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FINAL REPORT

NOVEMBER 1999 TO JULY 2000

USAID/BHR/OFDA - Grant number: AOT-G-00-00-00030-00

**PROGRAM TO MONITOR AND IMPROVE THE
NUTRITIONAL STATUS OF MOTHERS AND
PRE-SCHOOL CHILDREN
IN KOSOVO**

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I. Executive Summary

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Type of Humanitarian Action and Grant information:

| | |
|--|--|
| Program Title | Program to monitor and improve the nutritional status of mothers and pre-school children in Kosovo |
| Grant number | AOT-G-00-00-00030-00 |
| Country: | Province of Kosovo |
| Disaster | Conflict/Civil war |
| Time Period Covered by This Report: | November 1999 to July 2000 |

Brief Summary of the Activities undertaken during the Reporting Period:

1. A total of 703 health care workers (doctors, nurses and assistants) throughout 15 municipalities were trained on breastfeeding and infant feeding practices and growth monitoring. The results of the baseline knowledge tests ranged from 45-60% and within the different municipalities. Post-training test results ranged from 68-87%.

➤ Expected Results

This fulfilled expected results.

2. An average of 60% of the health facilities within the 15 municipalities covered have received training. (All those health structures who trained received an illustrated module written in Albanian, covering all topics within the training).

➤ Expected Results

At the time of writing the proposal, the number of health facilities in the chosen municipalities was not known, hence no statistical expected results were predicted. However, this is considered a successful result.

3. Through local Women's groups, over 3,000 women in the community received training on appropriate breastfeeding and infant feeding practices as well as sensitisation to growth monitoring.

➤ Expected Results

This is considered a successful result.

4. Following a request from the World Health Organisation (WHO), chapters on Infant Feeding Practices and on Growth Monitoring have been written by Action Against Hunger. These are integrated into the module for the Province-wide training for General Practitioners within the Integrated Management of Childhood Illnesses (IMCI) programme. The expected result was that infant feeding practices and nutritional surveillance were to be incorporated into the public health policy.

➤ Expected Results

As the Public Health Policy has not been finalised it is difficult to predict the results. However, these modules can be considered a useful first step.

5. Distribution of growth monitoring equipment to 45 health establishments.

➤ Expected Results

Growth Monitoring has got off to a slow start due to limited time and motivation on the part of some health staff and due to a lack of agreement at the UNMIK policy level. However, Action Against Hunger has been able to contribute the combination of training staff, provision of monitoring equipment and the production of a module.

6. Production of a leaflet on infant feeding (weaning and complementary foods) in collaboration with UNICEF and WHO, for distribution to all Health Establishments within Kosovo.

➤ Expected Results

The expected results determined that within the targeted health care establishments key health care providers are trained and aware of appropriate feeding practices. This has been achieved. (See point 1 for test results).

7. Provision of training materials to the institute of Public Health and other organisations, in order to continue the sustainability of the programme. Handout of training distributed to health facilities and key organisations.

➤ Expected Results

See point 6 above. The number of incidents of inappropriate distribution of infant formula has reduced.

8. Provision of a Proposal for a two-day conference on infant feeding and growth monitoring to leading paediatricians and nurses in Kosovo. The idea of this conference was initiated by WHO and was supported by UNICEF, but unfortunately due to time limitations of WHO, it was not realised during this program duration.

➤ Expected Results

Though this was not planned within the original proposal, it seemed a logical consolidatory step to take. The preparation of this done by Action Against Hunger and the use of surveys and lessons learnt should enable its fruition in the months to come.

Programme Objective (Summary of Progress toward achievement of this objective)

To incorporate nutrition education and growth monitoring into the emerging health service at the primary and secondary levels in Kosovo and improve infant feeding and weaning practices amongst health care providers and mothers.

Indicator and Current Measure

As one main project objective was given in the proposal, it is only through the indicators provided for the specific activities that the programme can be measured. This is described above in the Brief Summary of Activities and in greater detail below in Programme Overview.

Budget for Objective: \$208,175

Cumulative Expenditures to Date: **\$178,575** **Balance:** **\$29,600 unspent**

II. Programme Overview

A. Programme Goal and Objective

Overall Goal

To Improve the nutritional status of mothers and Pre-School children in Kosovo.

Programme Objective (only one objective)

To incorporate nutrition education and growth monitoring into the emerging health service at the primary and secondary levels in Kosovo and improve infant feeding and weaning practices amongst health care providers and mothers.

B. Profile of Targeted Population and the Critical Needs identified in the Proposal

1. Mothers of pre school children and infants

Needs:

- Breast-feeding and infant feeding advice and support for Mothers of infants.
- Counseling and support for mothers having difficulty feeding their children.
- Advice, counseling and support for mothers whose children are experiencing growth difficulties.
- Nutritional support for malnourished mothers.

2. Health care providers in primary or secondary health facilities in Kosovo; community health visitors (patronage nurses), nurses, doctors, outreach workers.

Needs:

- Training of health care providers in appropriate infant feeding techniques.
- Education of health care providers in effective counseling and support techniques.
- Training of health care providers in order to monitor the weight and / or height of children.

C. Geographic Locations of all Major Programme Activities

The Programme was undertaken in 15 Municipalities in Kosovo Province. These are: Prizren, Suha Reka, Rahovac, Gjakove, Peje, Istog, Skenderaj, Glogovc, Vushtm, Fushe Kosove, Prishtine, Shtime, Kline, Podujevo, Malisevo.

III. Programme Performance

Due to a certain overlap amongst the Specific Activities, some of these have been grouped together within this section of the report. The Specific Activities referred to in the proposal are now grouped under Activities I to V

| | Specific Activity in Proposal | C1.1 | C1.2 | C1.3 | C1.4 | C1.5 | C1.6 | C1.7 | C2.1 | C2.2 | C2.3 | C2.4 |
|----------------------|-------------------------------|------|------|------|------|------|------|------|------|------|------|------|
| Activities in Report | | | | | | | | | | | | |
| I | | ✓ | ✓ | | | | | | ✓ | | | ✓ |
| II | | | | | ✓ | ✓ | | | | | ✓ | |
| III | | | | ✓ | | | ✓ | | | | | |
| IV | | | | | | | ✓ | | | | | |
| V | | | | | | | | ✓ | | ✓ | | |

A. Programme Performance

A.1 Actual Accomplishments

Table 1: Calendar of Activities

| Type of activity | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|--|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Recruitment of trainers | √ | | | | | | | | | |
| Training of trainers | | √ | | | | | | | | |
| AAH nutritional survey | | | √ | | | | | | | |
| Preparations and introductions | | √ | √ | | | | | | | |
| Training in ambulantas and HH | | | | √ | √ | √ | √ | √ | √ | √ |
| Negotiation with WHO on growth monitoring charts | √ | √ | √ | | | | | | | |
| Child health module for GP training meetings | | √ | √ | √ | √ | √ | | | | |
| IMCI meetings | | | | √ | √ | √ | | | | |
| Chapters for child health modules completed | | | | √ | √ | | | | | |
| Proposal for infant feeding conference and discussions | | | | | | √ | √ | √ | | |
| Training handout completed | | | | | | | √ | √ | | |
| Infant feeding leaflet completed | | | | | | | | √ | √ | |
| Distribution of growth monitoring equipment | | | | √ | √ | √ | √ | √ | √ | √ |
| Recruitment of outreach workers | | | | | √ | √ | | | | |
| Training of outreach workers | | | | | | | √ | √ | | |
| Training of women in the communities | | | | | | | √ | √ | √ | |
| Evaluations using case studies | | | | √ | √ | √ | √ | √ | √ | |
| Evaluation of training performance | | | | | | | | √ | √ | √ |
| Evaluations of knowledge gain by health staff | | | | | | √ | √ | √ | √ | √ |
| Donation of posters for continuation of training in Kosovo | | | | | | | | | | √ |

A.1.I

Specific Activities C1.1 & C1.2 : Within the primary and secondary health structures, ensure prompt change in highly inappropriate infant feeding practices, through training personnel directly involved in infant nutrition. **Specific Activity C2.1 :** Improve the knowledge and practices of national and international health professionals operating in Kosovo, in line with WHO/UNICEF standards for infant nutrition. **Specific Activity C2.4 :** Monitor infant feeding practices within the health structures and the community.

Results Expected

- *Within the targeted health care establishments key health care providers are trained and aware of appropriate infant feeding practices.*
- *Knowledge and practices of infant nutrition undertaken by health care providers are in accordance with WHO standards.*
- *Inappropriate feeding practices are detected and sensitive advice given accordingly.*
- *Inappropriate infant feeding practices within health care establishments will decrease.*

• **Geographical coverage of training**

Each municipality has at least one health house (secondary structure), which supports a number of ambulantas (primary structure). The aim of the program was to target relevant staff from all of the health facilities throughout 15 municipalities of Kosovo. This represents 50% coverage of the province. The map of Kosovo in **Annexe A** shows the municipalities covered in the program. **Annexe B** shows a list of health facilities for each of the municipalities currently proposed by UNMIK as future structures that will receive funding. Within each municipality AAH was able to train in an average 60% of the health facilities (with a coverage range of 38% to 100%). The areas where coverage was low represents municipalities where training commenced late or where there were a large number of minority facilities. The latter were not secure for the training teams. In addition some of the facilities were not functioning or consisted of a single member of staff. AAH initially informed UNMIK, WHO and UNICEF of the program and subsequently made contacts with 14 of the health house directors responsible for the primary and secondary structures in December and January. All the directors and those subsequently appointed showed interest and motivation for AAH to begin training their staff.

• **Training methodologies and materials**

The training was undertaken by three AAH teams each consisting of two trainers. These were led and supported by a training co-ordinator, an infant feeding councillor and a team supervisor. AAH had difficulties recruiting enough suitably qualified staff for the supervisory and coordinator positions.

The AAH trainers were trained making use of a variety of training methodologies normally used for "training of trainers". These consisted mainly of case studies, role-plays and discussions. They were trained by the two international nutritionists and with the assistance of a breastfeeding consultant from WHO and "training of trainers" facilitators from other NGOs namely International Medical Corps and World Vision. As much as possible these methodologies were utilized for the training of the health professionals. These formats have been shown to be more effective in the training of adults than traditional didactic techniques.

Although modern media such as slides and videos would have been useful tools, due to the erratic electricity supply, these were not relied upon. Hence alternative approaches using a variety of materials were utilised for the training sessions. Most notably canvass paintings by a locally commissioned artist were used in all places for all the sessions. The training also included practical demonstrations and participation such as the use of anthropometric equipment and participants placing foods onto a food pyramid to illustrate the various food groups.

• **Content of training and personnel trained**

The training sessions were conducted in individual health facilities over a 4-week period. The first 2 sessions were on breastfeeding, the third on infant feeding and the fourth on growth monitoring (see **Annexe C** for basic training outline). The training sessions covering the former topics were based on information provided in internationally recognised WHO/UNICEF guidelines.

Table 2 shows the maximum number of health workers that attended the training sessions from the health facilities for each municipality. The majority of those trained were doctors, nurses and technicians. In total, a maximum of 703 health staff attended the training sessions from the health facilities (see **Annexe D** for a breakdown for each training topic per place within the municipalities). Overall this number met the predicted levels anticipated in the mid term report with slight variations per municipality.

Table 2: Number of health care staff trained per municipality compared to predicted numbers.

| Municipality | Predicted numbers | Maximum number trained | Comments and Reasons |
|-------------------------|-------------------|------------------------|---|
| <i>Peje</i> | 50 | 66 | <i>A greater number of ambulantas existed in Peje town than had been shown on the original list obtained prior to the start of the program.</i> |
| <i>Klina</i> | 50 | 24 | <i>This is a small municipality with fewer staff than predicted. Training took place in all the facilities except 1 ambulanta with only one member of staff.</i> |
| <i>Malisheve</i> | 50 | 23 | <i>This is a new municipality created after the conflict without formal administrative set-ups and hence staff. The ambulantas were therefore rarely staffed by more than 1 or 2 people. Most of the staff were based at the health house.</i> |
| <i>Istog</i> | 50 | 39 | <i>AAH had expected more staff to attend at the health house level. However, many of the doctors were attending training sessions on other topics provided by a different organisation and hence had limited time.</i> |
| <i>Skenderaj</i> | 50 | 64 | |
| <i>Prizren</i> | 65 | 109 | <i>A large number of staff participated in a discussion workshop at the health house.</i> |
| <i>Rahovec</i> | 50 | 57 | |
| <i>Gjakove</i> | 50 | 72 | |
| <i>Shtime</i> | 10 | 18 | |
| <i>Pristina, Obilic</i> | 65 | 81 | <i>These 2 municipalities were considered as 1 for two reasons. there is a great deal of overlap in the catchment populations of the two. There were more health facilities therefore than anticipated. As it was not possible to cover some of the minority areas for safety reasons, the neighbouring area was covered instead.</i> |
| <i>Fushe Kosovo</i> | 10 | 16 | <i>It was not possible to train staff from the health house.</i> |
| <i>Vushtrri</i> | 50 | 25 | <i>Many of the staff from this municipality had received training from WHO in 1999, and hence were reluctant to participate within the programme.</i> |
| <i>Gllgovc</i> | 50 | 54 | <i>Some Staff had already received breastfeeding training from WHO in 1999.</i> |
| <i>Suhareke</i> | 50 | 42 | |
| <i>Podujeve</i> | 50 | 13 | <i>Some Staff already received breastfeeding training from WHO in 1999. Training in this municipality started late because the director was not interested in any more training for his staff at the beginning.</i> |
| Total | 700 | 703 | Overall targets met. |

- **Collaboration with other organisations**

In areas where other organisations were providing similar education programs (e.g. family planning, maternal and child health) AAH arranged either to provide training of their trainers in order to ensure the same messages were disseminated to the community/health professionals or provided further information for inclusion in their programs. Local women's NGOs were particularly enthusiastic for AAH to train their groups. Some of these groups included NGOs working in some of the municipalities not originally on the AAH list. Table 3 below shows the outreach and increased impact the AAH program had through other organisations. However 6 municipalities which are minority areas were not covered for security reasons. It was not possible to collaborate with organisations working in these areas both of local and international origin.

Table 3: Municipalities where there is an impact of the program either directly via AAH trainers or indirectly with other organisations.

| | <i>Municipalities</i> | <i>Coverage of OFDA program</i> | <i>Collaboration with International NGO's</i> | <i>Collaboration with Local women's NGO's</i> |
|----|-----------------------|---------------------------------|---|---|
| 1 | Podujevo | | IMC, WV | DRITA |
| 2 | Prishtine | | WV | *RGF |
| 3 | Vushtrri | | WV | |
| 4 | Glogovc | | MDM | |
| 5 | Fushe Kosovo | | MDM, DOW | |
| 6 | Skenderaj | | | **MGF |
| 7 | Istog | | | |
| 8 | Peje | | | MGF |
| 9 | Kline | | IMC | |
| 10 | Malisheve | | | MGF |
| 11 | Gjakove | | TF | MGF & ***MQ |
| 12 | Rahovac | | | MGF |
| 13 | Shtime | | | *RGF |
| 14 | Suhareke | | | MGF |
| 15 | Prizren | | | |
| 16 | Obilic | | MDM | MQ |
| 17 | Ferizaj | | IMC | |
| 18 | Gnjilane | | IMC | MQ |
| 19 | Kamenica | | IMC | |
| 20 | Mitrovitca | | CARE | MGF & MQ |
| 21 | Decan | | | MGF |
| 22 | Lipijan | | | Flaka |
| 23 | Vitina | | | Legjenda |
| 24 | Kacanik | | | Inicijativa e gruas |
| 25 | Gora (Dragash) | | | |
| 26 | Zvecane | | | |
| 27 | Strpce | | | |
| 28 | Novo Brdo | | | |
| 29 | Leposavic | | | |
| 30 | Zubin Potok | | | |

* RGF = Qendra per rehabilitimin gruas dhe femis ** MGF = Qendra per Mbrojtjen e gruas dhe femis
 *** MQ = Motrat Qiriazhi WV = World Vision, MDM = Medicine du Monde, DOW = Doctors of the World and TF = Tearfund.

- **Monitoring of infant feeding practices**

The training provided for health professionals included assessment and follow up of the infant feeding problems so that appropriate and relevant advice was given to the mothers of such children on a continued basis.

A.1.II

Specific Activity C2.3: Improving infant feeding practices of mothers, by providing them with practical advice and support through health facilities.

Results Expected

- *Mothers are confident in their knowledge and capacity to feed their children appropriately after instruction from trained health care providers, and know how to access further information or support if required.*
- *The number of mothers beginning to breastfeed their children immediately after birth, and continuing exclusively for 6 months increases.*
- *Mothers begin relactation when deemed necessary and infants receive nutrition appropriate for their age.*
- *Mothers positively adapt the diet of their child following appropriate advice from health care providers*

- **Women's groups in Kosovo**

There are many women's groups throughout the province set up by motivated individuals, although most of the work was not funded until recently. Currently, however UNHCR funds the Kosovo Women's Initiative (KWI) by providing financial support to projects run by women's groups throughout the province. The projects mainly range from literacy to income generation. Each women's group comes under an umbrella of an international organisation, which, on receipt of a proposal, consider the provision of funding to the specific groups. At least one local women's group per municipality exists, although not all of these have received funding or have become sufficiently influential enough in their domains.

- **Training of women in the community**

In addition to the training of health professionals, in order to influence and change infant feeding practices, 15 women were recruited as outreach workers to convey the same messages to women in the communities. Training was organised at this local level in order to build up confidence in the knowledge and capacities of women in order to feed their children appropriately. As described above for the trainers of health workers, the outreach workers were also trained using "training of trainer" techniques in order to adequately train women in their communities.

Initially the recruitment was only successful in 13 of the 15 municipalities. The last 2 outreach workers were recruited in June. In Rahovec municipality no suitable and motivated individuals were found at the early stages of the programme. In Fushe Kosovo/Polje municipality, there were logistical difficulties in recruiting an individual and arranging training due to issues of security. In all cases the women began by raising awareness of their proposed activities in their respective communities and made contacts with key local individuals usually through national women's NGOs or staff at ambulantas. The training sessions were conducted in private homes, school halls, rooms in ambulantas and premises of women's groups.

The training sessions consisted of breastfeeding, infant feeding practices and sensitising mothers to the idea of growth monitoring. The women used similar materials for their training sessions as the trainers of health care providers. The canvass paintings were scanned and copies made onto card.

The women attending the sessions came from all sections of the communities with a wide age range (16 to 80 years). In total, 3,342 women attended the breastfeeding and 3,068 for the infant feeding workshops throughout all the municipalities. **Table 4** shows how many women attended these sessions per municipality. As much as possible the trainers encouraged visits to health professionals not only when the child was ill but at other times for example for growth monitoring purposes.

Table 4: Number of women trained per municipality on breastfeeding and infant feeding.

| Municipality | Breastfeeding training session | Infant feeding training session | Comments and Reasons |
|---------------------|---------------------------------------|--|---|
| Peje | 143 | 47 | <i>Peje has many villages and opportunities for training. However without transport, this worker had difficulty travelling around the municipality.</i> |
| Klina | 417 | 374 | <i>Kline has a very organised women's group with which this outreach worker was involved with.</i> |
| Malisheve | 211 | 156 | <i>Although this is a new municipality created after the conflict without formal administrative set-up, the communities are motivated. The trainer will continue training in this municipality.</i> |
| Istog | 157 | 181 | <i>An area with a strong women's group activities. The trainer was already part of a women's group. The trainer will continue on a voluntary basis within her organisation.</i> |
| Skenderaj | 216 | 193 | <i>Another region, which was devastated in the conflict. The outreach worker had difficulties travelling to the villages.</i> |
| Prizren | 234 | 185 | <i>The outreach worker for this municipality had difficulties travelling without transport.</i> |
| Rahovec | 51 | 53 | <i>It was not possible to find a suitable worker until 6 weeks before the end of the program. The trainer worked in the health house and will continue the work.</i> |
| Gjakove | 282 | 276 | <i>This trainer was a former nurse in the region and was able to capitalise on contacts at the hospital and collaborate with other NGOs. The trainer will continue on a voluntary basis.</i> |
| Shtime | 162 | 149 | <i>This trainer had difficulties travelling to villages without her own transport. Shtime is one of the smallest municipalities.</i> |
| Pristina | 209 | 209 | <i>Although having the majority of women's groups in the province there are other organisations working on a similar topic and it was difficult to reach more people.</i> |
| Vushtrri | 231 | 254 | <i>This outreach worker had difficulties initially with making contacts in the municipality.</i> |
| Glogovc | 419 | 419 | <i>The trainer will continue on a voluntary basis within her organisation.</i> |
| Suhareke | 282 | 292 | <i>The trainer will continue on a voluntary basis within her organisation</i> |
| Podujeve | 272 | 224 | <i>The trainer will continue on a voluntary basis within her organisation.</i> |
| F. Kosovo | 56 | 56 | <i>The Serbian community is drastically reduced and there are very few women left in the communities in this municipality.</i> |
| Total | 3,342 | 3,068 | |

A1.III

Specific Activities C1.4 & C1.5 : Actively discourage inappropriate usage of infant formula and other specialized infant foods, particularly pre-prepared weaning foods and improve knowledge and practice of all international humanitarian agencies directly or indirectly involved in the feeding of infants and young children.

Results Expected

- *Inappropriate use of infant formula and other specialised infant foods significantly decreases.*
- *Incidents of inappropriate distribution of infant foods and breast milk substitutes by humanitarian organisations drop in response to sensitisation.*

During the conflict a number of donations resulted in widespread untargeted use of infant formula and baby food both at the household level and in health institutions. AAH advised health care providers, women, local NGOs and international NGOs about appropriate use of such products as an integral part of the education program. As part of the program mothers were advised that breast milk substitutes were far from being superior to breast-feeding and freshly prepared weaning foods were cheaper and more nutritious than commercially available produce. When asked to provide formula by health workers or mothers, AAH trainers provided counselling on breastfeeding or appropriate feeding where possible. Key health workers, mothers and warehouse managers were made aware with advice and provision of simple posters to alert them to such donations (see **Annexe H**). The posters were also distributed to mothers at a summer festival organised by Children's Aid Direct (CAD) in which AAH held a stall. The festival was aimed at raising awareness on health issues and mine awareness.

- **Collaboration with other organisations**

Sensitisation of all humanitarian organizations concerned at food, health and nutrition co-ordination meetings continued. AAH also continued to monitor these distributions, in close collaboration with other agencies and organizations – most notably UNHCR and WHO. UNICEF, WHO and UNMIK provided their support for the program. AAH contacted all known organisations involved in health education through mailing and at meetings. The response generated led to collaborations with some of these organisations as described in section I of specific activities.

A1.IV

Specific Activity C1.3: Provide appropriate nutritional support for mothers and their children. **Specific Activity C1.6:** Establish a nutritional surveillance system for the detection and monitoring of malnutrition in pre school children in Kosovo.¹

Results Expected

- *Moderately malnourished beneficiaries gain weight at an appropriate level compared to the treatment received.*
- *The rate of malnutrition amongst 6 – 59 month old children and their mothers decreases.*
- *Health care providers in targeted health establishments are able to correctly perform the anthropometric measurements necessary to undertake nutritional surveillance.*
- *Children present at the health care establishments for regular nutritional surveillance.*
- *Any child found to have growth problems receives appropriate advice and support from the trained health care providers at the health care establishment.*

¹ The data collected from the nutritional surveillance system will be fed into the Institute of Public Health / WHO epidemiological surveillance system which is currently in place.

- **Practices on growth monitoring**

The present practice followed by health professionals throughout the region is to measure infants from birth until they are about 1 year old on a regular basis. This is however dependent on the mother taking the child to the health centre and the type of equipment available at that establishment. However the weight of the child is normally the only measurement taken. Beyond a weight measurement, further nutritional assessment and hence appropriate advice and support are not specifically a regular part of a consultation. Hence once a child is 1 year old, their measurements are taken only if they present for other reasons to a health centre. In certain areas measurements are also taken prior to entry to school.

The AAH training sessions with health professionals made them aware of the necessity for a regular nutritional surveillance of children by presenting the benefits to be gained both for the child as well as the population. As a result, 98% of those trained thought it was important to measure children up to 5 years old. Currently 43% said they were performing some sort of monitoring either on a monthly basis (31%) or each time the child visited the health centre (33%). The majority (54%) said that they would like to measure children properly following the guidelines presented to them.

Training in the community and women's groups also included sensitisation and the introduction of the importance of regular monitoring of their infants. The training on growth monitoring therefore consisted of improving awareness on the necessity to monitor children on a regular basis and how to take the appropriate measurements. It also included what to do with the measurements in terms of providing appropriate support and advice to mothers utilising the knowledge gained from the sessions on breastfeeding and infant feeding.

It was advised that severely malnourished individuals were to be referred to the hospital. At the end of the Action Against Hunger nutrition activities, it was necessary to ensure that WHO were aware that the previous supply of the appropriate pre-prepared nutritional products (following the WHO protocol of the severely malnourished) provided by Action Against Hunger no longer exists, hence this responsibility was passed on to the UN. For the treatment of the moderately malnourished cases, at the primary and secondary health structure level AAH initially provided nutritional products such as enriched porridge from stocks for the treatment of moderate malnutrition. A nutritionally balanced recipe to replace the porridge, which can be prepared locally, was subsequently introduced.

- **Provision of Training Modules for General Practitioners**

Steps taken by Action Against Hunger to include growth monitoring (GM) in the Province-wide policy (led by WHO) included the advocacy for the inclusion of GM in the training of General Practitioners (GP). AAH wrote 2 chapters for the training of GPs. The growth monitoring section as well as infant feeding section will be part of the child health module in the training, which will commence, under WHO in September 2000. The current health structures utilise a top-heavy approach. 90% of care is expected to be transferred to the ambulanta or family centre levels. The training by AAH of the staff at this level therefore ensures that the concepts of growth monitoring are in place.

- **Nutrition survey**

Since AAH returned to Kosovo in June 1999, a team of monitors actively sought malnourished children and provided nutritional advice and support. This wealth of experience was incorporated into the training of health providers with specific reference to growth monitoring.

The trainers participated in the survey undertaken in January 2000 (funded by UNHCR). In terms of assisting the program the survey served two purposes.

- To determine the rate of malnutrition for the province: 1.1% level of acute malnutrition (<-2 z-scores Weight/Height) and 7.1% chronic malnutrition (<-2 z-scores Height/Age). Discussion of these results was included in the training to health structure staff.

- An infant feeding questionnaire was conducted at the same time. This helped to provide a deeper understanding of the knowledge, beliefs and practices on infant feeding in the communities thereby directing the training on this subject.

- **Donation of equipment for nutritional surveillance**

As described in the interim report, UNICEF were supportive of the initiative to introduce nutritional surveillance or growth monitoring to Kosovo. They provided AAH with 14 height boards and 15 baby weighing scales. MSF were also able to donate 10 height boards and 10 Salter scales, which were distributed to health establishments. The remainder of the equipment came from funds for the program and remaining AAH stocks. Hence more sets of equipment were donated to health establishments than originally anticipated. The table in **annexe I** shows the total number of equipment AAH were able to donate to each of the health facilities in the 15 municipalities. These were delivered to the health houses and main ambulancias. The table also lists the places, the types of equipment and where they were donated. In most of the health centres all the staff attending the growth monitoring sessions were trained on how to use the equipment by the AAH trainers. Unfortunately due to supplier problems not all the equipment arrived before the end of the project. However the directors responsible for the health establishments identified to receive the new equipment were informed of the late delivery.

- **Usage of equipment and modified index**

In recognition of the low incidence of acute malnutrition in Kosovo, AAH agreed with WHO to adapt the growth monitoring tool. The nutritional indice normally used by WHO is the weight for age (W/A) chart from the IMCI handbook. This is contrary to normal AAH recommendations for nutritional surveillance, who use Weight/Height, the only reliable indicator to detect acute malnutrition. The agreed procedure with WHO was to measure the weight of the children and utilise a modified W/A chart. However where any case fell below -2 z-score of W/A, then the height was measured and the percentage of the median in W/H was calculated. The IMCI chart was adapted accordingly.

A1.V

Specific Activity C1.7 : Participate in the orientation of public health policy concerning infant feeding practices, treatment of malnutrition and growth monitoring. **Specific Activity C2.2** - Establish an efficient and self-sustaining mechanism in Kosovo to continue to improve the education of health professionals, in order to empower mothers and influential family members.

Results Expected

- *Key players in the emerging health system are identified*
- *Appropriate infant feeding practices and nutritional surveillance are incorporated into public health policy.*
- *Health care establishments have access to infant feeding councillors and the information is available to mothers throughout the population.*

- **Involvement in Public health policy**

The health structure in Kosovo is predominantly top heavy. WHO with the help of local doctors and international NGOs developed a training module for doctors throughout Kosovo to specialise in family health medicine (General practitioners). This is a very important policy development for Kosovo, which will alter the practice of health care provided to the communities. The primary health care level of the province is expected to improve with up to 90% of patient care being dealt with at this level.

As part of 6 modules AAH wrote 2 chapters on infant feeding and growth monitoring for the child health module. Training for the GP's commenced in July with the child health module due to start in September. The child health module also includes breastfeeding. Although this chapter was written by WHO, AAH made a significant contribution by making suggestions on the content.

All registered doctors in the province were initially invited to apply for the positions to take part in the 6-month training program. There was a vast response from the doctors throughout the province, which hopefully will be repeated for the next round of selection. The incorporation of nutrition especially breastfeeding, infant feeding and growth monitoring will play a part in future preventative practices of doctors. The plans for a similar program for nurses have not commenced yet.

- **Integrated management of childhood illnesses**

AAH were involved with WHO and other NGOs in the adaptation of the integrated management of childhood illnesses (IMCI) for Kosovo. Breastfeeding, infant feeding and growth monitoring play an integral part of the management of childhood illnesses. The training of 20 Kosovar doctors started in August and these individuals will then train others as a follow up. As described in specific activity IV, AAH worked with WHO to adapt the weight for age charts that will be used in any future growth monitoring programs.

- **Sustainability of activities**

Dissemination of AAH survey findings to organisations involved in reproductive health and health education as well as UN organisations ensured the continued reminder of the importance of nutrition to the society. As the program came to a close, AAH identified organisations keen to continue or incorporate the topics of the program into their activities. **Annex J** lists individuals and organisations that have received AAH training materials and will continue to utilise them. AAH have asked for a quarterly report from them in order to maintain contact. This will ensure continuity of the messages to mothers and health professionals across the region.

- **Infant feeding conference**

Following on from an initial idea by WHO to undertake a collaborative infant feeding conference for doctors from the Paediatric and GP associations, Action Against Hunger, alongside Save the Children Fund (SCF) prepared an initial planning for the running of this conference. This idea was also supported by the Institute of Public Health and UNICEF. Part of the objective (see **Annexe K**) was to introduce growth monitoring to an even wider audience, which would have also included UNMIK. Unfortunately WHO were not able to commit the resources required in order for the conference to go ahead during the period of the Action Against Hunger programme. AAH has passed on data that can be used if further discussions on this take place in future.

A.2 Reasons Why Established Targets were not met, and the resultant impact on the Objective

A2.I

- Due to data protection, it was not possible to obtain a list of personnel from UNMIK in order to calculate the proportion of staff reached by the program. However the training was successful in that in most municipalities, more than the predicted number of staff with regular contact with mothers and children attended the training sessions. In the main, all staff at the ambulanta level attended the sessions. However at the health house level this varied depending on the size and number of departments present.
- Table 1 (see A1.I) goes some way to explaining why not all the facilities per municipality were covered on the program. In some municipalities the health house or ambulantas were in minority areas (e.g. Fushe Kosovo health house). In such situations it was not possible to go there for the training due to security reasons. In certain ambulantas the security of the AAH staff would have been compromised through travelling via a minority area. In others the ambulantas were either very small or there was only a single room, used by one health worker. Where possible, if these places were close to another larger ambulanta the staff were collected and taken to join another group for training. In certain areas the presence of different ethnic groups did not prevent AAH from training health workers. In one such ambulanta in Fushe Kosovo the local people have come up with their own compromise. The facility served both Kosovo Albanians and Serbians as well as other minority groups.
- Due to the nature of the work in health centres, patients always had to come first. This meant that finding mutually acceptable times for training was difficult. The trainers tried to arrange the sessions at times which were suitable and not disruptive to patient care.
- The long distances and poor roads meant that only a few centres or ambulantas could be reached each day. The lack of transport for local people also meant that AAH could not expect the staff to attend another centre without giving per diem. In some areas AAH provided transport for staff from one health centre and took them to a neighbouring one for training. In addition AAH policy for security and safety reasons required all field staff to return to base by 5pm each day. This placed a constraint on the number of places that could be visited each day.
- The presence of many NGOs in Kosovo meant that it was difficult to make training arrangements in some of the health centres especially the health houses. Several organisations working in these centres were providing training programs in other health aspects. This meant that not all staff were available to attend AAH sessions or it was difficult to arrange dates to do the training.
- Training commenced at a late stage for two of the municipalities due to constraints on the times of the health staff (Podujevo) and finding a suitable Serbian trainer (Fushe Kosovo). Although a trainer was found for Fushe Kosovo, it was not possible to gain permission to train in the health house or any of the other Serbian ambulanta. However, Action Against Hunger was able to conduct training in one mixed ambulanta in this municipality

A2.II

- The training in the communities was originally intended to commence at the start of the program. The recruitment of the outreach workers was slow as it was difficult to identify appropriate groups at the start to help in finding suitable women willing to travel around their municipalities on their own. The total numbers of women trained in each municipality are therefore lower than would have been if the sessions had commenced at the same time as the training of the health professionals.

- The outreach workers also worked for only 3 days a week.
- As most of the women did not have their own means of transport, travelling around their municipalities was difficult. It was not possible to solely rely on public transport to get them between villages at whatever time they required. This meant that training took place in only one village per day.
- It was difficult to arrange rooms for the training sessions in villages where there were no women's groups. School rooms and ambulanta rooms were used in the afternoons. The former was not possible during the school holidays.
- The mothers turning up to the sessions, especially in areas where the population are well used to humanitarian organisations, expected donations of items such as food, nappies and clothes for their children. Many were disappointed when this was not offered.
- Over the hot summer holiday period a number of festivals and demonstrations were planned in villages, which disrupted the training sessions.

A2.III

- Commercially infant formula and weaning foods are still available on the market. Action Against Hunger has been able to advise suppliers to modify the label on the pots of baby food to ensure an appropriate language, although this opportunity has been rare.
- There are still distributions of infant formula and specialised baby foods to the hospitals. These are normally donor driven and therefore different brands are received. As this means labels are in other languages, the different brands are prepared in the same manner. This may lead to over or under dilution of the formula, which may lead to associated problems of diarrhoea, or under nutrition.

A2.IV

- At the time of the interim report AAH expected to be able to report on patterns of malnutrition in sentinel sites (health houses) so that the knowledge gained could be incorporated into the developing primary health care planning. This has not been possible due to the fact that all the training for these sentinel sites did not take place until the last couple of months of the program.
- In those places where AAH were able to train staff earlier in the program, although the staff were keen and supported the idea of this preventative method of health care, the general motivation and incentive to measure children on a regular basis was not there. However in places where the staff were well motivated they were still not measuring on a regular basis. This was because they were only measuring those children they saw as visibly underweight or when the mother reported feeding problems. However any child found to have growth problems received appropriate feeding advice and support from the trained health care providers.
- The late delivery of equipment due to supplier difficulties meant that many places were not able to commence using the equipment in the appropriate manner for monitoring purposes. The impact of the donations of the equipment will therefore be much later.
- The ability, commitment and motivation of the staff trained in the health structures were affected by many factors including salaries and insecurity of positions at all levels. These obstacles affected many of the objectives of the program. For example the referral system for sending malnourished children to the sentinel sites did not function. No reliable data were collected for infants presenting with feeding problems. Ideally each primary health facility should have height boards and scales in order to monitor growth effectively in the population.

A2.V

- It was not possible to achieve a fully functioning surveillance system across the municipalities of the program as AAH were heavily reliant on the UN organisations. Although they were supportive of the ideas and engaged in discussions it was not a priority for them at this time.
- It was difficult to measure the current reported practices on growth monitoring.
- On a broader scale the UNICEF *Baby Friendly Hospital Initiative* has not yet started at the tertiary health structure level. This held constraints for the AAH program, as the same correct message were not being delivered at the hospital level where negative practices may be initiated. AAH actively encouraged UNICEF to start this program.

B. Positive Effects of the Programme on Individuals, Families or Communities

B.I

The awareness of key health care providers on appropriate infant feeding according to international standards and adaptation of various foods for Kosovo was raised in discussions with the health staff during the training sessions. These were assessed both qualitatively and quantitatively.

- **Qualitative assessments**

Table 5 below shows examples of some of the infant feeding problems identified in Kosovo which, were brought to the attention of health professionals, and in which practices are now beginning to change, following the training.

Annexe E shows examples of some of the qualitative data gathered. These case study examples were general responses given by the health professionals to those presented to them before and after the AAH training. The case studies were devised in order to raise awareness on some of the common and solvable problems on infant nutrition found in Kosovo.

- **Quantitative assessments**

In addition evaluations of the impact of the training at the health establishments were also assessed with a two-part questionnaire. The first part (see Annexe F) examined quantitatively the knowledge gained from the training using simple questions of the key messages of the training. As much as possible the questionnaires and some of the case studies were utilised before and after the training sessions. Figure 1 therefore shows at the municipality level the average results prior to the training and afterwards. There was a significant change in the knowledge with an improvement ranging from 11 to 39% depending on the municipality.

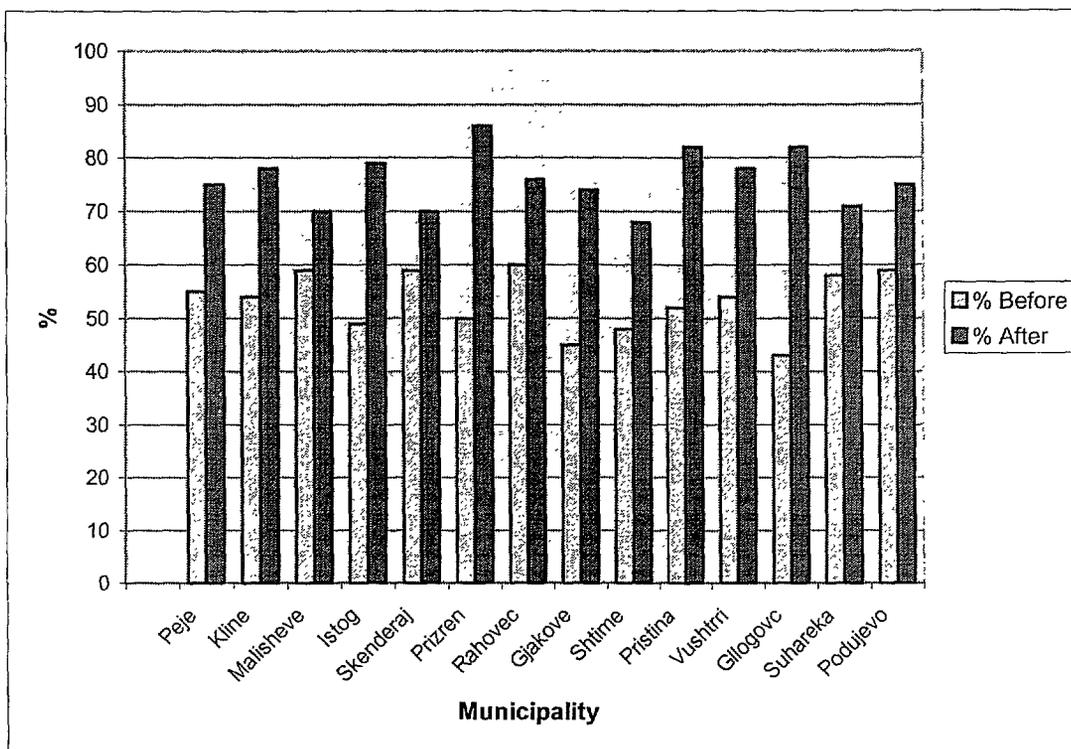
It was not immediately clear why there were more improvements in certain areas. Any potential bias from the different training teams can be discounted as no significant differences were seen from these teams.

The second evaluation questionnaire (Annexe G) examined the current practices on infant feeding following on from the training at the health establishment level. Overall, 99% of the health professionals tested acknowledged that the 3 training topics had been useful mainly because their knowledge on the subjects had been updated. 91% said they learnt new information from the sessions; this was mostly from the breastfeeding (64%) and infant feeding/weaning practices (63%) sessions. Although this evaluation indicated an increase in the advice on feeding practices given by health professionals, the level was not assessed at baseline level in order to make a comparison. However it was encouraging that 89% of the health professionals had, since the training, been providing sensitive and regular advice to mothers on breastfeeding (64%) as well as infant feeding (40%). In addition 82% responded that they had been able to pass on the information learnt from the AAH training (either verbally or through the handouts) to colleagues.

Table 5: Problems on infant feeding identified which health professionals are now prepared to follow recommendations.

| Problem identified | Simple reasons for discouraging practice | Practical alternatives suggested |
|---|--|---|
| Mothers breastfeed only for short periods of time and early introduction of other food and drinks to diet. | Exclusive breastfeeding to infants up to 6 months leads to a reduced chance of infection and in addition the child receives maximum nutritional benefit of breast milk | Encourage exclusive breastfeeding for the first 6 months and in addition to complementary food to at least one, preferably two years. |
| Infant formula introduced because mother experiences difficulties with breastfeeding | Poor positioning and attachment leads to a variety of breastfeeding problems such as pain, cracked nipples etc. Close contact with baby leads to bonding. | Encourage mothers to initially attach and achieve better positioning through talking and assessing as well as demonstration. |
| Infant formula introduced because mothers and health professionals believe mothers milk is insufficient. | Infants taking formula were 5x more likely to be admitted to hospital with diarrhoea than breastfed ones. | Infant formula not to be encouraged unless absolutely necessary. Assessment of breastfeeding if mother presents with problem. |
| Cow's milk introduced too early. | Infant's kidneys unable to cope with high solute load e.g. sodium and protein. These represent the major differences between animal milk and human milk. Others include immunogenic factors and growth factors in breast milk specifically for humans. | Discourage use of this as alternative to breast milk. If this is taken as a drink before 12 months it is important to ensure that it is diluted 2:1 (milk and water). |
| Biscuits such as Plazma introduced at <6 months of age. Often given mixed with milk in a bottle. | Biscuits such as plazma contain too much sodium and protein for the kidneys to easily eliminate. | Recommend that wheat products be introduced after 6 months of age. Biscuits given occasionally but not in bottle. |
| Tea (Russian and Indian) introduced at <6 months. Often taken with sugar. Sometimes recommended for treatment of diarrhoea. | Tea contains polyphenols and phytates, which block absorption of iron from diet. | Encourage exclusive breastfeeding for up to 6 months. Thereafter encourage use of cooled boiled water, diluted fruit juice and if necessary flower tea without sugar instead. |
| Low consumption of fruit and vegetables during weaning. | Inadequate intake of vitamins and minerals as well as fibre to aid digestion. | Encourage increased intake of 3-5 portions per day. |
| Watery early foods given for weaning. | Insufficient energy, vitamin and mineral content. These are necessary for rapid growth of infants | Examples to introduce high energy and fat to diet include the addition of macaroni in soups. Preparation of griz and other porridge with oil and milk. |

Figure 1: Chart showing the improved knowledge of health staff per municipality.



No evaluation was undertaken in Fushe Kosovo due to the late start of the training within this municipality.

B.II

The age group of those attending the sessions ranged from late teenage years up to elderly women. This was especially important as one of the observations from the AAH survey in January was the significant influence of mother-in-laws in determining whether a mother starts to breastfeed, continues exclusively or begins to introduce other foods at an early age. The presence of women of all generations ensured the messages went to all for discussion.

Due to the large numbers within the training sessions held by the women's groups, it was not considered possible to assess the knowledge gains through any formal testing. Hence informal discussions before and after the training were held amongst smaller groups. This helped to present different experiences and exemplify those practices taken on board.

Generally the response from the women of all age groups at the end of the sessions were to compare between themselves, their own experiences with what the trainers had discussed. A prioritisation of points that the women considered most important from within the training content included:

- *The importance and benefits of breastfeeding exclusively for up to 6 months to the child and the mother.*
- *The advantages of breast milk and the disadvantages of artificial milk.*
- *The differences between breast milk and cow's milk.*
- *The importance of beginning breastfeeding as soon after birth and not waiting after 2 hours.*
- *The possibility of continuing to breastfeed if they became pregnant.*
- *When, how and why to begin weaning with the appropriate foods for their children.*

The duration of the programme was too short to realistically expect major behavioural changes. However there were some successful examples changes in infant feeding practices, as seen below:

- *A woman considered that her breast milk was insufficient for her 3-month old infant, and had hence changed to infant formula. Following on from the training in which she learnt that relactation is possible, and through receiving help from the trainer who lived close by, within a week, she was able to breastfeed her child again.*
- *An infant of two months constantly refused the breast, hence causing the mother great concern. However the infant often showed signs of interest in the breast when he was about to sleep. The suggestion to try rousing techniques to wake up a sleepy infant in order to feed led to successful breastfeeding on demand.*
- *A grandmother who had sole responsibility for a young infant, decided to try giving breast milk to the infant in her care, through induced lactation. Unfortunately, due to the distance required to travel to the home, no monitoring had taken place in regards this case, at the time of writing.*
- *Some women, on understanding the importance exclusive breastfeeding for up to 6 months, changed their plans for imminent return to work and felt determined to stay at home to care for the infant during this time. This too, has not been possible to monitor.*

B.III

It appears that the number of incidents of inappropriate donations reduced considerably during the time-frame of the programme. As Action Against Hunger relied on being informed of these incidents, following its strong awareness campaign to organisations and other groups, it is not possible to precisely identify the reason for reduced incidents of inappropriate donations. Beyond correct adherence to the messages disseminated, the reduction may also simply be due to a lower interest on the part of potential donors or past stocks being out of date, destroyed or used up.

A typical example of inappropriate donations to which AAH was alerted following the awareness campaign is that given below:

- *An untargeted distribution of 40 boxes of infant formula were left outside a school gate. The school took the boxes to their local MTS branch for distribution. This formula had in fact already exceeded its sell-by date, although this had not been realised by the school. AAH advised the recall of the product and on how to destroy them. A poster was put up in the branch giving a warning about the use of the product.*

B.IV

- **Usage of Anthropometric Measuring Equipment**

Although the health care staff were used to measuring equipment, AAH showed them how to use them correctly. Subsequent evaluation visits by the trainers showed that they were using the equipment correctly. As observations were sufficient it was not appropriate to formally test them on their abilities.

As mentioned above children used to be taken for regular measurements normally prior to 1 year old. Subsequently weight was only taken when a child presented with a problem to the health centre. From the evaluations performed by the health staff, 98% thought it was important and hence in favour of measuring on a regular basis until a child was 5 years old as a result of the AAH training. However in practice only a few motivated individuals with access to equipment were continually measuring children older than 1 year. The majority sight the lack of equipment and time as the reason they had not commenced.

- **Malnutrition rate**

For Kosovo wide, as it was not possible to include a survey within the proposal, AAH were not able to determine whether the rate of malnutrition had changed over the period of the training. At the health structure levels AAH did not distribute administrative means for recording of cases of malnutrition, as this had not been agreed at the policy level. Records of measurements where they have been made have either been the existing cards or in notebooks. The W/A chart AAH gave were simply photocopies of what had been agreed with WHO on possible future tool for Kosovo. The average number of children measured and therefore the rate of malnutrition detected was not available.

- **Nutritional surveillance in health centres**

The introduction of a growth monitoring or a nutritional surveillance program provides an early warning system for policy decision makers by identifying of growth faltering patterns in any one area. As part of the AAH training of health care providers the importance of growth monitoring and the benefits to the community and health of the infants were emphasised. Where they had equipment or AAH were able to donate to them, they were shown how to take correct anthropometric measurements.

However in order for them to commence using the W/A charts and actually monitor children on more occasions than at present requires either UNMIK policy level agreement or very motivated and enthusiastic individuals. Both of these are lacking to a great extent in the health facilities.

B.V

- **GP and IMCI training**

The training of the GPs has yet to commence on the infant feeding topics. However training in IMCI began in August and again the impact of this is expected to be long term.

- **Continuation of training by other organisations**

Other organisations having agreed to take the responsibility of utilising the posters will report to AAH in 3 months time. For some of the women this represents voluntary work. The livelihood situation in Kosovo is still precarious and it is not clear if these women will be able to sustain the training activities in rural communities at the same level as when they worked for AAH.

- **Infant feeding Conference**

Although the conference did not go ahead as planned, it is still on the agenda as it received support from organisations involved in health promotion activities.

C. Effects of Unforeseen Circumstances on Overall Programme Performance

No severe “unforeseen circumstances” were inflicted upon the programme. The poor security of the situation resulted in an inability to visit certain health houses or ambulantas if these lay in minority areas and also resulted in shorter days than had been intended. However, where possible, if the chosen ambulantas were close to another larger ambulanta the staff were collected and taken to join another group for training. A year has passed since the United Nations Mission in Kosovo (UNMIK) became responsible for civil administration in the province. As reported in the mid term report, the Joint Interim Administrative Structure (JIAS) started operating on the 1st of February 2000. This followed an agreement reached between UNMIK and local politicians. As a result 19 departments are responsible for implementing policy decisions made by the Interim Administrative Council (IAC). Each department has co-heads representing the various Kosovar political parties and the international communities.

At the time of writing the proposal, it was hoped that Action Against Hunger would be able to play a prominent role in implementing the nutritional aspects of the Health Policy. The expatriate nutritionist with Action Against Hunger had held positive discussions with WHO and UNICEF to this effect. Furthermore, while Action Against Hunger planned to work with the primary and secondary aspects of the health system, UNICEF planned to work at the tertiary level, notably in implementing its Baby Friendly Hospital Initiative. It was considered essential that this be put into place as the hospital is generally the first place in which the new mother receives any form of advice on feeding her infant. Unfortunately, these hopes and assumptions have not been entirely fulfilled.

- Firstly, as mentioned above, mothers of new-born babies receive their initial lessons on infant feeding practices in the hours and days after birth in the hospital. As the intake of colostrums is not recommended, and alternative liquids to that of breastmilk are provided, it is clear that the need for the UNICEF Baby Friendly Hospital Initiative is urgent. However, unfortunately, despite indications to the contrary before the start of the programme, this has not been set up to date. The programme of Action Against Hunger had aimed to reinforce the good messages of the BFHI during the later stages of infancy. Instead however, much of the programme was orientated towards counteracting the inappropriate messages received.
- Secondly, nutrition has played a very small role in the health policy. In the initial “Interim Health Policy” written in 1999, a Joint UN Statement on Donations of Breast-Milk Substitutes which was prepared by the UN, with the collaboration of Action Against Hunger, gave guidelines in regards to the distribution of breast feeding substitutes. However, it was only in May 2000, that a Task Force was set up to review the interim health and health promotion policy in order to make improvements and reform by comparisons with the rest of the Balkan region and the rest of Europe. The key areas in this are the future structure of the health service, training of staff, the role of private services in the health sector and the various financing options. Unfortunately, very little discussion and inclusion of nutritional issues appears to have been included in these respective policies.
However, one essential programme supported by the Department of Health and Social Welfare (DHSW) includes the Integrated Management of Childhood Illnesses (IMCI). This is a WHO/UNICEF tool developed world wide to reduce infant mortality and improve healthy growth of children under 5 years old by treating and preventing the most common illness of children. The most common illnesses affecting children aged between one week and 5 years include malnutrition, diarrhoea, pneumonia, and measles². Although the Province-wide training for IMCI had not begun by the time the Action Against Hunger programme had finished, it is hoped that the contribution that Action Against Hunger made in the writing of chapters for the IMCI would provide a sustainable contribution.

² Figures from health care facilities Kosovo wide collated by the Institute of Public Health (IPH) showed that cases of acute diarrhoea in children under 5 years old for the first half of this year were at 5,793. Lower respiratory infections were also a common problem. Surveys conducted by AAH have shown that inappropriate feeding practices such as the introduction of foods and drinks at too early an age or a poorly balanced diet may lead to a higher incidence of morbidity than could be expected for the region. A high percentage of mothers begin breastfeeding (92%), but only 17.8% practice this exclusively during the first months. The high incidence of diarrhoea and anaemia may be influenced by these practices. However poor water quality and inadequate hygiene practices may also play a role.

IV RESOURCES USE / EXPENDITURES

Action Against Hunger managed to reach the objectives (see above) with less expenses than planned.

The total expenditures for the program has been \$178,575.46

Out of a budget of \$208,175, there is an unspent balance of \$29;599.54

See details in the attached SF 209.

| | | | | | | | | | | |
|--|--|---|---|-----------------|--|--|---|--|--|--|
| FINANCIAL STATUS REPORT <small>(Follow instructions on the back)</small> | | | 1 FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED O F D A | | 2 FEDERAL GRANT OR OTHER IDENTIFYING NUMBER AOT G -00-00-00030-00 | | OMB Approved | PAGE 1 | OF 1 PAGE | |
| 3. RECIPIENT ORGANIZATION <small>(Name and complete address, including ZIP code)</small> Action Against Hunger USA 876 Avenue of the Americas, New York, New York 10001 | | | 4 EMPLOYER IDENTIFICATION OR IDENTIFYING NUMBER | | 5. RECIPIENT ACCOUNT NUMBER BANK ACCOUNT | | 6 FINAL REPORT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 7 BASIS <input checked="" type="checkbox"/> CASH <input type="checkbox"/> ACCRUAL | |
| | | | 8 PROJECT / GRANT PERIOD (See instructions) FROM 11 19 99 11/19/99 TO (5, 19, 2000) 7/31/00 <small>(Month day year)</small> | | | 9 PERIOD COVERED BY THIS REPORT FROM 11/19/99 TO (MONTH, DAY, YEAR) : 7/31/00 | | | | |
| 10 STATUS OF FUNDS | | | | | | | | | | |
| PROGRAMS / FUNCTIONS / ACTIVITIES --> | | (a) EXPATRIATE | (b) LOCAL STAFF | (c) LOGISTICS | (d) FOOD REHABILITATION | (f) ADMINISTRATIVE COSTS | (f) OVERHEADS | (g) TOTAL | | |
| a Net outlays previously reported | | \$ 30,231.00 | \$ 18,210.00 | \$ 3,479.00 | \$ 1,401.00 | \$ 474.00 | \$ 7,875.59 | \$ 61,670.59 | | |
| b Total outlays this report period | | 21,299.05 | 41,689.75 | 12,285.83 | 15,270.49 | 11,430.52 | 14,929.23 | 116,904.87 | | |
| c. Less : Program income credits | | | | | | | | - | | |
| d Net outlays this report period <small>(line b minus line c)</small> | | 21,299.05 | 41,689.75 | 12,285.83 | 15,270.49 | 11,430.52 | 14,929.23 | 116,904.87 | | |
| e Net outlays to date <small>(line a plus line d)</small> | | 51,530.05 | 59,899.75 | 15,764.83 | 16,671.49 | 11,904.52 | 22,804.82 | 178,575.46 | | |
| f. Less : Non-Federal share of outlays | | | | | | | | - | | |
| g Total Federal share of outlays <small>(line e minus line f)</small> | | 51,530.05 | 59,899.75 | 15,764.83 | 16,671.49 | 11,904.52 | 22,804.82 | 178,575.46 | | |
| h Total unliquidated obligations | | | | | | | | - | | |
| i Less . Non-Federal share of unliquidated obligations shown on line f | | | | | | | | - | | |
| j. Federal share of unliquidated obligations | | | | | | | | - | | |
| k. Total Federal share of outlays and unliquidated obligations | | 51,530.05 | 59,899.75 | 15,764.83 | 16,671.49 | 11,904.52 | 22,804.82 | 178,575.46 | | |
| l Total cumulative amount of Federal funds authorized | | 59,000.00 | 69,310.00 | 22,900.00 | 20,380.00 | 10,000.00 | 26,585.00 | 208,175.00 | | |
| m Unobligated balance of Federal funds | | 7,469.95 | 9,410.25 | 7,135.17 | 3,708.51 | 1,904.52 | 3,780.18 | 29,599.54 | | |
| 11 INDIRECT EXPENSE | | A. TYPE OF RATE <small>(Place "X" in appropriate box) <input type="checkbox"/> PROVISIONAL <input type="checkbox"/> PREDETERMINED <input checked="" type="checkbox"/> FINAL <input type="checkbox"/> FIXED</small> | | | 13 CERTIFICATION I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purpose set forth in the award documents | | SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | | DATE REPORT SUBMITTED | |
| | | b RATE | C BASE | D. TOTAL AMOUNT | | | | | | |
| 12 REMARKS : Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation | | | | | | TYPED OR PRINTED NAME AND TITLE | | TELEPHONE (Area code, number and extension) (33) 01-53-80-88-71 | | |

269-102

PROGRESS REPORT

STANDARD FORM 269 (7-75)
Prescribed by Office of Management and Budget
Or N° A-110

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Conclusions & recommendations

The training program was successful in that 703 health professionals attended the sessions and were made aware of the issues and problems on infant feeding pertaining to Kosovo. A key constraint for the program was however the ability to evaluate the program effectively. Given that an educational program although raises awareness does not change practices immediately. AAH initially decided it was not appropriate given the context to present to the health professionals any form of test. Hence case studies and discussions were the initial tools utilised to assess the impact of the program. Although this was not quantitative, it gave an idea of the effect of the program. All trained staff were keen to show their knowledge and gave examples since the training where they had advised mothers. Quantitative tests of knowledge in some of the health centres were introduced later in the program for before and after the training sessions. Analysis of this showed a gain in knowledge of between 11 and 39% depending on the municipality. The impact of the program therefore was successful in terms of improving and updating the knowledge of the health professionals. However changes in practices are rather more difficult to quantify.

Training in the communities of groups of women was also successful as the attendance and response from the women were extremely positive. Quantitative measurement at the community level was however even more difficult to assess as there are many influences on the community. The collaboration with other NGOs and UN organisations continued in order to avoid duplication of the program. This also led to a higher impact of the essential information of the program. Attendance at the regular weekly meetings on the emerging health system ensured the inclusion of infant feeding on the agenda.

The feedback from the evaluation of health professionals suggested that the needs were there for further training especially for women and other health staff based in hospitals. An overwhelming majority of 92% health professionals thought that mothers required further training. However they were also keen for hospital practices to change. Hence 64% thought also that training should occur at this level. For health professionals the latter group are very important as practices on breastfeeding begin in hospitals. If the mothers do not receive the right management at the start then they are more liable to give up when problems appear at a later stage. Training of women is extremely important, as they are receptive and able to directly make changes in practices. AAH ensured that there was continuity for the program through other organisations taking part in similar work so that messages on the subject are passed on to both doctors and women in the communities. The majority of health professionals were keen for WHO (62%) to do this training. Although international NGOs were also thought as potential trainers (29%).

Although the program was successful in achieving the results detailed in this report it is too soon following from an educational campaign to expect major changes in the practices in the community. Some of the messages have immediate impacts whereas others such as the nutritional surveillance require further inputs and support. The recommendations following from this program therefore are for:

- Evaluations of the impact of the present program in the communities.
- Continuation of training with inclusion of further evaluations at community level.
- New training program incorporating the ideals of the baby and mother friendly initiatives at the hospital level.
- Advocacy for the policy level decision on commencement of growth monitoring at all family health centres.
- Capacity building of local organisations such as the institute of public health in order to sustain the same messages over a longer period.
- Empowerment of women's groups to include this type of training along with other health promotion activities and formation of self help groups.

AAH recognize that the objectives set for this program were very ambitious and not quantifiable as would have been preferred in order to see the impact more vividly. Given that overall constraint, the above-mentioned achievements of the program show that the intended results were realized in the majority of the specific objectives. However, it has to be pointed out that the realizations will take a further step in its own cycle to become actual practices. In that respect, AAH has reservations that discontinuing the training program at this stage might have a negative effect on the gained knowledge and its practice

ANNEXE A: MAP OF KOSOVO



ANNEXE B: LIST OF HEALTH FACILITIES IN THE PROGRAM MUNICIPALITIES

| Municipality | Health House/Ambulanta Covered by program | Health House / Ambulanta Not covered by program |
|---------------------------|--|---|
| Peje | Baran Leshan Ozdrim Peje Disp. (Health House) Peja Emergency (No.3) Peje Amb (No.4) Raushiq Vitomirice Zahac | Peje Amb 1 Peje Amb 2 Peje Amb 5 Glllogjan Doberdol Gorazhdefe Testenik Trebovic Radafc Novoselle Loxhe Kuqishte Drelaj |
| Percentage covered | 41% | |
| Kline | Cerrovike Drenoc Grabanice Jashanice Kline Health House Shtupel Sverke Ujmir Zllakuqan | Gllareve Vollujake Jagoda Budisalc |
| Percentage covered | 69% | |
| Malisheve | Banje Bellanice Drenofc Kijeve Llapceve Malisheve Health House Ponorc | Terpeze Pagarushe Llozice Carralluke Ostrozub Dragobil |
| Percentage covered | 54% | |
| Istog | Banja Gjurakoc Istog Health House Rakosh Staradran Vrelle | Cerkolez Dubrave Osojan Zallq Kaliqan |
| Percentage covered | 55% | |
| Skenderaj | Kline e Eperme Likofc Llaushe | Aqareve Klodemice Qubrel |

| | | |
|---------------------------|--|---|
| | Polac Prekazi I Eperme Qirez Rrezalle Runik Skenderaj Health House Turiceve | |
| Percentage covered | 77% | |
| Prizren | Dushanove, Gjonaj Hoqe e Qytetit, Korishe Lubiceve Lubizhde Mamushe, Prizren I Health House Prizren II Health House Romaje, Skorobiste Zhur Zym, | Raline Amb Lakuriq Amb Pirane Reqan Blacne Velezhe Kushnin Krajk Musnicove Lubinje |
| Percentage covered | 57% | |
| Rahovec | Bellacerke, Cifllak, Krushe e Madhe Rahovec Health House Ratkoc | Rahovec I Eperme Hoqa e Madhe Apterushe |
| Percentage covered | 63% | |
| Gllgovc | Arbri e Eperme (Obri) Arllat, Baice, Dobrashec, Gllanaselle Gllgovc Health House Gradice Komoran Nekoc Stankoc Terstenik Vasileve | |
| Percentage covered | 100% | |

| | | |
|----------------|---|--|
| Gjakove | Bec, Bishtrazhin Cermjan Dol Erenike, Gjakove I Health House | Jatex Gergoc Krelan Damjan Dujake Jablanica |
|----------------|---|--|

| | | |
|------------------------------|--|---|
| | Gjakove II Health House Gushe (a) Lipovac (b), Malliq (a) Novoselle e Eperme Orize Ponoshec (a), Rogove Sheremet Skivjan | Doblibare Lipovec |
| Percentage covered | 67% | |
| Shtime | Muzeqine Shtime Health House | Petrove Petreshtice |
| Percentage covered | 50% | |
| Pristina & Obiliq | Barileve Besi, Pristina St. 6 Keqekoll, Llukare Matiqan Milloshev, Nente Jugoviq, Prishtina St. 3, Prishtin St. 4, Obiliq Health House Sibofc Millosheve (Kopiliq) Cervina Vodica (Palaj) | Pristina Health House Prishtina St. 1 Prishtina St. 2 Prishtina St. 5 Shaljanet Koliq Gracanica Dabishefe Hajvali Mramor Slivove Gracanica Preoce Llapljeselo Cagljavica Donja Bernica Viti Bullaj Babimoc Brezhnice Plementina |
| Percentage covered | 40% | |
| F. Kosovo | Dobrev (Miradi e Ulet) Sllatine Bardh I Madh (Bellocefc) Train St. Amb | Fushe Kosovo (Kosovo Polje) |
| Percentage covered | 80% | |
| Vushtrri | Dumnic e Ulet Novaline, Novoselle (Maxhunaj) Pantina Samodregje Smrekovnice | Vushtrri Health House Lumi I Madh Dervar Dubofc Prilluzhe Strofc |
| Percentage covered | 50% | |
| Suhareke | Grejkoc, | Duhel |

| | | |
|-------------------------------|--|--|
| | Mushtishte Nishor Samadregje Sopin Studencan, Suhareke Health House | Bukosh Movlan Gjinoc |
| Percentage covered | 64% | |
| Podujeve | Batllave Gllamnik Luzhane Majanc, Orllan, | Podujeve Health House Brece Pollate Kerpimeh Bajqine Dumnice Bradash Shajkofc |
| Percentage covered | 38% | |
| Average Total coverage | 60% | |

ANNEXE C: BASIC TRAINING OUTLINE

1st Session - Breastfeeding

- Importance of exclusive breastfeeding to the infant and the mother in Kosovo
- Advantages of breastfeeding and disadvantages of artificial substitutes
- Successful breastfeeding – how to.

2nd Session – Breastfeeding

- Milk production (hormonal cycle)
- Positioning and attachment at the breast
- Common problems associated with breastfeeding and their management

3rd Session – Infant feeding

- Importance of proper feeding for growth, development and protection against infection.
- Main food groups, their sources and uses (water, carbohydrates, protein, fruit, vegetables, fats and sugars).
- Complementary and weaning foods for infants in Kosovo.
- Problems found in Kosovo from AAH surveys – diarrhoea and anaemia, cow's milk, tea, plazma biscuits and commercially prepared baby foods.

4th Session - Growth monitoring (Nutritional surveillance)

In this session the idea of growth monitoring is introduced. Any growth-monitoring programme seeks to identify children whose growth is faltering and thereby able to establish:

- The reason why,
- The action to be taken,
- The follow up and some sort of national reporting.

In this way children can be identified before they become malnourished. The following are also discussed.

- Why follow growth monitoring, benefits to individuals and health system (cost)
- How When Where Who etc
- Donation and demonstration of how to use the growth monitoring equipment, i.e. weighing scales, height boards and weight for age charts.

ANNEXE D NUMBER OF HEALTH PERSONNEL TRAINED PER TOPIC

| Municipality | Health House /Ambulanta | No. trained B/F 1 | No. trained B/F 2 | No. trained I/F | No. trained G/M | Total minimum | Total maximum |
|------------------|-------------------------|-------------------|-------------------|-----------------|-----------------|---------------|---------------|
| Peje | Baran (b) | 3 | 5 | 3 | 3 | 3 | 5 |
| | Leshan (c) | 2 | 2 | 2 | 2 | 2 | 2 |
| | Ozdrim (a) | 3 | 3 | 3 | 3 | 3 | 3 |
| | Peje Paediatric | 28 | 17 | 21 | 21 | 17 | 28 |
| | Peja Emergency | 13 | 13 | 13 | 13 | 13 | 13 |
| | Peje Amb 4 | 5 | 5 | 5 | 5 | 5 | 5 |
| | Raushiq (b) | 1 | 2 | 2 | 1 | 1 | 2 |
| | Vitomirice (a) | 2 | 2 | 2 | 4 | 2 | 4 |
| | Zahac (c) | 4 | 4 | 4 | 4 | 4 | 4 |
| Subtotal | | | | | | 50 | 66 |
| Kline | Cerrovike (c) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Drenoc (a) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Grabanice (a) | 2 | 2 | 2 | 2 | 2 | 2 |
| | Jashanice (b) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Kline HH | 7 | 6 | 8 | 8 | 6 | 8 |
| | Shtupel | 3 | 3 | 3 | 3 | 3 | 3 |
| | Sverke (c) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Ujmir (b) | 4 | 4 | 4 | 4 | 4 | 4 |
| | Zllakuqan | 3 | 3 | 3 | 3 | 3 | 3 |
| Subtotal | | | | | | 22 | 24 |
| Malisheve | Banje (b) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Bellanice (b) | 2 | 2 | 2 | 2 | 2 | 2 |
| | Drenofc (a) | 1 | 1 | 1 | 0 | 0 | 1 |
| | Kijeve (a) | 3 | 4 | 3 | 3 | 3 | 4 |
| | Llapceve (c) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Malisheve HH, | 13 | 9 | 9 | 9 | 9 | 13 |
| | Ponorc (c) | 1 | 1 | 1 | 1 | 1 | 1 |
| Subtotal | | | | | | 17 | 23 |
| Istog | Banja | 10 | 9 | 9 | 4 | 4 | 10 |
| | Gjurakoc | 8 | 7 | 6 | 5 | 5 | 8 |
| | Istog HH | 7 | 7 | 7 | 7 | 7 | 7 |
| | Rakosh | 5 | 5 | 5 | 5 | 5 | 5 |
| | Staradran | 4 | 2 | 2 | 2 | 2 | 4 |
| | Vrelle | 5 | 5 | 5 | 5 | 5 | 5 |
| Subtotal | | | | | | 28 | 39 |
| Skenderaj | Kline e Eperme | 7 | 7 | 7 | 7 | 7 | 7 |
| | Likofc | 4 | 4 | 4 | 4 | 4 | 4 |

| | | | | | | | |
|----------------|--------------------|----|----|----|----|------------|------------|
| | Llaushe (a) | 6 | 7 | 6 | 7 | 6 | 7 |
| | Polac (b) | 5 | 9 | 7 | 7 | 5 | 9 |
| | Prekazi I Eperme | 3 | 3 | 3 | 3 | 3 | 3 |
| | Qirez (b) | 3 | 3 | 3 | 4 | 3 | 4 |
| | Rrezalle | 1 | 1 | 1 | 1 | 1 | 1 |
| | Runik | 7 | 6 | 7 | 7 | 6 | 7 |
| | Skenderaj | 16 | 10 | 14 | 14 | 10 | 16 |
| | Turiceve (a) | 6 | 6 | 6 | 6 | 6 | 6 |
| | Subtotal | | | | | 51 | 64 |
| Prizren | Dushanove, | 3 | 3 | 2 | 2 | 2 | 3 |
| | Gjonaj | 3 | 3 | 3 | 3 | 3 | 3 |
| | Hoqe e Qytetit, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Korishe | 2 | 2 | 2 | 2 | 2 | 2 |
| | Lubiceve | 2 | 2 | 2 | 2 | 2 | 2 |
| | Lubizhde (a) | 3 | 3 | 3 | 2 | 2 | 3 |
| | Mamushe, | 4 | 4 | 4 | 4 | 4 | 4 |
| | Prizren I, | 14 | 15 | 14 | 14 | 14 | 15 |
| | Prizren II* | 60 | 60 | 60 | 60 | 60 | 60 |
| | Romaje, | 4 | 4 | 4 | 4 | 4 | 4 |
| | Skorobiste | 1 | 1 | 1 | 1 | 1 | 1 |
| | Zhur | 8 | 8 | 8 | 8 | 8 | 8 |
| | Zym, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Subtotal | | | | | 106 | 109 |
| Rahovec | Bellacerke, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Cifllak, | 4 | 4 | 4 | 4 | 4 | 4 |
| | Krushe e Madhe | 6 | 4 | 6 | 6 | 4 | 6 |
| | Rahovec* | 37 | 37 | 37 | 37 | 37 | 37 |
| | Ratkoc | 8 | 8 | 7 | 7 | 7 | 8 |
| | Subtotal | | | | | 54 | 57 |
| Gjakove | Bec, | 1 | 1 | 1 | 1 | 1 | 1 |
| | Bishtrazhin (b), | 1 | 1 | 1 | 1 | 1 | 1 |
| | Cermjan | 8 | 8 | 8 | 11 | 8 | 11 |
| | Dol (b), | 1 | 1 | 1 | 1 | 1 | 1 |
| | Erenike, | 4 | 4 | 4 | 4 | 4 | 4 |
| | Gjakove I | 7 | 7 | 7 | 7 | 7 | 7 |
| | Gjakove II, | 15 | 15 | 15 | 15 | 15 | 15 |
| | Gushe (a) | 0 | 0 | 0 | 0 | 0 | 0 |
| | Lipovac (b), | 2 | 2 | 2 | 1 | 1 | 2 |
| | Malliq (a) | 0 | 0 | 0 | 0 | 0 | 0 |
| | Novoselle e Eperme | 4 | 4 | 4 | 4 | 4 | 4 |
| | Orize | 5 | 5 | 9 | 5 | 5 | 9 |
| | Ponoshec (a), | 6 | 4 | 4 | 4 | 4 | 6 |
| | Rogove | 5 | 5 | 5 | 5 | 5 | 5 |
| | Sheremet | 2 | 2 | 2 | 2 | 2 | 2 |
| | Skivjan | 2 | 2 | 2 | 4 | 2 | 4 |
| | Subtotal | | | | | 60 | 72 |
| Shtime | Muzeqine (a) | 3 | 3 | 3 | 3 | 3 | 3 |
| | Shtime (a) | 15 | 15 | 15 | 15 | 15 | 15 |
| | Subtotal | | | | | 18 | 18 |

| | | | | | | | |
|------------------------------|-------------------|----|----|----|-----------|-----------|----|
| Pristina & Obiliq | Barileve | 3 | 3 | 3 | 2 | 2 | 3 |
| | Besi, | 4 | 4 | 3 | 4 | 3 | 4 |
| | Cervena | 3 | 3 | 3 | 3 | 3 | |
| | Vodica(Palaj) | | | | | | 3 |
| | Keqekoll, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Llukare | 4 | 3 | 3 | 3 | 3 | 4 |
| | Matiqan | 4 | 4 | 3 | 3 | 3 | 4 |
| | Milloshhev, | 3 | 3 | 3 | 2 | 2 | 3 |
| | Nente Jugoviq, | 3 | 3 | 2 | 2 | 2 | 3 |
| | Obiliq | 25 | 24 | 22 | 22 | 22 | 25 |
| | Prishtin St. 3, | 15 | 15 | 15 | 15 | 15 | 15 |
| | Prishtin St. 4, | 8 | 8 | 6 | 6 | 6 | 8 |
| | Prishtin St. 6, | 3 | 5 | 5 | 5 | 3 | 5 |
| Sibofc | 2 | 2 | 2 | 2 | 2 | 2 | |
| Subtotal | | | | | 68 | 81 | |
| F.Kosovo | Bardh I Madh | 6 | 6 | 6 | 6 | 6 | 6 |
| | Dobrev | 3 | 3 | 3 | 3 | 3 | 3 |
| | Sllatine | 3 | 3 | 3 | 3 | 3 | 3 |
| | Train St. Amb | 4 | 4 | 4 | 4 | 4 | 4 |
| Subtotal | | | | | 16 | 16 | |
| Vushtrri | Dumnic e Ulet | 3 | 3 | 2 | 3 | 2 | 3 |
| | Novaline, | 4 | 4 | 2 | 2 | 2 | 4 |
| | Novoselle e Magj, | 3 | 3 | 3 | 3 | 3 | 3 |
| | Pantina | 5 | 5 | 4 | 4 | 4 | 5 |
| | Samodregje | 3 | 4 | 4 | 4 | 3 | 4 |
| | Smrekovnice | 4 | 6 | 6 | 6 | 4 | 6 |
| Subtotal | | | | | 18 | 25 | |
| Gillogovc | Arbri e Eperme | 2 | 2 | 2 | 2 | 2 | 2 |
| | Arllat, | 3 | 1 | 3 | 3 | 1 | 3 |
| | Baice, | 3 | 3 | 2 | 3 | 2 | 3 |
| | Dobrashec, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Gillanaselle (b) | 2 | 2 | 2 | 2 | 2 | 2 |
| | Gillogovc HH* | 17 | 17 | 17 | 17 | 17 | 17 |
| | Gradice (b) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Komorani | 15 | 12 | 14 | 14 | 12 | 15 |
| | Nekoc (a) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Stankoc (a) | 1 | 1 | 1 | 1 | 1 | 1 |
| | Terstenik | 5 | 5 | 5 | 5 | 5 | 5 |
| | Vasileve | 2 | 2 | 1 | 2 | 1 | 2 |
| Subtotal | | | | | 47 | 54 | |
| Suhareke | Grejkoc, | 3 | 2 | 1 | 1 | 1 | 3 |
| | Mushtishte | 10 | 10 | 9 | 0 | 9 | 10 |
| | Nishor | 2 | 2 | 2 | 2 | 2 | 2 |
| | Samadregje | 3 | 3 | 2 | 3 | 2 | 3 |
| | Sopin | 3 | 3 | 3 | 3 | 3 | 3 |
| | Studencan, | 4 | 6 | 4 | 6 | 4 | 6 |
| | Suhareke HH* | 0 | 0 | 15 | 15 | 15 | 15 |

| | | | | | | | |
|-----------------|-----------------|------------|------------|------------|------------|------------|------------|
| | Subtotal | | | | | 36 | 42 |
| Podujeve | Batlave | 2 | 2 | 2 | 2 | 2 | 2 |
| | Gllamnik | 2 | 2 | 2 | 2 | 2 | 2 |
| | Luzhane | 4 | 4 | 4 | 3 | 3 | 4 |
| | Majanc, | 2 | 2 | 2 | 2 | 2 | 2 |
| | Orllan, | 2 | 2 | 3 | 3 | 2 | 3 |
| | | | | | | 11 | 13 |
| | Total | 657 | 635 | 644 | 634 | 602 | 703 |

ANNEXE E: CASE STUDY EXAMPLES

Responses to Case Studies used for OFDA Training of health care workers

1. A pregnant woman comes to see you and wants advice because she does not want to carry on breastfeeding her 8-month-old baby. She is poor and has 6 other children. She cannot afford much but has been buying infant formula and giving mashed vegetables. What is your advice on appropriate weaning foods for her situation?

BEFORE TRAINING

- *In most cases they preferred to advise the woman to stop breastfeeding the child altogether. The reason given was that it is hard for the mother to provide enough nutrients for 2 others over the same period.*

AFTER TRAINING

- *They agree that continuation of breastfeeding during pregnancy is possible and will advise mothers to continue for as long as possible. They will advise the mother to drink and eat a balanced meal herself and use the money to buy food for the whole family.*

2. You attend a paediatric ward and find out some mothers feed their babies tea sweetened with sugar and plazma. What possible problems might this cause and how would you go about changing this practice.

BEFORE TRAINING

- *In paediatric ward, if they think the child is very ill, they will sometimes recommend this treatment.*

AFTER TRAINING

- *They think they must change this practice as it may lead to reduced iron absorption.*

3. Lolita is 4 months old when her mother brings her to see you in the Ambulanta. Her mother wants to know what foods she should introduce to her daughters diet. Until now, she has breastfed her child with the occasional bottle of infant formula. What advice do you give her?

BEFORE TRAINING

- *If the mother has any milk they tell her to continue with breastfeeding but often.*

AFTER TRAINING

- *It's not necessary to give infant formula – just continue to breastfeed. If the child appears to want more, start introducing foods like fruit, vegetables, soup etc.*

4. Lume has been through a stressful time and feels her flow of milk is thin and watery. She doesn't think this is good enough for her 5-month-old baby. Her doctor has told her to give vitamin A and

D drops plus diluted cows milk in a bottle. The child now has diarrhoea quite often. What is your advice to her?

BEFORE TRAINING

- *Continue with cows milk and normal food.*

AFTER TRAINING

- *Give vitamin A and D and breastfeed more, as well as family foods.*

5. Besa comes to see you with breast problems, which you diagnose, as mastitis. She has stopped breastfeeding over the last week her 1-month-old son. She has heard there is an organisation in the area, which can provide infant formula. She wants to know where she can get some for her son. What do you suggest to her?

BEFORE TRAINING

- *Treat mother for mastitis with tablets and stop breastfeeding.*
- *Stop breastfeeding for a short time. Give drugs to fight infection and pain, then continue breastfeeding afterwards.*

AFTER TRAINING

- *Massage breast to relieve pain.*
- *Do not stop breastfeeding, as the milk is not bad for the child. The most important thing for the mother is to continue breastfeeding as this will relieve the breast.*

6. A mother comes to see you with a 1-year-old child with diarrhoea. You weigh the child and find they fall below the line for weight for age chart for their age. There are no previous records of the weight of this child except the birth weight. You check the height and find their weight for height is below 80%. What support do you give to her and her child and what follow up procedures will you use.

BEFORE TRAINING

- *Generally recommend ORS, drugs and tea.*

AFTER TRAINING

- *Stop giving tea, but continue with ORS, more liquids and food without fat.*

ANNEXE F: EVALUATION QUESTIONNAIRE PART A

| | Before | After |
|---|--------------------------|--------------------------|
| 1. What are some of the advantages of breastfeeding? | | |
| Freely available | <input type="checkbox"/> | <input type="checkbox"/> |
| Correct temperature | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased infection risk | <input type="checkbox"/> | <input type="checkbox"/> |
| Better mental development for the infant | <input type="checkbox"/> | <input type="checkbox"/> |
| Lower risk of illnesses | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What kind of feeding is best for a child < 6 months old | | |
| Infant formula only | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding only | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding or infant formula with tea or juices or other | <input type="checkbox"/> | <input type="checkbox"/> |
| Breastfeeding with cows milk | <input type="checkbox"/> | <input type="checkbox"/> |
| Plazma and cows milk | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. When is it not possible for a woman to breastfeed? | | |
| When she is traumatised or stressed | <input type="checkbox"/> | <input type="checkbox"/> |
| When her child is sick | <input type="checkbox"/> | <input type="checkbox"/> |
| When her breast is painful or infected | <input type="checkbox"/> | <input type="checkbox"/> |
| Majority of women can breastfeed | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. A mother should feed her baby | | |
| Every 4 hours | <input type="checkbox"/> | <input type="checkbox"/> |
| As often as the child wishes | <input type="checkbox"/> | <input type="checkbox"/> |
| At least 8 times a day | <input type="checkbox"/> | <input type="checkbox"/> |
| When she has time | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Most problems associated with breastfeeding are due to | | |
| Incorrect positioning and attachment | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of confidence on the mother's part | <input type="checkbox"/> | <input type="checkbox"/> |
| Stressed or traumatised mother | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of sufficient milk from the mother | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. When should a mother start breastfeeding? | | |
| Within one hour of giving birth | <input type="checkbox"/> | <input type="checkbox"/> |
| After 1 day | <input type="checkbox"/> | <input type="checkbox"/> |
| It is not important when she starts | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. When a child < 6 months old has diarrhoea, what can the mother give? | | |
| More breast milk | <input type="checkbox"/> | <input type="checkbox"/> |
| Herbal or Russian tea | <input type="checkbox"/> | <input type="checkbox"/> |
| No change | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral rehydrating solutions (ORS) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. When should a baby start to eat for the first time? | | |
| 1-3 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 4-6 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 7-11 months | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 months and after | <input type="checkbox"/> | <input type="checkbox"/> |
| | Before | After |

9. What foods should you give the baby as its first food?

- | | | |
|----------------------|--------------------------|--------------------------|
| Rice | <input type="checkbox"/> | <input type="checkbox"/> |
| Yoghurt | <input type="checkbox"/> | <input type="checkbox"/> |
| Fruit and vegetables | <input type="checkbox"/> | <input type="checkbox"/> |
| Biscuits and cakes | <input type="checkbox"/> | <input type="checkbox"/> |
| Cows milk | <input type="checkbox"/> | <input type="checkbox"/> |

10. By the time the infant is 1 year old what should they be eating?

- | | | |
|--|--------------------------|--------------------------|
| Biscuits and cows milk | <input type="checkbox"/> | <input type="checkbox"/> |
| Fruit and vegetables | <input type="checkbox"/> | <input type="checkbox"/> |
| Special baby foods like chocolina and Frutek | <input type="checkbox"/> | <input type="checkbox"/> |
| All the family foods | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast milk only | <input type="checkbox"/> | <input type="checkbox"/> |
| Family foods and breast milk | <input type="checkbox"/> | <input type="checkbox"/> |

11. What foods are rich in iron?

- | | | |
|--------------------|--------------------------|--------------------------|
| Eggs | <input type="checkbox"/> | <input type="checkbox"/> |
| Meat e.g. liver | <input type="checkbox"/> | <input type="checkbox"/> |
| Vegetables | <input type="checkbox"/> | <input type="checkbox"/> |
| Tea | <input type="checkbox"/> | <input type="checkbox"/> |
| Biscuits and cakes | <input type="checkbox"/> | <input type="checkbox"/> |

12. What are the disadvantages to feeding with infant formula?

- | | | |
|----------------------------------|--------------------------|--------------------------|
| Higher risk of infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Higher incidence of diarrhoea | <input type="checkbox"/> | <input type="checkbox"/> |
| Less bonding with the mother | <input type="checkbox"/> | <input type="checkbox"/> |
| Higher risk of eczema and asthma | <input type="checkbox"/> | <input type="checkbox"/> |

13. Why should children be weighed and measured?

- | | | |
|---|--------------------------|--------------------------|
| To assess their nutritional status | <input type="checkbox"/> | <input type="checkbox"/> |
| To follow their progress in growth | <input type="checkbox"/> | <input type="checkbox"/> |
| To see how big they will be as an adult | <input type="checkbox"/> | <input type="checkbox"/> |
| To identify growth faltering | <input type="checkbox"/> | <input type="checkbox"/> |

ANNEXE G: EVALUATION QUESTIONNAIRE PART B

Part B - OFDA Evaluation of training

The following questionnaire will help us to evaluate the effectiveness of our training program. It will be useful for us and other organisations when planning future training programs and policy. Thank you for completing it for us.

Place -----

Number of people -----

| | Yes | No | Not sure |
|--|-----|-----|----------|
| 1. Overall, did you find the 3 training topics useful? | [] | [] | [] |

If yes, which topic and why? -----

If not, why? -----

| | | | |
|---|-----|-----|-----|
| 2. Did you learn anything new from any of the sessions? | [] | [] | [] |
|---|-----|-----|-----|

If yes, which topic and how useful is it to you? -----

If not, why? -----

3. Have you had a chance to use the information learnt from the sessions to advise mothers?

[] []

If yes, which topic and how often? -----

If no, give a reason -----

4. Did you find the methodology used for the training was suitable for you?

[] [] []

If yes what was good about it -----

If no what was bad about it or could be improved -----

Yes No Not sure

5. Do you feel enough time was devoted to each of the topics?

If no, which one required more time? -----

6. Do you think enough information was given for each topic?

If no, which ones were insufficient? -----

7. Were the materials used for training purposes appropriate?

If yes, what was good about it? -----

If no, what could have been better? -----

8. Were the materials/handouts given to you, appropriate for each topic?

If yes, what was good about it? -----

If no, what could have been better? -----

9. Have you been able to pass on what you learnt or any handouts to other members of staff who were unable to attend the training sessions.

10. Do you think it is necessary to measure the growth of infants up to 5 years old and continually monitor their growth using a weight for age (W/A) chart here in Kosovo?

Why? -----

11. Are you monitoring the growth of any infants using the weight for age chart at present?

Why? -----

12. If yes to question 11, how often do you weigh each child -----

Yes No Not sure

13. If not using at present do you think you will in future?

If no or not sure what will make you start using the charts? -----

14. Do you think there are further needs for training on breastfeeding, infant feeding and growth monitoring?

for yourselves

other health staff in ambulanta/health houses

for other health staff in hospitals

women in the community

15. Who do you think should do this training?

UNMIK health staff

WHO staff

IPH staff

Local NGOs

International NGOs

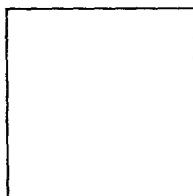
16. Do you prefer the trainers

to come to your health centre to train you or

to invite you to go to the nearest town to join others

Please write any further comments

ANNEXE H: POSTERS WARNING OF BREASTMILK SUBSTITUTES



Attention all procurement agencies

It has come to our attention that products (infant formula, cow's milk products, infant cereals, pots of pureed baby food & baby bottles) aimed at feeding young infants continue to come to Kosovo.

We would like to bring to your attention the following points:

- Nearly all women can breast feed their babies.
- WHO/UNICEF strongly recommend that **breast milk alone has everything** the baby needs to grow in the first 6 months of life.
- Giving infant formula or similar products is counterproductive to breast-feeding which is healthy and safe.
- Even underweight and traumatized mothers can produce adequate quantities of good quality milk.
- **Feeding the mother** would be a more cost effective and safe way of ensuring good nutrition for both mother and child.
- Any **NECESSARY** infant feeding products should be **MEDICALLY TARGETED** and supplied in quantities sufficient to feed the recipient infants as long as they need the product. These products should be labelled clearly in the appropriate language.
- Mothers facing difficulties in breast-feeding need medical counselling and a lot of encouragement, not a tin of infant formula.

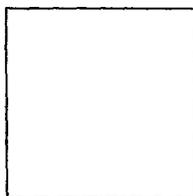
Imagine yourself living as a mother in Kosovo. The water from the well is not always clean, and the firewood supply is poor. The house is crowded and hygiene is difficult to maintain. Your baby is screaming to be fed.

Q. How do you make up a bottle of powdered milk properly in this situation?

A. You can't – but if you are breastfeeding your baby, you don't need to!

If you receive infant formula from outside donations, please contact Action Against Hunger, UNICEF or WHO.

ANNEXE H: POSTER WARNING OF BREASTMILK SUBSTITUTES AIMED AT MOTHERS



Attention all mothers

It has come to our attention that products (infant formula, cow's milk products, infant cereals, pots of pureed baby food & baby bottles) aimed at feeding young infants continue to come to Kosovo.

We would like to bring to your attention the following points:

- Nearly all women can breast feed their babies.
- WHO/UNICEF strongly recommend that **breast milk alone has everything** your baby needs to grow in the first 6 months of life.
- Giving infant formula or products like cow's milk, infant cereals, and pots of pureed baby food and baby bottles is counterproductive to breast feeding, which is healthy and safe.
- Even underweight and traumatized mothers can produce adequate quantities of good quality milk.
- **Feeding yourself** would be a more cost effective and safe way of ensuring good nutrition for both you and your child.
- If you face difficulties in breast feeding then you need medical counselling and a lot of encouragement, not a tin of infant formula.

As a mother in Kosovo, you know the water and electricity supply are poor. So hygiene is difficult to maintain. When your baby is screaming to be fed:-

Q. How do you make up a bottle of powdered milk properly in this situation?

A. You can't – but if you are breastfeeding your baby, you don't need to!

If you receive infant formula donations, please contact Action Against Hunger, UNICEF or WHO.

ANNEXE I: HEALTH CENTRES WHERE EQUIPMENT HAVE BEEN DONATED

Type of equipment donated to each municipality

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|--------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Kline | Drenoc | To donate | To donate | | |
| | Kline HH | 1 | 1 | 1 | 1 |
| | Shtupel | To donate | To donate | - | - |
| | Sverke | 1 | - | 1 | - |
| | Ujmir | 1 | - | 1 | - |
| | Zllakuqan | To donate | To donate | | To donate |
| Total | | 6 | 4 | 3 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|--------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Istog | Banja | 1 | 1 | 1 | 1 |
| | Gjurakoc | To donate | To donate | - | To donate |
| | Istog HH | 1 | 1 | - | 1 |
| | Rakosh | To donate | To donate | - | - |
| | Vrelle | To donate | To donate | To donate | - |
| Total | | 5 | 5 | 2 | 3 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|--------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Peje | Baran | 1 | - | 1 | - |
| | Leshan | 1 | - | 1 | - |
| | Ozdrim | To donate | To donate | - | - |
| | Peje Paediatric | 1 | 1 | 1 | 1 |
| | Peja Emergency | 1 | 1 | 1 | 1 |
| | Peje Amb 4 | 1 | - | 1 | 1 |
| | Vitomirice | To donate | To donate | - | - |
| | Zahac | 1 | - | - | 1 |
| Total | | 8 | 4 | 5 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|----------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Gjakove | Cermjan | 1 | - | 1 | 1 |
| | Erenike, | To donate | To donate | - | - |
| | Gjakove I | 1 | 1 | - | - |
| | Gjakove II, | | | | |

| | | | | | |
|--------------|--------------------|-----------|-----------|----------|----------|
| | Novoselle e Eperme | 1 | - | 1 | 1 |
| | Orize | 1 | - | - | - |
| | Ponoshec | 1 | - | 1 | 1 |
| | Sheremet | To donate | To donate | - | - |
| | Skivjan | 1 | - | 1 | 1 |
| Total | | 8 | 3 | 4 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|---------------------|------------------------------------|---------------------|--|--------------------------------------|--|
| Glogovc | Arbri e Eperme | 1 | - | 1 | 1 |
| | Baice, | 1 | - | 1 | 1 |
| | Glogovc HH* | 1 | 1 | 1 | - |
| | Komoran | 1 | 1 | 1 | - |
| | Terstenik | To donate | To donate | - | - |
| Total | | 5 | 3 | 4 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|---------------------|------------------------------------|---------------------|--|--------------------------------------|--|
| Skenderaj | Kline e Eperme | 1 | | 1 | 1 |
| | Llaushe | To donate | | | To donate |
| | Polac | 1 | To donate | 1 | |
| | Runik | 1 | To donate | 1 | |
| | Skenderaj HH | 1 | | 1 | 1 |
| | Turiceve | To donate | | | To donate |
| Total | | 6 | 2 | 4 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|-----------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| | | | | | |
| Podujeve | Lluzhane | To donate | To donate | To donate | To donate |
| | Orllan, | 1 | | 1 | 1 |
| Total | | 2 | 1 | 2 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|---------------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Pristina | <i>Barileve</i> | 1 | - | 1 | 1 |
| Obilic & | Bellocefc (Guri Bardh) | 1 | - | 1 | - |
| F. Kosovo | Fushe Kosovo | To donate | | To donate | - |
| | Matiqan | 1 | To donate | 1 | 1 |
| | <i>Milloshev,</i> | 1 | - | 1 | - |
| | Obiliq | 1 | 1 | 1 | - |
| | Prishtin St. 3, | To donate | To donate | - | - |
| | Prishtin St. 6, | 1 | 1 | 1 | 1 |
| | Sllatine | 1 | - | 1 | 1 |
| Total | | 9 | 4 | 8 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|----------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Prizren | Gjonaj | 1 | To donate | 1 | 1 |
| | Hoqe e Qytetit, | 1 | - | 1 | 1 |
| | Korishe | 1 | | 1 | 1 |
| | Romaje, | To donate | To donate | To donate | - |
| | Zhur | 1 | - | 1 | 1 |
| | Zym, | | - | - | - |
| Total | | 5 | 2 | 5 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|------------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Shtime | Muzeqine | To donate | To donate | To donate | To donate |
| | Shtime | 1 | 1 | 1 | 1 |
| Gjithësej | | 2 | 2 | 2 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|-----------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Suhareke | Grejkoc, | To donate | To donate | - | To donate |
| | Mushtishte | - | - | - | - |
| | Nishor | To donate | To donate | To donate | - |
| | Samadregje | - | - | - | - |
| | Sopin | - | - | - | - |
| | Studencan, | To donate | To donate | To donate | - |
| | Suhareke HH | 1 | 1 | 1 | 1 |
| Total | | 4 | 4 | 3 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|------------------|----------------------------|--------------|--------------------------------|------------------------------|---|
| Malisheve | Banje | To donate | To donate | | To donate |
| | Bellanice | | | | |
| | Drenofc | | | | |
| | Kijeve | 1 | To donate | 1 | 1 |
| | Llapceve | | | | |
| | Malisheve HH, | 1 | 1 | 1 | 1 |
| | Ponorc | To donate | To donate | 1 | To donate |
| Total | | 4 | 4 | 3 | 4 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|---------------------|------------------------------------|---------------------|--|--------------------------------------|--|
| Vushtrri | Samodregje | To donate | To donate | | |
| | Smrekovnice | To donate | To donate | To donate | To donate |
| | Vushtrri HH | 2 | 1 | 2 | 1 |
| Total | | 4 | 3 | 3 | 2 |

| Municipality | Health house/ Ambulanta | Height board | Baby scales ("beam balance) | Baby scales (Salter type) | Electronic scales for children and adults |
|---------------------|------------------------------------|---------------------|--|--------------------------------------|--|
| Rahovec | Bellacerke, | - | - | - | - |
| | Cifllak, | To donate | To donate | - | To donate |
| | Krushe e Madhe | To donate | - | - | - |
| | Rahovec | 1 | 1 | 1 | 1 |
| | Ratkoc | 1 | To donate | 1 | 1 |
| Total | | 4 | 3 | 2 | 3 |

| Name of Person or Organisation | Type of activity and ability to sustain activities |
|--------------------------------------|---|
| Igballe Morina | Former outreach worker who also works part time for social service in Malisheve municipality. They are very active in rural communities in Malisheve. |
| Igballe Hakiqi | This outreach worker started a women's organisation in her Podujevo municipality. The organisation have received funding from KWI and hence will continue to include the AAH training as part of other programs. |
| Fatmushe Manaj | Active in women's organisation in Istog municipality. |
| Lumturie Mulaj | Active in women's organisation (Centre for rehabilitation of women and children).in Shtime municipality. |
| Krenare Selimaj | Nurse working in one of the ambulantas in Suhareke municipality. Used to work in the health house and hence has close links with staff there including the maternity. |
| Muzafere Kastrati | Nurse in Glogovc health house. Has been active in this environment since commencing training with AAH. Has support of director and will continue using material in centre. |
| Edona Rudi | Former nurse who has close links with Gjakova hospital. She will continue to be active in the maternity. |
| Shahe Thaqi | Nurse working in the health house in Rahovec municipality. Extremely keen to continue using materials in working with mothers in all departments and maternity. |
| Institute of Public Health (IPH) | Based at the hospital with main focus on health promotion activities. Currently undergoing capacity building and establishing a policy on health promotion in conjunction with WHO. Have 5 other regional branches throughout the province and currently involved in health promotion activities as well as coordination with NGOs. |
| Medicin Du Monde (MDM) | Maternal and Child health education activities as well as running of mobile clinics. |
| Children's Aid Direct (CAD) | Health education programs throughout their areas of responsibility. |
| Swiss Red Cross (SRC) | Health education including training of doctors. |
| Doctors of the World (DOW) | Health education especially maternal and child health. Mobile clinics. |
| Pristina Hospital (Paediatrics Dept) | This department already has an active nurse who talks to mothers about breastfeeding and food preparation. |

Table 5: Individuals and organisations continuing to use AAH training posters for other education programs for mothers.

**Proposal
for
Nutrition Conference**

**Prepared
for**

UNICEF

Date of Conference: 4th/5th August 2000

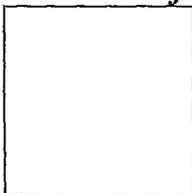
Place of Conference: Grand Hotel, Pristina, Kosovo

Total cost: 17,720 DM

**Proposal submitted
by:**

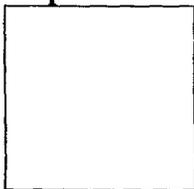
Action Against Hunger -UK & Save the Children

Aims & Objectives of Conference



- Problems of poor breastfeeding and infant feeding practices at all health care establishments as well as in the home will be addressed. The aim will be to facilitate key stakeholder group formation and strong links among health professionals. This will lead to further discussions on necessary policy decisions, which will follow internationally recognised standards for breastfeeding and the introduction of complementary foods.
- Initiate steps towards the organisation of focus groups for women to empower them and other influential members of the community to set up support groups for breastfeeding and infant feeding.
- Cascade of information from attendees to others within their immediate sphere of contact so that appropriate messages will be given to mothers both pre and post natally.
- Growth monitoring has strong links with infant feeding. A child who reaches their growth potential provides an indicator for successful infant feeding. The idea of growth monitoring will be introduced and the potential this has for early identification of nutritional problems such as chronic malnutrition will be discussed. Chronic malnutrition is a significant problem in Kosovo and its reduction must be part of the long-term aims of the health system.

Expected Outcomes



Short term

- *Awareness in all participants of the preventable problems associated with infant feeding in Kosovo and a willingness to take action at their health establishments. This should lead to immediate changes in practices and advice given to mothers at health establishments.*
- Information sharing between participants (health staff, NGO workers and women's groups) and to other colleagues on the subject matter.

Long term

- Presentation of a paper containing practical solutions, which can be presented to UNMIK to aid in policy decisions on the subject.
- Better collaboration between national key players to work on breastfeeding, infant feeding and growth monitoring improvements Kosovo wide.
- First steps towards the set up of a breastfeeding committee with key individuals in collaboration with UNMIK and UNICEF in the commencement of a Baby Friendly Hospital Initiative.