component of primary healthcare in Montenegro and represent a key service for improving the health of children, pregnant women, new mothers and families through preventive and counselling work in home settings, particularly in communities with greater health and social needs. Although Montenegro is currently applying a universal home-visiting model, additional visits are also carried out as needed by home-visiting (“patronage”) nurses, providing a foundation for the development of a progressive model. Given the presence of indicators of inadequate healthcare and parenting practices, it is necessary to strengthen home-visiting services to ensure timely and continuous support for all families – particularly those in vulnerable circumstances – and thereby improve child health and early childhood development.

The Universal Progressive Home-Visiting Programme Maturity Model Assessment (UPHVMMMA) is a UNICEF standardized tool for assessing the maturity of systems that enable and support home visiting. It is based on best practices and frameworks developed by the World Health Organization (WHO) and covers key health system domains. The model aims to identify strengths and areas for improvement, guide decisionmakers in optimizing services, and encourage dialogue among all stakeholders. In doing so, it contributes to improving the quality, accessibility and sustainability of home-visiting services for children and families.

The assessment itself consists of two types of analysis: contextual analysis and an assessment of Universal Progressive Home Visiting (UPHV) domains. The contextual analysis uses quantitative indicators on demography, the economy, healthcare and early development to assess the environment for the delivery of home-visiting services.

These findings, together with the results of the maturity model assessment, which contains over 250 questions, are used to formulate recommendations and improve the home-visiting system.

CONTEXT

In Montenegro, the maternal and infant mortality rates are among the lowest in the region. These indicators confirm significant progress in maternal and neonatal care. However, despite positive outcomes in this area, there are ongoing challenges that point to the need for further improvements in support for families. Immunization rates are below the recommended levels, particularly in certain regions, among vulnerable groups and for specific vaccines. This is especially evident in the case of MMR vaccine coverage, where the first-dose rate in 2023 stood at 24% (WHO/UNICEF, 2023) – the lowest in the Europe and Central Asia region. There are also low rates of exclusive breastfeeding in the first six months (around 20%) (MONSTAT i UNICEF, 2019), inadequate nutrition – particularly in Roma settlements, where one in five children experiences stunting – and inadequate parenting practices in terms of developmental stimulation and non-violent upbringing. The need to improve child health and development outcomes provides a strong rationale for expanding home-visiting services, particularly in communities at higher risk.

The home-visiting service is part of primary healthcare, which in Montenegro is defined as the basic level of the health system. The service is currently organized in 18 out of 25 municipalities, ensuring high territorial coverage as one of the key prerequisites for universal access to healthcare at the community level.

Services are defined by the *Rulebook on Detailed Conditions with Regard to Standards, Norms and the Manner of Delivering Primary Healthcare through a Chosen Doctor’s Team or Chosen Doctor*. The number of preventive home visits for mothers and young children is defined in the Decree on the Scope of Entitlements and Standards of Healthcare

under Compulsory Health Insurance. Despite this regulatory framework, the performance of home-visiting nurses in carrying out visits related to maternal and child health is inadequate, as the prescribed visits are only partially being completed – particularly when it comes to pregnant women and children after their first year of life.

Until 2022, the primary source of public health expenditure funding was health insurance contributions. However, in 2022, a significant public revenue reform was introduced, changing the financing model for the health system: instead of direct taxes and contributions, the system is now funded through general taxation. Financing for home-visiting services is difficult to identify clearly within healthcare centres' budgets and expenditures. This is due to the applied financing mechanism, whereby the Health Insurance Fund (HIF) uses line-item budgeting to finance all healthcare centre activities, including home visits.

A total of 251 home-visiting nurses are employed across healthcare centres in Montenegro. Of the 18 healthcare centres, 14 reported having home-visiting nurses delivering preventive services, totalling 35 nurses. The remaining four centres have organized their services in such a manner that all nurses provide both preventive and curative care; it is therefore estimated, on a full-time equivalent basis, that 40 home-visiting nurses are engaged in delivering preventive services nationwide. According to population coverage standards, the overall number of home-visiting nurses is adequate at the national level; however, the distribution between preventive and curative duties runs counter to the existing standards (the recommended ratio of 5:1 in favour of prevention is effectively reversed to 5:1 in favour of curative work).

This situation results in insufficient performance by home-visiting nurses and incomplete coverage of preventive services across different age groups of children. According to the methodology of this study, planned visits are not being achieved for any target population. Coverage – except for

newborns, where it stands at 87% – does not exceed 31% for any group.

Based on the total number of required home visits and the assumption that one nurse can carry out three visits per day, it is estimated that 101 nurses are needed nationally. This number decreases to 60 if each nurse conducts five visits per day. Given that only around 40 nurses are dedicated exclusively to home visits for pregnant women and young children, an additional 61 nurses would be required at the national level to ensure all necessary visits are carried out, assuming an average of three visits per nurse per day. The deficit is particularly pronounced in some healthcare centres (Podgorica alone has a shortfall of 25 nurses). Conversely, some smaller centres show a nominal surplus of capacity, indicating potential to redistribute workloads or combine home visits with other duties.

KEY FINDINGS PER HEALTH SYSTEM DOMAIN

POLICY, REGULATORY AND STRATEGIC FRAMEWORK

Montenegro has a well-developed regulatory and strategic framework that formally supports the work of the home-visiting service as part of primary healthcare. Based on rulebooks and strategic documents, the home-visiting service is, in theory, an integral and legally defined component of primary healthcare (PHC) and operates as a separate organizational unit within healthcare centres. More than half a million home visits are carried out annually, confirming that the service is widely embedded within the system. However, there is a significant gap between the regulatory framework and actual practice.

Although policies and rulebooks exist, their implementation is inconsistent and fragmented, for the following reasons:

- There are no binding, standardized protocols for all types of home visits at the national level.

- Preventive visits account for a small proportion of all visits carried out, while the majority are curative in nature.
- Pregnant women and children over one year of age are insufficiently covered, despite being identified as priority target populations in the rulebooks and strategies.
- In practice, the system's focus remains on curative services, raising the question of whether policies were genuinely intended to include a strong preventive component or whether implementation has drifted from the original intent.
- There is no formal mechanism for monitoring the quality of home visits, nor any system for evaluating their impact on maternal and child health.
- The absence of binding procedures further impedes the implementation of the preventive model.

All of this indicates that, although the legal framework and political support do exist, the delivery of preventive home visits as a routine primary healthcare practice has not yet been fully achieved in line with the defined standards. The system is functioning, but not in accordance with the prescribed norms and strategic objectives, particularly with regard to prevention, early development and continuous support for families with young children.

GOVERNANCE

In Montenegro, the relevant bodies and defined mechanisms for oversight, coordination and policy implementation in the healthcare sector formally exist, including for the home-visiting service. Nevertheless, their effectiveness is limited, as responsibilities are often reduced to the formal performance of obligations, while the operational component, quality monitoring and consistent implementation remain weak. In practice, it is not always clearly defined which nurses provide preventive home-visiting services and according to which plans and objectives, or whether the working methods set out in the Protocol are

being followed. Differences exist between healthcare centres, there is no uniform service structure at the national level and there is no clear chain of accountability. In some settings, home-visiting duties are carried out by staff with varying profiles (home-visiting nurses, general care nurses, medical technicians), which further contributes to inconsistent service delivery.

Structures and bodies for cross-sectoral coordination (covering health, education and social protection) have been established, but collaboration remains limited and uneven, with no genuine integration of responses to family needs. A multi-sectoral approach is present in strategic documents but is only partially applied in practice, while operational coordination remains fragmented and insufficiently realized on the ground, particularly at the local level.

Furthermore, there is no systematic mechanism for monitoring the quality of home visits, evaluating their impact or providing feedback for programme improvement. Results from healthcare centres and local reports are rarely used for management and decision making at higher levels. Managerial practices are often ad hoc and unstructured.

It is important to highlight that home-visiting nurses and other field workers have no formal representation in the national-level planning and decision-making processes, despite being best-placed to understand families' needs in the field. This results in the loss of a crucial source of information for improving the system.

FINANCING

Over the past five years, Montenegro has undertaken a significant reform of its healthcare financing system. Until 2022, the system was predominantly funded through health insurance contributions. However, following their abolition in 2022, the country transitioned to a model in which the health system is financed from general budgetary revenues through taxation and transfers to the Ministry of Health (MoH) and the Health

Insurance Fund (HIF). The HIF remains the principal channel through which funds are distributed to healthcare institutions. In practice, this means that the existing HIF infrastructure continues to be used, but the source of funds has shifted (from contributions to the general budget).

This reform has enabled universal health insurance coverage, as it is based on residency rather than employment status. At the same time, it has increased pressure on the central budget and has heightened the need for transparent and efficient allocation of funds, potentially raising concerns about long-term financial sustainability.

Home-visiting services are financed within the overall primary healthcare budget. There is no dedicated budget line for this service, so funding allocations depend on internal decisions by healthcare centres and HIF management. This model has several consequences:

- Home-visiting activities compete with other primary healthcare services for funding.
- Financial details related to budget setting are not clearly regulated or transparently documented.
- There is no financial mechanism to ensure that preventive visits are carried out in accordance with the prescribed norms.

As a result, although more than 500,000 home visits are conducted annually, the vast majority are curative, while preventive visits for pregnant women and for children over one year of age remain significantly underrepresented, despite being defined in rulebooks and strategies. Decisions on visit priorities are made at the level of individual healthcare institutions, often on an ad hoc basis and without clear criteria.

The financing system tracks neither the structure of visits nor their outcomes, focusing primarily on the number of services delivered, coded for reimbursement purposes. Home-visiting nurses' salaries are aligned with general pay grades for primary

healthcare workers and do not reflect the specific demands, additional expertise or fieldwork which characterize home-visiting services. There are no incentive mechanisms, allowances for remote areas or differentiated coefficients for additional competencies or higher volumes of preventive work. As discussed later, this limits motivation and reduces the profession's attractiveness, further hindering implementation of the preventive policies outlined in strategic documents.

DATA AND INFORMATION SYSTEMS

Montenegro has a well-developed national healthcare information system, but without a clearly defined coordinating body. The technical infrastructure exists within the primary healthcare domain; however, it does not provide uniform and comprehensive support for home-visiting services. The existing digital components are not standardized, and their application lacks consistency. Data is collected primarily at the level of individual healthcare institutions and is not always available for analysis at the national level.

The absence of a centralized and interconnected information system hinders evidence-based decision making and effective resource targeting. Alongside electronic record keeping, parallel paper-based documentation is still maintained. Data largely relates to the number of planned and completed visits that have been invoiced, while the Health Insurance Fund primarily uses this information to monitor contracted service volumes and calculate reimbursements.

Home-visiting nurses submit work reports mainly upon request from managers or in accordance with a monthly schedule, although some staff do not submit reports at all. Current statistical reports do not fully reflect the actual categories of home-visiting activities. The statistical survey programme does not align with contemporary visit types or target groups. Furthermore, no standardized indicators have been defined for analysing service performance.

WORKFORCE

According to the Ministry of Health's organizational structure, a dedicated unit is responsible for healthcare workforce planning, including the home-visiting service. Procedures and guidelines exist to support planning, along with occasional analyses that include workforce assessments. This suggests a solid strategic foundation; however, challenges remain in systematic monitoring and long-term workforce projections. A basic regulatory framework exists for staff recruitment and deployment, but in practice it is not always aligned with field needs. Although supporting documentation is in place, staff distribution across regions and institutions remains uneven.

Montenegro has a system of continuous professional development, including training programmes for home-visiting nurses. While these programmes support the development of knowledge and skills, their continuity, coverage and systematic implementation are limited. Training is delivered sporadically, often through projects and short courses, and without a nationally standardized approach.

In the absence of a chamber of nurses or a licensing system, the accreditation of training programmes and awarding of certificates are overseen by the Centre for Vocational Education and Training within the Ministry of Education.

The lack of continuous professional development and structured supervision represents a barrier to the quality and standardization of home-visiting services. Basic supervision mechanisms exist, and supervisors have received relevant training and certification. However, supervision is neither consistently implemented nor standardized, and the quality of evaluation varies across institutions. It is often more administrative than supportive or mentoring in nature.

In some municipalities, staffing shortages limit service availability and increase the workload of the existing personnel. The absence of precise workforce data

complicates the development of strategies for optimal resource allocation. Although a healthcare workforce database exists – maintained at both the national and health centre levels – data disaggregated by location, level of education and type of work is not being sufficiently utilized in practice for policy adjustments or staff redistribution.

ACCESS TO ESSENTIAL SUPPLIES

Montenegro has an established national logistics management system within the health sector, responsible for the planning, procurement and distribution of essential medical supplies. Documented guidelines for logistics and inventory management are in place, providing a foundation for standardized supply chain operations.

However, consumption planning does not adequately reflect the specific needs of Universal Progressive Home Visiting (UPHV) services (e.g. consumables for home visits, transport-related costs). Healthcare centres have basic storage capacity and, although regulated procedures for distribution exist, capacities are not always sufficient, particularly in remote or smaller municipalities. Information from healthcare centres suggests that the minimum standards are generally being met, but infrastructure quality varies.

Despite the existence of basic institutional infrastructure, there is no medium-term strategic logistics plan (3–5 years), which limits long-term planning and alignment with broader health policies. The absence of such planning frameworks makes it difficult to monitor consumption trends and respond effectively to increased demand (e.g. during crises or expansions in home-visiting services). Procedures for the rational use of consumables and medical supplies are defined; however, while basic consumption indicators are tracked, more detailed analyses of efficiency are lacking. Limited integration with the health information system further constrains the ability to monitor usage at the level of individual visits or services.

SERVICE DELIVERY

Although there is no single formal procedure for planning home visits at the national level, some healthcare centres do develop daily, weekly or monthly work plans. However, there are no standardized criteria for prioritizing families or types of visits. As a result, planning is largely based on historical practice or available staffing rather than on a systematic needs assessment. Vulnerable and at-risk groups are not consistently prioritized. Risk identification does occur to some extent (e.g. through general practitioner records, social services or the home-visiting nurse's own assessment), but there are no mandatory tools or protocols to ensure that all vulnerable families are identified and followed up consistently across municipalities. A Guidelines (Marković i drugi, 2024) and Protocol for Conducting Home Visits (Durković i drugi, 2025) exists, but these documents primarily describe the content and sequence of visits rather than enabling flexible adaptation to family needs. In practice, there is no structured mechanism (such as an algorithm or assessment tool) to support the planning of individualized visits tailored to family needs. Without a standardized approach to needs and risk assessment, the quality and content of visits depend heavily on the individual judgement and experience of the home-visiting nurse, resulting in inconsistent service delivery. There is also no requirement to document visit objectives or plan follow-up steps with families, making it difficult to track progress over time.

Data collection mechanisms are underdeveloped. Information is primarily gathered on the number of visits rather than their content, underlying needs, reasons or outcomes. Consequently, the system lacks the data necessary for strategic planning, resource allocation and programme adaptation, including the development of a structured progressive component.

Service quality is not systematically monitored. Although supervisory structures exist, supervision and coordination depend largely on individual initiative rather than

clearly defined processes. There are no standardized quality indicators, feedback mechanisms or systematic evaluations of visit content.

Training for home-visiting nurses is available but remains sporadic and non-mandatory, and staff competencies are not regularly assessed. This limits opportunities for needs-based professional development and quality assurance.

A low level of community participation is evident, reflected in the following:

- Service users are not involved in planning home-visiting programmes.
- Parents and families lack formal mechanisms to provide feedback on service quality.
- Local communities are not involved in needs assessments.
- Non-governmental organizations and local initiatives rarely collaborate with home-visiting services.
- Findings from visits and family experiences are not used to inform programme improvements.
- Promotional and information activities are conducted occasionally but are not based on a systematic analysis of the target group's needs.

As a result, the community is largely treated as a passive recipient of services rather than an active partner in the planning, evaluation and adaptation of home-visiting programmes. Due to the absence of systematic procedures, quality monitoring, needs assessment mechanisms and community engagement, the home-visiting service remains inconsistent, dependent on individual initiative and only partially aligned with families' actual needs.

KEY RECOMMENDATIONS

In the area of policy, it is necessary to introduce a systematic process for assessing the impact of primary healthcare policies at the level of the Government of Montenegro

and the Institute of Public Health, including policies related to the home-visiting service. Strategies and action plans should clearly define the health and developmental outcomes that home visits are expected to achieve (e.g. increased breastfeeding and immunization rates, early detection of developmental delays, strengthened parenting capacities). It is also recommended to strengthen the normative and strategic framework through more precise provisions related to the health protection of vulnerable groups.

In the area of governance, it is important to institutionalize an integrated service delivery model through formal referral and feedback protocols between the home-visiting service, gynaecological, paediatric and social services. This would strengthen the continuity and comprehensiveness of care. It is proposed to develop a national referral and collaboration protocol between the home-visiting service, social protection, education and the NGO sectors, with clearly defined procedures, templates and timelines for action.

In the area of financing, it would be useful to consider transitioning from input-based finance models (line-item budgeting) to performance-based models — for example, payments linked to the number of home visits conducted, coverage of vulnerable groups or achieved outcomes (such as vaccination and early childhood development indicators). It is recommended to establish clear guidelines and criteria for budgeting home-visiting services, including a transparent resource allocation process based on needs and workload. It is also proposed to establish a formal policy defining the remuneration system for home-visiting nurses, including base salaries and additional allowances (e.g. for fieldwork, travel distance and risk exposure).

In the area of data and information systems, it is necessary to develop a national monitoring and evaluation framework for the home-visiting service, including: a core set of indicators (coverage, quality, service volume and outcome indicators), clear definitions,

data sources, frequency of data collection and institutional roles and responsibilities (health centres, the Institute of Public Health of Montenegro and the Ministry of Health). All health centres should be required to use a unified set of indicators, while tools and protocols for data collection should be standardized.

In the area of workforce, it is of key importance to develop a formal workforce planning and deployment plan for the home-visiting service, including: separation of staff delivering preventive services from those responsible for curative services; an analysis of the current situation and regional needs; forecasting of future workforce needs (based on birth rates, migration and socio-demographic factors); a recruitment and redistribution plan for existing staff; budget projections; and a training plan. This should be an operational document updated every two years. It is also recommended to establish a Chamber of Home-Visiting Nurses, or a Chamber of Nurses, Midwives and Technicians with a dedicated section for home-visiting nurses, mandated to oversee licensing and professional development. A system for periodic relicensing should also be developed.

In the area of access to essential supplies, it is recommended to establish a national accountability framework for the planning, procurement and distribution of home-visiting supplies. Consideration should be given to introducing quarterly supply planning based on the number of families and the projected volume of visits, as well as ensuring the continuous availability of standardized home-visiting bags with a complete set of equipment through centralized procurement and distribution.

In the area of service delivery, it is necessary to strengthen the staffing capacities of the home-visiting service, with a clear distinction between preventive and curative functions, particularly in those municipalities with the lowest coverage rates. It is recommended to develop a system of prioritized visits for children from socially vulnerable families,

large families, single-parent households and children at risk of neglect. Stronger linkages between paediatric services and the home-visiting service should also be established.

The objective of these recommendations is to further strengthen the home-visiting service so that it becomes more accessible to families, more effective in responding to their needs, and more strongly focused on prevention, early childhood development and comprehensive family support. In this way, Montenegro continues to strengthen the early childhood development support system and contributes to creating a healthier, safer and more nurturing environment for every child and family.

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