

**The UNFPA Kosovo (UNSCR 1244)*
Programme Evaluation Report**

Period covered by the evaluation (2013-2018)

The report is prepared under the UNFPA CLUSTER PROGRAMME
EVALUATION
of country programmes in Bosnia and Herzegovina, North Macedonia,
Serbia and Kosovo (UNSCR 1244)

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*References to Kosovo shall be understood to be in the context of Security Council Resolution 1244 (1999)

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Disclaimer: This is a product of the independent evaluation team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States.

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ABBREVIATION AND ACRONYMS

AH	Adolescent Health (AH)
AI	Administrative Instruction
AWP	Annual Work Plans
CCSP	Cervical Cancer Screening Programme
CDP	Common Development Plan
DHS	Demographic Health Survey
CDP	Common Development Plan
CGP	Clinical Guidelines and Protocol
CNMCR	Confidential Near-Miss Case Review
CPD	Continual Professional Development
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
EPC	Effective Perinatal Care
EU	European Union
FBO	Faith Based Organisation
FP	Family Planning
FMC	Family Medicine Centres
GBV	Gender Based Violence
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
JP	Joint Project
IMR	Infant Mortality Rate
KAS	Kosovo Agency for Statistics
KCCG	Kosovo Council on Clinical Guidelines and Protocols
LMIS	Logistics Management Information System
MCYS	Ministry of Culture, Youth and Sports
MEST	Ministry of Education, Science and Technology
MFMC	Main Family Medicine Centre
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MICS	Multiple Indicator Cluster Survey
MCH	Mother and Child Health
MCRH	Mother, Child and Reproductive Health
MMR	Maternal Mortality Ratio
MYCS	Ministry of Youth Culture and Sport
NBCC	National Board of Cancer Control
NCMA	National Committee for Maternal Audit
NGO	Non-Governmental Organization
NIPH	National Institute for Public Health
OB/GYN	Obstetrics and Gynaecology
OIK	Ombudsman institution in Kosovo
OHCHR	Office of the High Commissioner for Human Rights
OSRS	Obstetric Surveillance and Response System
RAE	Roma, Ashkali and Egyptian
PD	Population and Development
RH	Reproductive Health

PMR	Perinatal Mortality Rate
TB	Tuberculosis
TOT	Training of Trainers
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights
STI	Sexually Transmitted Infections
U5MR	Under 5 Mortality Rate
UCCK	University Clinical Centre of Kosovo
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNKT	United Nations Kosovo Team
WHO	World Health Organisation
WWC	Women Wellness Centre
YFHS	Youth Friendly Health Services

Key Facts Table

Geographic location	Kosovo (UNSCR 1244) is a landlocked country located in south-east Europe. It is bordered by Serbia to the north, The former Yugoslav Republic of Macedonia to the south, Montenegro to the east, and Albania to the south-east.
Total area	10,908km ¹
Terrain	The most noticeable topographical features are the Bjeshkët e Nemuna and the Sharr Mountains. The Bjeshkët e Nemuna mountain range, also known as the Albanian Alps are a geological continuation of the Dinaric Alps. The mountains run laterally through the west along the border with Albania and Montenegro. The southeast is predominantly the Sharr Mountains, which form the border with the former Yugoslav Republic of Macedonia. Besides the mountain ranges, the territory of Kosovo (UNSCR 1244) consists mostly of two major plains: the Kosovo Plain in the east and the Dukagjini plain in the west.
Population as of 2013 in thousands	1,78 million ²
Urban population 2013 in thousands	Prishtina (capital) ³
Natural Increase Rate in 2016	NA
Population Growth Rate (2017)	0.8%.
Government	Republic
% of seats held by women in parliament (2014)	32.5% of the parliament consists of women ⁴
GDP per capita PPP US\$ in 2017 (est.)	3,566 ⁵ in Euros 2017
GDP Real Growth rate in 2015 (est.)	4.2% ⁶ in 2017
Main industries	Minerals and metals production - and a variety of construction materials
Distribution of Family Income - Gini Index in 2011	23.2 ⁷ Rank 155 out of 157 nations.
Human Development Index Rank (2018)	Index 0.741 (2016) ⁸
Unemployment	29.4% ⁹
Life expectancy at birth 2015-2020 (est.)	71.65 years ¹⁰
Health expenditure (% of GDP) in 2016	2.32 ¹¹
Contraceptive prevalence (% of women ages 15-49) in 2012	12.3% ¹²
Unmet need for family planning in 2012	10.8% ¹³
% of people living with HIV, 15-49 years old in 2014	NA (97 cases ¹⁴)

¹ (Wikipedia, 2018) <https://en.wikipedia.org/wiki/Kosovo>

² (ASK, 2016) <http://ask.rks-gov.net/media/3672/kos-in-figures-2016.pdf>

³ (CIA, 2018) <https://www.cia.gov/library/publications/the-world-factbook/geos/kv.html>

⁴ (Gap Institute, 2017) http://www.institutigap.org/documents/31876_Gap%20analiza_perberja%20gjinore%20e%20bordeve.pdf

⁵ (Kosovo Statistical Office, 2018) <http://ask.rks-gov.net/media/4333/gross-domestic-product-gdp-production-approach-2017.pdf>

⁶ (Kosovo Statistical Office, 2018) <http://ask.rks-gov.net/media/4333/gross-domestic-product-gdp-production-approach-2017.pdf>

⁷ (CIA, World Factbook <https://www.cia.gov/library/publications/the-world-factbook/geos/mk.html>. 2018)

⁸ (UNDP, 2016) http://hdr.undp.org/sites/default/files/human_development_report_2016.pdf

⁹ (KAS, 2018) <http://ask.rks-gov.net/en/kosovo-agency-of-statistics/add-news/labor-force-survey-in-kosovo-q2-2018>

¹⁰ (World Bank, 2018) <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XK&view=chart>

¹¹ (MCC, 2018) <https://www.mcc.gov/who-we-fund/scorecard/fy-2016/XK>

¹² (Trading Economics, 2018) <https://tradingeconomics.com/kosovo/current-use-of-contraception-modern-method-percent-of-married-women-q1-lowest-wb-data.html>

¹³ (Trading Economics, 2018) <https://tradingeconomics.com/kosovo/unmet-need-for-family-planning-total-percent-of-married-women-q1-lowest-wb-data.html>

¹⁴ (UNAIDS, 2015) http://www.unaids.org/sites/default/files/country/documents/KOSOVO_narrative_report_2015.pdf

EXECUTIVE SUMMARY

Overview: The UNFPA Kosovo is for the first time implementing an official UNFPA Country Programme for the period of five years (2016-2020). As part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board, a Cluster Programme Evaluation has been planned to be conducted for all four UNFPA programmes in the region. This evaluation assessed UNFPA's first Programming Document in Kosovo. The findings of this evaluation will then be used during the drafting and preparation of the next programming cycle.

Objective, scope and methodology: The overall purpose of the programme evaluation is to demonstrate accountability to stakeholders on the performance of UNFPA offices, support evidence-based programming, and to draw key lessons from programmatic interventions, which would both support and provide guidance in the development of the new programming cycle. The scope of this evaluation included the examination of the relevance, effectiveness, efficiency, and sustainability of the existing programme adopted and implemented by the UNFPA office in Kosovo, as well as coordination with the United Nations Kosovo Team (UNKT) and the added value of the UNFPA office in Kosovo. The evaluation also looked at advocacy and partnership plans. The methodology applied during conducting evaluations comprised of (i) desk review of the key documents with the purpose of identifying the baseline situation, planned activities, and intended outputs and outcomes through the UNFPA office programmatic interventions and detailed review of the monitoring reports and secondary data/research to comprehend the actual progress achieved so far, (ii) semi-structured interviews with key informants (UNFPA staff, clients, and beneficiaries) and (iii) focus group discussions with the purpose of examining the degree to which planned activities are implemented, and the intended outputs and outcomes are actually being achieved.

Description of the Country Programme: The current UNFPA Programme is organised around three outcomes that cover the following areas of UNFPA mandate: (i) **Sexual and reproductive health:** which aims to support Kosovo's efforts to deliver integrated sexual and reproductive health services with a special focus on youth and vulnerable groups; (ii) **Adolescents and youth:** which is dedicated to improving the national capacity to design and implement community- and school-based comprehensive sexuality education programmes that promote human rights and gender equality; and (iii) **Population dynamics:** which is directed to strengthen institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on population dynamics, sexual and reproductive health, HIV and their links to sustainable development.

Key Findings – Relevance: There was evidence that all areas of work by the UNFPA office in Kosovo, i.e. Sexual and Reproductive Health and Rights, Adolescents and Youth, and Population Dynamics (PD) are well aligned with national objectives, the global UNFPA mandate, policies, and strategies and relevant to the needs of the final beneficiaries.

In terms of **effectiveness**, on Sexual and Reproductive Health and Rights (SRHR), from various interventions higher level results are observed in Effective Perinatal Care (EPC), Clinical Guidelines and Protocols (CGP) and with the K10 coalition although findings on EPC might contain a 'Hawthorne effect' since many positive findings were observed from the assessment visits where the staff was aware and informed in advance. Regarding the **CCSP**, the pilot programme on CCS is being implemented in Pristina and Prizren, from where about 5500 women had their samples taken. Nevertheless, due to a lack of suitable conditions as well as due to the clients' request, the procedure is only being offered by

gynaecologists within Primary Health Care (PHC), which are not part of the service package offered by PHC services according to the new Administrative Instruction on services offered by the Primary Health Care (PHC) facilities. On SRHR, despite the strong evidence for increased levels of knowledge, and counselling skills of PHC personnel about SRH topics due to trainings provided such as Family Planning (FP), Sexually Transmitted Infections (STI), Adolescent Health (AH), Logistics Management Information System (LMIS), Gender Based Violence (GBV), according to evidence collected, there is a low level of application and delivery of Sexual and Reproductive Health (SRH) services by the PHCs. On the other hand, Ombudsman institution in Kosovo (OIK) has produced the first National Assessment of the Reproductive and Sexual Rights in Kosovo, which provided a general and in-depth assessment of the reproductive and sexual rights in Kosovo for the first time in Kosovo, but it also served to advocate for the Ministry of Health (MoH) and other institutions to fulfil their obligations towards citizens in the area of Sexual and Reproductive Rights (SRR). The OIK considers that, out of 62 recommendations produced by the report, about 26 of them (or 42%) have been implemented satisfactorily. Regarding the **CSE** in formal education, the Curriculum Framework was adopted by the Ministry of Education, Science and Technology (MEST) integrated sexuality education within all grades of pre-university education. The UNFPA has responded by supporting the MEST and teachers on the implementation of sexuality education in formal education by developing manuals for teachers on sexuality education and by training of teachers on the delivery of sexuality education. In parallel to formal education, the UNFPA heavily supported various **non-formal education and outreach activities** that aim to raise awareness on safe sexual behaviour and promote gender equality. While there is some micro evidence about output level changes at the level of trainees, outreach is low and there is no data to measure outcome level changes (i.e. to utilisation or application of knowledge increases and whether this leads to behavioural change) both for trainees and for the wider population on SRHR and gender equality. In relation to **population dynamics**, there is qualitative evidence that UNFPA efforts significantly strengthened capacities of Civil Registration Agency and Kosovo Agency of Statistics (KAS) in the production, analysis, and the dissemination of the population data. In the area of vital statistics, a crucial improvement to be mentioned is the resolution of the issue of underreporting death cases, which has been addressed through enhancing cooperation between the Civil Registry Agency and Faith Based Organisations.

In relation to **efficiency**, in general, the amount of resources expended to achieve outputs through implementation of different programmatic activities appears to be reasonable. Considering that, during entire duration of the programme there were only two programme staff working in the UNFP office in Kosovo, the overall efficiency of the programme in terms of human resources utilized is considered very high. On average, SRHR and non-formal education components usually had a higher allocation of funding compared to Mother and Child Health (MCH), Cervical Cancer Screening Programme (CCSP) and other activities. Unfortunately, since there is lack of evidence to create a clear cause and effect relationship between UNFPA's interventions and improvements in key impact indicators, it was impossible to compute an analysis to gauge the overall efficiency of the interventions. Nevertheless, based on some qualitative efficiency analyses, which look at the utilisation of inputs such as those of local and international expertise and the use of tools and products developed and tested globally, UNFPA was highly rated by many stakeholders. Nevertheless, UNFPA can have higher efficiency gains by reallocation of funds towards interventions with stronger results within each programme areas and by consolidating interventions within each area of work, due to limited available resources. For example, in (i) mother and child care, (ii) sexual and reproductive health and rights and (iii) comprehensive sexuality education in non-formal education focus areas, there are too many activities allocated to different areas with different effects.

Finally, the degree of **sustainability** varies within the different area of work and within different interventions within the same area of work. While the UNFPA's work on population development, as well as activities directed at data analysis, has reached a comfortable level of sustainability, other focus areas (MCH, CCSP, SRH, and CSE) require additional attention in the next strategic planning phase to achieve a higher degree of sustainability. On Mother and Child Health (**MCH**), while most of the UNFPA interventions have static sustainability, (since capacities created within the MCRH Division, the National Committee on Maternal Audit (NCMA), CGP, MISP, EFP and within K10 coalition will continue to exist even if UNFPA withdraws from these interventions) not all these interventions have dynamic sustainability. For example, the Mother, Child and Reproductive Health (MCRH) Division within the Ministry of Health (MoH), due to lack of human capacities, it would be impossible to cover the policy making, legal framework development and monitoring of the availability and quality of MCH and SRH services within the health sector. The situation is somewhat similar with Effective Perinatal Care (EPC) and K10. Training and monitoring visits on EPC cannot continue without UNFPA support. Regarding the Cervical Cancer Screening Programme (**CCSP**), although Primary Health Care (PHCs) in two municipalities are capacitated to provide CCSP independently from UNFPA support, offering such services still has some issues with static sustainability, since the service delivery is done through a gynaecologist and not by Family Physicians, which as a service will not be part of the PHC. Dynamic sustainability of the CCSP on the other hand, is heavily dependent on whether policymakers will continue to support this screening programme and its expansion to cover all over the Kosovo Health Care System. On Sexual and Reproductive Health and Rights (**SRHR**), according to the survey conducted on the effectiveness of the training programmes delivered by the UNFPA on Family Planning Sexually Transmitted Infections, (STI), Logistics Management Information System (LMIS), Gender Based Violence (GBV), it appears that static sustainability is achieved in the mid-term since the majority of trainees expressed the need for training programmes to be repeated in 3 to 5 year of intervals. Dynamic sustainability of interventions is questionable due to the lack of resources and commitment from policy making level to take over training programmes and financed them by the Main Family Medicine Centre (MFMC) or by the Ministry of Health (MoH). In relation to **CSE**, training of teachers and manuals for teachers has a static sustainability since the result achieved so far (i.e. the increased knowledge and skills of teachers to deliver sexuality education) will continue to be used by teachers during the delivery of the sexuality education. Nevertheless, neither development of manuals nor training of teachers have dynamic sustainability since functions and services supported by the UNFPA cannot be replace entirely at the moment by the Ministry of Education, Science and Technology (MEST). Finally, most of the non-formal education and outreach activities appears to have static sustainability. However, since such activities other than social marketing are heavily dependent on UNFPA support cannot be categorised as sustainable in dynamic terms.

Finally, in each of the working areas, the UNFPA has made excellent use of its comparative strengths, thus bringing **added value** to its programmatic activities implemented in Kosovo. Many of the key results (in SRHR, CCSP, CSE, PD) would not have been achieved without the presence of the UNFPA.

Recommendations: 1) **The UNFPA office in Kosovo is recommended to introduce a more detailed M&E framework and invest more in data collection tools in the future programming document. The UNFPA should invest in the preparation of a detailed M&E matrix that captures the capacity and performance improvements and possible impact level changes for all interventions such as MCH, CCSP, SRH services, as well as the behavioural changes of targeted population on SRR gender equality etc.** These results should be then translated into proper statements of output, outcomes, and impacts and performance indicators, baselines, and targets, which are relevant to the result, and can be

monitored regularly. In relation to this, the UNFPA is also recommended to invest in gathering information regarding the baseline data on outputs, outcomes, and impacts and put into place a functional system for monitoring and tracking these indicators to ensure that comparable follow-up data is collected at regular intervals. This report argues that many of the outcome and impact level indicators are missing. Some of these indicators rely on a HIS (especially those related to service delivery) but others, such as on behavioural changes of targeted populations, can be computed through MICS or by producing a specific study for this purpose. This would be a valuable investment since monitoring the results would guide the overall effectiveness of the interventions applied by the UNFPA and would indicate the need for any adjustments to the interventions.

2) **UNFPA is suggested to further improve the allocative efficiency of the programme by reallocation of funds towards interventions with stronger results and by consolidating interventions within each area of work, due to limited available resources.** For example, in (i) mother and child care, (ii) sexual and reproductive health and rights and (iii) comprehensive sexuality education in non-formal education focus areas, there are too many activities allocated to different areas with different effects. UNFPA could improve efficiency in these areas by avoiding dividing the limited available resources into too many activities and by focusing on those interventions with greater results.

3) UNFPA's efforts should be directed first to explore whether conditions (creation of (i) full ownership and critical mass of commitment from institutions for a certain policy measure (in this case CGP) (ii) adequate capacities (which was built through training on the methodology of CGP development) and (iii) appropriate processes (which was established through AI on CGP), which is also entirely financed by sustainable funding mechanisms (by the Ministry's budget to design, implement and monitor policy initiatives by themselves) exist or can be developed especially in programmatic initiatives in relation to MCH, SRHR and CCSP and then decide to design or expand appropriate interventions in these focus areas in order to achieve greater and more sustainable results.

4) Since gynecology services will not be part of the PHCs, **UNFPA should re-think its strategy towards introducing or strengthening CCSP within the secondary healthcare system or invest heavily in changing the beliefs of targeted women population that such screening processes can be done by PHC through Family Physicians.**¹⁵ UNFPA has to support the creation of sustainable quality controls and improvement of reading PAP smears within Pathologic Institute with periodic double checks of randomized samples locally and internationally and support further on a follow-up mechanism to reliably track the management cycle of suspicious or confirmed cases of cancer.

5) Use the results of the pilot CCSP to generate political will, critical mass of commitment and wider population support for upscaling the programme.

6) **Support the Medical Professional Chamber, Primary Health Care Division in MoH toward achieving dynamic sustainability of training activities along with the development of a sustainable and standardised quality monitoring system of the effect of the training for Family Medicine to provide quality integrated SRH on FP and STI, and YFHS;**

7) Consider expanding training to relevant teachers on sexuality education. **The UNFPA should consider prioritising training for Biology teachers first, then target training of primary education teachers if there are significant budgetary limitations.** According to our estimates there should be around 930 Biology teachers, both in lower and upper secondary schools (about 560 in lower secondary and 370 in upper secondary schools)¹⁶ and about 7000 primary education teachers. Furthermore, in order to lower the cost of organising a training, the UNFPA could consider increasing the number of teachers that participate in each

¹⁵ Nevertheless, the later approach would also require investing in space, equipment and capacities of the Family Medicine Teams to carry on PAP test sample taking in their routine work as well as creating settings and conditions in which they will be able to provide such services respecting the privacy and confidentiality of their clients

¹⁶ If we take into account, the current cost of organising training and foresee that in each training there will be about 30 teachers of Biology then the total cost of organising training for all Biology teachers would be 62,000 euro

training, especially for the training targeting primary school teachers. 8) **Invest in data collection tools that will apply the same methodology in repeated terms after a certain period (usually four years) to be able to observe any changes in perceptions, attitudes and practices.** The peer education programme targeting youth should merge SRHR and gender equality components; gradually the programme should focus more on gender equality topics since SRHR issues will be covered by the formal education system. 9) Continue to facilitate the working group on vital statistics to address issues for the establishment of long-term cooperation between various institutions. Shift the support to demographic data analysis towards providing quality assurance assistance to KAS. 10) Expand measurement of many other SRHR indicators¹⁷ through the next MICS survey (see above) or alternatively produce a UNFPA sponsored report every four-to-five years for this purpose. 11) Given the success in initiating and developing the CGP, UNFPA should shift the support to KCCGP on developing and implementing the quality monitoring of the CGP implementation. Develop regular ad-hoc quality monitoring mechanisms within the MoH, Medical Chamber or Kosovo Obstetric and Gynaecologic Association (KOGA) to continuously monitor EPC. 12) Support achieving the dynamic sustainability of the EPC support (for both training and follow up visits) embedded entirely within the MoH, Medical Chamber or Kosovo Obstetric and Gynaecologic Association, as well as creating a critical mass of commitment from these institutions towards continued development of the EPC service delivery. Continue supporting the institutional development of the K10 to express their voice and advocate towards greater accountability for SRHR services and not only focusing on marking different international SRH days. 13) In order to increase effectiveness, **UNFPA is suggested to work on and advocate about strengthening the accountability framework to create adequate incentives of PHC for the delivery of SRH services. In parallel, UNFPA is recommended to continue advocating for the MoH to establish a budget line for contraceptives and support further OiK capacities to perform oversight and accountability function towards institutions in fulfilling SRHR.** 14) In the long run, work on the inclusion of the sexuality education into the MEST ToT system to enhance the dynamic sustainability of the interventions. 15) UNFPA needs to have a greater outreach and sustainability for peer education, and focus on digitalisation of the peer education content. Development of the mobile application for SRHR is important step in this direction. However, in order to achieve the intended impact, such content should be widely used by young people. Thus, the UNFPA should consider developing and implementing various promotion tools to reach out to young people. Such content should also be very much appealing for young people and might also require the establishment of a communication channel for follow up questions and answers by the young people. Discussions from focus groups with young people reveal the difficulty of getting the interest of young people for such content, even if it is accessible from the mobile phones, if they are not attractive to them.

¹⁷ Regarding the safe, effective, affordable and acceptable contraception method of their choice, STI, HIV and other concepts of SRHR as well as on gender norms and roles.

1. INTRODUCTION

The UNFPA Kosovo is for the first time implementing an official UNFPA Country Programme for the period of five years (2016-2020), developed in a participatory approach with partners and approved by the Executive Board in 2015.¹⁸ The current UNFPA Programme is organised around three outcomes that cover the following areas of UNFPA mandate: (i) ***Sexual and reproductive health***: which aims to support Kosovo's efforts to deliver integrated sexual and reproductive health services with a special focus on youth and vulnerable groups; (ii) ***Adolescents and youth***: which is dedicated to improving the national capacity to design and implement community- and school-based comprehensive sexuality education programmes that promote human rights and gender equality; and (iii) ***Population dynamics***: which is directed to strengthen institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on population dynamics, sexual and reproductive health, HIV and their links to sustainable development.

UNFPA offices in all countries in the administrative cluster of the Eastern Europe and Central Asia region have harmonized their programming cycles ending in 2020. For this reason, according to the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) which was approved by the Executive Board, the evaluation of all four programmes in this region was planned around a similar period. The findings of this evaluation will then be used during the drafting and preparation of the next programming cycle. Conducting parallel evaluations for the four programmes will also allow to extraction of transferable lessons learned from various programmes and used in the next programming cycle. Following three years of implementation of the programme, the UNFPA has undertaken an external final evaluation to review the relevance, effectiveness, efficiency and sustainability dimensions of the programme. In order to be consistent with other country programmes evaluations, the current evaluation covers the period between 2013 - 2018. Nevertheless, the major focus of this evaluation has been the period between 2015-2018 since the UNFPA office in Kosovo conducted an external programme performance evaluation in the beginning of 2015 covering the period 2010-2014.

1.1. Purpose, Scope and Methodology of the Evaluation

1.1.1. Purpose and objectives of the programme performance evaluation

As part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board, a Cluster Programme Evaluation has been planned to be conducted for all four UNFPA programmes in the region. The overall purpose of the programme evaluation is to demonstrate accountability to stakeholders on the performance of UNFPA offices, support evidence-based programming, and to draw key lessons from programmatic interventions, which would both support and provide guidance in the development of the new programming cycle. This evaluation provides an independent assessment of the performance of the UNFPA Programme in Kosovo and records achievements against the expected outputs and outcomes set forth in the last Kosovo Programming Document.¹⁹

1.1.2. Scope of the evaluation

The scope of this evaluation will include an examination of the relevance, effectiveness, efficiency, and sustainability of the interventions adopted and implemented by the UNFPA office in Kosovo, as well as coordination with the United Nations Kosovo Team (UNKT) and added value of the work of the UNFPA

¹⁸ Previously, the UNFPA office in Kosovo operated on a project-by-project basis environment.

¹⁹ UNFPA (2015): UNFPA Programming Document for Kosovo (UNSCR 1244)

office in Kosovo. For the relevance of the programme, the main focus will be to review the extent to which the current programming or interventions of the UNFPA office in Kosovo are in compliance with and responsive to the needs and priorities of the final beneficiaries and the corporate UNFPA policies and strategies.

For the effectiveness of the programme, the evaluation will reconstruct the programme intervention logic and will examine (i) the degree to which the programme interventions: a) produced the desired outputs and b) further influenced the achievement of different levels of outcomes described in the intervention logic and c) whether they further contributed to the realization of the intended impact where clear evidence exists and (ii) to what extent these results were achieved through the implementation of the UNFPA interventions.

For the efficiency of the programme, the focus will be to review the extent to which the programme resources are utilised and the extent to which the UNFPA made good use of its technical and human resources to achieve the results.

For sustainability, the evaluation will appraise both static and dynamic considerations. Static sustainability reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. Dynamic sustainability on the other hand, looks for system changes, i.e. whether functions and services supported by UNFPA and the production of the results will continue to be achieved beyond UNFPA support.

In relation to the coordination with the UNKT, the key areas for review are the extent to which the UNFPA contributed to the achievement of the UNDAF/Common Development Plans' outputs and outcomes and to the functioning of the coordination mechanisms within the UN Agencies. Finally, for the added value, the evaluation will review the country office positioning within the development community and other UN Agencies in order to respond to the needs of beneficiaries, while adding value to the national development results²⁰.

The assessment, as per requirements in the Cluster Evaluation Design Report, will also cover the cross-cutting planning areas as outlined in partnership, resource mobilisation, and communication plans.²¹ This evaluation was conducted between November 2018 – January 2019, while almost all field work was completed during November – December 2018.

1.1.3. Methods for data collection and analysis/ Methodology

The methodology applied during conducting this evaluation comprises (i) desk review of the key documents with the purpose of identifying the baseline situation, planned activities, and intended outputs and outcomes through the UNFPA office programmatic interventions and a detailed review of the monitoring reports and secondary data/research to comprehend the actual progress achieved so far, (ii) semi-structured interviews with key informants (UNFPA staff, implementation agency staff, representatives from the Government of Kosovo and NGOs, clients, and beneficiaries) and (iii) focus group discussions with the purpose of examining the degree to which planned activities are implemented, and the intended outputs and outcomes are actually being achieved.

²⁰ For details please see Evaluation Matrix in Annex 4.

²¹ Clark, S. (2018): UNFPA Four-Country Cluster Evaluation Design Report

Desk review: For the purpose of this evaluation, the following documents were reviewed: The UNFPA Corporate Strategic plans, UNFPA Kosovo Programming Document, The United Nations Kosovo Team (UNKT) Common Development Plan (CDP), Annual Work Plans (AWPs), the Standard Progress Reports, the CDP Progress Reports, various studies that were conducted through UNFPA support, and so forth.²²

Semi-structured interviews: Interviews with UNFPA office staff and partner organisation were organised using a semi-structured questionnaire to get closer feedback about interventions supported by UNFPA and results achieved (See instruments in Annex 6). The evaluation team has organised more than 40 in-depth interviews with different stakeholders. The full list of people interviewed is presented in Annex 1.

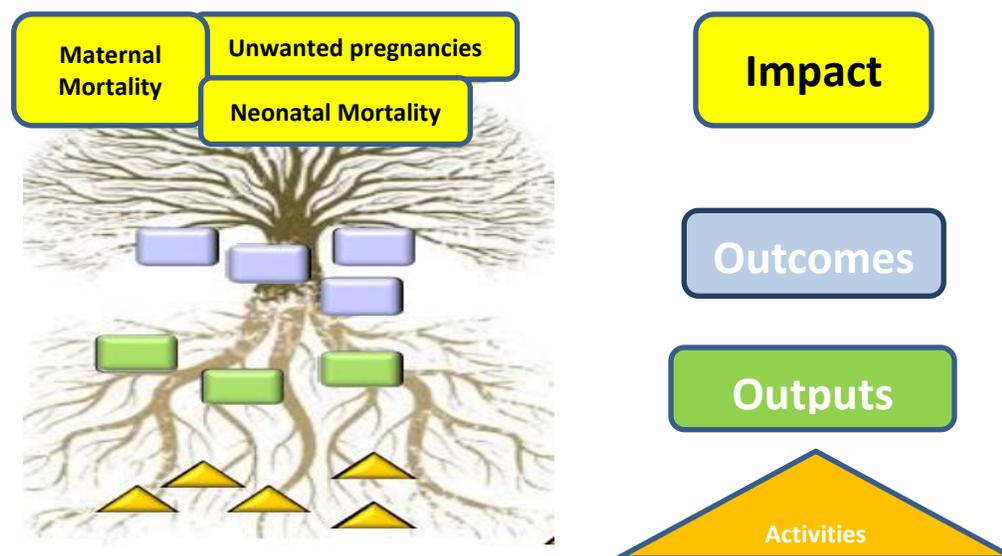
Focus Group Discussions: For collecting in-depth information regarding the key aspects of the evaluation, the team also organised 10 different focus group discussions with key implementation staff and beneficiaries of UNFPA interventions, such as those from peer education programmes, gender equality training, MISP, Effective Perinatal Care, Gender Based Violence (GBV), Orientation Program for Adolescent Healthcare, and the Cervical Cancer Screening Programme.²³ Focus group meetings had around 6-10 participants, which is considered an optimal number for conducting such discussions. The methodology used in conducting the focus groups was of a dual moderator focus group approach. This methodology uses two moderators: the first who facilitates the sessions and the second who takes the notes and ensures that all the intended topics are covered and answered by the participants. While the main discussion points for the focus groups are summarized in this report, separate minutes of the discussions for each focus group discussion (in Albanian) are attached to this report in Annex 5.

The analytical model for assessing the effectiveness of the UNFPA programme follows an “intervention or impact logic or causal model”, which incorporates the results on three different levels: output, outcome, and impact.²⁴ Based on this model, programme activities are performed in order to achieve outputs that result in the desired outcomes, and at the same time contribute to the intended impact. Under this model, the UNFPA responsibility and accountability for the results varies considerably between the different levels of the results. At the output level, the UNFPA is directly responsible and accountable for the achievement of the result, since outputs are directly controlled and achieved through the work or interventions supported by the UNFPA. However, at the outcome and impact level, the UNFPA is not responsible, but accountable for the achievement of the results since their realization depends on the institutions and beneficiaries’ uptake. The team has designed six different intervention logic models to cover all possible interventions of UNFPA implemented during this period. These intervention logic models then were grouped into three main categories in order to perceive inter-connections of different interventions and results. The first one is Mother and Child Health, which covers (i) access to services that can help mothers have a fit pregnancy, safe delivery and healthy baby as well as (ii) services facilitating prevention and early diagnosis and treatment of reproductive tract cancer, more specifically the Cervical Cancer Screening Programme. The second group is Sexual and Reproductive Health and Rights (SRHR) which covers information and services for FP, STI, HIV, GBV, gender equality etc. from (i) primary health care (PHC) providers and from (ii) formal education and (iii) community outreach. Finally, the third group of intervention logic models covers interventions related to population dynamics, data availability and data processing capacities.

²² For full list of documents reviewed please see the References section.

²³ The full list of focus groups organised is presented in Annex 1.

²⁴ Outputs are formulated as changes in national capacity (skills and abilities), and outcomes as changes in the performance and behaviour of institutions and people, and impact as improvements in human lives such as a reduction in the maternal mortality ratio.

Figure 1: Impact logic or causal model

1.1.4. Limitations

There are several limitations with the proposed methods. It was not feasible for this evaluation to employ quantitative research methods (i.e. collect statistically representative models for certain results) and identify an attribution factor between the realization of outputs and achievements of any outcomes.²⁵ For this reason, this evaluation is inherently qualitative in nature, trying to gather and analyse the evidence for the achievement of outputs and their “contribution” to the realization of outcomes. The samples of interviews and group meetings chosen are purposive, and not representative of the target population of both implementation partner organisations and beneficiaries. There are possible biases in the selection of respondents (both stakeholders and beneficiaries) and their locations since they are selected on a non-random basis during the collection of evidence for the achievement of the outputs. To minimize the possibility of bias, all the interviews were conducted in private without the presence of any UNFPA staff members.

1.1.5. Process Overview

As outlined in the TOR, the evaluation process was divided into four phases:

Phase 1: Desk review – The evaluation team cooperated with the UNFPA office for the identification and collection of a wide range of relevant documents and data. These materials were the basis for the identification of planned activities and intended outputs and outcomes to be achieved. During this phase, the evaluation team, in cooperation with the UNFPA staff, identified the stakeholders associated with activities, output, and outcomes. This work provided the basis for selecting a list of stakeholders for interview.

²⁵ The impact evaluation is intended to determine more broadly whether the intervention had a desired effect on beneficiaries and whether those effects are attributable to the intervention itself since there may be other factors or events that can influence the impact that are not caused by the intervention. To ensure methodological rigour, an impact evaluation needs to determine the counterfactual which is usually accomplished through the use of a quasi-experimental or experimental analysis technique and through comparing control groups (those who do not participate in a programme) with the treatment group (individuals who do receive the intervention).

Phase 2: Data collection – Following the desk review, semi structured interviews and focus groups were conducted with key informants (UNFPA office staff, as well as stakeholders). These interviews and focus groups were the basis for the data collection regarding the activities implemented, the outputs achieved, and outcomes reached.

Phase 3: Drafting the Evaluation Report: In this phase, the information collected was analysed, and the draft evaluation report was prepared. The draft report went through an internal and external review process. The evaluation team also completed the evaluation matrix, required for all four programmes of the region.

Phase 4: During the final phase, the Evaluation Reference Group, comprised of key stakeholders, was consulted, and comments were addressed in the final version of the report.

Chapter 2. Country Context

Socio-economic situation

Kosovo remains one of the poorest countries in Europe with very high unemployment and poverty rates compared to other countries in the region, which have changed during recent years. Based on the latest report produced by the Kosovo Agency of Statistics (KAS) on Consumption Poverty in 2015, the percentage of population in Kosovo living below the poverty line²⁶ (i.e. unable to meet human needs) decreased to 17.6 percent in 2015 from 30 percent in 2011. Similarly, the percentage of population in Kosovo living below the extreme poverty line²⁷ (i.e. unable to meet even basic survival needs) decreased to 5.2 percent in 2015 from 10 percent in 2011.

Similar to poverty, the labour market outcomes also improved during these years. Nevertheless, the improvements were much higher in the labour force participation rate²⁸ and the employment rate²⁹ rather than in the unemployment rate³⁰. The labour force participation rate (and the employment rate) increased from 37.6 percent (25.2 percent) in 2015 to 42.8 percent (29.8 percent) in 2017. Likewise, significant progress was achieved in reducing the share of youth outside employment, education and training (from 31.3 percent to 27.4 percent) during these years. Nonetheless, very limited progress was achieved in decreasing unemployment rates. In 2017 approximately, 30 percent of the labour force was estimated to be unemployed down from 32.9 percent in 2015. The same is true for youth unemployment. Despite these improvements, the rate of labour force participation and employment rates are low by international standards, while the unemployment rate is high. The unemployment rate in the last three years has been within the range of 30-33 percent and is two times higher than the average rate in the region, and four times more than the EU average. Similarly, the measures of labour resource utilisation, such as the labour force participation rate and employment rate are the lowest in the Western Balkan region and significantly lower than the EU average. These same indicators for women are extremely low. In 2017, the unemployment rate for women was 36.6 percent against 28.7 percent for men, while the labour market participation rate for women was 20.5 percent against 65.3 percent for men and the employment rate for women was 12.7 percent against 46.6 percent for men.

Economic growth is the most powerful instrument for reducing poverty and improving standards of living. During 2015-2017 in Kosovo, on average, the GDP grew by approximately 4 percent per year. Growth was largely driven by private consumption and investments (driven also by private sector investments which grew from 17.9 percent of GDP in 2015 to 19.7 percent of GDP in 2017)³¹ while the government's consumption had a negative impact on the overall economic growth. Growth in private consumption was driven by the steady growth of remittances and by domestic lending. The current pace and pattern of this growth (which was based on private consumption fuelled also by remittances and non-productive private investment such as construction) was not sufficient to translate into significant changes in other development indicators such as rapid improvements in unemployment rates, or to achieve better education and health outcomes.

²⁶ Living below the poverty line of Euro 1.82 per adult equivalent per day. References???

²⁷ Living below the extreme (food) poverty line of Euro 1.30 per day. References???

²⁸ Ratio of employment and unemployment to working age of population.

²⁹ Employment to working age population ratio.

³⁰ Unemployed to labour force (employed and unemployed people) ratio.

³¹ While overall gross fixed capital formation increased to 27.3% in 2017 from 25.8% in 2015 (IMF, Country Report for Kosovo No. 1830).

The education sector experienced a steady increase with respect to the overall number of enrolments especially in upper secondary and tertiary education.³² Similarly, the percentage of students that dropped out from upper-secondary education is also in decreasing trend. Nevertheless, in recent years due to declining birth rates, the total number of students attending primary and lower secondary education especially has been decreasing.³³ The gender equality index for enrolment in education, which tries to measure gender equality in enrolment in education, is fairly equal, but falls slightly in upper secondary education (from 1 to 0.99).³⁴ Despite very positive outcomes concerning the enrolments rates of students attending education, especially in tertiary education, there are growing concerns about issues and challenges with regards to the quality³⁵ and the relevance of the education system at different levels. According to the OECD Programme for International Student Assessment (PISA) results, which assesses the extent to which 15-year-old students have acquired key knowledge and skills on the core school subjects of science, reading and mathematics, Kosovo underperforms significantly.³⁶ It was at the bottom end, compared to all other participating countries in all three main subjects (science, reading and mathematics).

Reproductive Health

With regard to the overall health conditions, Kosovo shows much poorer results compared to any other country in the region, though there are sustained improvements in selected indicators of maternal and child health. Life expectancy at birth³⁷ is about 71.6 years in Kosovo,³⁸ 9 years lower than Albania, 5 years lower than Macedonia and Serbia and 11 years lower than the EU average.³⁹ The perinatal mortality rate⁴⁰ was 12.1‰ in 2015 according to the Perinatal Situation report produced by the Ministry of Health and it is lower compared to the 2011 figure which was calculated at 17.3‰. However, this figure is still high compared to European countries, where the perinatal mortality rate is lower than 7‰.⁴¹ The most frequent causes of infant mortality have been: lower respiratory tract infections, acute infective diarrhoea, perinatal causes, congenital malformations and unclassified conditions. For the first time since 2000, there has been an increase in the neonatal mortality rate from 3.7‰ (in 2014) to 5.1‰ (2015), showing the vulnerability of the improvements in some key indicators. There are no official reported cases of maternal deaths since 2013, although the reporting of maternal mortality is not so reliable (does not capture the inputs from the private hospitals while the media continues to report individual cases of maternal deaths). While the maternal mortality ratio per 100,000 live births was 10.5 in Kosovo in 2012 according to the Perinatal Situation report, the same rate from the regional countries, for example in Macedonia it was 7, and this ratio in the main European countries was 4⁴² during the same year. According to the Kosovo Agency of Statistics in 2016, the infant mortality was 8.5 per 1000 live births, whereas according to MICS mortality of infants

³² MEST Annual Statistical Report with educational indicators, (2016/17).

³³ Source: MEST Annual Statistical Report with educational indicators, (2016/17).

³⁴ MEST Annual Statistical Report on Educational Indicators (2016/17)

³⁵ Note that neither the number of students enrolled at a level of study nor the amount of resources invested in education can indicate the quality of education.

³⁶ OECD (2016): PISA 2015 Results in Focus

³⁷ Indicates the number of years a new-born baby would live if health conditions prevailing at the time of its birth were to stay the same throughout its life.

³⁸ <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=XX>

³⁹ UNDP, Kosovo Human Development Report, 2012.

⁴⁰ Perinatal mortality is defined by WHO as weight specific (≥ 1000 g) fetal deaths and early neonatal deaths per 1000 births (live births + stillbirths)

⁴¹ WHO Statistics for Europe, <http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/data-and-statistics>

⁴² Ministrie e Shendetesise, Statistikat Shendetesore per Nenet dhe Femijet, 2012.

is 12 per 1000 live births. This is almost three times higher compared with those in EU countries, where the average infant mortality rate was 3.6 per 1,000 live births in 2015.⁴³

Table 1: Key mother and child health indicators

	2000	2012	2013	2014	2015	2016	2017
Perinatal mortality rate⁴⁴	29.1‰	17.34‰	16.26‰,	11.99‰	12.13‰	8.5‰	12.4‰
Foetal mortality rate⁴⁵	14.5‰	11.0‰ (2011)	10.09‰	8.4‰	7.1‰	6.3‰	6.8‰
Neonatal mortality rate⁴⁶	14.8‰	7.5‰ (2011)	6.23‰	3.7‰	5.1‰	6.4‰	7.6‰
Maternal mortality rate	23‰	10.5‰	0 cases reported officially	0 cases reported officially	0 cases reported officially	No data	No data

Source: MoH/NIPH, Perinatal Situation Report

The main concern in relation to the health system is the quality of health services and low financing. Thus, citizens have to cover health services with out-of-pocket expenditures estimated from 30 to 50% in 2014. Correspondingly, services for reproductive health are of poor quality.

Table 2. Health expenditure as share of GDP by country of the region

Country	Health expenditure as share of GDP (WB, 2015)	Country	Health expenditure as share of GDP (WB, 2015)
Albania	6.82	Macedonia, FYR	6.09
Bosnia and Herzegovina	9.38	Montenegro	5.97
Croatia	7.40	Serbia	9.41
Kosovo	2.66 ⁴⁷		

Source: World Bank <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS>

On the other hand, Kosovo is currently categorised in the group of states with a low rate of HIV. The infection rate is below 1% of the general population and below 5 percent of all groups threatened by the growing risk of HIV.⁴⁸ Between 1986 - 2017, 114 cases of HIV and AIDS have been recorded (70 with AIDS and 44 with HIV) with 46 cases of deaths as a result of AIDS. During 2017, 3 new cases were reported

⁴³ https://www.ined.fr/en/everything_about_population/data/europe-developed-countries/birth-death-infant-mortality/

⁴⁴ The perinatal mortality rate is calculated as: (# of perinatal deaths / total # of births (still births + live births)) x 1000. A stillbirth is the death of a fetus weighing 500g or more, or of 22-weeks gestation or more if weight is unavailable (ICD 10). An early neonatal death (END) is the death of a live newborn in the first 7 days (i.e., 0-6 days) of life. https://www.measureevaluation.org/prh/rh_indicators/womens-health/nb/perinatal-mortality-rate-pmr

⁴⁵ Fetal mortality rate: The ratio of fetal deaths divided by the sum of the births (the live births + the fetal deaths) in that year.

<https://www.medicinenet.com/script/main/art.asp?articlekey=3420>

⁴⁶ Neonatal mortality rate: The neonatal period covers birth up to but not including 28 days. The numerator of the neonatal mortality rate therefore is the number of deaths among children under 28 days of age during a given time period. The denominator of the neonatal mortality rate, like that of the infant mortality rate, is the number of live births reported during the same time period. The neonatal mortality rate is usually expressed per 1,000 live births. <https://www.cdc.gov/ophs/csels/dsepd/ss1978/lesson3/section3.html>

⁴⁷ Preliminary estimate from WHO.

⁴⁸ NIPHK (2017): Epidemiological Situation Report for HIV / AIDS / STI.

and there were no cases of deaths.⁴⁹ Nevertheless, there is relatively high prevalence of risk behaviour in key populations: 67 percent of female sex workers reported not always using condom with the client last month, and nearly two-third of men who have sex with men reported to not always using condoms in the past 12 months.⁵⁰ According to the MICS results, more than one-third of young women and two-thirds of young men used no condom during last sexual intercourse with non-marital, non-cohabiting partners in last 12 months, while only 17 per cent of them correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission (MICS 2015). Furthermore, according to the study “Health Behaviour in School-Age Children⁵¹ about 13 percent of the students aged 11-15 had their first sexual intercourse and 26.5 per cent of them have not used protection. Although Demographic Health Survey Data from 2009 and MICS survey data from 2013 are not entirely comparable due to changes in methodology, as a common pattern, there has been no substantive improvement in the rate for modern contraceptive use, which remains around 14% (and around 19% for Roma, Ashkali and Egyptians) according to MICS results.⁵²

Table 3: Method of contraception (%)

No	Description	Overall (%)	Roma, Ashkali and Egyptians (%)
1.	Modern methods	13.7	19.4
	a. Female sterilisation	0.6	3.9
	b. Male sterilisation	0.1	0.0
	c. IUD	4.6	2.5
	d. Injectables	0.2	0.9
	e. Implants	0.0	0.0
	f. Pill	2.7	3.2
	g. Male condom	5.3	8.5
	h. Female condom	0.0	0.0
	i. Diaphragm/Foam/Jelly	0.0	0.0
	j. LAM	0.2	0.4
2.	Traditional methods	52.1	33.3
	k. Periodic abstinence	0.1	0.0
	l. Withdrawal	51.3	32.3
	m. Other	0.6	1.0
	Any method	65.8	52.7
	No method	34.2	47.3

Source: KAS & UNICEF (2015): *Multiple Indicator Cluster Survey (MICS), 2013-2014 and for Roma, Ashkali and Egyptian Communities in Kosovo: Key Findings.*

There are no reliable figures on the number of unwanted pregnancies and intended terminations of pregnancies, since a large number of abortions are actually not registered. Following the 2009 law on the termination of pregnancy, induced abortion remains legal in Kosovo up to 10 weeks after conception. It is allowed beyond this limit, only after the approval of a medical committee, for health reasons or in relation

⁴⁹ MoH (2017) National HIV/AIDS Strategic Action Plan Kosovo 2018-2022 and NIPHK (2017): Epidemiological Situation Report for HIV / AIDS / STI.

⁵⁰ UNFPA (2016): Kosovo Programming Document.

⁵¹ WHO & UNFPA Offices in Pristina (2014): Health Behaviour in School-Age Children in Kosovo: A WHO Collaborative Study.

⁵² KAS & UNICEF (2015): Multiple Indicator Cluster Survey (MICS), 2013-2014; Monitoring the Situation of Children and Women. Summary Report

to crime, rape, incest, etc. Yet, it is generally admitted that many abortions take place beyond the ten-week period. Similarly, the law does not allow for sex-selective abortions. According to the Gender Bias Report, abortion is common in private health clinics and these clinics tend to under-report these abortions in order to avoid taxation and/or inspection while abortion may in fact be an important source of income.⁵³ In terms of statistics, according to MICS 2013/14 results, 7.5 percent of women age 15-49 years in Kosovo have had at least one induced abortion and almost one fifth (17 percent) of the 45-49 age group. Among women who had an abortion, 71 percent had one abortion while 25 percent had two or three abortions, and four percent had four or more. The percentage of women with at least one induced abortion increases by age, lower education level and by poverty level and it is higher in rural areas than in urban areas.⁵⁴ The MICS has also estimated the adolescent birth rate⁵⁵ for women age 15-19 years (15‰ for the overall population and 69‰ for marginalized Roma, Ashkali and Egyptian (RAE) women and unmet need for contraception (8.9% defined as percentage of women of the 15-49 age group who are currently married or in union who are fecund and want to space their births or limit the number of children they have and who are not currently using contraception; for RAE women it is 18.1%).⁵⁶

Population Dynamics

Kosovo has more reliable data on population now than when the first population census activity was conducted after the conflict. Based on population data, as of 2011 there were about 1.8 million residents living in Kosovo, excluding the north of Kosovo, which refused to be part of the census.⁵⁷ Kosovo's population is relatively young. The average age of the population (April 2011) is equal to 30.2. Young women and men under 25 years old make up 47.3% of the population. Of these, 28 percent of the population is younger than 15 and 19.3% are aged between 15 and 24 years⁵⁸, comprising about 30% of the working-age population. Today, only 8% of the population of Kosovo are elderly (above age 65), compared to 19% in the EU (including all 28 countries) and 22% in Italy. This youthful age distribution will inevitably lead to further growth in the population and the labour force.⁵⁹ This structure of population enables the proportion of people of working age to be considerably higher than the proportion of people in non-productive age. Although this offers a big potential for development and a large demographic dividend, at the moment, Kosovo is not utilizing this potential due to the low level of labour market utilisation rates (low level of employment rate and high level of unemployment and inactivity rate). The failure to provide the youthful population with economic opportunities has increased the risks of outward migration and brain drain. Since autumn 2014 until spring 2015, outward migration pressures increased considerably. KAS estimates that in 2015 around 75,000 of Kosovo inhabitants (or about 4.2% of total population) left Kosovo.⁶⁰

The sex ratio at birth is close to 110 male births per 100 female births. This is a level lower than those observed in Asia or in the South Caucasus, which have highest sex ratios skewed towards males, but it is equivalent to an average deficit of 5% of female births compared to EU countries.⁶¹ This is due to gender-

⁵³ UNFPA & Kosovo Agency of Statistics (2016): Gender Bias in Kosovo.

⁵⁴ Kosovo Agency of Statistics (2015): Multiple Indicator Cluster Survey 2013-2014.

⁵⁵ Also referred to as the age-specific fertility rate, which is defined as the number of live births to women in a specific age group during a specified period divided by the average number of women in that age group during the same period, expressed per 1,000 women (MICS 2013).

⁵⁶ UNICEF (2015): Roma, Ashkali and Egyptian Communities in Kosovo Multiple Indicator Cluster Survey 2013-2014. Key Findings, page 8.

⁵⁷ However, the population of the north of Kosovo was estimated to be 40,196 individuals, or 2.3% of Kosovo population.

⁵⁸ KAS, Kosovo Population and Housing Census 2011.

⁵⁹ It is estimated that in the next five years, approximately 150,000 youth will reach their working age, while 80,000 people will retire at the same time. Five years ago, these numbers were 200,000 and 50,000 respectively.

⁶⁰ KAS, Assessment of the Kosovo Population for 2015.

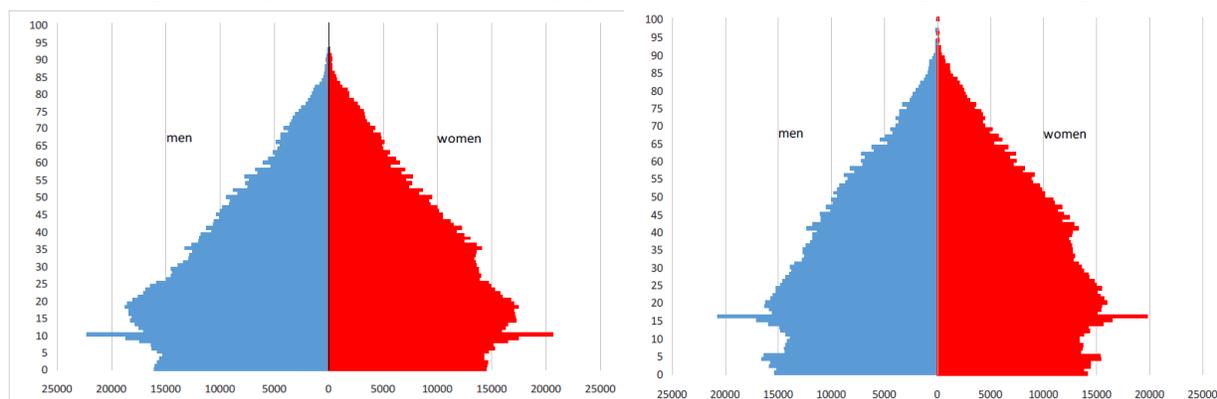
⁶¹ UNFPA & Kosovo Agency of Statistics (2016): Gender Bias in Kosovo.

biased sex selection. Smaller families and lower fertility rates, the availability of (illegal) sex-selective abortions and the family system which is strongly biased in favour of sons has contributed to such a result.⁶²

Kosovo is in the phase of a demographic transition, where birth rates are declining but still are much higher than the death rates, contributing positively to an increase of population. The fertility rate, which was 5 children per women in 1982, decreased to 2.1 children per women in 2011. During this demographic transition process, further declines in fertility rates and significant changes in the age structure of the population are expected. According to the Kosovo Population Project Report produced by the Kosovo Agency of Statistics, the fertility rate is expected to continue to decline to 1.7 children per women in 2031 and 1.5 children per women in 2061, a level comparable to the current fertility rate in the European Union.

The graphs below provide the population pyramids on January 1st, 2011 and January 1st, 2017, for population estimations by age and gender according to the Population Project report. Based on these graphs, the large generation which was born in 2000, moves up in the pyramid over time. Also, the age groups of the population between 20 and 30 are significantly reduced between 2011 and 2017 due to the large emigration flows in 2015 and 2016 in particular. Table 4 on the other hand, captures the projected trends in age distribution for the next 50 years. While the youngest age group, age 0-14 years old is projected to decrease from almost 28% to 12% of the total population, the oldest age group, age 65+, may increase more than fourfold (from 7% to 29% of the population).

Figure 2: Pyramids of the Kosovo population 2011 and 2017 by gender and age.



Source: Kosovo Agency of Statistics, Kosovo Population Projection 2017 -2061

Table 4: Population by age-group breakdown, in percentage

Years	Population by age, in %		
	0-14	15-64	65 +
2011	27.8	65.3	6.9
2061	12.4	58.6	29

Source: Kosovo Agency of Statistics, Kosovo Population Projection 2011 -2061

⁶² UNFPA & Kosovo Agency of Statistics (2016): Gender Bias in Kosovo.

Chapter 3. UN KOSOVO TEAM (UNKT) AND UNFPA STRATEGIC RESPONSE

3.1 UN Kosovo Team's Programming

The UN agencies, funds, and programmes, which operate in Kosovo, and comprise the UN Kosovo Team (UNKT), laid out their assistance framework for both government and civil society through the UN Common Development Plan (CDP) (an UNDAF-like planning document). The second UNKT CDP for the period 2016-2020 harmonized UN Agencies and programme interventions around three strategic themes: (i) Governance and Rule of Law, (ii) Social Inclusion and (iii) Environment and Health, aiming to contribute to the achievement of nine (9) development outcomes.

The UNFPA has been directly contributing to the achievement of three (3) UNKT CDP outcomes: two on duty bearers⁶³ and one on right holders⁶⁴ by covering all programmatic activities. The UNFPA programmatic activities on MCH, CCSP and SRH contribute directly to the CDP outcome 3.2 which is about improving coverage of quality and equitable essential health care services for Maternal, Neonatal, Child and Reproductive Health (MNCRH) and Non-Communicable Diseases (NCD). On the other hand, all of the UNFPA's interventions that support community and formal education based comprehensive sexuality education contribute to achievement of the last CDP outcome which is about right holders aimed to support changes in people's behaviours through adoption of more healthy behaviours, including on SRHR (outcome 3.3.). The programmatic activities on population dynamics, is linked to the duty bearer outcome which is related to the application of evidence from population data by institutions to their policy making decisions (outcome 1.3.1).

3.2 UNFPA Strategic response

The UNFPA's existing programme is organized around three outcomes that cover the following areas of UNFPA's mandate: (i) **Sexual and reproductive health:** programmes which aim to support Kosovo's efforts to deliver integrated sexual and reproductive health services with a special focus on youth and vulnerable groups; (ii) **Adolescents and youth:** which is dedicated to improve national capacity to design and implement community and school based comprehensive sexuality education programmes that promote human rights and gender equality; and (iii) **Population dynamics:** which is directed to strengthen institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on population dynamics, sexual and reproductive health, HIV and their links to sustainable development.

In addition to direct affiliation with the UNKT's CDP (an UNDAF- like planning document as explained above), the current UNFPA programme is fully aligned with national priorities, the UNFPA Strategic Plan 2018 – 2021 and with the Sustainable Development Goals (especially with the SDG 3 and 5).⁶⁵ UNFPA programmatic activities directly contribute to achievement of strategic and specific objectives of the

⁶³ Duty bearers are those actors who have a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations.

⁶⁴ Rights-holders are individuals or social groups that have particular entitlements in relation to specific duty-bearers.

⁶⁵ According to the Rapid Integrated Assessment conducted by UN Development Coordination Office in Kosovo, out of 13 SDG targets within SDG3, 5 are fully aligned, 5 partially aligned, 1 not aligned and 2 not relevant to the Sectoral Strategy on Health, although MoH has not explicitly referred to these SDG targets and indicators. Nevertheless, since the Sectoral Strategy on Health was requested to be revised by the new Cabinet of the MoH, no information is available about the status of intervention and results foreseen by the Strategy including on SDG targets and indicators that are linked to this Strategy.

Sectoral Strategy for Health covering the period of 2017-2021.⁶⁶ The UNFPA programme is linked to the following specific objectives of the Sectoral Strategy for Health:

- (i) The SRH component is linked to the Specific Objective 1.2 of the Sectoral Strategy on *mother and child health* which aims to improve perinatal and mortality rates;
- (ii) The Adolescent and youth component is directly linked to the Specific Objective 1.1. on the *Promotion of healthy lifestyle* which aims to educate lower and upper secondary students on health and healthy lifestyles;
- (iii) Certain sub-components of SRH, such as the cervical cancer screening programme and the provision of contraceptives, are linked to the specific objective 3.7 on the *Delivery of health services*, aiming to improve Screening Programmes for breast, cervical cancer and supply of essential medical products to health institutions including products related to SRH.

UNFPA interventions are also fully in line with the draft Strategic Plan for Mother and Child Health and Reproductive Health, covering the period of 2018 – 2021.⁶⁷ UNFPA interventions are in line with Strategic Objective 1 (Preserving and Promoting Mother, Child and Reproductive Health) and all four specific objectives (Promote policies and standards in maternal, child health and reproductive health; Continuous improvement of the quality of health services for mother, child and reproductive health at all levels of health care; Strengthening family medicine related to mother, child, and reproductive health and Awareness of the population in the field of maternal, child health and reproductive health).

All UNFPA Kosovo interventions are also aligned and contribute to the achievement of all four UNFPA (global) Strategic Plan outcomes.⁶⁸ The Sexual and Reproductive Health component of the UNFPA Kosovo interventions contributes to the achievement of UNFPA global Outcome (1) Every woman, adolescent and youth everywhere, especially those furthest behind, has utilised integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence. The Adolescents and Youth component of UNFPA Kosovo interventions contributes to the achievement of global Outcome (2) Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts. Certain interventions under Sexual and Reproductive Health and Adolescents and Youth components contribute to the achievement of global Outcome (3) Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings. UNFPA Kosovo's Population Dynamics interventions contribute to the achievement of global outcome (4) Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.

Most recently, the UNFPA Office in Kosovo has directed their interventions to support three main target groups: 1) women, 2) adolescents and youth and 3) minority communities, especially Kosovo Serbs. These groups are more negatively affected by poverty and the under development of certain outcomes (see the above situation analysis for details). The UNFPA Office in Kosovo continuously supports women through its work on Mother, Child and Reproductive Health (MCRH) as well as GBV. Youth is one of the main groups targeted through sexual and reproductive health education and awareness raising campaigns. UNFPA has not only strongly supported youth organisations through technical assistance in the field of peer education, but also in promoting their participation in the development of the Strategy for Youth and

⁶⁶ MoH (2016): Sectoral Strategy for Health, 2017-2021

⁶⁷ MoH (2019): Strategic Plan for Mother and Child Health and Reproductive Health, Draft Plan for the period 2018-2021

⁶⁸ UNFPA (2017): UNFPA Strategic Plan, 2018-2021 and Annex 1. Integrated Results and Resources Framework

its action plan.⁶⁹ Both the component of MCRH and SRHR education and awareness raising campaigns were successfully expanded in the northern municipalities and other municipalities where Kosovo Serbs make up the majority of population.

3.3 Coordination with UNKT

According to the Development Cooperation Office, the UNFPA is one of the most active UN Agencies dealing with the coordination of efforts within UN Agencies. UNFPA is deputy chair of the result group mandated to coordinate UN Agencies' effort under strategic theme number three (3), which is about environment and health. UNFPA actively contributes to organising regular planning, exchange and reporting meetings. Through these result group meetings, UNFPA coordinates closely with WHO on MCH and UNICEF in MCH and in data gathering for organizing MICS seeking synergies and contribute to ensuring programme complementarity and avoid overlaps. UNFPA is a member of the cross-cutting gender group which aims to coordinate actions on gender equality and support gender mainstreaming in joint programming. UNFPA is part of the Security and Gender Coordination Group, which is composed of public institutions (police, government agencies), women's organisations, European Union Special Representative (EUSR), European Union Rule of Law Mission in Kosovo (EULEX), Organization for Security and Cooperation in Europe (OSCE), NATO Mission in Kosovo (KFOR) and UN agencies and coordinates efforts to promote gender equality in Kosovo.

UNFPA is also one of the Agencies which has benefited the most from the joint programming, which emerged through coordination with UNKT. UNFPA is a part of almost every joint programme developed and implemented in Kosovo through various UN Agencies, Funds, and Programmes. This was UNFPA also ensures programme complementarity. For example, a joint project on Justice 2020 and GBV (Support in Addressing Gender Based Violence Project), which is being implemented by UNFPA, UNICEF, UN Women, OHCHR, and UNDP, has allowed the UN Agencies that have different mandates to approach the issue from a different perspective. This applies a more comprehensive approach in order to tackle GBV in Kosovo, when compared to the stand-alone UN Agency projects. This Joint Project (JP) has allowed the implementation of stronger joint advocacy efforts.

⁶⁹ Ministry of Culture, Youth and Sport (2013): Youth Strategy 2013-2017 and Action Plan 2013-2015.

Chapter 4. Findings: answers to the evaluation questions

4.1 Sexual and Reproductive Health and Rights

4.1.1 Maternal and Child Health

Due to relatively high perinatal, neonatal and maternal mortality rates, UNFPA in Kosovo, together with WHO, has continued to implement activities on improving maternal and child health. These activities have contributed towards strengthening integrated maternal, child health services through a series of interventions, including advocacy, capacity building, policy development, implementation, and monitoring and evaluation of services.

Interventions

Technical support to the Mother, Child and Reproductive Health Division in the MoH

The UNFPA Kosovo office has provided continuous and comprehensive support to the Mother, Child and Reproductive Health (MCRH) Division in MoH, in policy making, legal framework drafting and monitoring of the delivery of mother and child health services.

With regards to policy making, the UNFPA supported the MCRH division to develop a strategic plan for MCRH, to include MCRH components into the new Sectoral Strategy for Health and contributed to the development of many other strategies, including the HIV Strategy 2014-2019, and the Reproductive Health Commodity Security Strategy etc. On the legal frameworks, the UNFPA supported MoH in preparing the Concept document on Reproductive Health Law, drafting several administrative instructions, such as those for clinical guidelines and protocols, and methods and modern tools for family planning. After approval of the concept document, UNFPA now is supporting the working group in charge for revising the law on reproductive health.

Technical support was also provided by UNFPA to the MCRH Division to collect perinatal data annually, and to analyse and produce the annual Perinatal Situation Report. Being the only report on this field, in absence of a Health Information System, the report has been the best reference for all stakeholders working on the MCRH field, despite some limitations in data gathering.

During 2014, the MoH was supported by UNFPA to establish line services for mother and new-born health, as a pioneering approach to improve links and coordination of the health services at all levels for mother and new-born health. Expecting the introduction of the health insurance fund, UNFPA advocated actively with the MoH to ensure the provision of essential maternal care services free of charge.

Support to National Committee on Maternal Mortality Audit (NCMMA)

Following the introduction of the WHO Maternal Mortality Audit approach "Beyond the Numbers" as an effective and reliable tool for quality improvements of maternal health, the UNFPA supported stakeholders to discuss the concepts of maternal mortality audits and confidential near-miss case reviews (CNMCR) and possibilities of their implementation in Kosovo. In 2016, with the support and guidance from UNFPA and WHO Kosovo, the MoH appointed the National Committee on Maternal Mortality Audit (NCMMA), tasked to start with CNMCR at an institutional level and with maternal death audits on a biannual basis. In 2018, a concept and methodology for establishing a National Obstetric Surveillance and Response System (OSRS) for Countries in Western Balkans was developed, including a draft architecture and administrative

arrangements for organizing the OSRS and the logical structure of the electronic reporting application for the OSRS. This initiative is in line with the 2030 Agenda and UNFPA's vision and work with the Government focused on the transformative and people-centred result of ending preventable maternal deaths. The OSRS identifies near-miss cases through routine electronic reporting sent by nominated reporting clinical staff (obstetricians, anesthetists, midwives) in each participating hospital. Participation in the OSRS is undertaken as part of hospitals' commitment to ongoing improvement in quality evidence-based care. The types of near-miss cases investigated through the OSRS are decided at the national level according to the key questions and challenges identified from the maternity services in country and may change over time. The development and implementation of this system is complementary to the WHO Beyond the Numbers (BTN) initiative.⁷⁰

Clinical Guidelines and Protocols (CGP) development

The UNFPA initially supported the MoH to revise the Administrative Instruction (AI) for CGP development which was initially promulgated in 2010. For this purpose, the UNFPA organized a training on CGP development, adaptation and approval for local experts and members of working groups. These groups were engaged in revising the AI for CGP development and drafting a new version that offered a better description of the overall process from initiation of the specific CGP to its approval by the AGREE instrument.⁷¹

Furthermore, the UNFPA provided continuous support for building local capacity towards establishing a sustainable CGP process, by organising various local and international trainings. For this purpose, according to information obtained during an in-depth interview with the Kosovo Council on Clinical Guidelines and Protocols (KCCG), about 127 (about 55% women) different health care providers were trained on the methodology of CGP development including CGP on SRH. These training courses were evaluated very highly by local participants and strongly recommended to their colleagues. Furthermore, with UNFPA support and guidance, the MoH adapted a training package on the CGP development process to be used for all services and accredited the training programme as a part of continuous professional development programme in Kosovo. Finally, the UNFPA supported the development and adaptation of a limited number (five) of CGPs in the area of MCRH.

Effective Perinatal Care (EPC)

Due to the high maternal and neonatal mortality rates in Kosovo, since 1999 UNFPA, WHO and other international organisations were focused on helping local health institutions in improving the quality of healthcare services with emphasis on perinatal health care services. More recently, the UNFPA and WHO, in partnership with MoH, introduced a two-week training on EPC which was developed by WHO Europe. Initially the Training of Trainers was organised under the facilitation of three international EPC facilitators and was delivered to certified local EPC facilitators (about 14). Subsequently, the training on EPC was launched in 2013, by initially training more than 95 percent of the staff at the Gynaecology and Obstetrics ward in Prizren General Hospital (obstetricians, midwives, anaesthesiologists, neonatologists, paediatricians and neonatology nurses) and continued until 2018 covering all regions with nearly 100% of staff trained.⁷² Trainings were organised by the EPC Coordination Group, consisted of local certified trainers. A completely new approach employed by this training course was the team work of all

⁷⁰ Mihai Horga, Meeting report on Sub-regional Workshop on the National Obstetric Surveillance and Response System (OSRS) for Countries/Territories in Western Balkans, Bucharest, Romania, 28-29 November 2018.

⁷¹ The Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument was developed to address the issue of variability in guideline quality. To that end, the AGREE instrument is a tool that assesses the methodological rigour and transparency in which a guideline is developed.

⁷² While around 80% of the staff in the ObG Clinic of UCKK was trained during this period.

professionals involved in the provision of perinatal care; this was considered as vital to improve the overall quality of perinatal health care services. In order to support the application and the implementation of the knowledge and skills presented by the EPC course, four weeks after each training, about 3-5 certified facilitators/assessors usually conducted follow-up visits in the institution where the trainees are employed. Thus, every year about 4-7 follow-up visits were organised, for which assessors produced the quality assessment reports and handed them over to MoH. In addition, the UNFPA advocated actively on strengthening the role of midwives in overall perinatal care, especially during delivery. In this regard the UNFPA office provided active support to young midwives and the establishment of the Kosovo Midwifery Association.

Minimum Initial Service Package (MISP)

The UNFPA has assisted the adoption and integration of the MISP through various activities. UNFPA initially supported the Kosovo Red Cross in organising ToTs and delivering training on MISP to PHC personnel. During 2013- 2017, around 370 healthcare providers were trained (about 78% women) on this programme.⁷³ The training has been accredited and became part of the CDP programme for family physicians and nurses. In parallel, the UNFPA assisted the integration of MISP into local and central level emergency action plans. At the central level, the UNFPA supported the development of the MISP Annual Work Plan to become part of the Emergency Public Health Action Plan, which is also part of the National Contingency Plan of Emergency Preparedness and Response. The Emergency Public Health Action Plan is still under development, whereby MISP facilitators are members of the working group for drafting this plan. Similar to central level efforts, since 2016, the UNFPA, in cooperation with Red Cross Kosovo and in partnership with MoH, the municipal health authorities and the PHC management, supported the introduction, adaptation and integration of the MISP in the health components of the local Emergency Preparedness and Response Plans in six municipalities.

Creation of a coalition of NGOs (K10)

In order to strengthen the joint work and advocacy efforts of NGOs for improving public policies and service delivery on MCH and SRHR, in 2016 UNFPA facilitated the creation/establishment of the coalition of NGOs – K10. The mission of the K10 coalition is to support the involvement of civil society organisations in advocacy and policy dialogue and policy development regarding reproductive health and reproductive rights. The UNFPA has supported the establishment as well as the institutional development of the K10.

Relevance⁷⁴

The perinatal and neonatal mortality rates in Kosovo remain high. Although the decrease of the perinatal mortality rate is significant, from 29.1‰ in 2000 to 12.13‰ in 2015 (MoH, 2015), it is still higher than in most countries in the region.⁷⁵ The same can be said for the foetal mortality rate and the early neonatal mortality rates. Thus, there is high relevance of the interventions presented above. The interventions presented above were designed to offer comprehensive support to MCH focusing on improvements in policies, service delivery such as those produced by EPC training and the introduction of evidence-based

⁷³ UNFPA Kosovo, Training Database.

⁷⁴ Since relevance of UNFPA programming to national, UNKT and global UNFPA policies and strategies have been already covered in section 2.2, the relevance sections for each component will review the extent to which the interventions of the UNFPA office in Kosovo comply with and are responsive to the needs and priorities of the final beneficiaries.

⁷⁵ Albania 20‰; Bosnia and Herzegovina 20‰; Serbia and Montenegro 13‰; Croatia 9‰ in 2000 – (WHO. Neonatal and perinatal mortality: country, regional and global estimates.)

CGP and in monitoring frameworks such as CNMCR and Maternal Mortality Audit/OSRS programmes that were and still remain very important given the development stage of the health system. On the other hand, UNFPA's interventions related to MISAP are highly relevant in the context of emergency preparedness which has been implemented for the first time in Kosovo.

Effectiveness

Outputs

Strengthen capacity on MCRH Division

With capacity building efforts supported by UNFPA, the MoH successfully developed the first Strategy for mother, child, adolescent and reproductive health covering 2011 -2015, the HIV Strategy, the 2014-2019 Reproductive Health Commodity Security Strategy (RHCS), and incorporated the MCRH into the 2017-2021 Health Sectoral Strategy and the SRR into the Youth Development Strategy. Similarly, in relation to the legal framework, the MoH prepared the concept document on reproductive health law as well as drafted and approved administrative instructions, such as those for clinical guidelines and protocols (AI No. 8/2015) and on methods and modern tools on Family Planning (AI 07/2013). Despite the development of these strategies, there is limited information about their implementation due to weak monitoring and reporting capacities and limited inter-ministerial cooperation mechanisms. The Mother, Child and Reproductive Health Division (MCRHD) within MoH is still entirely based on the work of one person, who, despite her commitment and professionalism, cannot cover all aspects of this wide and important field of health care. In terms of monitoring the key indicators of the MCH, the MCRHD successfully continued to produce the Perinatal Situation Report on yearly basis, providing very important quality and performance indicators in the field of perinatal care. During recent years, data quality and coverage have improved, including data from private institutions and sometimes even data from Serb majority municipalities. Recently, however, as per the MoH Minister's decision, the responsibility to produce this report has been transferred to the National Institute of Public Health (NIPH). This transfer may have bearing on the future effectiveness of this reporting.

Increase capacities of NCMMA to implement Maternal Mortality Audits/OSRS and CNMCR

Despite its establishment and creation of adequate capacities, the NCMMA has not been able to conduct any CNMCR or maternal mortality audits, although a decision was made to start with near miss case reviews at hospital level: one at tertiary level and one at the secondary level of care in Prizren general hospital. There seems to be some reservation to undertake such reviews due to potential consequences of these reviews, but also due to the absence of a legislative basis that would regulate the auditing process, ensuring professionalism and the confidentiality. As per the new OSRS guidance documents, the initiative will be updated and implemented at hospital level. When a participating hospital reports a near-miss case, it then reports through the same electronic system anonymous information on the woman's demographic and clinical characteristics, risk factors, and management according to the relevant protocols and outcomes. The information reported is based on standardized reporting forms agreed at national level.

Clinical guidelines and protocols developed

The CGP development/adaptation process was institutionalized during 2017. Under the guidance and with the support of UNFPA, trained local experts in 2016 have adapted three clinical guidelines for major causes of maternal mortality/morbidity in Kosovo (postpartum haemorrhage, eclampsia and preeclampsia, and cervical cancer screening), and a clinical guideline on Prevention of HIV Transmission from Mother to

Child.⁷⁶ During 2018, an additional eight Clinical Guidelines were developed instead of five planned. In addition, the Kosovo Council on Clinical Guidelines and Protocols (KCCGP) is planning to review the implementation of the first four CGPs published in 2018 after their distribution during the first half of 2019. Nevertheless, since these guidelines are just recently developed and approved it is too early to expect that have been put to routine use by healthcare providers and thus to judge their level of application. There is an agreed plan with MoH to develop protocols at the hospital level, which will derive from the national guidelines.

Increased capacities on Effective Perinatal Care

According to the pre- and post-test results and in-depth interviews, the EPC training and follow up visits have increased considerably the knowledge and skills of staff in Gynaecology and Obstetrics. Furthermore, through UNFPA support, some of the Gynaecology and Obstetrics facilities (OB/GYN Clinic of UCCK and PHC Maternity in Dragash) have been improved with midwifery sets, trolleys and wheelchairs. Moreover, in order to create conditions for continuous capacity building, improved competence and knowledge of current and future health staff, the UNFPA Kosovo jointly with WHO and UNICEF advocated intensively with the Faculty of Medicine of the University of Pristina to incorporate the EPC module within the training curriculum of Midwifery University Education. In addition, they have advocated for EPC to become a compulsory module of the CPD curriculum for the health professionals involved in perinatal and maternal health care services. While the initiative was well accepted by the Midwifery Department, it is still not approved by the Faculty of Medicine.

K10

In 2016, with continuous and comprehensive UNFPA support, the K10 coalition has been established. The coalition is led through a three-year rotation system, starting with the Action for Mother and Children (AMC) as one of the founder organisations. Each of ten-member organisations works within their mandates and in coordination with other members of the coalition in line with the coalition statutes. All relevant documents related to K10 such as statutes, regulations and the action plan were developed and approved within the first year of establishment. The coalition was named as K-10 (where K stands for Coalition and 10 for 10 sexual rights but also, by chance, represents the number of NGOs that currently are members of the Coalition). Acting as an independent advocacy hub and a watchdog of MCH and SRH/R policy, legal framework and service delivery in Kosovo, the K10 coalition was also recognized as a formal advocacy body in the field of SRHR by the Ministry of Health through a Letter of Support obtained by the Ministry.

Outcomes

Effective Perinatal Care

Reports from regular EPC follow-up assessment/visits showed initially encouraging results, especially in the General Hospital in Prizren but also in other maternities, including the ObG Clinic of UCCK. The most indicative positive changes that were found include: less routine episiotomies, decreased rate of unnecessary referrals and labour induction, prophylactic use of antibiotics, active management of the third stage of birth, baby-mother skin to skin contact, rooming in even after caesarean section, early breastfeeding initiation and breastfeeding on demand, improved communication and team work, less cervical and vaginal ruptures, strengthened and more active role of midwives in labour etc.⁷⁷

⁷⁶ These guidelines were selected after intensive discussion with relevant stakeholders and review of the main causes of perinatal mortality and morbidity based on the perinatal situation reports

⁷⁷ Some of the recommendations from EPC that are not implemented or partially implemented are: presence of the women's companion during the labour, epidural anaesthesia, routine use and utilisation of the WHO partograph and task shifting toward

According to interviewed assessors, many of these findings may reflect a ‘Hawthorne effect’ as the staff was aware and informed in advance about assessment visits. Therefore, instead of organising periodic and notified follow-up visits, the EPC National Coordinator proposed the development of regular ad-hoc quality monitoring mechanisms within the MoH, Medical Chamber or Kosovo Obstetric and Gynaecologic Association (KOGA). The overall impression from in-depth interviews with assessors and trainees is that new skills gained from EPC are applied but not in a consistent manner due to the absence of continuous monitoring frameworks.

Advocacy efforts of K10

Although the establishment process of the K10 coalition was challenged by a reservation from some of the smaller NGOs with the pretence that they will lose their autonomy and visibility being under the same umbrella with bigger and more organised NGOs, the UNFPA was able to find a way to motivate them to become part of the coalition and protect their autonomy. This was done by clearly defining and agreeing on a specific mandate under which each NGO will operate. In addition, the K10 coalition was seen as a good platform for joint resource mobilisation and further capacity building of the smaller NGOs.

K10 started its work in 2016 focusing on three different areas: (i) evidence-based advocacy efforts; (ii) awareness raising activities (which is explained under component of non-formal education), and (iii) institutional development. K10 organised many advocacy efforts towards contraceptive security, the inclusion of SRH services under the health insurance scheme, improvement of quality of SRH services, data collection, and patients’ rights. This was achieved by organising meetings with MoH, the assembly commission in charge of health and with municipality assembly members of Pristina and Prizren and advocating for their support.

Beside its continued work towards self-consolidation, during recent years, members of the coalition have worked intensively on increasing capacities of its members on advocacy, resource mobilisation, strategic planning and results-based programming and monitoring and evaluation.

The overall activities of K10 were positively rated by various stakeholders. Many of them attributed K10 activities as being creative, comprehensive, cost-effective, delivered with high competency and commitment. However, based on the in-depth interviews, further advancements are required internally in coordination and in a more equal distribution of the burden between members of the coalition and externally in being more targeted in advocacy efforts in order to reach greater results.

Impact

As it is presented earlier in the report (please see table 1), there are significant improvements in perinatal, neonatal and maternal mortality rates compared to early years of 2000. Although there is lack of evidence to create a clear cause and effect relationship between UNFPA’s interventions and improvements of perinatal, neonatal and maternal mortality rates and attribute such changes to UNFPA’s interventions, it is also difficult to disregard the positive contribution of UNFPA interventions implemented jointly with WHO in the last two decades towards continuous and steady improvements of maternal and perinatal mortality rates in Kosovo.

midwives (Midwives were considered premature for developmental stage of Kosovo health care system and faced unusual resistance by managerial staff).

Efficiency

From the total budget of the UNFPA Kosovo activities, 201,235 USD was the amount dedicated for the MCH component for the last three years cumulatively (on average 82,000 USD annually) or only about 10.5 percent of UNFPA budget for the last three years. This represents a lower allocation compared to SRHR components but higher compared to CCSP and population dynamics. The graph below provides yearly allocation and expenses and yearly proportions of allocation and expenses in relation to the total budget for the MCH component.

Figure 3: MCH Budget allocation and expenses (in USD)

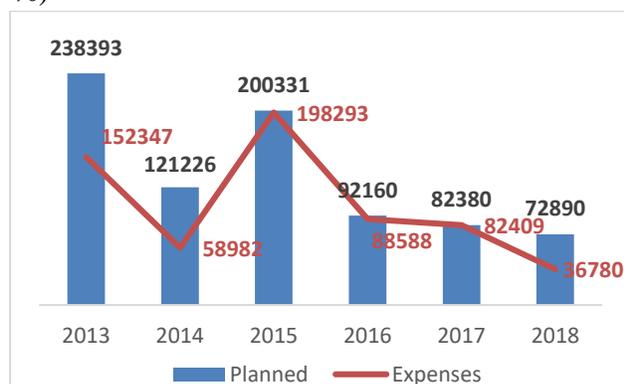
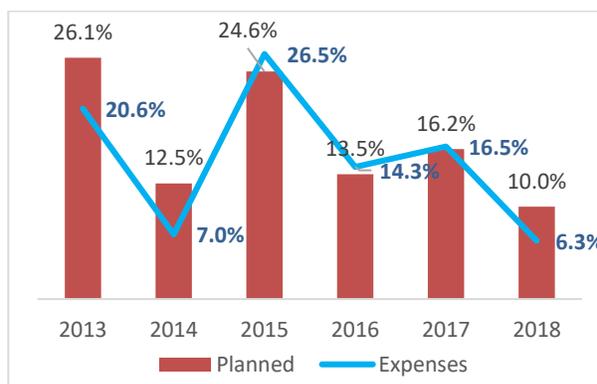


Figure 4: MCH Budget proportions (in %)



Source: UNFPA Annual Work Plans

From the graphs above, it is very clear that the portion of the budget dedicated for the MCH component fluctuated from year to year with a clear reduction in recent years, especially in the last year. Since there is lack of evidence to create a clear cause and effect relationship between UNFPA's interventions and improvements of perinatal, neonatal and maternal mortality rates and attribute such changes to UNFPA's interventions it is impossible to undertake cost effectiveness analysis to gauge the overall efficiency of the interventions. Nevertheless, some qualitative findings can be elaborated here. The utilisation of technical expertise (local and international) and utilisation of tools and products developed by WHO was positively rated, especially for interventions on EPC and the development/adapting of the CGPs. The division of the labour and cooperation with WHO was exemplary. While the know-how products of WHO were used for EPC, the UNFPA contributed heavily in organising ToT and delivering trainings through local trainers on EPC, using their extensive experience about training programmes for health care personnel on FP, STI, HIV, GBV. A similar division of the labour was applied during follow-up visits. The establishment of the K10 promises efficiency gains since it is expected to gain from the leverage effect of joint efforts with the same or even lower budget. Furthermore, certain efficiency gains can be achieved by closely reviewing the achievements of higher-level results (see outcomes discussed above) of different interventions and by reallocating resources towards interventions that produce greater and higher-level results from those that do not produce higher-level results. In this way, it is recommended that UNFPA could lower the number of interventions given the current smaller budget envelope.

Sustainability

Most of the UNFPA interventions have static sustainability.⁷⁸ The capacities created within the MCRH Division, the National Committee on Maternal Audit (NCMA), CGP, MISP, EFP and within K10 coalition will continue to exist even if UNFPA withdraws from these interventions. Nevertheless, not all these interventions have dynamic sustainability. While MCRH Division is fully capable of continuing to produce the Perinatal Situation Report (which is now under the responsibility of NIPH), due to lack of human capacities it would be impossible to cover the policy making, legal framework development and monitoring of the availability and quality of MCH and SRH services within the health sector. The situation is somewhat similar with EPC. Training and monitoring visits on EPC cannot continue without UNFPA support according to the EPC National Coordinator and the Chief of MCRH Division, since UNFPA still plays a major technical and financial role. An almost similar situation prevails with the K10 coalition. Although the coalition is established, it is still at an infant stage and heavily dependent from UNFPA funding. On the other hand, the development of the CGPs have reached dynamic sustainability and, as can be seen from the number of CGPs developed, the CGP development can be continued without any UNFPA support as the MoH has taken over this responsibility entirely.

4.1.2 Cervical Cancer Screening Program (CCSP) Services

Regarding the cervical cancer screening, the UNFPA office has mainly worked on three main directions: (1) increasing public awareness about the importance of national screening programs; (2) improving skills and knowledge of health professionals about the screening process and organisation in pilot municipalities and (3) advocating to policy-makers and relevant stakeholders about the importance and cost-effectiveness of the screening process to expand the coverage of screening.

Interventions

Conduct Needs Assessment on CCSP

Given the absence of cancer screening programmes in Kosovo, the UNFPA supported the preparation of a cancer needs assessment with regards to breast, cervical and prostate cancer screening services. The assessment was drafted in 2014 by an international expert jointly with two members of the National Board of Cancer Control (NBCC) and in a close collaboration with the MoH in Kosovo. The assessment argued that robust data on cancer rates in Kosovo are not available and urged putting in place effective prevention and control measures. Otherwise, the assessment argued, Kosovo's relatively young population will steadily consume an ever-larger proportion of the health care budget for cancer treatment. The assessment also reasoned that doing nothing to effectively address the issue of cancer in Kosovo is neither morally nor economically justified.⁷⁹ Furthermore, the UNFPA Kosovo, being part of the regional initiative to conduct the assessment of capacities for Cervical Cancer prevention in EECA countries, was able to support the development of "Policy Recommendations for the Municipality of Pristina" on implementing Cervical Screening in 2016. Based on the above-mentioned findings and limited budget that Kosovo is facing, international and local experts recommended the initiation of population-based CCSP.

⁷⁸ Static sustainability reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. Dynamic sustainability on the other hand, looks for system changes, i.e. whether functions and services supported by UNFPA and the production of the results will continue to be achieved beyond UNFPA support.

⁷⁹ Dr Davies, P.; Dr. Ahmedi, E.; Berisha, M. (2014) Assessment to Characterise the Current Situation & Capacities for the Prevention & Control of Breast, Cervical & Prostate Cancers in Kosovo".

Launching of the pilot CCSP

The UNFPA supported the launching of the pilot cervical cancer screening programme within the PHC in the municipality of Pristina and in subsequent phase within the Municipality of Prizren. The proper implementation of the CCSP in Pristina Municipality required trained staff, established standard operative procedures and, most importantly, a proper database for recording the data from PAP tests given the absence of an official National Health Information System.

Training: In close coordination with the Pristina Municipality Health Authorities, Management of Main Family Medicine Centre (MFMC) in Pristina, UNFPA, through its implementing partner, Action for Mother and Child (AMC), developed a training package and in 2016 trained seven Family Physicians (100% women) to take PAP smears in three Family Medicine Centres (FMC) in Pristina: Women Wellness Centre in MFMC, FMC 5 and FMC 6. To strengthen and enrich the CCSP in Pristina, the UNFPA has also provided all the support needed to one of the Gynaecologists working in FMC 6 in Pristina to attend and complete an online colposcopy training.

Standard Operating Procedures (SOPs): Quality issues of the PAP test and pathways of the procedure, like the proper technique of taking the PAP smear test and standardized coding, transporting and test readings, were identified as major concerns by the Coordination Group on CCSP during its initial meeting in April 2016. Thus, the UNFPA supported the development of the SOPs for the screening programme in 2017. The SOPs were developed and agreed to through a fruitful cooperation with the Department for Health and Social Welfare in the Municipality of Pristina, the National Board for Cancer Control, the MoH, the Main FMC in Pristina and the Institute of Pathology at the University Clinical Centre of Kosovo.

Database: In the absence of a reliable and operational National Health Information System, and with the aim of supporting and documenting the overall CCSP process, it was necessary to develop a database for recording data from PAP tests readings. The database was developed and maintained by the AMC until 2018. In order to ensure sustainability of the process, in continuous coordination with the MFMC management, this responsibility was transferred to the staff of the Women Wellness Centre (WWC) within the MFMC. For this purpose, the AMC trained the head nurse on how to register, collect and file the PAP test sample forms. Since the beginning of 2018, the head nurse has been registering the forms and maintains regular contact with AMC.

Provide training to pathologists

The Policy Recommendations document on Implementing Cervical Screening in the Municipality of Pristina found that the insufficient number of pathologists competent to read PAP smears and the lack of adequate equipment (microscopes and laboratory materials, etc.) are the main constraints toward completing the process of the pilot cervical cancer screening programme in Pristina.⁸⁰ The UNFPA facilitated several meetings with relevant stakeholders in Kosovo, and obtained a commitment, for the first time, from the Pathology Institute, to be part of the pilot services for CCS in the Municipality of Pristina. UNFPA supported them through providing additional equipment (microscope) and technical training with international expertise. For this purpose, an international expert from Croatia was engaged to train 28 pathologists and technicians from the Institute of Pathology on standardized reading of the PAP test during three consecutive training workshops in 2017. During the training it was agreed that a sample of the already

⁸⁰ European Cervical Cancer Association & UNFPA Kosovo (2016): Implementing Cervical Screening in Pristina, Kosovo. Policy Recommendations for the Municipality of Pristina.

interpreted PAP smears would be sent to the Institute of Pathology in Croatia for review as a quality control measure. In two consecutive reviews of 156 randomly selected samples, the Institute of Pathology in Croatia identified several quality problems in reading the PAP smears.

Support development and implementation of promotional materials on Cervical Cancer Screening

Through AMC, the UNFPA Office in Kosovo supported the MFMC in Pristina to produce several health promoting materials on cervical cancer screening. In this regard, the MFMC, through its Health Promotion Unit and with technical and financial support from AMC, was very active in marking important health days and developing and distributing health promotion leaflets and brochures related to cancer prevention. Furthermore, jointly with the National Institute of Public Health in Kosovo (NIPHK), the professional staff from MFMC organised lectures and interactive presentations for teachers and administrative staff of the schools and banks in the Municipality of Pristina. Promotional materials, such as an instructional video for PAP smear testing to be screened in the MFMC and other FMCs in Pristina, were also developed. In addition, an awareness raising campaign for PAP tests was also developed and aired by the public broadcaster, RTK.

AMC, the main UNFPA implementation partner in this process, has been successful in organising activities to promote health and to provide lectures involving marginalized groups, including the RAE communities on the importance of cervical cancer screening. Increased interest in and requests for these lectures influenced the AMC to duplicate the number of health promotion sessions.

The UNFPA also supported several other initiatives related to sensitization of key stakeholders and awareness raising of the general population on the importance and benefits of screening for genital cancers. Thus, every year since 2015 the UNFPA has supported the Kosovo Association of Gynaecologists and Obstetricians in marking the European Cervical Cancer Prevention Week in January, to raise awareness on the importance of cervical cancer screening. In this regard, different awareness raising activities were implemented, and two specific health promotion brochures, "Cervical cancer screening" and "Follow-up and treatment of an abnormal cervical smear," were printed and distributed through the *Koha Ditore* daily newspaper. Lessons learned during the pilot implementation in the Municipality of Pristina are now transferred and expanded to the Municipality of Prizren with continuous help and support from Pristina MFMC staff. In order to have higher outreach, recently the AMC developed an SMS campaign through messages inviting women for screening. This new approach is being tested in the municipalities of Pristina and Prizren.

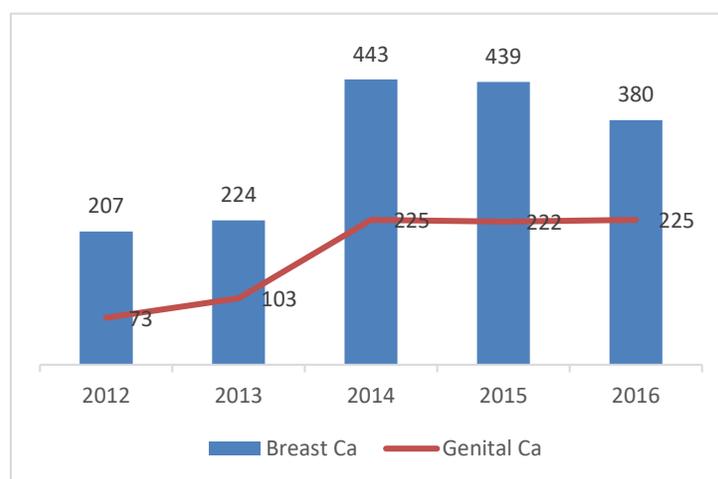
Support the National Board of Cancer Control (NBCC)

The support provided by the UNFPA office in Kosovo for the NBCC during its first years of activity (2011-2012) has continued through technical support to its members to improve their knowledge about the process of cancer screening and networking opportunities with European professional networks in the field. For example, the UNFPA and WHO offices in Kosovo have supported two members of the NBCC to attend the second module of the course at the European Schools of Screening Management (ESSM) in Lyon, France. While this event has been rated very highly by them, unfortunately none of them is still part of the NBCC. NBCC was also supported for the development of a National Cancer Control Programme through the WHO guidelines on National Cancer Control Programme Development.

Relevance

There is general opinion that the number of cases of cancer disease has been increasing since the conflict in Kosovo. Unfortunately, in absence of a reliable and functional National Health Information System, no reliable data on cancer incidence and prevalence can be found. Initiatives were put forward and supported by the UNFPA and WHO offices in Kosovo for the development of an electronic cancer register at the NIPH. Unfortunately, this register is still not functional. Nevertheless, available data from the Kosovo Agency of Statistics (KAS)⁸¹ shows that the number of treated cases from malignant diseases, despite issues of data reliability, is increasing (see Figure 5). According to Globocan⁸², cervical cancer represents 3.2% while breast cancer represents 11.6% of all new cancer cases in the world. In Kosovo, these figures are 9% in 2015 (from 4.6% in 2012) for genital cancer and 17.8% in 2015 (from 13% in 2012) for breast cancer.⁸³ Nevertheless, these trends could simple be the result of a lack of data reliability.

Figure 5: Number of persons treated with malignant diseases between 2012-2016



Source: Kosovo Agency of Statistics: Health Statistics for 2016.

Therefore, not only the absence of a national screening programme but also the high cancer incidence (although with data limitations) makes this pilot screening programme relevant. The relevance of the population based national screening programme is also high, given that developing the understanding of the screening process among policymakers is not easy as they favour immediate results over long-term investments for sustainable results that screening may provide. Furthermore, the poor referral system and low capacities make UNFPA efforts to develop SOPs and improve the reading capacities of the PAP smears very pertinent.

Nonetheless, the relevance of extending CCS process to PHC services and involving the Family Physicians to offer PAP test smears as a routine procedure in their work might be questionable given that there is a widespread belief among women that such services should be provided by gynaecologists (98.5% of women

⁸¹ Kosovo Agency of Statistics (2016) Health Statistics for 2016.

⁸² Globocan. Cancer Fact Sheet. Retrieved from IARC: <http://gco.iarc.fr/today/data/factsheets/cancers/23-Cervix-uteri-fact-sheet.pdf>

⁸³ Knowles, P. (2008). *Female Genital Cancer in Kosovo - a situational analysis of breast and cervical*. Pristina: Commissioned by the United Nations Population Fund.

reported that they prefer to receive antenatal care from gynaecologists)⁸⁴ while gynaecology services will not be part of the services offered by PHCs according to Administrative Instruction No. 08/2017 for PHC.⁸⁵ Thus, extending the CCS to PHC services and involving the Family Physicians in the PAP test smear taking will require extensive efforts to increase awareness among women and change their belief that such services can be given by Family Physicians. Large investments will be required in equipment and facilities of PHC along with capacity building efforts to strengthen Family Physicians' competence to perform such a service.

Effectiveness

Outputs

CCSP launched as a pilot

The UNFPA through its implementing partners produced the following outputs for launching of the CCSP within PHC in the Municipality of Pristina and then in the Municipality of Prizren. The SOPs, which cover the entire process of CCS (from proper technique of PAP smear taking and standardized coding, transporting and test reading) was finalized and approved by the Coordination Group of CCSG. The capacities of a limited number of Family Physicians were raised to take PAP smears in safe way. The database to register, collect and file the PAP test results was developed and handed over to the MFMC WWC during the second year of the implementation. The Chief Nurse in the WWC of MFMC in Pristina was trained and capacitated to collect and enter data on daily basis to the database for CCSP in the Municipality of Pristina. The same practice was then replicated in the Municipality of Prizren. Furthermore, according to in-depth interviews pathologists and technicians in the Institute of Pathology have improved knowledge and skills in the area of PAP smear reading⁸⁶ and reporting in order to improve the quality of the service.

Furthermore, many promotional activities were implemented to increase the awareness of women on regular CCSP, ranging from an instructional video for PAP smear testing to be screened in the Family Medicine Centres to an informative and invitational campaign for PAP tests aired on the public broadcaster, RTK; from development and distribution of leaflets and brochures to organising lectures and interactive presentations on CCSP. Despite these activities, there are no data to measure whether such activities have increased the awareness among targeted women population to conduct regular CCS. However, this does not mean that there is no impact; it simply means that there is no evidence to measure any effect of the awareness raising activities to targeted population. Nevertheless, some micro-evidence that exists from lectures shows quite positive results. According to the feedback obtained from the lectures, the participants provided positive feedback on the quality, organisation and content of the lectures and the lectures have contributed to significant improvement in participants' knowledge on CCSP.

Budget impact analysis on CCSP

By providing a Budget Impact Analysis for two reproductive health interventions in Kosovo (“provision of emergency contraceptive pills” and “national screening program for cervical cancer”), the UNFPA in Kosovo aimed to provide evidence not only on the effectiveness, but also on the efficiency and the

⁸⁴ UNICEF Kosovo. Antenatal care in Kosovo – quality and access. Pristina April 2009.

⁸⁵ MoH (2017): Administrative Instruction No. 08/2017 on Organizing, Structuring and Determining Services and Activities of Primary Health Care Institutions.

⁸⁶ This improvement is documented by Institute of Pathology protocols, such as on "Gynaecological Cytology – Exfoliative cytology and application", "Ovarian cytology - application and clinical significance in ovarian tumors" "Cytological changes in Douglas liquid in Cervical Cancer", and "Screening of pre-cancerous cervical lesions."

affordability of such services in Kosovo for the Ministry of Health to introduce such interventions.⁸⁷ The two interventions analysed in this study were selected due to better availability of data in Kosovo. According to this budget impact analysis, based on the assumption that 20% of women with CIN2-3 progress to carcinoma, a systematic screening programme is expected to avert up to 1,026 cases of cervical cancer and save treatment costs with a net budget impact of 1,124,397 € annually⁸⁸.

Outcomes

The pilot programme on CCS is being implemented in selected PHCs in the Municipalities of Pristina and Prizren according to the SOPs. Since the start of the pilot programme on CCSP in the Municipality of Pristina (July 2016) until the end of 2018, about 5,060 women have used the opportunity to do their PAP test in Primary Health Care institutions of the Municipality of Pristina. In Prizren since August 2018, when the CCSP started up, to mid-December of 2018 about 434 people had their samples taken and about 281 (or 64.7%) were informed with results. In order to expand the service to the entire population in the two targeted municipalities, during 2018, AMC introduced the system of notifying the potential clients through SMS messages after an agreement reached with relevant partners. As a result, about 3,100 SMS invitations were sent to women aged 21-65 in Pristina and about 1,940 in Prizren. Unfortunately, there is no statistic about the response rate to the SMS invitations from potential clients.

Despite these positive achievements, the PAP test smear taking is not being provided by the trained Family Physicians. Due to lack of necessary conditions (proper space for such a sensitive procedure and equipment, especially a gynaecologic examination table) as well as due to the clients' request, the procedure is being offered by gynaecologists within PHCs. Since gynaecology services are not part of the service packages offered by PHC services according to the new AI, such services will not be offered when all gynaecologists will cease to work within the PHCs. The situation is no different in Prizren. The UNFPA and AMC had to advocate strongly for hiring of one gynaecologist in the MFMC in Prizren since the AI 08/2017 does not foresee gynaecology services to be offered by the PHC. It was possible to hire one gynaecologist with a temporary contract, which will be very difficult to continue in the near future.

In relation to reading PAP smears, according to second quality control of samples sent to Zagreb, Croatia, there is some evidence of improvement in PAP test reading and reporting. The number of false positive cases (mainly Atypical Squamous Cells of Undetermined Significance-ASC-US) has decreased according to the staff interviewed for this evaluation report.

The overall duration (from the request for PAP test until the result is obtained) which takes about 6 weeks was considered too long by patients attending focus group discussions and also by health professionals.⁸⁹ In order to accelerate the process, there is a clear need to increase human resources, especially for pathologists in Pathology Institute of the UCK and more importantly in the General Hospital in Prizren

⁸⁷ Voncina, L.; and Haxhikadrja, A. (2016): Budget Impact Analysis for "provision of emergency contraceptive pills" and "national screening program for cervical cancer in Kosovo."

⁸⁸ Despite high cost for initiation of the CCSP in the national level (it is estimated according to the analysis 3.5 million Euros will be incurred for carrying out about 300.000 Pap-tests, and also for performing 50.000 follow-up examinations (colposcopy, biopsy and/or curettage), in return, it can be expected to prevent 1,026 cases of invasive cervical cancer, which would result in expensive treatment and possibly death over a 5 year period. According to this study, overall, due to these cases of cancer avoided, a screening program using Pap-smear testing can be expected to be cost-saving.

⁸⁹ The time needed from the request for a PAP test and the procedure is between 2-4 weeks, while from PAP smear taking until the result is obtained, takes an additional 2-4 weeks in Pristina.

where there is only one pathologist employed. These pathologists cannot cope adequately with the increased workload.

Despite the encouraging results from pilot implementation of the CCSP in Pristina, there is no decision yet from MoH to expand the program at a national scale and dedicate a special budget for CCSP (or any other cancer screening programme).

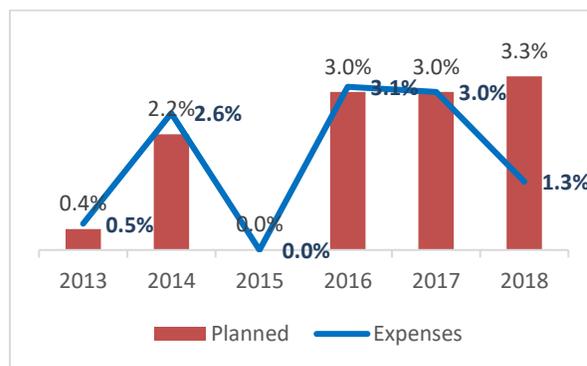
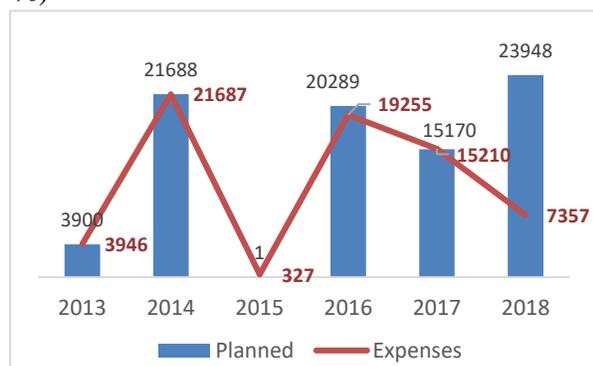
Impact

As the clients with suspicious results were referred into tertiary care, there are no reliable data about their further management. Thus, there are no data available about further treatment and effects of this treatment in saving human lives (i.e. impact level change).

Efficiency

From the entire portfolio of the UNFPA Kosovo activities, the amount dedicated for CCSP was about 59,400 USD or about 3.1 percent of UNFPA budget for the last three years.⁹⁰ The graph below provides yearly allocation and yearly proportions in relation to the total budget for this component.

Figure 6: CCSP Budget allocation and expenses (in USD) **Figure 7: CCSP Budget proportions (in %)**



Source: UNFPA Annual Work Plans

As can be seen from the graphs above, a very small portion of the budget was dedicated for this component of the work by UNFPA, which was also co-financed by municipalities. Nevertheless, implementation of CCSP can be clearly attributed to UNFPA’s interventions (since CCSP is only available in the two municipalities where UNFPA is working and not in other municipalities where it is not working). Thus, we can present some efficiency calculations for CCSP although the data is only available for the level of output (number of people screened) in the healthcare services perspective. Compared to the number of women that were examined through CCSP, it appears that UNFPA spent about 11.7 USD for each woman that took part in the programme. Since there is no information about further management of suspicious cases and effects of the further treatment, the same calculations cannot be computed for impact level (i.e. number of lives saved). Nevertheless, the budget impact analysis conducted by UNFPA also showed the clear efficiency

⁹⁰ 10,700 USD in 2016; 25,000 USD in 2017; and 15,000 USD in 2018.

gains that the health system can earn if the programme is scaled up and implemented at national level.⁹¹ Furthermore, the utilisation and combination of other inputs, such as local and international expertise which was facilitated by the AMC and use of tools and products such as SOPs, were also rated very highly by all the partners of the CCSP, which also contributed to the achievement of these results.

Sustainability

Although PHCs in two municipalities are capacitated to provide CCSP independently from UNFPA support, offering such services still has some issues with static sustainability, since the service delivery is done through a gynaecologist and not by Family Physician, which as a service will not be part of the PHC. Thus, static sustainability of the CCSP in these two municipalities will continue until the gynaecologist will cease to work in PHC according to the AI 08/2017.

Dynamic sustainability of the CCSP on the other hand, which looks at who will provide functions and services supported by UNFPA, is heavily dependent on whether policymakers will continue to support this screening programme and its expansion to cover all over the Kosovo Health Care System. The Budget impact analysis on CCSP is conducted to serve this purpose and to influence the will of the policy makers to continue to support and expand the coverage of CCSP.

4.1.3 Family Planning

Interventions:

Strengthening the capacities of the family medicine team to provide FP, STI, AH and GBV

Since 2008, the UNFPA has funded training activities of primary health care (PHC) personnel about sexual and reproductive health. Initially the training programmes were mainly focused on Family Planning (FP), gradually expanding to the Syndromic Management of Sexually Transmitted Infections (STI), Gender Based Violence (GBV) and then to Adolescent Health (AH). The UNFPA initially supported the development of the syllabus, a handbook for the trainer and trainees with the most up-to-date knowledge, evidence, tools and approaches; developed the Training of Trainers (ToT) program through the Centre for the Development of Family Medicine utilising the family medicine personnel,⁹² and supported the delivery of the training through local trainers across eight training sites for the primary health care staff (mainly family doctors and nurses). The accreditation of the training programmes was an additional motivation for trainees to work on their own capacity and competence development.

Capacity building for better provision of FP services was supported further by the UNFPA through the delivery of the Logistics Management Information System (LMIS) training on contraceptives, and support to primary health care providers with educative materials on family planning. Finally, a considerable amount of reproductive health commodities was donated to primary health care institutions during 2010-2014, since UNFPA was the main contraceptive donor to the MoH.

⁹¹ According to Budget Impact Analysis, based on the assumption that 20% of women with CIN2-3 progress to carcinoma, a systematic screening programme is expected to avert up to 1,026 cases of cervical cancer and save treatment costs with a net budget impact of € 1,124,397 annually.

⁹² Trainers were selected from the group of Family Medicine Trainers that showed enthusiasm and dedication to the programme. These attributes of the future trainers were most important factors that influenced the training delivery and capacity building of the PHC providers. Local trainers were also used to adapt the training material and to upgrade the training syllabus based on their own experience.

More recently, given the lack of experience of medical staff in dealing with adolescent health problems, the UNFPA, jointly with WHO, advocated for the establishment of youth friendly health services (YFHS). For this purpose, the UNFPA and WHO Kosovo offices initiated the creation of the National Coordination Group on developing and implementing Youth/Adolescent Friendly Health Services in Kosovo. The group was endorsed by the General Secretary of the MoH and initially conducted a pilot assessment of the healthcare providers' knowledge, attitudes and practices on adolescent health problems. Based on the results of the assessment, the group decided to organise a series of trainings on the WHO Orientation Program on Adolescent Health for Healthcare Providers (family physicians and nurses, psychologists and gynaecologists) initially in three municipalities (Pristina, Obiliq and Fushë Kosova), then in an additional four municipalities (Drenas, Lipjan, Gjilan and Gjakova). Altogether about 170 health personnel (about 87% women) were trained on Youth/Adolescent Friendly Health Services.⁹³

Training on GBV (GBV identification and managing of survivors) has been delivered for around 100 PHC workers (about 72% women) from eight municipalities. The training in 2017 was expanded successfully into the northern municipalities of Kosovo, whereby about 200 PHC personnel were trained.

All training programmes for PHC personnel were classroom based and delivered mainly by local trainers that went through a ToT programme. The trainings were conducted over a period of two-to-three days (70% was dedicated to theoretical and 30% to practical training).

The training programme on FP has reached a significant level of coverage, particularly given that the programme commenced almost a decade ago. According to the UNFPA Annual Reports and the internal training database, more than 700 PHC healthcare personnel (about 68% women) were trained on the provision of integrated SRH services for Family Planning and STI syndromic management. Compared to FP, the UNFPA expanded its training programme on GBV and AH relatively recently; thus, the coverage is much lower compared to FP.

Advocacy efforts with the MoH in establishing a budget line for contraceptives

Despite continuous investments on promoting the LMIS and continuous provision of modern contraceptive methods for free, the MoH often was unable to monitor contraceptive distribution due to a poor LMIS, which caused contraceptive stockouts, hindering client satisfaction with FP services. Therefore, UNFPA together with K10 supported stronger evidence-based advocacy efforts towards a higher level of responsibility of policymakers and relevant stakeholders on the provision of contraceptives. For this reason, in 2016, the UNFPA initiated a budget impact analysis for the “provision of emergency contraceptive pills” which were then used for advocacy efforts.

Support to the Ombudsman Institution in Kosovo (OiK) to conduct an assessment on reproductive and sexual rights in Kosovo

Reproductive and sexual rights being among the fundamental human rights, the UNFPA office in Kosovo has built a close cooperation with the Ombudsman institution, responsible for overseeing human rights' fulfilment based on the rights granted by the Constitution of Kosovo. The mutual cooperation between UNFPA and OiK has started in 2015 and materialized in 2016 with the first National Assessment of the

⁹³ Given this work, UNFPA also provided significant support to organising of the 20th European IAAH (International Association of Adolescent Health) Congress, held for the first time in Kosovo on 2016. Apart from financial support for the Congress, the UNFPA organised the “Youth and comprehensive sexuality education (CSE) – impact of CSE on youth empowerment” workshop that was very much acknowledged by participants.

Reproductive and Sexual Rights in Kosovo. As this was the first assessment of this kind that will serve as baseline and further reference for all other assessments in this field, the UNFPA assisted OiK with international expertise for the accomplishment of this task.

Relevance:

SRHR remains central within the UNFPA work in Kosovo. Given the low reliance on modern contraceptive use as per MICS Survey and relatively high prevalence of risk behaviours in the general population and youth (explained above in detail in section 1.2), the proposed interventions related to this area of work can also be considered as very relevant to final beneficiaries. Furthermore, the low availability and utilisation of good quality, human rights-based and integrated SRH, makes the UNFPA work pertinent, especially with Primary Health Care staff as an entry point into the Health Care System for the provision of such services. In the same perspective, the National Assessment of the Reproductive and Sexual Rights in Kosovo can be considered very relevant. The Assessment was carried by OiK for the first time with technical support from the UNFPA. OiK has closely monitored the implementation of the recommendations.

Effectiveness

Outputs

Strengthening the capacities of the family medicine team to provide FP, STI, YFHS and GBV

In 2017, the UNFPA supported an external assessment of the effectiveness of the SRH training programme.⁹⁴ The assessment utilised both quantitative and qualitative tools, such as a survey and focus groups. According to this assessment, PHC personnel reported very high satisfaction rates with regards to all types of training programmes (see table below). More than 75% of trainees reported that they were very satisfied with the delivery of training programmes. This was also confirmed with in-depth interviews conducted for this evaluation report. There was an overall consensus by the participants of focus group discussions that training sessions were well structured. They also provided positive feedback about material used and delivered upon the completion of the programmes. They were also satisfied with the practical content of the training and the inclusion of role plays in most of the training programmes.

Table 5: The satisfaction level of trainees with regard to training programmes

Training programmes/ Satisfaction	FP	GBV	STI	AH
Very satisfied	81%	79%	75%	80%
Somewhat satisfied	18%	21%	23%	20%
Very little satisfied	1%	0%	2%	0%
Total	100%	100%	100%	100%

Source: Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo

Both pre- and post-testing results of the trainees as well as a survey organised for the evaluation of trainings has shown an increased level of knowledge, and counselling skills about SRH topics based on a human rights approach that respects individual privacy, confidentiality and informed choice, along with a wide range of safe contraceptive methods in PHCs.

⁹⁴ Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo.

The evaluation assessment survey asked the participants to list three main lessons that they have learned during the training programmes as well as how they are able to apply them to clients. According to the results, about 66% of trainees were able to list three main lessons which can demonstrate the change in the knowledge on SRH, while about 26% were somewhat able and about 9% were only poorly able to list three main lessons that they have learned during the training programme on SRH. The assessment also compared knowledge increases between those who have and those who have not participated in the training programmes other than for FP since all trainees have participated in FP training. As can be seen from the figures below, for treatment of GBV clients and for knowledge in treatment of STI clients, and knowledge of AH clients, there is strong evidence that those that have participated in training programmes have greater knowledge and skills compared to those who have not participated in the training programmes.

Figure 8: Comparison of participants and non-participants on increased knowledge in the treatment of GBV clients

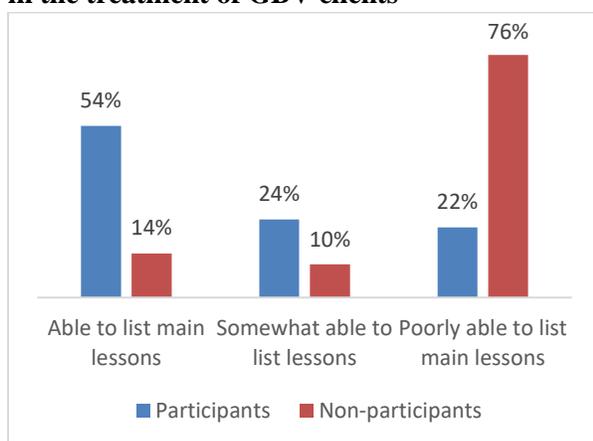
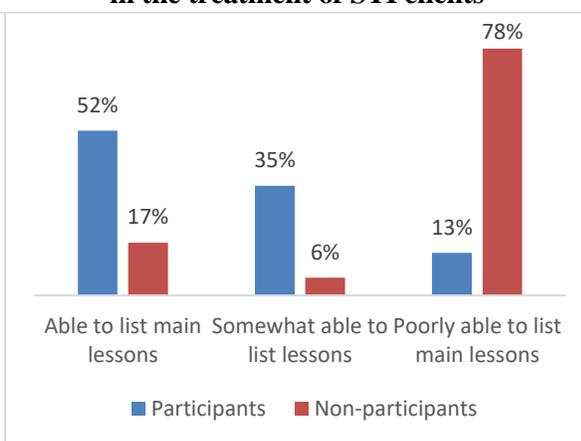
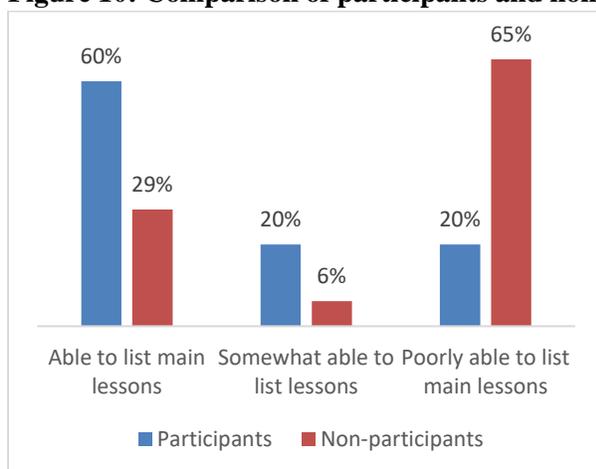


Figure 9: Comparison of participants and non-participants on increased knowledge in the treatment of STI clients



Source: Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo

Figure 10: Comparison of participants and non-participants on increased knowledge on AH clients



Source: Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo

According to the Forensic Doctor who facilitated the training course on GBV, the training on GBV assisted Family Physicians to correctly complete the medical reports for GBV survivors.

Advocacy efforts with the MoH in establishing a budget line for contraceptives

Through UNFPA assistance, the budget impact analysis for provision of emergency contraceptive pills was completed on December 2016 to build up a strong evidence-based recommendation for MoH in establishing a budget line for contraceptives.⁹⁵ The budget impact analysis confirmed the very high cost-effectiveness of provision of emergency contraceptive pills with an estimated net financial effect in savings to the health system in the amount 8,538 - 298,814 EUR annually. Since 2016, K10 has undertaken strong evidence-based advocacy efforts for contraceptive security, inclusion of SRH services under a health insurance scheme, improvement of the quality of SRH services, data collection, and patients' rights in the area of SRH. Nevertheless, there has been no decision to establish a budget line for contraceptives, while there is a rising awareness among policy makers about the inappropriateness of the current practice of provision of contraceptives (putting contraceptives within the same category as other essential drugs and distributing them based on the requests from PHCs).

The Ombudsman Institution conducted assessment on SHRH

The first National Assessment of the Reproductive and Sexual Rights in Kosovo⁹⁶ has provided a general and in-depth assessment of reproductive and sexual rights in Kosovo, while identifying achievements and barriers, against legal and constitutional guarantees and obligations. The assessment was focused on seven key SRR issues: contraceptive information and services; safe abortion; maternal health; HIV/AIDS; comprehensive sexuality education; violence against women; and reproductive system cancers. It also covered risk groups, including adolescents; Roma, Ashkali and Egyptian communities; men who have sex with men; female sex workers (FSW) and people with disabilities.⁹⁷ The Report produced 62 recommendations for addressing challenges obstructing the adequate realisation of SRR in Kosovo to different stakeholders such as ministries, Kosovo Assembly etc. The first of this kind of report produced by OiK provides the basis for continuous progress monitoring in relation to reproductive and sexual rights in Kosovo.

Outcomes

In the absence of a Health Information System that tracks the delivery of services, the evaluation assessment of training programmes applied quantitative and qualitative tools to provide proxy information on the application of the concepts learned as well as the delivery and utilisation of FP, STI, or other SRH services by PHC providers. Both the evaluation conducted for training programmes as well as in-depth interviews organised for this evaluation confirm a low level of application and delivery of SRH services by the PHCs.⁹⁸ When PHC personnel were further asked what are the main barriers that hinder wider application of SRH services, they reported that 'demand side' factors (such as 'lack of demand from clients' and 'lack of clients') play a much greater role in hampering widespread application rather than 'supply side' factors for

⁹⁵ The analysis has thoroughly reviewed the available evidence on the costs and effects of various programs targeted at reproductive health as: contraception; STI/STD testing, screening and treatment; cervical cancer screening; HPV vaccination and adolescent/youth sexual reproductive health programs. (Davis F, Ahmedi E dhe Berisha M. "Assessment to Characterise the Current Situation; Capacities for the Prevention; Control of Breast, Cervical; Prostate Cancers in Kosovo". Study funded the United Nations Population Fund for Population Development - Kosovo Office. Pristina 2016).

⁹⁶ OiK (2016): Sexual and Reproductive Health and Rights in Kosovo: A reality beyond the Law. A report on the National Assessment of Sexual and Reproductive Health and Rights by the Ombudsperson Institution of Kosovo.

⁹⁷ The assessment looked at three overarching questions: (i) what is the status of SRHR for the population of Kosovo, including marginalized groups? (ii) which key laws, policies and initiatives have been adopted by the Government, and what is their implementation status? (iii) what are the main consistencies and discrepancies between the constitutional protections for SRHR and the reality?

⁹⁸ Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo.

most of the training programmes, with the exception of FP services, where supply side factors demonstrates more dominance. With respect to FP, although ‘lack of demand from clients’ was the most widely selected option, supply side factors altogether, such as lack of SRH materials (i.e. contraceptives), lack of management support and monitoring for service delivery of SRH, high workload of PHC personnel, exceeds the demand side factors. On the other hand, lack of skills was the least chosen option among main barriers that hinder wider application of SRH services made by trainees for all types of training.

Figure 11: Main barriers for widespread application of FP services

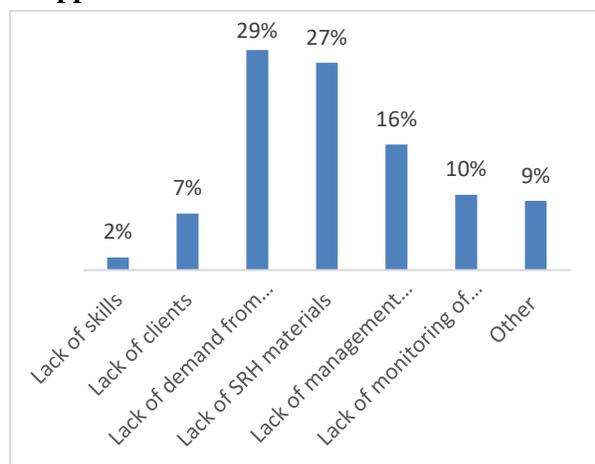
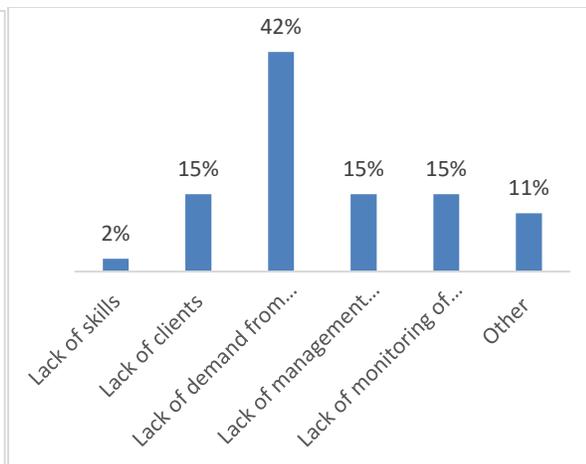


Figure 12: Main barriers for widespread application of GBV services



Source: Koro, L. & Lumi, D. (2018): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo

With regard to demand side factors, especially on FP and AH, PHC personnel highlighted that there is a low level of awareness among targeted populations about these services and that such services can be provided by PHC providers; whereas on STI, they claimed that the targeted population prefers to visit a gynaecologist over FM doctors. GBV trainees reported that victims are usually directed to emergency services and those that do visit PHC facilities are unwilling to admit and report such cases due to stigma and hesitation to report cases to health care providers.⁹⁹ According to the in-depth interviews, the lack of coordination among different actors dealing with GBV and the lack of a safe referral system makes the GBV reporting challenging for health care providers.

Similarly, the recent audit of Family Planning services provided in the PHCs of Pristina conducted in September 2018 revealed a very low provision and utilisation of these services.¹⁰⁰ Regarding the reproductive health commodities, during the visits conducted in eight primary healthcare institutions in the Municipality of Pristina for the audit, it was revealed that there were usual stock outs of reproductive health commodities due to the inefficiencies in the logistics of MoH but also in the absence of requests from PHC institutions to the Central Pharmacy in MFMC in Pristina. All interviewed stakeholders agree that PHC institutions currently are prioritizing other essential drugs to the detriment of available contraceptives, thus ignoring and hampering patients’ need for contraceptives. Despite this situation, after a series of advocacy

⁹⁹ See Koro, L. & Lumi, D. (2017): Evaluation of the Training Programmes organised by the UNFPA Office in Kosovo.

¹⁰⁰ See Uka S & Hyseni Morina F. (2018): Family Planning Services Provision in Family Medicine Centres of Pristina Municipality – Audit. UNFPA Office in Kosovo and MFMC in Pristina.

meetings, the MoH is still scrutinising the possibility of procuring contraceptives through a special budget line from the essential drug list, through a UNFPA third-party procurement modality.

Regarding YFHS, as a result of joint advocacy efforts of the UNFPA and WHO Kosovo offices, the Municipality of Pristina in 2015 officially announced re-opening of the Family Medicine Centre at the Students Centre in Pristina. This happened to be a very good investment for serving young students YFHS; more than 3000 youth receive primary health care services per year, including SRH services.

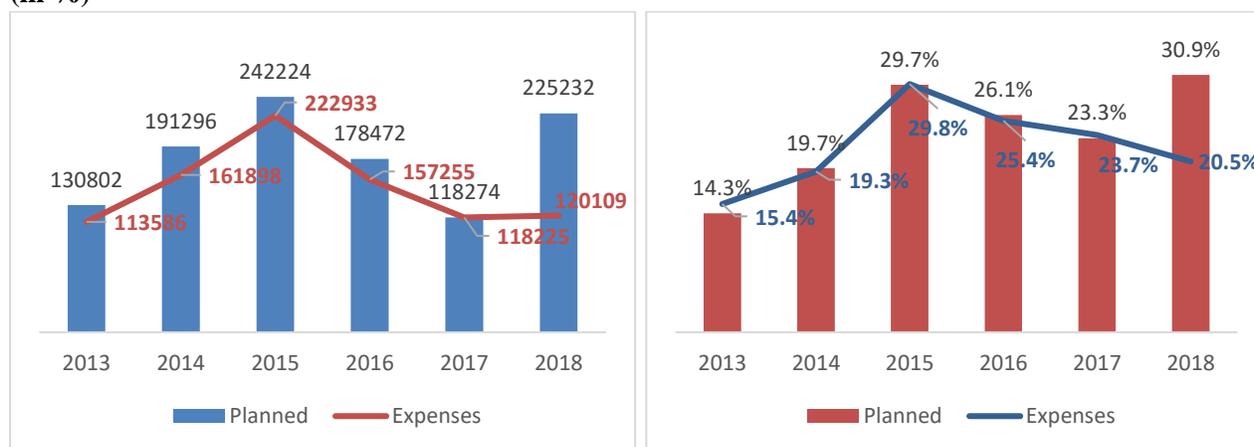
The Ombudsman Institution in Kosovo (OiK) Report

The OiK report served all involved parties to advocate for the MoH and other institutions to fulfil their obligations towards citizens in the area of SRR. These advocacy efforts have resulted in the establishment of the working group within MoH, for monitoring and reporting the realisation of the recommendations made by the assessment. OiK considers that out of 62 recommendations produced by the report about 26 of them (or 42%) have been implemented satisfactorily.¹⁰¹

Efficiency

Being one of the most important components of the UNFPA program, SRH has one of the highest portions of the UNFPA budget. During 2013 to 2015, the SRH budget was in an increasing trend, reaching 242,224 USD (or 29.7% of the total budget) in 2015. Since then, the budget dedicated for SRH entered in a decreasing trend, while in 2018 it again increased to 225,232 USD (or 30.9% of the total budget). The sharp decline in the SRH portion of the UNFPA budget in 2016 and 2017 is related to the interruption of contraceptive supply provision by the UNFPA office and transferring this responsibility to the MoH. The graphs below provide the yearly allocations and yearly budget proportions in relation to the total budget for this component.

Figure 13: SRHR Budget allocation and expenses (in USD); Figure 14: SRHR Budget proportions (in %)



Source: UNFPA Annual Work Plans.

¹⁰¹ The main ones already achieved worth mentioning are: (i) The Government should monitor and make efforts to ensure the enjoyment of SRHR by persons with disabilities; (ii) An inter-institutional coordination body on sexual and reproductive health should be established in the Ministry of Health to enhance coordination and communication between national institutions and between national and municipal bodies. (iii) An increased number of health inspectorates etc. Whereas among those recommendations that are not achieved worth mentioning are: (i) Ensuring privacy of SRH services; (ii) Establishing Health Insurance system with sexual and reproductive healthcare, including family planning and maternal care, should be included in the basic package of services under the fund, (iii) Absence of a National Health Information System.

Due to the lack of more exact data on the delivery and the utilisation of services on SRH it is not possible to compute pertinent calculations. Nevertheless, based on proxy evidence collected by the evaluation of training programmes on SRH, there is low level of application and delivery of SRH services by the PHCs. Thus, despite the allocation of substantial proportions of funds, it can be concluded that the low utilisation and delivery of SRH services by PHCs poses a major challenge in reaching efficient results. Nevertheless, based on financial reports submitted by implementing organizations UNFPA has spent in average around 90 euro to train one PHC personnel on SRH topics. However, the qualitative efficiency analysis, which looks at the utilisation of inputs such as those of local and international expertise, was highly rated by many stakeholders. Furthermore, the development and the utilisation of local trainers for the delivery of training programmes on SRH was highly valued by all PHC personnel. Moreover, the engagement of the OiK was highly appreciated, especially from the inputs obtained by the international experts, since the SRR assessment was done for the first time and reported to have provided an excellent learning experience during this assessment.

Sustainability

Static sustainability usually reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. Since results on the SRH services have been achieved to the output level, static sustainability of these outputs is directly linked to the need of repetition of the training programmes. According to the survey conducted on the effectiveness of the training programmes delivered by the UNFPA, the majority of trainees expressed the need for training programmes to be repeated in 3 to 5 year of intervals.

Dynamic sustainability on the other hand (which looks for system changes, i.e. whether functions and services supported by UNFPA will continue to be provided beyond the UNFPA support) is questionable due to the lack of resources and commitment from policy making level. Indeed, interventions like the delivery of training programmes on YFHS, STI syndromic management and FP, can be maintained and delivered without UNFPA support only if these programmes become part of the regular CPD programme for PHC personnel and are financed by the MFMC or by the MoH. According to the interviewed stakeholders, investments on enhancing healthcare providers' counselling skills on SHR should be made more sustainable instead of using a one-off training series, and followed by well-designed, regular and synchronised follow-up and monitoring activities. The training programmes on FP, STI, YFSH, etc and monitoring its effect through standardised quality assessments should be part of the Continuous Professional Development programme for health care providers, led by the responsible unit, whether it is the Professional Chamber, or the Primary Health Care Division in MoH.

4.2. Adolescents and Youth

4.2.1 Comprehensive Sexuality Education (Formal Education)

The Curriculum Framework which was adopted by the Ministry of Education, Science and Technology (MEST) in 2011 (Core Curriculum) and revised in 2016 regulates the entire pre-university education system in the Republic of Kosovo. This curriculum is based on core competencies and expected results. There are six core competencies in total. One of them aims to develop personal competences with the final result of being a healthy individual. These six core competencies then are divided into seven curricular areas. The concept of sexuality education is integrated into one of the curriculum areas (Physical Education, Sports and Health) which contributes to the achievement of the core competencies about a healthy individual.

Within the curriculum area “Physical Education, Sports and Health” the concept of sexuality education is envisaged to be developed at all grades and all levels of pre-university education. For this purpose, the MEST has developed results to be achieved (or learning outcomes) and themes to be taught on sexuality education within all grades of pre-university education. MEST has integrated these themes and learning outcomes into the following three subjects: Civic Education within primary education (grades 1-5) as well as Biology and Physical Education within lower and upper secondary education. The new curriculum framework was piloted in the 2013/2014 academic year in selected schools and now is being implemented in all grades and schools, albeit with limited tools (such as textbooks, manuals for teachers and students etc.). In parallel to these developments, the UNFPA started to support the MEST in the implementation of sexuality education in formal education by developing manuals for teachers on sexuality education and by training teachers on the delivery of sexuality education.

Interventions

Develop Manuals for Teachers on Sexuality Educations

To facilitate the delivery of sexuality education in formal education, the UNFPA supported the development of the Manuals for Teachers on Sexuality Education for all grades of pre-university education. UNFPA directly supported the working group responsible for drafting the manuals for helping teachers to teach pre-university students about sexuality education. The working group is comprised of two members from NIPH, two members from the MEST, one representative from the MoH and one curricula expert. The UNFPA supported the members of the working group for drafting the manuals for teachers about sexual education as well as their meetings, workshops and translation, editing, design expenses in relation to manuals. The UNFPA also supported the international peer review activities of the sexuality education manuals once the drafts had been prepared. The reviews assessed the extent to which the materials are aligned with WHO Standards for Sexuality Education in Europe and provided comments to the working group.¹⁰²

Training of teachers

In addition to developing manuals for teachers, the UNFPA supported piloting of a training programme for teachers of primary, lower and upper secondary education levels on sexuality education. Toward the last quarter of 2018, about 66 (51 women and 15 men) teachers of primary education (grade 1-5), and teachers of Biology and Physical Education for upper grades from selected schools in Pristina were trained in a two-day training on sexuality education. They were trained by working group members that were/are in charge of drafting the manuals. Following the training, the working group members were also required to provide additional advice and assistance to the trainees to support their teaching practices on this subject.

Relevance

The relevance of the intervention in the formal education sector is very high given that the content about sexual and reproductive health has been introduced into the educational curriculum for the first time and their implementation has started recently. The relevance of the specific interventions (both development of the manuals and training of teachers) is also high given that the inclusion of the concept on sexuality education in the core curriculum does not automatically lead to the delivery of good quality and holistic education on sexuality in schools. Thus, supporting skills and competences of the teachers on sexuality education is an important step. Most of the teachers will have to teach about this topic for the first-time.

¹⁰²See http://www.euro.who.int/_data/assets/pdf_file/0008/379043/Sexuality_education_Policy_brief_No_1.pdf?ua=1

Moreover, topics of sexuality education are still considered as taboo within the community of parents, students and teachers, an observation that was also confirmed by the focus group discussions with students and in-depth interviews with teachers. As a reflection of this situation, there are perceived barriers among teachers about how they will approach, teach and be open to these topics. Finally, the relevance of this intervention can also be considered as very high given the potential of formal education to cover all pre-university students with sexuality education throughout different grades of the schooling. Thus, interventions within formal education offer a huge opportunity towards the fulfilment of the right for every student to have access about sexuality education.

Moreover, the rapid spread of new media, particularly the internet and mobile phone technology, is leading to changing attitudes and behaviour towards sex among young people. These new developments require effective strategies to enable young people to deal with their sexuality in a safe and satisfactory manner. Formalized sexuality education can be well placed to reach a majority of the target group of young people if teachers are trained and motivated to deliver high quality sexuality education.

Effectiveness

Outputs

So far, draft Manuals for Teachers have been developed for all grades of pre-university education. The Manuals cover topics and lessons about the importance and purpose of the sexuality education for each grade, about teaching and evaluation methodologies and interlinks of sexuality education and learning outcomes. The Manuals also suggests teaching topics and possible in-class activities that can be used. The appendix of Manuals includes teaching materials and additional sources that help teachers in implementing the proposed models of teaching activities.

Furthermore, selected Manuals have been reviewed and assessed by an international expert about their alignment with WHO Standards for Sexuality Education in Europe. The work of the international expert is to make sure that Manuals reflect the holistic view of Comprehensive sexuality education instead of focusing primarily on individual issues or threats in relation to sex.¹⁰³

The work on developing the Manuals is expected to continue until the end of 2019, when working group members will review the comments submitted by the international expert and merge the Manuals for all grades into three main ones: one for primary education (for grades 1 to 5), one for lower secondary education (for grades 6-9) and one for upper secondary education (for grades 10-12). Thus, the realisation of the output regarding the manuals is expected to be completed by the end of 2019.

Regarding the training activities, there is some evidence that the pilot training programme contributed towards the achievement of the output. The pre-and-post training testing results show that the training programme had some effect toward increasing the level of knowledge among pre-university teachers on sexuality education, although the level of incorrect answers remained about 35% in post-test results for primary and upper secondary teachers and 8% for lower secondary teachers.

¹⁰³ According to the WHO Standards for Sexuality Education in Europe “Comprehensive sexuality education” seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. Young people [need] to know about sexuality in terms of both risk and enrichment, in order to develop a positive and responsible attitude towards it.” (WHO, Regional Office for Europe and BZgA, Standards for Sexuality Education in Europe, A framework for policy makers, educational and health authorities and specialists, 2010)

The feedback received from in-depth interviews with teachers is similar to the findings presented above. During in-depth interviews, teachers reported that they are much better capacitated and have more confidence in providing the content of sexuality education after the training programme. During in-depth interviews teachers have confirmed that there are perceived barriers among teachers (and it is more pronounced for older teachers compared to younger teachers) and that the training has helped them to start addressing these barriers and be more open to the discussion of the subject. They also mentioned that once they know how to approach and start teaching, in time they will feel more comfortable in delivering sexuality education using various methods to equip young people with adequate knowledge on sex. They also reported that this training showed them how to adapt the concept for different grades to be relevant to their age and to ensure consistency and completeness of the subject as a whole. The content of training, which was divided to help teachers know about the approach and the subject itself, was reported as adequate. Nevertheless, to increase effectiveness, they recommended organising a half-day follow-up session in group work. This session would be used to discuss teachers' efforts to apply such knowledge and skills during delivery of sexuality education as well as engage teachers to explain their direct experiences as much as possible.¹⁰⁴ In general, they highly valued the training, however complaints about a lack of tools in the schools, such as projectors and contraceptives, which can be used during teaching, were also reported. In order to increase the effectiveness of the training, the training should also make greater reference to the Manuals for Teachers.

Outcomes

It is too early to assess the higher-level results such as the ability of teachers to deliver qualitative and comprehensive sexuality education to all students as per the core curricula as well as using the Teachers' Manual and knowledge, skills gained during training programmes on sexuality education. Such results cannot be expected to be measured even in a limited number of schools, grades and classes in Pristina where the piloting training has occurred, since the training programmes has been delivered very recently. This is to be expected since some of the interventions have not been completed (such as Manuals) and others, such as training of teachers, are in an initial phase. For such an outcome to be measured, all (relevant) teachers should receive the final version of the Manuals, all of them should be trained and hopefully all them along with students should have textbooks (based on the new curriculum covering the themes on sexuality education). These textbooks are expected to be finalised by 2020. Thus, considerable time has to pass in order to be able to assess the delivery of sexuality education at schools and whether such education increases the knowledge, skills, attitudes and values of young students about sexuality.

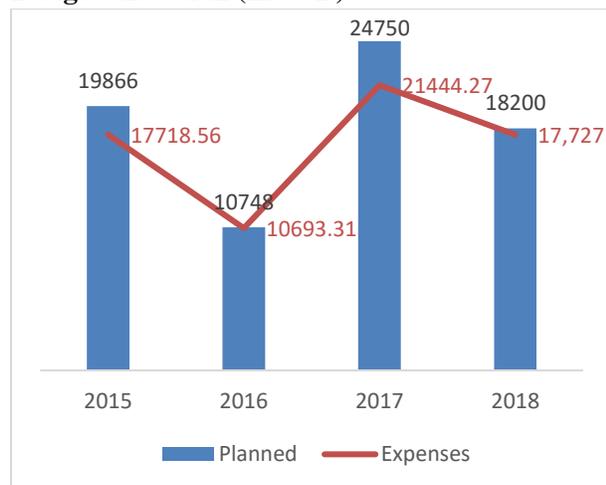
Efficiency

From the entire portfolio of the UNFPA Kosovo activities, the amount dedicated for formal education was about 73,560 USD (on average about 18,000 USD) or about 4.5 percent of the UNFPA budget for the last three years.¹⁰⁵ The graph below provides yearly allocation and yearly proportions in relation to the total budget for this component.

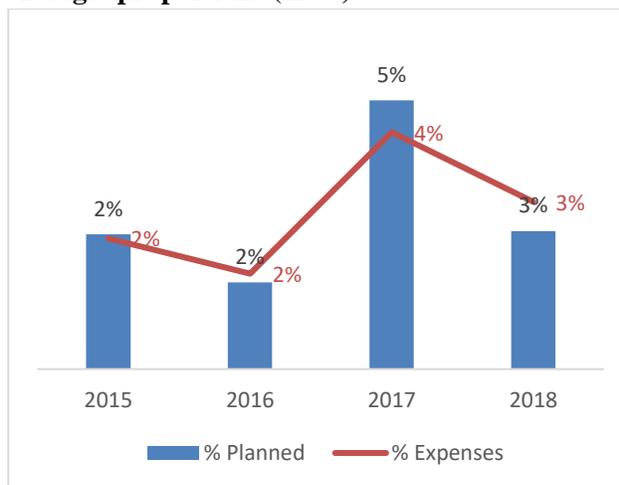
¹⁰⁴ They also suggested to organise trainings on Saturdays and to be organised during March-April since the themes of sexuality education are reserved to be taught during May-June.

¹⁰⁵ 10,700 USD in 2016; 25,000 USD in 2017; and 15,000 USD in 2018

**Figure 15: CSE (Formal Education)
Budget allocation (in USD)**



**Figure 16: CSE (Formal Education)
Budget proportions (in %)**



Source: Yearly Work Plans of UNFPA

As can be seen from the graphs above, a very small portion of the budget was dedicated for this component of the work by the UNFPA. Nevertheless, given the potential for reaching out to all students and all grades in pre-university education, such expenditures could be considered as highly efficient once they start to be materialised. Thus, given this high potential, the UNFPA should consider increasing the share of the budget for this component in order to initially boost the delivery of sexuality education and then to further strengthen the quality of such education.¹⁰⁶ If the overall UNFPA country budget is not likely to increase, the UNFPA should consider reallocation of funds from certain activities towards the completion of interventions initiated under this component.

Sustainability

Since results have been achieved up to the output level, this section will review the static sustainability of the outputs produced. As explained above, static sustainability usually reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. As such, the development of the Manuals will most likely have static sustainability at least in the mid-term (until 5 years), since Manuals will continue to be used by teachers without need for a major revision.¹⁰⁷ In order to reach higher coverage, the final version of the Manuals should be at least electronically delivered to all (relevant) teachers and uploaded in the MEST website for wider use.

Similarly, training of teachers also has a static sustainability since the result achieved so far (i.e. the increase knowledge and skills of teachers to deliver sexuality education) will continue to be used by teachers during the delivery of the sexuality education. According to the in-depth interview with teachers, the two-day training organised on sexuality education was adequate to them for this subject and they have not expressed any need to be re-trained.

¹⁰⁶ According to the financial reports submitted by the implementing agency, UNFPA spent about 70 euro for training a teacher for sexuality education which is relatively low using the local expertise

¹⁰⁷ With the assumption that there will not be any major changes in the core curriculum in the mid-term.

Dynamic sustainability on the other hand, looks for system changes i.e. whether functions and services supported by the UNFPA will be provided by the MEST or by other organisations without the need of UNFPA support. In this perspective, neither manuals nor trainings have the potential to reach dynamic sustainability. For example, the development of the Manuals does not have dynamic sustainability since there are no mechanisms in place other than UNFPA support that will continuously upgrade the Manuals developed for changing circumstances in the long run. Similarly, in order to achieve the dynamic sustainability of training for sexuality education, such training has to be included in the internal training system of the Ministry and offered on continuous basis to new teachers as well as to existing teachers in order to keep the knowledge updated and in line with new evidence, tools and approaches. The internal training system for teachers exists within MEST and is comprised of master trainers at the central level and trainers at the municipal level. Nevertheless, (although the inclusion would be easily achieved) the implementation of the sexuality education within the MEST internal training system for teachers will be difficult to achieve given there are many priorities with implementation of the new curriculum framework as well as limited funding available for the internal training system by the MEST.

4.2.2 Comprehensive Sexuality Education (Non-Formal Education)

Since comprehensive sexuality education has not been offered in formal education and it will take some time until all schools deliver quality sexuality education classes according to the new curricula framework, to fill this gap but also to ensure that non-school youth have access to sexuality education, the UNFPA supported outreach activities through various NGOs (Peer Education Network-PEN, Kosovo Population Foundation - KOPF, and Artpolis, Red Cross, Sinergia) by implementing different interventions to promote SRHR among pre-university students as well as some vulnerable adults. These interventions include awareness raising on STIs, contraceptive use and family planning, prevention of unwanted pregnancies, healthy lifestyles and gender equality. Such outreach activities that aim to raise awareness on safe sexual behaviour and promote gender equality were organised in the form of peer education throughout schools and community-based peer education, especially in rural areas, theatre-based education, social marketing and various awareness raising campaigns and exhibitions.

Intervention

Peer to Peer Education:

For the peer to peer education in schools, the UNFPA implementing partners worked jointly with the NIPH, which implemented the training of master trainers. The master trainers further trained young peer education trainers¹⁰⁸ from upper secondary school grades 10-12 to promote peer-to-peer education on SRH and rights, STI/HIV, GBV. Following the training, the young peer education trainers are supposed to take leadership in sharing their knowledge on SRHR with their peers through conducting various activities ranging from classroom sessions, to personal contacts, etc. The trainings for peer educators were short term (about 2 days and three hours each) and usually were delivered by the staff of implementing partners and PHC personnel in the PHC facilities. At the end of training young students were certified as peer educators.

In addition, UNFPA supported implementing partners (Red Cross and PEN) in organising peer education in communities targeting more vulnerable groups, such as rural youth, poor families, school dropouts, and members of Roma, Ashkali and Egyptian communities etc. Trainings were organised by volunteers of these

¹⁰⁸ Topics covered included risky sexual behaviour, STIs, HIV/AIDS, Family planning, contraceptive types and usage, unwanted pregnancies etc.

organisations for longer durations for poor families and shorter durations for youth and adolescents. The topics covered are similar to those presented above.

Since peer education for youth was widely used, the efforts to bring quality standards for youth peer education programmes was considered important and thus activities for the development of “Standards for Peer Education programmes” was initiated by the Ministry of Culture, Youth and Sports (MCYS), and the Department of Youth. In 2015, UNFPA decided to support this effort and finalise the development of the standards for youth peer education programmes based on the Y-PEER (Youth Peer Education Network) and the Y-PEER Toolkit, which provides the reference for peer education standards. UNFPA supported the working group and international experts in preparing the standards for youth peer education programmes.¹⁰⁹ These standards were subsequently approved; however, since they are voluntary standards, the MCYS does not have any information about their application.

Theatre Based Education

Another implementing partner of the UNFPA (Artpolis) promotes awareness-raising among young people through theatre plays about reproductive health and rights, gender equality, addressing issues of GBV in different municipalities of Kosovo, including for minority groups (Kosovo Serbs and Roma, Ashkali and Egyptians). The theatre plays are organised through a peer-to-peer theatre-based education manual and are usually performed by young students (about 20 for each play). After the performance, the participants have a chance to talk to actors about the topics covered, while the actors keep their play characters throughout the post-play moderation. Artpolis usually organises three to four plays in different municipalities each year. One of the successes of Artpolis is the expansion of its activities into the northern municipalities of Kosovo since 2015, and at the moment about 40% of their activities are implemented there.

Social marketing

UNFPA has continued to successfully support the social marketing component and distribution of affordable and good quality condoms, including in northern municipalities of Kosovo, which are populated by a majority of Serbian population. During recent years, through the implementing partner of UNFPA (KOPF), many condoms are sold commercially, and a portion are distributed for free during different youth outreach activities (see table 6 below for figures), such as small group sessions with youth (students), Info Point Stands, Sport Events (Love Plus Street-ball, Pristina International Marathon), and the marking of SRHR related days (including World Contraceptive Day, World AIDS Day, European HIV Testing Week).

Awareness raising campaigns and exhibitions

UNFPA supported K10 to organise many awareness raising activities in marking international days to raise awareness on SRHR issues. One of them is related to open salon discussions. K10 chooses a SRHR topic for discussion by communicating with youth through social networks and then identifies three panellists to discuss the topic more thoroughly.¹¹⁰ However, the outreach of this activity is very low (about 25 people per session). Another activity supported by K10 through its members is organising various awareness raising campaigns on SRHR. The partners of K10 pitch their ideas for campaigns (TV, radio, online etc) to be supported by K10. The campaigns then are implemented while marking international days. K10 also supports various activities of their members through marking international days and weeks, such as

¹⁰⁹ The standards provide conditions with which youth peer education programmes are designed, implemented, monitored and evaluated. Minimum standards have to be followed during planning, recruitment, training and supervision, management oversight, and monitoring & evaluation.

¹¹⁰ The invitation is circulated in social networks and usually such discussions are organised in university premises, such as career guidance offices or the EU Information and Cultural Centre.

European screening cancer week, Valentine’s Day, Promotion of healthy life style on Pristina International Half-Marathon, International Day of Families, International Nursing Day, World Population Day, International Youth Day, World Contraceptive Day, Eradication Poverty Week, International Emergencies Day, European HIV Testing Week, World AIDS Day etc.

Development of a mobile application on SRHR

In 2017 the UNFPA Kosovo office, jointly with the UNFPA Moldova, was a winner from the UNFPA Innovation Fund to develop a mobile application to provide information on SRHR for young people. The project aims to bring sex education for young people in every pocket given widespread use of smart phones. The app was developed in Moldova, however, the UNFPA office has worked on the adaptation of the app for use in Kosovo through organising focus group discussions and seeking feedback on the content of this application. At the moment the product is pending the approval of the UNFPA HQ for launching.

Gender Equality

In order to influence gender and social norms that promote gender equality, since 2016 the UNFPA has supported non-formal educational and promotional activities through its implementing partners. PEN organised training sessions on positive fatherhood, the roles of fathers and mothers and promoting gender equality norms for (i) PHC personnel (doctors, nurses, nannies) through a one-day training (ii) university students through two half-day trainings and (iii) with fathers, mothers and the expecting fathers and mothers for a duration of 11 months covering a specific topic each month.¹¹¹

Similar activities have successfully expanded in the northern municipalities of Kosovo since 2016. The UNFPA supported the NGO Sinergija to provide peer education programmes for youth on gender equality topics¹¹² including GBV based on the Programme M Manual.¹¹³ The programme targets upper secondary and university students in northern municipalities of Kosovo and in Gracanica and is delivered through an interactive one-day session as part of a curricular activity or as part of extra-curricular activities organised either in school or at Sinergija premises. Sinergija is also organising training for teachers and pedagogues on gender equality and the prevention of GBV, covering pre-university education teachers.

In addition, implementing partners organise various promotional activities, including panel discussions, exhibition events (such as “Super Dad”) etc. about gender equality and promote the positive role of parenting through marking international days (“Father’s Day”, “Girl Child”, “16 Days of Activism”).

Given the role of religious communities and FBOs to influence Kosovar society in addressing GBV and the initiation of behavioural change especially among young men, the UNFPA has entered for the first time in Kosovo into a very innovative partnership with Faith Based Organisations (FBOs) to raise awareness on GBV prevention and gender equality promotion. The UNFPA organised round tables with the Kosovo Islamic Community, both at the central and municipality level, about the role of Islam in the prevention of GBV, as well as workshops with imams on various topics regarding GBV. The partnership with FBOs was widened during 2017 to include the Orthodox Church and Bogoslavia, through the cooperation of its implementing partner Sinergija.

¹¹¹ Topic include Leadership, Expectations, Father’s Impact, Pregnancy, Birth, Caregiving, Reproductive Rights, Modern Family Planning Methods, Gender Equality, Non-violence, the Needs and Rights of Children, Division of Tasks in Caregiving and Final Reflections.

¹¹² The programme includes topics such as health, violence, positive roles of women and men, SRHR etc.

¹¹³ Care International (2011): Program M: Young Men’s Manual. Training Manual for Educators and Youth Workers

Relevance

The relevance of the interventions in the non-formal education sector is considered high given the lack of information on SRHR among young people as partly proven by MICS results (whereby only around 17% overall, and less than 10% of RAE young people aged 15-24 years, correctly identify the ways to prevent the sexual transmission of HIV, and many have major misconceptions regarding HIV transmission)¹¹⁴. The content about sex and reproductive health has just recently been introduced into the educational curriculum and it will take considerable time until the education system provides such an information adequately to young people. Nevertheless, as delivery of sexuality education in formal education expands, the relevance of these interventions may diminish other than those non-school youth.¹¹⁵ Furthermore, Kosovo is considered as a relatively young population since 34% of its population is under 18 years, and half of the population is under the age of 25. Due to social and cultural barriers the young people do not receive SRHR related information from their families either. The gender equality component can also be considered relevant given the gender inequalities presented above in section 1.2. Furthermore, many surveys highlight the presence of several forms of GBV widely accepted as social norms¹¹⁶ hence cooperation with FBOs is considered an exceptional opportunity to address these issues.

The relevance of the specific interventions is also considered to be high. For example, peer education approaches offer many benefits to programmes, target audiences, and communities, and empirical evidence has shown that well-designed and well-implemented programmes can be successful in improving the knowledge, attitudes, and skills of youth about reproductive health and HIV prevention.¹¹⁷

Moreover, the rapid spread of new media, particularly the internet and smart phone technology, provides unprecedented potential to offer information related to SRHR through them and reach out to much higher numbers of young people than can be reached through peer education programmes. Thus, the relevance of such interventions is high especially when combined with peer to peer education. Last but not least, the social marketing component also brings access to high quality condoms with an affordable price and accessible locations.

Effectiveness

Outputs

Increased awareness on SRHR including FP, STI, HIV and GBV

Regarding to the peer to peer education on SRHR, during 2013-2018 about 2,300 youth peer educators were trained (about 56 percent girls and 44 percent boys). Based on feedback obtained during a focus group discussion, to a large extent the young peer educators were satisfied with the topics covered as well as the way the training was delivered (i.e. duration and the quality of training).¹¹⁸ They were also able to present

¹¹⁴ Furthermore, according to the Health Behaviour in School-Age Children in Kosovo study, about 7% of young women and 37% of young men have had sex with a non-marital non-cohabiting partners, yet only 1/3 of these women and 2/3 of these men used a condom during the most recent encounter.(WHO & UNFPA Offices in Pristina (2014): Health Behaviour in School-Age Children in Kosovo: A WHO Collaborative Study).

¹¹⁵ Although dropout rates in primary and secondary schools has been decreased significantly during the period between 2011-2016/7 according to the MEST statistics (<https://masht.rks-gov.net/uploads/2018/02/raport-vjetor-statistikor-me-tregues-arsimore-2016-17.pdf>)

¹¹⁶ According to the survey organised by UNICEF (Study on Dimensions of Domestic Violence - Gender-based Violence in Kosovo Municipalities: Dragash, Gjakovë and Gjilan, 2015) on GBV, 28.4 % of men respondents indicated that they had perpetrated physical violence on their partner, 31.8% psychological violence and 0.8% sexual violence. The same survey found that about 55.4% of women aged 18 and above justify being hit or beaten by their husband in certain circumstances.

¹¹⁷ According to the Standards for Youth Peer Education Programmes, the following benefits are identified from peer education programmes: (i) *Peers are traditional providers of information to their peers.* (ii) *Peer education programmes are community-based and tend to be quite flexible;* (iii) *Peer education programmes can provide strong benefits to peer educators themselves;* (iv) *Peer education programmes can be economical.*(UNFPA, Ministry of Culture, Youth and Sports, National Institute of Public Health, Standards for Youth Peer Education Programmes In Kosovo, 2015).

¹¹⁸ Some of the recommendations from peer educators were to include videos that present real case studies to increase the effect of the training.

knowledge increases as a result of the training, specifically about the use of contraceptive methods, HIV, STI cases, unwanted pregnancies etc. The results from the pre and post-tests also confirm the knowledge increases of trainees due to the training. Nevertheless, when it comes to transmitting the knowledge to their peers, based on the feedback obtained, they were not able to transmit their knowledge beyond their close friends. As such, coverage of the peer education and its replication is expected to be low compared to the overall size of the targeted age group. Similarly, the situation is the same with the theatre-based education. According to the feedback obtained, the quality and effectiveness of the play was highly rated. Nevertheless, when it comes to coverage, such activities reach less than 1,000 people each year.

On the other hand, various awareness raising activities organised during the marking of international days and other events have much higher coverage of (young) people but with less depth. According to the input provided by the implementing partners, about 40,000 to 50,000 people were reached each year through various awareness raising activities such as campaigns, exhibitions, street plays etc. Nevertheless, there is no information about the effects of these activities in raising awareness on SRHR issues on the people reached. At national level, there is only one figure which partially measures the awareness level of young people concerning major issues related to SRHR. According to the MICS, in 2013/14, only around 17% overall, and less than 10% of young people aged 15-24 years from the Roma, Ashkali and Egyptian communities, correctly identified ways to prevent the sexual transmission of HIV and rejected major misconceptions regarding HIV transmission. However, since the most recent MICS study was conducted in 2013, and the next one is expected to be conducted in 2019, currently there are no basis to compare the actual current situation with the baseline and in this way to assess the wider effect of the UNFPA's programmatic activities. This comparison will not be possible until 2020.

Increased awareness on gender equality (including prevention of GBV)

Since 2016 when the training activities on promoting gender equality and violence prevention commenced, about 150 health care providers were trained (out of which 55 percent were women), while in total 244 students, fathers and men caregivers were reached through the training on Engaging Men in Fatherhood, Men as Caregivers, Family Planning and Caregiving (the share of women within students trained was 74%). On the other hand, in the northern municipalities of Kosovo about 2400 young people (the share of women ranged between 40% and 45%) were trained since 2015. Feedback from the students on the flow of the training and the topics it covered was positive. The results from the pre- and post-tests also show that training activities are having some effect on trainees. According to pre- and post-test results submitted by Sinergija, the training offered by them changed the perception of young people towards gender equality and violence. The percentage of correct answers related to gender equality increased from 45% to 95%, while for violence (including domestic violence) it increased from 26% to 92%.

Despite these positive results achieved at the trainee level, the coverage of activities is very low (about 1,000 people per year) compared to the overall targeted population, which in turn means that the magnitude of the effect is also low. In order to increase coverage, the UNFPA financed awareness raising campaigns on gender equality and violence prevention. These activities reached out about 2,000 direct participants annually and many others as followers in social media.

Furthermore, the UNFPA in partnership with FBOs organised a workshop with more than 100 imams on various topics regarding GBV. These interventions were very well accepted and highly evaluated by participants. As a result of this partnership, the Kosovo Islamic Community agreed to actively engage during *16 Days of Activism against GBV*, with imams covering topics on GBV prevention during weekly

preaching. Similarly, the partnership with the Orthodox Church and Bogoslavia, through the implementing partner Sinergija led to organization of spiritual nights on these topics by them.

Similar to SRHR, the UNFPA, jointly with OSCE, conducted an assessment in 2017/18 about men’s perspectives on gender equality based on the International Men and Gender Equality Survey (IMAGES). The study is based on the survey conducted with 1,000 men and 500 women and collected valuable information on men’s perspectives, attitudes and practices on a variety of topics related to gender equality.¹¹⁹

Social marketing

During recent years, there was a significant increase in the distribution of condoms in 2016. But since then the number of condoms sold has entered into a decreasing trend, reaching the level of 2014. However, during this period social marketing has achieved two important steps. One is related to the expansion of its activities to cover the entire territory of Kosovo, including the northern municipalities. The second one is related to the diversification of distribution channels. Although the main distribution channels remain to be in pharmacies and grocery stores, KOPH invested in the last five years in installing LOVEMAT condom machines in motels, hotels, cafeterias and restaurants throughout Kosovo. At the moment there are 150 installed LOVEMATs which have further improved the accessibility of condoms.

Table 6: Number of condoms sold and distributed for free

	No. of condoms sold	No. of condoms distributed for free
2013	726,547	30,672
2014	614,180	7,200
2015	726,963	69,336
2016	915,582	6,976
2017	628,608	20,592
2018 (until 31st of October)	510,075	18,772
Total	4,121,955	146,348

Source: KOPF figures

Outcomes

While there is some micro evidence about output level changes at the level of trainees by the implementing partners from UNFPA funded activities, there is no such data to measure the utilisation or application of the knowledge increases and to verify if it leads to behavioural change (outcome level change) for trainees of both the SRHR and gender equality trainings. Thus, it is not possible to assess any outcome level changes even within direct beneficiaries.

At the national level, the situation is very similar to the one described for the output level change. There is limited and partial information about measuring possible outcome level changes, which reflects increased utilisation of the information obtained and any (positive) behavioural changes towards safe sexual behaviour, gender equality and prevention of any types of violence. Some available information goes back to 2013 when the most recent MICS survey was initiated. According to this survey, the Contraceptive Prevalence Rate (CPR) among all women aged 15-49 years is 66% for any method, and 13.7% for modern

¹¹⁹ OSCE Mission in Kosovo & UNFPA Kosovo (2018): men’s perspectives on gender equality. Main findings from the International Men and Gender Equality Survey (IMAGES).

contraceptives. Since the next MICS survey will be conducted in 2019, until the results are available it is not possible to collect any evidence regarding the potential contribution of UNFPA activities to the wider population towards behavioural changes (i.e. outcome level change).¹²⁰ According to the MICS results, more than one-third of young women and two-third of young men used no condom during last sexual intercourse with non-marital, non-cohabiting partners in the last 12 months.¹²¹

Similarly, there are some figures in SRH behaviour of school age children which goes back to 2014. These figures can be considered only as baseline since there is no follow up study utilising the same methodology. Thus, it is not possible to assess any progress at the outcome level for this group either. According to the study “Health Behaviour in School-Age Children¹²² about 13.3% of respondents of age 11, 13 and 15 have responded that they had sexual intercourse, while 32.8% of them reported to have had intercourse when they turned 14. The condom remained the main means amongst adolescents in preventing the unwanted pregnancy, while a high percentage (26.5%) have not used any kind of protective measure at all.¹²³ Similarly, there is (one-time) information related to youth knowledge, attitudes and behaviour on Sexual and Reproductive Health and Gender Based Violence living in northern municipalities in Kosovo.¹²⁴ According to this survey conducted in 2017, about 59.0% of young respondents replied that they did not use any contraceptive during their first sexual intercourse, indicating that a large share of youth is prone to risky sexual behaviour, which may lead to possible consequences of unwanted pregnancies and sexually transmitted infections.

Similar information can be found for gender norms and attitudes. A study based on the International Men and Gender Equality Survey (IMAGES) provides valuable one-time information about men’s attitudes and practices – along with women’s opinions and reports of men’s practices - on a variety of topics related to gender equality in Kosovo.¹²⁵ However, such a study with the same methodology has to be repeated after a certain period (usually four years) to be able to observe any changes in perceptions, attitudes and practices.

Nevertheless, following the close partnerships between UNFPA and FBOs, there are some behavioural changes observed within FBOs. As a result of UNFPA interventions, the Kosovo Islamic Community was actively engaged during 16 Days of Activism against GBV while imams have covered topics on GBV prevention during their weekly preaching. Similarly, the partnerships with the Orthodox Church and Bogoslavia, led to organization of spiritual nights on these topics by them.

Impact (Lower number of undesirable pregnancies, abortions, STI cases, HIV, GBV cases)

There is limited data available to reveal any trends in some key impact indicators like HIV, STI or number of abortions. However, there is some data available that shows some negative trends in reported cases of

¹²⁰ However, this does not mean that the interventions of UNFPA office in Kosovo were not effective in producing outputs and contributing positively towards the achievement of the outcomes. It simply means that there is no evidence to judge whether these outputs and outcomes are actually achieved or not.

¹²¹ Please see KAS & UNICEF (2015): Multiple Indicator Cluster Survey (MICS), 2013-2014; Monitoring the Situation of Children and Women. Summary Report.

¹²² WHO & UNFPA Offices in Pristina (2014): Health Behavior in School-Age Children in Kosovo: A WHO Collaborative Study.

¹²³ Some other results that can be used as baseline are: smoking rate amongst Kosovar adolescents was 4.7%, while 10% of the adolescents consume alcohol and most of them do so rarely. Yet, the percentage of adolescents reporting the use of cannabis in the last 30 days is even lower (1.5%).

¹²⁴ “Survey on adolescents and youth knowledge, attitudes and behaviors on Sexual and Reproductive Health and Gender- Based Violence” (2017) *Results of the research in high schools and faculties in Mitrovica, Leposavić, Zvečan and Zubin Potok.*

¹²⁵ OSCE/UNFPA (2018) A Men’s Perspective on Gender Equality in Kosovo: Main findings from the International Men and Gender Equality Survey (IMAGES).

domestic violence. As can be seen from the table below, HIV is in a decreasing trend since 2016, while the number of domestic violence cases reported to the Kosovo Police is in an increasing trend. However, since it was not possible to collect any evidence regarding the possible results achieved at the outcome and outputs levels nationally, it is simply not feasible to attribute such improvements to the UNFPA’s work. Similarly, the increasing trend of domestic violence cases can well be a consequence of the empowerment of women reporting the perpetrators to the competent authorities rather than the increase of actual violence.

Table 7: Key impact indicators

	2013	2014	2015	2016	2017	2018
Number of abortions	N/A	N/A	N/A	N/A	N/A	N/A
Number of DV cases reported to the Kosovo Police	1,087	1,179	1,038	1,225	1,296 (958 women and 261 men)	1,166 (January – September) 901 women and 226 men)
Number of STI cases,	N/A	N/A	N/A	N/A	N/A	N/A
Number of HIV cases	1 new case	1 new case	1 new case	11 new cases	3 new case	N/A

Source: Kosovo Police, National HIV/AIDS Strategic Action Plan Kosovo 2018-2022

Efficiency

From the entire portfolio of the UNFPA Kosovo activities, during the last four years, on average, the amount dedicated for non-formal education was about 140,000 USD. Nevertheless, during the last two years there has been an increase in the gender equality subcomponent within non-formal education and altogether with peer education, they accounted about 50% of UNFPA yearly portfolio in 2018 from 26% in 2015.

Figure 17: CSE (Non-formal education) Budget allocation (in USD)

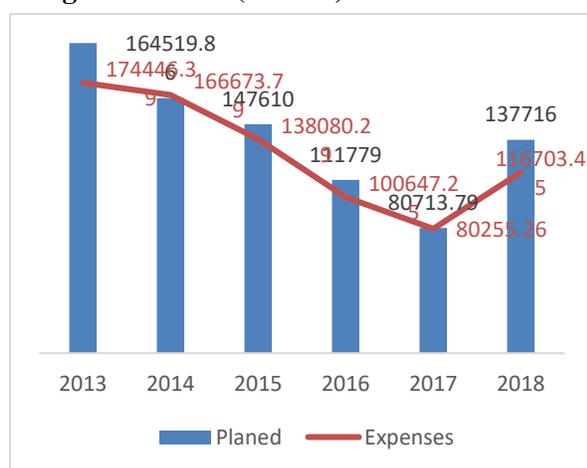
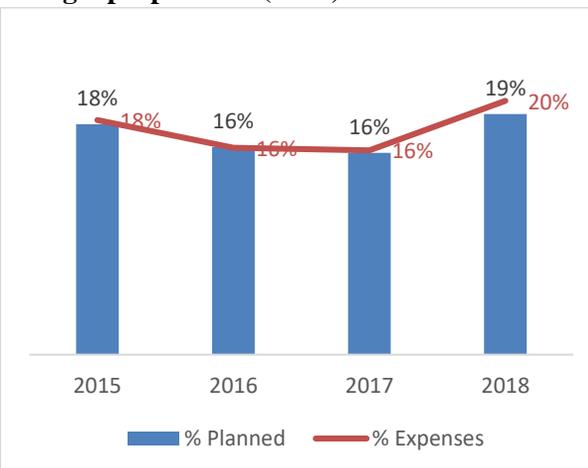


Figure 18: CSE (Non-formal education) Budget proportions (in %)



Source: Yearly Work Plans of UNFPA

Despite the allocation of this share of budget to non-formal education activities, the direct coverage of both peer education and gender equality components is low compared to the overall targeted population.¹²⁶ Within this budget it is not possible to cover a larger share of youth directly either.¹²⁷ Thus, in order to have higher efficiency gains, it is recommended that the UNFPA join resources instead of dividing them into different components and subcomponents¹²⁸ and combine peer education (both for SRHR and gender equality) with online services such as the mobile application for SRHR which is being developed. The same principle should also apply for K10 activities. K10 is implementing a great number of activities given the (low) budget and human resources available to them. Nevertheless, efficiency gains can be achieved through reallocation of resource from certain activities to others. For example, since the open salon discussions have low outreach, it is advised to reallocate funds to other activities that have higher outreach. On the other hand, there is good combination of utilisation of tools, approaches and technical expertise since, to a large extent, the interventions used in this component are based on local capacities using internationally endorsed products, such as the M Manual or YPEER.

Sustainability

Even if peer to peer education has low coverage it appears that this kind of education has static sustainability. According to the feedback obtained from focus group discussions, trainees have reported that the information obtained during the training will be sufficient and as such there is no need for re-training them on SRHR issues. Nevertheless, the feedback obtained from focus group discussions about the training on gender equality is less clear about static sustainability. Trainees provided different feedback, however there are many of those who reported that it is difficult to change the embedded social norms through a (short-term) training. Despite this uncertainty regarding the achievement of static sustainability for gender equality training, both the peer education and the gender equality trainings do not have dynamic sustainability since current interventions are fully dependent on UNFPA support. The achievement of the dynamic sustainability requires functions and services by the UNFPA to continue to be provided. Since such conditions are not created, these interventions cannot be categorised as sustainable in dynamic terms.

On the other hand, social marketing component is having both static and dynamic sustainability. The UNFPA HQ does the global procurement of condoms for KOPF and KOPF organises the distribution of condoms throughout Kosovo. All these functions will continue to be implemented even if the UNFPA office in Kosovo withdraws its support. The situation is similar with Kosovo Islamic Community. Their engagement with prevention of GBV and promotion of gender equality has potential to continue since such functions can be easily taken by them.

4.3 Population Development

In light of demographic changes and the migration pressure which are explained above in section 1.2, the data gathering and dissemination abilities in Kosovo have been of paramount importance in the last ten years. For this reason, the UNFPA has continued supporting Kosovo institutions to create a much more sustainable situation for data gathering as well as data management, dissemination and secondary data analysis.

¹²⁶ While all non-formal training activities (SRH and gender equality) on average reach 2000-2200 people annually, there are about 30,000 young people in each generation/age in Kosovo.

¹²⁷ According to the direct and indirect beneficiaries reached through non-formal education and outreach activities and fund spent for this focus area, it appears that UNFPA spent around 80 euros (ranging from 60 euro to 100 euros throughout different years) per direct beneficiary and about 2 euros for beneficiaries that are reached out through awareness raising activities.

¹²⁸ Such as dividing gender equality component into different target groups (for health personnel, university students and adults).

Intervention

Data gathering

Four major surveys were completed with the support of the UNFPA since 2012. All surveys were mentioned in the previous parts of the report. The first of them is MICS (Multiple Indicator Cluster Survey) which was implemented in 2012/13 by the Statistical Agency of Kosovo (KAS) and UNICEF (however, the results were analysed and disseminated in 2013-14). This survey is planned to be repeated again for a second round for Kosovo in 2019. The other surveys conducted with UNFPA support were (i) Health Behaviour in School-Age Children in Kosovo, which was conducted together with WHO in 2014; (ii) Survey on Adolescents and Youth Knowledge, Attitudes and Behaviour on Sexual and Reproductive Health and Gender-Based Violence” conducted in 2017 in northern municipalities of Kosovo; (iii) International Men and Gender Equality Survey (IMAGES) conducted in 2018 jointly with the OSCE Mission in Kosovo; (iv) and the analysis on factors influencing contraceptive use in Kosovo.¹²⁹

Data Analysis

In addition to data gathering, the UNFPA supported KAS in secondary analysis of census data on Population Projections and supported the participation of KAS experts in international conferences on Population Projections, and in the EUROSTAT working group on Population Statistics aiming at strengthening their capacities. Also, through the UNFPA support the first Population Situation Analysis (PSA) for Kosovo was finalised in the beginning of 2015.

Vital Statistics

The UNFPA has supported the improvement of data registry and management, including the civil registration system, data integration issues among various institutions, as well as technologies required for data dissemination. For this purpose, the UNFPA organised round tables and coordination meetings among key stakeholders such as the Statistical Agency of Kosovo, the Ministry of Health, the Agency for Civil Registration and the Ministry of Labour and Social Welfare.

Relevance

Kosovo is undergoing a demographic transition. During this process, further declines are expected in fertility rates, and significant changes in the age structure of the population. These changes in age structure will have a significant impact on public policies such as schooling, social welfare, health, and economic growth. During this process it is important to build institutional capacities in order to conduct analysis on key population trends and potential implications for public policies, and development processes. For example, findings from population data gathering and processing are very relevant for the Ministry of Labour and Social Welfare, to determine the rate of people entering retirement age, for social protection, budgetary implications, their strategies on how to cope with such changes, and labour market projections. Also, the Ministry of Education Science and Technology needs some of these data to determine the rate of children entering school, and different levels of education, and to determine the number of teachers needed for each school and municipality. Moreover, the data is relevant for gender comparisons in different aspects, like institutional representation, poverty levels by gender and so on. The Ministry of Health also needs this type of data to determine the levels of vaccination, and the Ministry of Finance needs this type of data for

¹²⁹ UNFPA & International Planned Parenthood Federation - European Network (2012): Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia.

budgetary planning for municipalities based on population size. Also, population data is very relevant for determining migration levels, which play a crucial role in the current Kosovo social climate.

Effectiveness

Outputs

Based on in-depth discussions, there is qualitative evidence that the UNFPA efforts significantly strengthened the capacities of the Civil Registration Agency and KAS for the production, analysis, and the dissemination of population data. Similarly, the Population Statistics Division within the Department of Social/Population Statistics of KAS feels fully capacitated in demographic data analysis and in calculating key indicators for the next population projection report, given there is lighter support for quality assurance or mentoring (about the calculations and the narrative report) by the UNFPA. The last Kosovo Population Projection (2017-2061) was produced by the Kosovo Agency of Statistics with external experts provided by UNFPA.

In relation to vital statistics, the UNFPA support efforts resulted in the establishment of the working group on improving civil registration information flow. Through this working group, the UNFPA facilitated data integration between the health system, which contains information on the number of births and deaths, and the civil registry, through the design of a MOU for this cooperation. In parallel, at the local level, the UNFPA supported most of the municipalities¹³⁰ to improve their death registry by gathering key institutions such as the municipality, the civil registry, and the Islamic Community.

Outcomes

Regarding data gathering, the data produced through MICS is reported to have been instrumental in financial gains for Kosovo from the Millennium Challenge Corporation funds. The data from MICS was used in 2015 to apply successfully for these funds, and this cooperation is still ongoing. Another key benefit which can be connected to MICS is the cooperation between the Ministry of Education Science and Technology and the EU, where MICS data for pre-school education played a role for the allocation of 8 million euros to build kindergartens. In addition, MICS is reported to be effective to study gender issues, since each MICS indicator is gender-disaggregated. This could help in increasing awareness in relation to issues like gender-based violence, reproductive health, and women's position in the society.

In the area of vital statistics, a crucial improvement to be mentioned is in relation to underreporting of death cases. For this purpose, a memorandum between Civil Registry Agency and Faith Based Organisations (mainly the Kosovo Islamic Community whereas the Catholic and Orthodox communities are not involved yet) were signed to address this situation. The implementation of the project started in August of 2016. Most regions are part of this cooperation to report death cases, with a few exceptions like Decan, Klina, and Istog. The number of reported deaths has increased after the involvement of Faith Based Organisations according to all the interviewed Working Group Members. However, since initially there were no data on this issue, it is not possible to calculate exactly how much the underreporting was reduced.

Impact

The impact of the data gathering and dissemination efforts and assistance by UNFPA is not easily measurable. There are good examples to be mentioned, where government agencies, mostly Ministries, use

¹³⁰ With exception of Decan, Klina and Istog.

the data for specific issues, but there is still room for improvement in terms of the widespread use of the data for evidence-based policy making.¹³¹ One frequent citation was found in the Strategy for Integration of Roma and Ashkali Communities for the period 2017 -2021. In, fact MICS is heavily used to report and compare many indicators regarding Roma, Ashkali, and Egyptian Communities, since there is a separate MICS survey dedicated specifically to these communities. This is especially important given the lack of data on these communities.

Efficiency

The financial expenses of the UNFPA Kosovo Population Development related program has averaged at 91,000 USD per year during the last six years. However, there is a large variation between years, with only 68,890 USD in 2013, jumping to 172,792 USD in 2014, and then quite rapidly decreasing during the years at 95,557 USD in 2015, 68,352 USD in 2016, and down to 39,054 in 2017. During the last year the budget was again increased to 101,028 USD. This large variation is connected to the cyclical aspects of the Population Development related surveys such as MICS, which is repeated every four to five years. Based on the allocated budget expenses, 97.7% of them were successfully utilised (excluding the last year 2018, where the budget utilisation data were only available up to 23.10.2018). The low utilisation rate in 2018 is only due to the data not being available yet – it does not necessarily imply underspending or bad financial planning.

Figure 19: Pop. Dev. Budget allocation and expenses (in USD)

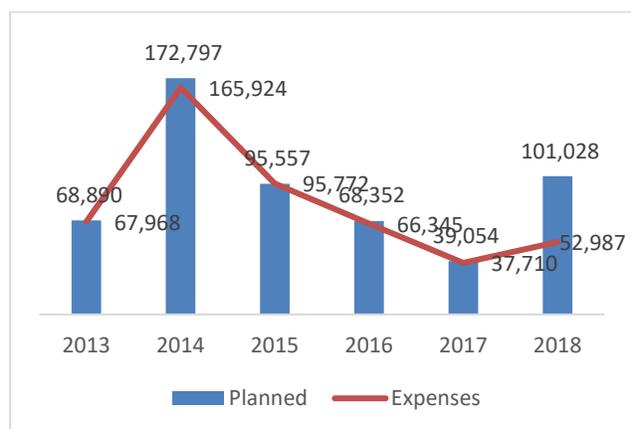
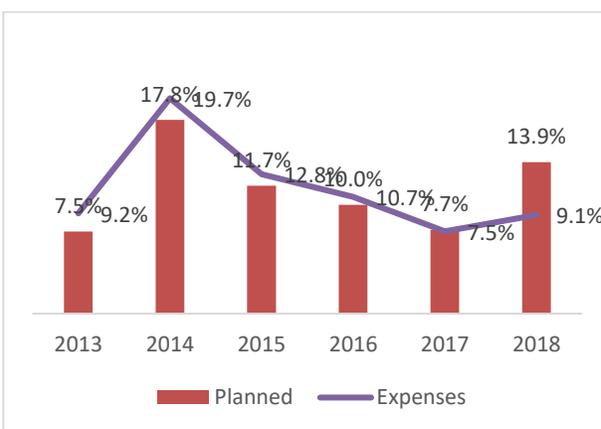


Figure 20: Pop. Dev. Budget proportions (in %) and expenses (in USD)



Source: UNFPA Financial Reports

Similarly, the budget proportion of the population development program varies across years, averaging at 11.4% of the total budget, reaching 17.8% in 2014, and also reaching 13.9% in 2018. The 2018 increase was due to the increase in the Core Funds for UNFPA Kosovo, and therefore part of that increase was allocated for the Population Development Area. Also, due to the upcoming MICS foreseen in 2019, most likely there will be an increase in the budget proportion for Population Development during the coming years. In relation to the efficiency of human resources of UNFPA, the interviewed partners in the focus groups gave very positive feedback regarding the qualifications and professionalism of the UNFPA staff

¹³¹ An in-depth Google search for citations of MICS in other documents showed 70 relevant citations, but 26 of them were media articles. The search failed to find any relevant government document, regulation, or policy which directly mentions MICS. MICS is mostly cited in reports of international organisations in Kosovo like UNICEF Kosovo, World Bank, UNDP, Council of Europe, OSCE, Council of Europe, European Centre for Minority Issues, International Labour Organisation, and KFOS.

concerned with Population and Development and commended their readiness to assist the implementing partners and their responsiveness.

Sustainability

The data gathering is less sustainable, since all the surveys conducted so far rely heavily on UNFPA and other organisations' funds, although there is a positive trend towards more sustainability for the next MICS survey. KAS considers itself a definite owner of the MICS and Kosovo government has decided to support MICS financially with 200,000 euros, and yet this is only a part of the total budget for MICS, which requires around 700,000 euros for one round.

The capacity enhancements on demographic data analysis have static sustainability. However, the achievement of dynamic sustainability depends on whether KAS is able to produce its population projections report with limited or no engagement of UNFPA. Similarly, the dynamic sustainability on improvement of the vital statistics is also questionable. There are many undefined legal aspects, such as the fact that legally the Faith Base Organisations are separate from the State Institutions. They are responsible according to the memorandum of understanding to play a role in the data gathering, which in other countries would be a direct responsibility of state institutions. Also, according to the Faith Based Organisations, the lack of financial support makes the cooperation of Faith Based Organisations for their reporting of death cases vulnerable. For this reason, their willingness to continue the cooperation in the long-term in the current form is at question from their side.

4.4 Added Value

Virtually all of the proposed interventions are within the UNFPA mandate, and suitable within its areas of comparative advantage. In some areas, the added value of UNFPA lies in the fact that it is the only development partner active in those areas. For example, the UNFPA is the only actor supporting the capacities of public institutions and NGOs in the field of SRHR. All the stakeholders interviewed have reported that without UNFPA's assistance this area would have witnessed significant weaknesses. Similarly, UNFPA is again the only organisation supporting population data analysis and projections. Without the support of UNFPA many studies, such as Kosovo Population Projection, would not be produced, nor would capacities be developed in this regard. Furthermore, the UNFPA acts as a facilitator, or a broker, playing an intermediary role in bringing various –stakeholders and organisations (such as the Kosovo Civil Registry Agency, Faith Based Organisations, KAS, and others) together and coordinate their efforts towards improving data for vital statistics. Without the convening power of the UNFPA, parties agreed that it would be almost impossible to bring all parties and discuss these issues altogether.

In addition, the UNFPA has proved to have a specific ability in policy dialogue, and particularly in placing sensitive themes on the national agenda. Inclusion of the MCRH component into the Sectoral Health Strategy for example, would not have been possible without UNFPA's presence according to the stakeholders' discussion. Moreover, UNFPA has made good use of its comparative strengths, thus bringing added value into the introduction of comprehensive education in formal education. While the Ministry of Education has integrated the concept on sexuality education into new core curriculum framework, it was the UNFPA who brought its local and international expertise and facilitated the actual initiation of implementation of sexuality education into the formal education system.

In the area of MCH, the UNFPA has cooperated strongly with WHO. Nevertheless, there was a clear division of the labour and close cooperation between WHO, whereby both agencies brought added value to the sector. For example, while the know-how products of WHO were used for EPC, UNFPA contributed heavily in organising the ToT and delivering trainings through local trainers on EPC using their extensive experience about training programmes for health care personnel on FP, STI, HIV, GBV etc.

4.5 Assessment of cross cutting plans

As part of cross cutting themes, this report is required to conduct a review of the advocacy and communication plan, the partnership plan, and the resource mobilisation plan.¹³²

4.5.1 Advocacy and communication plan

An advocacy and communication plan was prepared for comprehensive sexuality education (CSE). The theme (Reaching political decisions on including sexuality education in school curricula) was chosen based on the advocacy priority area defined for the regional countries. Nevertheless, such priority area was not relevant for Kosovo, since sexuality education was already included in the curriculum of formal pre-university education and the UNFPA had already started to support MEST and teachers in the actual implementation (please see section 3.4 for more information). However, the template of the plan looks satisfactory. Nonetheless, a column on the status of the measures undertaken or progress achieved, and input used is missing. Having a column on the status of the measures undertaken can assist the country teams to keep the document updated. Updating the document within certain intervals, such as every six months or every year, by the country teams should be also a formal requirement by the regional office. The template can be also simplified by not demanding inputs to be provided on M&E and Means of Verification for each measure undertaken, but rather to provide information on barriers/challenges addressed.

4.5.2 Partnership plan

The UNFPA Kosovo partnership plan, which was developed for the period of 2016-2020, was found to be heavily skewed towards listing all types of partnerships. According to the template, the UNFPA had to list all organisations from the UN System, the Government, CSOs and implementing partners and for each organisation, UNFPA had to define the reference to SP and CPD, types of collaboration, the partner's role, the expected results, indicators and targets for each year and provide justification on why the engagement with the respective partner was established. The UNFPA has provided a long list of all partners and inputs required by the template. Instead of providing a long list of all types of partners, it would be more effective if the country team focuses on establishing critical or most important partnerships to achieve crucial results. As such, the template should not be partner-focused but rather result-focused. In this way, for the achievement of one crucial result, country teams may engage (and list) in different types of partnerships and with different types of organisations. Furthermore, the template needs to have a column for a short narrative description of the progress achieved, which will require country offices to keep the document updated. In the current format for of the updating, the template will be very much time consuming. If the template focused on key partnerships, it would be much easier for the country team to update the status of the plan by providing inputs (both narrative and indicator based) about the progress achieved and any need for revision.

¹³² This section at the moment focuses only on advocacy and communication plan and the partnership plan. The resource mobilization plan will be added later in the report when UNFPA Kosovo specific plan is submitted for review.

5 CONCLUSIONS AND RECOMMENDATIONS

Conclusion 1:

The current M&E framework is limited to capture the capacity and performance improvements and possible impact level changes for all interventions such as MCH, CCSP, SRH services, as well as the behavioural changes of targeted populations on SRR gender equality etc. Furthermore, there are limited and partial data gathering tools about measuring many outcome and impact level changes. Some available information goes back to 2013 when the most recent MICS survey was initiated. Some other figures in SRH behaviour of school age children goes back to 2014. The situation is similar for gender norms and attitudes. A study based on the International Men and Gender Equality Survey (IMAGES) provides valuable one-time information about men's attitudes and practices – along with women's opinions and reports of men's practices - on a variety of topics related to gender equality in Kosovo.

Conclusion 2: UNFPA has too many activities allocated to different areas with different effects (especially in mother and child care, sexual and reproductive health and rights and comprehensive sexuality education in non-formal education focus areas). Given limited available resources such an approach can limit efficiency gains.

Conclusion 3:

The very positive results on CGP have shown the importance of ensuring the following conditions with public institutions in order to achieve greater and more sustainable results: creation of (i) full ownership and critical mass of commitment from institutions for a certain policy measure (in this case CGP) (ii) adequate capacities (which was built through training on the methodology of CGP development) and (iii) appropriate processes (which was established though AI on CGP), which is also entirely financed by sustainable funding mechanisms (by the Ministry's budget to design, implement and monitor policy initiatives by themselves).

Conclusion 4: Criteria-Effectiveness

From various interventions (such as technical support to the MCRH Division in MoH, NCMMA, CGP development, EPC, MISP, and the creation of the K10 coalition) higher level results are observed in EPC, CGP and with the K10 coalition. Although not consistent and findings might contain a 'Hawthorne effect' (since many positive findings were observed from the assessment visits where the staff was aware and informed in advance), reports from regular EPC follow-up assessment/visits showed encouraging results in EPC following the training and follow up support. After the technical support and revision of the AI on CGP, the Ministry adapted and approved about 11 CGPs beyond the 8 initially planned. Similarly, after its establishment, K10 has been actively engaged in coordination, evidence-based advocacy, awareness raising activities by engaging their members and improving internal capacities of its members.

Conclusion 5: Criteria-Sustainability

While most of the UNFPA interventions under this programme area have static sustainability, (since capacities created within the MCRH Division, the National Committee on Maternal Audit (NCMA), CGP, MISP, EFP and within K10 coalition will continue to exist even if UNFPA withdraws from these interventions) not all these interventions have dynamic sustainability. For example, the MCRH Division with MoH due to lack of human capacities it would be impossible to cover the policy making, legal

framework development and monitoring of the availability and quality of MCH and SRH services within the health sector. The situation is somewhat similar with EPC and K10. Training and monitoring visits on EPC cannot continue without UNFPA support.

Conclusion 6: Criteria-Effectiveness

The pilot programme on CCS is being implemented successfully in Pristina and Prizren according to the SOPs. Since the start of the pilot programme, in the Municipality of Pristina about 5060 women have used the opportunity to do their PAP, while in Prizren about 430 people had their samples taken. Despite these positive achievements, it has been observed that PAP test smear taking is not being provided by the trained Family Physicians. Due to lack of necessary conditions (proper space for such sensitive procedure and equipment, especially a gynaecologic examination table) as well as due to the clients' request, the procedure is being offered by gynaecologists within PHC which are not part of the service package offered by PHC services according to the new AI.

Conclusion 7: Criteria-Sustainability

Although PHCs in two municipalities are capacitated to provide CCSP independently from UNFPA support, offering such services still has some issues with static sustainability, since the service delivery is done through a gynaecologist and not by Family Physician, which as a service will not be part of the PHC. Dynamic sustainability of the CCSP on the other hand, is heavily dependent on whether policymakers will continue to support this screening programme and its expansion to cover all over the Kosovo Health Care System

Conclusion 8: Criteria-Effectiveness

The UNFPA has funded extensively the training activities of primary health care (PHC) personnel about SRH (such as FP, STI, AH, LMIS, GBV). Despite the strong evidence about increased levels of knowledge, and counselling skills of PHC personnel about SRH topics based on human rights approach, according to evidence collected, there is a low level of application and delivery of SRH services by the PHCs due to mix of supply side factors such as lack of SRH materials (i.e. contraceptives), lack of management support and monitoring for service delivery of SRH, and demand side factors (such as 'lack of demand from clients' and 'lack of clients') according to PHC personnel.

Conclusion 9: Criteria-Sustainability

According to the survey conducted on the effectiveness of the training programmes delivered by the UNFPA on FP, STI, LMIS, GBV, it appears that static sustainability is achieved in the mid-term since the majority of trainees expressed the need for training programmes to be repeated in 3 to 5 year of intervals. Dynamic sustainability of interventions is questionable due to the lack of resources and commitment from policy making level to take over training programmes and finance them by the MFMC or by the MoH.

Conclusion 10: Criteria-Effectiveness

The UNFPA has started to support the MEST and teachers on the implementation of sexuality education in formal education by developing manuals for teachers on sexuality education and by training of teachers on the delivery of sexuality education. Since topics of sexuality education are still considered taboo amongst parents, student and teachers, the importance of expanding this intervention can be considered as very high

given the potential of formal education to cover all pre-university students with sexuality education throughout different grades of schooling.

Conclusion 11: Criteria-Sustainability

UNFPA interventions such as training of teachers and manuals for teachers has a static sustainability since the result achieved so far (i.e. the increase knowledge and skills of teachers and manuals produced to deliver sexuality education) will continue to be used by teachers during the delivery of the sexuality education. Nevertheless, neither development of manuals nor training of teachers have dynamic sustainability since functions and services supported by the UNFPA cannot be replaced entirely at the moment by the MEST.

Conclusion 12: Criteria-Effectiveness

The UNFPA has heavily supported outreach activities that aim to raise awareness on safe sexual behaviour and promote gender equality in the form of peer education throughout schools and community-based peer education, especially in rural areas, theatre-based education, social marketing and various awareness raising campaigns and exhibitions. While there is some micro evidence about output level changes at the level of trainees by the implementing partners, outreach is considered to be low compared to the targeted population and there is no data to measure outcome level changes (i.e. to utilisation or application of knowledge increases and whether this leads to behavioural change) both for trainees and for more wider population on SRHR and gender equality. Furthermore, as delivery of sexuality education in formal education expands, the relevance of these interventions may diminish other than those non-school youth.

Conclusion 13: Criteria-Sustainability

Most of the non-formal education and outreach activities appears to have static sustainability. However, since such activities other than social marketing are heavily dependent on UNFPA support, they cannot be categorised as sustainable in dynamic terms.

Conclusion 14: Criteria-Effectiveness

There is qualitative evidence that UNFPA efforts significantly strengthened capacities of Civil Registration Agency and KAS in the production, analysis, and the dissemination of the population data. Similarly, the Division of Population Statistics within KAS feels fully capacitated in demographic data analysis and to calculate the key indicators for the next population projection given there is a little support for quality assurance by the UNFPA. In the area of vital statistics, a crucial improvement to be mentioned is the resolution of the issue of underreporting death cases although such solutions cannot be sustained in the mid-to-long term according to the key stakeholders.

Conclusion 15: Criteria-Sustainability

While the UNFPA's works on population development as well as those that are directed at data analysis have reached a comfortable level of sustainability, the data gathering is less sustainable, since all the surveys conducted so far rely heavily on UNFPA and other organisations' funds.

Recommendations

Recommendation 1: (linked to the Conclusion #1)

High Priority

The UNFPA office in Kosovo is recommended to introduce a more detailed M&E framework and invest more in data collection tools in the future programming document. The UNFPA should invest in the preparation of a detailed M&E matrix that captures the capacity and performance improvements and possible impact level changes for all interventions such as MCH, CCSP, SRH services, as well as the behavioural changes of targeted population on SRR gender equality etc. These results should be then translated into proper statements of output, outcomes, and impacts and performance indicators, baselines, and targets, which are relevant to the result, and can be monitored regularly. In relation to this, the UNFPA is also recommended to invest in gathering information regarding the baseline data on outputs, outcomes, and impacts and put into place a functional system for monitoring and tracking these indicators to ensure that comparable follow-up data is collected at regular intervals. This report argues that many of the outcome and impact level indicators are missing. Some of these indicators rely on an HIS (especially those related to service delivery) but others, such as on behavioural changes of targeted populations, can be computed through a MICS or by producing a specific study for this purpose. This would be a valuable investment since monitoring the results would guide the overall effectiveness of the interventions applied by the UNFPA and would indicate the need for any adjustments to the interventions.

Recommendation 2: (linked to the Conclusion #2)

High Priority

UNFPA is suggested to further improve the allocative efficiency of the programme by reallocation of funds towards interventions with stronger results and by consolidating interventions within each area of work, due to limited available resources. For example, in (i) mother and child care, (ii) sexual and reproductive health and rights and (iii) comprehensive sexuality education in non-formal education focus areas, there are too many activities allocated to different areas with different effects. UNFPA could improve efficiency in these areas by avoiding dividing the limited available resources into too many activities and by focusing on those interventions with greater results.

Recommendation 3: (linked to the Conclusion #3)

High Priority

UNFPA's efforts should be directed first to explore whether conditions (creation of (i) full ownership and critical mass of commitment from institutions for a certain policy measure (in this case CGP) (ii) adequate capacities (which was built through training on the methodology of CGP development) and (iii) appropriate processes (which was established through AI on CGP), which is also entirely financed by sustainable funding mechanisms (by the Ministry's budget to design, implement and monitor policy initiatives by themselves) exist or can be developed especially in programmatic initiatives in relation to MCH, SRHR and CCSP and then decide to design or expand appropriate interventions in these focus areas in order to achieve greater and more sustainable results.

Recommendation 4: (linked to the Conclusion #6)

High Priority

Since gynecology services will not be part of the PHCs, **UNFPA should re-think its strategy towards introducing or strengthening CCSP within the secondary healthcare system or invest heavily in changing the beliefs of targeted women population that such screening processes can be done by PHC through Family Physicians.**¹³³ **UNFPA has to support the creation of sustainable quality controls and improvement of reading PAP smears within Pathologic Institute with periodic double checks of randomized samples locally and internationally and support further on a follow-up mechanism to reliably track the management cycle of suspicious or confirmed cases of cancer.**

Recommendation 5: (linked to the Conclusion #7)

High Priority

Use the results of the pilot CCSP to generate political will, critical mass of commitment and wider population support for upscaling the programme

Recommendation 6: (linked to the Conclusion #9)

High Priority

Support the Medical Professional Chamber, Primary Health Care Division in MoH toward achieving dynamic sustainability of training activities along with the development of a sustainable and standardised quality monitoring system of the effect of the training for Family Medicine to provide quality integrated SRH on FP and STI, and YFHS;

Recommendation 7: (linked to the Conclusion #10)

High Priority

Consider expanding training to relevant teachers on sexuality education. **The UNFPA should consider prioritising training for Biology teachers first, then target training of primary education teachers if there are significant budgetary limitations.** According to our estimates there should be around 930 Biology teachers, both in lower and upper secondary schools (about 560 in lower secondary and 370 in upper secondary schools)¹³⁴ and about 7000 primary education teachers. Furthermore, in order to lower the cost of organising a training, the UNFPA could consider increasing the number of teachers that participate in each training, especially for the training targeting primary school teachers.

Make sure textbooks of pre-university education cover the right content on sexuality education which will be initially prepared in 2020;

¹³³ Nevertheless, the later approach would also require investing in space, equipment and capacities of the Family Medicine Teams to carry on PAP test sample taking in their routine work as well as creating settings and conditions in which they will be able to provide such services respecting the privacy and confidentiality of their clients

¹³⁴ If we take into account, the current cost of organising training and foresee that in each training there will be about 30 teachers of Biology then the total cost of organising training for all Biology teachers would be 62,000 euro

In order to support the delivery of the sexuality education, the UNFPA should consider developing and delivering more specific training for education inspectors, enabling them to monitor and support teachers during the delivery of the class as well as identify the most appropriate modality (i.e. perhaps through education inspectors or external exam, internal exam, by interviewing students etc. or combination of these methods) to measure the extent to which the sexuality education is being delivered and take follow up actions based on the results gathered.

Recommendation 8: (linked to the Conclusion #12)

High Priority

Invest in data collection tools that will apply the same methodology in repeated terms after a certain period (usually four years) to be able to observe any changes in perceptions, attitudes and practices.

The peer education programme targeting youth should merge SRHR and gender equality components; gradually the programme should focus more on gender equality topics since SRHR issues will be covered by the formal education system.

Recommendation 9: (linked to the Conclusion #14)

High Priority

Continue to facilitate the working group on vital statistics to address issues for the establishment of long-term cooperation between various institutions.

Shift the support to demographic data analysis towards providing quality assurance assistance to KAS.

Recommendation 10: (linked to the Conclusion #15)

High Priority

Expand measurement of many other SRHR indicators¹³⁵ through the next MICS survey (see above) or alternatively produce a UNFPA sponsored report every four-to-five years for this purpose.

Recommendation 11: (linked to the Conclusion #4)

Medium Priority

Given the success in initiating and developing the CGP, UNFPA should shift the support to KCCGP on developing and implementing the quality monitoring of the CGP implementation. Develop regular ad-hoc quality monitoring mechanisms within the MoH, Medical Chamber or Kosovo Obstetric and Gynaecologic Association (KOGA) to continuously monitor EPC.

¹³⁵ Regarding the safe, effective, affordable and acceptable contraception method of their choice, STI, HIV and other concepts of SRHR as well as on gender norms and roles.

Recommendation 12: (linked to the Conclusion #5)

Medium Priority

Support achieving the dynamic sustainability of the EPC support (for both training and follow up visits) embedded entirely within the MoH, Medical Chamber or Kosovo Obstetric and Gynaecologic Association, as well as creating a critical mass of commitment from these institutions towards continues development of the EPC service delivery.

Continue supporting the institutional development of the K10 to express their voice and advocate towards greater accountability for SRHR services and not only focusing on marking different international SRH days.

Recommendation 13: (linked to the Conclusion #8)

Medium Priority

In order to increase effectiveness, **UNFPA is suggested to work on and advocate about strengthening the accountability framework to create adequate incentives of PHC for the delivery of SRH services. In parallel, UNFPA is recommended to continue advocating for the MoH to establish a budget line for contraceptives and support further OiK capacities to perform oversight and accountability function towards institutions in fulfilling SRHR.**

Recommendation 14: (linked to the Conclusion #11)

Medium Priority

In the long run, work on the inclusion of the sexuality education into MEST ToT system to enhance the dynamic sustainability of the interventions.

Recommendation 15: (linked to the Conclusion #13)

Medium Priority

UNFPA needs to have a greater outreach and sustainability for peer education, and focus on digitalisation of the peer education content. Development of the mobile application for SRHR is important step in this direction. However, in order to achieve the intended impact, such content should be widely used by young people. Thus, the UNFPA should consider developing and implementing various promotion tools to reach out to young people. Such content should also be very much appealing for young people and might also require the establishment of a communication channel for follow up questions and answers by the young people. Discussions from focus groups with young people reveal the difficulty of getting the interest of young people for such content, even if it is accessible from the mobile phones, if they are not attractive to them.

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Annex 1. The Terms of Reference for the Evaluation of the Country Programme for Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia, the Republic of Serbia and Kosovo (UNSCR 1244)

A. INTRODUCTION

The United Nations Population Fund (UNFPA) is the lead United Nations sexual and reproductive health agency for ensuring rights and choices of all. The strategic goal of UNFPA is to achieve the three transformative results: ending unmet need for family planning, ending maternal death, and ending violence and harmful practices against women and girls. In pursuing its goal, UNFPA has been guided by the International Conference on Population and Development (ICPD) Programme of Action (1994), the Millennium Development Goals (2000) and the 2030 Agenda for Sustainable Development (2015).

The Terms of Reference (TOR) lay out the objectives and scope of the evaluation, the methodology to be used, the composition of the evaluation team, the planned deliverables and timeframe, as well as its intended use. The Terms of Reference also serve as a basis for the job descriptions for the evaluation team members.

The ToR is written by the evaluation managers of UNFPA country offices, Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia, and the Republic of Serbia and Kosovo (UNSCR 1244), with the support of the Eastern Europe and Central Asia Regional Office Monitoring and Evaluation Adviser. Final ToR is approved by the Regional Office for Eastern Europe and Central Asia on behalf of Evaluation Office before the launch of the evaluation.

Bosnia and Herzegovina, The former Yugoslav Republic of Macedonia, and the Republic of Serbia and Kosovo (UNSCR 1244), are UNFPA country offices that form one of the administrative clusters of the Eastern Europe and Central Asia region. The programmes of these offices have the harmonized programme cycle ending in 2020, therefore the cluster programme evaluation of all four programmes is planned as part of the UNFPA quadrennial evaluation plan (DP/FPA/2018/1) approved by the Executive Board.

The overall purpose of the cluster evaluation is to: a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources, b) support evidence-based decision-making, and c) contribute important lessons learned to the existing knowledge base on how to accelerate the implementation of the ICPD Programme of Action.

The primary users of this evaluation are the decision-makers in cluster countries where UNFPA operates, including the organization as a whole, government counterparts, and other development partners. The UNFPA Regional Office for Eastern Europe and Central Asia and UNFPA Headquarters divisions, branches and offices will also use the evaluation as an objective basis for programme performance review and decision-making.

The evaluation will be managed by a steering committee consisting of country office evaluation managers with guidance and support from the UNFPA Regional Advisor on Monitoring and Evaluation and the UNFPA Evaluation Office, and in consultations with the Evaluation Reference Group. A team of competitively selected independent evaluators will conduct the cluster evaluation and prepare the evaluation report and country case studies.

B. CONTEXT

a. Country Profile

Bosnia and Herzegovina

Bosnia and Herzegovina (BiH) consist of two entities (Federation of Bosnia and Herzegovina (FBiH) and Republika Srpska (RS)), and the Brcko District of Bosnia and Herzegovina (BD). Each of the entities and BD have own governments and parliaments/assemblies while at the state level there is the tripartite Presidency of BiH, the Council of Ministers of BiH and bicameral Parliamentary Assembly of BiH. FBiH is further divided into 10 cantons that have major responsibility for development of economic, health, education and social protection sectors. Finally, entities are divided into municipalities; 79 in FBiH and 68 in RS. In line with the 2013 Census report, the total number of citizens in BiH is 3.531.159¹³⁶. Population growth has a negative trend since 2007, while the fertility rate remains one of the lowest in the world. Population migrations to developed countries are also underway, where mostly young, skilled people dissatisfied with the current socio-political situation leave BiH, causing a major brain drain. Finally, UN estimates BiH will have at least 30% of persons over 65 years of age by mid-century.

The former Yugoslav Republic of Macedonia

Based on population estimates, the country had over 2 million inhabitants in 2017¹. The population is increasingly aging and the total fertility rate (TFR) is 1.50 live births per woman in the last few years, which is below the replacement rate. The 2002 Census was the last census undertaken in the country and it was evaluated by the international community as well organized. The country was granted EU candidate status since 2005, with accession talk to start 2019, if all agreed political steps with neighboring countries and international community are put in place.

The key issues that population faces regarding SRH is increasing maternal mortality and adolescent pregnancy, rise of STIs especially among young people, and low use of modern contraceptive. The rates are lower among rural, poor and low-educated women and due to the lack of sexuality education, cultural barriers, stigma and discrimination, especially for the Roma and other marginalized groups. The SRH health services lack referral pathways between different level of care as well as shortage of human resources and poor quality of care. The regulatory-administrative system for evidence-based clinical governance is in rudimentary stages.

Gender inequality and reproductive health and rights in the country are still lagging behind compared with the EU countries. Acceptance of domestic violence (DV) is closely associated with a woman's

¹³⁶The 2013 Census Report, although officially recognised by the BiH Agency for Statistics and the FBiH Institute for Statistics, as well as by the members of the International Monitoring Missions (including Eurostat, UNFPA, UNSD and UNECE), has been disputed by the RS Institute for Statistics for the reason of disagreement over the methodology used for data processing. Instead, the RS Institute for Statistics has developed own Census report that is in use in this entity. By the time this ToR is developed, there has been no agreement between government institutions on how this issue will be solved so different administrations are using different census results.

education level. Due to the societal gender social norms, especially vulnerable to gender based violence are members of the young key populations (defined as MSM, sex workers, PWID, PLHIV). Furthermore, these are especially vulnerable to HIV and other STIs. The harmful practice of early marriage, formal and informal, prevents girls from finishing education, acquiring skills and competences to work, thus making them more vulnerable to poverty and social exclusion.

The Republic of Serbia

The Republic of Serbia was granted status of the EU candidate country in 2012, and current reforms and all national policies are marked with the efforts to fulfill conditions for EU accession. Territory of Serbia is divided into regions which do not have any administrative power or legal subjectivity, but are functional territorial units for the purposes of regional planning and policy implementation. Within these regions Serbia is further divided into districts including the City of Belgrade as one district, and within districts into municipalities and cities which are the administrative units of local self-government. According to official estimation there were 7,058,322 inhabitants in 2016¹³⁷. Serbia has been facing unfavorable demographic trends: low natality rate, negative natural growth rate, slow increase in life expectancy, ageing (average age is 42,9) and increase in share of population aged 65 years and over, but also high level of internal migrations from rural to urban areas and emigration, resulting in overall negative migration balance.

Main challenges in sexual and reproductive health are low use of modern contraception, underreported, but still high number of induced abortions, insufficient knowledge of youth about the SRH and related risks, higher incidence and mortality from (preventable) cervical and breast cancers compared to EU. Gender inequalities are still underlined and there are persistent deep-rooted stereotypes and traditional roles of women and men in the family and society. Since 2015, the country have experienced a strong inflow of migrants, refugees and asylum-seekers taking the Balkan route to the Western Europe.

Kosovo (UNSCR 1244)

Kosovo (UNSCR 1244) is situated in the Western Balkans covering around 11 thousand square kilometers. After conflict cessation in 1999, the United Nation Security Council by its resolution 1244 established the United Nations Interim Administration Mission and the North Atlantic Treaty Organization-led Multinational Force was deployed. On 17 February 2008, the Kosovo (UNSCR 1244) Assembly declared independence followed by the establishment by the European Union of the European Union Rule of Law Mission within the framework of the United Nations Security Council Resolution 1244 aiming to support European integration. Kosovo (UNSCR 1244) is recognized as an independent country by 114 out of 193 United Nations members and by 23 out of 28 European Union (EU) members. Kosovo (UNSCR 1244) is a potential candidate for EU membership, a process that was accelerated with the signing of the

¹³⁷Statistical Office of Serbia (2017) *Demographic Yearbook 2016*, Belgrade.

<http://www.stat.gov.rs/WebSite/public/PublicationView.aspx?pKey=41&pLevel=1&pubType=2&pubKey=4225>

Stabilization Association Agreement in October 2015, in force since April 2016. The current Government was voted in on September 9, 2017.

According to the 2011 Census the population is 1.7 million with 60 per cent in rural areas. Northern Kosovo (UNSCR 1244) municipalities did not participate in the 2011 census. Total number of households is 300,000 with the average household size of 6 members. One out of every four Kosovars lives abroad and it is estimated that over 50,000 migrated illegally in 2015. Around 50 per cent of population is under the age of 25 and only 6 per cent over 65 years. The Total Fertility Rate is approx two children per women and the annual rate of population growth is 0.9 per cent. Life expectancy at birth is 70.2 years, 10 years lower than the European Union.

b. UNFPA Country Programme

Bosnia and Herzegovina

The 2nd UNFPA Country Programme Document for Bosnia and Herzegovina (DP/FPA/CPD/BIH/2) has been approved by the UNDP/UNFPA/UNOPS Executive Board at its second regular session in September 2014. The programme initially covered the period from 2015 to 2019, but has been extended at no cost for 1 year through 2020, following the respective extension of the UN Development Assistance Framework (UNDAF) for Bosnia and Herzegovina. The UNFPA financial commitment over 5 years towards the programme was approved at \$ 2.4 million from regular resources (\$ 0.8 million for sexual and reproductive health and rights component, \$ 0.7 million for adolescents and youth component, \$ 0.3 million for gender equality and women's empowerment component, \$ 0.3 million for population dynamics component, and \$ 0.3 million for programme coordination and assistance). UNFPA also committed to mobilize \$ 1 million from other resources to co-fund the programme. By mid-2018, UNFPA office in BiH has managed to fundraise over \$ 1.2 million, mostly for the gender equality and women's empowerment component.

Sexual and Reproductive Health initiatives have been focusing primarily on development of adequate population health policies that will develop systems aimed at improving the provision of family planning services, improving the reproductive health of general population (with focus on most vulnerable population groups) and providing adequate protection and health support to those affected by emergencies, along with improving the capacities of government stakeholders for the provision of such services in local communities. Youth initiatives have been mostly related to the provision of technical support and development of youth policies, as well as support to development and implementation of Comprehensive Sexuality Education curricula across the country. Specific focus has also been put on the prevention of early marriages among the Roma population. Initiatives related to Gender-based Violence were mostly focused on the prevention of stigma against the survivors of Conflict-related Sexual Violence (CRSV) and development of referral systems for the provision of support to this population group (including building capacities of institutional and religious stakeholders for first contacts with and provision of support to the survivors of CRSV). Finally, Population Dynamics initiatives mostly focus on the provision of evidence for development of population policies in the country, as well as support to development of policies on ageing and promotion of Healthy Ageing Centres.

The former Yugoslav Republic of Macedonia

UNFPA is present in the country since 2007 and the first UNFPA five year Country Program Document (CPD) 2016-2020, developed with the Government and other partners, was approved by the Executive Board in 2015. CPD's main focus is enhancing sexual and reproductive health and rights, and address gender based violence, with focus on youth and improving the use of population information in development policies.

The UNFPA financial commitment over 5 years towards the programme was approved at \$ 1.5 million from regular resources (\$ 1.1 million for sexual and reproductive health and rights component, \$ 0.1 million for adolescents and youth component, \$ 0.1 million for population dynamics component, and \$ 0.2 million for programme coordination and assistance). UNFPA also committed to mobilize \$ 1 million from other resources to co-fund the programme. By mid-2018, UNFPA office has managed to fundraise over \$ 0.5 million, mostly for the humanitarian preparedness and response in the period 2015-2016 from internal, UNFPA and donor resources, and, SRH and GBV activities and support to PwD.

In the country, UNFPA has well-established strong partnerships with the Government and its bodies, UN Agencies CSOs and academia. In 2018, UNFPA's co-funding Mechanism (Consistent with Executive Board decision (2013/31) is applied in the country for the first time.

UNFPA has built on the existing investments of the regional office in various areas, and supported national Government in drafting Action Plan to SRH Strategy (to be adopted in 2018). The achievements include development of national clinical guidelines adaptation, implementation and audit program, introduction of obstetric surveillance system, and introduction of MISP concept in the national policies. From the nationally born efforts, it's worth highlighting the development of family planning training package, conducting of a number of analysis and assessments, focusing on Market Segmentation Research, Logistics Management Information System, Emergency Obstetrics and Neonatal Care, Cervical and Breast Cancer Screening, Social Marketing, etc. A significant number of professionals were trained based on evidence-based practices in the fields of family planning; MISP; clinical management of rape and for the prevention and management of GBV; clinical guidelines development, adaptation and audit; and obstetrics surveillance. Though gender is not specific Outcome of the CPD it is cross cutting issue in all other outcomes, resulting in significant achievements in humanitarian preparedness and response as well as opening of the first in the Western Balkan region, sexual assault referral centers and raising awareness among you and engagement of men in gender equality efforts. UNFPA is part of the recently approved joint UN Programme on prevention of institutionalization of People with Disabilities (PwD), supported by UNPRPD Disability Fund. Over the next two years, UNFPA will implement SRH and GBV prevention and response activities among PwD in the South Western region of the country, in partnership with the Platform for SRH of persons with disabilities, led by NGO HERA.

UNFPA works through key populations community organizations and since 2017 have partnered with NGO Star Star to support community empowerment of young key populations for their rights and protection.

UNFPA partners with NGO “Macedonian Anti-Poverty Platform” to implement analysis, policy dialogue and advocacy for population data collection and analysis to understand population trends, SDGs implementation and advocacy for full implementation of Madrid Plan of Action for Ageing.

The Republic of Serbia

The work of UNFPA in Serbia started in 2006, guided by UNDAF framework. The first UNFPA five year Country Program Document (CPD) 2016-2020 was developed in 2015, in line with UNDAF (2016-2020) and the UNFPA Strategic Plan 2014-2017. CPD’s is concentrated on three areas: 1. Sexual and reproductive health services and rights; 2. Policies and programmes related to adolescents and youth and 3. Evidence based policies addressing population dynamics. Activities envisaged in CPD are being implemented through cooperation with all relevant governmental institutions, academia experts associations, UN Agencies and CSOs.

In the field of SRH, UNFPA CO supported the Ministry of Health in policy development and capacity building. The first National Program for Sexual and Reproductive Health and Rights was adopted at the end of 2017. In addition, CO supported development of the National Clinical Guidance for Modern Contraceptive Provision, and Procedure for SRH in emergency situation, based on MISP. Number of health professionals was trained on MISP, GBV and clinical guidelines development.

As part of humanitarian response, UNFPA CO Serbia provided the access to SRH service to the women and girls within migration population. UNFPA CO supported Ministry of Labour, Employment, Veteran and Social Affairs to develop Standard Operating Procedures of the Republic of Serbia for Prevention and Protection of Refugees and Migrants from Gender Based Violence and organized several trainings on this topic. UNFPA CO Serbia recognised vulnerability of boys and young men and supported BOYS on the MOVE life skills programme.

In the field of youth programs and policies, UNFPA CO is working on raising awareness on the importance of sexuality education in schools. CO also works with men and boys on abandoning harmful gender stereotypes, through trainings, public actions and campaigns. CO supported implementation of the International Men and Gender Equality Survey (IMAGES), the most comprehensive survey on men’s attitudes and practices related to gender equality. CO supported Ministry of Youth and Sports to review youth policy and work of youth organisations and to define recommendation to align goals of National Youth Strategy 2015 – 2025 with realisation of SDGs. In the field of rights-based policies that integrate evidence on emerging population issues, UNFPA CO is supporting several researches related to: status and needs of the elderly households in rural and urban areas, ways of balancing the work and parenting in Serbia, and demographic situation in several selected municipalities. Researches provide evidences for integrating issues related to population dynamics in national policies and programmes and elaborating targeted strategies and interventions to address the challenges identified.

Kosovo (UNSCR 1244)

Currently, UNFPA Kosovo (UNSCR 1244) is implementing its first Draft programming document for Kosovo (UNSCR 1244) developed in a participatory approach with partners, and approved by Executive Board in 2015. The UNFPA financial commitment over 5 years towards the programme was approved at \$ 1.5 million from regular resources (\$ 0.6 million for sexual and reproductive health and rights component, \$ 0.4 million for adolescents and youth component, \$ 0.3 million for population dynamics component, and \$ 0.2 million for programme coordination and assistance). UNFPA also committed to mobilize \$ 1 million from other resources to co-fund the programme.

The programme is based on Kosovo (UNSCR 1244) emerging priorities on governance and rule of law and on human capital and social cohesion and it seeks to support Kosovo (UNSCR 1244) efforts to: (a) develop integrated and high-quality sexual and reproductive health services that are affordable, accessible, and meet human rights standards; (b) empower youth and women, with particular emphasis on marginalized groups such rural and Roma, Ashkali and Egyptian; (c) Promote gender equality and address gender-based violence and harmful practices; (d) support to development of evidence-based population policies.

The Sexual And reproductive Health initiatives will focus on advocacy and policy dialogue, knowledge management, and capacity building for strengthening evidence-based health policy-making and planning; improving capacity of health personnel to deliver quality family planning, sexually transmitted infections, HIV and AIDS, adolescent friendly sexual and reproductive health services, cervical screening and response to gender based violence; strengthening reproductive health commodity security, including social marketing of male condoms; improving the population knowledge on sexual and reproductive health issues with the special focus on marginalized groups; strengthen institutional and civil society initiatives in addressing gender based violence, conflict related sexual violence, and gender-biased sex selection; integrating Minimum Initial Service Package for reproductive health in the emergency preparedness plans.

Adolescent and youth initiatives will focus on advocacy, policy advice and technical support for: improve availability and utilization of data for development evidence based, gender-sensitive sexual and reproductive health and rights-related policies and strategies on youth, with focus on marginalized groups, including the Roma, migrants and key populations at risk of HIV and sexually transmitted infections; revision of school curricula to incorporate comprehensive sexuality education that meet international standards, including human rights and gender equality;strengthening youth peer education programming and utilize new technologies to promote sexual and reproductive health and rights, including gender transformative programming. Population dynamics initiatives will focus on advocacy and policy dialog, technical assistance and capacity building in support evidence-based decision making at the central and municipal levels through: strengthen national capacities for population data collection, analysis, dissemination and use; support Kosovo authorities, independent human rights organisations, and civil society networks to use comprehensive methodologies for monitoring, analysing and reporting;partnerships for the development of comprehensive rights-

based and evidence-based population policies to address emerging population trends, population dynamics, gender and youth;

C. OBJECTIVES AND SCOPE OF THE CLUSTER EVALUATION

The overall objectives of a cluster evaluation: (i) an enhanced accountability of UNFPA and its country offices for the relevance and performance of their programmes and (ii) a broadened evidence-base for the design of the next programming cycle.

The specific objectives:

- To provide an independent assessment of the progress of each programme towards the expected outputs and outcomes set forth in the results framework of the respective country programmes;
- To provide an assessment of each country offices positioning within the developing community and national partners, in view of its ability to respond to national priority needs while adding value to the development results.
- To draw key lessons from past and current cooperation and provide a set of clear, specific and action-oriented strategic recommendations for the next programming cycle.

The evaluation (including country case studies) will cover all activities planned and/or implemented during the period: Bosnia and Herzegovina 2013-2018, The former Yugoslav Republic Macedonia 2010-2018, The Republic of Serbia 2010-2018, and Kosovo (UNSCR 1244) 2010-2018 within each programme: sexual and reproductive health and rights, adolescent and youth, population dynamics, gender equality and humanitarian response, and cross-cutting areas: partnership, resource mobilization, and communication). **The scope of the evaluation is extended beyond the current programme period to assess achievement/non-achievement of higher level development results.** Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects. The cluster evaluation should analyze the achievements of UNFPA against expected results at the output and outcome levels, its compliance with the UNFPA Strategic Plans for 2014-2017 and 2018--2021, the UN partnership Framework, and national development priorities and needs.

The evaluation will reconstruct the programme intervention logic and assess the extent to which the ongoing programmes have chosen the best possible modalities for achieving the planned results in the current development context. The evaluation will examine the programmes for such critical features as relevance, effectiveness, efficiency, sustainability, UN coordination, and added value. The evaluation will apply appropriate methodology including UNEG Handbook for Conducting Evaluations of Normative Work in the UN System¹³⁸ for assessing the equity and vulnerability, gender equality¹³⁹, human rights in development and humanitarian programme¹⁴⁰.

¹³⁸ UNEG Handbook for Conducting Evaluations of Normative Work in the UN System, <http://www.uneval.org/document/detail/1484>

¹³⁹ Integrating Human Rights and Gender Equality in Evaluations, UNEG, <http://www.uneval.org/document/detail/1616>

¹⁴⁰ Equity focused evaluation: https://mymande.org/sites/default/files/EWP5_Equity_focused_evaluations.pdf

Based on the conclusions and recommendations of the cluster evaluation, the UNFPA country offices will prepare a formal management response to ensure that all evaluation recommendations are considered and/or acted upon.

D. EVALUATION CRITERIA AND EVALUATION QUESTIONS

In accordance with the methodology for CPEs as set out in the UNFPA Handbook “How to Design and Conduct a Country Programme Evaluation” (2012), the evaluation will be based on finding answers to a number of questions covering the following evaluation criteria:

Relevance:

- To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and elderly persons, (ii) and in line with the priorities set by the international and national policy frameworks, iii. aligned with the UNFPA policies and strategies and the UN Partnership Framework, as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?
- To what extent has the country offices been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries?

Effectiveness:

- To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of the planned outcomes (i. increased utilization of integrated SRH Services by those furthest behind, ii. increased the access of young people to quality SRH services and sexuality education, iii. mainstreaming of provisions to advance gender equality, and iv. developing of evidence-based national population policies) and what was the degree of achievement of the outcomes?
- To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The former Yugoslav Republic of Macedonia, the Republic of Serbia, and Kosovo (UNSCR 1244), and in the area of maternal health / sexual and reproductive health including MISP?
- To what extent has each office been able to respond to emergency situation in its AoR, if one was declared? What was the quality and timeliness of the responses?

Efficiency:

- To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?

Sustainability:

- Are programme results sustainable in short and long-term perspectives?
- To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

UNCT Coordination:

- To what extent did UNFPA contribute to coordination mechanisms in the UN system at country level?

- To what extent does the UN Partnership Framework reflect the interests, priorities and mandate of UNFPA?
- To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?

Added value:

- What is the main UNFPA added value in the area context as perceived by UNCT, government and civil society organisations?

E. METHODOLOGY AND APPROACH

The cluster evaluation approach and methodology will include desk review, data collection and analysis methods.

Data Collection

The evaluation will use a multiple-method approach to data collection, including documentary review, group and individual interviews, focus groups and field visits to programme sites as appropriate. The collection of evaluation data will be carried out through a variety of techniques ranging from direct observation to informal and semi-structured interviews and focus/reference groups discussions. The evaluators will be required to take into account ethical considerations when collecting information.

Retrospective and Prospective Analysis

Evaluators may assess the extent to which programme results effects have been already achieved, but also look into the prospects, i.e. the likelihood of results being achieved. Evaluators are expected to conduct retrospective assessments for the most part, analysing *what* has happened and the reasons *why*, but prospective assessments are also an option to determine results of ongoing programme. However, whenever evaluators choose to conduct prospective assessments they should explicitly indicate it in the methodological chapters of the design and final reports. Evaluators should also explain the reason why a prospective assessment has been chosen.

Validation mechanisms

The evaluators will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the UNFPA programme staff and the Evaluation Reference Group. Counterfactual analysis is to be applied wherever possible to explore the cause-to-effect relationships within the programme being evaluated.

Stakeholders participation

The evaluation will adopt an inclusive approach, involving a broad range of partners and stakeholders. The Evaluation Manager in each office will perform a stakeholders mapping in order to identify both UNFPA direct and indirect partners (i.e., partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the government, civil-society organizations, the private-sector, UN organizations,

other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

An Evaluation Reference Group (ERG) will be established by the UNFPA Country Office in each country comprising key programme stakeholders (national governmental and non-governmental counterparts, Evaluation Manager from the UNFPA Country Office). The ERG will review and provide inputs to the country case study, provide feedback to the evaluation design report, facilitate access of evaluators to information sources, and provide comments on the main deliverables of the evaluation, in particular the country case studies at the draft stage.

F. EVALUATION PROCESS

The evaluation will unfold in five phases, each of them including several steps.

1) Preparation

This phase, managed by the UNFPA Offices, will include:

- Drafting of cluster programme evaluation (CPE) terms of reference (ToR);
- Establishing an Evaluation Reference Group (ERG);
- Receiving approval of the CPE ToR from the UNFPA Regional Office;
- Selecting potential evaluators;
- Receiving pre-qualification of potential evaluators from the UNFPA Regional Office;
- Recruiting evaluators and establishing an Evaluation Team chaired by the Evaluation Team Leader;
- Preparing the initial set of documentation for the evaluation, including the list of Atlas projects and stakeholder map.

The preparation phase may include a short scoping mission to the UNFPA Country Office in Bosnia and Herzegovina located in Sarajevo by the Evaluation Team Leader to gain better understanding of the development context, UNFPA programme and partners, refine the evaluation scope, etc.

2) Design phase

This phase will include:

- a documentary review of all relevant documents available at UNFPA HQ and CO levels regarding the programmes for the period being examined. For the evaluation of programmes in The former Yugoslav Republic of Macedonia, Kosovo (UNSCR 1244) and Serbia prior to their first approved Programme, other evaluative evidence documents for the period from 2014 will be reviewed;
- a stakeholder mapping – The evaluation managers will prepare a mapping of stakeholders relevant to the evaluation. The mapping exercise will include institutional and civil-society stakeholders and will indicate the relationships between different sets of stakeholders;
- an analysis of the intervention logic of the programme, - i.e., the theory of change meant to lead from planned activities to the intended results of the programme;
- the finalization of the list of evaluation questions and development of evaluation matrix for each office;

- the development of a data collection and analysis strategy as well as a concrete work plan for the field phase.

At the end of the design phase, the evaluation team leader will produce an evaluation design report summarizing the results of the above-listed steps and tasks. This report must demonstrate how the evaluators have understood the purpose and objectives of the CPE, its scope and criteria, the country's development context and programme intervention logic, selected evaluation questions, and should convincingly illustrate how the evaluators intend to carry out the evaluation and ensure its quality.

The design report must include the evaluation matrix, stakeholders map, final evaluation questions and indicators, evaluation methods to be used, information sources, approach to and tools for data collection and analysis, calendar work plan, including selection of field sites to be visited – prepared in accordance with the UNFPA Handbook “How to Design and Conduct a Country Programme Evaluation”. The design report should also present the reconstructed programme intervention cause-and-effect logic linking actual needs, inputs, activities, outputs and outcomes of the programme. The design report needs to be reviewed, validated and approved by the UNFPA Evaluation Steering Committee before the evaluation field phase commences.

The evaluation team leader will facilitate a training on evaluation methodology, evaluation tools, data collection, data analysis, and preparation of country case studies for national evaluators hired by UNFPA. The national evaluators will finalize country stakeholders map, adjust/translate data collection tools etc.

3) Field phase

After the design phase, the National Evaluation Team will undertake a two-week collection and analysis of the data required in order to answer the evaluation questions consolidated at the design phase, and to analyze the findings with a view to formulate the preliminary conclusions and recommendations of the country case study. At the end of the field phase, the Country Evaluation Team and Evaluation Team Leader will provide the UNFPA country office with a debriefing presentation on the preliminary results of the country case study, with a view to validating these preliminary findings and testing tentative conclusions and/or recommendations.

At the end of the field phase, Evaluation Team Leader will provide the Evaluation Steering Committee with a debriefing presentation on the preliminary results of the evaluation (online or in person), with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.

4) Synthesis phase

During this phase, the Evaluation Team will continue the analytical work initiated during the field phase and prepare a **first draft evaluation report and country case studies**, taking into account comments made by the Evaluation Steering Committee at the debriefing meeting.

This **first draft country case studies** will be submitted to each Evaluation Reference Group for comments (in writing). Comments made by the Evaluation Reference Group and consolidated by the evaluation managers will then allow the Evaluation Team to prepare a **second draft evaluation report and country case studies**. This second draft evaluation report will form the basis for individual office **dissemination seminar(s)**, which should be attended by all the key programme stakeholders in the office AoR. The **final**

evaluation report will be drafted shortly after the seminar(s), taking into account comments made by the participants.

5) Dissemination and follow-up

During this phase, UNFPA offices, including relevant divisions at UNFPA headquarters, will be informed of the evaluation results. The evaluation report, accompanied by a document listing all recommendations, will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once completed, this document will become the *management response* to the evaluation. The UNFPA offices will provide the management response within six weeks of the receipt of the final evaluation report.

The evaluation report, along with the CPE ToR and management response, will be published in the UNFPA evaluation database within eight weeks since their finalization. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

G. EXPECTED OUTPUTS/ DELIVERABLES

The evaluation team will produce the following deliverables:

- a cluster evaluation design report including (as a minimum): a) a stakeholder map ; b) the evaluation matrix (including the final list of evaluation questions and indicators) ; c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase. The design report should have a maximum of 70 pages;
- a first draft cluster evaluation report and four first draft country studies accompanied by a debriefing PowerPoint presentation synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the Evaluation Steering Committee during the (online or in person) debriefing meeting foreseen at the end of the field phase;
- a second draft cluster evaluation report and four country case studies (followed by a second draft, taking into account potential comments from the Evaluation Steering Committee) and . The evaluation report should have a maximum of 50 pages (plus up to 70 pages for each Case Study, and plus annexes); four PowerPoint presentations of the results of the evaluation for the dissemination seminars to be held separately in each office AoR, and led by the national evaluators;
- a final evaluation report including four country case studies, based on comments expressed during the dissemination seminars.

All deliverables will be written in English. The PowerPoint presentation for the dissemination seminars and the final evaluation report might need to be translated in local languages if requested by national counterparts.

Work plan/ Indicative timeframe

Phases/Deliverables	Dates
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<p>1. Drafting and approval of the ToRs</p> <ul style="list-style-type: none"> - <i>Evaluation ToR</i> - <i>ToR for the Evaluation Steering Committee</i> - <i>TOR for international evaluator</i> - <i>TORs for local evaluators, experts and assistants</i> - <i>TOR for the Evaluation Reference Group(s)</i> 	<p>July 2018</p>
<p>2. Recruitment/vetting of international and national experts</p>	<p>August - October 2018</p>
<p>3. Training workshop for national evaluators (5 days)</p>	<p>4th week of October 2018</p>
<p>4. Design phase:</p> <ul style="list-style-type: none"> - <i>Submission of the design report</i> 	<p>August - October 2018 <i>4th week of October 2018</i></p>
<p>5. Field phase</p> <ul style="list-style-type: none"> - <i>Bosnia and Herzegovina</i> - <i>Kosovo (UNSCR 1244)</i> - <i>The former Yugoslav Republic of Macedonia</i> - <i>Serbia</i> 	<p>November 2018 - February 2019 <i>November - December 2018</i> <i>December 2018 - January 2019</i> <i>January - February 2019</i> <i>January - February 2019</i></p>
<p>6. Synthesis phase (evaluation report + case studies):</p> <ul style="list-style-type: none"> - <i>1st draft case study for Bosnia and Herzegovina and presentation to Steering Committee</i> - <i>1st draft case study for Kosovo and presentation to Steering Committee</i> - <i>1st draft case study for The former Yugoslav Republic of Macedonia and Serbia, and presentation to Steering Committee</i> - <i>2nd draft case studies (for all 4 COs)</i> - <i>Draft cluster evaluation report</i> - <i>Dissemination seminars (in all four COs)</i> - <i>Final evaluation report and all four case studies (BiH, The former Yugoslav Republic of Macedonia, Kosovo (UNSCR 1244), Serbia)</i> 	<p>January - mid-June 2019 <i>Mid-January 2019</i> <i>Mid-February 2019</i> <i>End of March 2019</i> <i>3 weeks from presentation of 1st drafts</i> <i>1st week of May 2019</i> <i>March - May 2019</i></p>

	<i>Mid-June 2019</i>
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H. COMPOSITION AND QUALIFICATION OF THE EVALUATION TEAM

The evaluation team will consist of:

- a) **A Team Leader** with overall responsibility for development of cluster design report, facilitation of a training on evaluation design, field data collection, data analysis and submission of country case studies. Furthermore, s/he will lead and coordinate the work of the National Evaluation Team in the field phase and will be responsible for drafting of case studies together with national evaluators, as well as the quality assurance of all evaluation deliverables. Finally, s/he will be responsible for writing draft/final evaluation report. S/he will be in regular contact with the Evaluation Team remotely via Internet to get updates on the field work progress. In case s/he decides that the collected information is not sufficient or of good quality, s/he may request national evaluators to conduct additional interviews with key stakeholders or, as a last resort, s/he may travel to the country for preparing the draft country case studies. The Evaluation Team Leader should have the following qualifications:
 - Advanced degree in social sciences, political sciences, economics or related fields;
 - Minimum 7 years of experience of complex evaluations in the field of development aid for UN agencies and/or other international organizations in the position of lead evaluator,
 - Specialization in one of the programmatic areas covered by the evaluation (reproductive health and rights, gender equality, population and development, adolescent and youth policies)
 - Demonstrated ability and knowledge to collect and analyze qualitative and quantitative data (a training on data analysis using software e.g. SPSS);
 - Good knowledge and experience of programme evaluation in the humanitarian settings will be strong assets
 - Knowledge of demographic, political, social and economic conditions in the Western Balkans (preferable);
 - Familiarity with UNFPA or UN programming;
 - Excellent writing and communication skills;
 - Excellent command of both spoken and written English is required.

- b) **Four national evaluators** (one in each country office) with overall responsibility for coordinating field data collection, data analysis, drafting of Country Case studies with the Team Leader, and providing support to the Team Leader with drafting cluster evaluation report in addition to collecting data for one substantive component. Each national evaluator should have expertise in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or Population Dynamics. National evaluators will also facilitate evaluation dissemination seminars and will assist the Team Leader in embedding comments from these seminars into the Case Studies and joint evaluation report. Besides personal expertise in conducting complex programme evaluations, the evaluators should have a good knowledge of the national development

context and be fluent in the local language and English.

- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
- At least 5 years of experience in conducting evaluations as a member of evaluation team or individual evaluator for UN agencies and/or other international organizations;
- Demonstrated ability and knowledge to collect qualitative and quantitative data;
- Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
- Familiarity with UNFPA or UN programming;
- Excellent writing and communication skills;
- Fluency in local and English Language.

c) **National experts** (two or more in each country office), who will each provide expertise in one programmatic area of the evaluation. The expert will take part in the data collection and analysis work, and will provide substantive inputs into the evaluation processes through participation at methodology development, meetings, interviews, analysis of documents, briefs, comments, as advised and led by the National Evaluator and Evaluation Team Leader. The modality and participation of experts in the evaluation process, including participation in interviews/meetings, provision of technical inputs and reviews of the design report, drafting parts of the evaluation reports, will be agreed by the Evaluation Team Leader and done under her/his supervision and guidance. The necessary qualifications of the evaluators will include:

- Advanced degree in social sciences, medicine, public health, women's studies, gender equality, population studies, demography, statistics or related fields;
- At least 5 years of experience in implementing initiatives in at least one of the core subject area/s of the evaluation - Sexual and Reproductive Health, Gender-based Violence or Population Dynamics;
- Demonstrated ability and knowledge to collect qualitative and quantitative data;
- Knowledge of demographic, political, social and economic conditions in the area in which the evaluation will be conducted;
- Familiarity with UNFPA or UN programming;
- Excellent writing and communication skills;
- Fluency in local and English Language.

d) **Four research assistants** (one in each cluster office) that will collect, compile and analyze available data relating to four cluster countries in a form of the database. They will also be responsible for contacting relevant evaluation stakeholders and arranging field work for national evaluators, and logistical support for preparation of dissemination seminars. Besides personal expertise in conducting researches, the assistants should have a good knowledge of the national development context and be fluent in the local language and English. Research assistants will be supported and supervised by evaluation managers in each office.

- Bachelor's degree in statistics, social sciences, population studies, economics or related fields;
- Minimum 2 years of experience in data collection and analysis (with the use of the relevant statistical software packages);
- Knowledge of qualitative/quantitative research methods;

- Familiarity with UNFPA or UN operations;
- Fluency in written and spoken English

The Evaluation Team will conduct the evaluation in accordance to the “Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA” and their work will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

Remuneration and duration of contract

Repartition of work days among the Evaluation Team will be the following:

- For the Team Leader: a total of 60 work days – 12 work days for development of design report, 6 work days for preparation and facilitation of a training workshop for National Evaluators, 32 work days for joint development of four Case Studies with National Evaluators and off-site technical support to national evaluators if needed, and 10 work days for development of draft and final evaluation reports;
- For National Evaluators: a total of 32 work days each - 7 work days for participation at the training workshop, 15 work days for field work, and 10 days for development and presentation of draft and final Case Study report);
- For National Experts: a total of 27 work days each - 7 work days for participation at the training workshop, 15 work days for field work, and 5 work days for preparing draft and final Case Study.
- For Research Assistants: a total of 34 work days each - 10 days for reviewing and analysing data, 5 work days for preparation of field phase, 14 days for support during the field phase, and 5 work days for support to organisation of dissemination seminars.

Payment of fees will be based on the delivery of outputs, as follows:

Team Leader:

- Upon satisfactory submission of evaluation design report and facilitation of the training: 40%
- Upon satisfactory development of first draft Case Studies: 20%
- Upon satisfactory finalisation of the final evaluation report and Case Studies: 40%

National Evaluators:

- Upon satisfactory completion of the evaluation workshop and support to development of the design report: 30%
- Upon satisfactory implementation of the field phase, and development of first draft Case Studies: 30%
- Upon satisfactory facilitation of dissemination seminar and finalisation of the joint evaluation report with Case Studies: 40%

National Experts:

- Upon satisfactory implementation of the field phase and contribution to development of first draft Case Studies: 50%
- Upon satisfactory participation at the dissemination seminar and contribution to development of the final evaluation report with Case Studies: 50%

Research Assistants:

- Upon satisfactory review and analysis of data: 50%
- Upon satisfactory preparation and execution of the dissemination seminar: 50%

Daily Subsistence Allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees. DSAs and travel costs of the Team Leader will be shared among the four cluster offices.

I. MANAGEMENT AND CONDUCT OF THE EVALUATION

The evaluation will be guided by these terms of reference approved by the UNFPA Regional Office on behalf of UNFPA Evaluation Office, and the UNFPA Handbook “How to Design and Conduct a Country Programme Evaluation”. The evaluation and country case studies will be conducted by an independent Evaluation Team whose members are pre-qualified by the UNFPA Regional Office, but will be managed by the UNFPA Country Office.

The Evaluation Steering Group:

Cluster Evaluation Steering Committee (CESC) will have overall responsibility of evaluation design, implementation and dissemination of the evaluation results. The Evaluation Steering Committee will have overall supervision on the Cluster Evaluation Team (including International Team Leader and National Teams) and evaluation processes. CESC will be comprised of UNFPA Representative for the Balkans Cluster, four Assistant Representatives, CO M&E Programme Analyst and RO M&E Advisor.

The role of the CESC will include the following tasks, but not limited to:

- Develop and agree ToR for the evaluation along with ToR for Reference Group(s) and ToRs for all Evaluation Team members (International Team Leader, National Evaluators, National Experts and National Research Assistants);
- Act as first point of contact to the Evaluation Team;
- Develop initial list of stakeholders for interviews and propose documentation for review;
- Review and approve draft design report;
- Review and approve draft evaluation report (including preliminary findings, conclusions and recommendations) and Case Studies;
- Liaise with the Evaluation Reference Groups for any issues related to cluster evaluation;
- Provide management response to the final evaluation report;
- Review and approve the final evaluation report and Case Studies;
- Disseminate the final evaluation report to relevant stakeholders in each country.

The Evaluation Manager in each office will:

- Conduct initial stakeholder mapping and develop an Atlas project list for his/her office;
- Develop invitation and contact relevant local stakeholders for participation in the Evaluation Reference Group;
- Support the Evaluation Team in designing the evaluation;
- Provide ongoing feedback for quality assurance during the preparation of the design report and draft and final evaluation report with Case Studies;
- Provide research assistant with available internal and external data relevant to the programme evaluation;
- Liaise with the RO M&E adviser aimed to sharing evaluation updates or requesting evaluation assistance.

The Evaluation Reference Group(s) will be established at the level of each office and composed of representatives from the UNFPA office and relevant programme counterparts.

The main functions of the Evaluation Reference Group will be to:

- Provide the Evaluation Team with relevant information and documentation on the programme in their field of expertise;
- Facilitate the access of the National Evaluators to key informants during the field phase;
- Discuss the reports produced by the Evaluation Team, including the design report and draft and final evaluation reports with Case Studies;
- Advise on the quality of the work done by the Evaluation Team.

Bibliography and resources

For Bosnia and Herzegovina:

https://drive.google.com/drive/folders/1tUsvjWI9OwKH5GM7Q1N2BNVh_v4k1qs_?usp=sharing

For former Yugoslav Republic of Macedonia: <https://drive.google.com/drive/folders/1wEzxbaK3BDXwL-WVF2bd-XooNpIFjgQv?usp=sharing>

For Kosovo (UNSCR 1244):

https://drive.google.com/drive/folders/1CoYBKpCNKP8yBeb_d6ZcofvVNYjJwEip?usp=sharing

For Serbia:

<https://drive.google.com/drive/folders/1z7Per3XP8x3KQm6E4gtpQ7dkSEz1SGaC?usp=sharing>

Annex 2. Evaluation Matrix

COMPONENT 1: ANALYSIS BY FOUR FOCUS AREAS (Reproductive Health and Rights (RHR), Youth, Gender Equality (GE), Population and Development (PD))			
RELEVANCE (APPLIES TO ALL FOCUS AREAS)			
EQ1. To what extent is the UNFPA programme (i) adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled and older persons, and Roma, (ii) and in line with the priorities set by the international and national policy frameworks, (iii) aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners? Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?			
<i>EQ1.A To what extent is the UNFPA programme adapted to the needs of women, adolescents and youth, people at risk of HIV infections, disabled, older persons and Roma?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.A Assumption 1: The evolving needs of women, adolescents and youth, people at risk of HIV infections, disabled and older person and Roma, were taken into account in programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries).</u>	<ol style="list-style-type: none"> 1. Evidence of thorough needs assessments, studies, and secondary data analysis used in CP design. 2. The choice of target groups for UNFPA supported interventions is consistent with identified and evolving needs of marginalized populations. 3. Training designs have a focus on marginalized populations. 	<ol style="list-style-type: none"> 1.1 UNFPA needs assessment documents 1.2 UNCT common country assessment (CCA) 1.3 Available survey report e.g. Census, DHS, MICS etc. 1.4 UNFPA, UNCT and IP staff 2.1. Country Programme Document (CPD) 2.2. UNFPA Annual Plan 2.3. UNFPA and IP work plan and agreement 2.4. UNFPA and IP staff 3.1 UNFPA training reports 3.2 UNFPA and IP workplans 3.3 Staff interviews 	<ol style="list-style-type: none"> 1.1 Document review 1.2 Staff interviews 2.1 Document review 2.2 UNFPA and IP staff interview 3.1 Document review 3.2 Staff interview 3.3 Beneficiary interview
EQ1.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.			
<p>MCH: The perinatal and neonatal mortality rates in Kosovo remain high. Although the decrease of the perinatal mortality rate is significant, from 29.1% in 2000 to 12.13% in 2015 (MoH, 2015), it is still higher than in most countries in the region. The same can be said for the foetal mortality rate and the early neonatal mortality rates. Thus, there is high relevance of the UNFP interventions for the health of mothers and children.</p> <p>CCSP: Although there is no reliable data on cancer incidence and prevalence available data from the Kosovo Agency of Statistics (KAS) shows that the number of treated cases from malignant diseases, despite issues of data reliability, is increasing and are much higher than global figures. According to Globocan¹⁴¹, cervical cancer represents</p>			

¹⁴¹ Globocan. Cancer Fact Sheet. Retrieved from IARC: <http://gco.iarc.fr/today/data/factsheets/cancers/23-Cervix-uteri-fact-sheet.pdf>

3.2% while breast cancer 11.6% of all new cancer cases in the world. In Kosovo, these figures are 9% in 2015 (from 4.6% in 2012) for genital cancer and 17.8% in 2015 (from 13% in 2012) for breast cancer.¹⁴² Thus, not only the absence of a national screening programme but also the high cancer incidence (although with data limitations) makes this pilot screening programme relevant to the health conditions of women of all backgrounds. The relevance of the population based national screening programme is also high, given that developing the understanding of the screening process among policymakers is not easy as they favour immediate results over long-term investments for sustainable results that screening may provide.

SRHR: Given the low reliance on modern contraceptive use as per MICS Survey and relatively high prevalence of risk behaviours in the general population and youth, the proposed interventions related to this area of work can also be considered as very relevant to final beneficiaries. Furthermore, the low availability and utilisation of good quality, human rights-based and integrated SRH, makes the UNFPA work pertinent, especially with Primary Health Care staff as an entry point into the Health Care System for the provision of such services.

CSE (formal education): The relevance of the intervention in the formal education sector is very high given the potential of formal education to cover all pre-university students with sexuality education throughout different grades of the schooling and that the content about sexual and reproductive health has been introduced into the educational curriculum for the first time and implementation has started recently. The proposed interventions are also very much relevant given high prevalence of risk behaviours in the general population and youth. Moreover, topics of sexuality education are still considered as taboo within the community of parents, students and teachers; this observation was also confirmed by the focus group discussions with students and in-depth interviews with teachers.

CSE (non-formal education): The relevance of the interventions in the non-formal education sector is considered high given the lack of information on SRHR among young people and high prevalence of risk behaviours in the general population and youth as partly proven by MICS results. Nevertheless, as delivery of sexuality education in formal education expands, the relevance of this intervention will diminish. Furthermore, Kosovo is considered as a relatively young population, since 34% of its population is under 18 years, and half of the population is under the age of 25. Due to social and cultural barriers the young people do not receive SRHR related information from their families either. The gender equality component can also be considered relevant given the presence of gender inequalities in Kosovo; several forms of GBV exist in Kosovo, which are widely accepted as social norms.

PD: Since Kosovo is undergoing a demographic transition. During this process, further declines are expected in fertility rates, and significant changes in the age structure of the population. These changes in age structure will have a significant impact on public policies such as schooling, social welfare, health, and economic growth. During this process it is important to build institutional capacities in order to conduct analysis on key population trends and potential implications to public policies, and development processes.

EQ1.B To what extent is the UNFPA programme in line with the priorities set by the international and national policy frameworks?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ1.B Assumption 1: The evolving priorities set by the international and national policy frameworks were taken into account in UNFPA programme design (both CPD and Annual Planning) and implementation (e.g. targeting/selection of beneficiaries)</u>	1. Correlation of UNFPA program priorities with priorities set by UNFPA Strategic Plan and national policy frameworks.	1.1 UNFPA programme documents 1.2 UNFPA Strategic Plan and national policy frameworks. 1.3 UNFPA and IP staff	1.1 Document review 1.2 Staff interviews

¹⁴² Knowles, P. (2008). *Female Genital Cancer in Kosovo - a situational analysis of breast and cervical*. Pristina: Commissioned by the United Nations Population Fund.

EQ1.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

The current UNFPA programme is fully aligned with national priorities, and UNFPA programmatic activities directly contribute to achievement of strategic and specific objectives of the Sectoral Strategy for Health covering the period of 2017-2021.¹⁴³ The UNFPA programme is linked to the following specific objectives of the Sectoral Strategy for Health:

- (iv) The SRH component is linked to the Specific Objective 1.2 of the Sectoral Strategy on *mother and child health* which aims to improve perinatal and mortality rates;
- (v) The Adolescent and youth component is directly linked to the Specific Objective 1.1. on the *Promotion of healthy lifestyle* which aims to educate lower and upper secondary students on health and healthy lifestyles;
- (vi) Certain sub-components of SRH, such as the cervical cancer screening programme and the provision of contraceptives, are linked to the specific objective 3.7 on the *Delivery of health services*, aiming to improve Screening Programmes for breast, cervical cancer and supply of essential medical products to health institutions including products related to SRH.

UNFPA interventions are also fully in line with the draft Strategic Plan for Mother and Child Health and Reproductive Health, covering the period of 2018 – 2021. UNFPA interventions are in line with Strategic Objective 1 (Preserving and Promoting Mother, Child and Reproductive Health) and all four specific objectives (Promote policies and standards in maternal, child health and reproductive health; Continuous improvement of the quality of health services for mother, child and reproductive health at all levels of health care; Strengthening family medicine related to mother, child, and reproductive health and Awareness of the population in the field of maternal, child health and reproductive health).

EQ1.C To what extent is the UNFPA programme aligned with the UNFPA policies and strategies and the UNDAF (or equivalent document) as well as with interventions of other development partners?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ1.C Assumption 1: There is evidence of alignment between the UNFPA programme and a) UNFPA policies and strategies, b) the UNDAF (or equivalent document) and c) interventions of other development partners.</u></p>	<ol style="list-style-type: none"> 1. The objectives and strategies of the CP and the AWP are in line with the goals and priorities set in the UNDAF or equivalent document 2. ICPD goals are reflected in the CP and component activities 3. The CP sets out relevant goals, objectives and activities to develop national capacities 4. Evidence of mainstreaming South-South cooperation in the country programme 	<ol style="list-style-type: none"> 1.1 UNFPA programme documents (CPD, AWP, COAR etc.) 1.2 UNFPA Strategic Plan and Annexes 1.3 UNDAF (or equivalent document), interventions of other development partners. 1.4 UNFPA, UNCT and IP staff 	<ol style="list-style-type: none"> 1.1 Document review 1.2 Staff interviews

¹⁴³ MoH (2016): Sectoral Strategy for Health, 2017-2021.

	<p>5. Evidence of mainstreaming gender equality and women’s empowerment</p> <p>6. Evidence of human rights approach applied in programme design and implementation</p>		
<p>EQ1.C Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.</p> <p>All UNFPA Kosovo interventions are also aligned and contribute to the achievement of all four UNFPA (global) Strategic Plan outcomes and with the Sustainable Development Goals (especially with the SDG 3 and 5). The Sexual and Reproductive Health component of the UNFPA Kosovo interventions contributes to the achievement of UNFPA global Outcome (1) Every woman, adolescent and youth everywhere, especially those furthest behind, has utilised integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence. The Adolescents and Youth component of UNFPA Kosovo interventions contributes to the achievement of global Outcome 2 (Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts). Certain interventions under Sexual and Reproductive Health and Adolescents and Youth components contribute to the achievement of global Outcome 3 (Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings). UNFPA Kosovo’s Population Dynamics interventions contribute to the achievement of global outcome 4 (Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development).</p> <p>The UNFPA has been directly contributing to the achievement of three (3) UN Kosovo Team Common Development Plan (an UNDAF-like planning document) outcomes: two on duty bearers and one on right holders by covering all programmatic activities. The UNFPA programmatic activities on MCH, CCSP and SRH contribute directly to the CDP outcome 3.2 which is about improving coverage of quality and equitable essential health care services for Maternal, Neonatal, Child and Reproductive Health (MNCRH) and Non-Communicable Diseases (NCD). On the other hand, all of the UNFPA’s interventions that support community and formal education based comprehensive sexuality education contribute to achievement of the last CDP outcome which is about right holders aimed to support changes in people’s behaviours through adoption of more healthy behaviours, including on SRHR (outcome 3.3.). The programmatic activities on population dynamics, is linked to the duty bearer outcome which is related to the application of evidence from population data by institutions to their policy making decisions (outcome 1.3.1).</p>			
<p><i>EQ1.D Do planned interventions adequately reflect the goals stated in the UNFPA Strategic Plan?</i></p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p>EQ1.D Assumption 1: <u>The planned interventions adequately reflect the goals of the UNFPA Strategic Plan</u></p>	<p>1. The objectives and strategies of the CP and the AWP are in line with the goals and priorities set in the UNFPA Strategic Plan and Annexes.</p>	<p>1.1 UNFPA programme documents (CPD, AWP, COAR etc.) 1.2 UNFPA Strategic Plan and Annexes 1.3 UNFPA, staff</p>	<p>1.1 Document review 1.2 Staff interviews</p>
<p>EQ1.D Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.</p> <p>Please see above (EQ1.C) for required inputs</p>			
<p>EQ2. To what extent has the country office been able to respond to changes in the national development context and, in particular, to the aggravated humanitarian situation in countries?</p>			

<i>EQ2.A To what extent has the country office been able to respond to changes in the national development context?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ2.A Assumption 1: The UNFPA country office has a mechanism in place to facilitate responses to changes in the national development context.</u>	1. Evidence of a UNFPA mechanism to facilitate a response to changes in national development context.	1. UNFPA country program documents. 2. UNFPA and IP staff	1. Document review 2. Staff interviews.
EQ2.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD. Initially, UNFPA programmatic activities were incorporated in the strategic plan for MCRH. However, since 2016, MoH has decided to prepare an overarching Strategy (called Sectoral Strategy for Health) that includes all different strategic documents with a new set of policy objectives. In this case, UNFPA has been able to respond to such changes and supported MoH to incorporate MCRH components into the new Sectoral Strategy for Health covering the period of 2017-2021.			
<i>EQ2.B To what extent has the country office been able to respond to an aggravated humanitarian situation in countries, if such situation has existed?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ2.B Assumption 1: UNFPA has provided a timely, appropriate and sufficient response to an aggravated humanitarian situation.</u>	1. Evidence of UNFPA response to an aggravated humanitarian situation.	1. UNFPA country program documents (including annual work plans and annual reports). 2. UN and Government ministry documents. 3. UNFPA, IP and government staff	1. Document review 2. Staff interviews
EQ2.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD. There was no aggravated humanitarian situation in Kosovo. Kosovo was not affected by migration flow (it is not part of the main route of migration flows); it was not affected from floods as other countries in the region.			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ2.B Assumption 2: The current UNFPA CP reflects and is effectively aligned with these key policy/strategy areas: UNFPA Strategic Plan and strategies, goals of ICPD PoA, and the SDGs.</u> [NB: The SDGs were not adopted at the time of CPD drafting and approval. There is room in the country level strategic documents to respond to changes over time, and to react to emergencies. Two issues: a) respond to changes in context of changes in national	1. Degree of concurrence of UNFPA CP with UNFPA Strategic Plan, (2014-17 and 2018-21) policies and strategies, goals of ICPD PoA, and the SDGs.	1. UNFPA, ICPD and MDG, SDG policy and monitoring documents 2. Key Senior Policy informants within the four country/territory Ministries, UNCT and development partners.	1. Document review 2. Key stakeholder interviews. NB: The above for each of the four program areas).

<p>environment, SDGs, and b) respond to emergencies. The country has documents that should be ready for use for both types of changes. Did the country program actually respond as anticipated within the timelines etc.]</p>			
<p>EQ2.B Assumption 2: The degree of concurrence of UNFPA CP with UNFPA Strategic Plan, (2014-17 and 2018-21) policies and strategies, goals of ICPD PoA, and the SDGs is explained above at EQ1.C</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p>EQ2.B Assumption 3: <u>It is assumed that the UNFPA CP has explicitly attempted to attain consistency with the four separate areas: UNFPA policies, ICPD PoA, MDGs and the SDGs.</u> NB: The SDGs were not adopted at the time of CPD drafting and approval.</p>	<p>1. Evidence of explicit commitments on the part of UNFPA CP team to achieve consistency with the four areas.</p>	<p>1. UNFPA, ICPD, MDG, SDG and Country PoC policy and monitoring documents. 2. Key informants.</p>	<p>1. Document review, 2. Key stakeholder interviews.</p>
<p>EQ2.B Assumption 3: When the UNFPA CP was prepared, the SDGs were not adopted at the time, thus there is no specific reference at the impact level to SDGs. However, all UNFPA interventions contribute to the achievement of the Sustainable Development Goals (especially with the SDG 3 and 5). More specifically, UNFPA interventions contribute to the achievement of following SDG targets: 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births 3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all 5.1 End all forms of discrimination against all women and girls everywhere 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation 5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences</p>			
<p>EFFECTIVENESS (APPLIES TO ALL FOUR FOCUS AREAS)</p>			
<p>EQ3. To what extent have the intended programme outputs been achieved? To what extent did the outputs contribute to the achievement of these planned outcomes: (i). increased utilization of integrated SRH Services by those furthest behind, (ii). increased the access of young people to quality SRH services and</p>			

sexuality education, (iii). mainstreaming of provisions to advance gender equality, and (iv). developing of evidence-based national population policies; and what was the degree of achievement of the outcomes?

EQ3.A To what extent have the intended programme outputs been achieved?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ3.A Assumption 1: Assumes intended and unintended program outputs have been achieved to some extent.</u></p>	<ol style="list-style-type: none"> 1. Quantitative: Level of achievement against indicators/targets (as outlined in CP monitoring framework) over time within each of the four program areas: SRH, Youth, Gender and PD. 2. Qualitative: Stakeholder perceptions of achievement (quantity and quality) of outputs within each of the four program areas: SRH, Youth, Gender and PD 3. Good practices (strategy, achievement etc.) 	<ol style="list-style-type: none"> 1. AWP, COARs, Project Reports, CP, Revised CP Framework. 2. Stakeholders. 3. Most recent surveys and other available data within each of the four program areas: SRH, Youth, Gender and PD. 	<ol style="list-style-type: none"> 1.1 Document review. 1.2 Stakeholder interviews

EQ3.A Assumption1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.

Mother and Child Care (MCH):

Strengthened capacity on MCRH Division

With capacity building efforts supported by UNFPA, the MoH successfully developed the first Strategy for mother, child, adolescent and reproductive health covering 2011 -2015, the HIV Strategy, the 2014-2019 Reproductive Health Commodity Security Strategy (RHCSS), and incorporated MCRH into the 2017-2021 Health Sectoral Strategy and SRR into the Youth Development Strategy etc. Similarly, in relation to the legal framework, the MoH prepared the concept document on the reproductive health law, as well as drafted and approved administrative instructions, such as those for clinical guidelines and protocols (AI No. 8/2015) and on methods and modern tools on Family Planning (AI 07/2013). Through UNFPA technical support, MCRH Division was able to collect perinatal data annually, and to analyse and produce the annual Perinatal Situation Report.

Increase capacities of NCMMA to implement Maternal Mortality Audits/OSRS and CNMCR

Through UNFPA and WHO support, the MoH appointed the National Committee on Maternal Mortality Audit (NCMMA), tasked to start with CNMCR at an institutional level and with maternal death audits on a biannual basis. Despite its establishment and creation of adequate capacities, the NCMMA has not been able to conduct any CNMCR or maternal mortality audits, although a decision was made to start with near miss case reviews at hospital level.

Clinical guidelines and protocols developed

Under the guidance and with the support of UNFPA, trained local experts in 2016 have adapted clinical guidelines for major causes of maternal mortality/morbidity in Kosovo (postpartum haemorrhage, eclampsia and preeclampsia, and cervical cancer screening), and a clinical guideline on Prevention of HIV Transmission from Mother to Child. During 2018, an additional eight Clinical Guidelines were developed instead of five planned.

Increased capacities on Effective Perinatal Care (EPC)

According to the pre- and post-test results and in-depth interviews, the EPC training and follow up visits have increased considerably the knowledge and skills of 100% of staff in Gynaecology and Obstetrics in all regional hospitals as well as University Clinical Centre of Kosovo.

K10

With continuous and comprehensive UNFPA support, the K10 coalition has been established in order to strengthen the joint work and advocacy efforts of NGOs for improving public policies and service delivery on MCH and SRHR.

Cervical Cancer Screening Program (CCSP):

CCSP launched as a pilot

For launching of the CCSP within PHC in the Municipality of Pristina and then in the Municipality of Prizren, the SOPs which cover the entire process of CCS (from proper technique of PAP smear taking and standardized coding, transporting and test reading) was finalized and approved by the Coordination Group of CCSG. The capacities of a limited number of Family Physicians were raised to take PAP smears in safe way. The database to register, collect and file the PAP test results was developed and handed over to one PHC during the second year of the implementation. Furthermore, according to in-depth interviews, pathologists and technicians in the Institute of Pathology have improved knowledge and skills in the area of PAP smear reading and reporting in order to improve the quality of the service.

Budget impact analysis on CCSP

A Budget Impact Analysis for a national screening program for cervical cancer was produced; it aimed to provide evidence not only on the effectiveness, but also on the efficiency and the affordability of such services in Kosovo for the Ministry of Health to introduce such interventions.

SRHR:

Strengthening the capacities of family medicine team to provide FP, STI, AH and GBV

Both pre- and post-testing results of the trainees' as well as a survey organised for the evaluation of trainings has shown an increased level of knowledge, and counselling skills of PHC personnel about SRH topics (focused on FP, STI, GBV and Adolescent Health based on a human rights approach that respects individual privacy, confidentiality and informed choice, along with a wide range of safe contraceptive methods in PHCs.

Advocacy efforts with MoH in establishing a budget line for contraceptives

Through UNFPA assistance, the budget impact analysis for provision of emergency contraceptive pills was completed in December 2016 to build up a strong evidence-based recommendation for the MoH in establishing a budget line for contraceptives. Since 2016, K10 has undertaken strong and evidence-based advocacy efforts for contraceptive security, inclusion of SRH services under a health insurance scheme, and improvement of the quality of SRH services. Nevertheless, there has been no decision to establish a budget line for contraceptives, while there is a rising awareness among policy makers about the inappropriateness of the current practice of provision of contraceptives (which is putting contraceptives within the same category as other essential drugs and distributing them based on the requests from PHCs).

The Ombudsman Institution of Kosovo (OIK) conducted an assessment on SHRH

Through UNFPA's assistance, OIK has produced the first National Assessment of the Reproductive and Sexual Rights in Kosovo which has provided a general and in-depth assessment of the reproductive and sexual rights in Kosovo, while identifying achievements and barriers, against legal and constitutional guarantees and obligations.

Comprehensive Sexuality Education (CSE) (Formal Education):

Draft Manuals for Teachers have been developed for all grades of pre-university education to facilitate the delivery of sexuality education in formal education. Manuals have been reviewed and assessed by an international expert about their alignment with WHO Standards for Sexuality Education in Europe. Furthermore, UNFPA has piloted a training programme for teachers of primary, lower and upper secondary education levels on sexuality education. The pre-and-post training testing results show

that the training programme had some effect toward increasing the level of knowledge among pre-university teachers on sexuality education, although the level of incorrect answers remained high in post-test results for primary and upper secondary teachers.

CSE (Non-Formal Education):

Increased awareness on SRHR including FP, STI, HIV and GBV

Regarding to the peer to peer education on SRHR, during 2013-2018 about 2,300 youth peer educators were trained (about 56 percent girls and 44 percent boys). Both focus group discussions and the results from the pre and post-tests also confirm the knowledge increases of trainees due to the training. Nevertheless, when it comes to transmitting the knowledge to their peers, based on the feedback obtained, they were not able to transmit their knowledge beyond their close friends. As such, coverage of the peer education and its replication is expected to be low compared to the overall size of the targeted age group. Similarly, the situation is the same with the theatre-based education. On the other hand, various awareness raising activities organised during marking of international days and other events have a much higher coverage of (young) people (about 40,000 to 50,000 people were reached each year) but with less depth.

Increased awareness on gender equality (including prevention of GBV)

Since 2016, when the training activities on promoting gender equality and violence prevention commenced, about 1000 people per year were trained. The results from the pre- and post-tests also show that training activities are having some effect on trainees. Nevertheless, the coverage of activities is very low compared to the overall targeted population, which in turn means that the magnitude of the effect is low. Furthermore, as a result of the partnerships created with FBOs, the Kosovo Islamic Community agreed to actively engage during *16 Days of Activism against GBV*, with imams covering topics on GBV prevention during weekly preaching, while the Orthodox Church and Bogoslavia organized spiritual nights on these topics.

Social marketing

While the distribution of condoms has continued, during this period social marketing has expanded its activities to cover the entire territory of Kosovo, including the northern municipalities and has diversified the distribution channels by installing LOVEMAT condom machines in motels, hotels, cafeterias and restaurants throughout Kosovo.

PD:

UNFPA efforts strengthened the capacities of Civil Registration Agency and KAS significantly in the production, analysis, and the dissemination of population data. Such efforts have resulted in the establishment of the working group on improving civil registration information flow. Similarly, the Population Statistics Division within the Department of Social/Population Statistics of KAS feels fully capacitated in demographic data analysis and in calculating key indicators for the next population projection report given there is lighter support for quality assurance or mentoring by the UNFPA.

EQ3.B To what extent have the intended programme outcomes been achieved?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ3.B Assumption 1: Assumes all intended and unintended outcomes have been achieved to some extent.</u>	<ol style="list-style-type: none"> 1. Trend analysis (outcome indicators) to identify achievement of selected outcome indicators 2. Stakeholders' perspectives of changes (static/ positive/negative) 	<ol style="list-style-type: none"> 1. Secondary data (survey, census, reports etc.) 2. Stakeholders 	<ol style="list-style-type: none"> 1.1 Document review. 1.2 Stakeholder interviews

	<p>3. Stakeholders' perspectives on the most significant changes that have happened.</p>		
<p>EQ3.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD.</p> <p>MCH: <i>Effective Perinatal Care</i> Reports from regular EPC follow-up assessment/visits showed initially encouraging results, especially in the General Hospital in Prizren but also in other maternities, including the ObG Clinic of UCCK. The most indicative positive changes that were found include: less routine episiotomies, decreased rate of unnecessary referrals and labour induction, prophylactic use of antibiotics, active management of the third stage of birth, baby-mother skin to skin contact, rooming-in even after caesarean section, early breastfeeding initiation and breastfeeding on demand, improved communication and team work, less cervical and vaginal ruptures, strengthened and more active role of midwives in labour etc. Nevertheless, according to interviewed assessors many of these findings might contain a 'Hawthorne effect' as the staff was aware and informed in advance about assessment visits.</p> <p><i>Advocacy efforts of K10</i> K10 started its work in 2016, focusing on three different areas: (i) evidence-based advocacy effort by organising many advocacy efforts towards contraceptive security, the inclusion of SRH services under the health insurance scheme etc; (ii) awareness raising activities, and (iii) institutional development.</p> <p>CCSP: The pilot programme on CCS is being implemented in selected PHCs in the Municipalities of Pristina and Prizren according to the SOPs. Since the start of the pilot programme on CCSP in the Municipality of Pristina (July 2016) until the end of 2018, about 5,060 women have used the opportunity to do their PAP test in Primary Health Care institutions of the Municipality of Pristina. While in Prizren, since August 2018, when the CCSP started up to mid-December of 2018, about 434 people had their samples taken and about 281 (or 64.7%) were informed with results. Despite these positive achievements, the PAP test smear taking is not being provided by the trained Family Physicians but by a gynaecologist. In relation to reading PAP smears, based on quality control of samples sent abroad there is some evidence of improvement in PAP test reading and reporting.</p> <p>SRHR: <i>Service Delivery by PHC</i> According to the evaluation conducted for training programmes, as well as in-depth interviews organised for this evaluation, it was confirmed that there is a low level of application and delivery of SRH services by the PHCs. When PHC personnel were further asked which are the main barriers that hinder wider application of SRH services, they reported that 'demand side' factors (such as 'lack of demand from clients' and 'lack of clients') play much greater role in hampering widespread application rather than 'supply side' factors for most of the training programmes with the exception of FP services, where supply side factors demonstrate more dominance.</p> <p><i>The Ombudsman Institution in Kosovo (OiK)</i> The OiK report served all involved parties to advocate for the MoH and other institutions to fulfil their obligations towards citizens in the area of SRR. These advocacy efforts have resulted in the establishment of the working group within the MoH, for monitoring and reporting the realisation of the recommendations made by the assessment. The OiK considers that out of 62 recommendations produced by the report about 26 of them (or 42%) have been implemented satisfactorily.</p> <p>CSE (Formal Education):</p>			

It is too early to assess the higher-level results, such as the ability of teachers to deliver qualitative and comprehensive sexuality education to all students as per the core curricula as well as using the Teachers' Manual and knowledge, skills gained during training programmes on sexuality education. Such results cannot be expected to measure even in a limited number of schools, grades and classes in Pristina where the piloting training has occurred, since the training programmes has been delivered very recently.

CSE (Non-Formal Education):

While there is some micro evidence about output level changes at the level of trainees by the implementing partners from UNFPA funded activities, there is no such data to measure the utilisation or application of the knowledge increases and to verify if it leads to behavioural change (outcome level change) for trainees of both the SRHR and gender equality trainings. Thus, it is not possible to assess any outcome level changes even within direct beneficiaries. At the national level, the situation is very similar to the one described for the output level change. There is limited and partial information about measuring possible outcome level changes which reflect increased utilisation of the information obtained and any (positive) behavioural changes towards safe sexual behaviour, gender equality and prevention of any types of violence.

PD:

Regarding data gathering, the data produced through MICS is reported to be instrumental in production of the Strategy for inclusion of Roma, Ashkali and Egyptians since there is a separate MICS survey dedicated specifically to these communities. In the area of vital statistics, a crucial improvement to be mentioned is in relation to underreporting of death cases. For this purpose, a memorandum between Civil Registry Agency and Faith Based Organisations (mainly the Kosovo Islamic Community, whereas the Catholic and Orthodox communities are not involved yet) were signed to address this situation.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ3.B Assumption 2: Assumes that the majority of progress on intended outputs can be attributed to UNFPA CP. It is unlikely that all progress towards outputs can be attributed to a given intervention.</u>	1. Evidence of pertinent program activity in allied non-UNFPA CP program areas.	Review of non-UNFPA program activities and trends on context for UNFPA CP activities.	1. Document review, 2. Stakeholder interviews, 3. Site visits, 4. Training follow-up and client/beneficiary interviews.

EQ3.B Assumption 2:
While there is strong evidence to attribute a majority of progress on intended outputs to UNFPA interventions, there is less evidence to attribute such progress at the outcome level. In certain areas there is no or partial information about measuring possible outcome level changes such as any behavioural changes towards safe sexual behaviour, gender equality and prevention of any types of violence. The only area in which any progress at the outcome level can be attributed to the UNFPA is CCSP since CCSP is only available in the two municipalities where UNFPA is working and not in other municipalities where it is not working.

EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH)

EQ 4 To what extent has UNFPA contributed to an improved emergency preparedness in BiH, The former Yugoslav Republic of Macedonia, the Republic of Serbia, and Kosovo (UNSCR 1244), and in the area of maternal health / sexual and reproductive health including MISP?

EQ4.A To what extent has UNFPA contributed to an improved emergency preparedness?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
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<u>EQ4.A Assumption 1: There is an emergency preparedness plan, which is complete and updated.</u>	1. Level of UNFPA contribution to emergency preparedness plan.	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.
<p>EQ4.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD, but primarily to SRH</p> <p>The UNFPA has assisted the adoption and integration of the MISP through various activities. UNFPA initially supported the Kosovo Red Cross in organising ToTs and delivering training on MISP to PHC personnel. During 2013- 2017, around 370 healthcare providers were trained (about 78% women) on this programme.¹⁴⁴ The training has been accredited and became part of Continuous Development Programme (CDP) for family physicians and nurses. In parallel, the UNFPA assisted the integration of MISP into local and central level emergency action plans. At the central level, the UNFPA supported the development of the MISP Annual Work Plan to become part of the Emergency Public Health Action Plan, which is also part of the National Contingency Plan of Emergency Preparedness and Response. The Emergency Public Health Action Plan is still under development whereby MISP facilitators are members of the working group for drafting this plan. Similar to central level efforts, since 2016, the UNFPA, in cooperation with Red Cross Kosovo and in partnership with MoH, the municipal health authorities and the PHC management, supported the introduction, adaptation and integration of the MISP in the health components of the local Emergency Preparedness and Response Plans in six municipalities.</p>			
<i>EQ4.B Has UNFPA contributed to preparedness for MISP?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ4.B Assumption 1: UNFPA has contributed to MISP preparedness.</u>	1. Level of UNFPA contribution to MISP	Stakeholders at National and sub-national level. Available data on emergency preparedness.	1. Document Review, 2. Stakeholder interviews.
<p>EQ4.B Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD, but primarily to SRH</p> <p>Please see above.</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ4.B Assumption 2 : The activities and outputs have contributed to a measurable and meaningful extent to the achievement pertinent to emergency preparedness, maternal health and SRH including MISP.</u>	1. Pertinent indicators from CP Planning and Tracking Tool for output and outcome specific programme components pertinent to	1. Key stakeholders 2. Client beneficiaries 3. AWP, 4. COARs, 5. National, Regional quantitative data	1. Document Review 2. Stakeholder interviews within pertinent programme components, 3. Interviews and FGDs.

¹⁴⁴ UNFPA Kosovo, Training Database.

	<p>emergency preparedness, maternal health and SRH, including MISP.</p> <p>2. Stakeholder qualitative perceptions on impact of activities and pertinent output impact on outcomes.</p> <p>3. Client/beneficiary qualitative perceptions on impact of activities and output impacts on outcomes (It is acknowledged that that there is no direct UNFPA work with beneficiaries.)</p>	6. UNCT progress reports	4. Secondary data analysis. (NB: The above for each of the pertinent areas).
EQ4.B Assumption 2:			
Please see above.			
EFFECTIVENESS (THIS QUESTION APPLIES TO ALL FOUR FOCUS AREAS; BUT PRIMARILY TO SRH, ASRH AND GE)			
EQ5 To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared? What was the quality and timeliness of the response?			
<i>Comment(s) on this question:</i>			
<ul style="list-style-type: none"> This refers to all types of emergencies, not just GBV. Therefore, the interpretation needs to allow for a wider interpretation of this question, beyond GBV. The term AoR has been primarily focused on UNFPA leadership related to Gender-Based Violence Area of Responsibility (GBV AoR). UNFPA has been the sole lead for GBV AoR since 2016. 			
<i>EQ5.A To what extent has each office been able to respond to emergency situations in its Area of Responsibility (AoR), if one was declared?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ5.A Assumption 1: UNFPA is able to respond to emergency situations if they are declared.</u>	1. Measures of UNFPA emergency response preparedness.	1. UNFPA and UNDAF documents. 2. Government ministry documents pertaining to emergency response. 3. UNFPA, UNDAF and Government staff familiar with emergency response.	1. Document review and 2. Stakeholder interviews
EQ5.A Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, ASRH and GE. Kosovo was not affected by migration flow (it is not part of the main route of migration flows), it was not affected from floods as other countries in the region.			
<i>EQ5.B What was the quality and timeliness of the response?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ5.B Assumption 1: If UNFPA was asked to respond to an emergency situation, it</u>	1. Evidence of the nature of a UNFPA response to an emergency situation.	1. UNFPA and UNDAF documents.	1. Document review and 2. Stakeholder interviews.

<u>responded with quality and in a timely fashion.</u>		<ol style="list-style-type: none"> Government ministry documents pertaining to emergency response. UNFPA, UNDAF and Government staff familiar with emergency response. 	
EQ5.B Assumption 1: Findings including analysis for all pertinent program areas, but primarily to SRH, ASRH and GE. Please see above.			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ5.B Assumption 2: The UNFPA CP has encountered significant constraints as well as facilitating factors that both impeded and aided the achievement of results in the GBV AoR. (Need to point out that GBV is just one example of a type of emergency situation.) Need to prioritize all emergencies, including but not limited to GBV.</u>	<ol style="list-style-type: none"> Contextual information related to constraints and facilitating factors for specific activities and outputs within the GBV AoR, but also for all other types of emergencies that UNFPA may have addressed. 	<ol style="list-style-type: none"> Key informant interviews, Trends in pertinent indicators. COARs, Implementing agency reporting Media reports 	<ol style="list-style-type: none"> Document review, Stakeholder interviews with UNCT and IPs Site visits, and Client Beneficiary interviews. Secondary data analysis <p>(NB: The above for each of the four program areas).</p>
EQ5.B Assumption 2: See above. For GBV, when PHC personnel were asked why there is no delivery or little delivery of services to GBV victims, they reported that victims are usually directed to emergency services and those that do visit PHC facilities are unwilling to admit and report such cases due to stigma and hesitation to report cases to health care providers.			
EFFICIENCY (APPLIES TO ALL FOUR FOCUS AREAS)			
EQ6.To what extent has UNFPA made good use of its human, financial and technical resources, and has used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?			
Comment(s) on above question: <ul style="list-style-type: none"> There is an inherent subjectivity to the definition and measurement of what is “good use” of resources. 			
<i>EQ6.A To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the results defined in the UNFPA programme documents?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ6.A Assumption 1: UNFPA has made good use of its human, financial and technical resources to pursue the achievement of results defined in UNFPA programme documents.</u>	<ol style="list-style-type: none"> Amount of resources used to achieve the outputs/outcomes, compared to the value of achieved outputs. 	<ol style="list-style-type: none"> Key stakeholders; Documentation of programme inputs by category (human, financial, technical). 	<ol style="list-style-type: none"> Key stakeholder interviews Document review Budget review.

	<ol style="list-style-type: none"> 2. The planned inputs and resources were received as set out in the AWP's and agreements with partners. 3. The resources were received in a timely manner according to timeline set in the agreement. 4. Inefficiencies were corrected as soon as identified. 5. Trend analysis: Implementation rate, Distribution by sector/outcome 6. Access of internal or external human/technical resources to enhance programme effectiveness 7. Timely and quality TA provisions 	<ol style="list-style-type: none"> 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 	
<p>EQ6.A Assumption 1: Findings including analysis for all pertinent program areas Considering that, during entire duration of the programme there were only two programme staff working in the UNFP office in Kosovo, overall efficiency of the programme is considered very high. When it comes to budget allocation within different components, this has fluctuated among different components and within different years. Nevertheless, on average the SRHR and non-formal education components usually had higher allocations compared to MCH, CCSP and others. Budget allocation for population dynamics increased significantly when the UNFPA was engaged in data gathering such as with MICS. Unfortunately, since there is lack of evidence to create a clear cause and effect relationship between UNFPA's interventions and improvements in key impact indicators (such those of perinatal, neonatal and maternal mortality rates) it is not possible to attribute such changes to UNFPA's interventions. It was impossible to compute an efficiency analysis to gauge the overall efficiency of the interventions. In other cases, there was no data to measure any changes at the level of intended outcomes and impact, such as on potential improvements in sexual behaviour, gender equality and prevention of any types of violence, unwanted pregnancies etc. Thus, in such cases it was also not possible to compute any efficiency calculations. Nevertheless, some qualitative efficiency analyses, which looks at the utilisation of inputs such as those of local and international expertise and the use of tools and products developed and tested globally, was highly rated by many stakeholders. Nonetheless, the report argues that there is potential to improve allocative efficiency of the programme by reallocation of funds towards interventions with higher results and by avoiding dividing the limited available resources into too many activities within each area of work.</p>			
<p><i>EQ6.B To what extent has UNFPA used an appropriate combination of tools and approaches to pursue the achievement of the results defined in the UNFPA programme documents?</i></p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p>EQ6.B Assumption 1: UNFPA has used an appropriate combination of tools and approaches to pursue the achievement of the</p>	<ol style="list-style-type: none"> 1. Amount of human, financial and technical tools and approaches used to achieve the outputs/outcomes, 	<ol style="list-style-type: none"> 1. Key stakeholders; 	<ol style="list-style-type: none"> 1. Key stakeholder interviews,

<p><u>results defined in the UNFPA programme documents.</u></p>	<p>compared to the results achieved in outputs/outcomes.</p>	<ol style="list-style-type: none"> 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 	<ol style="list-style-type: none"> 2. Document review, 3. Budge review.
<p>EQ6.B Assumption 1: Findings including analysis for all pertinent program areas Regarding the focus area of MCH for example, the utilisation of technical expertise (local and international) and utilisation of tools and products developed by WHO was positively rated, especially for interventions on EPC and the development/adapting of the Clinical Guidelines and Protocols (CGPs). The division of the labour and cooperation with WHO was exemplary. While the know-how products of WHO were used for EPC, the UNFPA contributed heavily in organising ToTs and delivering trainings through local trainers on EPC, using their extensive experience about training programmes for health care personnel on FP, STI, HIV, GBV etc. A similar division of the labour was applied during follow-up visits.</p>			
<p>Assumption to be assessed</p>	<p>Indicator/Criteria</p>	<p>Source of information</p>	<p>Method and tools for data collection</p>
<p><u>EQ6.B Assumption 2: UNFPA CPs have expended resources to achieve outputs at a level that is consistent with standard norms for the cost of implementing program activities in each of the four program areas.</u></p>	<ol style="list-style-type: none"> 1. Amount of resources used to achieve the activities, outputs as compared to the standard norms for the cost of achieved outputs. 	<ol style="list-style-type: none"> 1. Key stakeholders; 2. Documentation of programme inputs by category (human, financial, technical). 3. Feedback on quantity and quality of TA provided to implementing agencies. 4. Atlas data. 5. COARs 6. IP reporting data. Training data. 	<ol style="list-style-type: none"> 1.Key stakeholder interviews, 2.Document review 3.Budget review of sentinel activities vs budget in AWP. <p>(NB: The above for each of the four program areas).</p>
<p>EQ6.B Assumption 2: In some areas such as on MCH there is lack of evidence to create a clear cause and effect relationship between UNFPA’s interventions and improvements of perinatal, neonatal and maternal mortality rates and attribute such changes to UNFPA’s interventions. In such situations it is impossible to undertake cost effectiveness analysis to gauge and compare the overall efficiency of the interventions. In other focus areas such, as CSE, it is either too early to assess outcome level change or there is no evidence to gauge the overall progress at the outcome level. The only focus area where there is clear attribution of UNFPA’s interventions and outcome level progress is the CCSP (since CCSP is only available in the two municipalities where UNFPA is working and not in other municipalities where it is not working). Thus, we can present some efficiency calculations for CCSP although the data is only available at the level of output (number of people screened) in the healthcare services perspective. Compared to the number of women that were examined through CCSP, it appears that UNFPA spent about 11.7 USD for each woman that took part in the programme. Since there is no information about further management of suspicious cases and effects of the further treatment, the same calculations cannot be computed for impact level (i.e. number of lives saved). Similarly, according to the financial reports submitted by the implementing agency, UNFPA spent about 70 euro for training a teacher for sexuality education which is relatively low using the local expertise. Similarly, based on financial reports submitted by implementing organizations UNFPA has spent</p>			

in average around 90 euro to train one PHC personnel on SRH topics. On other hand, according to the direct and indirect beneficiaries reached through non-formal education and outreach activities and fund spent for this focus area, it appears that UNFPA spent around 80 euros (ranging from 60 euro to 100 euros throughout different years) per direct beneficiary and about 2 euros for beneficiaries that are reached out through awareness raising activities.

SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)

EQ7 Are programme results sustainable in short and long-term perspectives?¹⁴⁵ NB: 3 years or less = short term. More than 3 years = long term.

Comment(s) on above question:

- For the purpose of this work, it is assumed that programme results are sustainable (short-term refers to up to three years, long-term is greater than three years.) Short-term and long term are somewhat subjective in nature and require a combination of qualitative and quantitative indicators to measure. Each can be addressed with a combination of quantitative and qualitative assessment approaches.

Comment(s) on indicators for above question:

- Short-term sustainability*
 - Short-term ability of institutions to continue functions without external support.
 - Measures of capacity building, esp. training activities.
 - Measures of ownership: Patterns of staffing turnover
 - Counterpart agency sources of budget, current and future.
- Long-term sustainability* can be measured quantitatively via the level of fund-raising or cost-sharing achieved by a UNFPA donor recipient has achieved for a given activity. Qualitatively, stakeholders provide their subjective impressions on the buy-in, ownership and institutional commitment of a UNFPA donor recipient to continue a given program activity in the absence of future UNFPA support.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
EQ7 Assumption 1: The UNFPA CP has supported programs that have results that can be sustained in the short- and long-term (up to three years and greater than three years) in each of the four program areas.	<ol style="list-style-type: none"> Short-term and long-term ability of institutions to continue functions without external support. Measures of capacity building, esp. training activities that endure for short versus long-term. Patterns of staffing turnover Counterpart agency sources of budget over time. 	<ol style="list-style-type: none"> CCA 2015 UNFPA CP COARs, AWP, s, Implementing agency reports. Training data. Stakeholders in management positions within Ministry and IPs Client beneficiaries. 	<ol style="list-style-type: none"> Key stakeholder interviews, Training follow-up interviews Client/beneficiary interviews Document review Budget review. <p>(NB: The above for each of the four program areas).</p>

EQ7 Assumption 1:
MCH:

¹⁴⁵ We have used the term ‘static’ and ‘dynamic sustainability’. Dynamic sustainability always ensures long term sustainability. However, static sustainability can be short term as well as much longer term. In such situations we always explained how many years of static sustainability was achieved. Static sustainability reviews the extent to which results achieved through the interventions will be maintained after UNFPA support is withdrawn. Dynamic sustainability on the other hand, looks for system changes, i.e. whether functions and services supported by UNFPA and the production of the results will continue to be achieved beyond UNFPA support

Most of the UNFPA interventions have static sustainability. The capacities created within the MCRH Division, the National Committee on Maternal Audit (NCMA), CGP, MISP, EFP and within K10 coalition will continue to exist even if UNFPA withdraws from these interventions. Nevertheless, not all these interventions have dynamic sustainability. While MCRH Division is fully capable of continuing to produce the Perinatal Situation Report (which is now under the responsibility of NIPH), due to lack of human capacities it would be impossible to cover the policy making, legal framework development and monitoring of the availability and quality of MCH and SRH services within the health sector. The situation is somewhat similar with EPC. Training and monitoring visits on EPC cannot continue without UNFPA support according to the EPC National Coordinator and the Chief of MCRH Division, since UNFPA still plays a major technical and financial role. An almost similar situation prevails with the K10 coalition.

CCSP:

Although PHC in two municipalities are capacitated to provide CCSP independently from UNFPA support, offering such services still has some issues with static sustainability since the service delivery is done through a gynaecologist and not by a Family Physician, which as a service will not be part of the PHC. Thus, static sustainability of the CCSP in these two municipalities will continue until the gynaecologist will cease to work in PHC according to the AI 08/2017. Dynamic sustainability of the CCSP on the other hand, which looks at who will provide functions and services supported by UNFPA, is heavily dependent on whether policymakers will continue to support this screening programme and its expansion to cover the entire Kosovo Health Care System.

SRHR:

According to the survey conducted on the effectiveness of the training programmes delivered by the UNFPA, the majority of trainees expressed the need for training programmes to be repeated in 3 to 5 year of intervals. Dynamic sustainability of the interventions and results achieved is questionable due to the lack of resources and commitment from policy making level. Interventions like the delivery of training programmes on YFHS, STI syndromic management and FP, cannot be maintained and delivered without UNFPA support since these programmes are not part of the regular CPD programme for PHC personnel and financed by the MFMC or by the MoH.

CSE (formal education):

Since results have been achieved up to the output level, this section will review the static sustainability of the outputs produced. The development of the Manuals will most likely have static sustainability at least in the mid-term (until 5 years), since Manuals will continue to be used by teachers without need for a major revision. Similarly, training of teachers also has a static sustainability since the result achieved so far (i.e. the increase knowledge and skills of teachers to deliver sexuality education) will continue to be used by teachers during the delivery of the sexuality education. According to the in-depth interviews with teachers, the two-day training organised on sexuality education was adequate to them for this subject and they have not expressed any need to be re-trained. Nevertheless, neither manuals nor trainings have the potential to reach dynamic sustainability. For example, the development of the Manuals does not have dynamic sustainability since there are no mechanisms in place other than UNFPA support that will continuously upgrade the Manuals developed for changing circumstances in the long run. Similarly, in order to achieve the dynamic sustainability of training for sexuality education such training has to be included in the internal training system of the Ministry and offered on continuous basis to new teachers as well as to existing teachers in order to keep the knowledge updated and in line with new evidence, tools and approaches.

CSE (non-formal education):

Even if peer to peer education has low coverage it appears that this kind of education has static sustainability. According to the feedback obtained from focus group discussions, trainees have reported that the information obtained during the training will be sufficient and as such there is no need for re-training them on SRHR issues. Nevertheless, the feedback obtained from focus group discussions about the training on gender equality is less clear about static sustainability. However, both the peer education and the gender equality trainings do not have dynamic sustainability since current interventions are fully dependent on UNFPA support. On the other hand, the social marketing component is having both static and dynamic sustainability.

PD:

The data gathering is less sustainable, since all the surveys conducted so far rely heavily on UNFPA and other organisations' funds, although there is a positive trend towards more sustainability for the next MICS survey. On the other hand, the capacity enhancements on demographic data analysis have static sustainability. However, the achievement of dynamic sustainability depends on whether KAS is able to produce its population projections report with limited or no engagement of UNFPA. Similarly, the dynamic sustainability on improvement of the vital statistics is also questionable. There are many undefined legal aspects, such as the fact that legally the Faith Base Organisations are separate from the State Institutions and yet they are responsible according to the memorandum of understanding to play a role in the data gathering, which in other countries would be a direct responsibility of state institutions.

SUSTAINABILITY (APPLIES TO ALL FOUR FOCUS AREAS)

EQ8 To what extent have the partnerships established by UNFPA promoted the national ownership and sustainability of supported interventions, programmes and policies?

Comment(s) on above question:

- Data will be collected on partnerships established by UNFPA to assess national ownership and sustainability of supported interventions, programmes, and policies. In some cases, it may be difficult to distinguish interventions from programmes and policies. The evaluation will rely in part on self-reports of partnership stakeholders, which may be biased toward making a favourable impression to donors.

Comment(s) on indicators for above question:

- Short- and long-term sustainability of UNFPA supported partner institutions to continue, replicate or adapt programme functions without external support. Measures of national ownership and sustainability in different types of interventions, programmes and policies.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ8 Assumption 1: The UNFPA CP has succeeded in developing partnerships that promote the national ownership and sustainability of supported interventions, programmes and policies.</u></p> <p>Comment on Assumption to be assessed for question. In some countries it may be that there are not many partnerships that have been successfully established by UNFPA.</p>	<ol style="list-style-type: none"> 1. Short and Long-term ability of UNFPA supported partner institutions to promote national ownership and sustainability of supported interventions, programmes and policies. 2. Measures of capacity building, esp. training activities. 3. Patterns of staffing turnover and counterpart agency 4. Long-term budgeting over time (evidence of Ministry or other entity buy-in). 	<ol style="list-style-type: none"> 1. National Ministry Strategic Planning documents, 2. UNFPA CP, COARs, AWP, s, 3. Implementing agency reports. 4. Training data. 5. Stakeholders in management positions and beneficiaries. 	<ol style="list-style-type: none"> 1. Key stakeholder interviews with Senior policy makers within Ministry and IPs, 2. Document review, 3. Budget review. 4. Training follow-up interviews. <p>(NB: The above for each of the four program areas).</p>

EQ8 Assumption 1:

Please see above in EQ7 Assumption 1.

COMPONENT 2: ANALYSIS OF UNFPA Country Programme UNCT Cooperation and Value Added

UN COUNTRY TEAM COORDINATION

EQ9 To what extent did UNFPA contribute to coordination mechanisms in the UN system at country level?

Example: Results teams led or assisted by UNFPA.

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ9 Assumption 1: The UNFPA CO has made consistent positive contributions to the consolidation and functioning of UNCT coordinating mechanisms (working groups and joint programs) toward implementation of the UNDAF in each of the four program areas.</u>	Reported level of UNFPA CO staff participation in: 1. UNCT planning and coordination functions. 2. Pertinent UNCT theme groups 3. Other UNCT administrative bodies for coordination of activities. 4. Concrete examples of UNFPA CO participation in the process of consolidation of UNCT coordination procedures and programs.	1. UNCT staff at senior management and theme group levels. 2. UNCT Theme group minutes	1. Stakeholder interviews with UNRC and members of UNCT theme groups and UN agencies. 2. Document review of coordination of joint program activities (NB: The above for each of the four program areas).

EQ9 Assumption 1:
According to the Development Cooperation Office, the UNFPA is one of the most active UN Agencies dealing with the coordination of efforts within UN Agencies. UNFPA is deputy chair of the result group mandated to coordinate UN Agencies' effort under strategic theme number three (3), which is about environment and health. UNFPA actively contributes to organising regular planning, exchange and reporting meetings. UNFPA is a member of the cross-cutting gender group which aims to coordinate actions on gender equality and support gender mainstreaming in joint programming. UNFPA is part of the Security and Gender Coordination Group, which is composed of public institutions (police, government agencies), women's organisations, EUSR, EULEX, OSCE, NATO and UN agencies and coordinates efforts to promote gender equality in Kosovo. UNFPA is also one of the Agencies which has benefited the most from the joint programming which emerged through coordination with UNKT. UNFPA is a part of almost every joint programme developed and implemented in Kosovo through various UN Agencies, Funds, and Programmes. For example, a joint project on Justice 2020 and GBV (Support in Addressing Gender Based Violence Project), which is being implemented by UNFPA, UNICEF, UN Women, OHCHR, and UNDP, has allowed the UN Agencies that have different mandates to approach the issue from a different perspective. This applies a more comprehensive approach in order to tackle GBV in Kosovo, when compared to the stand-alone UN Agency projects. This Joint Project (JP) has allowed the implementation of stronger joint advocacy efforts.

UNCT COOPERATION

EQ10 To what extent does the UNDAF/UN Partnership Framework, reflect the interests, priorities and mandate of UNFPA?

Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ10 Assumption 1: UNFPA global mandates are being effectively implemented within the UNDAF in all four program areas.</u>	1. Mapping of key global UNFPA (e.g. SP 2014-2017 and SP 2018-2021) mandates and priorities	1. UNFPA Global Strategy documents (UNFPA SP 2014-2017 and SP 2018-2021)	1. Document review, 2. Key stakeholder interviews with UNFPA CO staff as well

	within UNDAF strategic documents and annual program activities for each of the four program areas.	<ol style="list-style-type: none"> 2. Senior UNFPA CO and UNCT management, 3. UNDAF strategy and reporting documents 4. UNDAF Midterm review, 5. UNDAF Annual Reports. 6. UNFPA CP COARS 	<p>as UNCT (UNRC and theme group members).</p> <p>(NB: The above for each of the four program areas).</p>
<p>EQ10 Assumption 1: The UNFPA has been directly contributing to the achievement of three (3) UNKT CDP outcomes covering all programmatic activities. The programmatic activities on population dynamics, is linked to the duty bearer outcome which is related to the application of evidence from population data by institutions to their policy making decisions (outcome 1.3.1). The second (duty bearer) outcome is about improving coverage of quality and equitable essential health care services for Maternal, Neonatal, Child and Reproductive Health (MNCRH) and Non-Communicable Diseases (NCD) (outcome 3.2), whereby UNFPA programmatic activities on SRH contribute directly to the improvement of the quality and equitability of the essential health care services for MNCRH. The last outcome is about right holders contributing to the change of people’s behaviours through adoption of more healthy behaviours, including on SRHR (outcome 3.3.). All of the UNFPA’s interventions that support community and formal education based comprehensive sexuality education contribute to achievement of this third UNKT outcome.</p>			
COMPONENT 3: ANALYSIS OF THE CP’s STRATEGIC POSITIONING			
UNCT COORDINATION			
EQ11 To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?			
<p>Comment(s) on above question:</p> <ul style="list-style-type: none"> • Alignment with UNFPA mandates may have changed over time due to the 2018 -2021 Aligned CP Output and Outcomes framework. 			
<p>Comment(s) on indicators for above question:</p> <ul style="list-style-type: none"> • Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF. 			
<i>EQ11.A To what extent did UNFPA contribute to ensuring programme complementarity, seeking synergies and avoiding overlaps and duplication of activities among development partners working in countries?</i>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<u>EQ11.A Assumption 1: UNFPA has contributed to ensuring program complementarity, seeking synergies and avoided overlaps and duplication of activities among development partners.</u>	<ol style="list-style-type: none"> 1. Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. Qualitative data on UNCT recognition of UNFPA CO contributions to UNDAF. 	<ol style="list-style-type: none"> 1. Senior UNFPA staff management, 2. CPD, 3. UNDAF documents, 4. UNDAF Midterm review, 5. UNCT Annual Reports. 	<ol style="list-style-type: none"> 1. Document review, 2. Key stakeholder interviews.
<p>EQ11.A Assumption 1: Findings including analysis for all pertinent program areas: 1. Reproductive Health and Rights, 2. Youth, 3. Gender and 4. PD. The utilisation of technical expertise (local and international) and utilisation of tools and products developed by WHO was positively rated, especially for interventions on EPC and the development/adapting of the CGPs. The division of the labour and cooperation with WHO was exemplary. While the know-how products of WHO were used for EPC, the UNFPA contributed heavily in organising ToT and delivering trainings through local trainers on EPC, using their extensive experience about training programmes for health care personnel on FP, STI, HIV, GBV etc. A similar division of the labour was applied during follow-up visits. There is also close cooperation</p>			

<p>between various UN Agencies on GBV. UNFPA was a part of joint programme on GBV (Support in Addressing Gender Based Violence Project), which was also implemented by UNICEF, UN Women, OHCHR, and UNDP. This has allowed the UN Agencies that have different mandates to approach the issue from a different perspective. For example while UNFPA was supporting PHC capacities to deal with GBV cases and working with FBO organizations, UNDP was supporting income generating activities of GBV victims, while UN Women was supporting rule of institutions to react promptly on GBV cases. UNFPA also has close cooperation with UNICEF in data collection processes especially on MICS whereby SRH components is financed by the UNFPA.</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ11.A Assumption 2: The UNFPA CP's core mandated activities, outputs and outcomes as implemented within the Country's UNDAF are recognized and acknowledged by UNCT.</u></p>	<ol style="list-style-type: none"> 1. Congruence of UNDAF and UNCT activities, outputs and outcomes with the 2018 - 2021 UNFPA Aligned CP framework. 2. Qualitative data on UNCT recognition of UNFPA CO contributions. 	<ol style="list-style-type: none"> 1. Senior UNFPA staff management, 2. Senior UNCT staff (UNCR and theme group members) UNFPA CP and PoC documents, 3. UNDAF Midterm review, UNCT Annual Reports. UNCT theme group minutes. 	<ol style="list-style-type: none"> 1. Document review, 2. Key stakeholder interviews with UNCT senior staff as well as UNFPA CO staff. <p>(NB: The above for each of the four program areas).</p>
<p>EQ11.A Assumption 2:</p> <p>UN Development Coordination Office highly recognized UNFPA core mandated activities and their contribution to the realization of outputs and outcomes that are part of Common Development Plan (an UNDAF like document). Furthermore, from individual UN Agencies WHO has praised the openness and close cooperation of UNFPA especially in the area of MCH, while UNICEF highly appreciated contribution and inputs provided for the data collection processes such as for MICS.</p>			
<p>ADDED VALUE</p>			
<p>EQ12 What is the main UNFPA added value in the country context as perceived by national stakeholders?</p>			
Assumption to be assessed	Indicator/Criteria	Source of information	Method and tools for data collection
<p><u>EQ12 Assumption 1: Assumes that UNFPA has added value in one or more areas within the country context.</u></p>	<ol style="list-style-type: none"> 1. Examples of activities that were influential for the results in a program area. 2. The perceptions of key national stakeholders. 	<ol style="list-style-type: none"> 1. Senior stakeholders at GVT Ministries, UNCT, UNFPA CO, and IP agencies 2. UNFPA program reporting documents. 3. Site Visits 	<ol style="list-style-type: none"> 1. Document review 2. Key stakeholder interviews
<p>EQ12 Assumption 1:</p> <p>In some areas, the added value of UNFPA lies in the fact that it is the only development partner active in those areas. For example, the UNFPA is the only actor supporting the capacities of public institutions and NGOs in the field of SRHR. All the stakeholders interviewed have reported that without UNFPA's assistance this area would have witnessed significant weaknesses. Similarly, UNFPA is again the only organisation supporting population data analysis and projections. Without the support of UNFPA many studies, such as Kosovo Population Projection, would not be produced, nor would capacities be developed in this regard. Furthermore, the UNFPA acts as a facilitator, or a broker, playing an intermediary role in bringing various –stakeholders and organisations (such as the Kosovo Civil Registry Agency, Faith Based Organisations, KAS, and others) together and coordinates their efforts towards improving data for vital statistics. Without the convening power of the UNFPA, parties agreed that it would be almost impossible to bring all parties and discuss these issues altogether. In addition, the UNFPA proved to have a specific ability in policy dialogue, and particularly in</p>			

placing sensitive themes on the national agenda. Inclusion of the MCRH component into the Sectoral Health Strategy for example, would not have been possible without UNFPA's presence according to the stakeholders' discussion. Moreover, UNFPA has made good use of its comparative strengths, thus bringing added value into the introduction of comprehensive sex education within formal education. While the Ministry of Education has integrated the concept on sexuality education into a new core curriculum framework, it was the UNFPA who brought its local and international expertise and facilitated the actual initiation of implementation of sexuality education in the formal education system. In the area of MCH, the UNFPA heavily cooperated with WHO. Nevertheless, there was a clear division of the labour and close cooperation between WHO whereby both agencies brought added value to the sector. For example, while the know-how products of WHO were used for EPC, UNFPA contributed heavily in organising the ToT and delivering trainings through local trainers on EPC using their extensive experience about training programmes for health care personnel on FP, STI, HIV, GBV etc.

Annex 3. List of people interviewed:

Nr.	Areas	Name and Surname	Organization	Position	Gender
1	All Areas	Visare Mujko Nimani	UNFPA	Programme Specialist	W
2	All Areas	Zarife Miftari	UNFPA	Programme Analyst	W
3	Sexual Education in formal education system	Lulavere Behluli	Ministry of Education Science and Technology	National Coordinator	W
4		Rifat Batusha	KOPF	Executive Director	M
5		Mimoza Janova	SHFMU „ILIRIA“ Prishtine	Teacher of Biology (for 6-9 grades)	W
6		Blerina Hoxha	SHML „Xhevdet Doda“ Prishtine	Teacher of Biology (for 10-12 grades)	W
7	SRHR Support the coalition of K10	Elvanda Gojani	Action for Mothers and Children	K10 Coordinator	W
8	Non-formal education (Peer Education)	Mirushe Emini	Ministry of Culture, Youth and Sports	Head of Section for Health Education and Health Promotion	W
9	Non-formal education (Peer Education)	Zana Krasniqi & Stefana Zivkovic	Artpolis	Director & Responsible for the activities in northern municipalities	W/W
10	Non-formal education (Peer Education) / gender equality Support the coalition of K10	Kadri Gashi	PEN (Peer Educators Network)	Project Coordinator – Young Men Initiative	M
11	Non-formal education (Peer Education) Support the coalition of K10 Contraceptives advocacy efforts with MoH in establishing a budget line for contraceptives	Rifat Batusha	KOPF	Director	M
12	Non-formal education (Peer Education) / gender equality	Stefan Veljkovic	Youth Educational Club Synergy	Project Coordinator	M
13	Non-formal education (Peer Education)	Burim Seferi	Red Cross	Coordinator	M
14	GBV, Strengthening of primary health care services to provide integrated quality SRH on FP, STI syndromic management, identification, management and referral of GBV survivors	Albana Morina	Primary Healthcare		W
15	MCRH, Adaptation and implementation of clinical guidelines on MCH	Arberesha Turjaka	Ministry of Health	Head of Division of Quality	W
16	MISP	Lulzim Çela	CDF	Programme Coordinator	M
17	Conduct initial analysis on CCS Develop the database for recording the data from Pap tests	Mrika Aliu	Action for Mothers and Children	Executive Director	W
18	GBV	Drita Lumi	National Expert	Trainer	W

19	SOP on CCSP Increased professional and technical capacity of FMC to implement CCS	Erzen Begolli	Prishtina Main Family Health Center	Doctor	M
20	GBV	Flamur Blakaj	National Expert	Trainer	M
21	Increased professional and technical capacity of FMC to implement CCS	Hana Bejiqi	Prishtina Health Center	Gynecologist	W
22	GBV	Shqipe Ukshini	Psychiatry Clinic, UCCK	Psychologist	W
23	YFHS	Rrezart Halili	MFMC Pristina	Deputy Director	M
24	Support of Ombudsperson	Majlinda Lulaj	Ombudsperson of Kosovo	Deputy Head of	W
25	MISP	Makfire Fazliu	Kosovo Red Cross	Health Program Coordinator	W
26	MCRH, GBV	Mehmet Uka	National Expert	Trainer	M
27	Promotional materials on CCSP	Dr. Florina Ushaku Grezda	MFMC Pristina	Doctor	W
28	MCR - Effective Perinatal Care	Memli Morina	University Clinical Center	Gynecologist	M
29	Support National Board on Cancer Control Promotional materials on CCSP Update the National Programme on Cancer Control + further scale up Services on CCSP expanded	Merita Berisha	National Institute of Public Health of Kosovo	Head of Observatory for Mother and Child	W
30	YFHS, CCSP, MISP, MCRH	Merita Vuthaj	Division of Mother and Child Health	Chief of Division	W
31	SHR, CCSP	Mrika Aliu	Action for Mothers and Children	Executive Director	W
32	GBV, Strengthening of primary health care services to provide integrated quality SRH on FP, STI syndromic management, identification, management and referral of GBV survivors	Murat Mehmeti	National Expert	Trainer	M
33	Improve quality of services in the area of PAP smear reading	Ramadan Sopa	Department of Pathology	Director	M
34	Improve quality of services in the area of PAP smear reading	Reshat Mati	Institute of Pathology	Pathologist	M
35	MCH -Effective Perinatal Care	Shpresa Behluli	National Board on Cancer Control	Doctor	W
36	Support National Board on Cancer Control	Elvis Ahmedi	National Board on Cancer Control	Head of Board	M
37	Increased professional and technical capacity of FMC to implement CCS	Luljeta Peqani	QMF 6 Pristina	Family Physician	W
38	CCSP Strengthening of primary health care services to provide integrated quality SRH on FP, STI syndromic management, identification,	Vjollca Zeqiri	Prishtina Main Family Medical Center	Doctor	W

	management and referral of GBV survivors				
39	Increased professional and technical capacity of FMC to implement CCS	Lumturije Kërliu Sveçla	QMF 11 Pristina	Family Physician	W
40	Population Development	Avni Kastrati	ASK (Kosovo Statistical Agency)	Head of Population Statistics	M
41	Population Development	Erdon Arifaj	ARC (Civil Registry Agency) – (in Ministry of Internal Affairs)	Head of Civil Status Sector	M
42	Population Development	Abedin Sadriu	BIK (Kosovo Islamic Community) – Faith Based Organization	Religious Services Officer	M
43	Population Development	Arjeta Gjickolli	UNICEF	Data Management	W

Some of the people in the list above were interviewed more than once by different consultants, and hence the total number of interviews is in reality more than 44, reaching 53.

Focus Groups Conducted:

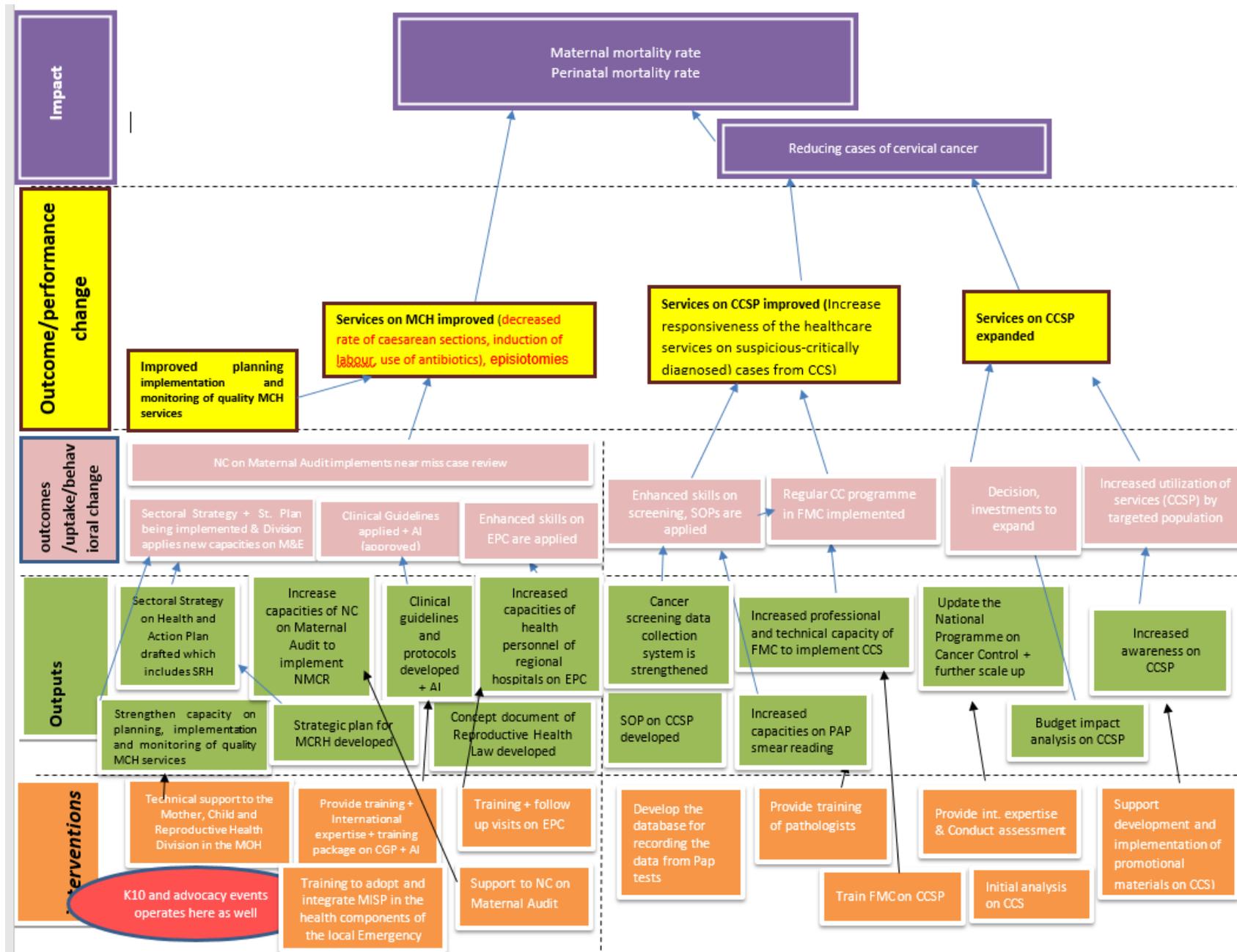
Focus Group Nr.	Areas	Type of focus group	Location	Organization
1	Non-formal Education	One focus group with peer education trainers	Drenas	KOPF
2		One focus group with peer education trainers	Lipjan	KOPF
3		One focus group with youth who received gender equality training	Prishtina	PEN
4		One focus group with Artpolis artists	Prishtina	Artpolis
5		One focus group with Artpolis artists and beneficiaries	Gracanica	Artpolis
6	Effective Perinatal Care	One focus group with QKUK (Main University Clinical Center) doctors and nurses who received training	Prishtina	UNFPA
7	GBV	One focus group with QKMF (Main Family Medicine Center) doctors and nurses who received training	Viti	UNFPA
8	Orientation Program for Adolescent Healthcare	One focus group with QKMF (Main Family Medicine Center) doctors and nurses who received training	Lipjan	UNFPA
9	MISP	One focus group with youth who received emergency training in Prishtina and Fushe Kosova	Prishtina	Red Cross
10	CCSP	One focus group with beneficiaries	Pristina	MFMC Pristina

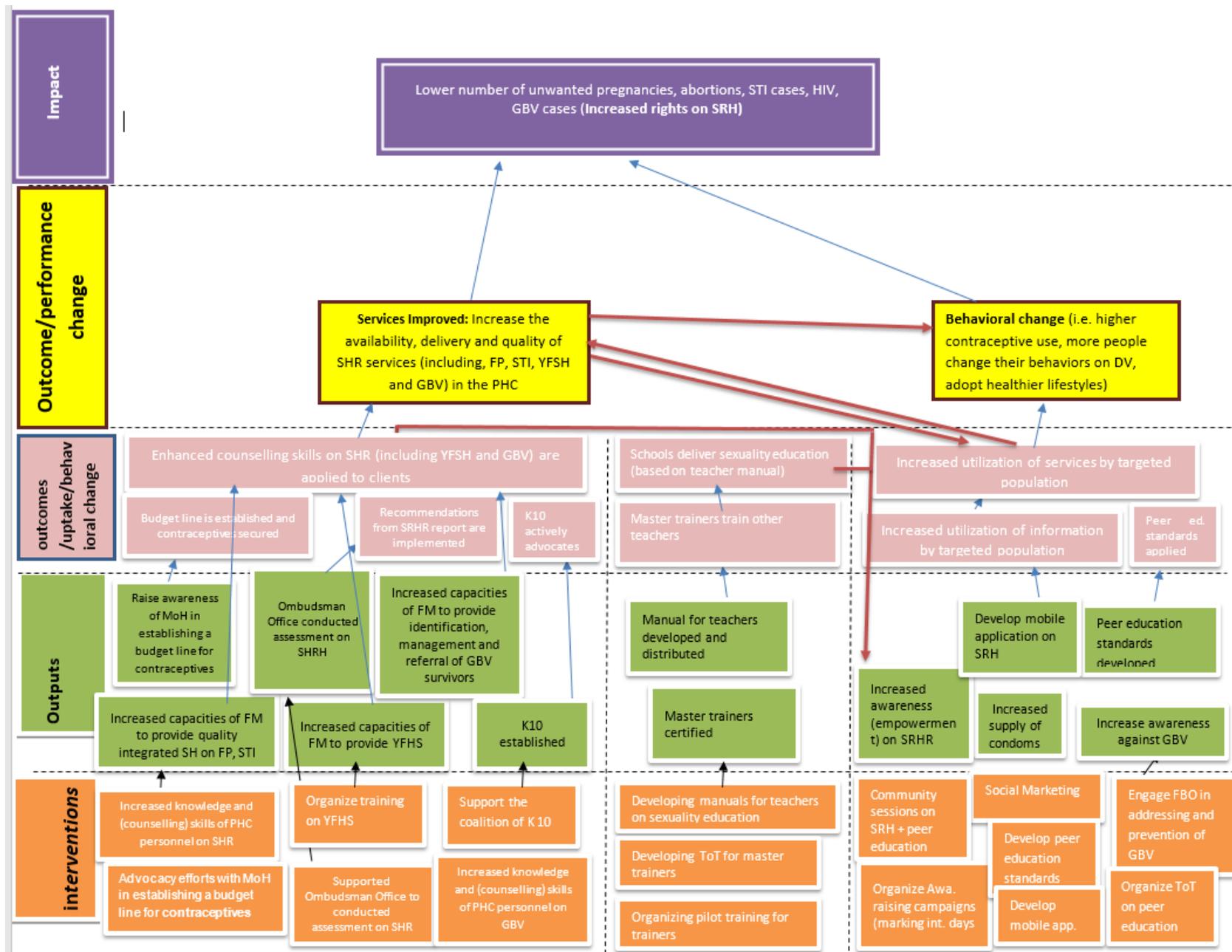
Gender Balance Report of Interviewees and Focus Groups for UNFPA Kosovo Program Evaluation

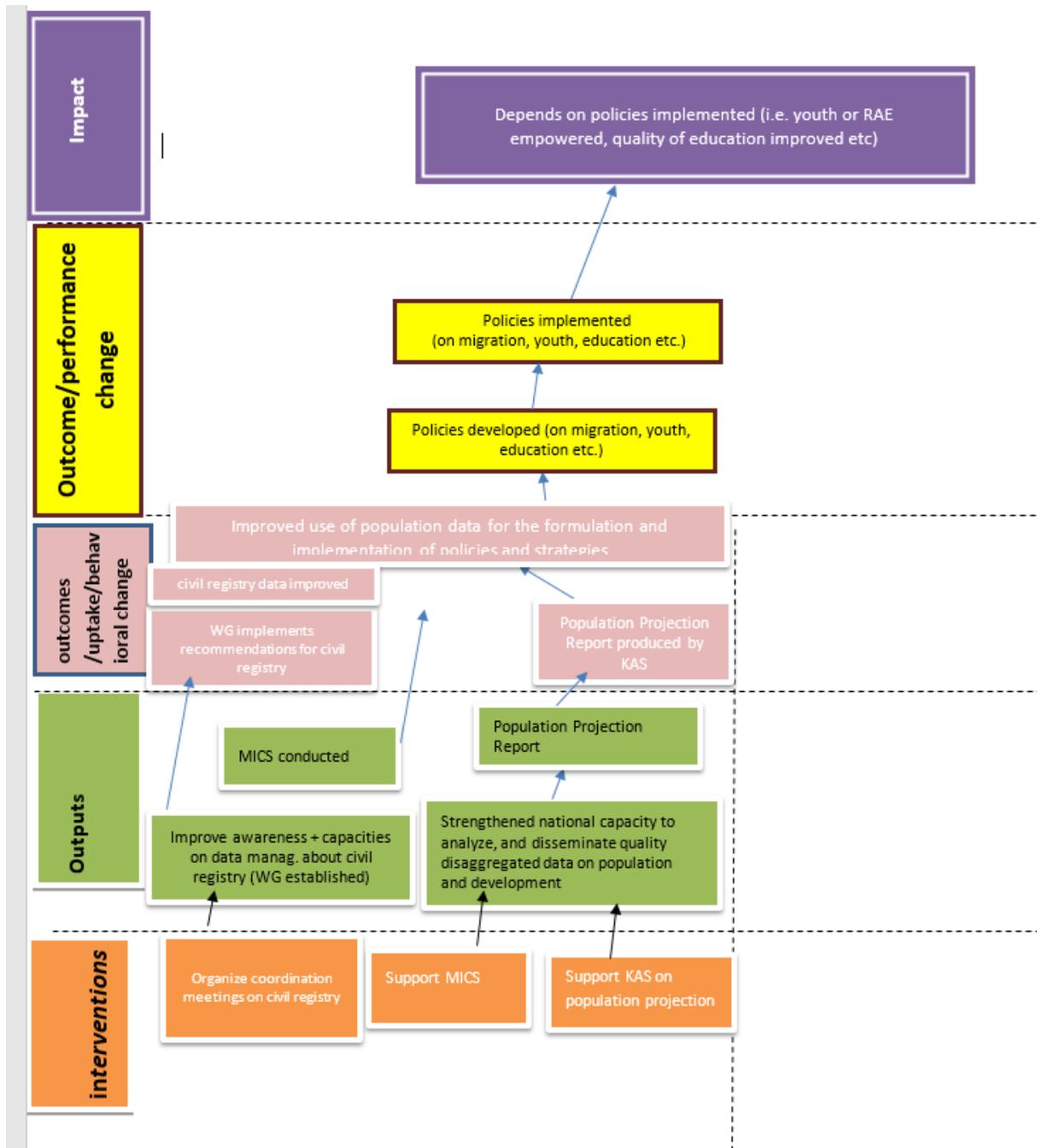
Area	Interviewees		Focus Groups		Total	
	Men	Women	Men	Women	Men	Women
Maternal and Child Health	2	5	2	7	4	12

Cervical Cancer Screening Program	3	9	0	6	3	15
Sexual and Reproductive Health & Rights	4	8	6	6	10	14
Comprehensive Sexuality Education (Formal Education)	1	5	5	5	6	10
Comprehensive Sexuality Education (Non-Formal Education)	5	6	10	14	15	20
Population Development	3	2	0	0	3	2
TOTAL	18	35	23	38	41	73

Annex 4. Results Chain







Annex 5. RESULTS AND RESOURCES FRAMEWORK FOR KOSOVO, 2016-2020

Result	Performance Indicators	Baseline	Target	Actual situation (end of 2018)	Means of Ver.
Outcome 1: Sexual and reproductive health	Modern contraceptive prevalence rate	13.7%;	15.5%	Data will be available by 2020	MICS
Output 1: Increased national capacity to deliver integrated sexual and reproductive health services for women, men and youth with special focus on vulnerable groups including in emergency and humanitarian settings	Number of guidelines, protocols and standards for delivery of quality SRH and HIV services (including for adolescents and youth) that is aligned with international standards	1	5	11 guidelines are developed	Kosovo Council on Clinical Guidelines and Protocols
	National system for maternal death surveillance and response established	No	Yes	Yes, National Committee on Maternal Mortality Audit was established	
	Costed integrated Sexual Reproductive Health action plan developed	No	Yes	In progress, Integrated Sexual Reproductive Health action plan is being developed	Budget Impact Analysis report
	Gender-based violence prevention, protection and response integrated into national sexual and reproductive health programmes	No	Yes	Clinical Guidelines and intersectoral SOP on GBV was drafted and approved	CGP and SOP
	Number of civil society initiatives involving men and boys in addressing gender equality and gender-based violence	3	7	More than 7	Reports from implementing partners
	Minimum Initial Service Package for reproductive health in crisis situations integrated into national emergency preparedness plans	No	Yes	In progress at national level and completed for 6 municipal level plans	
Outcome 2: Adolescent and youth	Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (female / male)	female 17.4% male 16.8% (2013)	female and male at least 25%	Data will be available by 2020	MICS
Output 1: Increased national capacity to design and implement community and school based comprehensive sexuality education	Percentage of secondary schools that introduce comprehensive SRH education aligned with international standards	0	10%	In progress, at the moment only schools of municipality of Pristina	Administrative records from training of teachers

(CSE) programmes that promote human rights and gender equality.					
Outcome 4: Population dynamics	Completed evaluations on strategic interventions around sexual and reproductive health and adolescent and youth exist	No	Yes	So far three completed ¹⁴⁶	Assessments
Output 1: Strengthened institutional capacity for the formulation and implementation of rights-based policies that integrate evidence on population dynamics, sexual and reproductive health, HIV and their links to sustainable development	Number of formulated policies and programmes based on identified priorities using Population Situation Assessment	0	3	1 so far (Strategy for integration of Roma and Ashkali Communities for the period 2017 -2021)	Strategy Document
	National inquiry concerning the exercise of reproductive rights and right to sexual and reproductive health conducted by a National Human Rights Institution exists	No	Yes	Yes, OiK has produced the first National Assessment of the Reproductive and Sexual Rights in Kosovo	The report from OiK
	Tracking and reporting mechanism to follow up on the implementation of reproductive rights recommendations and obligations established at national level.	No	Yes	Yes, it is established by OiK and so far out of 62 recommendations produced by the report about 26 of them (or 42%) have been implemented satisfactorily	OiK

¹⁴⁶ (1) External assessment of the effectiveness of the SRH training programme on FP, STI, GBV, YFHS etc; (2) Budget Impact Analysis for national screening program for cervical cancer; (3) Budget Impact Analysis for provision of emergency contraceptive pills

Annex 6. Evaluation Tools

Questionnaire for Ministry of Education on Comprehensive Sexuality Education (CSE)

<p>1. Date and Location of Interview: __Day__Mo__Year</p> <p>2. Location of Interview: _____</p> <p>3. Name:</p>

Introduction

Activity Assessment

1. What kind of support the Ministry received for CSE?
2. What do you think about the quality of the support provided?
3. Are there alternative (better) ways to provide this support ?

Relevance

4. Was the support relevant to your needs?
5. Was it useful?

Output assessment

6. What products you have been delivered through UNFPA support? (manual for teachers on CSE)
7. Would you be able to develop without UNFPA support?

Outcome assessment

8. Are you using the products developed?
9. If yes at what extent you are using?
10. What are you expecting to change with the products ?
11. If you not using why?

Recommendation:

What recommendations do you have to improve the UNFPAs support?

UNFPA CP Evaluation

Questionnaire for Agency of Statistics of Kosovo

Information filled/obtained or verified prior to the interview and during interview scheduling:

<p>4. Date and Location of Interview: __Day__Mo__Year</p> <p>5. Location of Interview: _____</p> <p>6. Name:</p> <p>7. Contact information for clearance:</p> <p>8. Position and Organization:</p> <p>9. Position with respect to policy: Does the respondent work at a level where he/she has an understanding of national donor policy issues? Circle one: Yes No.</p> <p>10. Number of years has worked in this position: _____Years</p> <p>11. Confirmation that respondent knows what the UNFPA CP.</p> <p>12. Confirmation that respondent is familiar with Population Dynamics Area of the Program.</p>
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Introduction:

Thank you for agreeing to meet with me today. My name is Alban Fejza. I am part of a team of evaluation consultants hired by UNFPA to conduct an project evaluation of the UNFPA CP for 2013- 2018. The UNFPA Kosovo Program has been implemented in collaboration with a wide range of Kosovo institutions, NGO's and other stakeholders. As you might know, one of the main stakeholders for the one

part of the UNFPA program related to Population Development is your institution, ASK (Agency of Statistics of Kosovo).

The goal of this interview is only to evaluate the period from 2013 to 2018, now that many of the components have been implemented.

This evaluation will assess as objectively as possible, the following five criteria: relevance, effectiveness, efficiency, sustainability, and added value, and in the end you will be able to give your comments and your recommendations as well.

Since your institution is only involved in the UNFPA sub-program of Population Development, our scope of evaluation will be only this part, and the other stakeholders involved in other parts of the UNFPA program will give their feedback on other parts of the program.

This interview will contribute towards the development of final evaluation document for UNFPA Kosovo Country Program, and it should serve in the future to inform and help key stakeholders, UNFPA, various Ministries and donors, to make reasonable choices regarding the approach towards interventions in the country and the components that should be maintained, modified or added in the upcoming projects.

Ground Rules: This interview is confidential and voluntary. Your name will not be linked to any of the findings. If you are willing to be quoted, this is appreciated. But no data will be associated with your name unless cleared in advance by you. You can end the interview at any time and have no obligation to answer any questions asked.

Is it ok, if I record the interview to refer to it later, and to make sure that I do not miss any important information? The recording will remain confidential and I will delete it as soon as I extract the relevant information for the UNFPA program, but we may also not record it. You are free to choose.

Thank you. May we start?

Questions only included :

(After interviewee asked for further clarification about the content of the interview, wanting to know the content beforehand)

- Ok, let me give you an overview, so in other words, in relation to Population Development, the purpose is to evaluate how the UNFPA program has supported ASK, how it has supported the MICS survey, how it has helped to build national capacities, how this has helped in data quality improvement, how this has helped in population projections, and how these have been used by other institutions, maybe for policy development, and this is the general idea, but I will ask you the questions specifically further on.
- So, now that we have clarified that, can you tell me up to which level do you think the UNFP Kosovo program which was planned has been achieved? Explain.
- Can you please inform me what report you are referring to. Are you referring to the Population Projection report ?
- This raises another question: When did the UNFPA support to your institution start ?
- Now let me remind you again that the scope of this evaluation is only from the year 2013, so can you now inform me which areas, and which interventions has UNFPA been involved in since 2013?
- So, the main contribution has been expertise? Explain

- So, the MICS survey is supported by two organisations, UNFPA and UNICEF? Elaborate?
- The areas which you mentioned – vital statistics, MICS survey, and Population Projections, can you please explain how **relevant** do you consider these? Please give me an answer for each of them separately, and for all of them together.
- How **effective** has it been? Please explain for each of them separately and for all of them together.
- In relation to **efficiency**, how efficient do you consider these interventions, or how efficient do you consider your cooperation with UNFPA, and I am referring here both to the financial aspects, human capital aspects, and other aspects, or efficiency in general? Elaborate.
- So, is there any way you consider you would be able to achieve the same goals with less efforts?
- Regarding **sustainability**. How sustainable do you consider this part of the program? Please give me two answers. One for the next 3-4 years, and the other for the long-term.
- How much do you consider there is a need for repeating the support already give, like the expertise, workshops etc.?
- What is the **added-value** of UNFPA program?
- Since, a lot of things are coming in your mind, maybe it would help if you rank the top three aspects of the UNFPA which you consider to have added the most value?
- So, tell me if I understand this correctly. Since 2013, most of the UNFPA support has been through experts/expertise and workshops?
- Since you mentioned, Population Census (which was conducted in 2011), but maybe other data analysis aspects continued in other years, has UNFPA supported you regarding this?
- So regarding the Population Projections aspect, you consider that you do not need a lot of support anymore, and that you have enough human capacities now for this, but for other aspects like Vital Statistics you would welcome the support? Explain.
- Up to what level do you consider that your partnership with UNFPA has promoted National Ownership of the Population Development area/programs/projects? How much do you feel like you are an owner of the achievements in the last five years?
- Are you using these two software applications which you just mentioned? How often?
- Now let me ask you one question about the impact of the UNFPA support. How much do you think your data are being used to create evidence based policies, and how do you consider this should be done?
- Are there any supporting documents which your institution would be willing to share to help us make a better and more evaluation of the UNFPA program.
- Do you have any recommendations?
- Is there anything which you would like to mention or comment on, which I did not cover?
- One more thing, since you mentioned the workshops, can I ask you whether those workshops were evaluated by you through a questionnaire or some other means?

Thank you.

For use with participants of Peer-to-Peer Education, Gender Equality Training and Theatre Play

Unique FGD ID Number	____ _ <i>To be filled by evaluation team</i>
Interviewer/Facilitator Name(s)	
Notes on this form taken by (name)	
Date of FGD	Day: ____ ____ Month: ____ ____ Year: 2018
Location: Name of District/City	
Location: Specific Site/Facility	

Introduction: Hello and Thank you for agreeing to meet with us today. Our names are Levent and Alban. We are evaluation consultants and have been hired to conduct an evaluation of UNFPA/Kosovo supported programs that have been implemented since 2013.

We would like to ask you questions about PEN/Artpolis/KOPF supported programs.....

And discuss whether these activities have affected your knowledge, beliefs, as well as attitudes, behaviour, practices related to gender equality/GBV/FP, STI etc. .

Participation in this discussion today is voluntary and you may decline to answer any individual question. The information you provide will be kept strictly confidential and will not be disclosed to others.

One of us will be asking the questions, while the other will take notes based on what you say.

We would also like to record the discussion. Is this acceptable to you?

(If any of the participants object, we will not do any recording).

Before beginning, we would like to recommend some ground rules for our discussion.

1. This conversation should be treated as confidential. Whatever is discussed here should not be shared outside of this group after the discussion has finished.
2. Please respect each other's opinions.
3. The information you provide will not be linked to you in any way. Your honest responses to our questions will be highly appreciated.

This is an open discussion and everyone is entitled to his or her own opinions so please feel free to express what you think and feel.

We hope it will not take more than an hour and a half.

If any of you would prefer not to participate you can leave any time. Can we begin? Thank you.

All probes are optional but all questions should be asked.

I. Activity assessment (30 minutes)

Participation

- 1a) When did you participate in peer to peer training/ gender equality training / theatre play?
- 1b) How do you heard about the training/ theatre play?
- 1c) What are the mains reasons for deciding to follow this training/theatre play?

Relevance

- 1d) Was the topic relevant to your needs?
- 1e) Was the training sessions/ theatre play relevant to your needs?
- 1f) Was it useful?

Other considerations

- 1g) What do you think about the quality of training/ theatre play? Was it well planned and delivered?
- 1h) Is there a need to repeat this training/theatre play?
- 1i) Are they alternative (better) ways to provide this training?

II. Output Assessment (10 minutes)

- 2a) Can you please list three main things that you learned during this training/ theatre play?

III. Outcome assessment (30 minutes)

- 3a) Are you applying these lessons?
- 3b) Which of the lessons you are applying?
- 3c) How you are applying?
- 3d) Which of the lessons you are not applying?
- 3e) What are the main reasons that hinder application?

Recommendations (5 min)

What recommendations do you have to improve the training /theatre play?

Thanks for your participation and assistance