FIGO SAVING MOTHERS AND NEWBORNS PROJECT IN KOSOVO:

Reduction of Maternal and Newborn Mortality in Kosovo

FINAL EVALUATION

Sara L Nam

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CONTENTS

ACRONYMS

AIP	ALARM International Program
ALARM	Advances in Labour and Risk Management
ANC	Antenatal care
CME	Continuing Medical Education
DHS	Demographic and Health Survey
EU	European Union
FIGO	International Federation of Gynaecology and Obstetrics
IMR	Infant Mortality Rate
KMA	Kosovo Midwives Association
KOGA	Kosovo Obstetrics & Gynaecology Society
MDG	Millennium Development Goal
MOH	Ministry of Health
OSCE	Organisation for Security and Cooperation in Europe
PHC	Primary Health Care
SBA	Skilled birth attendant
Sida	Swedish International Development Co-operation Agency
SMN	Saving Mothers and Newborns Initiative
SOGC	Society of Obstetricians and Gynaecologists of Canada
UCCK	University Clinical Centre of Kosovo
UNFPA	United Nations Population Fund
UNMIK	United Nations Mission in Kosovo

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EXECUTIVE SUMMARY

Introduction

This evaluation assesses the achievements of the project, Reduction of Maternal and Newborn Mortality in Kosovo, which ran from January 2007 to December 2010. The overall objective was to strengthen the capacity and sustainability of the Kosovo Obstetrical Gynaecology Association (KOGA) and the Kosovo Midwives Association (KMA), to take an active part in improving the quality of maternal and newborn care in Kosovo. The specific objectives were to:

- Strengthen the organisational capacity of KOGA and KMA.
- Assume a leadership role in the development and implementation of national standards and protocols related to maternal and newborn care in regional and university maternities in Kosovo.
- Initiate partnerships with other stakeholders or peer institutions such as professional associations in the regions, EU and within FIGO, including women's and clients' groups.

Key Achievements

Conducting an assessment using an organisational capacity tool helped to identify organisational strengths and weaknesses, resulting in several activities that support improved maternity care, including:

- Holding an election for the KOGA Presidency
- Revision of the KOGA Strategic Plan for 2008-2018, approved in May 2010
- Development of a database of all KOGA members
- Establishment of a KOGA web site that updates members on activities and events, news articles, and clearly sets out the Statutes of the organisation

Several training activities were organised including advocacy training, several continuing medical education events and training of trainers to provide the *Advances in Labour and Risk Management (ALARM) International Program (AIP)* increasing the capacity within the country to conduct this course.

Importantly, eleven clinical standards have been developed (two more than proposed) with the support through the project. These represent the first such guidance developed by clinicians.

Challenges

Whilst the project has made many significant achievements, it has also encountered challenges, and the most important include:

- Capacity and management of in-country human resources in terms of time and remuneration as staff were working part-time on the project stretching themselves financially and time-wise.
- Lack of understanding of the financial reporting requirements meant that project funding was put on hold in June 2010 pending clarification of financial reports and their reconciliation.
- Further financial barriers related to exchange rate fluctuation contributed towards the cessation or non-initiation of project activities, contributing to a perceived loss of trust in KOGA by its members.
- Leadership among midwives was poor and legislative barriers limit the scope of midwifery practice in Kosovo.
- The reporting of activities and outcomes has made it difficult to assess the achievements fully, and to report the activities according to the log frame and indicators agreed upon.

- It is not clear to what extent the project has developed partnerships with women's and youth organisations.

Key Lessons Learned

- Financial and project management capacity cannot be assumed from an in-country team and can impact on the ability to report fully upon activities and achievements.
- It is difficult to assess the quality of outputs reported upon remotely without adequate reporting of relevant expenditures against reported outputs.
- Regular financial audit checks and regular project visits by the FIGO Secretariat of projects may help to identify projects where capacity in financial management needs support.
- The lack of an appropriate strong champion among midwives as the Midwife Mentor's counterpart limits the level of achievement that can be made in relation to strengthening the agenda for midwives.
- Strong leadership and a desire to work together from both professional organisations is pivotal in enabling close collaboration. Joint planning for the project, including inputs to the logical framework may facilitate achieving joint outcomes.

Key recommendations

- Terms of Reference for the in-country project team members could state individuals' responsibility for reporting and financial accountability, and appropriate capacity development needs to be provided to achieve this.
- FIGO may consider implementing a system of simple in-country audit checks of projects to verify the quality of financial expenditure against outputs, and of the financial management system.
- Longer in-depth training on the use of a logframe as a management tool should be considered for project staff. Individualised training for country programmes in developing feasible logframes would also be beneficial, with support in the regular review and up-dating of these logframes with project teams' input.
- Provision for translators needs to be made in countries where language barriers limit communication between Mentors and their counterparts.

1. INTRODUCTION

This evaluation assesses the achievements of the project, *Reduction of Maternal and Newborn Mortality in Kosovo,* which ran from January 2007 to December 2010.

The project is one of ten International Federation of Gynaecology and Obstetrics (FIGO) projects that are part of its *Saving Mothers and Newborns* (SMN) Initiatives. The project runs through to June 2011, and the other participating countries are Haiti, Kenya, Moldova, Nigeria, Pakistan, Peru, Uganda, Ukraine and Uruguay.

The report is structured into the following sections (Box 1).

Box 1: Signpost for report sections

Section 2	Sets out the ***background*** to the Saving Mothers and Newborns Initiative and the country specific project. This is presented in detail for completeness.
Section 3	Outlines the evaluation ***methodology***.
Section 4	Summarises the ***project achievements***.
Section 5	Summarises the ***project challenges***.
Section 6	Reviews ***project management***, including relationships between FIGO and the Kosovo project team.
Section 7	Lists the ***lessons learnt***.
Section 8	Provides the ***conclusion*** and ***recommendations***.

2. BACKGROUND

2.1 FIGO

FIGO brings together professional societies of obstetricians and gynaecologists on a global basis in order to promote the well-being of women and their children and to raise standards of practice in obstetrics and gynaecology. As the successor to FIGO's Save the Mothers Initiative, The Saving Mothers and Newborns (SMN) Initiative secured 4.6 million US dollars, of which a large part was contributed from the Swedish International Development Co-operation Agency (Sida)[1].

2.2 Saving Mothers and Newborns Initiative

Box 2: Millennium Development Goals

MDG 4: Between 1990 and 2015 reduce by two thirds the mortality rate among children under five.

MDG 5: Between 1990 and 2015 reduce by three quarters the maternal mortality ratio.

The SMN Initiative was launched in 2006 with the goal of reducing maternal and newborn morbidity and mortality, and to contribute to the achievement of Millennium Development Goals (MDG) 4 and 5 (Box 2). Its secondary objectives include:

1. Strengthening the capacity of national professional societies to engage in maternal-newborn health through the design and implementation of projects in the field;
2. Strengthening cooperation between FIGO and national societies, and also between societies in regions or of different economic levels;
3. Strengthening cooperation between national societies and national stakeholders involved in safe motherhood and newborn health;
4. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.

The Initiative aims to build and sustain the capacity of obstetrics, gynaecology and midwifery societies in participating developing countries to conduct essential projects relevant to the promotion of safe motherhood and the improvement of neonatal health.

Two key features of the initiative are: 1) north-south partnerships through the establishment of twinning mechanisms between obstetrics, gynaecology and midwifery societies in developed and in the implementing countries; and 2) increasing women's access to new, cost-effective and evidence-based technology for the reduction of maternal and newborn mortality.

2.3 The Country Context

In 1999, Kosovo came under the administration of the United Nations Mission in Kosovo (UNMIK) in partnership with the European Union (EU) and the Organisation for Security and Cooperation in Europe (OSCE). The health system collapsed during the period of the war from 1990–1999 along with the health information system. This means that Kosovo is characterised by a lack of accurate demographic data. The last commonly accepted census in Kosovo took place in 1981 with UNFPA conducting a country-wide demographic and health survey in 2003 among nearly 4,000 households[2].

Independence was declared on February 17, 2008. The Republic of Kosovo was established, and based on estimates, the population is over 2 million. The average

[1] From WHO website, **FIGO Saving Mothers and Newborns Initiative (SMN)**, updated on 18 June 2010, available from URL: http://www.figo.org/projects/newborns [Accessed on 22 February 2011].
[2] SOK and UNFPA (July 2003) Demographic, Social and Reproductive Health Situation in Kosovo, Results of a Household Survey. Available from URL: http://www.unfpakos.org/docs/DHS-2003/English.pdf [Accessed on 04 April 2011]

population growth rate is estimated to be 1.6%. Over half of the population is under 25 years of age; only 9% are over 60 years of age and women of childbearing age (15-45 years) constitute an estimated 48% of the female population.

Box 3: Overview of issues pertaining to assessment of maternal and perinatal mortality in Kosovo

The maternal, perinatal, infant and child health status of Kosovo's women and children is poor compared to the rest of Europe. The infant mortality rate (IMR) was estimated at 49 per 1,000 live births, while the under 5 mortality rate was estimated at 69 per 1000 in 2003 (DHS 2003). The crude birth rate was 23/1000.

Maternal mortality data in Kosovo were scarce and unreliable when a UNFPA EmOC assessment was conducted in 2008; the report states that there was no comprehensive vital registration available precluding the conventional approach of counting maternal deaths to monitor trends in mortality. Health professionals criticized the quality of the post mortem examinations and pathology service and expressed concern that an in depth enquiry would uncover more deaths, resulting in increased mortality rates.

(Taken from UNFPA, Asatiani T. (October 2008) FRCOG Assessment of Emergency Obstetric Care in Kosovo; Available from URL [accessed on 04 April 2011]: http://www.unfpakos.org/documents/AssesmentofemergencyobstetriccareinKosovoEng..pdf)

In 2000, WHO implemented monthly monitoring forms to monitor maternal and neonatal activity, which were distributed to all public maternity units in the country (except from two hospitals in Mitrovica North and Graqanica due to political sensitivities) and two private institutions in Pristina. The database is housed with the Ministry of Health under the *Director of the Gynecology and Obstetrics Clinic, University Clinical Centre of Kosovo, Pristina*. There is no system to collected information about home deliveries or deliveries in private clinics. The database provides a good picture of maternal and neonatal outcomes including perinatal outcomes, some of which are summarised in the table below that shows figures up to 2006, when the FIGO project started:

	2000	2001	2002	2003	2004	2005	2006
Fetal Mortality Rate (%)	14.5	14.4	14.7	15.9	14.4	13.3	12.5
Early neonatal mortality rate (%)	14.8	14.5	12.6	11.8	11.4	9.0	10.79
Perinatal mortality rate	29.1	28.7	27.1	27.6	25.6	22.1	23.2
Caesarean Section Rate	7.5	9.1	10.3	11.3	12.3	13.9	16.4

(Taken from: Lulaj,S. (Draft, March 2011), Perinatal Situation In Kosovo for 2000 – 2010)

Despite steady improvements, in 2007 perinatal and neonatal mortality were still more than double the European Regional rates at 20 per 1000 live births and 8.8 per 1000 respectively (compared to 7.82 and 3.61 across Europe)[3]. These high mortality levels reflect the on-going need for improved access to antenatal care and capacity building of healthcare professionals to prevent, detect and refer health problems that occur during pregnancy and childbirth[4]. Continuous Medical Education (CME) has not been a feature of the medical profession in Kosovo although a CME Board has recently been implemented. Additionally, maternity facilities were reportedly poorly equipped[5], and midwives do not have autonomy to act as more than Nursing Assistants to doctors[6].

[3] Cullen, R (July 2008) FIGO Reduction of Maternal and Newborn Mortality In Kosovo: Interim Report by Options.
[4] Cullen (2008) *ibid.*
[5] KOGA (2005) FIGO Reduction of Maternal and Newborn Mortality In Kosovo: Original Proposal.
[6] Personal communication with Project Midwife Mentor, Ms Cathy Ellis (30 March 2011).

2.4 Reduction of maternal and newborn mortality in Kosovo

Objectives

As stated in the original project proposal, the **overall objective** was to strengthen the capacity and sustainability of two professional associations, the Kosovo Obstetrical Gynaecology Association (KOGA) and the Kosovo Midwives Association (KMA), to take an active part in improving the quality of maternal and newborn care in Kosovo.

The specific objectives were to:

- Strengthen the organisational capacity of KOGA and KMA with regard to the following: project management skills, communication capacities, development and maintenance of partnerships based on participatory decision making processes, working with the sexual and reproductive health approach.
- Assume a leadership role in the development and implementation of national standards and protocols related to maternal and newborn care in regional and university maternities in Kosovo.
- Initiate partnerships with other stakeholders or peer institutions such as professional associations in the regions, EU and within FIGO, including women's and clients' groups.

Two key levers that the project planned to use to inform and enable its implementation were firstly, to build constructive partnerships with decision making authorities such as the Ministry of Health (MoH), the Directors of public health institutions, and secondly, to build public partnerships with civil organisations such as women groups and youth organisations.

The clinical component of the project is based in three institutions delivering around half the births in Kosovo: the regional hospitals of Gjakova and Prizren, and the tertiary centre of the University Clinical Centre of Kosovo (UCCK) in Pristina. The main activities are the provision of training, conferences and continuing medical education, and the development and implementation of protocols, a strategic plan and a health information system. The final phase has a community awareness component.

In addition to the FIGO Funding, KOGA had agreement from the MoH that 20% of the total budget would be supported by the MoH over the five years of the project.

A FIGO Steering Committee was established in order to: approve the project's action and implementation plans; support the project in determining activities; and monitoring and evaluating the project. It consisted of one representative from each of:

1. Ministry of Health – Office for Mother and Child Health
2. Gynaecology Clinic – University Centre, Pristina
3. KOGA
4. Kosovo Midwife Association
5. Civil society organisation - Women groups
6. Kosovo Committee for Mother and Child Health
7. Neonatology Department
8. SOGC- as the project partner organisation.
9. Observers: one representative from each of: WHO, the UNFPA and UNICEF.

Annex 5 sets out the measurements of the indicators that report to these outputs.

3. EVALUATION METHOD

This desk-based evaluation took place in the second half of March 2011, and a mix of qualitative and quantitative data informed the findings.

The consultant reviewed project documentation provided by FIGO and the project implementers. FIGO provided a list of stakeholders to interview; additional information was supplemented by key informants by follow-up telephone calls or email communication between 28 and 30 March 2011.

Triangulation of information was established to an extent through key informant interviews and with data provided in reports. However, without access to financial records and on-site visits where meeting with all team members is possible, it is difficult to confirm achievements and assumptions made.

The report was sent to all key informants for review, verification and comments prior to submission to the commissioning body, FIGO.

Significant limitations of the evaluation include that persons identified as key members of the project team were not interviewed due to language barriers and the report was not reviewed by them. A limited number of stakeholders were able to or were interested in participating. Feedback and comments were provided by two participants only and no feedback from in-country persons was provided, despite concerted efforts. This has led to some gaps in knowledge, and this is an inherent limitation of a desk-based review of this nature.

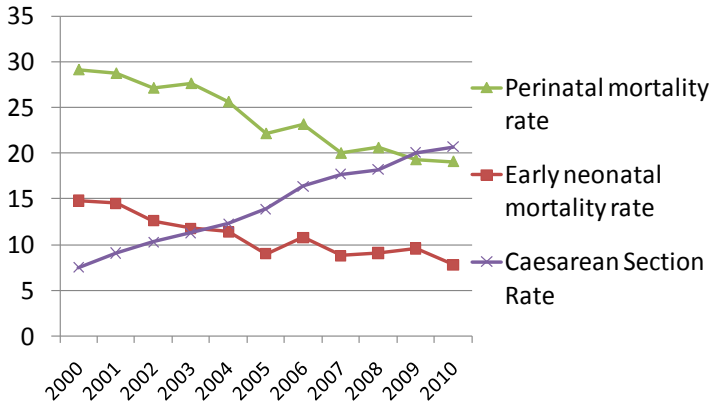
4. PROJECT ACHIEVEMENTS

4.1 Achievements related to aim

Overall, the project has conducted many activities and seems to have contributed towards strengthening the KOGA capacity as an organisation, and the capacity of its members. The project has contributed towards the inclusion of midwives in issues relating to maternal and neonatal health and towards raising their profile to an extent.

The quality of care is reflected in the continued downward trend of perinatal mortality from the 2000, in particular from the project baseline in 2006 of 23 to 19 per 1,000 live births; and of the early neonatal mortality rate from 10.8 in 2006 to 7.8 per 1,000 live births in 2010 [7]. Although the caesarian section rate sits at 20.7% in 2010, it is not possible to comment on the impact of the project as this data comes from all maternities across the country.

Figure showing perinatal mortality rate and early neonatal mortality rate per 1,000 live births & C/S rate per 100 births in Kosovo maternity units.



4.2 Key achievements relating to outputs

- **Strengthening of KOGAs organisational capacity**: through the FIGO twinning activity, SOGC provided their organisational capacity tool to identify organisational strengths and weaknesses. As a result of the FIGO project, several key tools have been developed that support the ability of KOGA to fulfil its role and have strengthened its credibility as a meaningful organisation that is contributing to activities that support improved maternity care, including:
  - For the first time in 17 years, an **election for the KOGA Presidency** was held in 2007 – there had not previously been a formal election process in place. A new president was appointed, and the previous president was invited to join the project Steering Committee.
  - Revision of the **KOGA Strategic Plan for 2008-2018** was debated and approved in May 2010. This includes their vision and mission statement, and outlines the Association's plans to address the following issues: Medical issues and market regulation of health services (including how to work towards protection of members); Education (specifically, re-registration and CME); Standards of clinical work; Partnerships and international cooperation; Public relations; Organisational structure (including collaboration with the KMA) and development and membership information.

[7] Lulaj, S. et al. (March 2011) DRAFT: Perinatal situation in Kosovo from 2000 to 2010. MoH, KMCHC, KOGA, KPA, NIPH, MAK

- A **database of all KOGA members** has been created that enables the identification of all members by, for example, area of work (primary, secondary care, etc); areas of speciality and level of training.
- A **web site** has been created that updates members on activities and events, news articles, and clearly sets out the Statutes of the organisation (see box 4). The web site also holds a link to access the Manual of Standards in Obstetrics and Neonatology, but this link was broken during the time the evaluation took place. The web site was last updated in 2010, and it current plans are for this to be updated as necessary.

Box 4: Snapshot of home page of the KOGA web site

URL: http://www.shogjk.org/home/[Accessed 1 April 2011]

- **Lobbying and advocacy**, included training in the 2010 KOGA Annual Conference. Some of these advocacy events have led to the professionalisation of the organisation and its members, whilst also widening its scope to include other sections of the membership to increase the capacity for sustainability of the organisation and activities. Some successful examples of advocacy efforts are shown in box 5.

Box 5: Overview of issues pertaining to assessment of maternal and perinatal mortality in Kosovo

KOGA, through lobbying from the Project Staff, agreed to implement a system where gynaecologists are required to re-license as a prerequisite to becoming a KOGA member. Negotiations are taking place between KOGA and with Board of Licensing at the Ministry of Health regarding this process.	Through project members, KOGA is advocating to amend its constitution to allow the future registration of individuals who are not 'medics' as members or as part of the staff; this section of the membership would be open to individuals who can demonstrate good management or fund raising skills on behalf of KOGA to support the sustainability of the organisation and its activities.

- Several **training activities** have been organised by KOGA, sometimes in collaboration with other organisations, often with joint-funding from the FIGO project. The project mentors and associates revised and participated in many of the workshops on capacity building and the Alarm International Programme (AIP). The list of conferences and training events held through the project or in collaboration with the project is shown in Annex 6.

- **Eleven standards have been developed** (two more than proposed), most of them were adapted by clinicians and academics in country based on the protocols from the SOGC's AIP materials, which are evidence based. One protocol on prenatal care was developed by the Project Director, and reviewed by the SOGC mentor. These protocols were translated into English and reviewed by the project mentors, then subsequently approved by the MoH. Some were based on the SOGC protocols and include decision making trees to guide clinicians in management of patients (see table below for list of standards developed). These are the first set of national guidance produced by any clinical body in Kosovo and as

such, represent a significant step forward in promoting clinical quality and governance.

Table listing standards developed through the project and approved by MoH

Obstetrics:	Newborn:
1. Management of Labour	1. Care of the Healthy Newborn
2. Post Partum Haemorrhage	2. Perinatal Asphyxia
3. Obstructed Labour	3. Newborn Resuscitation
4. Post Partum Infection	4. Neonatal Sepsis
5. Hypertension of Pregnancy	
6. Complications of unsafe abortion	
7. Pulmonary Embolus in Pregnancy and the Puerperum	

- **Continuing Medical Education (CME)** events have been held on each of the topics covered in the 11 standards; these events occurred throughout the project time lines at the three pilot sites. There is no record in the end of year narrative or trip reports for the number, type or topic of CME seminars, or of the number or type of participants.
- **Strengthening skills of clinicians through the ALARM International Program (AIP)**: the FIGO project built upon AIP work done by the SOGC previously, and supported the translation of all AIP course 4 edition manual; the printing of the AIP notebook and presentations were funded by WHO. Box 6 details the AIP components.

Box 6: Overview of ALARM International Program

The SOGC's ALARM (Advances in Labour and Risk Management) International Program is a training tool designed to reduce maternal death or injury in developing countries. The five-day program targets health professionals who provide obstetrical care, reviewing the top maternal killers and suggesting essential tools and problem management with the goal of improving care for mothers and newborns. To be as effective as possible, the ALARM International Program is sensitive to realities and conditions in which our international partners work. By focusing the program on less developed or developing countries, the ALARM International Program (AIP) promotes evidence-based practice while avoiding high-cost solutions for low-resource environments in an effort to direct the effort where it is most needed.

The AIP has been developed with an emphasis on sexual and reproductive rights which form an integral part of the program's content. Discussions of women's reproductive and sexual health as an issue of social justice occur alongside hands-on practice of clinical procedures. By sensitising participants to the range of social, economic, cultural, and legal factors that can limit women's access to quality care, the AIP works to promote women's sexual and reproductive health in a comprehensive way.

The AIP is delivered by a multidisciplinary team of dedicated SOGC volunteers alongside practitioners from our partner countries that include obstetricians, midwifes, nurses and family doctors. The adult learning methods of the AIP combines evidence based theory, hands on practice, workshops, role play as well as pre- and post-evaluations that include written and practical exams (OSCEs: Objective Structured Clinical Examinations).

Once the clinical components have been reviewed, the course ends on a full-day monitoring and evaluation workshop which introduces and familiarises the participants to the "Maternal Death Audit". The AIP goes beyond being a 5-day training course when given within a framework of pre-existing monitoring and evaluation activities in our partner countries, thus allowing us to assess the change in practice and the impact of our collective efforts to reduce maternal and newborn mortality in the long term.

From SOGC Web site, URL: http://iwhp.sogc.org/index.php?page=176 [Accessed 29 March 2011]

The AIP is based on field experience that shows an 80% drop in Maternal and Newborn mortality rates where a skilled attendant is at delivery. It is a three day obstetric course of lectures, workshops and Objective Structured Clinical Examinations (OSCE).

In Kosovo the written exam is an open-book test of 40 multiple choice questions and the oral exam consists of 4 stations that include a Breech delivery, Post Partum hemorrhage, shoulder dystocia and other pertinent subjects. The lectures and workshops covered in the three AIP days were based on 11 protocols adopted by KOGA. It also included a chapter on antenatal care and an expanded version of Monitoring and Evaluation module to include Mortality and Morbidity. In Kosovo, there is lots of opportunity for discussion and exchange of practice ideas during the course and exam process. The emphasis is placed on the oral exam; if a deficiency is identified, a remedial action occurs during the exam to support all clinicians to achieve competency and there are thus no 'failures', and the certificate shows successful participation in the AIP course.

In total, 60 doctors and some midwives (number not specified in reports) were trained in AIP through this project from Pristina and Gjakova, but not from Prizen as there was no budget for the instructors (there had been AIP training previous to this project in Prizen). Eight AIP instructors were previously trained from the SOCG project in 2002-2004. A further six AIP instructors were trained through the FIGO project in February 2011, bringing the total number of AIP instructors in the country to 14.

Box 7: Reports on AIP training in Kosovo

"[In the AIP course at Prishtina], the OSCE's reflected that the information presented was well received, and no participants failed. The average mark was 80%. 33 ObGyn's, Family Physicians and Midwives received their certificate. It was obvious that both the Instructors and Course participants appreciated the three days of interaction and crowned with the celebration of success. The ability to use the AIP course to introduce the Protocols was well done."	"In our visit to Gjakova in 2009, we were reviewing Outcome Indicators, and examining the caesarian section rates. They had decreased their caesarian section rate from 25% to 20.5% by implementing a three-physician Consultation Committee to review elective sections before they were done. This was a result of most of the obstetric staff having taken the AIP."
"We taught the use of forceps and vacuum extractor for assisting deliveries. We found they were keen on learning the use of forceps because they had not learned their use in their training. [However], we thought it more appropriate to emphasise vacuum [extraction] as this was what they were used to and could therefore be a safer option for assisted deliveries."	"When breech delivery was taught, we would emphasise 'hands off' during the labour and guiding the breech during delivery. They were used to pulling out the baby when the legs presented [before the AIP course]. This created much discussion on the topic."

Source: Mentor Trip reports & Personal communication (31 March 2011)

- **Partnerships with other regional societies**: KOGA has demonstrated cooperation with other regional professional societies through the organisation of joint conferences, for example, the *Turkey-Kosova Reproductive Health Conference* in 2009. Please see annex 6 for description of collaborations with other organisations in planning and organisation of seminars and conferences.
- **Increase in the recognition of midwives:** activities conducted throughout the project that aimed to build initial links between the KOGA and the KMA included having the President of the KMA sitting on the KOGA Executive Committee, and having her participate in the project planning meeting in London at the outset of the project. The project's Obstetric Mentor noted that "during the Perinatal Situation Round Table, there were numerous comments about the need to have more trained Midwives in the maternities". The Midwife Mentor has since supported training for Midwives in support of these requests, for example, their participation in the AIP with doctors, including having one midwife trained as a AIP Trainer, by supporting midwives activities and participation in all conferences and training arranged through the KOGA. This mixing of cadres in training sessions has not previously occurred in Kosovo, and went someway to promoting communication between the cadres. Additionally, KOGA supported a meeting of midwives in 2008.

5. PROJECT CHALLENGES & LIMITATIONS

Whilst the project has made many achievements, it has also encountered challenges.

5.1 Capacity and management of in-country human resources

With the exception of the Project Administrator, personnel working on the project were funded on a part-time basis and the funding was not considered sufficient to cover loss of earnings. Project staff felt that this led to a conflict of interest, taking time from their other responsibilities, and was not adequate in motivating them for the level of commitment required.

In-country, only the Project Manager spoke fluent English after the departure of the Project Administrator in July 2010, and this was a limitation in terms of communicating with donors and international advisers.

5.2 Financial restrictions

In June 2010, project funding was put on hold pending clarification of financial reports and their reconciliation which dated back to 1st July 2009.

During this period, the Project Administrator secured a new posting with another organisation. This meant that the Project Manager was left to complete all reporting, managing the accounts, searching for continued funding, etc. placing further pressure on his time.

As a result, activities were focused on two pilot sites: Pristina and Djakova and activities were prioritised from the work plan and the AIP at Prizen hospital as the third pilot site did not take place. Additionally, several meetings planned were postponed.

The lack of planned activities and meetings latter resulted in a perceived loss of trust in KOGA by its members.

In addition to these challenges, there were exchange rate fluctuations between the project financing in USD and Euros, which the project had to convert funds to. These fluctuations meant the further budget reduction in June 2010 impacted on the project even more, and complicated financial reporting.

5.3 Leadership among midwives

KOGA had made provisions to collaborate with and include midwives in the project through the Kosovo Midwives Association (KMA). The current KMA President has been in the role for the life of the KMA since its establishment 7 years ago, and there have been no elections since then. Whilst there is evidence of some desire to move forward in strengthening the role of midwives (the KMA president indicated to the project's Midwife Mentor that she would like assistance in strengthening the KMA), a lack of leadership and motivation was prevalent from KMA. For example, an organisational needs assessment was conducted as a result of support from the Midwife Mentor, but findings were not addressed and there were a lack of response to communication (partly due to the computer-illiteracy of the KMA President) despite efforts by the Midwife Mentor.

The KMA is restricted by the limited scope of midwifery practice in Kosovo and this is evidenced by the lack of midwifery participation in the review of obstetric standards and protocols. However, there appears to be little or no motivation to raise the profile and standards of midwifery from the KMA leadership. Midwifery protocols were under review in 2009 by the MoH, but midwifery representation at these meetings were limited to a small number of KMA representatives.

There are pools of committed individuals among midwives, particularly in the younger more-recently qualified midwives, who show motivation and potential to move forward the agenda for raising the profile and scope of midwifery. This includes non-KMA midwives and

midwives who have qualified at degree level in the UK, but no provision has been made in differentiating their skills from that of a nursing assistant.

Without the legislative and professional scope of midwifery practice being developed, and without adequate leadership, it will be hard to develop the role and profile of midwives in Kosovo. There has been discussion of KMA merging with KOGA, but this is not likely to support the development or autonomy of the KMA or its members.

5.4 Reporting

Plans for the development of software for gathering of maternal and perinatal data were discussed intensively in 2008, and the aim was to test this in Gjakova and then extend it to Prizren and Pristina. However, this has not occurred due to the lack of funds.

The reporting of activities and outcomes has made it difficult to assess the achievements fully, and to report the activities according to the agreed log frame and indicators. Examples of missing information which would have contributed towards the final evaluation include: percent increase in post test scores at each training[8]; number of antenatal notebooks distributed and number and proportion of women with a completed antenatal notebook at each project site. Additionally, the reporting on the numbers of staff trained in AIP has been drawn from narrative and trip reports, and none of the reports record how many CME events occurred or numbers attended.

It is probable that the gaps in reporting, particularly reporting about numerical data, is partly due to the amount of work that project staff have to manage. However it is difficult to assess the reporting, recording and communication systems without visiting the project site. Having clear and well-defined Terms of Reference for project personnel would partly contribute to clarity in reporting these data.

5.5 Partnerships with community organisations

It is not clear to what extent the project has developed partnerships with women's and youth organizations. Although narrative reports state the occurrence of meetings and attendance by civil society organisations at symposiums and membership on the project's Steering Committee, it is not clear what outcomes there have been from these meetings in relation to the project objective.

[8] Although prior to the FIGO project, such data was held and all AIP courses had their evaluations including pre and post tests filed with the SOGC office in Ottawa (personal communication with project Mentor, 12 April 2011).

6. PROJECT MANAGEMENT

The Steering Committee met first in April 2006, but was limited in its ability to move the project forward until the Letter of Agreement was signed at the end of the year; the project was finally launched on January 12th 2007. The strategic selection of members has led to support of various activities (conferences, AIP training material publication, etc), and contributed towards developing links with other key players in the field.

6.1 Project personnel

The project implementers in country did not have Terms of Reference for their positions and the overlap in their roles was highlighted in the interim report of 2008. Project Management skills were considered to need strengthening by FIGO at the outset of the project; whilst steps were taken to amend this by employing an administrator, there are still gaps in reporting (both financial and activity / outcome reporting), and the lack of clarity on TORs could have contributed towards this.

The in-country team members were geographically disparate, with the Project Administrator and Project Director based in a Pristina, but the Project Manager based different location – Gjakova. Discussions with the Project Manager and Mentor revealed this not to be a barrier in communication. The Project Manager travelled frequently to Pristina to meet with the Project Director and Administrator there, and the use of funds for fuel that has been questioned would have contributed to improved communication. Additionally, cell phone communication was reportedly used to provide the necessary access on a daily basis.

It seems that more activities were implemented in the first pilot site, Gjakova, where a FIGO project committee was established made up of obstetricians, gynaecologists, midwives, nurses and pediatricians. It is not clear whether a project committee was set up at each pilot site. The achievements at Gjakova would have benefited greatly from having a motivated key project team member here, and other sites may have benefited from having similar input at an equivalent level from a dedicated member of the project team who had the capacity to drive forward to project.

6.2 The log frame

Multiple changes in the log frame were found to be time consuming and frustrating for the project team to deal with and to report upon. Technical support from Options had made suggestions as to how to strengthen the log frame and had these suggestions been adopted, it might have made the log frame a more useful tool to use. For example, some items listed as indicators are activities, and indicators listed do not completely report on expected results.

6.3 Relationship between the project team and FIGO

In response to issues in reporting, the FIGO Financial Administrator visited the project in August 2009 followed by the Project Manager in April 2010. The purpose of the much appreciated visit by the Financial Administrator was to enhance the team's capacity in financial management and the Project Manager's visit was meant to assist the team in revising their work plan. In addition to these visits, there have been numerous phone calls between the project staff, FIGO finance coordinator and Project Manager and with both mentors, as well as letters provided to the project team from the FIGO Safe Motherhood and Newborn Committee Chair (Committee responsible of overseeing the projects) to try to find ways to move forward. However, financial reconciliation has remained unclear to the time of this evaluation, highlighting the need for more support on this issue. See more on this in section 6.4, below.

There were several changes in the structure of FIGO Secretariat that contributed towards some difficulties in communication for the in-country team. The SMN Initiative

management moved to the SOGC, and the financial management remained in London, resulting in a change of personnel that the in-country team communicated with for some aspects of the project. In all, there were four changes to the FIGO Project Manager, and the in-country team were not always clear on who to communicate with about various issues.

6.4 Twinning Mentor & Societies

The twinning arrangements in Kosovo were based upon pre-existing relationships between the Twinning Society, SOGC, and both Mentors had been involved in the country through a prior project with the SOCG and Canadian Nurses Association. Both mentors have demonstrated commitment in their support to the project, visiting on a regular annual basis (twice per year for the Obstetric Mentor and at least once a year for the Midwife Mentor).

Both Mentors had a similar perspective on their roles as advisers and offering support in a non-threatening manner that the recipient will appreciate and value and that will empower them to move forward with confidence towards what they want to achieve. However, how much a mentor can achieve is enabled or limited by whether their support is desired or not. Whilst the Obstetric Mentor was able to support the project team in moving forward with their agenda, the Midwife Mentor was limited in the scope of her role in supporting midwives; whilst several Kosova midwives demonstrated their eagerness to move forward the agenda for midwifery in their country (including non-KMA members), the lack of motivation from the KMA leadership limited what could be done.

6.5 Financial Management

Three members from the Kosovo team attended the 2006 meeting that FIGO convened for the SMN country project partners. At this meeting, participants were provided with a simple financial reporting tool that is based in Microsoft Word.

After recognising the difficulties in reporting finances, the FIGO secretariat visited the team in Kosovo to provide training in the use of a simple Excel-based financial reporting tool that is user friendly and allows simple reconciliation. This training was provided to the Project Administrator based in Pristina, who was then tasked with training the Project Manager (based in Djakova). However, this training was inadequate and the financial reporting in the last 18 months of the project has been poor. There were, at the time of this evaluation, still issues outstanding on the financial reporting.

An additional limitation noted by FIGO is the lack of continuity in financial management at the FIGO secretariat as the financial administrator only joined halfway through the project, so the support that he was able to offer was limited.

6.6 Sustainability

Sustainability of the project *per se* is not assured due to lack of continued funding. However, the project has managed to demonstrate capacity within KOGA to attract funds to support activities. For example, in printing the AIP course materials and in collaborations for national and international conferences. Additionally, the most active personnel in country remain in their positions with KOGA and as clinicians, and they will be able to continue to advocate for the development of KOGA and KMA through these roles.

Further to this, the KOGA has developed links with the Royal College of Obstetricians and Gynaecologists (RCOG) under the auspices of the RCOG-Eurovision project[9], where experts from the RCOG are involved in offering guidance and support to European colleagues and counterparts. The 2010 KOGA conference held in May culminated in the signing of a Memorandum of Understanding between the RCOG and KOGA to promote the education and training of doctors working in the field of women's reproductive healthcare in Kosovo;

[9] See following URL for further information: http://www.rcog.org.uk/international/projects/eurovision

this collaboration will be an important initiative that contributes towards sustainability.

7. LESSONS LEARNT

7.1 Lessons learnt for FIGO

- Financial and project management capacity cannot be assumed from an in-country team: project implementers may have multiple demands on their time, particularly if they are not funded fully through the project; implementers may not have management or financial expertise. Both these capacity issues can impact the ability to report fully upon activities and achievements.
- It is difficult to assess the quality of outputs reported upon remotely without adequate reporting of relevant expenditures against reported outputs.
- More frequent financial audit checks of projects may help to identify projects where capacity in financial management needs support. Additionally, holding individuals to account on finances and ensuring that those individuals fully understand how to demonstrate accountability is key, for example, through agreeing clear Terms of Reference for project team members.
- The site visit from a member of the FIGO Secretariat was much appreciated: this increased motivation among the team, enabled identification of specific financial issues in the field and provided support to address those issues.
- Whilst legislative restrictions on the role and scope of midwives in Kosovo exist, a more important barrier is the lack of a strong champion who has potential leverage as the Midwife Mentor's counterpart. This limits the level of achievement that can be made in relation to strengthening the agenda for midwives. Additionally, the support and leadership from the national Midwives Association is pivotal in enabling activities to be planned and implemented.
- The use of a logframe as a living management tool that should be regularly reviewed and updated is not clear among some stakeholders.
- Making provision for enabling communication where there are language limitations is important. Support for translators and training in English / computer literacy could have facilitated communication between the Midwife Mentor and her counterpart. The Obstetric Mentor's communication was facilitated by his fluency in German as a shared language.
- An assessment of the motivation by both midwives and obstetricians associations to work together prior to approving a project may help to identify potential barriers in achieving joint outcomes.

7.2 Lessons learnt for the Project

- Ensuring adequate project and financial management capacity is key to being accountable to donors, and in being able to report achievements and challenges.
- Good communication mechanisms are important in maintaining motivation among the project team, and barriers to effective communication can lead to reduced motivation. Foreign language skills are important in order to communicate with donors and other international players; having a limited number of project personnel who speak English or other donor languages will place great strain on the few individuals who do speak these languages and are therefore always relied upon to ensure reports and other communications are conducted and disseminated.
- Strong leadership and a desire to work together from both professional organisations is pivotal in enabling close collaboration; joint planning for the project, including inputs to the logical framework may facilitate achieving joint outcomes.

8. CONCLUSION

The project has been successful in achieving its core deliverables in two of the three pilot sites, particularly in the first half of the implementation period. In particular, in strengthening the organisational capacity of KOGA (objective 1) and assuming a leadership role in the development and implementation of national standards and protocols (objective 2). Partnerships with other stakeholders have been established through the steering committee and the organization of and participation in collaborative symposiums (objective 3). The project appears to have had less of an impact in strengthening the KMA (objective 1) and in demonstrating outcomes from links with women's and clients' groups.

The project outputs, as reflected in the annual narrative reports, appear to become weaker as the project came to an end. This is in part due to the set-back of an office fire and downward budgetary changes. It is difficult to make a clear evaluation of the successes and challenges of the project as the detail of activities (particularly relating to numerical reporting) is limited.

It is evident that greater support was needed by the project in terms of managing and reconciling financial matters. Factors impacting the reporting of this project include the lack of clarity in Terms of Reference of team members and the limitation on time capacity of key implementers.

Limitations in the scope of midwifery practice hampered the advancement of midwifery components of the project, and this was further impacted by poor leadership among the midwives professional association despite calls for collaboration from the obstetricians and gynecologists association.

Caution needs to be exercised in interpreting this evaluation due to the inherent limitations of a desk-based enquiry of this evaluation and the limited input of stakeholders.

9. RECOMMENDATIONS

9.1 FIGO

- Terms of Reference (TOR) for the in-country project team members should explicitly state their responsibility for financial accountability, and the TORs should specify how this can be achieved.
- FIGO could consider conducting an assessment of project and financial management skill on the ground, or be assured of plans to obtain the appropriate skill (through including the assessment as part of a TOR for employing a Project Administrator); or through supporting attendance at financial management training as a capacity building activity.
- FIGO may consider implementing a system of simple in-country audit checks of projects to verify the quality of financial expenditure against outputs, and of the financial management system.
- Longer in-depth training on the use of a logframe as a management tool should be considered for project staff and more individualised training for country programmes in developing feasible logframes. Support should also be provided for the regular review and up-dating of these logframes with inputs from the project team.
- Provision for translators needs to be made in countries where language barriers limit communication between Mentors and their counterparts.

9.2 The project team

- In order to attract and secure donor funding, ensure key personnel are familiarised with donor reporting requirements – this is important to ensure sustainability of efforts and for linking with donors and to assure donors of accountability in reconciliation and reporting of funds. This could entail attending professional courses in proposal writing financial/grant management. This would develop capacity for KOGA in the leadership of programme implementation.
- Developing a human resources structure that is stronger in communications, particularly in other languages (eg. English / German / French) that would facilitate communication with large donors by reducing communication barriers.
- The KMA would benefit from a revision of its constitution and several key strategic activities that would raise its profile. KOGA could support the KMA in achieving professional recognition by supporting these activities, and in advocating for appropriate changes in the Association, in particular[10]:
  - Addressing governance: this requires regular and frequent meetings of the Board, revision of a transparent and accountable constitution that includes the free and fair election of a President on a regular basis.
  - Establishment of portfolio of services for the membership. Services could include: regular information of the membership on development in midwifery in Kosovo and abroad, information on opportunities for continuous professional development, training opportunities through association, and legal assistance for members.
  - Engage in advocacy work for the rights of midwives, development of the extended scope of midwifery practice, advancement of basic and continuing education for midwifery and improve communication skills among KMA leadership, including computer skills.
  - Encourage greater engagement of KMA membership in advancing the KMA agenda through the formation of committees addressing a range of professional issues (such as fund raising, protocols, ethics, etc).

[10] Adapted from the Midwife Mentor Trip Report from May 2009.

Annex 1: Summary Health Profile Kosovo (from 2005)

Taken from http://www.unfpakos.org/demographicProfile.htm [Accessed on 29 March 2011]

Persons: number, age & sex distribution

			Female	Male
Population estimate:	2,000,000	% 0 - 14 years: % 15-59 years: % 60 & older:	31.7% 58.4% 9.9%	34.5% 56.9% 8.6%
Male : Female ratio for ages 0-19:	107-109:100.0(2003)			
Crude birth rate:	23/1000 (2003)			
Crude death rate:	7/1000 (2003)			
Rate of annual increase:	14.6/1000			
Life Expectancy :	75 years (2003)			
Illiteracy rate of those 7y & older:	5.95 %		9.1 %	2.8%
% of workforce unemployed:	53%			

Reproductive Health

Perinatal:

Maternal death ratio:	Unknown*	Official Government data based on hospital records indicate 6.9, however health information system is not functioning and data from private health facilities are not reported at all.
Reported infant mortality rate:	23.7 / 1000	
Adjusted infant mortality rates based on survivorship of children ever born:	49 / 1000 (2003 D/RHS)	
Perinatal deaths:	22.8 / 1000	
Neonatal deaths:	9.7 / 1000	
% of Caesarean section:	14%	
% of pregnant women who had 0 to 2 medical visits during their pregnancies:	47% (1999)	
% of newborns delivered in health facilities:	95% (1999)	

Women's fertility, contraceptive prevalence:

Total Fertility Rate	2.9		
Contraceptive Prevalence Rate:	**1999**	**2003**	**2006**
	32.0%	55.0%	26.2%
Usage of modern contraceptives:		**2003**	**2006**
		23.0%	26.2%
Usage of traditional contraceptive methods:		**2003**	**2006**
		32%	29.7%

Sexually Transmitted Infections (STI):

STI prevalence & incidence:	No data. Pristina Clinical University Centre Blood Transfusion Unit tests donated blood & special requests for syphilis, hepatitis B&C, & HIV.		
New HIV cases reported to Institute of Public Health:	**2000**	**2001**	**Total since 1986**
	6	11	65
Main means of HIV transmission	thought to be from needle sharing among intravenous drug users		
TB Prevalence:	67.4/100,000 (2002)		

Annex 2: Stakeholders contacted

Project contacts	Name	Organisation / Country	Date of interview	Level of Participation
Project Manager	Dr Albert Lila	Project Manager	29 March 2011	SSI by telephone
Obstetric – Gynaecology Mentor	Dr Ferdiand Pauls	SOGC Representative	30 March 2011	SSI by telephone
Midwife Mentor	Ms Cathy Ellis	SOGC Representative	31 March 2011	SSI by telephone
FIGO Financial Administrator	Mr Raj Waghela	FIGO, UK	29 March 2011	SSI by telephone

SSI – semi-structured interview

Annex 3: Documents reviewed

Listed in chronological order

Title	Author	Date
Reduction of the maternal and newborn mortality in Kosovo	KOGA with KMA	April 2005
Demographic, Social and Reproductive Health Situation in Kosovo, Results of a Household Survey, July 2003	SOK & UNFPA	2005
FIGO Project Annual Narrative Report, 2007	Dr Albert Lila, Project Manager	19 April 2008
FIGO Reduction Of Maternal and Newborn Mortality In Kosovo	Rachel Cullen, Options	July 2008
FIGO Project Annual Narrative Report, 2008	Dr Albert Lila, Project Manager	17 March 2009
FIGO Project Annual Narrative Report, 2009	Dr Albert Lila, Project Manager	(no date on document)
FIGO Project Annual Narrative Report, 2010	Dr Albert Lila, Project Manager	Draft, March 15 2011
Perinatal situation in Kosovo for 2000-2010	Prof. Dr. Shefqet Lulaj	March 2011
Comments on original logframe	Options	(No date, assumed to be 2006)
Trip reports	Ms Moya Crangle	Apr 25-29 2010
	Mr Raj Waghela	Jul 21-23 2009
	Dr Ferd Pauls	Jan 10-15 2007 Apr 21-29 2007 Oct 08-17 2007 Apr 07-14 2008 Nov 15 -22 2008 Oct 12-18 2009 Feb 07-18 2011
	Ms Cathy Ellis	Apr 21-29 2007 Nov 15 -22 2008 May 16-22 2009 May 10-18 2010

Annex 4: TORs

FIGO Saving Mothers and Newborns (SMN) Project Final Evaluation
Terms of Reference

Background:

The goal of this 4 year project has been to reduce maternal and newborn morbidity and mortality and contribute to the achievement of MDG goals 4 and 5 in a series of low income countries. Secondary objectives of the project include:

5. Strengthening the capacity of national professional societies to engage in maternal-newborn health through the design and implementation of projects in the field;

6. Strengthening cooperation between FIGO and national societies, and also between societies in regions or of different economic levels;

7. Strengthening cooperation between national societies and national stakeholders involved in safe motherhood and newborn health;

8. Increasing the credibility of national societies locally to provide technical support to Ministries of Health and national professional councils.

The project has been implemented in a number of countries wherever possible through twinning mechanisms between ob/gyn societies of developed countries with those in the implementing countries (north-south partnerships). In turn, the ob/gyn societies in the low income countries were expected to partner with national midwifery societies, Ministries of Health, civil society organisations and other relevant stakeholders to ensure harmonisation of the project with the health policies and practices in the countries and the proper implementation and sustainability of the tenets of the project
The key innovation of this initiative has been to increase women's access to new, cost-effective and evidence-based technology for the reduction of maternal and newborn mortality in the countries concerned. Thus, the individual projects should have included staff training and re-training using modules such as the ALARM International program, maternal mortality audits, improvement of antenatal and delivery services, improvement of emergency obstetrics care (EOC) in selected districts, the development and dissemination of obstetric management protocols and algorithms, introduction and dissemination of partogram monitoring of labor and consolidation of the use of essential drugs like misoprostol and uninject for the prevention and treatment of post-partum hemorrhage. Projects were also intended to work with local communities to increase awareness on issues related to safe motherhood, and to promote increased utilisation of interventions to reduce maternal and newborn morbidity and mortality.

Scope of work (general):
FIGO has engaged Options to undertake a final evaluation, in the form of a critical review, of each project and to provide individual country reports and an overall evaluation report to submit to the funder (SIDA). These reports will summarise and state to what extent the objectives of the project have been achieved.

Individual projects have been sited in ten countries and individual reviews are required for each project. Five reviews will take place in-country (Peru, Uganda, Pakistan, Haiti and Nigeria) and five will be desk-based (Kosovo, Kenya, Moldova, Uruguay and Ukraine). The reviews will take place between April 2010 and July 2011. Concise individual reports

will be submitted to FIGO after each review. A summary report will also be prepared when all reviews are completed.

FIGO recognises that measuring the maternal health impact of this project is not feasible. However there may be areas/examples where this has occurred. In this case, vignettes could be provided in the report to illustrate this. This final evaluation needs to take into consideration and highlight in the report the fact that the project has had limited funding.

Objectives of each review:

- To evaluate the acquired capacity of the ob/gyn and midwifery society to conduct projects relevant to the promotion of safe motherhood and the improvement of maternal health
- To report on and evaluate any of the following indicators that were listed in the initial project proposal:
    - Improvements in access to essential obstetrical care services and new technologies
    - Improvements in access to skilled birth attendants
    - Improved health facilities
    - Lowering of maternal case fatality rate
    - The level of community mobilisation and participation
    - Improvements in access to health facilities with basic equipment, supplies and medication for basic obstetrical care services and new technologies such as tamponade and uniject
    - How social and cultural barriers to maternal care have been identified and addressed
    - Improvements in collaboration and the engagement of health providers, governments, community organisations and civil society to understand why women and newborns are dying and how to prevent it
- To describe what the project has meant to each country project and professional society as well as FIGO as an organisation
- To list the lessons learnt for FIGO
- To present the successes, challenges and shortcomings of the project, together with a discussion of possible recommendations for the future direction for each country's project (if the project is continuing beyond the period of FIGO funding)

Desk review to include (Kosovo):

• A series of phone interviews with key individuals within the project including the partners etc. (A full list of interviewees will be provided in advance of the review).
• A critical review of any written material (narrative reports etc), and other evidence individuals in the project can cite to support the endline review.
• Interviews with mentors, FIGO staff and SMNH Committee members as necessary.

A draft interview schedule will be provided before the evaluation, together with a draft report structure. However, the consultant will need to use his/her professional judgement in deciding if there are other issues that also need to be explored and/or which key issues need to be investigated in greater depth than the draft interview schedule provides. Both qualitative and quantitative evidence should be presented in the report to support the consultant's findings.

A brief summary of the project is provided at the end of this document.

Deliverables:

Report of the individual country evaluation. (Individual country reports will be approximately 10 pages long, although this will be confirmed prior to the evaluation).

Timeline:
The evaluation will occur following completion of the project's funding from FIGO and SIDA (December 2010). It is intended that the project will have submitted final documentation which will be made available to the consultant, as will other key documents such as the report of an earlier baseline review, annual narrative reports etc.

The desk-based review will take place between 29th and 31st March. **The total assignment should take no more than 5 days**. The breakdown of days is:

1 day	Preparation
3 days	Review
1 day	Report writing

The evaluation should be submitted to Options 10 days after the review. Options will provide the first comments on the draft written outputs within 2 weeks of submission and will share the report with SOGC for feedback. The consultant will finalise written outputs, responding to comments received, and submit final versions within two days of receipt of comments.

Languages:
English is the language requirement for this assignment.

Summary of the Kosovo project:

Project title: "Capacity building for reduction of maternal and newborn mortality in Kosovo".

This FIGO project aims to strengthen the organisation and management of the Kosovo Obstetrical Gynaecology Association (KOGA) and Kosovo Midwives Association (KMA), to improve the quality of maternal and neonatal health care, to create a partnership between KOGA and KMA as well as with women's civil society organisations. The clinical component of their project is based in three institutions: the regional hospitals of Gjakova and Prizren, as well as the tertiary centre of University Clinical Centre of Kosovo (UCCK) in Pristina. The main activities of the project are the provision of training, conferences and continuing medical education and the development and implementation of protocols, a strategic plan and a health information system. The final phase of the project has a community awareness component.

Annex 5: FIGO report framework

Table reporting indicators for Output 1: To strengthen the organisational capacity of KOGA and KMA to participate in national/regional initiatives (as reported)

	Baseline (before 2008)	2008	2009	2010
% of KOGA staff trained in project cycle management	2	7	0	5
No. of projects awarded *	1	2	3	1
No. times KOGA appears in media	10	15	20	25
No. meetings between KOGA and Civil society organisations	4	4	4	6
No. (%) KOGA members sensitised at SRHR at each site		32- 15%	47-22%	> 50%
No. (%) KMA		10- 5%	15-8%	>25%

[a] Not reported for each separate site.

Table reporting indicators for Output 2: To assume a leadership role in the development and implementation of national standards and protocols related to maternal and newborn care in 3 pilot sites (which results in improved maternity care and improved health of women)

	Baseline (before 2008)	2008	2009	2010
No. of new national protocols developed	0	0	0	0
Gjakova				
No. staff trained in AIP*	Not reported	Not reported	Not reported	Not reported
No. of ANC notebook distributed	2,500	2,500	2,500	2,500
No. of (%) women with ANC notebook	5%	15%	20%	30%
Prizren				
No. staff trained in AIP*	Not reported	Not reported	Not reported	Not reported
No. of ANC notebook distributed	4,000	4,000	4,000	4,000
No. of (%) women with ANC notebook	10%	15%	20%	25%
Pristina				
No. staff trained in AIP*	Not reported	Not reported	Not reported	Not reported
No. of ANC notebook distributed	5,000	10,000	10,000	10,000
No. of (%) women with ANC notebook	0	10	17	25

* Four midwives were trained in AIP prior to the FIGO project trained and one during the project.

Annex 6: Conferences and training events held through the FIGO project or in collaboration with the project

(only events that were verified by reports or trip reports are listed in chronological order)

Date	Title of training event	N° of attendees	Collaboartion?
2007	**First National Symposium for Midwives: "Role of Midwife, before, now and in the future"**		UNICEF, WHO
April 24-26 2007	**AIP**, Pristina.	27	
April 27-28 2007	**Annual Conference of KOGA 'Days of Feto-Maternal Health'** (focus on introduction of 9 protocols developed through the project, and development of KOGA strategy and activities)	Included KMA members, Women health group / I NGO and MOH representatives	KOGA, Kosovo Paediatric Association (KPA) and KMA supported by WHO, UNFPA and UNICEF, FIGO – SIDA, SOROS and under authority of Ministry.
2008	5 CME workshops held at Gjakova Maternity.	>100	
November 17 2008	AIP Instructors workshop in Prishtina.	6 AIP instructors + Project director	
November 18-20 2008	AIP course in Gjakova	33 KOGA & KMA members including family doctors	
2008	30 % membership trained in SRH & R approach, in pilot site of Gjakova hospital	(Dates & number of participants on these training days not reported)	
November 21 2008	**Capacity building workshops** for KOGA and KMA (project cycle management, financial management, monitoring & evaluation)	50% staff trained, board & local executive committees (Dates & number of participants on these training days not reported)	Ms Liette Perron, the Manager of the SOGC Partnership Program.
April 10 2008	**Perinatal Annual Conference** presenting findings of the Perinatal Situation in Kosovo 2000 to 2007.	(attended by Project Mentor, Dr Pauls)	MoH, WHO, UNFPA, UNICEF, Institute of Public Health, and FIGO.
May 21-22 2009	**Annual conference of KOGA** (including 6 training courses in antenatal care, US screening, building of skills on advocacy for reproductive health, neonatal restitution certification & laparoscopy theory.	> 300	

Date	Title of training event	N° of attendees	Collaboartion?
August 27 2009	**Turkey-Kosova Reproductive Health Conference**: a forum for sharing experiences (comparisons of provision of RH in both countries, projects in RH in turkey) and some technical updates (use of dopplar, fetal originas of adult diseases, infertility, ovarian cancer, invasive foeatal procedures).		Turkish Perinatalogy Association
May 13-15 2010	**KOGA Annual Conference: 'Together for Healthy Women & Children'** (included 6 training courses on antenatal care, ultrasound screening, building of skills on advocacy for reproductive health, neonatal restitution certification, inferitility & about national st&ards developed by KOGA)	> 350	Organised jointly with the RCOG & funded by the Prime Minister's office, Ministry of Health, Pharmaceutical companies, WHO, UNICEF, UNFPA, USAID-AIHA, RCOG. (Reported extensively in Narrative report 2010).
March 11-13 2010	**Foetal echocardiography**	25 gynaecologists & 5 paediatrics	Support from MoH' provided (It is not clear whether this is financial support or Ministry approval).
November 25-26 2010	**Future of gynaecology-oncology** & training for Colposcopy	> 200	ESGO (European Society of Gynaecological Oncology).