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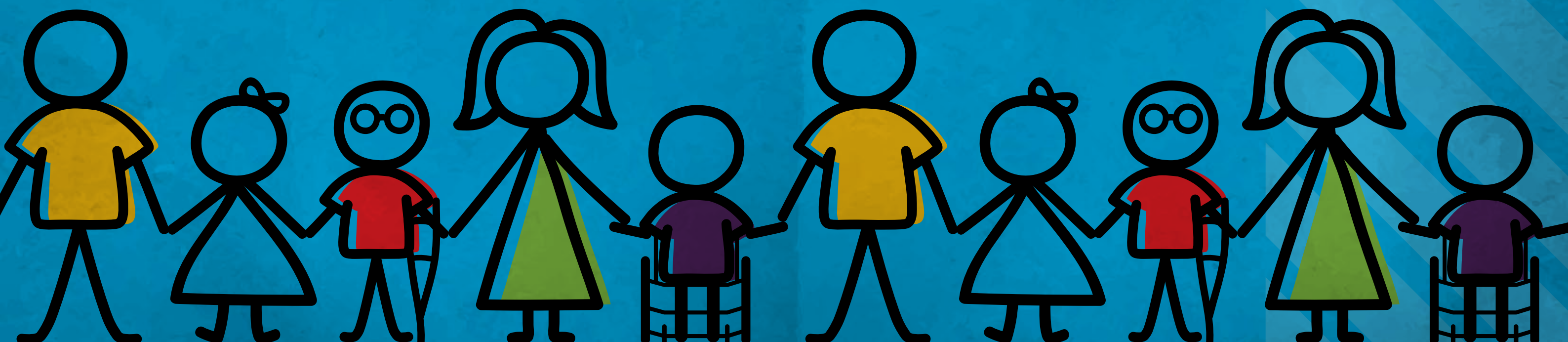
SMALL BEGINNINGS, STEADY FOOTPRINTS

The Case Study of the Home Visiting programme in Kosovo



SMALL BEGINNINGS, STEADY FOOTPRINTS

The Case Study of the Home Visiting programme in Kosovo[1]

1 All references to Kosovo shall be understood in the context of United Nations Security Council Resolution 1244 (1999)

Acknowledgments

This Case Study is the result of a collaborative and consultative process managed by the United Nations Children's Fund (UNICEF) Kosovo Office, involving Kosovo institutions and other partners. The exercise was carried out in collaboration with the Ministry of Health; the Ministry of Education, Science, Technology, and Innovation; the Ministry of Finance and Transfers; Family Health Centers; and other relevant partners.

Day-to-day management and guidance were provided by Ms. Sajeda Atari, UNICEF Early Childhood Development Specialist; Mr. Bekë Veliu, UNICEF Health Officer; Ms. Arjeta Gjikolli, UNICEF Monitoring and Evaluation Officer; and Ms. Jehona Luta, UNICEF Maternal and Child Health Consultant. UNICEF program staff in Kosovo contributed valuable technical inputs and suggestions for the finalization of this case study.

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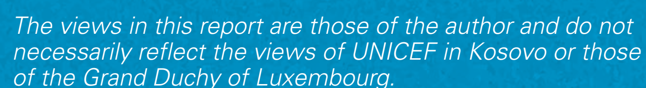

The views in this report are those of the author and do not necessarily reflect the views of UNICEF in Kosovo or those of the Grand Duchy of Luxembourg.

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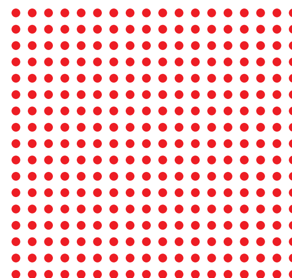
1. Introduction: A Case Study of the HV Programme in Kosovo

Scope and purpose of the case study

The Home Visiting Programme (HV) was established in 2014 by the Ministry of Health supported by UNICEF and since then it has rapidly increased its coverage; thus contributing to improve maternal neonatal and child health and wellbeing, especially for the most vulnerable. However, as shown by the 2019-2020 MICS, achieving the best possible impact of the Kosovo HV programme is more necessary than ever to address the unfinished agenda of Reproductive, Maternal, Newborn and Child Health (RMNCH) and to fully achieve the potential of the programme to improve child development, with a focus on the most vulnerable communities.

To provide guidance for Kosovo authorities and donors for further expanding the programme coverage and increasing its quality, UNICEF a case study that documents the background, rationale and strategies of the HV Programme in Kosovo and describes its results, challenges, lessons learned, and recommendations derived from it. The case study is meant to update the findings of the evaluation made in 2019, when the programme was still in its early phases, taking into account the significant developments the programme made since then and the challenges that have been encountered in the implementation phase.

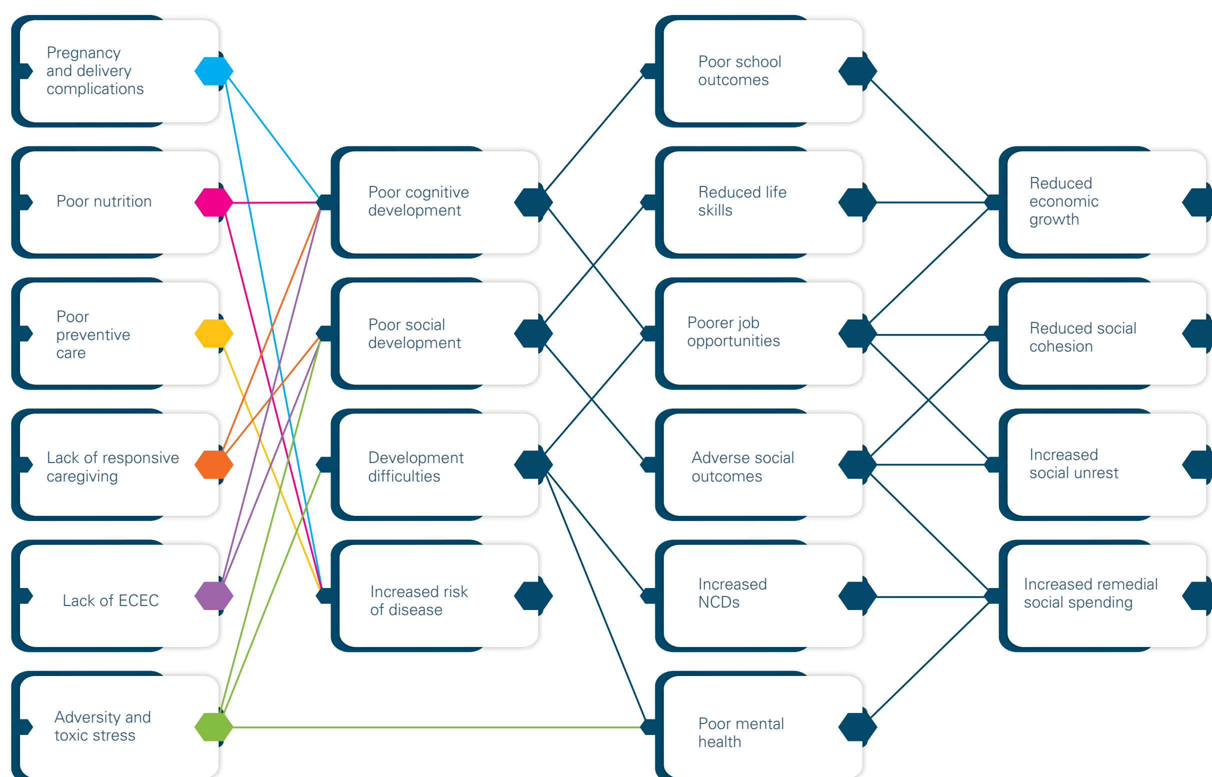


2. The Rationale of Home Visiting Programmes

Relevance of Early Child Development (ECD) for Health and Development Outcomes Over the Life Course

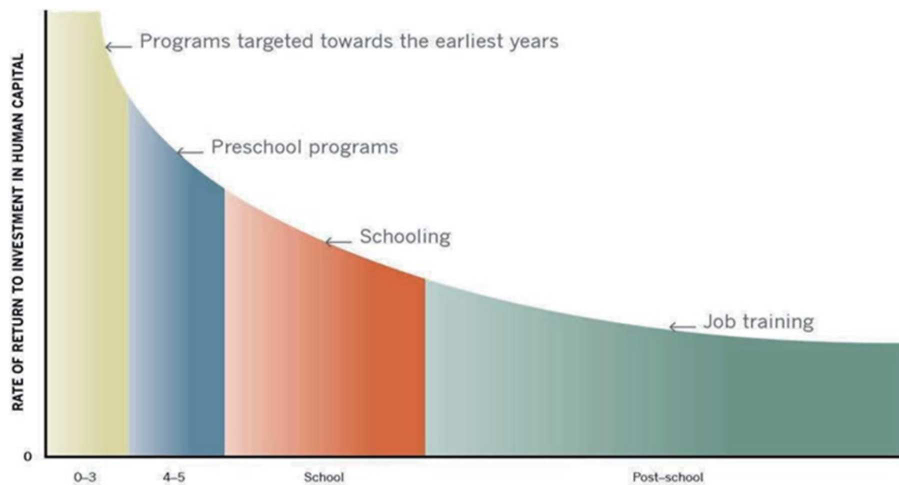
At the beginning of a child's life, and particularly during the period from conception to the second birthday, most of the structure of the brain and other body systems are built and the foundations for future health and development are laid (Shonkoff, 2008; Black,2017). Action is therefore necessary in this period to promote child health, foster holistic development, and prevent adverse events that can put at risk physical and mental health of mothers and children, hamper children's cognitive and socio-relational development, and contribute to social inequities. The consequences of suboptimal development and health in the earliest periods of life are multifaceted, span over the entire life course and have profound societal implications (fig.1).

Fig.1. The causal links between what happens in the early years and later health, education, and social outcomes *(Better Start in life for all children in Kosovo, UNICEF, 2021)*



The well-known chain of events that links early exposures to individual and societal outcomes explain why the rate of return of investment in human capital is higher in early childhood, as described in the time-honoured graphic developed by James Heckman, a Nobel laureate in economics science (fig.2).

Fig.2. The Heckman curve (Heckman, 2008)



Source: Heckman (2008)

The Nurturing Care Framework for a Comprehensive Approach to the Early Years

In 2018, the ***Nurturing Care Framework (NCF)***, developed jointly by WHO, UNICEF, the World Bank and an alliance of academic centres and professional societies was launched in Geneva. Based on increasing evidence from neuroscience, longitudinal studies, and economic evaluation, the NCF has further stressed the need for investing in early years to foster development and promote equity and social cohesion by building the five pillars of optimal development for every child since conception, as defined by the Framework, which includes: good health, adequate nutrition, safety and security, responsive caregiving, and early learning, in addition to ensuring universal access to the corresponding services. The NCF calls for stronger investments in the earliest and crucial years of life and recommends a "whole-of-society" effort to promote ECD as a fundamental pillar of economic and social development.

Importance of the Health Sector for ECD

The health sector can play a crucial role as an entry point for introducing the concepts and the practice of ECD among families. There are several reasons for this: health services, and particularly Primary Health Care (PHC) services, are accessed by the great majority of families; they have typically multiple contacts with pregnant women, their partners, and the child along the first years of life; health professionals are perceived by families as an authoritative source of information and advice (Engle and Tamburlini, 2007). The NCF further stressed the importance that health systems engage in promoting and protecting ECD for all and are proactive in reaching out for all disadvantaged households, indicating home visiting programmes as a key strategic element to achieve this (WHO, UNICEF, World Bank, 2018).

Effectiveness of Home Visiting Programmes

Home visiting (HV) programmes have been shown to be very effective in enhancing the capacity of PHC services to reach out for all households and increase the coverage of effective interventions for reproductive, maternal, newborn, and child health (RMNCH), particularly in disadvantaged or remote population groups (Lassi, 2016). HV programmes have the potential

to address equity issues and mitigate poor health and developmental outcomes associated with family socio-economic status through linking them with community resources and providing families with critical and life-long protective factors (Barlow, 2008; Lassi, 2016). Home visits run by paramedical professionals are effective in reducing Stillbirth Rate, Neonatal Mortality Rate and Maternal Mortality Rate in Low- and Middle-income Countries (Gupta, 2013). Cost-benefit and cost-effectiveness analyses indicate that many benefits of HV programmes, such as those related to child health and development, accrue in the long term (Bohingamu Mudiyanselage, 2021).

Advantages of the Universal Progressive Approach

The issue of universal versus selective HV programmes has been vigorously debated on the international stage. Although highly selective programmes may be more cost effective on a per-person-reached basis (McIntosh, 2009), they encounter serious limitations. First, they miss most opportunities of preventing risk, particularly when risk is not confined to a few individuals or population groups. In Kosovo, for instance, while it holds true that Roma, Ashkali, and Egyptians are at higher risk for a series of unfavourable outcomes, these outcomes, for example a maternal complication before, during, or after birth, or a neurodevelopmental disorder in a child can occur in all population groups. Second, highly selected interventions targeting specific population groups and households are inevitably perceived as stigmatizing; thus, decreasing their acceptance. On the contrary, universal approaches avoid the social stigma attached to selective services "for the poor" and recognize that many risk factors for health and development are not easily identified ***a priori,*** in absence of a careful assessment of household circumstances and characteristics. Based on global evidence and experience, the universal progressive model was recommended by the NCF, as it provides universal coverage and at the same time ensures that at risk population groups and individual households receive more intensive and integrated services (WHO, UNICEF, and World Bank, 2018).

3. The Development and Implementation of the Home Visiting Programme in Kosovo

History

Guided by the Convention for the Rights of Children – namely Article 6 on the right of every young child to comprehensive development and wellbeing – by ECD science, by global experiences on HV programmes, and with a focus on the unfinished agenda for RMNCH in the Region, the UNICEF Regional Office for Europe and Central Asia (ECARO) promoted a multi-country review on HV programmes and organized in 2012 a regional conference on Universal Progressive Home Visiting (UPHV) programme. The conference underlined that the health sector, through HV services, provides one of the best entry points for reaching specific population groups, including the most marginalized, with ECD-focused interventions; thus, contributing to strong foundations for lifelong health and wellbeing. Following the regional conference, UNICEF in collaboration with the Kosovo Ministry of Health (MoH), in November 2013, organized a National Conference on HV services.

Legal Framework and Structure

With continuous support provided by UNICEF, the structure, content, and standards of the HV programme in Kosovo were developed and approved by MoH and integrated into the PHC services within the Family Medicine system. The HV programme was included in the Health Sector Strategy (HSS) 2017-2021, in the Law on Child Protection in 2019, and in AI 04/2020 on Primary Health Care. In the Kosovo Government Program 2015-2018, the MoH recognized HV as a priority service within PHC[2]. The programme is implemented at three levels of PHC, depending on the place of residence of the beneficiaries: Main Family Medicine Center (MFMC), Family Medicine Centers (FMC), or Family Medicine Ambulances (FMA)1.

Design and Content

The HV is aimed at offering a major contribution to the health and wellbeing of families and children, especially the most vulnerable, through reduction of preventable maternal, perinatal, infant, and child deaths and complications; increase in the immunization rates of the population; improvement in neonatal and childcare; and support to early child development. In order to achieve these results, the programme is designed to improve access to PHC services for all pregnant women, children under the age of three, and their parents, with indicated specific attention for the most vulnerable families and population groups in Kosovo (notably Roma, Ashkali, and Egyptian communities).

The home visiting package includes, as key activities to be carried out by HV nurses, the following: assessment of the mothers and children's health, well-being, and nutritional needs; health education of families; referral and coordination with community support schemes[1].

2 Kosovo Case Study, Preliminary Report, UNICEF, 2019.

More recently emphasis has been put on developmental monitoring and promotion. The standard number of visits, which can be increased based on specific family needs, includes two visits during pregnancy and five visits for children from birth to 3 years of age.

Period	Timing of visit	Visit number
Before birth	From the first trimester to the second	1
	From the second trimester to the third	2
After birth	Within the first three days after birth	1
	From 4 to 6 months	2
	From 11 to 12 months	3
	At 18 months	4
	At 36 months	5

Implementation History and Development Plans

The HV programme is aligned with key national priorities as reflected in the National Development Strategy (NDS) report 2016-2021, which emphasized the 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. In 2021, the ***Better Start in Life for all children in Kosovo (UNICEF***, 2021) a policy brief based on the results of the 2019-2020 Multiple Indicator Cluster Survey (MICS), also recommended to further scale-up and strengthen the HV Programme as a crucial strategy to promote health and development, reduce inequalities and foster social cohesion (box 1).

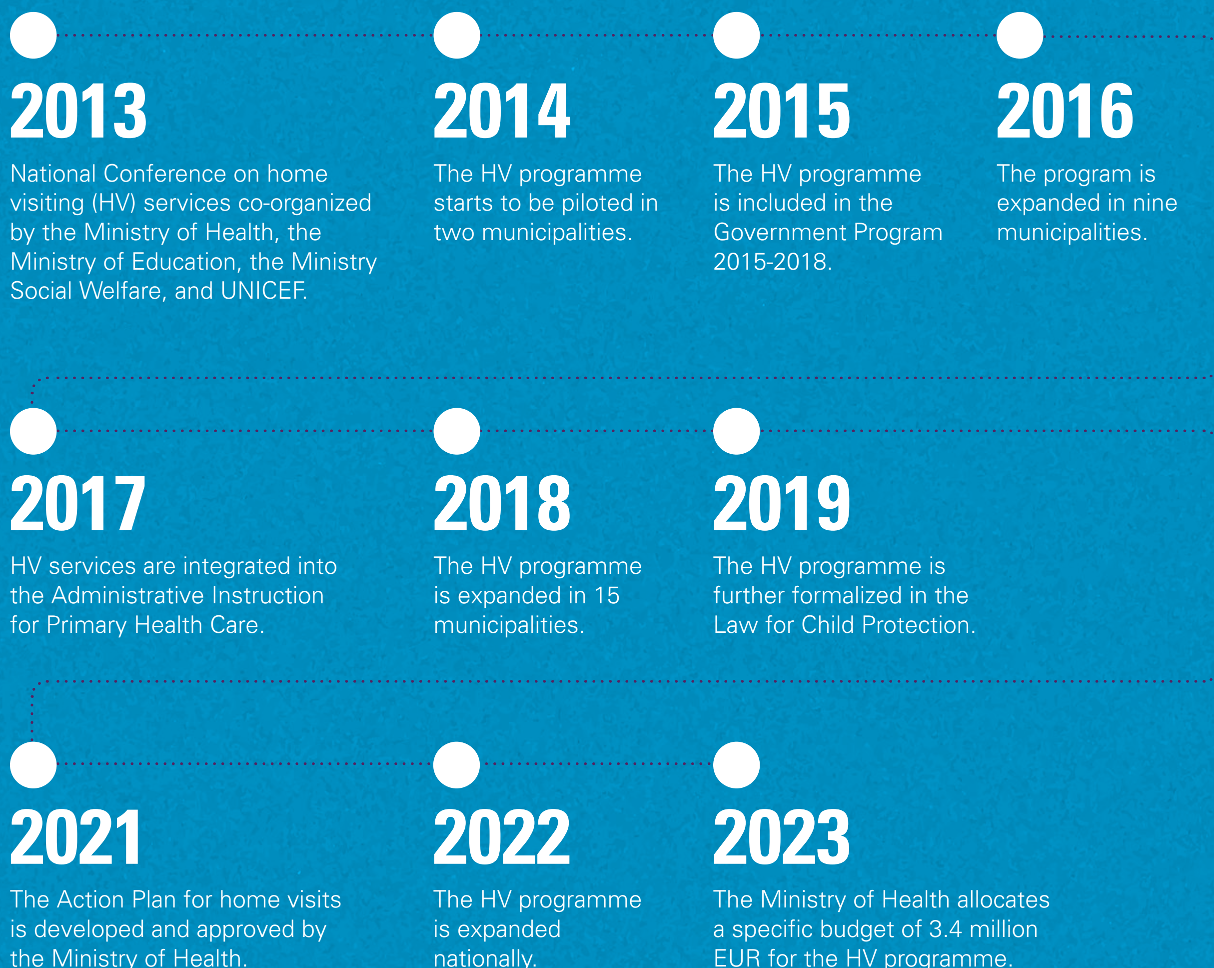
Box 1. Indications from the MICS: relevance of the HV programme.

The 2019-2020 MICS showed that neonatal infant and child mortality indicators did not show progress when compared with the previous 5-year period. The data suggest that lack of progress in key child mortality and morbidity are caused by gaps in the quality and equity of health care provision across the whole range of antenatal, perinatal, and postnatal health services. The MICS also showed that the poorest children, those whose mothers are less educated and those belonging to ethnic minorities, are at significantly increased risk of mortality, morbidity, unfavourable educational outcomes, and functional difficulties.

The overall picture emerging from MICS shows that all the five pillars of early childhood development (health, nutrition, early education, responsive caregiving, and protection), are still put at risk in Kosovo and that social disadvantage, particularly poverty, low parental education, and social exclusion, negatively influence all the key components of healthy development. In view of these data, the contribution of the HV programme is crucial to promote, with an equity lens, maternal and child health, prevent adverse events that can put at risk the health of mothers and children, and foster children's cognitive and socio-relational development.

The MoH manages this programme with technical support from UNICEF, based on a specific workplan first signed in 2015 and then renewed for the period 2021-2024. As for the financial aspect, continued advocacy efforts, backed by evidence, and with support from UNICEF yielded a 3.4-million-euro annual budget allocation by the Ministry of Health to local health authorities to sustain and enhance the HV programme, starting in 2023[3]. This major accomplishment contributes to consolidate the sustainability of the programme, which has been supported financially since its piloting by UNICEF through funds provided by the Grand Duchy of Luxembourg. Figure 3 summarises the main development steps of the HV in Kosovo from 2012 to 2023.

Fig. 3. Key implementation steps of HV programme in Kosovo



3 Kosovo Annual Report, 2022. https://www.unicef.org/kosovoprogramme/media/3986/file/English-2023.pdf

Scaling up

The HV model was initially piloted in Kosovo in two municipalities, Fushe Kosova and Dragash, in late 2013/early 2014; then it was rolled out to 15 municipalities by the end of 2018; to 34 by 2022; and to all municipalities by 2023 (fig.4). The progress made in just over a decade has been remarkable: today, the HV programme in Kosovo is one of the few in the region that has been implanted throughout Kosovo. This expansion was based on the commitment and engagement of the Kosovo government and MoH, as demonstrated by the ambitious HV Action Plan [4].

Fig. 4 Progress in HV programme implementation in Kosovo's municipalities

According to the latest available data, since the beginning of the programme, over 98,000 children and 25,600 pregnant women have been reached (Tab.1).

4 Ministry of Health, Action plan for home visits, 2021.

Tab 1. Reach of the HV programme throughout the years

Year	Number of municipalities	Number of health professionals trained	Number of home visits	Number of children visited	Number of pregnant women visited
2016	6	200	5,029	3,973	1029
2017	9	330	12,209	9,989	2,220
2018	15	170	14,448	11,522	2,926
2019	22	128	17,363	14,052	3,311
2020	22	781	21,451	18,017	3,434
2021	31	0	27,532	15,456	4,433
2022	38	405	37,335	16,375	5,520
2023[5]	38	191	19,404	8,625	2,772
TOTAL	**38/38**	**2,2056**	**154,771**	**98,009**	**25,645**

The coverage of the Home Visiting programme has also constantly improved over the years: according to data from the Kosovo Agency of Statistics, there were 22,632 live births in 2022, and the 16,375 children who were reached at least once through the program account for 72% of the 2022 birth cohort. 2,205 healthcare professionals, educators and social workers have been trained using the *Supporting Families for Nurturing Care* Resource Package developed by UNICEF and International Step by Step Association (ISSA)[7].

5 Data as of June 2023.
6 Out of 4,299 health workers in Primary Health Care
7 The Supporting Families for Nurturing Care Resource Package is based on the most recent scientific evidence and the Nurturing Care Framework. It consists of 22 modules, which cover topics not typically included in pre-service or in-service nursing and medical education. These modules empower home visitors to take a strengths-based approach, promoting nurturing care and positive relationships between caregivers and children. The package can be accessed through this URL: https://www.issa.nl/home_visiting.

4. Review of the HV Programme in Kosovo

Review Methods

The case study has been designed to collect information across key dimensions of the HV programme: design, structure, and content; coverage and reach; quality; governance; human resources; intersectoral collaboration; monitoring evaluation and learning; and sustainability. The recommendations deriving from this case study are meant to inform the Ministry of Health as well as UNICEF and other partners for further strengthening the programme and improving the quality of its services.

Methods have included:

1. An in-depth desk analysis of the available documents, surveys, and action plans – providing information on the HV programme in Kosovo). The main information sources that have been accessed to document the status of the implementation and the results of HV in Kosovo are:
    - Stocktaking on home visiting in Kosovo (2017);
    - The Kosovo Case Study (2019); the Policy brief based on MICS (2021); the HV action plan (2021);
    - Report on the analysis of the HV costing (2021);
    - Home Visiting exchange visit in Albania (2023);
    - Situation analysis on early childhood intervention in Kosovo (2023);
    - HV data reporting (2023).

2. A field work including:
    - Interviews with relevant stakeholders (Ministry of Health, Ministry of Education, Ministry of Finance/Department of Social and Welfare, National Institute of Public Health/HV trainer) and with two UNICEF officers that have followed the programme since its early phases.
    - Focus group discussions (FGD) with HV nurses, HV coordinators (19 participants), and beneficiaries (7 pregnant women, 16 parents of children aged 0-3 years old, 21 parents from Roma, Ashkali, and Egyptian communities), to acquire further qualitative inputs on the perceived strengths and weaknesses of the HV.

    The rationale for further data collection among key stakeholders is two-fold:

    a. to confirm, modify, or refine the results of the desk review and to finetune the indications emerging from it
    b. to build awareness among key stakeholders about the programme relevance and promote their participation to programme strengthening

A complete list of people involved is included in Annex 1. FGDs and interview outlines are reported in Annex 2.

The following sections report the findings of the review according to the key dimensions of the programme which have been explored through the desk review and the field work.

Design Structure and Contents

The design of the programme, as described in official documents of the Ministry of Health, is coherent with the principles of a universal progressive approach recommended internationally. The HV is embedded in the PHC system and precisely in the Family Medicine Centers to fully exploit the potential of the health sector to achieve universal coverage. The data available from the programme show that vulnerable groups receive more visits than the general population: one in 10 children reached by the programme are from the Roma, Ashkali, and Egyptian communities and over 9% of all visits have been made to Roma, Ashkali, and Egyptian households, which represent around 2% of the population. The number of home visits/number of eligible population ratio is therefore more than fourfold for the Roma, Ashkali, and Egyptian households than for the other households, showing that the programme is already reasonably progressive.

The contents of the programme respond to the need of addressing RMNCH priorities and ECD. To achieve this, HV nurses have been trained, using the modules made available by UNICEF ECARO, in all main RMNCH issues. The training has been comprehensive, provided to all HV professionals and extended to over 50% of other PHC professionals such as midwives and doctors, in order to improve consistency of approach and messages. Contents of the trainings are up to date and methods appropriate. The FGDs with HV nurses showed that they were greatly appreciated by front line workers. At the same time, HV nurses asked for opportunities for continuous professional development.

Further training is ongoing to enhance their capacity in promoting child development and conducting developmental monitoring, aligned with the family-centered approach of the International Guide for Monitoring Child Development (GMCD)—an effective, internationally validated tool for developmental monitoring[8]. This further step raises the issue of the necessity to ensure a sufficient frequency of visits to enable continuity in developmental monitoring. While the number of visits currently planned per child (5 over the first three years) is sufficient for most children, guidelines and instructions should be provided to health workers for additional visits required for children at risk or with developmental delays. Additionally, considering the significance of developmental monitoring after the second year of birth, it is recommended to adjust the timing of the last standard home visit from 36 months to a period from 30 to 36 months. This would enable home visitors to detect developmental risks and delays with good accuracy and offer timely support.

Moreover, an effective developmental monitoring system requires an adequate referral system and Early Childhood Intervention (ECI) capacity, which is not currently widely available in Kosovo. The ECI Situation Analysis found services fragmented and not yet able to to provide contemporary ECI services, which will require ECI professionals including psychologists, ECI specialists, speech/language, physical and occupational therapists, or social workers available at the main family medicine centers level, as indicated by health sector interviewees. They observed that in Kosovo, these services are usually offered by NGOs and private clinics.

8 The GMCD is intended to monitor children from birth to 3.5 years of age and assesses seven functional domains: expressive and receptive language, gross and fine motor skills, relating, play and self-help. The monitoring component is combined with the developmental support component, using information on how the child is developing to advise the family what should be supported and how.

Coverage and Reach

In order to develop its full potential, the HV programme needs to achieve full coverage of the target population with the planned number of visits. According to the latest available data[9], the number of visits carried out in 2022 was 37,335, while, based on the number of live births in the same year (22,632) and the planned number of visits per pregnant women (2) and per child 0-3 years (5), the expected number of home visits would be over 100,000 per year. This is without taking into account additional visits to be made to at risk households. In the evaluation report (the Kosovo Case study, 2019) which examined, over the period 2014-2018, the extent to which its efforts to promote HV in Kosovo had contributed to address some of the critical health system-level bottlenecks, a critical aspect identified was that the frequency and the number of visits included in the programme was insufficient for ensuring a timely detection of all at risk situations. Indeed, the frequency of visits depend on the number of HV staff, a crucial issue that will be discussed in the next section as it is key also to ensure coverage and reach.

This gap is currently being addressed through further recruitment of HV nurses, according to the HV action plan. As mentioned by many of the interviewed persons, both HV staff and coordinators, in order to ensure sufficient capacity to carry out the planned number of visits, the increase in the number of HV nurses needs to be combined with a more efficient use of their time, through improved transport means, digitalization of data collection, and facilitation in finding addresses and booking visits. The first two bottlenecks are being addressed: UNICEF has allocated 11 vehicles in 2022 and the Ministry of Health distributed 22 vehicles in November 2023. Digitalization of data recording is also underway. It has also been suggested that, once the first visit to a pregnant woman or to a newborn baby has been carried out and no risks have emerged, the subsequent visits could be planned at the family medicine centres or ambulances; thus, saving HV nurses' time.

A separate issue concerns the ability of the service to reach the most disadvantaged, and this issue has encountered some difficulties. These difficulties have emerged from the focus groups with the HV nurses. Disadvantaged households, particularly minority groups, may have difficulties accepting home visits. Additionally, there have been occasional concerns about personal security reported by HV nurses. These challenges may be related to the shame some families feel about revealing inadequate housing conditions or could be culture-based. Addressing these issues may require specific training for the programme staff to emphasize the importance of considering cross-cultural aspects when working with specific minority groups.

Quality

The issue of quality is crucial as the quality of the content of the visits is a key determinant of the effectiveness of the programme. Issues regarding quality assurance include both requisites for content quality and a system for quality improvement. The first aspect is ensured by selection of personnel and adequate training, both of which have been addressed by the programme, with the continuous support provided by UNICEF. While standards for the contents of the home visits have been developed and training ensured, there is no established system to allow the assessment of the quality of the delivered contents. There is a checklist that HV nurses can use to guide the visit but no systematic data collection regarding the quality of the HVs, nor there is a formalized continuous quality improvement mechanism. Supervisory systems have been developed in theory, according to which external supervision should be performed by external supervisors from MoH and UNICEF and internal supervision should be performed by a HV coordinator at the MFMC, but it has not yet been systematically implemented nor based on a clear methodology.

9 The coverage data may not be fully accurate due to the limitations of the partially functional health information system.

Leadership and Governance

At the central level, the HV programme is overseen by the Ministry of Health, specifically the Division for Primary Health Care. Additionally, the Ministry has established a Working Group for the Home Visiting programme. This Working Group comprises directors from the MFMCs and serves in a consultative capacity. It convenes on a quarterly or biannual basis to discuss challenges, share insights with the Ministry, and plan the way forward for programme implementation.

In 2022, the Ministry of Health established a smaller technical working group to revise the programme. The goal is to enhance its progressive design and better meet the needs of vulnerable families. This working group is responsible for developing recommendations and approving final decisions regarding any programme changes.

At municipal level, each municipality has a Home Visiting coordinator, who has the role of coordinating the visits and the home visiting staff at municipal level. The coordinators are appointed by the directors of Main Family Medicine Centers and usually report to them or head nurses. At the end of the month, the coordinators report back to the Ministry of Health on the number of children and pregnant women reached. The nurses are also involved in the overall discussions about implementation of the programme. UNICEF organizes, on a quarterly basis, meetings with HV coordinators and nurses who conduct home visits, to discuss the challenges and lessons learned.

Human Resource Management and Capacity

As previously mentioned, the training provided to HV staff has been comprehensive and of high quality. However, HV staff have reported several challenges, including difficulties in finding household addresses, transportation management issues, and a lack of incentives. Cultural acceptance among minority groups for the concept of public officers 'visiting' homes has also been a concern. To address these issues, a two-pronged approach is needed. On the supply side, enhancing the communication skills of HVs, particularly when introducing themselves to new households and ethnic minorities, is crucial. On the demand side, working with community leaders to explain the purpose and benefits of home visits for mothers, children, and other family members is essential.

In general, the whole issue of motivation of the staff needs to be addressed strategically. Given that no financial incentive system can be developed for HV programme alone, as it requires a health sector-wide system, professional incentives should be developed. These may include flexible timetables, provision of day care for mothers so to facilitate conciliation with family commitments, promoting participation of HV nurses to the management of the programme, both locally and centrally.

Monitoring Evaluation and Learning

The correct and continuous collection of data is very important to learn from experience and timely inform decisions on what kind of actions are needed to improve the programme and ultimately improve the wellbeing of families and their children.

However, HV programme in Kosovo lacks a comprehensive monitoring and evaluation system. The 2019 Kosovo Case study highlighted the absence of outcome and impact data. While data for monitoring programme outputs, such as the number of visits and their distribution among beneficiaries by age, are available, there is limited information about the backgrounds of the beneficiaries. As a result, we are unable to monitor the extent to which at-risk households and

families belonging to specific minorities are being reached and with what level of intensity. Furthermore, there is no data available to monitor programme outcomes, such as the issues addressed during visits and the problems identified and referred, as well as the programme's impact on specific factors like access to prenatal care for pregnant women, immunization rates, child hospitalization, and developmental practices.

The coverage rate for both pregnant women and young children (any contact and all the planned visits) is a key indicator to be monitored in all municipalities. Socio-demographic information should be recorded for all beneficiaries in order to be able to assess the extent to which the programme is capable to comply its progressive design, by producing the distribution of the visits according to risk factors. Data collection on performed visits need to include the denominator (eligible population including pregnant women, children 0-1 and 1 to 3). Such a system needs to be developed with a sensible choice of indicators that need to be easy to collect, reliable and most importantly, relevant for mothers and child health and child development and wellbeing. To avoid work overload, such system could be based on periodical data collection and limited to a representative sample of the population.

Data collection still relies on paper and needs to be fully digitalized. Current plans now include the digitalization of data collection and their integration into the Health Information System. To achieve this, equipment such as laptops and tablets have been distributed with the support of UNICEF, and the trainings of HV staff have been completed in early 2023. However, the digital system has not yet been fully implemented. In this regard, MoH officers acknowledge that digitalization is one of the most significant challenges to address, and this challenge applies to the entire health sector.

Intersectoral Collaboration

From the field work it appears clearly that the collaboration with other sectors, for both facilitation of first contacts with beneficiaries and referrals, could be improved. Intersectoral collaboration is increasingly emphasized as crucial to improve all components of NFC (WHO, 2018).

One of the interviewees mentioned the recent approval of the Law on Early Childhood Education (Law No. 08/L-153 10 July 2023) which should be helpful in properly addressing the intersectoral collaboration as it contains a specific article (art. 25) related to this issue. A reorganization of the collaboration mechanisms among the involved ministries, which will clarify roles and responsibilities, is planned. With respect to the HV this should allow to broaden the scope of the programme from the current predominant medical focus on a more "nurturing care" approach.

The management of the HV programme at local level should periodically interact with other health services, education, and social services so as to set common goals and procedures, for example in sharing information about difficulties and risk factors of households, mothers and children, and building synergies in order to address the needs of families, provide opportunities for health care and education, in the direction of educating communities and healthy cities.

This will produce benefits of the programme on community development that will be well beyond the direct beneficiaries of the HV programme, as intersectoral collaboration enhances the effectiveness of all services. Although this aspect is not explicitly indicated among the objectives of the HV programme in Kosovo, community development can be viewed as both a precondition and an important side product of an effective HV programme. Improved health literacy, social cohesion and inclusion, institutional capacity, and intersectoral collaboration can facilitate the work of home visitors and be a product of the programme.

Sustainability

The central authorities allocated EUR 3.4 million to sustain and enhance the HV programme for 2023[10], which will help consolidate the programme and its sustainability, which has been ensured since its piloting by the financial support provided by the Grand Duchy of Luxembourg, through UNICEF. However, this does not fully ensure the needed further programme expansion in terms of staffing.

According to interviews with representatives from key institutions and UNICEF officers, although the Ministry of Health allocated a specific budget for the HV programme, there are significant challenges in utilizing this budget properly. Since the budget has been allocated for goods and services and cannot cover staff costs municipalities, due to lack of capacity to proper plan for the programme, are using it for procuring goods that not necessarily are relevant for the HV programme. As a consequence, municipalities still rely on UNICEF to cover the cost of equipment, such as HV kits, as well as of trainings, meetings, workshops etc.

The HV programme also suffers from the wider weaknesses of the Kosovo Health System. Among these, there is the lack of a functional health insurance scheme, despite attempts to establish it. This means that there is no way to set up performance-based payment schemes, to provide incentives to health workers who do additional work, as it may be the case of the Home Visiting programme, to cover extra time and reward specific performances.

A gradually increasing financial resource for the HV should be included in Kosovo developmental plans which requires commitment from the government as a whole, since the benefits of the programme are distributed across several societal dimensions (health, education, social cohesion, economic development etc.). More stringent guidelines on the use of budgetary allocations to Municipalities are necessary to avoid diversions in the use of funds allocated to the HV programme. In general, municipal officers should increase their understanding of the purposes of the programme and their commitment to support it. Social communication to make the general public aware of the benefits of the programme may produce effects on the commitment of municipalities.

In view of the planned full handover of the programme from UNICEF to the MoH by 2025, the government and the Ministries should increase their technical capacity to coordinate all aspects of the programme (financing, training, infrastructure and materials, monitoring and evaluation etc.).

10 Kosovo Annual Report, 2022. https://www.unicef.org/kosovoprogramme/media/3986/file/English-2023.pdf

5. The way forward: How the HV Programme in Kosovo Can Be Strengthened

The HV programme in Kosovo was developed to contribute to the health and wellbeing of families and children, especially the most vulnerable, through a reduction of preventable maternal, perinatal, infant and child morbidity and mortality and a support to early child development.

The HV programme, due to its universal progressive design, alignment with most recent scientific evidence and international recommendations, integration in the PHC services, and countrywide extension, is ideally structured to provide a very significant and increasing contribution to ensure a good start in life to all children in Kosovo. To maximize its beneficial impact, the HV programme needs to substantially increase its capacity to reach out for all families, improve its focus on those at higher risk and ensure quality in all the interventions it has been planned to deliver.

To achieve these objectives, drawing from the findings of the desk review and the fieldwork involving interviews and focus groups with all HV stakeholders, a series of recommendations can be made for the Ministry of Health and the partners supporting the programme. Recommendations are listed according to the dimensions of the programme which have been considered for the review.

DESIGN STRUCTURE AND CONTENT

- The current design of the programme should be maintained; however, considerations should be made to further **strengthen the progressive mandate** by increasing its capacity to identify at risk situations through pre-defined risk factors (e.g., poverty, minorities, disability etc.) and observation of the home environment (e.g., neglect, violence etc.).
- Considering the plans for introducing developmental monitoring, and the importance of assessing speech delays after the second year of birth, it is recommended to adjust the timing of the fifth standard home visit from **36 months** to a range between **30 to 36 months.**
- A **checklist for risk identification** needs to be developed, along with clear guidelines on when additional visits and/or multi-professional support may be necessary.

COVERAGE and REACH

- To address the challenge of understaffing, a **plan for a gradual increase in HV staff** needs to be developed. This plan should consider the availability of newly trained nurses and the budgetary constraints at both central and municipal levels. These considerations should be integrated into Kosovo’s development plans.
- It is crucial to establish **annual coverage objectives** at both the national and municipal levels. These objectives should be tailored to the progress of implementation, especially in terms of available staff (HV nurses/population ratio), and the percentage of disadvantaged population.

- **Enhancing nurses’ time efficiency** could entail supporting the identification and location of new eligible beneficiaries and expediting the digitalization of HV recording forms.
- At the FMC level, the **distribution of HV tasks among nurses should be reassessed**. This should be done taking into consideration the most rational and efficient allocation of nurses’ time between fieldwork and other responsibilities. The distribution may vary among municipalities based on logistical considerations and coverage goals.

QUALITY

- A **continuous quality assurance system** should be established. Ideally it should be inspired by the participatory action-oriented quality assessments developed at regional level by WHO and the needs assessment tools developed by ISSA[11]. Plans should be made to have this system implemented within 2024.
- **Periodic (monthly) meetings among HV coordinators and nurses** should be maintained as a routine and include, besides addressing contingencies, paying attention to continuously improving efficiency and quality.
- The introduction of a **peer-to-peer periodic supervision system** carried out by HV nurses should be considered also as a mean to professional recognition of the best performing nurses, who could be identified and entitled to become (for a part of their work) peer advisor. This measure could also be piloted in a couple of municipalities to assess costs and benefits.
- At the same time the responsible of the programme at central level should **periodically meet with field workers** in order to be fully aware of the problems encountered.

LEADERSHIP AND GOVERNANCE

- The governance of the system, overseen by the Ministry of Health and guided by recommendations from the HV working group, is **adequate** and should be **maintained**. Ensuring continuous inputs from frontline workers to the local and national authorities is important as well as promoting exchange of experience among them and with working groups at national level.
- Officers in charge of the HV programme at central level should **meet periodically to share the progress in programme implementation** and related problems and to ensure coordinated action.

11 **The Home Visiting Workforce Needs Assessment Tool** aims to help Ministries and government agencies reflect on the ways in which they can support personnel delivering home visiting programs across sectors for pregnant mothers and caregivers with children under 3. Drawing inspiration from the UNICEF Pre-Primary Diagnostic and Planning Tool, this tool is intended for countries with home visiting programs at either the sub-national or national levels. The target includes home visitors who work directly with young children and their families, as well as supervisors and trainers (Early Childhood workforce initiative, ISSA and R4D, 2019).

HUMAN RESOURCE MANAGEMENT AND CAPACITY

- The ability of HVs to provide advice to caregivers about how to promote **child development through responsive caregiving** is crucial to improve developmental outcomes and prevent the early establishment of developmental gaps and difficulties and should be supported. The planned training in GMCD is appropriate for this purpose and should be made available to all HV providers.
- With respect to **developmental monitoring**, which is also covered by the GMCD, piloting it should start in areas where referral is possible for appropriate ECI. Referral mechanisms and criteria should be discussed with the ECI referral centers.
- To maintain **continuity in developmental monitoring**, ensuring an adequate visit frequency is critical. While the planned number of visits per child (5 over the first three years) suffices for most children, detailed **guidelines and instructions** should be developed for health workers for additional visits needed for children at risk or with developmental delays.
- Future trainings should include practical and interactive sessions aimed to increase nurses' capacities to **deal with complex circumstances**. HV trainers should meet on a yearly basis to discuss the result of their work and consider innovation in content and methods also including the front-line workers.
- A **training module** should be considered to increase the capacity of HV nurses to reach out effectively, both culturally and logistically, for the most vulnerable. Recruitment of HV nurses among minority groups should be planned. Personal security instructions should be included in the training so that HV nurses increase their skills when faced with potentially threatening situations.
- Attention should be paid to provide all HV nurses with **job aids** such as parenting apps, including those already introduced (Foleja) and means to increase their visibility and identity (such as branded t-shirt and bags). Pregnancy and child booklets should be better utilized as a mean to ensure compliance to preventive advice provided by the programme and empower families.

MONITORING, EVALUATION AND LEARNING

- It will be useful to develop and establish, building on the experience made so far with the existing data collection system, **a monitoring and evaluation framework** capable to produce relevant indicators on: a) coverage of beneficiaries by typology, risk, and key contents; b) issues addressed during visits and the problems identified and referred; c) the programme's impact on specific factors like access to prenatal care for pregnant women, immunization rates, child hospitalization, and developmental practices. An ad hoc consultancy may be considered to assist in developing the monitoring and evaluation framework, through a consultative participatory process which includes the HV staff.
- Currently used forms by HV nurses (checklist templates) should be revised to achieve a more **holistic and ECD** oriented focus. This also should be planned as a task of the working group on the HV programme established by the Ministry of Health.

INTRA and INTERSECTORAL COLLABORATION

- Collaboration with places of birth/maternity hospitals should be strengthened in order to ensure a timely start of the first visit (for both pregnant women and newborn babies) and to avoid missing families.
- Mechanisms and tools to facilitate and guide **intersectoral collaboration** within municipalities, primarily between the HV program and the social welfare and education sectors, need to be established. Ad hoc guidelines should be issued by the Ministry of Health, in coordination with other relevant ministries, regarding intersectoral referral mechanisms. Collaborative links, especially with the social welfare and education sectors, are of particular importance.

SUSTAINABILITY

- Gradually **increased financial resources** should be devoted to the HV programme, in agreement between MoH and municipalities and in accordance with the plans for extension of the programme coverage, as well as enhanced technical capacities for its management. Additional funds are particularly needed to increase the availability of staff and achieve full coverage of the planned number of visits Kosovo-wide, ideally with fully dedicated HV nurses.
- The **capacity of local authorities for budgeting** and managing the funds should be strengthened along with rigorous rules to ensure proper use of budgetary allocations.
- The objectives of the HV programme and the work of HV nurses should be supported by a **social communication** campaign on the importance of preventive actions and the benefits of HV. National and local media and social media should be involved.

Implementing these recommendations implies the financial commitment of both central and municipal authorities and strengthened intersectoral and interagency collaboration again at both central and municipal level. The role of UNICEF in providing guidance and technical support to central and local governments will remain crucial.

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7. Annexes

Annex 1: Focus group discussions and interview guides

MINISTRY OF HEALTH - INTERVIEW

1. Local Implementation and Oversight:

- How does the Ministry of Health collaborate with municipalities to ensure the effective implementation of the Home Visiting Programme at the local level?
- What mechanisms are in place to provide guidance and support to municipalities in delivering the Programme's services?

2. Public Health Impact:

- From the perspective of public health, how does the Ministry of Health view the Home Visiting Programme's contribution to improving the well-being of families and children?
- What specific health outcomes or indicators does the ministry monitor and aim to improve through this Programme?

3. Training and Capacity Building:

- How do you ensure that health professionals are equipped with the necessary skills to address diverse family and child health needs?

4. Data Utilization and Analysis:

- How does the Ministry of Health utilize data collected through the Home Visiting Programme to inform health policy decisions and resource allocation?
- Can you provide examples of how insights from Programme data have led to targeted interventions or improvements in health services?

5. Partnerships and Stakeholder Engagement:

- What partnerships does the Ministry of Health foster with other relevant stakeholders (such as local organizations, academic institutions, or international organizations) to enhance the impact of the Home Visiting Programme on public health?
- How do these collaborations contribute to the Programme's success?

6. Addressing Health Disparities:

- How does the Ministry of Health taking specific measures through the Home Visiting Programme to address health disparities and inequalities among different communities or population groups, such as minority communities, children with disabilities?
- How does the Programme account for varying health needs in different regions or municipalities?

7. Communication and Public Awareness:

- How does the Ministry of Health communicate the benefits and availability of the Home Visiting Programme to families and communities?
- What steps are taken to ensure that families are aware of the services and resources offered?

8. Long-Term Vision for Health Impact:

- How does the Ministry of Health envision the Home Visiting Programme contributing to long-term improvements in maternal and child health outcomes?
- What strategies are in place to sustain and enhance the Programme's impact over time?

9. Barriers and Challenges:

- Are there any regulatory or bureaucratic challenges that your ministry has encountered in supporting the Home Visiting Programme?
- Are there specific barriers that need to be overcome to further enhance the Programme's impact?

10. Ministry's engagement and support

- What is/are the value/s that the Ministry attributes to the HV Programme?
- Is there any issue that the Ministry would like the HV take more care of?
- What is the contribution that the Ministry has given to the UHV Programme so far?
- How can the Ministry provide further support to the HV?

MINISTRY OF HEALTH – FORMER CHEIF OF PRIMARY HEALTH CARE DIVISION

1. Reflecting on Your Role:

- As someone who had a significant role in overseeing the Home Visiting Programme, could you share some key achievements or milestones that you are particularly proud of during your tenure?
- What were the main challenges you encountered in managing the Programme, and how did you address them?

2. Lessons Learned:

- Based on your experience, what are the most valuable lessons you've gained from overseeing the Home Visiting Programme? Are there any insights that you believe would be beneficial for current and future Programme managers to know?

3. Programme Enhancement:

- Considering your deep involvement with the Programme, are there any specific areas where you believe enhancements or adjustments could be made to further improve its impact and effectiveness?
- Are there any aspects of the Programme that you would recommend expanding upon or refining based on evolving health needs and societal changes?

4. Interagency Collaboration:

- Throughout your tenure, how did you find the collaboration between the Ministry of Health, municipalities, and other relevant ministries? Are there any recommendations for strengthening these interagency partnerships?

5. Innovation and Adaptation:

- Were there instances during your tenure where you introduced innovative approaches or adapted strategies within the Home Visiting Programme? Could you share examples and the outcomes of these initiatives?
- What advice would you give to those seeking to introduce innovative elements into a Programme like this?

6. Sustainability and Long-Term Impact:

- As the Programme continues to evolve, what strategies would you recommend ensuring its long-term sustainability and continued positive impact on maternal and child health?
- How can the Programme adapt to changing demographics and health priorities to remain relevant and effective?
- Do you think UNICEF's support is always needed or the MoH can fully take over the programme?

7. Advocacy and Communication:

- In terms of advocating for the Programme's importance and securing necessary support, what strategies have you found most effective? Are there any communication channels or methods that you would recommend utilizing?

8. Empowering Local Stakeholders:

- How did you work to empower and support municipalities in their role as implementers of the Programme? Are there specific strategies you would recommend fostering strong collaboration and capacity-building at the local level?

9. Data-Driven Decision Making:

- The use of data is crucial in Programme management. How did you leverage data and insights to make informed decisions about the Home Visiting Programme? Are there any data collection or analysis practices you would suggest?

10. Legacy and Continuity:

- As you reflect on your time overseeing the Programme, what legacy or lasting impact would you hope to have left behind? What advice would you offer to your successor to maintain the Programme's positive trajectory?

11. Resource Allocation:

- During your tenure by your advocacy the home visiting programme reached a budget allocation of 3.4 million EUR. Could you provide insights into the how the resource distribution can be arranged by the municipalities for the Home Visiting programme?

MINISTRY OF EDUCATION / MINISTRY OF FINANCE

1. Programme Understanding and Alignment:

- How does a programme such as the Home Visiting contribute to/ align with the overarching goals and priorities of your ministry/department?
- How would you describe the significance of the Home Visiting Programme, as an intervention targeting young children and their families, in achieving the broader objectives of your ministry?

2. Collaboration and Coordination:

- Is there any form of collaboration between your ministry and other relevant ministries in supporting the Home Visiting Programme? Can you please elaborate?
- How do you think effective coordination and communication among the various ministries can be strengthened to ensure the Programme's success?

3. Policy and Strategy:

- Are there any policy frameworks or strategies that guide your ministry's involvement in the Home Visiting Programme?
- How do you see the Home Visiting Programme does/could complement other initiatives your ministry is implementing?

4. Ministry's engagement and support

- What is/are the value/s that the Ministry of…. attributes to the UHV Programme?
- Is there any particular issue that the Ministry of….would like the UHPV take more care of?
- What is the contribution that the Ministry of…. has given to the UHV Programme so far?
- How can the Ministry of…provide further support to the UHPV?

5. Barriers and Challenges:

- Are there any regulatory or bureaucratic challenges that your ministry has encountered in supporting the Home Visiting Programme?
- Are there specific barriers that need to be overcome to further enhance the Programme's impact?

NATIONAL INSTITUTE OF PUBLIC HEALTH / HOME VISITING TRAINER

1. Building Communication Skills:

- Effective communication is essential for home visitors. What strategies do you employ to enhance the communication and interpersonal skills of health professionals during the training?

2. Contributing to Maternal and Child Health Goals:

- How do you view the impact of the training Programme on improving the knowledge for maternal and child health outcomes?
- Do you think the HV modules should be incorporated to universities curriculum?

3. Hands-On and Practical Training:

- Does the training incorporate practical experiences and real-world scenarios to prepare health professionals for their roles as home visitors? Can you please explain or give an example?

4. Research and Innovation:

- As part of the Institute of Public Health, how do you integrate research findings and innovations into the training Programme for the Home Visiting Programme?

5. Addressing Challenges and Concerns:

- What are some of the common challenges or concerns that health professionals might face when conducting home visits? How do you think the training Programme prepare/ can prepare them to address these challenges?
- Do you as a trainer think that home visitors are equipped to handle sensitive or complex situations that may arise during visits? Can you please explain or give an example?
- Do you want to add a question about areas of development/enhancement for the current training programme? Suggestions for improvement?

UNICEF

1. Can you describe the initial motivations and goals behind UNICEF's support for the Home Visiting Programme during your time as the head of the Health and Nutrition team?
2. What were some of the challenges and opportunities you encountered while establishing the programme, and how did you address them?
3. Could you share key milestones and achievements that marked the early stages of the programme's implementation under your leadership?
4. What went well with the collaboration of UNICEF with other stakeholders? What actions was taken to ensure the programme's success and impact?
5. In your view, what were the most significant lessons learned during the initial phase of the programme's development and implementation?
6. What role did the programme play in improving maternal and child health outcomes in the target communities during your work?
7. Based on your experiences and insights gained from your respective role in the Home Visiting Programme, what key recommendations would you offer for ensuring the sustainability, scalability, and continued impact of the programme in the future?
8. How can the lessons learned from the programme's journey contribute to the design and implementation of similar initiatives?
9. Shifting towards the progressive approach of the programme, what do you recommend should be done?

UNICEF

1. As the head of the Health and Nutrition team during the expansion of the Home Visiting Programme to 22 municipalities, could you elaborate on the objectives of the expansion?
2. How did you work with other stakeholders, including the Ministry of Health and local communities, to successfully scale up the programme and reach more beneficiaries?
3. What were some of the challenges and successes that you encountered during the expansion phase, and how did you address them?
4. From your perspective, how did the programme contribute to improving maternal and child health outcomes in the expanded areas, and what evidence of impact did you observe?
5. What advice or insights can you offer to ensure the sustainability and further growth of the Home Visiting Programme in the years ahead?
6. Can you think of a strategy that central level along with UNICEF has adapt or evolved as the programme expanded to new municipalities?
7. Based on your experiences and insights gained from your respective role in the Home Visiting Programme, what key recommendations would you offer to stakeholders, including UNICEF and the Ministry of Health, for ensuring the sustainability, scalability, and continued impact of the programme in the future?
8. How can the lessons learned from the programme's journey contribute to the design and implementation of similar initiatives?
9. Shifting towards the progressive approach of the programme, what do you recommend should be done?

FOCUS GROUP TOPICS FOR THE DISCUSSION WITH HOME VISITORS

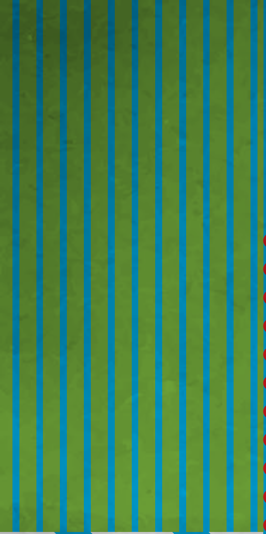
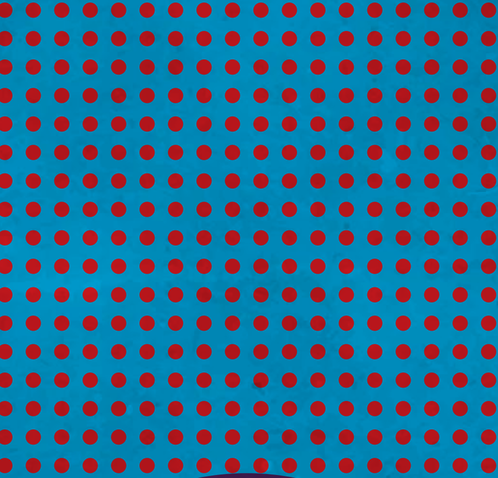
- Which are the main difficulties you encounter in the delivery of the programme?
- Do you have any suggestion for addressing them?
- How do you consider the proposals below for strenghtening the Programme (
    - Setting up clear Programme objectives on a yearly basis, both nation-wide and by municipality
    - making HV staff and coordinators both accountable for results and rewarded for achieving them
    - Defining the number and content of home visits according to existing risk factors at household level
    - Planning a communication campaign and considering specific actions to build trust between HV personnel and communities.
    - Planning for increasing the availability and deployment of HV nurses, ensure quality preservice and in service training, improve their status and foster internal leadership.
    - Promoting, also to reduce time spent in filling up and analyze records, the informatization of data recording.
    - Developing a participatory quality assessment and include a peer-to-peer supervision with system and continuous professional development.
    - Revising the M&E system taking into account the need for assessing the performance of the program in disadvantaged groups and households.

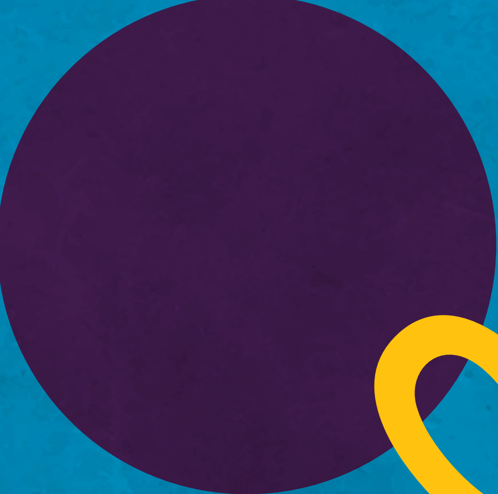
FOCUS GROUP DISSCUSIONS WITH BENEFICIARIES

- What are, in your opinion, the most important aspects you discussed about with the nurse during home visits?
- What are, if any, the practice you introduced or changed regarding your health or the health of your child?
- Is there any specific topic you would like the home visits to address?

Annex 2. List of Key Informants

Name & Surname	Title and institution
Agron Gashi	Health Specialist, UNICEF - ECARO O/P Warsaw, Poland Former Health and Nutrition Officer, UNICEF Kosovo
Albana Morina	Family Doctor, Main family Health Center in Prishtina Former Chief of Primary Health Care Division of the Ministry of Health
Bekë Veliu	Health Officer UNICEF Kosovo
Dafina Mucaj	Health Specialist, UNICEF - ECARO O/P Czech Republic Former Health and Nutrition Officer, UNICEF Kosovo
Jehona Luta	Maternal and Child Health consultant UNICEF Kosovo
Laberie Luzha	Chief of the division for preschool education – Ministry of Education
Mentor Morina	Director of the Department for Social Policy and Families – Ministry of Finance
Merita Vuthaj	Chief of the Division for Maternal and Child Health Care – Ministry of Health
Arjeta Gjikolli	Monitoring and Evaluation Officer, UNICEF Kosovo
Sajeda Atari	Early Childhood Specialist/head of ECD Pillar, UNICEF Kosovo
Valbona Zhjeqi	Social Medicine Specialist, National Institute of Public Health of Kosovo. National trainer, HV training programme



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