COUNTRY COVID-19 INTRA-ACTION REVIEW (IAR)

REPORT

Kosovo
5 October - 8 October 2021
Pristina

1. EXECUTIVE SUMMARY

WHO Europe, in partnership with EU Western Balkan project funding, conducted a COVID-19 Intra-Action Review (IAR) in Kosovo[1] between 5 and 8 October 2021. The main objective of the IAR mission was to provide an opportunity to share experiences, collectively analyze and systematically document the ongoing response to COVID-19 by identifying challenges and best practices, and accordingly propose priority actions. The comprehensive review approach requested by Kosovo also offered an opportunity to review preparedness and response functions in general resulting in long-term priority actions that can feed into generic health system strengthening and capacity building activities beyond COVID-19.

Seven pillars were reviewed in total including case management, Infection Prevention and Control (IPC), surveillance, country-level coordination, national laboratory system, risk communication and community engagement and Public Health and Social Measures (PHSM). This pillar selection was based on Kosovo´s request and priority needs and the review process was supported by a number of background documents including earlier assessments and capacity building missions. This mission was also supported by Germany's Robert Koch Institute.

A number of best practices were identified including the activation of multidisciplinary and interinstitutional expert committees for enhanced coordination and harmonization of protocols, leveraging on existing capacities such as the well-established incident management system, staff commitment, ability to rapidly mobilize volunteers and other medical staff, and reallocation of beds and facilities in response to the increasing number of hospitalizations. Furthermore, as best practices the participants mentioned significant expansion of laboratory capacity at national and regional level, training activities and knowledge exchange with other countries and international partners across the pillars, active use of social media for risk communication and 24-hrs toll-free helplines, epidemiological data analysis to support decision making as well as rollout of other studies (e.g. vaccine effectiveness and seroprevalence).

The participants brought up several common challenges. These included inadequate and out-of-date legal framework on communicable diseases, scarce and not sustainable government funding to public health system linked to chronic understaffing in all technical areas, deficient quality management, digital health infrastructure and interoperable electronic registers, old or inadequate laboratory and hospital infrastructure and interrupted testing and diagnostics of other pathogens and diseases. The participants also mentioned communication challenges to hard-to-reach and vulnerable populations (e.g. no print media for those normally relying on the format), pandemic fatigue and compliance to Public Health and Social Measures (without appropriate economic support to alleviate negative impacts), that subject-matter experts weren´t sufficiently involved in recruitment of new staff, vaccine hesitancy, lack of official protocols for patient transportation from clinics to intensive care units, shortage of PPE stockpiles, and no systematic evaluation of IPC compliance in healthcare facilities.

The IAR discussions resulted in the following 13 cross-cutting priority actions to improve the current COVID-19 response and strengthen Kosovo´s preparedness and response to epidemics in general including:

Short-term actions

- Accelerate the review and revision of the legal framework on communicable disease prevention and control (including emergency procurement).

[1] All references to Kosovo should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

- Extend contracts for surveillance, laboratory and hospital staff working on short-term contracts currently running until end of 2021 and secure involvement of subject-matter experts in the recruitment process of new staff.

- Maintain current laboratory testing, surveillance and emergency response capacities after 2021.

- Develop a laboratory information management system for COVID-19 (and subsequently expand to other pathogens).

- Provide continuous training for health care workers (in particular on IPC and cause of death assessment).

- Address pandemic fatigue with appropriate economic and social supporting mechanisms and communication campaigns.

Mid-to long-term actions

- Develop a long-term public health workforce strategy including mapping of the competencies and profiles needed in future across the public health-related disciplines.

- Develop and cost a National Action Plan for Health security based on available assessments and reviews.

- Ensure sustainability of preparedness and response capacities developed during the pandemic by gradually increasing government funding for public health.

- Accelerate development of the health information system, including full digitalization of surveillance and laboratory information systems.

- Establish a national public health research network and strengthen research capacities and infrastructure across all the response pillars.

- Revise academic curricula of health-related programmes and risk communication and implement or ensure access to international stand-alone training modules to meet the changing job requirement needs

- Procure a stock of medical supplies and equipment and establish a structure for essential stockpile management and distribution

Building on the momentum of the IAR process, the Minister of Health in Kosovo, Dr Dafina Gexha, convened a high-level debriefing of financial and technical partners on the IAR outcome, including the key challenges and best practices for each pillar, and the immediate and long-term recommendations. A consensus was reached amongst partners to ensure and support the implementation of recommendations to improve the current COVID-19 response and strengthen Kosovo´s preparedness and response to epidemics in general.

2. Acronym list

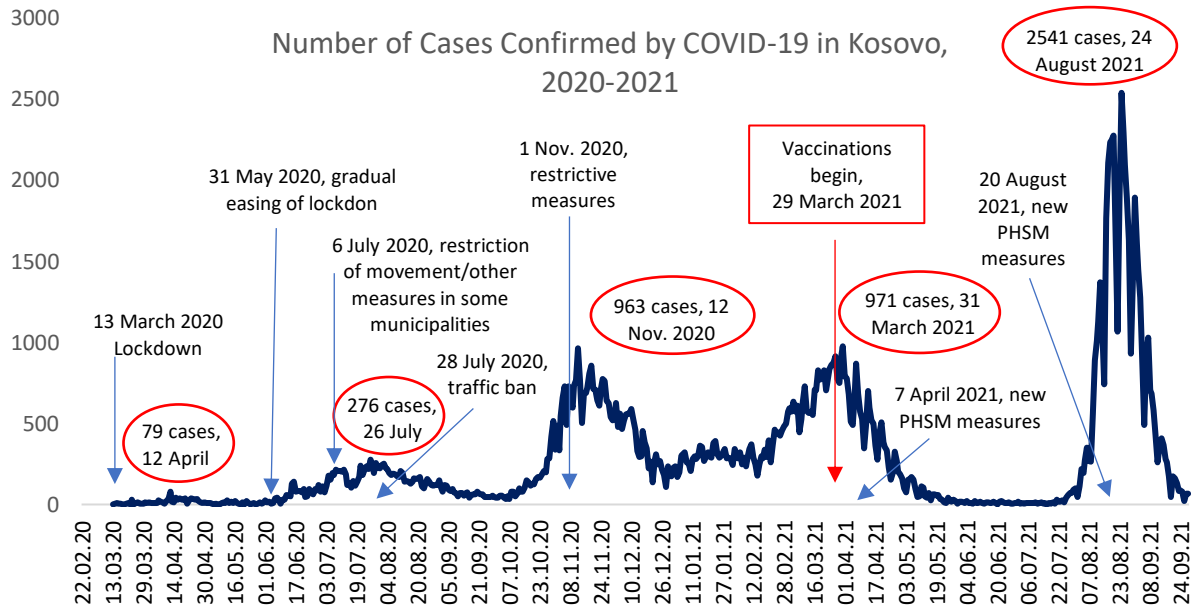
AMR	Anti-Microbial Resistance
BI	Behavioral Insights
CM	Clinical Management
COVAX	COVID-19 Vaccines Global Access
COVID-19	Coronavirus disease 2019 (SARS-CoV-2)
CPH	Centers of Public Health
ECDC	European Center for Disease Prevention and Control
EOC	Emergency Operations Center
HCW	Healthcare worker
IAR	Intra-Action Review
IMS	Incident Management System
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
IPC FTE	Infection Prevention and Control Focal Point
IPH	Institute for Public Health
KAP	Knowledge, Attitudes and Practices
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOIA	Ministry of Internal Affairs
NGO	Non-Governmental Organization
NIPH	National Institute of Public Health of Kosovo
NITAG	National Campaign Plan for Vaccination
PH	Public Health
PHC	Primary Health Care
PHEIC	Public Health Emergency of International Concern
PSHM	Public Health and Social Measure
PPE	Personal Protective Equipment
PSA	Public Service Announcement
RCCE	Risk Communication and Community Engagement
RKI	Robert Koch Institute

SOP	Standard Operation Procedure
TBD/TBC	To be determined/To be confirmed
ToR	Terms of Reference
ToT	Training of Trainers
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO EURO	World Health Organization Regional Office for Europe
WHO	World Health Organization

3. CONTEXT OF THE COVID-19 RESPONSE AND OBJECTIVES OF THE IAR

2.1 Context of the COVID-19 situation and response

The first two cases of COVID-19 were reported on 13 March 2020 and as of 12 October 2021, a cumulative total of 160,421 cases and 2,963 death cases were reported across all municipalities. From the outset of the pandemic the Ministry of Health (MoH) and National Institute of Public Health (NIPH) developed the National Emergency Preparedness and Response Plan for COVID-19 Pandemic, which has been guiding the response activities over time. Kosovo has experienced four waves of the pandemic and the highest number of cases were reported during the latest fourth wave in August-September 2021. However, the true attack rate in the country is likely higher due to underreporting and under-ascertainment of cases.



2.2. Objectives:

Recognizing the importance of constant improvement of the COVID-19 response system, the MoH decided to conduct an Intra-Action Review (IAR) of the response and requested WHO to support the planning and facilitation process. Overall, the IAR aimed to identify immediate, mid-and long-term actions to be taken to improve the current COVID-19 response and strengthen Kosovo's preparedness and response to epidemics in general.

The specific objectives of the COVID-19 IAR in Kosovo were:

- To provide an opportunity to share experiences and collectively analyze the ongoing in-country response to COVID-19 by identifying challenges and best practices;
- To identify immediate, mid-and long-term actions to be taken to improve the current COVID-19 response and strengthen Kosovo's preparedness and response. To facilitate consensus building among and the compiling of lessons learned by various stakeholders during the response to improve the current response by sustaining best practices that have demonstrated success and by preventing recurrent errors;
- To document and apply lessons learned from the response efforts to date to enable health systems strengthening;

- To provide a basis to validate and update the Country COVID-19 strategic preparedness and response plan and other strategic plans accordingly.

4. METHODOLOGY OF THE IAR

Date(s) of the IAR activity	5 – 8 October 2021
Location(s)	Pristina, Kosovo
Set-up	☐ Online ☒ Onsite ☐ Mixed (online and onsite)
Participating institutions and entities	▪ MoH (Secretary general, EOC, Legislation department, Financial department, logistic and procurement departments, pharmaceutical department communication) ▪ National and sub-national IPHs (surveillance, laboratory, IPC, emergency management) ▪ Hospital & University Medical Center (clinical case management) ▪ Ministry of Internal Affairs ▪ Sanitary inspectorate (AUV) ▪ Ministry of Finance ▪ EOC within Ministry of Internal Affairs ▪ Primary Health Care ▪ Partners (UN, WB, EU, Embassies and other NGO)
Total number of participants and observers (if applicable)	60 participants + 13 observers/external facilitators = 73 total
Period covered by the review	January 2020- September 2021
Response pillar(s) reviewed	☒ Country-level coordination, planning and monitoring ☒ Risk communication, community engagement, and infodemic management ☒ Surveillance, case investigation and contact tracing ☐ Points of entry ☒ National laboratory system ☒ Infection prevention and control ☒ Case management and knowledge sharing about innovations and the latest research

	☐ Operational support and logistics in the management of supply chains and workforce resilience ☐ Strengthening essential health services during the COVID-19 outbreak ☐ COVID-19 vaccination ☐ Vulnerable and marginalized populations ☐ National legislation and financing ☒ Public health and social measures ☐ Other possible topics and cross-cutting issues (please specify): -

Methodological details	The participants contributed to the review of their pre-identified pillars, mentioned above. The IAR took place over 3 days at a hotel and for each response pillar, the review structure was similar including three standard steps after the introduction: *Introduction*: Overview of the epidemiological situation in Kosovo was presented on the first day and response measures in each pillar were summarized prior to the detailed review discussions. This allowed establishment of a baseline for the review. *Step 1:* What went well? What went less well? Why? Based on the overview of the ongoing response, the discussion started to identify and analyze what worked, what did not work so well and why. Participants collectively analyzed actions undertaken during the COVID-19 response to date, identified the best practices and challenges, their impact on the response and why they occurred (the enabling/limiting factors). *Step 2*: What can we do to improve the response? Participants identified and developed activities to address the causes of the challenges identified in the current COVID-19 response as well as activities to institutionalize best practices. *Step 3*: Way forward. A preliminary implementation plan for these activities was developed. Among the activities, participants identified what can be addressed immediately to improve the ongoing response; and what can be done in the mid or long-term to improve the response and to strengthen the health system in general (beyond COVID-19). Participants considered the establishment of a follow-up team to document progress in implementing the key activities identified. On the final day of the mission, the preliminary findings were first presented (by the respective country focal points in each pillar) to all expert participants followed by a general discussion. Thereafter, the Minister of Health presented findings to high-level representatives (international partners, donors, national decision-makers).

5. FINDINGS

Pillar 1. Country-level coordination

Pillar Description

This pillar reviews the operational, tactical and strategic coordination of the response, including the activation and operations of an incident management system (IMS) and the emergency operations center (EOC) for decision making, management and quick intervention. In addition, this pillar reviews the functioning of procedures and platforms for coordination with various health and non-health sectors of the government, national and international partners and stakeholders, including UN, NGOs, donors and private industry. Ultimately, this pillar reviews whether coordination at all levels was enabled rapid information dissemination, resource mobilization and sharing, efficient decision making and effective distribution of roles and responsibilities.

General Observations

Kosovo-level planning and coordination is one of the response pillars of the Strategic Preparedness and Response Plan for COVID-19 which Kosovo launched in April 2020.

The key activities under this pillar included to 1) apply existing public health emergency preparedness and response plans, 2) brief and prepare existing national emergency response committee/s, 3) engage decision-makers and politicians , 4) prepare supportive financial resources for response operations, 5) review and prepare the legal basis for all public health response actions, 6) develop plans for essential service continuity and recovery operations, 7) conduct risk assessments to inform response actions, 8) establish procedures to share data and risk assessment findings with national and international stakeholders, 9) activate interinstitutional coordination mechanisms to support preparedness and response, 10) conduct a simulation exercise to test response mechanisms , 11) engage with donors and existing programs to mobilize/allocate resources and capacities to implement operational plans, and 12) prepare supportive financial resources for response operations.

The review of this pillar included key stakeholders from the government and partner organizations. Those are Ministry of Health, National Institute of Public Health, Academia, UN Resident Coordinator's office, UNICEF and UNDP.

After a thorough discussion and experience sharing from participants, a group consensus was reached, and 9 challenges and 8 best practices were identified around coordination, planning, human resources and legal framework.

6 short term and 3 mid to long-term priority activities were formulated to strengthen Kosovo-level coordination of the COVID-19 response.

***** Please note that TBD is used when this level of detail wasn't discussed.***

PILLAR:	Country-Level Coordination		
BEST PRACTICES		**IMPACT(S)**	**ENABLING FACTORS**
1.	Inclusion of all institutions in a multi-disciplinary manner for COVID-19 response.	Makes collaboration across institutions much easier & more streamlined Approximately 300 decisions made by the Government & Ministry of Health during the pandemic response. MoH has been mandated to monitor those decisions and the implementation supported by other institutions.	The existing laws and response plans (emergency response). Institutional responsibilities.
2.	Existence of cost analysis tools for policies, plans and legal documents.	Implementation of the plan (for each one). Mobilization of funding to support implementation of plans or policies. Effective use of resources (funding).	Institutional responsibility for the policy production and implementation. Done by special committee (Commission for Policy Costing).
3.	Existing funding mechanism for emergency response (government emergency funding, semi-annual budget law review, and repurposing of funds from other budget lines).	Prevents overspending/depletion of emergency fund. Allows MoH capacity to rapidly deliver funds in case of acute emergency. Lowering morbidity and mortality in the context of COVID-19.	Ministry of Health maintains ability to allocate or not allocate funding in specific cases.

4.	Creation of a separate account, opened on behalf of government for private sectors to donate funds for COVID-19 response.	Allows MoH to reallocate funding where there are gaps.	Solidarity and reciprocity.
5.	Existence of national coordination mechanism against COVID-19 (NITAG, mass immunization plan, June – Present).	Population will be immunized against COVID-19 Approximately +1,400,000 citizens vaccinated within 3-month timeline.	COVAX initiative- Bilateral agreement with Pfizer. Vaccination campaign enabled by donors. Public health impact of vaccination campaigns and communication for citizens. Presence of national campaign plan for vaccination (NITAG).
6.	Implementation of measures imposed by government upheld by law enforcement officers (e.g., police).	More people will adhere to public health and social measures. Decreases infection spread.	PHSMs imposed by government upheld by law enforcement.
7.	Mobilization and immediate support by partners and donors.	Drugs, equipment, PPE and ventilators immediately available for use via strategic partners.	Existence of in-country mechanism for coordination of technical assistance. EU coordination mechanism for assistance.
8.	Support and response by health professionals and essential workers (i.e., emergency responders, primary caregivers, ICU, etc.).	Prevention of infection spread while offering essential health services at all levels and uninterrupted continuation of essential services.	Legal and institutional responsibilities on behalf of workers and health care professionals. Government decision regarding those working in essential services.
9.	Existence of an incident management system and emergency operation centers.	Scaling up of the response. Coordination, communication and intersectionality.	Activization of national preparedness plan and its supporting functions.

10.	Presence of multisectoral response due to COVID-19		
11.	Activation of national response plan	Subsequent development of the following: • National plan for immunization against covid-19 • Plan for massive vaccination of citizens of Kosovo • Plan for testing and investigation of COVID-19 • Plan for expanding capacities in health care facilities • Guidelines for protection from COVID-19 (7 versions) in different fields (9-10 guidelines).	TBD
12.	Availability of funds from donors and government early in pandemic	TBD	TBD
13.	Involvement of NGOs, CVO, CBO and private sector	TBD	TBD

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Lack of clarity and knowledge regarding individual responsibilities of different responsible institutions for pandemic management at the beginning of the pandemic (i.e.,	Confusion of roles between actors and institutions. Lack of coordination/understanding	No initial experience on management and coordination of a pandemic of this scale. Lack of specific provision within legal framework regarding clarity of roles.

	ministries, municipalities, law enforcement, etc.).	between ministries/actors and those working in the field.	No simulation exercises or plans tested. Hesitation to make timely decisions in the face of an unknown disease.
2.	Absence of adequate updated legal framework regarding communicable diseases.	Law did not hold up in court and was easily overturned. Inadequate enforcement regarding PHSM/other measures implemented to prevent infection. Problems in implementation.	Law enacted in 2008 is outdated and includes organizations that no longer exist and does not consider pandemic of this scale (COVID-19).
3.	Lack of coordination of funding from donors to meet country's needs and priorities.	Lack of access to fund policies and action plans.	Donor funding primarily handled by outside international organizations rather than local government entities.
4.	Difficulty with ongoing communication with northern municipalities throughout pandemic timeline.	Lack of focal persons/contacts. Reliance on UN and local contacts to establish communication.	Lack of compliance and responsiveness with government decisions that have been made.
5.	Inadequate allocation/distribution of human resources across the country throughout pandemic timeline.	Not enough personnel available considering capacity/volume of infected persons (borders, etc.)	Health workers were overstretched by high volume of work. Temporary solution only regarding 3-6-month short-term contracts. Lack of evidence-based planning for HR.
6.	Lack of evidence-based planning on COVID-19 response and monitoring framework.	Lack of reliable data. Lack of evidence-based decision-making.	Only provisional mechanism established during the pandemic. Lack of standard operating procedures (SOP) for monitoring in general.

		Lack of documentation for learning.	
7.	Lack of sustainable funding for the COVID-19 response and all hazards preparedness and response actions in general.	Kosovo cannot provide quality healthcare services to the public. Increase economic burden for citizens (out-of-pocket costs for health services). Delay in health operations.	Insufficient funding for the public health sector overall.

PRIORITIZED ACTIONS		DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT	INDICATORS
a. For immediate implementation:					
1.	Review and update the 2008, Law on Prevention and Control of Communicable Diseases.	January 2022 (Q1)	Minister of Health, Government, and Parliament (Kosovo Assembly)	Technical support Financial support provided by EU Political commitment	TBD
2.	Establish regular communication with Northern Kosovo municipalities in the context of COVID-19.	Immediately (Q421)	Ministry of local Government of Kosovo, Ministry of Community, Ministry of Health	Political support by EU office and UN agencies	TBD
3.	Regularly revise the national COVID-19	Immediately (Q421)	Minister of Health, Government of Kosovo	Technical support from international partners	TBD

	strategy based on lessons learned and other scenarios in the context of COVID-19.			Financial support from partners	
4.	Allocation of additional funds for the COVID-19 response via the Kosovo Government.	Immediately (Q122)	Government of Kosovo, Ministry of Finance, Parliament (Assembly of Kosovo)	TBD	TBD
5.	Extension of contracts for human resources through 2022 for COVID-19 response.	Immediately (Q122)	Ministry of Finance, Government of Kosovo	Financial support from the government and donors	TBD
6.	Reinforce coordination role of Ministry of Health within donor coordination meetings in partnership with World Bank.	Immediately (Q122)	Ministry of Health, partners	TBD	TBD
b. For mid to long-term implementation:					
1.	Develop long-term human resources strategy, including to support emergency preparedness and response. This includes mapping of the future workforce (10-year plan, 2022-2032).	Q4 2022	Ministry of Finance, Ministry of Health, Ministry of Public Administration, Government of Kosovo	Financial support Technical support of Ministry of Public Administration and partners Political will	TBD

2.	Revision of the Regulation for Donor Coordination	Q4 2022	Strategic Planning Office of the Government, Ministry of Health, line ministries	Technical support Financial support Political will	TBD
3.	Develop and cost National Action Plan for Health Security based on available assessments and reviews.	2022+	Ministry of Health, Ministry of Finance, Public Health Institute, Ministry of Interior	Technical support from WHO Financial support from partners Costs & national action plan	TBD

Pillar 2. Risk communication

Pillar Description

This pillar reviews the functioning of Risk Communication and Community Engagement in terms of ensuring effective exchange of real-time information, advice and opinions between experts and people facing threats to their health, as well as trusting relationships between at-risk communities and emergency responders that enable them to work together to address health-related issues. The pillar reviews the effectiveness and comprehensiveness of RCCE-IM plans (standard elements including listening, formative research and infodemic management; developing, testing, disseminating and evaluating messages and materials that are tailored to language, culture, education and other relevant needs; community engagement to build trust to co-develop and adapt public health measures; capacity building; coordination; working with the media; monitoring and evaluation; budget; and timeline) as well as available resources, staff, coordination, and monitoring and evaluation. This pillar aims to identify areas for strengthening transparency and trust in managing public concerns and building the capacity of communities resilient to misinformation and disinformation.

General Observations

Several best practices were identified during the review of the RCCE pillar response. Inter-agency coordination for communication activities and strong collaboration with international partners was established as an immediate response to the COVID-19 pandemic. In particular, it was noted that the “Interinstitutional Communication Coordination Group,” established in January 2020 and composed of communication experts of the Government, namely

the Office of the Prime Minister, the Ministry of Health and the National Institute of Public Health, created an enabling environment to bring relevant stakeholders and partners together in COVID-19 risk communication and response actions.

A strategic communication plan for COVID-19 was developed as an integral part of the strategic work of the Strategic Planning Committee and Strategic Planning Steering Group, and it was adopted for the months of July-September 2020. The document and communications activities were amended and updated accordingly over the course of the pandemic response.

Other similarly identified best practices included regular media briefings and updates held by the healthcare authorities on the progress of the pandemic response, the operation of several dedicated COVID-19 helplines and other services, the conduct of five waves of behavioral insights and other formative research studies, the recent establishment of the RCCE communication hub with partner support, as well as close cooperation between healthcare experts, health authorities, and mass media.

While collaboration and coordination have reportedly had a positive impact initially, over time RCCE capacities were challenged by pandemic fatigue and burnout, in addition to the shortage of appropriately trained RCCE specialists at both national and local level and a network of poorly trained health reporters, lack of updated RCCE Plan and relevant SOPs on different stakeholders' roles and responsibilities, as well as the absence of a consolidated infodemic management mechanism in place.

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PILLAR:	**Risk Communication and Community Engagement**		
BEST PRACTICES		**IMPACT(S)**	**ENABLING FACTORS**
1.	Use of official webpage developed by institutions followed by extensive use of mass and social media channels to communicate with target population from the very beginning of the pandemic.	Public was reached with critical health information, which was readily available, continuously disseminated and adapted accordingly. KAP surveys revealed a higher level of knowledge of COVID-19 amongst students, which was also positively related to the practice of preventive measures.	Coordination mechanism in place between health and non-health sectors. Regular media briefings press conferences and interviews. Close cooperation between healthcare experts, health authorities, and mass media.

2.	Collaboration between state institutions and key international partners is very strong and dissemination of information was coordinated.	High level of trust in state institutions based on findings of Behavioral Insights research studies. Coordination of all messages provided to the public.	Fear of COVID-19 led to high adherence to COVID-19 preventive measures, especially at the beginning of the pandemic.
3.	Reach out to all target population groups, including hard-to-reach and vulnerable populations: (*For example*: Critical communication material on COVID-19 was adapted into 7 languages, PSA videos were aired for free on TV networks, communication material was adjusted to local culture, recent door-to-door campaign targeting minority populations with no access internet (i.e., Egyptian population), visits to Roma communities with partners support from UN agencies and Government Ministers)	Targeted marginalized population groups were reached with information, i.e., Roma and Egyptian communities, migrant population. Increase of positive practice of health-related behavior, such as higher vaccination uptake at later stage of communication.	Available funding Support from international organization with funding and resources for producing communication materials, such as informative posters, banners, infographics, etc.
4.	Establishment of task forces (from January 2020) and committees/working groups for communications to review and approve communication material on a continuing basis (i.e., on health promotion and education)	Ensuring better coordination for accurate and up-to-date information. Useful/ Rational use of resources.	Experience with previous outbreaks showed what type of working groups worked, i.e., avian flu, measles etc. Existing mechanisms and working groups from previous responses, i.e., SOPs in place since 1999. Previous investment in preparedness activities, such as the development of essential public health operations, public

		Higher quality of communication products.	health emergency preparedness plan at the government and MoH levels.
5	5 types of 24h toll-free helplines and psychosocial support were provided to the public and maintained 1st hotline located at NIPH: Support from NIPH professional and volunteering students from medical faculties; 2nd hotline located at MoH's Operations Centre, in charge of coordinating all other institutions; 3rd hotline located at the Ministry of internal Affairs (questions related to lockdown) 4th hotline provided psychosocial support for citizens 5th hotline focused on domestic violence	Increased level of information provided to the population. Increased levels of trust and transparency.	Available funding. Volunteers from medical faculties, MoH/NIPH staff were mobilized and dedicated.
6	RCCE experts involved in relevant task forces (i.e., education task force)	RCCE response were incorporated in other sectors. Communication recommendations provided by RCCE experts.	Task teams were available at national, municipal and school/institutional levels, and requested input from RCCE experts.
7.	Heightened importance of RCCE activities during the pandemic led to increase in HR for RCCE at partner organizations and	Increase in RCCE staff. Increase in staff working on infodemic management, social	Additional resources.

	stakeholders supporting communication activities	media from international organizations.	
8.	Successful communication campaign, focusing also on vaccination for the period Jan – March 2021, taking into findings from recent waves of Behavioral Insights (BI) study	Use of BI insight data to better target campaign to priority populations. Successful communication impact campaign.	Five waves of BI study conducted, focusing on three components, knowledge, fear, vaccines CT.
9	BI studies conducted in 5 waves for internal use to target communication and outreach activities, as well as serve as basis for planning future communication activities.	Enabling evidence-based decision making Reducing knowledge gap of vaccine hesitant target group.	Lead by NIPH supported by WHO
10	Representatives from different stakeholders (religious communities, business associations, trade unions, sport associations, etc.,) were included in working groups since April 2021.	Increased acceptance and practice of PHSM introduced by government. Connecting different stakeholders and enabling needs assessment of stakeholders. Supported consensus building between stakeholders involved Participatory decision-making by stakeholders.	Establishment of working groups with a participatory approach. Previous year NIPH produced all necessary documents and SOPs, instructions were implemented in a common document and these instructions were made specific for each sector.

11	Recent establishment of **"Communication Hub"** with partners support to assist MoH with RCCE specialists to focus on addressing fake news	Operational in 3 weeks and will report to MoH	Support from partners.

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Daily newspapers stopped printing through the lockdown to move online and did not start printing again after the ease of pandemic restrictions. Lack of media measurement and monitoring services. No Internet domain name for Kosovo.	Limited reach of older age groups and other target populations relying on print press for information. Lack of reliable media measurement and monitoring services such as ratings, clipping, etc., impedes measurement of communication impact and performance. Tailored- made online communication activities are being impacted (i.e. Planning, targeting and messaging)	Online newspapers are a different, less-expensive business model the printed press. Expensive media measurement services. Kosovo lack its own top-level domain name and that may take some time to rectify.
2.	Shortage and lack of trained and qualified RCCE specialists at national and local level institutions	Overstretched existing staff dealing with RCCE tasks leading to staff burnout. Quality of RCCE products is impacted.	No sustainable budget for hiring or training RCCE specialists. PH specialization is not very attractive, i.e., medical staff not interested in PH specialization due to lack of incentive. HR Plan existing, but RCCE response not adequately addressed (strategy for health care promotion and education targeting media available, but postponed due to the pandemic).

		MoH communication staff were overburdened, especially at the beginning of the pandemic.	No dedicated long-term working group established to tackle all issues relevant to communication, including sustainable RCCE capacity building and training. Lack of trained communication group that will continue systematically plan and implement RCCE activities
3.	Lack of RCCE training for healthcare institution specialists, including media and journalists	Negative impact on quality of reporting Negative impact on health literacy Lack of specialized journalists and reporters on public health issues	Lack of time/capacity of existing staff to organize trainings. Training fatigue and the need for appealing technical trainings and qualified trainers. Lack of a RCCE training plan
4.	Large variety and increased number of media outlets, with some not using verified sources, resulting in increased demand for interviews and media inquiries	Increased workload for appointed experts to handle media inquiries Dissemination of rumors/disinformation if not addressed	Lack of established press and media services to be provided to the media on a continuous basis Lack of certified fact checking services Lack of appointed pool of experts from health care professionals to readily respond to media inquiries Lack of training on how to deal with media (technical and political level)
5.	No consistent mechanisms in place to deal fake news and infodemic management (i.e., there is no structure in place to collect and analyze this type of information)	No system to detect and manage rumors Disorientation of the public leading to non-compliance with PHSM	Lack of training on infodemic management Lack of social media listening and monitoring and other formative research mechanisms

6.	External factors affecting consistent communication and practice of PHSM and recommendations	Lack of consistent communication leading to non-compliance of population with PHSM, resulting to an increase of case numbers	Frequent political changes and government reshuffles, and changes of cabinet ministers Chronic fatigue of people working in communication due to workload Pandemic fatigue of population and vaccine hesitancy
7.	Fragmented research activities with no mechanism in place to coordinates all related research studies.	Duplication of work Waste of financial and human resources No prioritization of key pandemic communication issues	Different actors conducting research No coordinating mechanisms that oversees implementation of RCCE response activities
8.	Knowledge/information Management: Lack of internal database /digital catalogue which would consolidate all documents/plans as well as activity planning and overview of ongoing activities	Difficult to access relevant documents Lack of consistent information exchange between relevant institutions Lack of knowledge of ongoing activities	No coordinating mechanism/ capacity to establish and maintain database
9.	No systematic mapping of availability of community leaders and organizations that deal with community leaders who can communicate to vulnerable populations	Lack of feedback mechanisms of needs of vulnerable population	Difficulty to identify relevant community leaders No stakeholder mapping/situational analysis

10.	Lack of updated RCCE Plan, which is operationalized and includes updated SOPs on roles and responsibilities and on information exchange between stakeholders, to ensure coordinated activity planning across of levels (central to local)	Lack of coordination between stakeholders Lack of coordination on RCCE activities	Lack of political will, resources and time to invest in updating plan
11.	Current law that sanctions ppl who distribute fake news is not being enforced, not holding persons/organizations who spread misinformation	Continued spread of misinformation that is not being addressed. Reduction of vaccination uptake amongst key target population groups (i.e., due to fake news of expired vaccine, and other rumors and fake news being spread about vaccination)	Lack of adequate law enforcement practices Continued rumors/ misinformation by individuals/organizations
12	Social network campaigns were often conducted ad hoc and not based on evidence or on prior analysis in particular at beginning of pandemic Need to strengthen use of research data in policymaking as basis for communication campaigns	Fragmented messaging not reaching targeted population Wear out of key messages awareness	Lack of adequate coordinated use of research data

PRIORITIZED ACTIONS	DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT	INDICATORS

a. For immediate implementation:					
1.	Establishment of a working group on RCCE with agreed terms of reference to include relevant stakeholders	By end of 2021	MoH & NIPH	Support from partners including WHO, UNICEF	MoH decision for WG has been issued Finalization of ToR First meeting taken place
2.	Updating of existing national RCCE plan	By end of Oct 2021 to submit request of submission in order to have permission to update plan by Mid- 2022	Submission of request by office of MoH, Plan updating will be done by RCCE Working Group & partners	TBD	Updated RCCE Plan endorsed by the government
3.	Situation analysis and needs assessment for RCCE capacity building including training and human resources and identification of *community leaders* considering needs of all relevant stakeholders (i.e. MoH, NIPH, national& local)	March/April 2022	RCCE Working Group & partners	TBD	Situation Analysis Report Needs Assessment Report Human Resource capacities need to be clearly identified, mapped and costed to feed into annual budget
4.	Based on needs assessment results develop training package for different target groups (PH professionals, media etc.)	Mid- 2022	RCCE Working Group & partners	TBD	Outline and framework of training package
5	Engage with newly established communication hub to strengthen	Ongoing	Communication Hub (UNICEF supported),	Resources from partners and other donors	Operationalization of Communication Hub

	media and press services and tackle misinformation		RCCE Working Group & partners		Joint workplan with hub and RCCE working group Provision of package of services (i.e. media monitoring and social media listening) Infodemic Management training for communication staff and journalists # of awareness campaigns on traditional and social media
6	Identification and development of digital solution to improve internal /external knowledge/information management amongst RCCE stakeholders (research activities, RCCE activities and document management)	Q3-4 2022	RCCE Working Group & partners	Financial resources from partners (UNICEF, WHO) Communication Hub Information management specialist/IT	Information management platform established and maintained
b. For mid to long-term implementation:					
1.	Roll- out of training package (ToT cascaded) 1.1 Development of curriculum and training package 1.2 Application of trainings to medical chambers for accreditation	Q3- Q4 2022	RCCE Working Group & partners 4 medical chambers	Financial, logistical support Identification of trainers Training materials	Accreditation # of trainings and trainees

2.	Provision of psychological and well-being support for RCCE specialist	Support package to be determined by end of 2021 with rollout from 2022	RCCE Working Group	TBD	TBD

Pillar 3. Surveillance

Pillar Description

This pillar reviews the functioning of the surveillance and early warning system to timely collect, analyze and interpret signals; to diffuse information to decision-makers and to trigger appropriate response action. In addition, this pillar reviews the operations of the Rapid Response Team, including its activation, composition and training required to effectively conduct case investigation, contact tracing and contact monitoring. Finally, this pillar also reviews other technological innovations used to supplement contact tracing during the COVID-19 response.

General Observations

Case Detection: The new cases are detected through the family health centers, hospitals or contact tracing. Then symptomatic individuals are transferred for testing at the virology laboratory, Microbiology Department at Central IPH or any of the new labs in the regional IPH. The test turnaround time is 24 hours or less (especially in the regional labs).

Case Investigation and Contact Tracing: epidemiologists usually conduct the case investigation within 24 hours of receiving the lab results. During the investigation; contacts are also identified, listed, and classified to high and low risk and contacted in the same call if they are household contacts or contacted separately if they are not, within another 24 hours from the investigation. Symptomatic high-risk contacts are immediately sent for testing at IPH (national or regional).

Isolate and quarantine: IPH (national and regional) usually shares the name of individuals on self-isolation or quarantine with the police and the municipality inspectors to be monitored for 14 days. Epidemiologists also conduct few follow-ups calls within 14 days to check about the health status

and inform about the end of the isolation/quarantine period. Individuals are also advised to report symptoms immediately so they can be tested and transferred to the proper care.

Reporting, data flow, and the use of Go.Data: Every day the virology lab shared the results of samples tested with the epidemiology department via a google sheet. Then the results are shared with epidemiologists at the national and regional IPHs for case investigation and contact tracing. After the investigation cases are entered into an excel sheet and uploaded to Go.Data along with their contacts. **Go.Data** is now used across all regions with key epidemiologists and data clerks trained on the use of Go.Data.

Research: Kosovo has started conducting a population-based sero-epidemiology study to have a better understanding of the extent of COVID-19 infection and the cumulative incidence of infection in the population. Also, behavioral insight study (5 waves) and disease burden study have been conducted. Now preparations are ongoing to conduct a vaccine effectiveness study.

***** Please note that TBD is used when this level of detail wasn't discussed.***

PILLAR:	Surveillance		
BEST PRACTICES		**IMPACT(S)**	**ENABLING FACTORS**
1	Timely preparedness measures put in place prior to the detection of first COVID-19 cases (e.g. global guidance and SOPs adapted to the local context)	Early detection of the first COVID-19 cases followed by swift implementation of contact tracing. Early implementation of adapted public health measures	The existence of WHO guidance, that could easily be adapted to Kosovo's context Rapid development and acceptance of the COVID-19 preparedness and response (Feb 14, 2020)
2	Strong communication and coordination between the national and regional institutes of Public Health as well as the municipalities and family medicine centers.	Better coordination of the COVID-19 surveillance response	Existence and proper use of formal and informal communication channels
3	Surveillance tools (forms) were developed and disseminated for use.	Facilitated standardized data collection at all levels.	The existence of WHO guidance, that could easily be adapted to Kosovo's context

4	Analysis of the COVID-19 epidemiological situation is shared daily with MoH and other stakeholders.	Data for decision making made available for MoH and other stakeholders. Contributed to daily updating and informing the public about the evolution of the pandemic.	Government commitment to ensure transparency on the COVID-19 situation.
5	Continuation of contact tracing even during the pandemic waves, despite the high workload.	No interruption in the contact tracing activities. Early identification of cases that were in contact with a case. Timely management and follow up of contacts (e.g. guidance to contacts to quarantine, especially household contacts)	High commitment of national and regional IPH staff.
6	Expanding the lab testing capacities in the regions (6 new regional labs were opened for testing)	Lab results were obtained faster and sent earlier to the epidemiologists. This allowed quick triggering of the surveillance response activities (e.g. case investigation and contact tracing).	Donor financial support Political will
7	Implementation of surveys during the pandemic (e.g. sero-epi study, vaccination effectiveness study, disease burden study, behavioral insight study)	Preliminary results available during the pandemic, allowing a better understanding of the trajectory/evolution of the pandemic (e.g. the sero-epi study that described the true attack rate and Vaccine effectiveness study allow the assessment of the real-	Partner support

		life effectiveness of COVID-19 vaccines)	

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Lack of integrated and digitalized surveillance system of communicable diseases within the health information system The current surveillance system does not cover all the needs of the IPH (not digitalized, lost time spent on communicating between institutions, suboptimal data quality, lack of alert system within the surveillance system)	Extra efforts from the National Public Health Institute to obtain the data from different institutions (e.g. physical visits to hospitals, regional IPHs, and other stakeholder offices) Occasional delay of aggregated data especially when there is a high number of cases (e.g. influenza season, COVID-19 pandemic) Suboptimal data quality and completeness, especially from primary health care and private institutions.	Paper-based reporting system especially from the primary health care level to the regional IPHs. Lack of comprehensive health information system.
2.	Lack of an updated law, that addresses the surveillance system of communicable diseases	Rapid creation of a COVID-19 dedicated law during the pandemic to address the gap in the existing law Many decisions were questioned during the COVID-19 pandemic, especially regarding the possible violation of human rights by public health measures (e.g. quarantine and isolation measures)	General law on communicable diseases is waiting to be finished/updated and then accepted by the Parliament.
3	Refusal of the local level (primary health care centers or municipalities) to perform contact tracing despite trainings and provision of IT equipment (e.g. iPads /tablets)	Contact tracing continued to be performed by the national and regional institutes (therefore high work burden for epidemiologists)	Professionals at the local level have no time to allocate to contact tracing as they have other tasks to perform (e.g. treatment of COVID-19 patients),

			Professionals at the local level requested an additional payment to perform contact tracing, and this was not accepted by the MoH. Prior to the pandemic; contact tracing for all infectious diseases is performed by national and regional IPH staff, and not local staff (staff at the family medicine centers).
4	Lack of a comprehensive database for COVID-19 cases, that would include epidemiological, clinical, and microbiological/lab data	Necessity to keep parallel systems to meet the IPH data reporting requirements (e.g. daily press release must be sent to the MoH earlier than when the Go.Data analysis is available) High work burden on national and regional IPH staff for data entry in the several data collection systems. Integration of the historical data from excel sheets into GoData was delayed for several months due to technical issues with the software. Impossibility to use a unique identifier for each COVID-19 case, as there is no digitalized Health Information System that would provide the civil information (e.g. id number, address) Only aggregated data on health care capacities available (e.g. number of hospitalized cases, under treatment, with oxygen, with respirator) (data is sent daily from the clinical centers to the national level)	Different data sources need to be collated into one general database (from regional authorities, labs (public and private labs)). Not all of them have access to Go.Data. It is then easier to keep Excel files for all data sources. Limited data management human resources in the clinical centers to forward the clinical data to the national IPH, including “clinical coders”, that are trained for disease classification.
5	Death certificates of COVID-19 cases, that are sent to the statistical agency of Kosovo, do not indicate the main cause	Difficulty in determining the cause of death (whether due to COVID-19 or not).	Lack of training of clinicians to identify the most likely cause of death.

	of death but include several possible causes of death.		
6	Lack of human resources for surveillance activities, at the national, regional and local levels (especially noticeable at the regional level)	Multiplication of time-consuming tasks and responsibilities among the existing staff (e.g. data collection, data analyses, case identification, participation in working groups, writing SOPs)	No additional staff recruited for IPH during the pandemic, despite the increased workload (except 5-7 volunteers at the national level, a few data clerks for GoData, and a few temporary workers at the regional level) Low motivation of staff to work/specialize in public health (lower salary, less possibilities to work privately)

RECOMMENDED ACTIONS		DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT
a. For immediate implementation:				
1.	Recruit an expert at the IPH to ensure the extension of the current surveillance system, which will expire at the end of 2021	October-December 2021	IPH	WHO: financial and technical Support
2	Refer the issue of local level professionals not performing contact tracing to the health inspector to act/solve.	October-December 2021	MoH	None
3	Train clinicians to define the cause of deaths (not only COVID-19)	January-March 2022	IPH	WHO: financial and technical Support
4	Develop a plan for training and skill development of the current IPH staff	October 2021- 2022	IPH	WHO, RKI

5	Continue discussing with labs about the use of Go.Data, including addressing their needs for additional human resources.	October-December 2021	IPH, MoH	WHO
b. For mid to long-term implementation to improve the ongoing response to COVID-19 outbreak (including for next waves):				
1.	Continue the ongoing process of updating the law that addresses the surveillance of communicable diseases	January-December 2022	MoH	TBD
2	Include the role of the local level in contact tracing activities in the updated law, in order to enforce the law	January-December 2022	MoH	TBD
3	Develop an integrated digitalized surveillance system EITHER alone OR within the Health Information System	Starting 2022	MoH, IPH	WHO
4.	Continue the discussion with the relevant offices to improve the work conditions for health professionals specializing in Public Health	Starting 2022	MoH	WHO: technical support
5.	Increase data management capacities in the clinical centers (e.g. trained human resources, equipment)	Starting 2022	MoH	WHO: technical support

Pillar 4. National laboratory system

Pillar Description

This pillar reviews the functioning of the National Laboratory System to provide timely confirmation of COVID-19 cases in the country, including the collection and safe transportation of specimens to national and international reference laboratories, as necessary. In addition, this pillar reviews the diagnostic tools (both PCR and point-of-care tests) developed and used by a country during the COVID-19 outbreak and how these impacted the response and control efforts. Finally, this pillar reviews the sharing of specimens with laboratory networks for phylogenetic analysis of the SARS-CoV-2 genome, as well as the monitoring, detection and sharing of sequences and information on variants of concerns with the international community.

General Observations

On March 13, 2020, the first case of SARS-CoV-2 infection in Kosovo was declared by the Ministry of Health. In the beginning of the pandemic the Virology Laboratory in the National Institute of Public Health (NIPH) was the only national public health laboratory capable of performing COVID-19 diagnostics with limited resources (equipment, reagents and lab staff). Laboratory capacity of the NIPH in terms of new equipment, reagents and new lab staff, as well as national capacities were gradually scaled up with the help of international donors and partners. From January 2021 there are 6 additional laboratories in the regional Centers of Public Health (CPH), which can perform PCR tests with capacity up to several hundreds of tests per day. Laboratories at the regional CPH increased their capacities with immunological analyses and introduced detection of antibodies. While NIPH is working in two shifts, and if necessary, in three shifts, CPHs are working in one shift. New laboratory staff for the NIPH and regional CPH received training for molecular detection and biosafety by WHO, Robert Koch Institute and on job at the NIPH according the schedule for each regional CPH.

SARS-CoV-2 testing in the public health laboratories is free of charge. Procurement of the reagents, equipment and supplies is centralized, made by the Ministry of Health and based on the estimated needs of the labs collected by the NIPH. For detection of the SARS-CoV-2 variants real time RT-PCR tests are used for detection of different mutations. NIPH has equipment for sequencing. Due to the lack of training, which is in the process of organization, samples for sequencing are sent to international laboratory engaged by ECDC. Use of PPE, sampling and transport of samples from the regions to the NIPH are performed according recommendations from the NIPH. Some SOPs are available. National and subnational public health labs participated in WHO organized EQA for molecular detection of SARS-CoV-2. There is Laboratory Information System in the frame of the laboratory, but no connection with the epidemiology department, clinicians and GPs. Sharing of lab data is through excel tables distributed at the end of the working day via e-mail resulting in laborious manual steps.

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PILLAR:	**National Laboratory System**	
BEST PRACTICES	**IMPACT(S)**	**ENABLING FACTORS**

1.	Establishment of six PCR-laboratories in regional Centers of Public Health and enhanced capacity of the NIPH laboratory	Increased testing capacity in all of Kosovo More timely testing and reporting	World Bank Grant Training support from relevant partners
2.	Continuous training of staff throughout Kosovo	Increased testing capacity in all of Kosovo Increased nr of trained human resources in the regions More timely testing and reporting	Commitment of the staff in regions and at the NIPH Training support from relevant partners
3.	Well-functioning coordination between the NIPH and CPH	Standardization of several practices (considering region-specify contextual factors) Timely knowledge exchange	Good personal relationships prior to the pandemic Good laboratory network under the NIPH (centralized system)
4	Licensing system and MoH oversight of private laboratories	Increasing testing capacity Less pressure on public health laboratory system (traveler testing)	MoH NIPH-developed criteria
5.	Sufficient pool of lab technicians and medical doctors with appropriate degrees	Increased human resources, surge capacity Increased testing capacity	Enough graduates in universities and other educational institutions MoH initiative by the request of NIPH in creating more specialization positions for microbiology

6.	Possibility to use international networks and funding (WHO and ECDC for sequencing	Better monitoring of molecular epidemiology, variants of interest/concern	International support (ECDC, WHO, RKI)
7.	Centralized procurement process of reagents, supplies and equipment	Harmonization of testing procedures Proper planning	Good laboratory network under the NIPH (centralized system)
8.	Participation in EQA of national and subnational laboratories	Demonstration of quality of the laboratory results	Good laboratory network under the NIPH (centralized system) International support (WHO, ECDC)

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Very limited testing resources and capacities in particular when the pandemic started.	Suboptimal response Increased burden on the public health laboratory system and personnel	Limited emergency preparedness plans including laboratory functions, simulation exercises Limited political visibility of the importance of public health laboratory system
2.	Ineffective and delayed procurement process	Obstacles for routine testing Delays in scaling up testing capacity	Anti-COVID law implemented by the government did not include details on procurement processes, which could facilitate timely procurement of laboratory equipment and reagents Concern over misuse of the existing procurement law

3.	Pressure on public health laboratories caused by testing of travelers	Increased burden on the public health laboratory system and personnel Diverted focus from clinical testing	Government decision on offering free of charge testing including travelers
4.	Insufficient implementation of a quality management system in the laboratories (public and private)	Insufficient monitoring of quality	Lack of accreditation process due to insufficient investments Limited human resources in quality management
5.	No NIPH involvement in the selection of new laboratory staff (coordinated by the MoH)	Overly time-consuming retraining of new staff Decreased performance and quality of the testing system	Limited transparency in the recruitment process Trained staff with testing experience had no advantage in the selection process
6.	Insufficient Kosovo-wide laboratory information management system	Delays in reporting and epidemiological investigations Overall burden on laboratory staff due to many manual steps Privacy issues since regular email used for sending personal details	Lack of health information system in Kosovo, which delays the process on laboratory information system development Limited political visibility of the importance of public health Laboratory Information and Management System (LIMS)
7.	Old or inadequate infrastructure of the NPHI laboratories	Slow or difficult introduction of new equipment and new testing procedures due to the limited or inadequate lab space.	Lack of funding for infrastructure development

8.	Testing of other pathogens was interrupted during pandemic peaks and when human resources were scarce	Limited testing of other pathogens Lack of diagnosis, control measures and timely treatment of other communicable diseases Increased burden of disease (non-COVID-19)	Insufficient human resources for COVID-19 and non-COVID-19 testing simultaneously
9.	Limited or no mobile sampling stations	People could only get tested in healthcare institutions (leading to queues) Limited # of sampling sites	Limited financial support and understanding of the added value of mobile sampling stations
10	Lack of strategy for long-term sustainability of molecular (including sequencing) and serological testing capacities in Kosovo beyond COVID-19	Lost opportunity to provide improved molecular and serological testing Kosovo-wide Lost long-term returns of the initial investments on the laboratory system done in the pandemic	Limited financial support and understanding of the added value Potential loss of interest to invest in public health laboratory system over time (“panic and forget” cycle)

PRIORITIZED ACTIONS	DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT	INDICATORS
a. For immediate implementation:				

1.	Maintain current SARS-CoV2 laboratory testing capacities (including mobile sampling sites)	Ongoing	MoH NIPH	Ministry of Finance Government International partners	Number of tests performed Number of additional staff Number of functional mobile sampling sites
2.	Increase the number of trained laboratory technicians with long-term contracts	Immediately (Q4 2021)	MoH NIPH	Ministry of Finance Government International partners	# of employed lab technicians with long-term contracts
3.	Introduction of a fee for testing travelers (without clear medical reason)	Immediately (Q4 2021)	MoH	Technical support from NIPH Government	Testing fee in place
4.	Involve NIPH in the process of staff recruitment	Immediately (Q4 2021)	MoH	NIPH	Inclusion of NIPH experts in selection boards Inclusion of testing experience as advantage in the selection process

5.	Develop a Laboratory Information Management system (for COVID-19, then expanded to other pathogens)	Immediately (Q4 2021)	MoH	Technical support from NIPH and international partners Financial support from international partners	TBD
6.	Establish EQA for private laboratories performing SARS-CoV2 testing	Immediately (Q4 2021)	NIPH	Technical support from international partners, MoH	Number of institutions included in the EQA Report on performance
b. For mid to long-term implementation:					
1.	Ensure sustainability of molecular and serological testing capacities developed during the pandemic	2022+	MoH NIPH	Ministry of Finance Government International partners	TBD
2.	Review and revise legislation related to emergency procurement of medical supplies	2022+	MoH	Technical support from international partners (EU in particular)	Established working group

3.	Implement the Laboratory Quality Management System	2022-23	NIPH	Technical support from international partners Financial support from MoH and international partners	Quality Management System in place

Pillar 5. Infection prevention and control

Pillar Description

This pillar reviews infection prevention and control measures implemented in diverse settings with suspected or confirmed COVID-19 cases, particularly if community spread is already present, including but not limited to healthcare facilities, workplaces, public transportation, entertainment facilities, airline, cruise vessels and other locations where people may gather in close proximity (e.g., long-term care facilities, camps and camp-like settings, informal settlements, low-income housing, dormitories for students and migrant workers, prisons). In addition, this pillar reviews whether there are adequate water and sanitation infrastructure for healthcare facilities in community settings.

General Observations

A number of best practices were identified during the review of the IPC pillar response. Previously established guidance on hand hygiene in healthcare settings and basic infection prevention and control was found to be beneficial in the immediate response to COVID-19. Previously published instruction for hospital prevention and regular monitoring at national and subnational level for healthcare settings was taken on via visits to all municipalities to meet emergency committees to focus on infection prevention control at the beginning of the pandemic. From this, the “Scientific Advisory Board” was established which gave advice to the Minister of Health regarding which measures for infection prevention control should be established.

Additionally, a national action plan for hospital infection was signed in December 2020 alongside budget and financing, enabling further support allocation to infection prevention and control in the context of COVID-19.

Throughout the entirety of the pandemic, the lack of qualified staff (both nurses and doctors) was acutely felt, especially those trained and qualified to train for infection prevention and control. An overall lack of personal protective equipment (PPE) at the beginning of the pandemic caused healthcare workers to utilize the same PPE more than was recommended as all aspects were lacking. Nursing staff continuously were overburdened and experience severe pandemic fatigue, burnout and trauma from loss of colleagues, patients and family members. A consensus was found that primary healthcare staff were not prepared at the beginning of the pandemic at the level that the situation of COVID-19 required.

Through discussion, 11 best practices and 11 challenges were found in relation to the Infection Prevention and Control pillar. From this, 8 short term and 11 mid-to-long term activities were identified and presented at the culmination of the intra-action review.

***** Please note that TBD is used when this level of detail wasn’t discussed.***

PILLAR:	**Infection Prevention & Control**	
BEST PRACTICES	**IMPACT(S)**	**ENABLING FACTORS**

1.	First administrative instruction for hospital prevention (2011) published.	Driving force to make change as consequences for noncompliance were established. Second person in hierarchy of institutions was provided power of authority of implementation.	Template from Croatia (utilized as a jumping off point). Visit from ECDC.
2.	Guidance on hand hygiene in healthcare settings and basic infection prevention and control (IPC).	Further evidence-based research. Surveillance data has been utilized for further quality improvement.	Collaboration with key international actors (partners and other professional society).
3.	Training of trainers (ToT) for hospital workers for infection prevention and control (IPC) prior to COVID-19 pandemic.	Healthcare workers prepared to implement IPC measures in the context of COVID-19 prior to the pandemic. Continuous training onsite by trainers for other healthcare workers of all facilities in primary, secondary and tertiary care and other facilities (i.e., airports, veterinary, police, schools, prisons, ground crossings, vulnerable populations). ToT hosted 12-13 March 2020 for infection prevention control (IPC).	Interim guidance on IPC provided by WHO in English language (translated to Albanian four days after publication). Dedication and commitment of healthcare staff to uptake this responsibility of training colleagues and younger professionals. Existing network of persons responsible for IPC (including retirees).
4.	IPC draft national plan existing since 2018 and approved with small amendments in 2020.	IPC is empowered via publication of National Action Plan.	National Action Plan on Antimicrobial Resistance signed December 2018 and budget was provided.

			National IPC draft existed prior to COVID-19 pandemic and required only small adjustments (including COVID-19) to be published in 2020. Planning for 3 years total.
5.	Existence of National Commission for Prevention and Control of Hospital Infection (2006).	Continuously improved and strengthened IPC recommendations and interventions. Developed draft plan. Easily transitioned to serve throughout pandemic in context of COVID-19. Enabled research and use of data in decision making on cost effectiveness of IPC measures.	Existed since 2006 with small changes. Enthusiasm of healthcare workers to provide voluntary contributions (i.e., time, intellect, etc.). Membership of different sectors represented within Commission (14 members).
6.	14 WHO documents related to IPC and other important areas (i.e., risk assessment, quarantine, masks WASH, PPE, mental health, community transmission, lab testing, home care, cluster investigation and migrant communities).	Guidance provided focus on triage, care, waste management, WASH (all IPC components). Informational letter shared in the network of hospitals and primary care centers after confirmation of first case in Kosovo.	Existing WHO documents/guidance. Translated and distributed to all hospitals and primary care facilities.

7.	Regular monitoring and guidance at national level for municipalities and healthcare settings as a part of national coordination response with focus on IPC.	Gave advise to Minister of Health regarding which measures for IPC should be established. Visits conducted March, April, May, June 2020. Regular visits to meet emergency committees and healthcare facilities to focus on IPC at beginning of pandemic.	Staff conducting visits on voluntary basis. Readiness of facilities to receive guidance and implement/follow. Risk communication and media demands on IPC explanations.
8.	Mechanism in place at a national level for planning of procurement and supplies, including IPC, commodities, PPE, etc. for health facilities.	Plan of assessment based on needs. Adaptation and use of plan provided option for weekly update of services/goods required (compared to quarterly update prior to the pandemic). MoH can quickly assess who needs what throughout duration of COVID-19 pandemic.	General supply chain exists, not only for healthcare facilities. Budget already allocated, only necessary to increase in accordance with supply and demand. External help provided by international donors for procurement of PPE.
9.	Commitment of healthcare workers/professionals to support on all levels.	Mobilization of additional healthcare workers/workforce at all levels.	Retirees, young doctors/nurses/professionals, etc. committed to providing assistance/support. IPC curricula addressed in academic medical curriculum overall (i.e., patient safety and AMR added recently as two main subjects).
10.	New MoH decision for 11 standard operation procedures (SOPs) regarding infection prevention and	Regulation of IPC measures in healthcare facilities.	Ministry of Health support. IPC experts' commitment at national level.

	control (IPC) will be implemented by Q421.	Required implementation with timeline and compliance to standards. Continuous updating of SOPs based on emerging evidence.	Experts engaging in development of SOPs. Existing network of IPC focal points. Existing enabling international guidance.
11.	Ongoing research, data collection and analysis on infection prevention and control (IPC).	Guiding the decision making on IPC interventions. Improving practices (i.e., nursing, patient safety, other facility practices).	Existing network of focal points. National level responsible for this. Current monitoring system. Commitment of experts.

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Staff shortages, especially nurses, in primary, tertiary and other healthcare facilities.	Mobilization of families to support with daily routines of care of patients (i.e., water, bathing, etc.). Staff shortages severely impacted quality of care for patients. More focus on emerging needs for medical care and lack of psychological and social connection with patients, patient families, etc. Other healthcare services and routine procedures for chronic diseases were suffering.	Scarce resources for overall healthcare workforce capacity (i.e., salaries, public/private sector, etc.). Nurses and healthcare professionals were not properly trained in patient care or IPC in the context of COVID-19. Given community driven transmission, also a limiting factor due to many healthcare workers being infected. Healthcare staff experiencing traumatic experience and burnout due to COVID-19 pandemic. Doctors and nurses leaving for private sector due to higher salaries or abroad (intensive care specialists, anesthesiologists, etc.).

		Routine immunization was impacted.	
2.	Infection prevention control not financed by government and healthcare facilities.	No standard operating procedures. Outbreaks of infectious diseases. Increased morbidity, mortality and cost.	Political will for funding is inadequate. Frequent governance turnover and long transition times which delayed decision-making throughout duration of pandemic. Scarce resources overall at the national level.
3.	Lack of reserve or potential mechanism for reserve of personal protective equipment (PPE).	Overall lack of PPE in case of health emergency, particularly in first months of the pandemic. Increased risk of infection for healthcare workers and patients at healthcare facilities. Shortage of PPE within community overall. The need to look for other potential sources for PPE supply, including community and external donors.	No established mechanism for reserve/backstock of PPE. Scarce resources. Insufficient funding. No approved budgetary action plan prior to pandemic for IPC that would have regulated reserves of PPE, etc.
4.	Inadequate IPC training for intensive care units, primary healthcare settings and other facilities.	Not enough staff qualified to properly prepare equipment for use. New staff enrolled but unavailable for IPC case	No established plan prior to the pandemic for IPC. No funding. Last training held in 2016 for ICU, staff have changed another training is needed.

		management due to need for training.	
5.	Discontinuation of contracts of trained healthcare personnel to train in the context of COVID-19 in medical care, including IPC.	Continuity of training capacity interrupted. Increased costs for newcomers to be trained. Delays due to necessary time for training and acquisition of skills. Time gap for service entry procedures/contractual agreements.	Governance turnover interrupted training contracts for healthcare workers. Non-regulation of contracts for healthcare professionals. Laws and regulations implemented.
6.	Lack of regular evaluation of healthcare facilities for compliance with IPC standards.	Insufficient operationalization of IPC instruction in hospitals.	Decreased incentives during the pandemic (incentives decreased over period of pandemic). Inadequate operationalization for inspections (lack of funds, lack of resources, lack of capacity, scarce resources, etc.)
7.	Difficulty securing funding for repurposing clinics for proper ventilation that meets COVID-19 standards (recommended by WHO).	Poor ventilation. Crowding of facilities that have proper ventilation. Increased risk of infection.	Governance turnover and challenges accompanying this (i.e., political will). Existing infrastructure (engineering controls not respected at the time original buildings were built). Scarce resources.
8.	Unavailability of appropriate psychological support for healthcare workers.	Chronic fatigue. Decreased quality of care.	Healthcare workers not allowed to take vacation. Burnout and trauma of working with COVID-19.

		Lack of motivation for work overall. Lack of counseling/patience with patients and patients' families.	Losing relatives, friends and colleagues due to COVID-19. Constantly working in a high-risk and stressful environment.
9.	Inadequate implementation of preventative measures (i.e., masks, sanitizers, non-pharmaceutical interventions) in communities.	Increased risk of community transmission. Increased hospitalization, morbidity, rates of infections, deaths, etc.	Scarce resources for supply of non-pharmaceutical commodities to communities. Not enough risk communication and information sharing for communities. Marginalized and vulnerable populations not reached by interventions or information.
10.	Insufficient inspection by relevant institutions for infection prevention control measures in communities.	Increased community transmission. Non-compliance with recommended IPC measures in communities due to lack of enforcement.	Beyond responsibility of only the Ministry of Health. Other structural barriers such as sanitary inspectorate not reporting to MoH but other institutions. Inadequate law enforcement.
11.	Managerial challenge in ensuring compliance of IPC standards in health facilities, especially surgical departments, due to contracting or hiring of external companies based on questionable tender rules.	Loss of quality of cleanliness according to IPC standards. Limited control of deliverables. Potential loss of life of patients or endangerment of patient care. Misuse of antibiotics given belief that antibiotics will prevent infection due to unsanitary conditions.	Non-compliance on behalf of outside company who contracts hygienists to clean in healthcare facilities (external company from hospitals, etc.), especially in surgical departments. Infectious control experts not invited to participate in tender procedure when hiring external companies.

PRIORITIZED ACTIONS		DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT	INDICATORS
a. For immediate implementation:					
1.	Finalization of the 11 standard operation procedures (SOPs) regarding infection prevention and control (IPC).	December 2021	Ministry of Health, Commission on Infection Prevention and Control, Members of Commission (11) and regional focal points	Funding for time dedicated to work External funding available (only for catering)	11 approved standard operating procedures (SOPs)
2.	Training for healthcare staff and auxiliary staff for infection prevention control (a costed budget for training).	3-6 months	Ministry of Health, Commission on IPC, external funding agency	Funding for translation of materials Funding for trainers Funding for catering	# of people trained Provision of training for 8 hospitals
3.	IPCAT (Infection Prevention Control Assessment Tool) conducted at all facilities.	3-6 months	Commission on IPC, focal points in the facilities	TBD	8 facilities complete IPCAT and submit to the Commission

4.	Empower IPC at facility level via better coordination, specifically, at least one visit at each facility to operationalize the IPC standard operation procedures.	Q122	Commission on IPC, focal points in the facilities	MoH support + funding for visits	8 facilities visited and consensus meetings conducted
5.	Mobilize the inspectorate to ensure evaluation and compliance with IPC in healthcare facilities.	6 months	MoH, Commission on IPC, the Inspectorate	Inspectorate funding	Inspectorate participates in/conducts the evaluation on compliance with IPC Inclusion of inspectorate response within administrative instruction Regulatory bases for routine involvement of inspectorate
6.	Psychological support for healthcare workforce based on WHO guidance (verify guidance?).	6 months	Commission on IPC, healthcare facilities, relevant experts	MoH funding Potential external support	New curriculum # of staff trained
7.	Increased communication on IPC for communities (link to Pillar 2).	6 months	MoH, Commission on IPC, healthcare facilities	MoH funding Potential external funding	New information materials and videos (leaflets, brochures, etc.) for communities

8.	Ensure infectious prevention professional is included within tender dossier and results for external private hygiene companies hired to provide cleaning services for healthcare facilities.	3-6 months	MoH, Commission on IPC, healthcare facilities	Healthcare facilities funding	# of new tenders with IPC expert on hiring committee Amended tender regulation procedures
b. For mid to long-term implementation:					
1.	New hiring to reflect previous training and work in COVID-19 context as a priority for hiring of healthcare professionals.	6-12 months	MoH	TBD	Reflected in new calls for hiring of healthcare professionals
2.	Increase of doctors and nursing staff in healthcare facilities including ICU, primary care, clinical facilities (i.e., suburban or rural communities, less saturated spaces) to assure adequate IPC standards are upheld (outside of the context of COVID-19 but with the purpose of future	1-2 years	MoH	Funding for additional positions	Job descriptions promoted for additional positions Additional staff hired

	health emergency preparedness).				
3.	Full-time epidemiologists in healthcare facilities adequately trained to serve as focal points to manage future IPC teams and infection prevention control in general.	1-2 years	MoH	Funding for positions Funding for training	8 facilities will have full-time focal points
4.	Increase financing overall for IPC as a long-term action.	1-2 years	MoH, Commission on IPC	MoH, government and external donor funding	Increase budget for IPC
5.	Consideration of ventilation standards for clinics to remain in compliance with IPC standards.	>2 years	Ministry of Health, hospitals, relevant construction agencies	Funding for engineering control	All new buildings must comply with ventilation recommendations and IPC standards
6.	Possibility to receive government support for securing reserve of PPE and other important supplies for future potential emergencies.	1 year	Ministry of Health, Commission on IPC	Government of Kosovo (Parliament), Ministry of Health	Funding for assured procurement of PPE for at least one extra 1-2 months than current plan to prevent other emergencies
7.	Regulate the frequency of inspectorate evaluations of	Ongoing	Inspectorate, Commission on IPC, Ministry of Health	Inspectorate funding	Inspectorate includes regular evaluations of compliance with

	compliance with IPC in healthcare facilities.				IPC in healthcare facilities in annual activity plan
8.	Review of the administrative instruction on IPC 05/2011.	1 year	Ministry of Health, the Commission on IPC, WHO	Funding (in-kind contribution) from Ministry of Health, WHO, national experts	Revised instruction
9.	Comply with international standards of assuring recommended IPC nursing staff per # of beds (1 IPC nurse per 250 beds).	1-2 years	MoH, the Commission on IPC	Funding from government for additional staff	1 IPC nurse per 250 beds
10.	Ongoing trainings in psychological support for healthcare workforce.	>6 months	Commission on IPC, healthcare facilities, relevant experts	MoH funding Potential external support	Institutionalized curriculum # of staff trained # of trainings per year
11.	Ensure infectious prevention professionals are always included within tender dossier and results for external private hygiene companies hired to provide cleaning services for healthcare facilities.	>6 months	MoH, Commission on IPC, healthcare facilities	Healthcare facilities funding	# of new tenders with IPC expert on hiring committee All improved/appropriate tender regulation procedures which have been amended within IPC standards, including IPC expert

Pillar 6. Case management

Pillar Description

This pillar reviews actions taken to manage and care for COVID-19 cases, as well as to share clinical information, including treatment protocols for COVID-19 cases. In addition, this pillar reviews how clinicians were involved during the COVID-19 outbreak response, including being connected to the latest innovation, participating in national or international clinical trials, and conducting other research to identify effective treatment protocols for COVID-19 patients with different demographics and underlying conditions.

General Observations

Overall, it was clear that staff shortage both nurses and doctors remains the biggest challenge. The groups reported that currently 46 anesthesiologists who can do the actual ICU support of severe cases are dedicated fully for COVID-19. Overall, in Kosovo there are 120 anesthesiology/ICU specialists. Also, in Kosovo there are only 48 infectious disease specialists, but the needs of care are much higher.

***** Please note that TBD is used when this level of detail wasn't discussed.***

PILLAR:			
BEST PRACTICES		**IMPACT(S)**	**ENABLING FACTORS**
1	Adoption of case definitions since the pandemic beginning (January 2020)	Facilitates case management and referrals at all levels	Overall response plan developed by the MoH, that required clarifications on case definitions Involvement of a multidisciplinary committee to agree on case definitions
2	Adoption of the case management protocol/guidelines (April 2020: first draft provided to all clinics and continuously adapted to new available evidence, August 2020: MoH approval)	Clarity of actions for proper case management specialists in all district level facilities	Creation of working teams with various medical experts (from national and regional care) to review the existing evidence and agree on the best practices at that time for patient treatment Use of WHO guidelines to adapt to the Kosovo context

3	Development of a national Committee for COVID-10 clinical management (affiliated to the University Clinic)	Decisions on important topics for all care levels (e.g. communication of proper use of PPE (e.g. posters, written guidelines))	Committee include multidisciplinary experts
3	Evidence-based decision on removal of experimental treatments (e.g., HIV antiretroviral treatment)	Allows proper clinical management in line with current evidence base approaches	Evolving scientific evidence
4	Exchange of experiences with other countries (e.g. use of Personal Protective Equipment (PPE), patient treatment)	Fast assimilation of key information to apply to the Kosovo context	Kosovo medical staff working in other countries
5	Timely and continuous training provided to additional Kosovo medical staff to support the care management and PPE use by healthcare staff in all facilities	Additional needed capacity prepared to be able to engage in COVID-19 case management	Dual training from Kosovo and international (Germany) staff; WHO resources used
6	Trained staff for the management of infectious diseases (e.g. Swine flu, hemorrhagic fevers), and additional trainings provided	Qualified staff not afraid of dealing with COVID-19 patients, especially at the beginning of the pandemic	TBD
7	Increase of the infrastructure to accept COVID-19 patients in intensive care (e.g. transfer of non-COVID-patients to regional hospitals, dedication of more wards to COVID-19)	Increased capacity for COVID-19 patient management, especially in the pandemic peaks	Good cooperation Staff commitment/dedication to give up additional staff to COVID-19 patients
8	Organized patient transportation, and set up of one dedicated COVID-19 ambulance	Timely reaction to COVID-19 patients No disturbance for other services (e.g. acute care, cardiovascular care)	TBD

9	Continued and maintained management of non-COVID-19 patients with communicable and/or non-communicable diseases	Continuous patient management	Flexibility of medical staff in their practices (e.g. phone call to patients, treatment provision for months in advance (e.g. HIV, chronical hepatitis))
10	Increased human resources thanks to volunteers, and transfer of medical staff (e.g. nurses, doctors)	TBD	Visits of specialists to support care teams in the hospitals MoH support to provide additional medical staff
11	Management of the public opinion / Media communication (provide information and send information but not to spread fear)	TBD	Support of the WHO to write the first leaflets for patients, that were disseminated in clinics at all levels, including in primary health care
12	Relatively no shortage of Personal Protective Equipment (PPE), respirators, oxygen and treatment at all care levels	Continuous care management No need to re-use PPE at the national (except at the regional level) No staff infected in the first covid-19 pandemic wave	Financial support from donors Moving of respirators from private hospitals to other care institutes for COVID-19 patients MoH funding to buy medical supply (e.g. treatments, liquid oxygen reservoirs instead (oxygen bottles) Reserve of PPE from donations (Ebola PPE from WHO) Very early request for face masks to the MoH at the pandemic beginning Discussion with regional hospital in March 2020 that revealed the lack of equipment at the regional level
13	Conduction of trainings for Intensive care unit (ICU), use of Personal Protective Equipment (PPE) and respirators	TBD	TBD

	CHALLENGES	IMPACT(S)	LIMITING FACTORS
1	Constantly evolving case management guidelines	Staff under pressure (continuous consultation with colleagues to know which care management to adopt)	Limited available scientific evidence
2	Legal barriers in participating in clinical trials (e.g. solidarity trial)	Limitation of research abilities	Depending on MoH decision
3	Shortage of staff and increasing staff demand (especially in the suburb clinics)		# of anesthesiologists at the regional level High turn-over of nurses due to their short contracts (6-9 months)
4	Lack of staff for treating critical cases (providing invasive care)	Despite enough beds and equipment in ICU, impossible to accept more COVID-19 patients because of staff shortage (anesthesiologists, nurses)	In Kosovo, treatment of severely ill patients remains under the responsibility of anesthesiologists (n=46 in public sector and n=15 in private sector) The staff is not allowed by the law to perform non-invasive care of COIVD-19 patients
5	Lack of practical training /skills development on Intensive care in the medical doctor curriculum	TBD	TBD
6	No MoH approved SOPs and instructions on COVID-19 Patient transportations from clinics (outside the city and non-COVID clinics) to intensive care wards	High burden on medical staff, especially for severe cases Lacking equipment and specialized staff during the transport	No regulation/SOPs to regulate patient transportation

		Lacking formal instructions on roles of staff, dedication of equipment, etc.	
5	Episodic suspension of routine services of ambulances (for transfer of patients)	TBD	TBD
6	Late detection and referral of severe COVID-19 case via ambulatory care at the Primary care level	TBD	TBD
6	Lacking equipment, especially at the regional level (e.g. oxygen), especially at the pandemic beginning	TBD	TBD
7.	Limitation of the existing infrastructures, that did not allow to have one COVID-19 hospital but require re-organization	TBD	TBD
8	Lack of a Health Information System	Slow transmission of the information from national to regional level Lost time in communication to gather the patient history Administrative burden on the doctors Not adapted care for patients	No proper computer equipment at the national and regional levels
9	Inadequate capacity of the local level (primary health care) to identify COVID-19 cases during home visits, and refer them	TBD	TBD
10	Intra-hospital infections in the intensive care units (ICU)	TBD	Patients transferred between wards Insufficient number of nurses per patient

11	Lack of rehabilitation services to care for Post-COVID-19 treatment	COVID-19 patients need to stay longer in the regular COVID-19 services (average of 5 days) before being sent home	TBD

RECOMMENDED ACTIONS		DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT
a. For immediate implementation:				
1	Mapping the workforce i.e. revision of the existing staff in all clinics to formulate recommendation of minimum staff per structure/capita (in context of COVID-19 pandemic, and beyond COVID-19 to be prepared for other health emergencies)	by Quarter 1, 2022	MoH	WHO
2	Reward/motivate the staff that has worked and still works on COVID-19 response (e.g. monetary stimulation)	by Quarter 1, 2022	MoH	TBD
3	Provide additional intensive care training to medical doctors (ICU specialists, intensivists, infectiology, pulmonologists and other specialists) to enable them to ensure care for moderate to severe COVID-19 cases	by Quarter 1, 2022	MoH	WHO
4	Mobilize primary health care staff for home visits to early identify COVID-19 cases with high risk to develop severe clinical manifestations (e.g. mobile	by Quarter 1, 2022	MoH	TBD

	teams), and adequately refer them for further care			
5	Strengthen the evaluation of the compliance with Infection Prevention and Control (IPC) measures, especially related to the transfer of patients (to prevent nosocomial infection within hospitals)	REFER to PILLAR 6.IPC	TBD	TBD
6	Approve SOPs/instructions on severe cases management (including patient transportation)	by Quarter 1, 2022	MoH (strategic development unit)	TBD
7	Increase the number of permanent contracts for nursing staff increase the number of nurses per patient	by Quarter 1, 2022	MoH	TBD
8	Update the master curriculum on infectious disease specialty in medical school to include case management of COVID-19	by Quarter 1, 2022	University hospital	TBD
b. For mid to long-term implementation:				
1	Revise and update the current case management guidelines with the newest available evidence to align with WHO guidelines and address misuse of antibiotics	By Q1-2 2022	MoH	TBD
2	Considerate how to include Kosovo medical clinics in research activities on COVID-19 and beyond COVID-19	TBD	WHO	TBD

	(optional – move to general observations)			
3	Continuously strengthen research activities, including on COVID-19 and beyond COVID-19 (optional – move to general observations)	TBD	WHO	TBD
4	Maintain the increased number of permanent contracts for nursing staff	TBD	MoH	TBD
5	Speed up the reform of the legislation to ensure the provision of medical insurances and higher salaries for nurses and doctors to work in the public sector in Kosovo, to prevent them for wanting to move abroad (ongoing MoH efforts on the “Law on Health” and “Law on salaries” to fit with EU requirements) Expectation: develop a standard of care that would regulate the ratio of doctors, including infectiology, pulmonologists and anesthesiologists per capita	2022-2023	MoH	TBD
6	Include an elective module for intensive care in the continuous education curriculum for specialized doctors (certified training) Strengthen intensive care training of the specialists that are ongoing their specialization	TBD	University Hospital	TBD

7	Speed up the ongoing development of a digitalized Health information system	TBD	MoH	TBD
8	Enable services for long term post-COVID-19 treatment/patient rehabilitation in dedicated services	By end of 2022	MoH	TBD
9	Maintain the interdisciplinary work through the functioning committees	TBD	TBD	TBD
10	Consider providing legal protection for doctors to ensure their work with severe COVID-19 cases*, to avoid accusation/lawsuits	TBD	TBD	TBD

Pillar 7. Public health and social measures

Pillar Description

This pillar reviews the public health and social measures (PHSM) taken by country authorities at the national and subnational levels to control, limit and break the human-to-human transmission of SARS-CoV-2. These may include but are not limited to physical distancing rules, mandatory mask-wearing in certain enclosed public spaces, closure of non-essential businesses and schools, curfews, border closure, among other measures imposed in the country through laws, mandates, orders and regulations or non-legally-binding recommendations. This pillar can be used to review the timing and effectiveness of these measures, as well as the community perception regarding the PHSMs imposed. In addition, this pillar can be used as an opportunity to gather diverse information using a whole-of-society approach to adjust PHSM to ensure both the attainment of public health goals, as well as the acceptance and cooperation of the population to follow the PHSMs implemented.

General Observations

A number of best practices were identified during the review of the public health and social measures response. A “Committee on Infectious and Communicable Diseases” was established and functional from January 2020 and was responsible for creating the necessary manuals and standard operating procedures in response to COVID-19. Additionally, a general manual for anti-CVOID-19 measures was quickly established from the beginning of the pandemic by the National Institute of Public Health. This manual was utilized by other institutions and organizations in order to prepare their own guidelines and responses to COVI-19.

The Ministry of Health and Ministry of Education established an advisory group to support the process of re-opening of schools in the context of COVID-19 in August 2020. In the same timeline, a traffic light system was implemented for all public health and social measures based on local epidemiological situations (green, yellow or red). Additionally, in April 2021, an interdisciplinary committee involving all relevant stakeholders was established in order to coordinate directly with the Ministry of Health to update public health and social measure protocols and recommendations. The committee comprised of 9 sub-groups covering main public health and social measures indicators or topics, with representatives from relevant sectors participating in each sub-group.

A highlight and key observation taken from this discussion was the fact that a well-functioning mechanism existed to provide recommendations from the Ministry of Health and National Public Health Institute to the government regarding public health and social measures. From this existing mechanism, a majority of the recommendations brought forward were implemented throughout the duration of the pandemic.

The existing “Law for Infectious Diseases” established in 2008 had not been updated by 2020, thus COVID-19 was not included which proved difficult when implementing public health and social measures. Pandemic fatigue and disbelief on the part of the public in valid reasons for public health measures to be so strict led to non-compliance with measures, even when fines were implemented to ensure compliance. Law enforcement also lacked the legal standing to enforce these fines due to court rulings which found some public health and social measures unconstitutional.

Like others, uncertainty severely impacted decision-making at the beginning of the pandemic. Effects of public health and social measures implemented by the government have been felt in all areas of the economy and population overall.

**** Please note that TBD is used when this level of detail wasn’t discussed.***

PILLAR:	**Public Health and Social Measures**		
BEST PRACTICES		**IMPACT(S)**	**ENABLING FACTORS**
1.	A committee on infectious and communicable diseases established and functional from January 2020.	Necessary manual and standard operating procedures (SOPs) developed.	Multi-sectoral and multi-disciplinary coordination.
2.	NIPH established general manual for anti-COVID-19 measures from beginning of pandemic published on MoH website.	Manual was utilized by multiple institutions/organizations in order to prepare their own guidelines.	Preparations and mobilization of all necessary materials based on international standards (guidelines, SOPs, etc.) began early January 2020.
3.	Phone numbers/hotlines were established for COVID-19 response within emergency operational centers for the public in MoH, NIPH and Ministry of Internal Affairs, and activated 13 March 2020.	Citizen questions and concerns immediately answered. Updated advice provided for citizens regarding COVID-19 measures and recommendations.	Multi-sectoral and multi-disciplinary coordination (MoH, Ministry of Internal Affairs, law enforcement, NIPH, etc.). Available staff and volunteers and capacity at EOCs

		Support hotline was subsequently opened which provided psychological support to citizens.	
4.	A well- functioning mechanism to provide recommendations by the MoH and NIPH to the government on PHSM exists.	Decision and announcements on PHSM were timely and based on epidemiological indicators (i.e., PHSMs implemented when needed). Recommendations by key health agencies were mostly taken into consideration and implemented by the government.	Good collaboration across sectors (MoH, NIPH, government, etc.). Different working groups were established which provided further support and coordination.
5.	Development of summary document, consolidating all available guidance and recommendations for COVID-19, published June 2020.	Public had access to overview of all recommendations, available guidance (150 pages).	NIPH capacity to consolidate information and update summary document continuously
6.	MoH established working group (June 2020) and developed action plan to combat mental health impact during and post-COVID-19.	Action plan for mental health, during and post-COVID-19 published for public access (September 2020).	TBD
7.	Traffic light system (green, yellow, red) implemented for PHSM measures based on local epidemiological situations, established August 2020.	Management of PHSMs became easier and more feasible. Relevant stakeholders and public quickly informed of PHSM decisions, enabling further	Availability of epidemiological data and analysis to inform categorization of subnational levels

		monitoring and checking for PHSM adherence.	
8.	MoH and Ministry of Education established advisory group to support process of re-opening of schools in the context of COVID-19 in August 2020.	Harmonized recommendations which were jointly prepared by MoH and Ministry of Education.	Collaboration across multiple sectors (MoH + Ministry of Education + NIPH). Recommendations from institute interdisciplinary committee with multiple stakeholders adapted by this working group to implement in schools.
9.	Interdisciplinary committee involving all relevant stakeholders established April 2021 to coordinate directly with the MoH to update PHSM protocols and recommendations. The Committee is comprised of 9 sub-groups covering main PHSM topics with representatives from relevant sectors participating in the subgroups	Instructions consistently updated and published based on new government decisions. Input from relevant stakeholders considered within subgroups leading to increasing acceptance of public and sectors. Other institutions use these instructions in order to draft their own instructions based on separate needs (i.e., education, businesses, etc.).	Collaboration across multiple sectors (i.e., Chambers, state stakeholders, gastronomy, etc.). The process of updating was easily facilitated and implemented based on temporary status of implementation. Representatives from relevant sectors were invited to participate (i.e. education, transport, business, gastronomy etc.)
10.	Pre-COVID-19 preparedness activities, standard operating procedures (SOPs), development plans, simulation exercises and contingency plans.	Activities helped in immediate PHSM response, coordination and management early in the pandemic.	Avian influenza preparation plan previously established and was utilized as basis for development of COVID-19 preparedness plan. Existing national response plan (est. 2010) provided easy pathway for immediate activation of emergency response to COVID-19 (especially with support of Emergency Support Function 8 for public health and medical services, 2019).

			MoH, NIPH, Ministry of Interior Affairs all had the mechanism to trigger emergency operation centers in the face of an infectious disease emergency.
11.	From beginning of pandemic, media and social media were utilized to communicate PHSM measures to the public.	Quick access for citizens to PHSM changes, recommendations and requirements.	Multi-sectoral collaboration and coordination with media/journalists
12.	Epidemiological data analysis (situation reports, Go.Data platform) continuously used to inform development of recommendations on PHSMs.	Daily update on cases (15:00). Weekly situation reports (Thurs.) published on the website, accessible to the public.	Rapid collection of data using Excel to inform daily updates.
13.	Readiness of volunteers to participate in response to the emergency.	Increased surge capacity, workforce, etc. (essential in beginning of pandemic). Increased security of institutions to face emergencies.	Commitment of volunteers to emergency response. Call for volunteers.

CHALLENGES		IMPACT(S)	LIMITING FACTORS
1.	Preparedness and contingency plans and SOPs available, however not regularly tested or practiced before COVID-19.	Lead to additional time and resources needed to train/communicate to staff on SOPs at the beginning of the pandemic.	No dedicated simulation exercises developed covering public health (infectious disease) emergency as scenario at national level.
2.	Uncertainty at the beginning of the pandemic due to virus and what steps need to be taken.	Fear in the population in general due to uncertainty.	No evidence-based information regarding emergence of COVID-19 available at beginning of pandemic

		Reluctance to act on the part of professional institutions. Indecision of when to ease/implement measures, communication/announcement of PHSM measures.	
3.	Existing Law for Infectious Diseases established in 2008 did not cover COVID-19.	Impacted enforcement of PHSM measures at the beginning of the pandemic. Required very quick conception and implementation of new law: For the Prevention and Fighting of COVID-19 Pandemics in the Territory of Kosovo (25 October 2020).	Update will be conducted in 2022 for Law of Prevention of COVID-19. COVID-19 was not included in the system for surveillance as other diseases were (2008).
4.	Belief amongst the public that PHSM restrictions were too strict or overly exaggerated based on behavioral insights (BI) survey results.	PHSM measures not followed due to lack of enforcement and population non-compliance. Economy and businesses were suffering.	Law lacked specific articles of enforcement for some indicators (i.e., masks). Population experienced pandemic fatigue. Lack of adherence or vigilance regarding PHSMs implemented.
5.	At the beginning of the pandemic, decision-making regarding requirements at border crossings for quarantine for incoming travelers was difficult to implement.	Confusion and miscommunication regarding implementation of quarantine rules. Unable to communicate necessary measures of restrictions to incoming travelers.	Insufficient communication/awareness regarding requirements.

5.	Some health services, particularly elective surgeries had to be suspended at different time intervals for chronic diseases as acute cases were prioritized.	Elective services and surgeries were suspended. Lack of provision of services regarding chronic diseases. Challenge for sick persons who needed these types of services.	Lack of capacity. Not enough space to separate COVID wards in hospitals.
6.	Vaccine uptake is improving, however vaccine hesitancy remains a challenge amongst certain population groups (i.e., pregnant women, children/youth, persons with pre-existing conditions).	Improving recently, however when cases are reduced a direct decrease in number of vaccinations can be seen. Approximately 50% of population were vaccine-hesitant prior to arrival of vaccines.	Based on Behavioral Insights study, the following reasons for vaccine hesitancy are: Fear of post-vaccination complications due to pre-existing conditions or other medical reasons. Vaccination center not close by or access to vaccination is not easy. Women are more hesitant to take vaccine compared with men. Concerned about serious vaccine-related conditions. Refusal to believe the presence of virus is cause for vaccine hesitancy. Cultural and religious concerns. Persons who have recovered from COVID-19 expect to remain immune. Social media and social networks promoting infodemia and disinformation regarding vaccines (distrust in vaccines).

7.	Effects of PHSMs implemented by government have been a significant challenge to the economy and population overall.	Incentives for individuals who were COVID-19 positive (municipality initiative). Incentives not effective due to marginalized populations not being impacted.	Protracted emergency Government provided some incentives to businesses, but it was insufficient over course of pandemic.
8.	Absence of medical insurance in Kosovo for citizens at the national level.	Citizens must pay out of pocket for medications, procedures, services, etc. Impacted persons who may seek services regarding COVID-19 (medications, care, treatment, etc.). Family members providing care.	TBD

PRIORITIZED ACTIONS		DESIRED DATE FOR COMPLETION	RESPONSIBLE FOCAL POINT	REQUIRED SUPPORT	INDICATORS
a. For immediate implementation:					
1.	Development and rollout of induction training for surge capacity staff (i.e., volunteers, health professionals, etc.) based on functions of	3- 6 months	MoH & relevant services involved	Support with development of training material for each function	Mapping of Response Functions and terms of references Developed training adapted for each response function

	deployment that they will be operating within. Induction training to cover functions for all-hazard, beyond COVID-19 1. Mapping of functions. 2. Development of package for each function based on mapping.				
2.	Development of a plan in order to organize and sustain campaigns to improve PHSM uptake considering new developments (i.e., vaccine hesitancy, BI data, epidemiological situation).	Q4 2021	MoH and NIPH	Logistics Financial support Partners	Plan for upcoming campaigns # of successful campaigns implemented
3.	Organization of workshop on best use of Behavioral Insights	Q4 2021	NIPH	WHO support for delivering training	Use of BI data in policy making

	studies' data with relevant stakeholders.				
4.	Plan for and assign dedicated budget line in annual national budget for communication campaign and awareness activities for PHSM for sustainable financing of campaigns which go beyond COVID-19	Q1-Q2 2022	MoH	External donors and partners.	TBD
5,	Continue with conducting BI studies within a 3-month interval.	Q4 2021	NIPH	WHO	TBD
6.	Review and endorsement of Action Plan for Mental Health.	3-6 months	MoH	Costing and budgeting and approval	TBD
b. For mid to long-term implementation:					
1.	Continuation, finalization and endorsement of drafting action plan for infectious diseases.	3+ months	MoH	TBD	TBD
2.	Review of existing emergency preparedness plans (Focus on Function 8	Approx. 3-6 months (depending on pandemic)	MoH (review of Function 8)	TBD	TBD

	related to public health and health services).				
3.	Review and update national curriculum (public health and family medicine) in order to include modules on managing public health emergencies (i.e., surveillance, reporting, data collection, preparedness/response, PHSM monitoring, etc.).	6-12 months	MoH, NIPH, medical professional chambers (5)	Technical support from partners Funding for material development and identification of adequate trainers	TBD
4.	Review and update national curriculum undergraduate studies in the field of medicine (general, other branches).	6-12 months	Medical faculty, MoH, NIPH	Technical support from partners Funding for material development and identification of adequate trainers	TBD
5.	Development of a simulation exercise strategy and program to systematically conduct simulation exercises as part of continuous professional development focusing on SOPs in health emergencies or relevant	6-12 months	Agency for Emergency Management, MoH, NIPH, medical professional chambers	TBD	Strategy development and program planning Costed

	emergency plans and procedures.				
6.	Establishment of national public health research network.	1-2 years	NIPH, MoH, medical faculty and medical chambers	Donor community	TBD
7.	Development of national plan on behavioral research.	1-2 years	NIPH, MoH, medical faculty and medical chambers	TBD	TBD
8.	Development and rollout of induction training for surge capacity staff (i.e., volunteers, health professionals, etc.) based on functions of deployment that they will be operating within. *1.* Mapping of functions. *2.* Development of package for each function based on mapping.	1-2 years	MoH, Management of relevant services involved	Partner organizations	TBD

6. THE WAY FORWARD

The findings of this review will provide a basis for rapid as well as more long-term actions to improve the current COVID-19 response and strengthen Kosovo´s preparedness and response to epidemics in general. The report will be finalized and approved by the country, recommended actions prioritized together with key international partners, and the implementation of the action plan will be monitored by a dedicated focal point(s). WHO Country Office will support the follow-up process and facilitate further technical support from the WHO Regional Office and other international partners.

7. ANNEXES

Agenda

Agenda
Country Intra-Action Review for COVID-19 response
Location: Hotel International Prishtina

	TUESDAY October 5	
TIME	**SESSION**	**FACILITATORS:**
08:30-09:00	Registration and administrative formalities and instructions	
09:00-09:30	Opening & Introduction of the participants	Dr Dafina Gexha Bunjaku (MoH) Ms Ulrika Richardson (RC UNDCO) Dr Abebayu Assefa Mengistu (WHO)
09:30-09:40	Safety and security measures in the context of COVID-19	WHO
09:40-10:00	Overview of COVID-19 situation in Kosovo	Prof Ariana Kalaveshi (NIPH)
10:00-10:15	Coffee break	
10.15-10:30	Introduction to the WHO Intra-Action Review methodology, scope and objective of the IAR	Dr Jussi Sane WHO RO

Page Break

TUESDAY October 5			
Parallel Sessions 1 - What worked well? What worked less well? And why? *Participants work to identify the challenges and best practices of the response in separate Groups according to the IAR Pillars.* **10:30-12:30**			
Group/Pillar	**External WHO facilitators**	**Country focal points**	**Location/Room Online link**
Country-level coordination	Abe Mengistu Landry Mayigane	**Dr Arsim Çavdërbasha** (Naser Ramadani, Mentor Sadiku, Arbëresha Turjaka, Pashk Buzhala)	
Risk communication	Thanas Goga Tanja Schmidt	**Dr Faik Hoti** (Merita Berisha, Flora Basholli, Drita Zajmi, Bukurije Selimi, Shpend Qamili, Dafina Zuna, Orgesa Arifi)	
Lunch **12:30-13:30**			
Parallel Sessions 1 *(continued)* **–** **What worked well? What worked less well? And why?** *Participants work to identify the challenges and best practices of the response.* **13:30-15:30**			
Coffee break **15:30-15:45**			
Parallel Sessions 2 - What can we do to improve the COVID-19 response and strengthen Kosovo's preparedness and response to epidemics in general **15:45-16:45**			

Parallel Sessions 2 cont/3 – The Way Forward: *discussion on the best way to implement these activities moving forward.* **16:45-17:30**
Closing of the day **17:30**

WEDNESDAY October 6			
08:30-09:00 Registration and administrative formalities and instructions			
Parallel Sessions 1 - What worked well? What worked less well? And why? *Participants work to identify the challenges and best practices of the response in separate Groups according to the IAR Pillars.* **9:00-10:45**			
Group/Pillar	**External WHO facilitators**	**Country focal point**	**Location/Room Online link**
Pillar 3: Surveillance	Rawi Ibrahim Delphine Perriat	**Dr Ariana Kalaveshi** (Pranvera Kaçaniku Gunga, Njomza Malaj, Teuta Fejza, Shqipe Krasniqi, Burbuqe Shkodra, Rejhane Zhushi, Sanije Hoxha Gashi / Rina Hoxha)	
Pillar 4 : National laboratory	Golubinka Boshevska Jussi Sane	**Dr Xhevat Jakupi** (Zana Deva, Ajhane Sejfiu, Donjeta Hajdari, Brikenda Sharapolli, Safete Kamberi)	

Pillar 5: Infectious Prevention and Control	Elena Vovc Kayla King	**Dr Lul Raka** (Elvana Podvorica Agreta Gecaj – Gashi, Lirije Beqiri, Valton Sahiti,Osman Maxhera)	
Coffee break **10:45-11:00**			
Parallel Sessions 1 *(continued) –* **What worked well? What worked less well? And why?** *Participants work to identify the challenges and best practices of the response.* **11:00-12:30**			
Lunch **12:30-13:30**			
Parallel Sessions 2 - What can we do to improve the COVID-19 response and strengthen Kosovo's preparedness and response to epidemics in general **13:30-15:00**			
Coffee break **15:00-15:15**			
Parallel Sessions 2 cont/3 – The Way Forward: *discussion on the best way to implement these activities moving forward.* **15:15-17:00**			
Closing of the day **17:00**			

THURSDAY October 7

<table>
<tr><td colspan="4">08:30-09:00 Registration and administrative formalities and instructions</td></tr>
<tr><td colspan="4">Parallel Sessions 1 - What worked well? What worked less well? And why?
Participants work to identify the challenges and best practices of the response in separate Groups according to the IAR Pillars.
9:00-10:45</td></tr>
<tr><td>Group/Pillar</td><td>External WHO facilitators</td><td>Country focal point</td><td>Location/Room
Online link</td></tr>
<tr><td>Pillar 6: Case management</td><td>Elena Vovc
Delphine Perriat</td><td>Prof. Salih Ahmeti (Dr Lindita Berisha-Ajazaj, Dr Bahrie Halili
Dr Blerta
Haraqia, Dr Ajete Aliu, Dr Murat Mehmeti, Dr Hatixhe Gashi, Dr Albina Ponosheci, Dr Vera Berisha, Arjeta Zogaj, Dr Sadie Avdiu,
Dr Nderim Hasani,Dr Artan Ahmeti, Dr Besim Luri, Dr Hamzë Selmani, Dr Gazmend Spahija,)</td><td></td></tr>
<tr><td>Pillar 7 : Public Health and Social Measures</td><td>Tanja Schmidt
Kayla King</td><td>Dr Pashk Buzhala (Merita Berisha, Flora Basholli)</td><td></td></tr>
<tr><td colspan="4">Coffee break
10:45-11:00</td></tr>
<tr><td colspan="4">Parallel Sessions 1 (continued) –
What worked well? What worked less well? And why?
Participants work to identify the challenges and best practices of the response.
11:00-12:30</td></tr>
</table>

Lunch **12:30-13:30**
Parallel Sessions 2 - What can we do to improve the COVID-19 response and strengthen Kosovo's preparedness and response to epidemics in general **13:30-15:00**
Coffee break **15:00-15:15**
Parallel Sessions 2 cont/3 – The Way Forward: *discussion on the best way to implement these activities moving forward.* **15:15-17:00**
Closing of the day **17:00**

FRIDAY October 8
08:30-09:00 Registration and administrative formalities and instructions
Plenary presentation of initial findings & discussions: *Each pillar group will present their findings followed by general discussion* ***9:00-10:30***
Closing of the IAR **10:30-11:00**
Lunch **11:00-12:00**
High-Level Debrief session 14:00-16:00

List of participants

1. *Dafina Gexha MoH*
2. *Arsim Qavdarbasha MoH*
3. *Mentor Sadiku MoH*
4. *Arberesha Turjaka MoH*
5. *Albana Morina MoH*
6. *Pashk Buzhala MoH*
7. *Faik Hoti MoH*
8. *Dren Rexha Unicef]*
9. *Arta Haliti Unicef*
10. *Dafina Mucaj Unicef*
11. *Shpend Qamili UNDCO*
12. *Naser Ramadani NIPH*
13. *Ariana Kalaveshi NIPH*
14. *Merita Berisha NIPH*
15. *Florije Miftari Basholli NIPH*
16. *Drita Zajmi NIPH*
17. *Pranvera Kacaniku Gunga NIPH*
18. *Rejhane Zhushi PHC*
19. *Teuta Fejza Regional IPH*
20. *Burbuqe Shkodra Regional IPH*
21. *Shqipe Krasniqi Regional IPH*

22. Njomza Malaj, NIPH

23. Lul Raka NIPH

24. Agreta Geci Gashi HUKC

25. Osman Maxherraj PHC

26. Xhevat Jakupi NIPH

27. Salih Ahmeti HCUCK

28. Lindita Ajazaj Berisha HCUCK

29. Valbon Krasniqi HCUCK

30. Nderim Hasani HCUCK

31. Gazmend Spahija HCUCK

32. Murat Mehmeti HCUK

33. Zana Deva NIPH

34. Donjeta Hajdari NIPH

35. Pranvera Abazi NIPH

36. Ajhane Gashi Sejfiu Regional IPH

37. Safete Kamberi Regional IPH

38. Sanije Gashi NIPH

39. Rina Hoxha NIPH

40. Magbule Rexhepi NIPH

41. Brikenda Sharapolli, Regional IPH

42. Lirije Beqiri HCUCK

43. Valton Sahiti, Regional Hospital

44. Bahrije Halili, HCUCK

45. Blerta Haraqija HUCK

46. Ajete Aliu HUCK

47. Albina Ponosheci HUCK

48. Vera Berisha HUCK

49. Hatixhe Gashi HUCK

50. Arjeta Zogaj HUCK

51. Artan Ahmeti HUCK

52. Besim Luri Regional Hospital

53. Bukurije Seljimi WHO

54. Orgesa Arifi MoH

Composition of the IAR team

Role	*Pillars For Review*	*Name*		*Organization*	*Main responsibility*
IAR lead coordinator		Country Focal Point	Dr. Dafina Gexha Bunjaku	MoH	IAR oversight
		External partners	Abe Mengistu, Jussi Sane Tanja Schmidt Isme Humolli	WHO RO Europe WHO CO Kosovo	
Lead external facilitators /assistant facilitators and country focal points	Country-level coordination	Country Focal Point	Naim Bardiqi	Minister's Cabinet, MoH	Lead the facilitation in the sessions
		External partners	Abe Mengistu Landry Mayigane	WHO RO Europe WHO HQ	
	RCCE & infodemic management	Country Focal Point	Faik Hoti	MoH	
		External partners	Thanas Goga Tanja Schmidt	WHO CO Albania WHO RO	
	Surveillance	Country Focal Point	Naser Ramadani, Arijana Kalaveshi	NIPHK	
		External partners	Rawi Ibrahim Delphine Perriat	WHO Balkan hub RKI Germany	
	The national laboratory system;	Country Focal Point	Xhevat Jakupi	NIPHK	

		External partners	Golubinka Boshevska Jussi Sane	WHO Balkan hub	
	Infection prevention and control;	Country Focal Point	Lul Raka	NIPHK	
		External partners	Elena Vovc Kayla King TBC	WHO	
	Case management	Country Focal Point	Salih Ahmeti	Infectious Diseases Clinic	
		External partners	Elena Vovc Delphine Perriat	WHO	
	Public health and social measures	Country Focal Point	Naim Bardiqi, Minister's Cabinet, Naser Ramadani	MoH, NIPHK	
		External partners	Tanja Schmidt Kayla King	WHO	
Note-taker and report writer			Kayla King	WHO	
Additional Supporting staff				WHO Pristina Office	Admin & IT support
					Finance

8. ACKNOWLEDGEMENTS

All participants from key stakeholder institutions in Kosovo are thanked for their interactive and transparent discussions and contribution to the IAR mission. Robert Koch Institute is thanked for its financial and technical support.