External Review: Final Report

December 2018

"Accessible Quality Healthcare" (AQH) Project - implemented in Kosovo

SDC contract no 81038924

On behalf of

Swiss Cooperation Office Kosovo

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2 ABBREVIATIONS

AKM	Association of Kosovo Municipalities
AQH	Accessible Quality Healthcare Project
BCC	Behaviour Change and Communication
CBPP	Capitation Based Performance Payments
CCNE	Centre for Continuing Nurse Education
CDFM	Centre for the Development of Family Medicine
CPG	Clinical Practice Guideline
CME	Continuing Medical Education
DHSW	Director of Health and Social Welfare
DM	Diabetes Mellitus
FMC	Family Medicine Centre
HE/HP	Health Education and Health Promotion
HEC	Health Education Committee
HIS	Health Information System
HRC	Health Resource Center
HSS	Health Sector Strategy
HT	Hypertension
IEC	Information, Education and Communication
KAPB	Knowledge, Attitude, Practice and Behaviour Survey
KHP	Kosovo Health Project
LuxDev	Luxemburg Development
MEST	Ministry of Education, Science and Technology
MFMC	Main Family Medicine Centre
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NCCPG	National Commission for Clinical Practice Guidelines
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NIPH	National Institute of Public Health
PHC	Primary Health Care
PHC TEG	Primary Health Care Technical Expert Group
PIU	Project Implementation Unit
PRAK	Patients' Rights Association of Kosovo
QIPs	Quality Improvement Projects
QoC	Quality of Care

RAE	Roma, Egyptian and Ashkali
SC	Save the Children
SDC	Swiss Agency for Development and Cooperation
STEPS	WHO STEPwise Approach to Surveillance
TA	Technical Assistance
TNA	Training Needs Analysis
ToRs	Terms of Reference
ToT	Training of Trainers
WB	World Bank
YPO	Yearly Plan of Operations

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4 EXECUTIVE SUMMARY

4.1 Overview

The first 2.5 years of implementation of the AQH project have seen immense progress affecting profoundly the primary health care management of diabetic and hypertensive patients and those at risk in the selected project municipalities.

Data that can provide evidence of the effectiveness of the project activities is not yet in, partly because there were unforeseen problems with the health information system (HIS), and partly because there is still 1 more year of the project to run.

Even so, it is clear to the Reviewers that deep changes have been achieved from the attention to detail given to the 3 levels of the system: the clinical staff, the managers, and the population. Using Diabetes and Hypertension as "tracer" conditions, the project has been able to develop realistic and effective processes of care at these 3 levels, while also highlighting bottlenecks discovered as the project progresses (eg poor record keeping, lack of clinical equipment).

The AQH team has spent effort in adjusting the project to local needs and this should continue. The AQH PIU comprises an outstanding team of international and national staff members. There appears to be excellent cooperation between the project staff and the key partners comprising the PHC staff, managers (including the Ministry of Health), and patient groups. This bodes well for the planned follow-on Phase II due to commence in early 2020.

In some senses, the project is reviving the capacity of the relatively neglected PHC services (in comparison to the hospital sector) in the country and enhancing their value in the eyes of the authorities and - particularly - for the most vulnerable citizens.

Within the constraints of the future project phase funding, the question is not so much what to do, but what not to do! How quickly should the project scale up to new municipalities, as per the request of the Minister of Health? How many new (tracer) topics can be added? And what new issues may need to be addressed to further strengthen the PHC system.

This review looks at the lessons learned and offers options for SDC/AQH Project leaders to consider how best to move forward without losing what has already been gained.

4.2 Summary of Recommendations for Phase II

Main:

1. In general, to continue the current 3 Outcome activities, integrating them whenever possible and completing the coverage of interventions in the current 12 municipalities (Section 12.1). Efforts should focus on further developing and using the skills of local experts to manage these.
2. To consider to introduce at least one more SP topic into the Project, commencing in the already supported municipalities. Asthma appears to be a growing problem, affecting particularly the vulnerable populations, and would make better use of the capacity and focus of SC (Section 12.2).
3. To expand geographically to more MFMCs, with several options possible while being cautious that, if overdone, expansion can limit project impact. Equipment procurement, implementation of the SPs and management training could form the core activities of this expansion (Section 12.3).
4. In expanding geographically, to use a process of developing partnerships between the AQH-support MFMCs and new MFMCs (Section 12.3.2).
5. Pilot the expansion of the Community Scorecard to more municipalities through SC using existing tools, knowledge and experience (Section 11.3.1).
6. Finalise the Integrated Care model, adjust it according to the capacity of the Social Workers, and consider establishing it through a partnership mechanism with other interested municipalities (Section 9.2.2).

Additional:

7. The AQH-trained Quality Coordinators should be supported to monitor the ongoing use of the 2 SPs and making action plans to address issues. The MoH's Division of Monitoring and Evaluation should be encouraged and supported to oversee this process Section (9.2.2)
8. Review the system of delivering original reporting forms to the NIPH, and assess the potential to make this more efficient by sending soft-copies (Section 11.2).
9. Strengthen the capacity of the Professional Chambers (who will take over the CPD and accreditation functions) (Section 12.1.3.1).
10. Implementation of a prospective cohort study looking at what the AQH-supported NCD SPs achieve could prove to be a useful adjunct to the project (Section 9.2.2)
11. Consider how to maximise the efficiency of the AQH partnership, perhaps by sub-contracting aspects of the work to SC in the future phase (Section 11.3.1)

Related to AQH Project PHC system strengthening

12. Review collaboration with institutions (eg NIPH, CDFM), and find new ways to collaborate effectively (Section 12.1.3.1)
13. Cooperate and develop the NGOs taking into account their missions (Section 12.1.3.3)
14. Improve the data-collection system and consider including project indicators into the national data reporting system (Section 10.1)
15. Review the responsibilities and functions of the AKM H&SW Collegium. Design and conduct an audit to ascertain how far this organisation is fulfilling its remit and promote thinking about what more it could do to support the development of PHC services (Section 11.2).
16. Review the financial control of the PHC budgetary mechanisms, to allow savings made in running costs to be used for capital expenditure, and not automatically lost at the end of the financial year. The AKM Collegium of Directors of HSW could look into this, and possibly a WB Trust Fund could be used to support the review (Section 11.2).
17. Improve the MoH system of equipment procurement (AQH cooperates with MoH to purchase equipment for the new MFMCs, or via WB (Trust Fund) support (Section 9.2.1).

Specific responses to TOR questions

Brief answers are given to each of the questions raised in the ToR and these can be found in Annex 5.

5 OBJECTIVES OF THE EXTERNAL REVIEW

The main objective of this external review was to assess the project's **performance, achievements** and **gaps** including evaluation according to the DAC criteria: effectiveness, efficiency, impact, relevance, sustainability of the project approach and set-up for Phase I.

It would also **provide strategic recommendations** towards the planning of Phase II, for SDC to use the findings and recommendations to guide decision-making related to AQH II (strategic planning/steering) and for purpose of documentation, institutional learning and accountability (End of Phase Report for AQH I).

6 METHODOLOGY OF THE REVIEW

Dr Peter Campbell (International Expert) and Dr Ilir Hoxha (National Expert) were selected to carry out the External Review in Kosovo from 3-14 December 2018.

The Review process included the following aspects:

- reading relevant documents (see Annex 3 for the full list of reference documents)
    - this was mostly carried out prior to commencement of the trip, and continued during the Review as points were highlighted or new materials recommended.
- interviews
    - Interviewees were selected initially by the Reviewers, and this was then revised after discussion with SDC and the PIU.
    - All meetings and statements were treated with the utmost confidentiality by the Reviewers.
    - Relevant members of the PIU accompanied the Review team on site-visits, and this allowed the Reviewers to discuss issues with them in more depth maximising the value of the journey time. It also allowed the PIU staff to give more detailed explanations about the comments made by interviewees. Throughout, the Reviewers were in control of the meetings, leading with their own questions and free to follow directions of ideas that were felt to be relevant.
- site visits for observation
    - 6 municipalities were visited.
    - The list of facilities visited is found in Annex 2- Schedule of the Review Trip.
    - The sites were chosen after discussion with SDC, the PIU and some were added in the course of the trip as they were recognised to be relevant.
- data analysis
    - See Annex 4 for indicator spreadsheet

Records for all meetings and site visits were stored confidentially on one laptop with updated firewall and antivirus system.

The Terms of Reference of the External Review included a number of specific questions to be answered by the Reviewers (see ToR in Annex 1). These questions formed the core of the questions for which answers were sought by the Reviewers. Of particular importance was the issue of sustainability: how can the project ensure that its achievements (if relevant, efficient, and effective producing an impact) will be sustainable in the long term.

7 Outline of Findings & Conclusions

The findings are divided in 5 main sections according to the 5 DAC Criteria regarding both the current Phase and the Strategic recommendations towards the planning of Phase II), as described in the Objectives of the ToR.

There is also and an Annex section with specific responses to questions raised in the ToR:

1. **Relevance**
2. **Effectiveness**
3. **Efficiency**
4. **Impact**
5. **Sustainability**
6. **Specific responses to Questions in the ToR:** brief answers are given to each of the questions raised in the ToR and these can be found in Annex 5

8 Relevance (DAC I)

The project is highly valued by the PHC staff, by patients attending their clinics, and by the authorities, in particular the Minister of Health. It is clearly focused on PHC, and is taking what has been developed over the years and empowering it to provide more accessible services to patients.

8.1 Two Priority NCD Conditions

The project is a health systems' support project that has started with a Service Package (SP) focus on addressing the Non-Communicable Diseases of Diabetes Mellitus (DM) and Hypertension (HT). While this is open to criticism - in that there are many other worthy causes such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), cancers etc - this approach does have significant advantages at this early stage of the project.

First, it hastens the AQH team to develop its own skills and expertise in these 2 topic areas, which in turn develops respect from the PHC counterparts, the nurses and doctors. Management of these conditions has been carried out by national clinicians using certain routine and established ways for many years, and the effort and convincing power needed to change deeply held concepts (eg treatment regimens, frequency of consultations, counselling information, lab tests etc.) cannot be underestimated.

Second, it allows the project to delve deeply into the day-to-day functioning of the PHC system, identifying bottlenecks to good service delivery and finding ways to address the issues. At each step, the project has worked, whenever possible, to ensure concrete solutions are developed to address the issues identified, such as the development of the patient DM and HT record booklets, brochures on the conditions, and individual facility solutions to local problems through the coaching and supportive supervision processes. This has included in-depth discussions with clinicians when problems were encountered in the use, format and storage of patient notes, identification of patients with NCDs, and in the availability of medications.

Thirdly, by combining these two service packages with other aspects of the health system, in particular the management approach and involvement of the community, the project is able to draw everything together to optimise the delivery of care for the patient's (and not primarily the doctor's) benefit. In particular, the management training aspects have the potential to ensure better sustainability of the project later on as the health systems and decision makers are empowered through a new understanding and skill-set to further promote the achievements gained (improved finance-seeking mechanisms, human resource management, procurement experience, effective project and quality improvement designs).

Following the logic that the healthcare providers are significantly strengthened in their clinical management of DM and HT, there is every chance that health data in the selected municipalities will

begin to improve. However, the weak link is the availability of appropriate medications (eg for blood pressure and blood glucose control) on a continuous basis. The MoH have been made aware of this and say that they are increasing their procurement of the medications, but this is out of the hands of the AQH project, and it remains to be seen how consistently this continues.

8.2 Theory of Change

The original theory of change assumed that better targeting of clients' needs and improved management of services would raise the quality of primary health service delivery on the one (supply) side. While on the other (demand) side, generating demand for quality primary health services, by involving populations in shaping the services, would together lead to increased rational utilisation of all health services and improved health status of the population.

The project operates in the triangle of:

- Improving the quality of service provision, reducing access barriers and making services more responsive to patients' needs -**provider component**
- Strengthening service integration at municipality level through improved management, stronger inter-sectoral collaboration, increased effectiveness and accessibility of health services and by addressing contextual determinants and risk factors for ill health- **municipality, inter-sectoral and regulatory component**
- Promoting an active patient role for the delivery of PHC services, positively influencing health seeking behaviour, particularly for the poor and current non-users or low-users, and promoting healthy lifestyles at population levels – **population component**

The project has adhered carefully to these 3 aspects, placing a strong emphasis on linking both the supply and demand side. This has been achieved by keeping the focus on the two key Service Packages of Diabetes Mellitus and Hypertension. On the supply side, the clinical staff have been trained (PEN protocols) and reorganised (equipment provision, Health Resource Center support by nurses) to offer a higher quality of service for the population. Managers have been assisted by various means (including Supportive Supervision, QIPs, Quality Management training etc) to enable the service providers to function at a higher level. And the population have been involved through Health Education initiatives (printed materials, media campaigns, the Community Scorecard pilot) to become more aware of their needs with regard to the 2 conditions and the availability of services at PHC level to help them.

Such strong integration has produced a number of benefits. It has convinced the clinical staff of their need to improve their knowledge and skills in these areas, and has significantly increased the role of the nurses and the way clinical staff now work together as a team. The Health Resource Centers established at each facility demonstrate tangible evidence to the patients of a shift in thinking of the clinical staff towards valuing their needs and concerns. Distribution of the DM and HT patient care booklets has empowered the patients to understand better their needs and puts into their hands control of their management.

The AQH project staff has worked hard to nurture participation of all stakeholders at every step, and this has led to a feeling of ownership of the project activities at all the sites visited. In particular, collaboration with the managers has allowed excellent cooperation at each step, and a feeling that the managers have earned respect for their involvement and the tangible changes that have occurred at their facilities.

Finally, by linking the 2 conditions so clearly to the population health education activities, a full circle of care service has been achieved with patients appreciating the efforts of the health staff to care for their needs and, especially in the case of the Lipjan Community Scorecard pilot, gaining a new empathy for the constraints faced by the clinical staff (e.g. with regard to medication availability).

This all means that, in general, many aspects of the project goals are in the process of being achieved within the timeframe of AQH Phase I: for the **provider component**, the quality and responsiveness of services and reduction of barriers in the municipalities of activity are being improved; for the **municipality, inter-sectoral and regulatory component,** there are strong indications of improved management and some service integration capacity at the municipality level; and for the **population**

component, the infrastructure (HE centers and corners) and service provider capacity (counselling skills, materials) to promote healthy lifestyles and address risk factors of NCDs is improved.

There are some weaknesses compared to the original goals, but these are understandable in a project of this size and scope and they do not detract from the overall achievements, particularly considering the 2.5 year implementation timeframe. Examples include the fact that the Inter-sectoral work is in its earliest stage (IC pilot), few regulatory mechanisms been enacted, and an active role for patients in the delivery of PHC services is in its infancy.

The knowledge, skills and products developed through the project are now sufficiently matured to allow the project to begin to scale up to new municipalities. Expansion can progress at a faster rate in the 2nd phase, since little has to be developed from scratch.

8.3 Project Environment

The AQH project is one of 3 relatively large-scale projects with a focus on health care in the country.

8.3.1 The Kosovo Health Project (KHP)

This is funded through the World Bank (WB) and has been focusing on developing the Social Health Insurance (SHI) system. It has been underperforming compared to initial expectations with a recent substantial reduction in the planned budget from 26 million to 15 million. The KHP is planned to end on 30 Oct 2019 after 5 years of implementation and there is no certainty about a follow-on project, with a mission due to take place in February 2019 to begin to clarify the situation.

The KHP supports capacity building and establishment of **building blocks for introduction of SHI**:(Cost $5.82 M). This includes building capacity of Health Insurance Fund, especially the IT capacity; preparing health institutions to interact with the Health Insurance Fund; and now planning to train health managers on health financing.
It also supports **primary health care strengthening**:(Cost $9.10 M). At the start, the KHP provided MCH equipment to secondary and tertiary level hospitals in Pristina. Currently, this is mostly carried out through developing systems for registering patients in the adapted Health Information System, and then offering a Capitation-Based Performance Payment (CBPP) now covering approximately 50% of the municipalities. However, to date all payments are made using the WB funds, with no clear timeframe for raising the payments from the SHI system.

There is also a **project management and communications component**:(Cost $0.77 M)

8.3.2 The LuxDev-funded Health Support Programme in Kosovo (Phase II)

This is the other large healthcare project which was ready to commence in early 2015, but only approved at the end of 2015 and commenced in 2016.

It has 3 main Outcome areas:

1. To build capacity of the MoH in fulfilling its core functions;

2. To improve the performance and quality of public sector health services

3. To scale up the HIS in the public sector. This latter Outcome area was planned to require the most funding but, unexpectedly after 8 years of work to complete and test the system in pilot sites, the 3rd Outcome on HIS-development was halted while the government looked to develop its own system from scratch. This is likely also to take around 8 years to develop. This has meant that the LuxDev project is now focusing more on Outcomes 1 & 2, and is building up the infrastructure, especially in terms of equipment, in 2 large hospitals of Kosovo outside Pristina.

8.3.3 AQH Project position

Both the KHP and the AQH had planned to benefit from the HIS system, the KHP in order to manage the Capitation Based Performance Payments (CBPP) payment system, and the AQH to monitor the progress of

the PHC reform process, linked also to the CBPP over time. With its delay, both projects have now found alternative ways to collect and manage data. This is more serious for the KHP, since indicators related to performance payments can no longer be handled effectively.

For the AQH project, this is more of an annoyance than a setback, and the AQH team have developed their own monitoring system which will, in time, produce the necessary data linked to the 2 SP areas of focus, namely DM and HT. The long-term sustainability of such a "makeshift" data collection system is open to question, but the data collected can be used to later feed in to the next HIS whenever it becomes functional.

In terms of the KHP SHI-system, the delay only means that there is less money available (from SHI payouts) at the PHC centers that can be used to make improvements. However, since the AQH is reasonably well funded, it is able to go ahead and bring about necessary and desired improvements to many facilities without relying on other sources. This also makes sense since, for the foreseeable future, the only funds being made available are those of the WB, and it is not clear how any planned improvements would link to the reforms being developed through AQH.

Hence, for the AQH, the delays and problems related to each of these other projects is of no immediate concern, but is causing problems in collection of early project indicator data which, in a number of cases, has meant that it is either inaccurate or deficient.

9 Effectiveness (DAC II) - Performance & Achievements

9.1 Project Timeframe

The Accessible Healthcare Project implemented in Kosovo and funded by the Swiss Agency for Development and Cooperation (SDC) was preceded by an inception phase of 10 months in 2015, which was then followed by the implementation phase initiated on 01 Jan 2016 and due to be completed on 31 Dec 2019. This is shown diagrammatically in the table below:

Table 1: Timeframe of Inception and Phase I of AQH Project

Year Minus 1	Year 1		Year 2		Year 3		Year 4	
01-Mar-15	01-Jan-16	01-Jul-16	01-Jan-17	01-Jul-17	01-Jan-18	01-Jul-18	01-Jan-19	01-Jul-19
Inception	Planning, setup	Implementation 2.5 years				External Review		

This table highlights how the Inception Period was a time for defining the project activities and realistic objectives, followed by an initial establishment period of 6 months when team staff members were hired, partnerships and agreements with organisations and institutions were developed, and organisational processes put in place.

By the time of this External Review, all achievements of the project are the result of a limited duration of work: 2.5 years.

9.2 Two Main Directions

Considering that full implementation has only been carried out over the past 2.5 years, the AQH Project is highly performing, with numerous activities underway. These can be viewed as **Hard** (equipment, refurbishing) and **Soft** (training, materials, technical support) as follows:

Activities		Municipalities of Kosovo covered	
		Number	%
Hard	Basic equipment sets	12	32%
	QIPs	12	32%

	Health Resource Center/ Health Corners	12	32%
	Training Centres	3	
Soft	Service Packages on DM & HT PEN protocols	5	13.2%
	Integrated Care with SW	1	2.6%
	QoC Surveys	38	100%
	KAPB Survey	12	
	Management Training	38	100%
	Supportive Supervision	12	13.2%
	Quality Management	7	
	Peer Review/Benchmarking	5	13.2%
	Quality Audits	12	
	MasterPlans started	12	32%
	Motivational Counselling	12	32%
	Health Resource Center/ Health Corners	12	32%
	IEC materials, Media Campaigns	12	32%
	Community HE sessions	12	
	Community Scorecard Training on Patients' Rights Infection Control training Gender and Social Inclusion training	1 12 12 12	2.6%

9.2.1 A. Hard Improvements

Sets of either 15 or 18 items of **basic PHC equipment** for the Main Family Medicine Centers (MFMCs) and for the branch Family Medicine Centers (FMCs) have been procured. These sets consist of high quality & fully functional items (often public tender procedures are unable to offer this) which are highly appreciated by the staff.

The clinical staff say that it gives them confidence in their work, and earns the respect of their patients. Many of the PHC staff were previously trained to use such items, but only now are they able to fully utilise these skills. They are able to function more comprehensively to fulfil their role as PHC clinicians, and can offer their patients more accurate diagnoses (eg for ear and eye conditions, correct blood pressure levels, glucose & HbA1C levels).

Patients also stated that, since the diagnostic equipment and laboratory tests are nearby, less travel (and costs) are required by the patients, making the PHC centers more accessible and trusted.

The AQH-supported municipalities have received high quality equipment using the SDC-approved procurement mechanisms. If such equipment is procured through MoH processes, there is a strong likelihood that the equipment will be of significantly poorer quality. *If the AQH PIU is able to teach and support the MoH to conduct an improved procurement process, then the financial contribution from the MoH may be of value*. If not, it may be better to use the AQH funds and procurement system to ensure the entire country has PHC facilities equipped with useful and effective equipment for the foreseeable future.

One item considered by the External Reviewers to be missing from the basic equipment set is a peak flow meter set (adult and child), needed for diagnosis of asthma should the project include this as an additional NCD in a future phase.

The so-called **Quality Improvement Projects** have been carried out in 2 rounds, with 21 projects implemented and 3 still in process at the time of this Review.

Each QIP involves numerous processes, including initial designs carried out by the facilities, checking and clarifications and support from AQH staff, revisions, rechecking, the approval process and, finally,

implementation organised by AQH. Accepting that the AQH project has been fully operational for 30 months (2.5 years), then this means the QIPS have been conducted at a rate of almost 1 per month, which is a great achievement.

Each and every facility visited was keen to show off and demonstrate "their" QIP. These comprise numerous improvements to facilities and services including more convenient reception areas, better patient flow, new HRCs for counselling & testing patients, better storage of patient records, and easier access by patients to vaccination services now provided in the FMCs (which will ultimately result in lower overall health system and Out-of-Pocket payment costs to the patients).

There was a strong feeling of ownership by the PHC staff who had been involved in developing their own improvement idea and designing and applying for the projects themselves. Going through the process had also increased their managerial capacity as they were able to practise the knowledge and skills offered through Outcome 2 of the project, for example using LFA, Ishikawa, the "Why" questions and process mapping.

Although questions were raised that these projects tended to focus on renovation and equipping, these were designed based on both felt and actual needs. Real improvement gains were seen by the Review team in terms of increased vaccination availability and capacity at one MFMC, better storage capacity for patient records, improved patient flow, and making good use of room space to create patient counselling areas. The AQH project has also shown itself ready to take the viewpoints of the PHC clinical staff seriously, again increasing ownership in all the reforms the Project seeks to bring.

In addition, 3 **cluster Family Medicine Training Centres** in Pristina, Gjakova and Mitrovica have been refurbished and set up with teaching equipment and furniture.

9.2.2 B. Soft Improvements

The **Service Packages** (SPs) focusing on **Diabetes Mellitus** (DM) **and Hypertension** (HT) using the WHO PEN protocols have rolled out to 5 municipalities. This is understood to be a difficult process, since clinical staff have strongly held beliefs that are deeply entrenched from years of repeated usage.

However, as stated earlier, the 2 tracer topics (DM & HT) allow the AQH project to focus on other parts of system such as enhancing nurse involvement in counselling on them, diagnosing them and using developed Health Education and Health Promotion materials. Nurses feel more involved and empowered through the development of the Health Resource Centers and Health Corners, combined with the motivational counselling training on these topics they have received.

Working towards implementation of the 2 SPs has also had the effect of highlighting the need to improve patient notes, echoed by the findings of the audit on their use.

For sustainability, it is important that the SPs become normal practice, with PHC staff expected to follow them by the MoH. AQH is already working with the MoH National Council for Development of CPGs to produce national protocols on DM & HT. The Council will monitor and emphasise the use of the CPGs - but what capacity do they have for this? Apparently, their ineffectiveness is not entirely due to lack of resources, but also willingness. *Perhaps an audit of the Council's activities would be useful*.

The AQH-trained Quality Coordinators can also help to ensure ongoing use of the 2 SPs by monitoring their implementation and making action plans to address issues. The MoH's Division of Monitoring and Evaluation should be responsible for overseeing this process.

Integrated Care with Social Workers (SW) takes a step beyond the Service Packages and promotes the involvement of the Social Workers to provide joint home visits together with the PHC facility nurse. This is being piloted only in 1 Municipality, Fushe Kosovo, and currently targets 300 over 65-year olds who have been identified as having Diabetes.

This pilot highlights the need for patient-centered care, and enhances cooperation with the Social Workers and their potential role in supporting patients whose health care needs overlap with their social "daily life" needs.

At the time of the Review, 15 joint visits had been conducted, with a couple of patients having social needs. For example, 1 patient required a wheelchair for increased mobility, and the Social Workers were applying for it. However, on visiting the Social Workers, it became clear that – while they appreciate the need for joint visits - they feel under time pressure with so many other pressing needs and a lack of staff to manage everything.

The Reviewers therefore suggest, once sufficient joint visits have been conducted to allow the nurses and SWs to understand each other's roles and responsibilities, that the nurse alone visits the identified group of diabetics, and then requests joint visits with the SWs when there are obvious needs from which the patient can benefit from a joint approach. This should be checked as part of the final evaluation.

A number of **PHC health-related surveys** have been conducted. The QoC Surveys, having started as a mechanism to assess the needs of the 12 AQH pilot municipalities has - at the request of the Minister of Health - covered the rest of the country. It has proved to be a useful activity since it has included all PHC staff levels and both MFMCs and FMCs. It has taught and demonstrated the use and practice of evidence-based planning which may help to reduce (but not eliminate) political interference in decision-making. The findings have proven useful in deciding the levels of PHC equipment and priority training (SP) topics, which appear to the Reviewers to be most appropriate at this stage.

In addition, soon after project commencement a Knowledge, Attitude, Practice and Behaviour (KAPB) survey was conducted to evaluate the levels of understanding in relation to PHC issues including NCDs and risk factors. This was useful in guiding the project to select topics and to plan activities.

The Health Education campaign on DM & HT risk factors was evaluated using data from 400 respondents from the targeted population. The main finding of the evaluation that will help inform the design of future campaigns was that national TV was by far the most popular outlet.

In addition, there are ongoing discussions to establish a **prospective patient cohort study** of 1000 people under STPH supervision. SDC are interested as are NIPH and the Medical Faculty. The focus will be on NCDs including DM and HT. The methodology and tool are currently being drafted, with major issues regarding how to follow-up of each person. There are still a number of hurdles to overcome, including the need for ethical approval and (grant) funding. *Care should be taken not to absorb too many project resources in carrying this out.*

Management Training has been carried out on 6 topics and is being rolled out to all the Municipalities of the country. These topics are being approved by the postgraduate education authorities, which means they can be used in future by other training institutions and will be in demand from those seeking CPD credits.

In addition, the AQH project has carried out in-depth and on-site training supported by short-term international and national expert counterparts on management topics including supportive supervision, coaching on quality improvement processes and on clinical audit and peer review/benchmarking.

The Reviewers feel that since quality processes are at such an early stage of development, and the capacity of the facilities to absorb so many new ideas is weak, it could be worthwhile to merge the on-site supportive supervision with only one or two basic quality improvement processes, rather than attempt to train the facilities in a broad variety of quality techniques. Later on, the breadth could be increased as the facilities gain more experience.

The on-site support is highly valued by the management and administration staff at both municipal & facility levels. This is because the approach of the trainers/mentors has been to link management teaching to daily practice issues, showing them how the concepts taught in a classroom environment are applicable to real life situations. The Supportive Supervision has been consistently praised at each site visited due to the approach and flexibility of the trainers and their highly practical on-site support. Staff say they are now implementing management tools such as SWOT analysis by themselves, and see them as useful solving for daily management issues, not just for official improvement projects. They stated that they feel an increased confidence in their role as managers to approach ongoing problems.

In particular, the Municipality Directors of H&SW have increased their understanding and links to PHC workers and the issues they face. Over the longer term, the AQH project is also developing the management capacity of Kosovo's leaders, as some of them may rise to even higher positions in the future.

Since this on-site support is proving so effective, there is a question about how it could be possible to institutionalise it in the future. This will not be easy, since it is highly dependent on retaining skilled and experienced teachers.

One option to ensure sustainability of these interventions will be to develop the staff members in each Main Family Medical Center (MFMC) who have been assigned to deal with quality coordination, namely the officer for Quality Assurance. Such staff members can be further nurtured into becoming a type of master coach or trainer who can take over quality management coaching in the future in MFMC.

Some of the module topics are already part of existing Primary Health Care specialist training program. The latest updated information and materials introduced through the project can be used to update these existing courses. More importantly, these courses can become part of the Continuous Medical Education program that can be run in the future through the CDFM/Medical Chamber setup or other entities providing CME for primary care physicians and staff.

Perhaps the project can encourage the AKM Collegia on H&SW to consider taking on a role in developing the training into an educational program useful also for Municipal leaders.

The development of **PHC MasterPlans** is in its early stages in the pilot Municipalities. This involves extensive data collection and discussions with stakeholders, and the facility managers appear to be very excited by the possibilities. It is clear that in working on this process, the staff will put into practice the management planning skills the project has been training them in (auditing, data collection and analysis, SWOT analyses, benchmarking etc).

There is one concern about this: is the AQH project raising the expectations of the facility staff too high? Meaning that, having completed the plan and highlighted the areas for improvement, who will be able to support implementation of the ideas, especially if increased funding is required.

Motivational Counselling training has commenced in 5 Municipalities. There is no doubt that the training is highly appreciated by all PHC staff involved, Drs and Nurses together. "Now we know how to talk to the patients", and "we never knew how to do this effectively before" were comments given to the Reviewers. Staff say they have increased confidence to talk to patients on changing their lifestyles and behaviour, and this is also enhancing and improving their relationship to their patients.

Health education (HE) **and promotion** (HP) activities have been developed in parallel to the Service Packages with an increasing emphasis on increasing the understanding of the population towards DM and HT (and initially also on diarrhoeal diseases and immunisation).

Information, Education and Communication (IEC) materials have been developed, and used as booklets/brochures to stock the Health Resources Centers and Health Corners that have been developed, to provide health messages on the TV screens installed in the reception areas, and to reach outside the facilities through health promotion media (including radio and TV) campaigns.

In addition, specific awareness sessions on clinical topics (DM, HT and - early on in the project- on Immunisation and diarrhoea), available PHC services, patient rights- complaints have been held for the communities by selected local NGOs.

As a result, the facilities look modern, attractive and welcoming to patients and this approach is leading, according to the facility staff, to increased identification of at-risk cases.

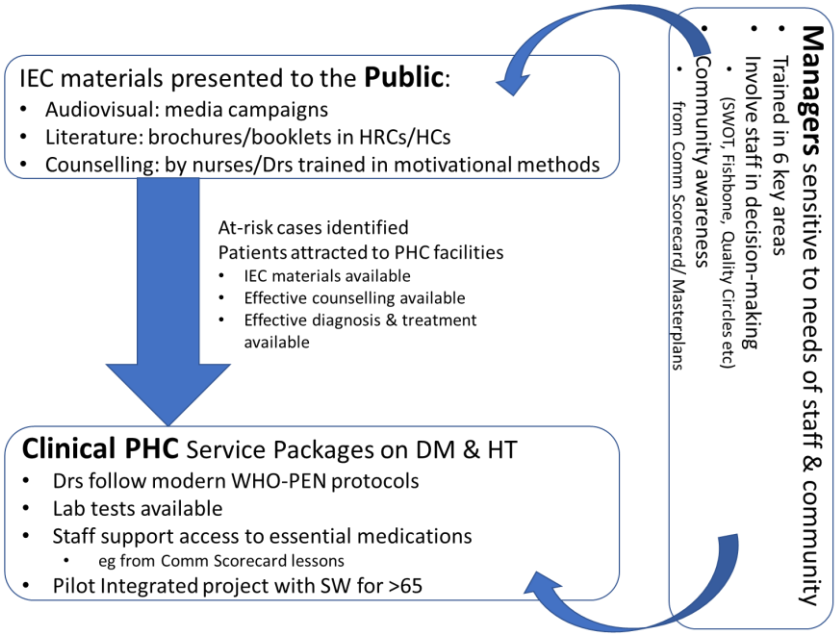
The pilot Community Scorecard in the Lipjan municipality, a part of AQH efforts to improve patient feedback mechanisms, has introduced some very new concepts for the clinical staff and community alike. The community's opinion has become more respected & appreciated by clinical staff, and the issues faced

by the medical staff have become more understood. For example, whereas once the community were highly critical and complaining about how there were stockouts of essential medications at the facilities, after the intervention the complaints have reduced and the clinical staff have begun to look for ways to alert members of the community when drugs do become available.

Not only has the pilot in Lipjan increased the value of the PHC viewpoint of the community, but their views have also been supplemented through various other AQH initiatives including the management training, roundtables held by NGOs on patient rights, and support for some municipality roundtables developing health sector strategies towards the Masterplans.

Figure 1 below highlights how the various AQH outcomes cohere together to ensure better care for patients with DM and HT, with active participation and involvement of the 3 stakeholder groups: the public, the clinicians and the managers.

Figure 1: Links between the AQH Outcomes



10 Impact (DAC III)

It is early to say for sure, but with good inputs and processes (and a valid Theory of Change) there is no reason why the hoped-for impact will not be achieved. More time is needed to reveal this.

10.1 Indicator Data Analysis

Annex 4 contains a brief analysis of the progress of the AQH project up to the time of this External Review according to the planned indicators. In making the analysis, it should be remembered that the project still has 1 year to go before Phase I is completed.

Impact Indicators: Flaws in the collection of early data preclude a good analysis at this stage.

Outcome 1

a. % increase of utilization for tracer diseases in 11 Municipalities: this apparently shows increases for asthma and diarrhoea, but decreases for hypertension and diabetes from 2016 -2017. The reliability of the data is questionable, and interpretation at this stage is difficult. Once the data collection is standardised, results will become more meaningful over time.
b. Pilot facilities providing service packages deliver outreach services to vulnerable groups: this has not yet happened in the project, but is planned in the coming year.

Outcome 2

a. No. of MFMC where quality audits based on Quality Management principles are undertaken: here there is 100% achievement of the audits.
b. No. of Municipalities with input from communities included in their planning, and monitoring/review: 3 sites out of a total of 6 have achieved this so far.

Outcome 3

a. % people with knowledge of risk factors for diabetes: data collection is so far incomplete
b. % people consulting doctor if they feel that their blood pressure has increased: data collection is so far incomplete
c. No. of community-driven initiatives related to tracer diseases per Municipality that aim at improving their health: no progress has been made since project implementation has started.

Output Indicators

Table 2 below summarises briefly progress on the 15 Output Indicators (details in Annex 4).

Table 2: Summary of progress in Output Indicators

	Outputs	Indicator			Comments
		1	2	3	
Output 1	Training courses for service providers for implementation of SP are carried out; courses & trainers integrated in national training system.				On track
Output 2	Support data collection and analysis capacity for improved M&E in selected Municipalities				On track
Output 3	A "service package" for tracer diseases is developed and access to this package is guaranteed at pilot PHC facilities				Difficulty of MFMC to collect Ind. 2 data
Output 4	Development, piloting and M&E of integrated care services at community level, with support from communities				In process
Output 5	Selected PHC facilities have the infrastructure and equipment for delivery of basic PHC services				To be measured at end of Phase I
Output 6	Institutional processes/ procedures defined, (re)designed and translated into practice				In process
Output 7	Supportive supervision systems (including coaching) are implemented along referral lines				On track
Output 8	A management training package is developed and applied for PHC facilities				On track
Output 9	Municipal staff are trained and supported to conduct participatory quality auditing for improved M&E in health facilities				On track
Output 10	Continuous quality improvement projects that respond to patients' needs implemented at facility level				On track
Output 11	Peer Review and Benchmarking procedures are developed and piloted				Planned for end of Phase I
Output 12	Pilot Municipalities engage in annual participatory health planning & produce Health Masterplans				In process
Output 13	NIPH is supported to develop and implement a training package on communication skills for health promotion and education for community leaders/CSOs/CBOs				Reliance on NIPH for this. Unclear if feasible
Output 14	Communities and vulnerable groups reached with health promotion/ education activities for common health problems, healthy practices & when/ where to seek care				On track
Output 15	Selected community leaders/CSOs/CBOs have capacities to advocate for patients' rights and to engage in feedback mechanisms with health services providers and managers				Ind. 1 planned ot be measured at end of Phase I. Ind. 2 making progress
				Key	
					Quantitative progress is as planned
					Quantitative progress is not (yet) as planned
					No indicator

While 8 out of 15 Outputs are clearly on track (when measured quantitatively), 7 are not.

However, some of these are awaiting end of Phase I survey/assessments (eg Outputs 5, 11 & 15) and others are still in process (Outputs 4, 6 & 12). Questionable at this stage is Output 13 that relies on the capacity of the NIPH to implement.

Overall, the progress appears to be satisfactory, with most interventions feasible by the end of Phase I.

Data Collection for AQH Phase II

The current data collection system and its importance to allow meaningful analysis is found to be satisfactory since it provides enough data to be able to reflect the project progress. Some indicators and available data are of high quality (i.e. KAPB survey data).

Nevertheless, there is room for improvement without attempting to overdo the M&E to the extent that it takes too much resources and unnecessary time.

1. The current system struggles with impact-level indicators as well as some outcome indicators including:
   - at impact level, morbidity due to circulatory diseases in PHC in the age group 50 years and above is reduced;
   - % increase in PHC visits of population in project Municipalities;
   - % increase in PHC visits of population in selected facilities with majority RAE populations;
   - and at outcome level, % increase of utilization for tracer diseases in 11 Municipalities.

   ***Suggestion**: A review of the data collection system at Municipal level should be done to gain a better and more in-depth understanding of the issues. The project should consider hiring someone with valid experience on a temporary basis. It was not clear to the Reviewers if the project team understands how the data is collected at the municipality level.*

   Depending on this, there are two options on how to move forward. First, the project team or external adviser could advise municipalities on how to improve the data management and reporting by municipalities and in turn the AQH project would have better data of the impact. Secondly, situations like this can be solved by engaging independent enumerators who would go to the records and would re-collect data in a systematic way. In an ideal situation these would be external people but existing staff at municipalities may also be involved, but with the increased chance for reoccurrence of similar problems.

2. Having a manual data collection system for such an important project with a large budget is not appropriate as it allows for mistakes and inconsistencies. However, to be fair, the Reviewers have not noted any such mistakes in the review of the existing system. The manual system also makes M&E activity labour-intensive for things that could be dealt with by a simple, automated Excel spreadsheet.

   ***Suggestion**: A programmed Excel sheet that allows validated data entry and calculation of data should replace the existing manual calculation system.*

3. Some other indicators, definitions and reporting can be improved further.
   For example, there are indicators like:
   - number of community-driven initiatives related to tracer diseases per Municipality that aim at improving their health;
   - training courses for service providers for implementation of SP are carried out; courses & trainers integrated in national training system;
   - a “service package” for tracer diseases is developed and access to this package is guaranteed at pilot PHC facilities.

   ***Suggestion**: These indicators can be operationalized better. For example, the indicator “number of community-driven initiatives related to tracer diseases per Municipality that aim at improving their health” can measure the size of these initiatives, their impact on communities (number of people affected), whether they have changed any structural aspect of service provision and, long-term, if other stakeholders have been involved, how many, etc.*

Efficiency (DAC IV)

10.2 Planned Inputs vs Outputs

Although not analysed in detail, it appears that the project is keeping to the planned budget, while at the same time accomplishing its many planned interventions (see Annex 4 on ongoing indicator data analysis) through competent staff and partners. As explained in the Impact section, it is too early to state how far the envisaged impacts/outcomes have been achieved in the context of the project setup, but the relevance and theory of change of the project remain in place, and there is no reason to doubt that the steps being taken are valuable towards reaching the project objectives.

The AQH project has been able to respond to the Minister's request to expand some activities beyond the initial agreed scope, with minimal reduction to the core activities.

The project is making effective use of the resources it employs, in particular, through increasing the development of national experts who are becoming potential independent trainers. *This means that, in the future Phase, the project will make even better use of the resources that are made available without having to bring in so many external experts.*

10.3 Project Gaps

Overall, there are not many gaps in the project, based on the decision to focus on a limited number of clinical areas and geographical scope in the first phase. As stated earlier, AQH is still at an early stage (only 2.5 years of actual implementation) and time is required before the results become more obvious.

In terms of **geographical coverage**, the DM and HT SPs still need to be rolled out to all 12 selected municipalities with accompanying activities. While not envisaged in the ProDoc for Phase I, this can happen in Phase II.

In terms of **clinical (tracer) topics**, while the focus on DM and HT makes sense, *consideration could be given to preparation for other NCD topics, perhaps including asthma (which could link more to the core target group of Save the Children).*

Although UNICEF have supported the **system of vaccination** in the past, the Reviewers have noted shortcomings that have been addressed through an AQH QIP in Malisheve and Rahovec and future expansion of the project should remain sensitive to such needs. The AQH project will play a key role in the redevelopment of PHC across the country, and the vaccination system is intrinsic to this level of service provision. *Whether AQH implements the improvements, or passes on the findings and responsibility to UNICEF, is of less importance than ensuring the vaccination system is fully functional and effective for the majority of the population, and especially of the least mobile and most vulnerable members of the population.*

With the failure of LuxDev to fully implement the **HIS**, there has been an unforeseen gap in the **data collection/transfer system** between facilities and institutions. Currently, having responded to this issue, AQH indicator data is hand-collected from the MFMCs: but could such data collection be included in routine official reporting? *This would entail AQH staff becoming involved in high-level discussions in the context of all the other indicators being officially collected by the MoH. A clear rationale on how they are used for learning and to benefit the care provided to patients must remain clearly in focus, to prevent unnecessary overload.*

Related to the previous point is the difficulty for the MFMCs to have to deliver (currently by hand) original copies of the **reporting forms to the NIPH**. The AQH could help support actions to address this issue that is costing time and money for each and every MFMC. According to the NIPH, this is a legal requirement, *but perhaps this could be reviewed and a revised system established, for example using email.*

Municipalities do not have autonomous **control in managing the budgets** of the PHC system. In contrast to the other Municipality divisions, they are unable to use running cost funds for capital costs. Hence, at the end of the year, any efficiency savings made from the operational costs are delivered back to the central authorities, with a risk that next year's running costs will be reduced according to the level of unused funds in the previous year.

This latter weakness in PHC financial management could ideally be addressed through the intervention by the H&SW Collegium of the **Association of Kosovo Municipalities** (AKM). This organisation is currently receiving substantial financial subsidisation from SDC. However, a number of sources revealed that the Collegium is not proving to be effective at resolving such issues. While the AQH project is already considering working with the AKM to develop future strategies, *an additional option that could be proposed and organised directly through SDC would be to clarify the role and mandate of the AKM (especially the meetings of the H&SW Collegium) and to conduct an audit to see where they stand with respect to their remit. Analysis of the results, coupled with open discussions, could result in self-reflection and an increased awareness and perhaps willingness to reform the agenda and goals of the organisation.*

10.4 Project approach & set-up for Phase I

10.4.1 Organisational Setup

PIU

The Reviewers were unanimous that the AQH project has a well-rounded project design suited to the Kosovo PHC context. It is managed and run by a highly qualified team with substantial experience in primary care and the health care sector.

The project follows an excellent implementation strategy providing considerable Technical Assistance via the Project Implementation Unit (PIU) and supplemented by international and national mentors and trainers who are available to guide the MFMCs in achieving agreed activities and objectives.

As the project developed, it became increasingly evident that more on-site support was needed especially for Outcome 2, increasing the management capacity of the staff and managers. Short term international experts were taken on, one of whom – Hilary Adams – was available to be contracted from within Kosovo. In addition, AQH took on national experts to work alongside and be mentored by the international experts, thereby creating a pool of national experts for the future and creating the potential for the project to be more efficient in its use of resources as the next phase commences.

There was initial over-optimism and reliance on partners (NGOs, National Institutions) who had at first appeared to be capable to fulfil their agreed roles and responsibilities. In reality, it soon became clear that they were not able, or willing, to do so. This slowed down the project implementation and the PIU was forced into taking steps to address the issues such as taking on extra staff and short-term consultants, and had to spend time and effort developing the capacity of some partner NGOs.

NIPH

So far as the NIPH is concerned, its foreseen role in leading and implementing HE/HP initiatives has fallen far short of expectations. In the end, the project has found some ways to make up for this, such as using NGOs to implement some of the initiatives. There appears to be no easy answer to this issue, since NIPH is officially tasked to be responsible, and yet has been unable to sufficiently deliver.

While it may be argued that funding NGOs to carry out some of the tasks is unsustainable, yet by empowering them there is a chance that some activities could continue if the NGOs continue to function. Identifying dependable individuals within the NIPH system is also a way forward, but it still does not answer the question about how the system as a whole should fulfil its role in this area (for more on this, see Section 12.1.3.1 Integration with Institutions)

SC

SC was an initial consortium partner, and has extensive networks in Kosovo - especially in the north.

In the early implementation stage, there was a major expectation-mismatch between the Consortium partners STPH and Save the Children (SC) with regard to payments and responsibility for managing Outcome 3. The current setup is a compromise between conditions set by taxation rules, requirements of SDC to have only one implementation unit and adaptations required in the project setup to make up for the unfulfilled expectations of the STPH partner regarding the technical skills of the SC Kosovo team. After lengthy discussions, this was eventually resolved with the key SC staff member for community health

education work being seconded to the PIU office and payments for Outcome 3 being channelled through the SC organisation.

Payments for backstopping are now being made both to the SC-Switzerland office, and to the SC Kosovo office. With these two backstopping fees, what has been the value of SC in the AQH project and is it appropriately related to the funding? This is not an easy question for the Reviewers to answer, since there have been many inputs from SC - as shown in the table below - and the quality and effectiveness of these inputs is not readily ascertained. Of particular note is the fact that the support afforded by SC at the commencement of the project was invaluable, allowing the AQH project to operate from the SC Kosovo office before registration was completed, and supporting all activities that were conducted in the northern municipalities.

Overall, the organisational setup of the AQH project has evolved to become highly effective, after initial misalignment of expectations and following clarifications of roles and lines of authority between STPH and SC. Each partner brings value, but the value of the SC in relation to the proportion of funds allocated for backstopping is questionable, and this could be re-organised in the future phase to ensure the most efficient use of funds. *The Reviewers suggest to consider that SC is given a sub-contract in the future phase to cover the activities in which they have expertise, including expanding the Community Scorecard to other areas, for work in municipalities in the north, for areas where there are high proportions of RAE communities and for any other areas that are the specific expertise of SC.*

Table 3: Inputs of SC to the AQH Project (excluding secondment of Elvira Rasimi)

	AQH Activities of SC	SC-Switz	SC-Kosovo
1	Provided office and logistical support in AQH start-up phase: project rented office space at SC Kosovo and paid SC Kosovo office staff for work related to AQH		1
2	Head of SC_K represented SC Kosovo in the AQH Steering Committee		1
3	Annual workplans shared by AQH team with SC-Kosovo for comments		1
4	Involved in monthly coordination meeting with the AQH team, updating them on work of SC Kosovo and discussing different initiatives		1
5	Supported PIU in identification of local partners: SC Kosovo did NGO partnership assessment of financial mechanisms and administration mechanisms for 5 NGOs, which were afterwards contracted by AQH		1
6	Supported KAPB survey in Year 1 including design of KAP ToR: SC-Swiss supported hiring an international expert by AQH	1	
7	International TA was hired by SC-Swiss to design Advocacy and Campaigns giving inputs to materials developed and assisted in hiring the creative agency. SC Kosovo officer was part of the selection Commission of the creative agency in Kosovo.	1	1
8	Implemented health education advocacy campaigns in Mitrovica & Jakova municipalities: 1-day activity at the start of Health Education campaigns		1
9	SC-Swiss hired International TA hired to support AQH on work with NIPH to develop standards/ guidelines for production/ approval of HE materials	1	
10	Hired international expert to pilot the Community Scorecard	1	
11	Supported the international expert to develop the Community Scorecard, using shared experience of using it in other Kosovo projects and areas (Education, Social Welfare). Provided continuous feedback on the process.		1
12	Arranged workshop on Social Accountability tools for Community Scorecard process.		1
13	Conducted capacity building activities for selected partners to help build advocacy and communication skills, MEAL, fundraising & reporting.		1
14	In the northern municipalities with SC presence & understanding of the situation, supported the QoC study.		1
15	In the northern municipalities with SC presence & understanding of the situation, supported implementation/ mobilisation of communities related to Outcome 3		1

10.4.2 Vulnerable Groups

The health needs of the Roma, Ashkali and Egyptian (RAE) communities are primarily addressed through the fundamental design and focus of the project. Firstly, the AQH project aims to improve the PHC services, which are the closest to these populations for whom mobility (eg transport costs) are an issue. Secondly, the project has focused on municipalities with higher proportions of the RAE communities (eg Fushe Kosovo, Obiliq, Mitrovica). Thirdly, by addressing DM and HT, a higher proportion of RAE people are affected.

Health education campaigns include pre-testing for RAE communities and include sign language where appropriate. The campaigns are designed to ensure inclusion of communities with low literacy levels and are coordinated through relevant NGOs including Health for All.

Other groups including elderly & multi-morbidity patients are addressed through interventions like service packages and integrated care. In addition, several rounds of Gender and Social Inclusion training have been provided for clinical staff in all 12 municipalities. Gender equality is not strongly addressed, although the topic is included in training courses for clinical staff, and the AQH project has set an example by employing roughly equal numbers of each gender.

Also, the project is successfully working in one Serbian municipality namely Gracanica, and the QoC study has covered all minority municipalities.

During the Review, it was voiced out that the RAE groups can be treated by the health service providers somehow in parallel– and at a reduced level – compared to the care received by the majority groups. *The Review team were unable to take this further, but are aware that this has been explored by AQH project (Barriers to Access Study) as well as other research work. Even if it cannot be completely resolved, perhaps some simple measures could be developed to reduce any inequities in health provision.*

11 DAC V: Sustainability into the next phase

Until now, the reform changes are very dependent upon the AQH project (funding and technical support). However, as capacities are built in all areas (clinical, management and population counselling/awareness) there will be increasing sustainability, especially if partnerships between municipalities can be developed and encouraged.

11.1 Strategic issues for planning Phase II

11.1.1 Expansion

A key issue for the future is how to **expand to new municipalities.** In Phase I of the AQH project, after 2.5 years of implementation, 12 municipalities were selected to work with, so far focusing on 5 with whom the 2 full Service Packages have been developed.

In addition, the project is carrying out one pilot on integrated care in Fushe Kosovo, and one with the Community Scorecard in Lipjan. Also, at the request of the current Minister of Health, the Quality of Care study has covered the rest of the municipalities together with training on the 6 management topics (in a classroom setting). On meeting with the Minister, the Review team were told that he wishes the project to expand its other core activities to as many more municipalities as possible. But how quickly should this go, without damaging the key gains of the project to-date?

11.1.2 Tracer Topics

The second aspect is the **number of tracer topics** taken on by the project. Until now, this is mainly focused on DM and HT. Other potential options include additional NCDs covered by WHO PEN protocols including asthma, Chronic Obstructive Pulmonary Disease (COPD) and cancer screening.

11.1.3 Integration with the Health System

11.1.3.1 Integration with Institutions

There is a need to continue to **strengthen the capacity of national stakeholders/partners** including the PHC Division of MoH, the Professional Chambers (who will take over the CPD and accreditation functions of the MoH Divison of PHC), the NIPH (including to streamline PHC-related information transfer and data handling), the AKM-supported H&SW Collegium (which could take on a more meaningful role intervening in the day-to-day PHC-related problems faced by the Directors of H&SW). Also, there is the possibility **to further strengthen the capacity of NGOs** such as PRAK and Health for All, many of whom will remain after the AQH project ends.

Working with the major institutions has been found to be difficult. However, since they have specific responsibility for carrying out interventions related to the goals of the AQH project, efforts to improve the collaboration should continue. This will likely require more time spent with them and, if needed, new capacity should be added in the development of relationships with such key stakeholders, to press forward to find synergies that will allow the dissemination of experiences and anchorage of project achievements in the system. Some specific suggestions include the following:

Center for Development of Family Medicine (CDFM)

CDFM has played a key role in the establishment of primary health care in Kosovo. Taking the point of view that the functions of the CDFM should be preserved, independent of the agency that fulfils them, then the establishment of the Medical Chamber for physicians provides an opportunity to place some of the functions of the CDFM within the Chamber. The deputy head of the Chamber is a primary care physician, whilst the head of the Chamber is cognizant of all of CDFM achievements. One of the project team members of AQH is also one of the key persons involved in development of family medicine, and this particular individual can facilitate such efforts. Management of this transition could become one of the project outcomes that could leave a sustainable mechanism for future developments in primary care. At the very least, it would strengthen the Medical Chamber and its role in primary care. In this case, the current project arrangements with trainers associated with primary care, which seems to be through

agreements with individuals, rather than through an institution, could be awarded through the CDFM/Chamber itself.

Municipalities

Exchange of experience regarding managerial issues related to primary health care among municipalities is important. The project could use the **Association of Kosovo Municipalities (AKM)** interface for performing this function despite its hesitation to interact with the project. There is potential for the **AKM Collegium of H&SW** to be more involved in discussing, addressing and resolving issues faced by the Municipality Directors of H&SW in their daily work including, for example, the limitations imposed by the financial authorities on switching funds between running and capital costs, and losing unspent running costs at the close of the financial year.

One option is for the project team members to establish and normalise such exchanges of experience and later to hand-over the responsibility for organising it to specific members of the Association, who may be given a title (eg. Coordinator of Primary Health Care Managers) for carrying out such tasks. Also, there can be facilitation of such an exchange by involving the Medical Chamber/CDFM including Ministry of Health representatives (primary care officer and strategic department staff).

The project can also leverage/lobby the power of the Swiss Embassy or SDC, since the Association is a beneficiary of Swiss-funded support. One pathway forward would be to push for an audit of their work. This should be developed from their expected roles and responsibilities (Terms of Reference) to ascertain how far they have been fulfilled in practice. This could provide clear evidence to all stakeholders of any shortcomings, and could motivate the Collegium to respond accordingly. Such an audit would be beyond the scope of the AQH project, but PHC would be the ultimate beneficiary.

The project could also consider offering institutional grants to facilitate such an exchange via the Association, or to pay for an AKM facilitator to manage this process (as previously requested by the AKM): but both of these are less sustainable in the long-term.

Ministry of Health

Increased reliance on the Ministry can be encouraged. The project could place more emphasis on working with MoH administrative staff (not relying on the Minister who is busy and changes every few years) regardless of what problems may arise. This would fit with the current climate in which new some core positions within in the Ministry have been filled by new appointees, including the strategic department. These are result of the Minister's effort to reform the Ministry by bringing a new cadre of civil servants. The main project counterparts would be a permanent secretary, primary care office and office for strategic planning. Through regular meetings initiated by the project leadership, interaction with the Ministry should be used to align project activities with existing government strategies. It could also provide the opportunity for the project experience and lessons learned can inform strategic and policy decisions by the Ministry of Health when it comes to primary care. Thus, project outcomes may be transferred into structural changes such as administrative instructions, strategic plan objectives etc. via inputs from the project.

National Institute of Public Health (NIPH)

As mentioned in Section 11.3.1 (Organisational Setup), the role of the NIPH in leading and implementing HE/HP initiatives has not materialised as planned. However, further effort is needed to strengthen the NIPH in its roles, particularly given the importance of this stakeholder for the smooth implementation of the project, and the future sustainability of project achievements.

One approach suggested by the Reviewers is to make an agreement with the MoH to work with the NIPH using a clear Action Plan, with agreed responsibilities and timeframes, and at the same time to agree on a process by which this is reviewed regularly, preferably with the involvement of the Minister of Health or a high level MoH representative. This would allow evaluation of the causes for any failure to deliver, and to establish the steps needed to address this. Ultimately, since the NIPH is responsible - over the long term - for a number of interventions supported by the project, efforts to develop this process could allow it to become more effective.

Alternatively, the project could work with regional NIPHs that operate with municipalities. Institutional grants can be an employable mechanism. Although people involved from regional NIPH centers may still benefit they can do so via institutional channels and not on an individual basis. Hiring people outside of the institutional setup creates negative expectations and reduces possibilities for sustainable efforts.

Another option is to engage in work with specific NIPH departments, again with institutional grants or partnerships.

The last option would be to work with individuals, researchers, leaders of departments, to carry out their agreed tasks with payments linked to their progress, promoting staff ideas/initiatives to engage in improvement of the NIPH at central or regional level.

Such activities (with the best possible NIPH cooperation) will require interaction and approval with the Director's office, which cannot be bypassed. It will be important to find ways to convince the leadership of NIPH about this. A joint workshop - to define and agree project support - with the leadership of NIPH and regional branches can be a first step to create a new mode of operation with this institution. Any of these setups should be designed to complement activities foreseen within the 3rd component of AQH project.

Continuing with contracts for NGOs to carry out the activities not fulfilled by the NIPH is perhaps less sustainable, but has the advantage that the NGO capacity is developed, to the long-term benefit of the country, but with the disadvantage that the use of the skills and capacities developed may depend on the future funding directions of other donors.

11.1.3.2 Ownership by the Municipalities/Facilities

In order to strengthen the sustainability of the initiatives and gains, the **sense of ownership** by national stakeholders/partners - including at the municipality level where it is already reasonably good - should be further enhanced (see next Section 12.3.2: Expansion by Partnerships). This is to counter the perception that people may feel, despite their inclusion and involvement, that they are still following what is "on offer" and therefore the perception that (even subconsciously) the project "is doing things to them", with the danger that the situation reverts when the project ends - as has happened with other donor-driven projects in Kosovo.

11.1.3.3 Cooperation with NGOs

The project has not been so successful in developing a sustainable system of operation with NGOs, who on the whole tend to be donor-driven.

Part of the problem is related to the inability to adjust project design to the work of NGOs, the translation of project aims and objectives to NGOs' scope of work, and also limited capabilities of the involved organizations. The Reviewers felt that the NGOs had little long-term vision on what they are doing within their project flow. Also, the troublesome relationship within consortium key members has not reflected well in the advancement of this part of the component.

Having said that, it appeared that the most meaningful engagement was with Health-for-All, who have a clear overarching goal and target group, and leaders who are committed to them both. They seemed to be active in bridging the needs of communities with the project activities, facilitating interaction of the community with the health care institutions. Perhaps these aspects could be analysed, and other NGOs encouraged to learn from them through workshops or meetings.

NGOs still need a lot of technical support and mentoring and the project team should be aware that these organizations will have to grow along with the project. Save the Children have taken some steps in this direction, but it was not clear to the Reviewers how effective this has been: further analysis of the NGOs (before and after SC support) could help clarify this.

There are almost no "ready-made" NGOs operating in the health system of Kosovo. However, the project should not be trapped into supporting NGOs that do not deliver or fail to achieve their mission: for example, instead of representing patients, the NGO represents health experts; instead of representing diabetic patients, they represent the physicians' interests. The project should instead condition its

support to strengthen the organization's missions, not to bypass them. It can take the form of support of specific activities that align with objectives of the AQH project or, institution support that will aim to address multiple segments of capacities of NGOs, i.e. governance, management, project management, advocacy, visibility, etc. Perhaps a (new) project staff member could take on such a strengthening role in the future phase.

The QIP system has worked well with the health facilities, and a similar approach could be taken for the collaboration with NGOs. Forms and required document templates could be developed to allow connection of NGO activity support to project logframe and impact objectives. Proposals for support by NGOs should be allowed to build bridges around what these organizations are doing - or have an interest to do. Making them conduct activities that only the "project" needs will do no good for their sustainability, and instead project support should also take into account what makes sense for the NGOs work. The AQH project should engage with SDC to adjust existing arrangements and space should be allowed also for the future; changes in context of project operation will continue to re-appear and flexibility to act beyond what is written in the logframe should be acceptable. Quarterly reviews could be held to evaluate progress, permitting small adjustments over the year. Project staff should engage in joint proposal development. It will be important to provide a framework of activities that would be supported under such a scheme.

In issues where there is no single NGO to take a lead on a project activity, coalitions can be created, for example in cases of patient protection rights or health education activities. There should always be a leading institution with the rest offering a supportive role, including interested individuals or even physician associations specialized in one particular field (cardiology, internal medicine, etc.). In such cases, it will be important to have a very committed and dedicated partner taking over this exercise who places a very committed staff member to manage activities of potential coalitions. The project should have some say in selection of the latter.

More use could be made of the experience of other parties active in the sector. First and foremost, the AQH project could make better use of the network available via Save the Children operations in Kosovo (not HQ). They have developed systems of operation, they know organizations and people and, whatever decision is made about the structure of the consortium, more use is made of their network to strengthen the 3rd project component. Solidar Suisse Kosovo is another active entity in the health sector that can serve such a purpose.

11.2 Further strengthen existing AQH project municipalities

5 out of the 12 AQH-selected municipalities have been supported to fully implement the 2 SPs. This can continue to be expanded to the other 7 perhaps step-by-step at a rate of 2-3 per year, in order not to sacrifice any quality of intended service delivery.

Consider to introduce at least one more SP topic into the Project, commencing in the already supported municipalities. Asthma appears to be a growing problem, affecting particularly the vulnerable populations, and would make better use of the capacity and focus of SC.

HE/HP activities would also be combined with the development of the SPs in these other 7 municipalities. SC- Kosovo have stated that they are ready to expand the Community Scorecards to the other 7 municipalities without the need for further international expert inputs. Throughout this time, the 12 MFMCs can prepare to share their experience and ideas with other municipalities (to be discussed in detail in the next section).

Simultaneously, data will continue to be collected to provide increasing evidence on the level of effectiveness of the AQH strategy and to prove, or adapt, the theory of change.

11.3 Expand to new municipalities

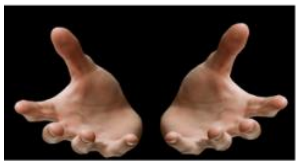
The beneficiary PHC institutions have not received substantial external support for years and, with the exception of smaller interventions carried out by UNFPA and UNICEF, this is the only large-scale project

active in targeting primary care institutions. This increases the possibility that institutions feel that "everything you deliver is OK" without questioning it out of fear of losing that support.

The Reviewers understand that the AQH project team has so far done everything possible to treat all partners/stakeholders as equals, to explain the AQH plans and to earn acceptance and approval of the project initiatives through meetings, discussions and explanations. However, the selection of Municipalities and choice of clinical and management topics has been led by the AQH team, and there is a sense that the staff in the facilities are still somewhat awaiting and dependent upon the assistance that can be provided by the project.

For the future, the overarching concern should be to increase national ownership of the AQH project-related initiatives. Without this, no matter how many more municipalities or topics are included, the danger of reversion to the status quo after project completion is real. To address this, the aim for the future would be to further nurture the following sentiment:

*"its what **we** want,* *not what **you** want for us"*

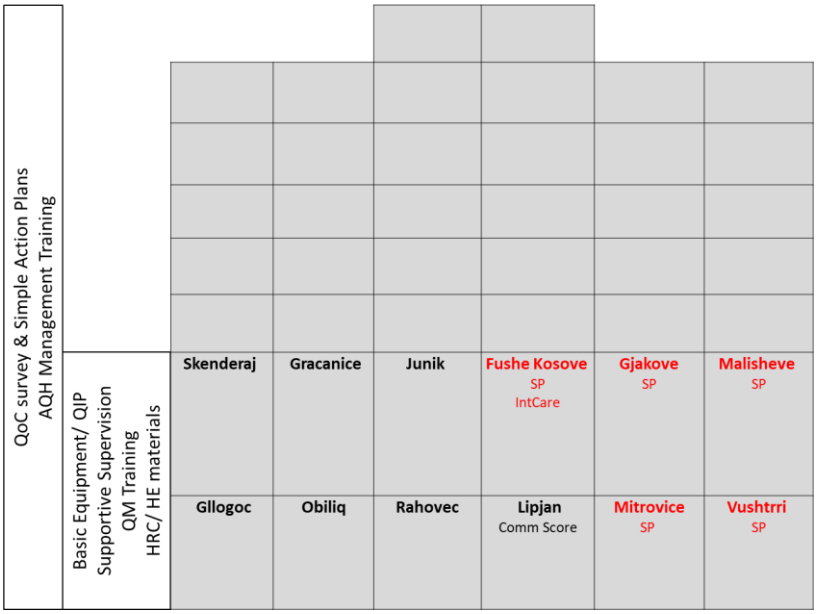


Achieving this will not be easy, and ultimately may not be possible in an environment where the AQH project holds the power: namely the funds and technical ability. However, if such a sentiment is sought after and achieved - even to a small degree - the benefits for Kosovo will be long lasting. In any future Phase, there is the potential to nurture this in the project development, as described in the roll-out options set out below.

11.3.1 Current Phase I Expansion Status

Figure 2 below highlights how the AQH project has covered 5 municipalities with the 2 SPs, 7 more with other core activities, and has rolled out the QoC survey and management lessons to all the others so that 38 municipalities (boxes) are covered in total at the Minister's request.

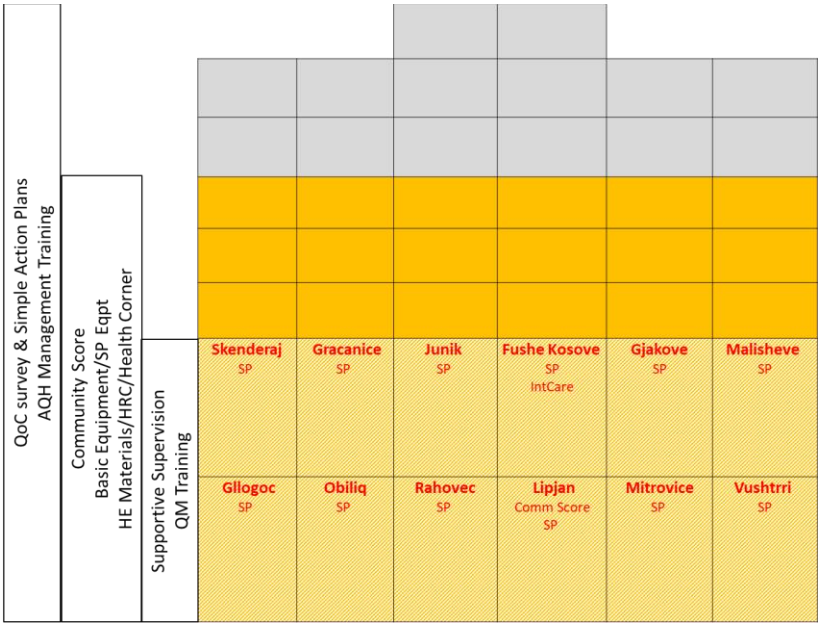
Figure 2: Current AQH Coverage



11.3.1.1 Option A: Partial Expansion in Phase II

Figure 3 below gives one option for future expansion of the project. In this scenario, the project expands a group of activities to a proportion of the municipalities. Here it is shown as 3 rows of 6 municipalities, but it could be 1 row, or 2, or any variation agreed during the inception period of the next Phase.

Figure 3: Option A for future expansion

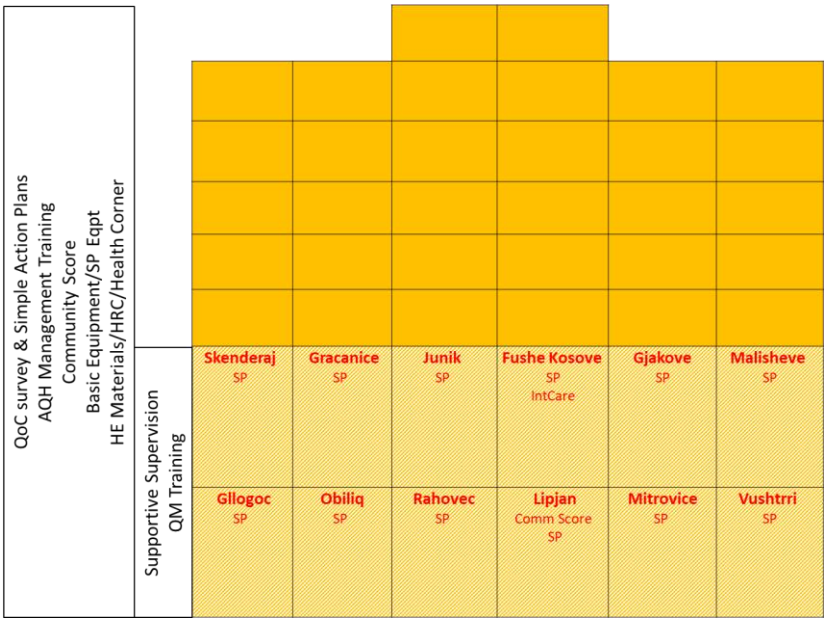


This has the advantage that the AQH project dictates at what speed it is capable of rolling out its activities while ensuring the high quality and uptake of the improvements it is able to offer. The disadvantage, linked to the earlier issue raised about future sustainability, is that the sentiment for the counterpart facilities and institutions becomes that of, “what you want for us”.

11.3.1.2 Option B Full expansion in Phase II

An alternative would be for AQH to offer to expand selected interventions to all other municipalities. This is shown in Figure 4 below:

Figure 4: Option B for future expansion



This has the following advantages. Firstly, it would make maximum use of the recent QoC survey, whose results will only be valid for decision-making on PHC facility development needs for a limited time in the future (before other support eg from other institutions or donor agencies occurs). Secondly, it would be very much in line with the thinking and desire of the current Minister of Health. Thirdly, it is an opportunity for the AQH project to offer its services to the other municipalities, and to defer to their requests for support. Fourthly, if (as expected) the majority of the municipalities request the basic set of 15-18 items of equipment (plus the peak flowmeters and any other items found to be needed based on lessons learned in this initial Phase and on the results of the QoC survey), only one procurement process will be required with the potential for cost savings per item due to bulk procurement and transport discounts.

Given the constraints in human and financial resources, the feasibility of covering the whole country will depend on controlling the rollout in terms of how fast each municipality is covered, and by which interventions. Some control and oversight will undoubtably be lost, with reduced possibility to measure the progress and effective implementation. But accepting this loss of ability to monitor everywhere (except in the original core 12 municipalities) allows the project to reach so many more and, even if only 50% of them use their own initiative to adapt and improve their services based on their upgraded capacity, this will still be a huge achievement for the country. Instead of constant, regular monitoring, this could be limited to sampling the municipalities - according to the capacity of the team and based on a timetable of visits that measure the facilities' progress - at least 1-2 times over the course of the future Phase. However, having said this, in the opinion of the Reviewers, Option B may be beyond the capacity of the future project to handle effectively.

Any combination of Options A or B could also be considered.

11.3.2 Expansion by Partnerships

Whatever option is chosen, a **partnership process** for the roll-out could be used to nurture ownership of what AQH is able to support.

The idea for this comes from both the experience of Dr Ilir Hoxha, the national External Review Expert, and from discussions with MFMC and AQH project staff during the Review. Dr Hoxha recently worked on with the KSV/017 project funded by LuxDev. The technical team of LuxDev consultants supported individual hospital teams until improvement products were in an advanced stage. Then "experience-sharing workshops" would enable both partner hospitals to exchange ideas and learn from each other. This provided an opportunity for review and fine tuning of all products under development, including standard operating procedures and regulations that defined quality standards.

In a similar way, a partnership can be established between the AQH-supported MFMCs and other new MFMCs that wish to participate in the AQH project in Phase II. The new MFMCs could be invited to see what has happened in a designated partner AQH-supported MFMC, with staff answering their questions and explaining the steps they have undertaken and offering advice if requested. Following this, the new MFMC may develop a plan of actions which may require assistance from the partner AQH-supported MFMC. In helping out the new MFMCs, the AQH-supported facility can request help from the PIU as needed (see below for more details on how this could work).

This concept was met with enthusiasm when it was explained to staff at two of the MFMCs during the Review. In particular, the Reviewers noted how the attitude of the staff and managers changed on being told they could become givers of knowledge and skills, not simply receivers of it. The staff became more animated and critical of what they would want other facility staff to know, how they would advise them to start the process, how they themselves would need to prepare for such a role and what support they might need from the AQH team.

Such a partnership way of working could have **immediate advantages for the AQH project**, starting now even before the commencement of Phase II. The current facility staff could be involved in the design of the process, and would already begin to prepare mentally and in their daily work to show-off their achievements, to address issues that might still be unclear, and to be more self-critical about bottlenecks to good practice that they are encountering but may be reticent to share with the PIU. In short, even for

the current AQH-supported facilities, a stronger feeling of ownership, involvement and readiness for self-improvement may become evident as Phase 1 ends and Phase II commences.

An explanation of how this partnership process could function is described below.

Firstly, some type of **general introductory meeting** (eg a conference or workshop) could be held with the municipality PHC leaders. This could be done with the support of the AKM and, in particular, with the Collegium of Directors of H&SW or directly by the relevant MoH unit. The opportunity for Municipalities to participate in PHC strengthening through AQH would be explained and the options clarified. Perhaps the Minister of H&SW would be involved in the discussions.

If interested, then Municipalities will be expected to undertake certain steps with AQH support. They must **visit an existing AQH-supported MFMC** (their potential future pilot partner), and understand from them the progress that has been made and how. Perhaps AQH could work with existing facilities to develop a checklist of guiding questions for which the enquiring facilities should seek answers.

Following this, there could be a process by which each enquiring facility **selects from a list** the initiatives they would like to adopt. Some of these may be easily fulfilled with AQH support, such as procurement of equipment. Others, such as implementation of the DM and/or HT PEN protocols, could be more difficult. However, if the enquiring municipalities show a strong interest, then AQH could help to facilitate a partnership between an enquiring facility and an existing AQH-supported facility. With material support from AQH (necessary equipment, PEN protocols, HE/HP materials etc), the enquirers could simply copy what they see being implemented by the partner "example" facility, who share ideas, experience and expertise. They could also request additional support from the PIU once they have begun to implement changes.

A condition for involvement (perhaps the only condition) could be that the enquiring facility agree to **establish an M&E process** to monitor the progress and results of their work, including a focused audit on some particular aspect of their work in the future.

The Reviewers have noted the effectiveness of the medical record audit, and what an impact it is having upon the current AQH-participating facilities, underscoring their poor compliance and stimulating improvement initiatives. This same technique could be employed to monitor and catalyse improved performance of the enquiring facilities where few direct AQH inputs are able to be provided due to the limited capacity of the project in comparison to the scale of the rollout.

In organising this process, AQH facilitates and guides the formation of the partnerships between municipalities (who is best partnered with who?), provides support as requested to the original experienced MFMCs according to their felt needs as they seek to help new enquiring MFMCs, and establishes agreed activity timeframes for implementation. This could be planned in phases according to the capacity of the experienced MFMCs and also of the AQH staff.

In expanding like this, AQH should use every opportunity to further develop & employ more local experts to support the process, using national institutions and NGOs as possible (to strengthen them).

11.3.2.1 Advantages of Partnerships

This may have advantages for the enquiring municipalities. Firstly, they are asked what they want and they can choose from a menu of options, promoting a feeling of ownership. Secondly, there will be increased sharing of ideas & experience between municipalities. Third, the original AQH-supported municipalities will adjust their role from support receivers to support givers, gaining a new appreciation of what is important, how they have benefitted, and what more they need for their new responsibilities. Fourth, they may become more intrinsically motivated to improve for sake of "showing off", and less from any AQH pressure/indicators.

The AKM Collegium on H&SW could increase its PHC role by leading the process and supporting the spread of ideas and innovation.

For the AQH project, if some partnerships become very effective, there may be less dependence on the technical assistance provided through the PIU: this would free up the PIU to focus on other aspects of the project (including expansion to more sites). In addition, if some interventions are not requested this may guide the AQH team on what is wanted and what is not (supplier-induced demand may be reduced), or to highlight if any adaptations are needed (eg to clarify why initiatives are needed, or to increase the attractiveness/ease of implementation.

11.3.2.2 Disadvantages of Partnerships

For the AQH project, increased effort may be required to establish the partnerships in terms of organisation, communication and relationship development.

Results will be less under the control of the project, and instead will depend on the response and initiative of the existing and new municipalities. This may also cause the AQH project to go slower while awaiting the initiative from new MFMCs/pilot MFMCs partnerships.

Partnerships will also require that the PIU is able to adjust flexibly according to demands, which means that planning of some activities will become less predictable. Linked to this is the possibility that the new MFMCs may implement activities in a different way than has been done so far, and this should be accepted as long as the overall goals are being achieved: it may even generate innovate new ideas.

For the original MFMC facilities, capacities may differ between the facilities (eg availability of sufficient human resources, interest to be involve in partnerships, technical progress to implement the activities) meaning that some will be more called upon to share with the new MFMCs, while others may be less involved. This could potentially lead to some bad feelings between the MFMCs.

An issue raised by staff at one MFMC was that staff are only contracted to work at their own MFMC, and may not be able to be paid if travelling to share ideas in another municipality. However, others suggested that this is not difficult to resolve, and would only require agreement with the municipality Directors of H&SP.

As partnerships take the lead in learning from each other, there may be less quality of implementation in the new MFMCs compared to the fully AQH-supported ones. But in the long term, this may be a worthwhile trade-off to build sustainability.

11.4 Additional options related to developing the PHC system

1. There is a problem with the flow of data from PHC to the NIPH. Currently, original reporting forms (eg for infectious disease cases) must be brought by hand to the NIPH. Such a practice costs time and money for each MFMC in the country, and distracts them from other activities.

   It was stated that delivery of the original forms may be a legal requirement. Is this true? and if so, could the regulations be adjusted to allow an email version to be forwarded to the NIPH? What would be needed for the NIPH to handle such “soft” data?

2. Support may be needed for the transition of CDFM, whose responsibilities towards FM specialisation programmes could in future come under the Chamber of Physicians. While the physical infrastructure for the restructuring process is being handled by LuxDev, the AQH project should work cooperatively with LuxDev to support the Chambers in absorbing their responsibility particularly towards ensuring the high quality of the work of the CDFM for FM specialisation. This would particularly mean allowing the PIU members with the relevant skills and experience to be given time to support this process.

3. In section 7.3.1 above it is explained that the MoH equipment procurement procedures are well known supply items of poor quality.

If it is agreed that the MoH will fund and procure items for the PHC level (eg some or all of the items include in the AQH basic equipment list) then the PIU could, with the agreement of the MoH, take the opportunity to support their processes and develop their mechanisms so that in the future procurement of high quality equipment becomes the norm. This is also something that could be addressed by the World Bank who have enormous experience in procurement mechanisms, perhaps as part of any ongoing financial cooperation (eg Trust Fund) from SDC.

Annex 1: Terms of Reference of External Review

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Swiss Cooperation Office Kosovo

Terms of Reference for an External Review of the project Accessible Quality Healthcare (AQH)

Final version: 06 Nov 2018

Introduction

The Swiss Cooperation Office Kosovo (SCO-K) is requesting the services of an experienced team of consultants (international and local), to conduct an external review of the project **'Accessible Quality Healthcare (AQH)'**, Phase I, financed by SDC. The external review will feed into the planning of AQH Phase II, in line with the Cooperation Strategy 2017-2020. These terms of reference outline the framework upon which the consultants shall provide their services to SCO-K.

Background

Swiss cooperation support to health

The Swiss Cooperation Strategy Kosovo for the period 2017-2020 aims to contribute to the progress of Kosovo on its path towards regional and European integration, fostering a democratic political system, a peaceful and cohesive society providing inclusive access to essential services, the rule of law and a social market economy.

Health is one of the four priority domains of cooperation. The objective of the domain is the following: *Key actors involved in health care provision, purchasing and regulation contribute to the development of a sustainable health care system that offers qualitative and affordable services to its population.* The domain outcomes have been defined as follows:

Outcome 1: *National and local public health institutions and facilities offer more qualitative, accessible and affordable services to citizens, including disadvantaged and excluded groups.*

Outcome 2*: The population improves its health literacy, adopts healthier behaviours and is empowered to demand the right to quality services.*

Within the above strategic framework, SCO-K has launched two health support interventions: the 'Accessible Quality Healthcare' (see a detailed description below) and 'Improving Financial Protection and Quality of Care' project (a Trust Fund TF with the World Bank WB). The aim of the TF with the WB is to support the design, implementation and monitoring of health sector reforms to make quality health care more accessible and affordable for all citizens of Kosovo. Technical support is provided to the following priority reform areas: i. procurement systems for drugs and medical supplies; ii. Improve the poverty targeting mechanism for health insurance subsidies; iii. Support the functionalisation of the Health Insurance Fund, particularly in contracting hospitals. With a total budget of CHF 2.24 million, the TF will continue providing this support until mid 2020. SCOK will be

launching an additional health support intervention in 2020. The focus of this intervention will be decided in the course of project identification work to be conducted in 2019.

Project description AQH

The **Accessible Quality Healthcare (AQH)** project is the flagship project of the health domain. It aims the following outcomes:

Overall Goal: The health of the population has improved, with strengthened healthcare providers and managers able to meet the needs of the patients (especially vulnerable groups), who are more aware of their rights and needs.

Outcome 1: Primary Health Care providers in partner municipalities deliver quality services that respond better to communities' needs, including those of vulnerable groups.

Outcome 2: Health managers in partner municipalities improve their performance in guiding service delivery towards continuous quality improvement that responds to communities' needs.

Outcome 3: Health awareness and care seeking of the population (in particular of vulnerable groups) improves and communities are empowered to demand the right to quality services and better access to care.

Theory of change (impact hypothesis): AQH builds on the understanding that better targeting of peoples' needs and improved management of services will raise the quality of services on the one hand – while on the other hand, generating demand for quality services and by involving people in shaping the services will together lead to an increased and rational utilization of all health services and improved health status of the population. Operating in the triangle of supporting providers, managers and the population, and their close interaction, AQH sets in motion a "change engine" towards continuous quality improvement (CQI) of the PHC system. CQI mechanisms will enable managers to address inefficiencies, freeing up resources to be used for further quality improvement, thus ensuring that maximum use is made of limited resources available. Moreover, by institutionalizing such CQI processes, AQH will build the capacities of managers in partner municipalities to respond to the incentives to be made available with the health insurance.

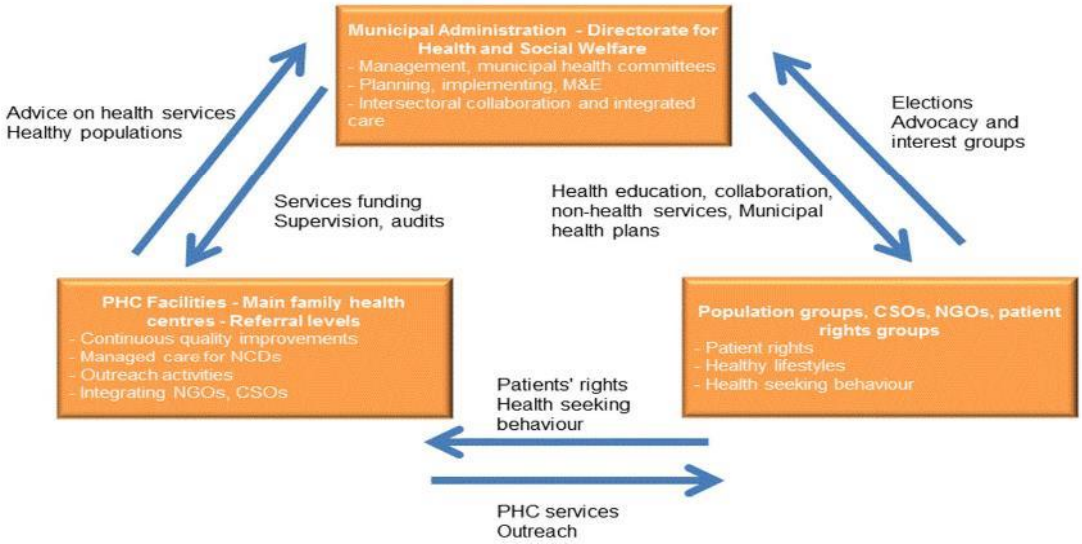


Fig. 1: Interlinkages of Outcomes in AQH >ToC

Preceded by an inception phase of 10 months in 2015, the first implementation phase of AQH was initiated on 01.01.2016 and will be completed on 31.12.2019. A **Swiss TPH-led** consortium with **Save the Children** has been awarded the implementation of AQH through an open public tender. Though the initial Entry Proposal envisages two phases (4y+4y) and subsequently a process of considering further support, SDC's vision for AQH is long-term and will most probably include a third phase (4y+4y+4y).

2.2.1 Phase I achievements (excerpt from the SCO-K annual report 2018; see Progress Reports for more details)

Present results of the Accessible Quality Healthcare (AQH) project show promising contributions towards improving the quality of PHC services in 12 partner municipalities. Swiss support has contributed to capacity building in health management and clinical areas through 21 training modules, all accredited as continuous professional development activities, including components of training of national trainers, anchored in the system for further roll out to all municipalities.
Health managers in 12 partner municipalities are more empowered in guiding service delivery towards continuous quality improvement that responds to communities' needs. 90 senior managers (38 f/52 m; 3 members of Serbian community) have completed the management training programme (a 6 module training on planning, management and financing). Upon introducing the concept of clinical audit, 36 quality auditing exercises were completed, aimed at identifying areas for improvement of services. Moreover, 22 quality improvement projects were implemented in an effort to transfer into practice concepts from the training programme. Recent testimonials from Directors of health facilities indicate that the support provided has triggered a new spirit of teamwork, participatory processes of planning and priority-setting and a focus on quality that has not existed before[1].
Making use of combined approaches at individual, community and population level, health education sessions on prevention of non-communicable diseases have reached a total of 157'120 persons[2]. Specific efforts were put on reaching out RAE communities with health education sessions. Furthermore, the motivational counselling approach in health education and promotion, as an integral part of PHC services stands at the core of the Service Package model on hypertension and diabetes, whose piloting was initiated in 4 municipalities in 2018. A total of 544 individuals (322f/222m) were reached with individual counselling sessions on hypertension and diabetes in 2018, aiming to empower people to change their health behaviour.

The promising results of the Swiss support to PHC triggered the interest of MoH to scale up PHC strengthening interventions to all municipalities. As a first step, Swiss support is directed to generating evidence regarding the current state of services and the development of priority action plans in all 38 municipalities. The evidence-based municipal action plans shall serve as an important basis for orienting future investments in PHC – both by the Government of Kosovo as well as the donor community- as well as serve as a basis for establishing PHC strengthening' partnerships between central and local level. Moreover, additional rounds of the above-mentioned management training are ongoing, targeting senior managers of all Kosovo municipalities.

- **Transversal themes**

The project mainstreams **gender equality** and **social inclusion of vulnerable communities** in many streams of work. Besides specific trainings on gender equality and social inclusion organized for the providers of care, the themes are prominent also in the health education work, be it through the awareness raising campaigns or individual sessions targeting in particular RAE community members. Moreover, the elderly over the age of 65 years are the target of an Integrated Care model, piloted in the Municipality of Fushe Kosova.

AQH promotes good governance by following a participatory approach, involving key national and municipality stakeholders in planning and decision-making. This participatory approach has contributed to enhancing commitment and ownership among stakeholders and is much appreciated.

- **Mid-term review**

An internal mid-term review of the project was organized in November 2017, concluding that the project is well set-up and the original concept is still valid. As a response to higher weaknesses of

[1] AQH assessment of health managers improved performance, September 2018
[2] The figure consists of the population reached through the awareness raising campaign (26% of the targeted population in the 12 partner municipalities i.e. 153'400; no gender/ethnicity data available) as well as community health education sessions, which have reached a total of 3'720 persons (2'296 f/1'424 m; of which 1'399 RAE)

stakeholders than originally planned, some approaches had to be adapted, including in some cases engaging more strongly into implementation. See the MTR report for more details.

Objectives of the External Review

The main objective of this external review is to assess the project's performance, achievements and gaps (responding to the DAC evaluation criteria: effectiveness, efficiency, impact, relevance and sustainability), the project approach and set up for the phase. It shall also provide strategic recommendations towards the planning of the 2nd phase.

SDC will use the findings and recommendations of this external review to guide decision-making related to AQH II (strategic planning/steering) and for the purpose of documentation, institutional learning and accountability (End of Phase Report for AQH I).

Key questions to be addressed by this review are the following (the below list is indicative and not exhaustive):

3.1 How is the project's performance assessed (following the DAC evaluation criteria)?

- Was the project's theory of change valid and realistic? Shall it continue being used as a guiding framework also on the 2nd phase?
- Notwithstanding issues with data availability and reliability, to what extent are project outcomes achieved / likely to be achieved?
- What was the role of the project towards the health sector reform? What are the implications of delays in the implementation of the Health Information System (HIS) and the mandatory health insurance (MHI) for the project? Are some adjustments required in the 2nd phase, respectively?
- To what extent is the project's approach – on organisational, institutional and technical level – appropriate? Which approach worked and which didn't? Why?
- While the project's participatory approach is generally appreciated and has led to increased ownership, particularly at municipal level, the situation with central level institutions is different. What are the lessons learnt in relation to the project's approaches towards central level institutions?
- Does the intervention strategy correspond to the needs and implementation capacity of partners? Was the general design ambitious, in terms of new concepts introduced?
- What approaches/concepts/streams of work are considered successful and worthy to scale up? Alternatively, are there elements of AQH that should be phased out?
- How do you assess the number/mix of municipalities selected for AQH I?
- Are the results achieved likely to be sustainable? What are the major factors influencing sustainability of outcomes and what adjustments are required accordingly in the 2nd phase?
- To what extent the support of AQH has strengthened the health system? Are there elements that can be carried forward by the system itself? Or is further support needed?
- How relevant and successful is the project's approach towards mainstreaming transversal themes gender equality and social inclusion?
- Do we adequately address the issues of 'vulnerable groups' and 'accessibility'? Is a more explicit focus/direct approach to social inclusion required? What are the lessons learnt and recommendations for the 2nd phase of AQH?
- Were there possibilities for increasing the use of country systems? In what areas shall such approaches be explored in the 2nd phase?
- How efficient and effective is the project's organisational setup? What is the contribution and added value of partners in this consortium?

3.2 What elements shall be considered in the planning of AQH II?

- What changes to the ToC, if any, are recommended for the 2nd phase?
- Considering the reform agenda (and its present status of implementation) and given international partners positions, where can AQH deliver its best contribution?
- What are effective channels/modalities for disseminating best practices at national level?
- What shall be the scaling up strategy to be followed in the 2nd phase? What is a realistic and reasonable number of partner municipalities to be added, if any?
- In view of issues with data availability and reliability in this context, what shall be the project's approach to developing own data sources (complementing the present data sets) or further invest in improving information systems of the country?
- Would a financial contribution from MoH add value?

Methodology

The consultants shall consider the following main steps for accomplishing the mandate:

- Briefing and debriefing with the SCO management
- Relevant desk review work (a list of documents proposed in Chapter 8)
- Interviews with relevant project partners at municipal and central level, donor representatives, NGOs, community representatives, beneficiaries
- Field visits to AQH partner municipalities
- Preparation of the report

The above list of steps is only indicative. The international consultant is expected to propose/design the final methodology.

Time Schedule

The mission is planned to take place in the period November – December 2018. The contractual assignment will encompass:

Description	International Consultant (Time Frame)	Local Consultant (Time Frame)
Relevant desk review and mission planning	3 days	4 days
Mission to Kosovo (including travel and (de-)briefings to SCO-K)	8 days	7 days
Report writing (5 days for the draft report and 2 days to finalize the report)	7 days	4 days
Total	**18 days**	**15 days**

Consultant Team and Logistics

The External Evaluation team will be composed by a team of one international consultant and one national consultant. The overall responsibility is with the international consultant who is the team leader. Both consultants will be hired by SCO-K. The Local consultant is expected to provide his/her expertise in relation to the local context specificities. He/she is expected to provide support in organizing and facilitating the interviews with stakeholders. If needed, an interpreter will be hired to

facilitate the communication during this mission. SCO-K and the AQH team will support the mission by providing contacts and documentation.

The consultants should possess the following qualifications:

- Good knowledge and proven expertise on health system reforms, incl. the experience in primary health care and in transition contexts;
- Excellent and proven experience in similar mandates;
- Excellent analytical skills, ability to propose recommendations; • Excellent coordination, communication and reporting skills; • Excellent in both spoken and written English.

Reporting

The report shall not be longer than 25 pages excluding annexes and it shall include the following chapters:

- Executive summary
- Methodology of the review
- Findings and conclusions (following the DAC evaluation criteria)
- Main recommendations for next phase
- Annexes

A draft report will be provided not later than two weeks after the mission in Kosovo. The final report will be delivered to SCO K not later than two weeks after the feedback of SCO K.

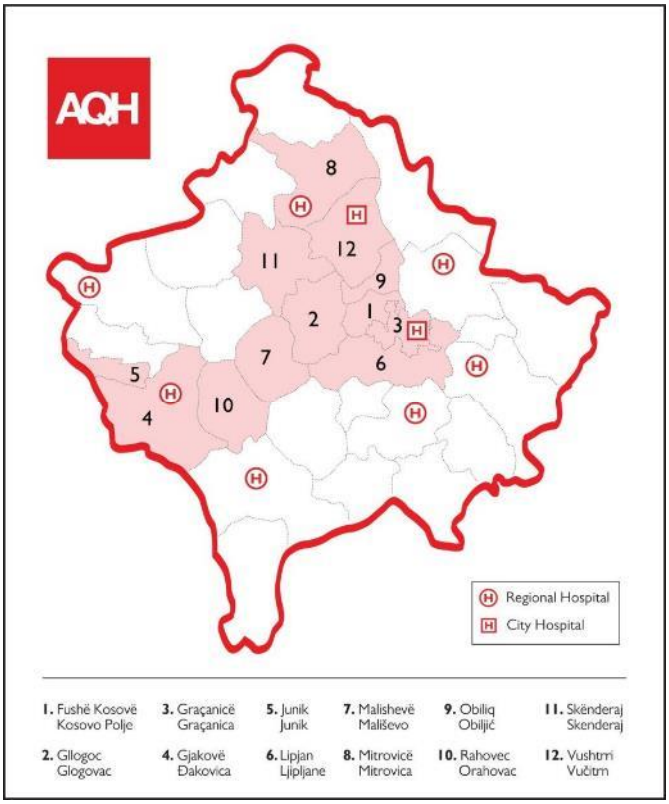
Documentation to be provided by SCO- Kosovo

- Swiss Cooperation Strategy Kosovo 2017 to 2020
- Project Document AQH
- Progress reports AQH
- MTR Report AQH
- CP Improving Financial Protection and Quality of Health Care in Kosovo (TF with WB)
- Progress reports TF with WB, including relevant Aide Memoires

Procedure for application

1. Technical proposal (max. 3 pages, excluding annexes), which shall include:
   - Understanding of the consultancy
     - Proposed approach and methodology to complete the task
     - Proposed timeframe
     - Financial proposal
   - Annexes
     - CV of the consultant
     - Relevant reference projects from previous successful mandates
2. The completed application shall be sent electronically to Merita Stavileci Mustafa, Senior National Programme Officer merita.stavileci@eda.admin.ch not later than 15 November 2018.

Annex 1: Map of AQH partner municipalities


AQH
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Regional Hospital
City Hospital
1. Fushë Kosovë Kosovo Polje
3. Graçanicë Graçanica
5. Junik Junik
7. Malishevë Mališevo
9. Obiliq Obilić
11. Skënderaj Skenderaj
2. Gllogoc Glogovac
4. Gjakovë Đakovica
6. Lipjan Ljipljane
8. Mitrovicë Mitrovica
10. Rahovec Orahovac
12. Vushtrri Vučitrn

Annex 2: Schedule of the External Review Trip

Dec-18				Details	Place
2	Sun			Peter arrives Pristina (20.00)	
3	Mon	am	09.00	Peter/Ilir introduction planning	Swiss D Hotel
			11.00	SDC	SDC office
		pm	14.00 - 16.30	PIU	PIU office
4	Tue	am	09.00	Peter/Ilir planning/discussions	Swiss D Hotel
			11.00	Kosovo Health Project (WB)	WB office
		pm	14.30	Work on Report	Swiss D Hotel
			18.30	Dorothee Chen (WB Trust Fund)	Skype
5	Wed	am	09.30 - 12.00	PIU	PIU office
		pm	13.30	PIU	PIU office
			15.30	LuxDev support project	LuxDev office
6	Thu	am	08.45 - 12.00	Fushe Kosova Municipality: integrated care, service packages, QIPs, mgt training, masterplans, health education, supportive supervision, NGOs, social welfare sector. We will invite PRAK to this meeting	MFMC and FMCs
		pm	13.30 - 16.00	Lipjan Municipality: Community Scorecard, QIPs, mgt training, masterplans, supportive supervision, health education, quality management, NGOs	MFMC and FMCs
			17.30	Skype call with Manfred Zahorka	Skype
			18.30	Skype call with Dorothee Chen (WB Trust Fund)	Skype
7	Fri	am	08.45	LuxDev support project	LuxDev
			10.30	Minister of Health: Uran Ismaili	MoH office
			15.00	Centre for Development of Family Medicine/PHC division MoH, combined with Centre for Continuous Nursing Education	CDFM office
			17.00	Save the Children	SCI
8	Sat			Review of findings with IH, Report Writing	Swiss D Hotel
9	Sun			Report Writing	Swiss D Hotel
10	Mon	am	09.30 - 11.00	Gracanica Municipality: QIPs, management training, supportive supervision	Main PHC facility
			11.00-12.00	Obiliq Municipality: Roma population	
		pm		PIU	PIU office
			13.00	NIPH	NIPH office
			15.00	Meeting with Ardita Tahirukaj, WHO	WHO office
			17.00	Skype call with Carlos Diaz of STC	Skype
11	Tue	am	08.00 - 15.00	Malisheve Municipality: SPs, health education, QIPs, management training, masterplans, supportive supervision	To be decided
		pm	15.00	Association of Kosovo Municipalities	AKM Office
			16.30	Chamber of Health Professionals	CoH office
12	Wed	am	08.45 - 12.00	Vushtrri Municipality: SPs, health education, management training, masterplans, QIPs, SS, NGOs	To be decided
		pm	14.00	Summarising ideas	Swiss D Hotel
13	Thu	am	09.00	Summarising ideas	Swiss D Hotel
			09.30	Wrap up with PIU team	SDC office
		pm	15.00	Debriefing with SDC	PIU office
14	Fri	am	09.00	Report and planning with Ilir	Swiss D Hotel
		pm	13.00	Peter departs for airport (flight 15.00)	

Annex 3: References used for External Review

AQH Project Document

AQH Annual Report 2016

AQH Annual Report 2017

AQH Progress Report Jan-Jun 2017

AQH Progress Report Jul- Dec 2017

AQH Progress Report Jan-Jun 2018

AQH Logframe (Revised Dec 2016)

AQH Mid-Term Review. Nov 2017

AQH Mid-term report on Supportive Supervision July 2.018

AQH Briefing for Minister of Health on AQH Activities March 2018

AQH Quality of Care Study Summary Report 2016

AQH Development of Integrated Care Model in Fushe Kosova Nov 2018

AQH Implementation of Supportive Supervision Report July – Dec 2017

AQH Knowledge, Attitudes, Practices and Behavior: Non-Communicable Diseases, Right to Health in Kosovo Dec 2016

AQH Coaching Quality Management Tools Implementation in PHC. Guiding Manual

STF Main Credit Proposal

STF Progress report Jul-Dec 2017

STF Progress report Jan-Jun 2018

Kosovo-Health-Project Restructuring Paper. June 2018

Kosovo Health Project Aide Memoire Feb-Mar 2018

Kosovo Health Project Aide Memoire Sept 2018

Swiss Cooperation Strategy Kosovo 2017-2020

Annex 4: Analysis of Indicator Data (to date of Review)

Available as a soft copy

Hierarchy of objectives Strategy of Intervention	Key Indicators	Baseline data	Data Sources	Target	Project progress Baseline	2016		2017		2018	Progress Rating	Reviewer notes
Overall Goal (Impact)	Impact Indicators[1]											
The health of the population of Kosovo has improved, with strengthened healthcare providers and managers able to meet the needs of the patients (especially vulnerable groups), who are more aware of their rights and needs.	Morbidity due to circulatory diseases in PHC in the age group 50 years and above is reduced	Baseline: Total: 78749 cases	Source: Morbidity report in primary health care in Kosovo, 2014, NIPH	Target: average % reduction		49.3%		44.6%				The data are reported by municipalities in aggregated form. Data show a very positive trend in terms of reduction of morbidity. But such figures are most likely reflection of data reporting flaws.
					78749	39942		43594				
		Male: 32724 cases			32724	18015		18236				
		Female:46025 cases			46025	21927		25358				
	% increase in PHC visits of population in project Municipalities	Baseline: Average visits for project municipalities 44,971[2]	Source: KAS Health Statistics 2014	Target: average % increase		74.5%		117.0%				The data are reported by municipalities in aggregated form. Data show a very positive trend in terms of increase of visits. But such figures are most likely reflection of data reporting flaws.
					44971	78463		97607				
	% increase in PHC visits of population in selected facilities with majority RAE populations	Baseline:	Source:	Target:		3.3%		-6.5%				The data are reported by municipalities in aggregated form. Based on such data project team has created a proxy estimate for all Roma, Ashkali and Egyptian beneficiary population. Data for this particular indicator seem to be more realistic. No substantial progress recorded.
		FMC 3 Brekoc: 2,092 visits	Facility data	average % increase	2092	2161		1956				
		FMC 5 Ereniku: 27,250			27250	10504		9890				
Outcomes	Outcome Indicators (in project Municipalities)	Baseline data	Data sources	Target								
Outcome 1 Primary Health Care providers in project municipalities deliver quality services that respond better to communities' needs, including those of vulnerable groups.	12 MFMC provide improved quality of services based on agreed structural and process quality standards [3]	Baseline: 68% (Average score)	Source: Baseline Assessment of Quality of Care in Kosovo, June 2016	Target: 85% (Average score)								The data are made available by AQH project, Quality of Care Study. Such data provides a very reliable source of information based on several domains of quality of services.
					68%							
	% increase of utilization for tracer diseases in 11 Municipalities	Baseline: Total No of visits: * Diabetes: 25540 Hypertension: 54282 Asthma: 1609 Childhood diarrhoea: 3116	Source: Municipal data (2015) HIS (2015)	Midline Target: 10% increase Target: 20% increase								The data are reported by municipalities in aggregated form. Data on immunization coverage is based on proxy estimate for all Roma, Ashkali and Egyptian beneficiary population. Data for this particular indicator seem to be more realistic although data reporting flaws seem to be present.
					25540	35181	37.7%	33419	30.8%			
					54282	82160	51.4%	63668	17.3%			
					1609	3915	143.3%	4423	174.9%			
					3116	5352	71.8%	6455	107.2%			
		RAE immunisation rates at FMC 3 Brekoc and FMC 5 Ereniku: 85% (Average score)	Facility data (2015)	Midline Target: 90% Target: 95%								
					85%	93.60%		91.40%				
	Pilot facilities providing service packages deliver outreach services to vulnerable groups	Baseline: 0	Source: Thematic workshops	Midline Target: 0 Target: 4 Municipalities								The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality. No progress has been made since project implementation
					0							

38	**Outcome 2**		No. of MFMC where quality audits based on Quality Management	Baseline:	Source:	Midline Target:											The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality.
39	Health managers in project municipalities improve their performance in guiding service delivery towards continuous quality improvement that responds to communities' needs.		principles are undertaken	0	Quality Management Training	6 MFMCs		0			12						Project has already managed to train managers from all MFMCs.
40						Target:											
41						12 MFMCs											
42																	
43			No. of Municipalities with	Baseline:	Source:	Midline Target:											The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality. The project has made partial progress in implementation of this outcome.
44			input from communities included in their	2 Municipalities	Healthcare Management Survey in Kosovo, June	4 Municipalities		2	2		1						
45			planning, and	(planning only)		Target:											
46			monitoring/review			6 Municipalities											
47	**Outcome 3**		% people with knowledge of risk factors for diabetes	Baseline:	Source:	Target:											The data is collected by a local company. Its a KAPB survey. This is high quality indicator as its estimate is based on rigorously performed data collection process with sample being representative of target population.
48	Health awareness and care seeking behaviour of the population in project municipalities improves (in particular of vulnerable groups) and communities are empowered to demand the right to quality services and better access to care			Total – 15%	KAPB survey	Total – 35%		15%									
49				(RAE 7%; Women 16%)		(RAE – 27%		7%									
50						Women – 36%)		15									
51																	
52			% people consulting doctor if they feel that their blood pressure has increased	Baseline:	Source:	Target:											The data is collected by a local company. Its a KAPB survey. This is high quality indicator as its estimate is based on rigorously performed data collection process with sample being representative of target population.
53				Total 10%	KAPB survey	Total – 30%		10%									
54				(RAE 23%*; Women 10%)		(RAE 43%; Women 30%)		23%									
55								10%									
56			No. of community-driven initiatives related to tracer diseases per Municipality that aim at improving their health	Baseline:	Source:	Midline Target:											The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality. No progress has been made since project implementation has started.
57				0	NGO mapping	1 initiative in 3 Municipalities		0%									
58						(Total=3)											
59						Target:											
60						2 initiatives in 12 Municipalities (Total=24)											
61																	
62	Outputs (per outcome)		Output Indicators	Baseline data	Data sources	Target											
63	Output 1	Training courses for service providers for implementation of SP are carried out; courses & trainers integrated in national training system.	% of service providers in pilot facilities trained on defined service package	Baseline: 0	Source:	Target:	Total	0	22		214		92				The information for this indicator is available in project reports and data are collected and processed by AQH team. The project is making steady progress in completing this output.
64					Not yet implemented	100%	Female		10		144		55				
65							Male		12		70		37				

			Training courses are approved by the relevant institutions as part of CPD	Baseline: 0	Source:	Target:										The information for this indicator is available in project reports and data are collected and processed by AQH team. The project has overpassed the target.
					Not yet implemented	2 training courses		0	2		18		1			
	Output 2	Support data collection and analysis capacity for improved M&E in selected Municipalities	No of Municipalities where M&E focal persons are trained	Baseline:	Source:	Target:										The information for this indicator is available in project reports and data are collected and processed by AQH team. The project has achieved the target.
				0	Thematic workshops/TNA report	12 Municipalities		0					12 (19 persons trained)			
	Output 3	A "service package"[4] for tracer diseases is developed and access to this package is guaranteed at pilot PHC facilities	Service packages for diabetes and hypertension are available by the end of the first phase in pilot Municipalities	Baseline:	Source:	Target:										The information for this indicator is available in project reports and data are collected and processed by AQH team. The project has achieved the target.
				0	Thematic workshops	4 Municipalities		0			2		4			
			% of patients diagnosed with diabetes and hypertension receiving service package	Baseline:	Source:	Target:										The information was supposed to be reported by MFMC. They have not been able to report such data hence project team has no information on this particular indicator.
				0	Thematic workshops	50%		0	No data to measure							
	Output 4	Development, piloting and M&E of integrated care services at community level, with support from communities	A model of people-centred integrated care services is developed and piloted in 1 Municipality	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality. Project has not yet started to implement this component.
					Thematic workshops	1 Municipality										
				0				0								
	Output 5	Selected PHC facilities have the infrastructure and equipment for delivery of basic PHC services	All selected PHC facilities have an infrastructure score* of at least 75%	Baseline: The mean infrastructure score over 40 PHC facilities is 56.8%	Source:	Target:										The data are made available by AQH project, Quality of Care Study. Such data provides a very reliable source of information based on several domains of quality of services.
					Baseline Assessment of Quality of Care in Kosovo, June 2016	90%[5]		56.80%								
	Output 6	Institutional processes/ procedures defined, (re)designed and translated into practice	Referral and counter-referral protocols for service packages are implemented and evaluated at municipality level	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. The nature of indicator is a simple binary variable that shows if the event has occurred or not in particular municipality. Project has not yet started to implement this component.
				0	Thematic workshops	4 Municipalities		0								

			Existing NCD CPGs are translated in local protocols and applied in facilities	Baseline: 0 Municipality	Source: Thematic workshops	Target: 12 Municipalities		0								The data for this particular indicator will be available in project reports. Project has not yet started to implement this component.
			Complaints procedures are functional (e.g. process in place, leads to improvement) in health facilities)	Baseline: 52% of managers reported to have received patients' complaints in the last month. Half of DHSW managers and over two-third (73%) of MFMC managers indicated to have solved all complaints received.	Source: Healthcare Management Survey in Kosovo, June 2016	Target: 50% of complaints are managed following a standardized procedure in 12 Municipalities		52% 50% 73%								The data for this particular indicator will be available in project reports. Project has not yet started to implement this component.
	Output 7	Supportive supervision systems (including coaching) are implemented along referral lines	No. of MFMCs providing supportive supervision to staff according to supervision framework	Baseline: 0 (framework not yet developed)	Source: Thematic workshops	No of supportive supervision visits No of MFMC undertaking supportive supervision visits		0 0	0 0		0 5		48 12				The data for this particular indicator will be available in project reports. Project has achieved substantial progress in implementation of this component.
	Output 8	A management training package is developed and applied for PHC facilities	% of PHC facilities in project Municipalities where managers are trained according to a nationally approved curriculum	Baseline: 0 (No National	Source: TNA analysis	Target: 90%		0	90		55	15%					The data for this particular indicator will be available in project reports. Project has achieved substantial progress in implementation of this component.
	Output 9	Municipal staff are trained and supported to conduct participatory quality auditing for improved M&E in health facilities	No. of Municipalities where staff is trained in auditing procedures relative to ISO standards	Baseline: 0	Source: Quality Management workshops	Target: 12 Municipalities		0			25 pax from 12 municipalities						The data for this particular indicator will be available in project reports. Project has achieved substantial progress in implementation of this component.
			No. of quality audits undertaken	Baseline: 0	Source Quality Management workshops	Target: 4 audits per Municipality (Total=48)		0			12 (48 audits)						The data for this particular indicator will be available in project reports. Project has achieved substantial progress in implementation of this component.

105	Output 10	Continuous quality improvement projects that respond to patients' needs implemented at facility level	% of MFMC and FMC having implemented quality improvement projects that respond to patients' needs in their facilities	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has achieved substantial progress in implementation of this component.
106				5% of facilities (4/81*100)=5%	Healthcare Management Survey in Kosovo, June	50% of facilities		5%	12		7	27% of facilities				
107																
108	Output 11	Peer Review and Benchmarking procedures are developed and piloted	No. of MFMCs participating in a benchmarking exercise at the end of the project phase	Baseline:	Source	Target:										The data for this particular indicator will be available in project reports. Project has not made any progress in implementation of this component.
109				0	Quality Management workshops	12 MFMCs		0								
110	Output 12	Pilot Municipalities engage in annual participatory health planning & produce Health Masterplans	No. of Municipalities where participatory planning processes are implemented	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has not made any progress in implementation of this component.
111				2 Municipalities	Healthcare Management Survey in Kosovo, June 2016	12 Municipalities		2								
112			No. of project Municipalities with approved Health Masterplans	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has not made any progress in implementation of this component.
113				1 Municipality	Thematic workshops	12 Municipalities		1								
114	Output 13	NIPH is supported to develop and implement a training package on communication skills for health promotion and education for community leaders/CSOs/CBOs	Training package on communication skills using BCC techniques is updated and implemented	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has not made any progress in implementation of this component.
115				0	HE/HP workshop with	12 Municipalities										
116	Output 14	Communities and vulnerable groups reached with health promotion/ education activities for common health problems, healthy practices & when/ where to seek care	% of community members (including RAE, rural women, men) reached through health promotion and education activities for tracer diseases per municipality	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has passed the targets for implementation of this component.
117				0	HE/HP activities not yet implemented	40%		0					53.30%			
118																
119																

120	Output 15	Selected community leaders/CSOs/CBOs have capacities to advocate for patients' rights and to engage in feedback mechanisms with health services providers and managers	% increase in awareness of patients' rights among population	Baseline:	Source:	Target:										The data is collected by a local company. Its a KAPB survey. This is high quality indicator as its estimate is based on rigorously performed data collection process with sample being representative of target population.
121				44% of respondents are informed about patient rights	KAPB survey	65%		44%								
122			No of public meetings/interactions between the facility and the communities to feedback on health issues, per Municipality	Baseline:	Source:	Target:										The data for this particular indicator will be available in project reports. Project has been making progress in implementation of this component.
123				0	NGO Mapping	Events in all 12 Municipalities		0	4	1						
124																
125														KEY		
126	[1] The revised HSS LF identifies an intervention to advance inter-sector, regional and national cooperation for data collection and reporting whereby 50 health indicators are reported in EUROSTAT. Our indicators may need to be revised when the EUROSTAT reporting is implemented and once these indicators are standardized in LuxDev HIS data sets.															Quantitative progress is as planned
127	[2] 2014 data is for 11 project municipalities (no data reported for Gracanica). Data is reported as 'Total No. of Visits to the FHC'															Quantitative progress is not (yet) as planned
128	[3] Quality standards are those included in the QoC study 2016															
129	[4] The service package includes the range of services along the continuum of care required by a specific disease (prevention, treatment, follow up, outreach, linkages between health and social welfare services) and the capacity of the system to respond (staff capacity, equipment, guideline, drugs, etc.).															
130	[5] Infrastructure score includes factors such as availability of electricity and water supplies, internet connectivity etc. that may be beyond the scope of the project to resolve															

Annex 5: Brief specific answers to ToR questions

ToR Ref	ToR Question	Summary of Key Findings	Reference in Report
3.1.1	Was the project's theory of change valid and realistic? Shall it continue being used as a guiding framework also on the 2nd phase?	Valid and realistic. Should continue to be used.	7.2.2
3.1.2	Notwithstanding issues with data availability and reliability, to what extent are project outcomes achieved / likely to be achieved?	Within realtively short implementation period (2.5 years), most major outcomes are being achieved. Those that are not yet, have a high likelihood of being achieved within the timeframe. Some may be deferred, since more unforeseen activities - ie QoC survey and management training - have been included	7.2.2
3.1.3	What was the role of the project towards the health sector reform? What are the implications of delays in the implementation of the Health Information System (HIS) and the mandatory health insurance (MHI) for the project? Are some adjustments required in the 2nd phase, respectively?	AQH is very influential as part of the health sector reform, improving the quality of selected NCD services provided which can be built upon if a new insurance (MHI) system is introduced. Delays in HIS are being overcome by the project (at least with short term solutions). Delay in the MHI is not affecting the project, but may affect the sustainability over the longer term if more funds are not made available for PHC.	7.2.3
3.1.4	To what extent is the project's approach – on organisational, institutional and technical level – appropriate? Which approach worked and which didn't? Why?	Highly appropriate, with strong efforts made by the PIU to involve the key stakeholders in planning and supporting them in implementation. Organisational: project set-up is generally effective. While the cooperation with SC-K has had many benefits, it is questionable whether -from the point of view of value for money - this should continue as a consortium, or should be switched to a type of (sub)contract. Institutional: cooperation with smaller NGOs and directly with municipal authorties has proven valuable, but more support than envisaged has been required. Cooperation with larger institutions including NIPH has not been as effective as foreseen, with key pertners not showing as much initiative as originally promised, but the AQH project has found some ways to work around this. Technical: in general very high level of technical inputs have been offered, very well received and respected by the key partners. Management aspects have required much more hands-on support than foreseen.	8.1
3.1.5	While the project's participatory approach is generally appreciated and has led to increased ownership, particularly at municipal level, the situation with central level institutions is different. What are the lessons learnt in relation to the project's approaches towards central level institutions?	See 3.1.4 above: the project has learned not to rely on agreements and promises made by such institutions, and to find alternative ways where possible to reach the planned goals such as working directly with municpalities and with other partners such as the CDFM. Although the prject activities fall under the normal responsibilities of some of htese large institutions, low salary conditions mean that the project priorities do not always correspond to those of the institution staff.	8.1

3.1.6	Does the intervention strategy correspond to the needs and implementation capacity of partners? Was the general design ambitious, in terms of new concepts introduced?	The strategy does respond to some of the key needs of the partner facilities and communities. But naturally, their needs are broader than what the project can offer within its time and budgetary scope. The design is ambitious especially with regard to new concepts of (a) NCD intervention (PEN protocols) - feasible and relevant for faciltiies (b) QM initiatives - feasible but with need for hands-on support, more complicated aspects may be less relevant at this stage such as (c) Integrated Care - feasible and relevant - adjustments may be needed to account for low capacity of SW system (d) Community Scorecard - relevant to some degree, but lessons learned in some places may be used to pro-actively address problems in other areas. It is more feasible if SC-K can implement the Scorecard without more international expert inputs, but long-term sustainability (future funding & technical support) is open to question.	8.1
3.1.7	What approaches/concepts/streams of work are considered successful and worthy to scale up? Alternatively, are there elements of AQH that should be phased out?	In general, most of the AQH approaches are worthy to scale up, although more time is needed to show concretely (particularly through indicators) how effectively they are performing (although there will almost never be "conclusive" proof. Integrated Care needs more time to be developed, to fit with available capacity, before any rollout is considered. QM concepts (in particular, the use of various tools within the facilities) should be kept to the minimum, with only 1-2 key aspects taught (eg SWOT analysis, fishbone diagrams, PDCA cycle) and established before moving on to other more in-depth topics.	10.1; 10.2
3.1.8	How do you assess the number/mix of municipalities selected for AQH I?	In view of how the project is progressing, the number seems to be about right. Perhaps a little too ambitious too attempt to reach 12 with all project aspects (especially the full SPs), but other aspects have been implemented in all (esp QIPs, HE/HP activities, equipment, management) to good effect, and there is still 1 year of the project remaining. The mix also seems appropriate, with large and small areas and a strong focus on the minority/vulnerable groups and fair geographical including ethnic spread.	8.2
3.1.9	Are the results achieved likely to be sustainable? What are the major factors influencing sustainability of outcomes and what adjustments are required accordingly in the 2nd phase?	In the short-term the results are sustainable since, at the facilities, this depends on the staff that have been trained and the reliability of the equipment supplied (which, being mostly simple, should have a long working-cycle). If staff later move away, or when equipment malfunctions, gains may be lost over time. If increased PHC funding comes from any source (including the planned MHI), sustainability may be more assured. The project is making excellent efforts to accredit the training courses with the relevant training institutions, and support will be needed to help them include these trainings in the standard training process/curriculum. Partnerships may also help sustainability in the future.	10.2 10.3

3.1.10	To what extent the support of AQH has strengthened the health system? Are there elements that can be carried forward by the system itself? Or is further support needed?	Examples of how the PHC system is strengthened include (a) the Municipality leaders (Directors of HSW) are trained in management of PHC (b) the 12 municpality PHC MFMCs are strengthened in both management and clinical practices (c) training programs introduced by AQH are accredited as part of the recognised system (d) an emphasis on Integrated Care (PHC & SW cooperation) of diabetics is promoted. At this point tin time, most of the support needs to be continued before it becomes part of the system. The project is building support for its initiatives, and setting the foundation for long term sustainability. The management training of Municipal Directors of HSW should now become part of an official system of training as a next step, and training programs should becme a normal part of the (continuing) professional development program of doctors. A process of developing partnerships may help to encourage elements of the reform processes to be carried forward by the system itself	10.2
3.1.11	How relevant and successful is the project's approach towards mainstreaming transversal themes gender equality and social inclusion?	In this early stage, the initial steps towards mainstreaming are relevant and useful. This includes the choice of municipalities to work with, the NCD topics, and the involvement of the community through HE/HP programmes. Specific practical training of staff has also occurred on these topics, utilising partnerships with organisations knowledgeable in these areas (eg Health for All and RROGRAEK) Gender equality is not strongly addressed, although the topic is inlcuded in training courses for clinical staff, and the AQH project has set an example by employing roughly equal numbers of each gender.	8.2
3.1.12	Do we adequately address the issues of 'vulnerable groups' and 'accessibility'? Is a more explicit focus/direct approach to social inclusion required? What are the lessons learnt and recommendations for the 2nd phase of AQH?	The current efforts of AQH should continue, with further strengthening of the NGOs and agencies involved in working with these groups. In general the AQH project is doing well to address isssues of social inclusion in its PHC planning and activities at facility and community level. One piece of research is advisable: to assess how far the RAE goups in particular are being treated in a parallel system to that received by the majoriy groups, and why this is and what can be done from both sides (the community, and from the health providers). Even if it cannot be completely resolved, perhaps some simple measures could be developed to reduce any inequities in health provision.	8.2
3.1.13	Were there possibilities for increasing the use of country systems? In what areas shall such approaches be explored in the 2nd phase?	Increased use of the Chambers is recommended, since they will take on some of the current responsibilities of the CDFM. Cooperation with LuxDev will be required, since they are supporting the development of the Chambers and, possibly, a new customised building. The AKM Collegium of HSW could also become more effective, and an audit (supported by SDC, but separate from AQH) is suggested to highlight its alignment with its expected responsibilities.	7.4 9.1 10.2.2 10.3
3.1.14	How efficient and effective is the project's organisational setup? What is the contribution and added value of partners in this consortium?	See 3.1.4 above: the organisational setup is effective, after initial misunderstandings and clarifications of roles and lines of authority Added value: each partner brings value, but the value of the SC-K in relation to the proportion of funds allocated for backstopping is questionable, and this could be re-organised in the future phase to ensure the most efficient use of funds.	8.1

3.2.1	What changes to the Theory of Change, if any, are recommended for the 2nd phase?	No changes required	7.2.2
3.2.2	Considering the reform agenda (and its present status of implementation) and given international partners positions, where can AQH deliver its best contribution?	To continue to focus on PHC. WB and LuxDev are focusing more on hospital levels, meaning PHC - which has had much previous investment in terms of technical support and funding - is very advanced for the region and is in danger of being neglected.	7.2.3
3.2.3	What are effective channels/modalities for disseminating best practices at national level?	See 3.1.13 above. The AQH project should continue to work with those partners who are effective. This includes the CDFM, some of whose functions are now being taken over by the Chambers. In this case, AQH should work with the relevant Chambers to develop their capacity in the project-related areas. Since NIPH have the remit to manage HE/HP activities, the project must continue to cooperate as best as possible, developing individual contacts and building their capacities as possible (within the constraints of poor salaries and pressure on staff to find other better paying work in parallel). The AKM Collegium for HSW could play a bigger role in enabling and disseminating best practices, and an audit of their activities to highlight this gap could be undertaken with SDC support.	7.4 9.1 10.2.2 10.3
3.2.4	What shall be the scaling up strategy to be followed in the 2nd phase? What is a realistic and reasonable number of partner municipalities to be added, if any?	Described in detail in the Report. There are a number of options proposed for both expansion of topics and of geographical coverage, together with a suggestion to utilise a partnership approach between AQH-supported municipalities and new ones.	10
3.2.5	In view of issues with data availability and reliability in this context, what shall be the project's approach to developing own data sources (complementing the present data sets) or further invest in improving information systems of the country?	See 3.1.3 above. The failure of the LuxDev project to fully implement the HIS has meant a loss of data availability and, potentially, reliability. However, the PIU has established specific data-collection and monitoring mechanisms that appear to be accurate, reliable and sufficient for the purposes of the project. Ideal will be if these mechanisms can be adopted into the future HIS system now being re-developed by the MoH, and the PIU should be involved in this process for PHC if possible. It is not advised that AQH gets involved in more than an advisory role in this process until the MoH has finalised its own strategy and system. Otherwise, all investment in this could be lost, just as it seems to have been for the LuxDev project.	7.2.3
3.2.6	Would a financial contribution from MoH add value?	The AQH-supported municipalities have received high quality equipment using the SDC-approved procurement mechansims. If such equipment is procured through MoH processes, there is a strong likelihood that the equipment will be of significantly poorer quality. If the AQH PIU is able to teach and support the MoH to conduct an improved procurement process, then the financial contribution from the MoH may be of value. If not, it may be better to use the AQH funds and procurement systzem to ensure the entire country has PHC faciltiies equipped with useful and effective equipment for the foreseeable future.	7.3.1