

# THE AMERICAN NATIONAL RED CROSS

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## ALBANIA CHILD SURVIVAL PROJECT DETAILED IMPLEMENTATION PLAN

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**Date of Submission:** April 30, 2004

**Cooperative Agreement No.:** GHS-A-00-03-00007-00

**Submitted to:** Attention: Susan Youll  
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**Project Location:** Albania  
Diber Prefecture: Diber, Mat, and Bulqize Districts

**Project Duration:** October 1, 2003 to September 30, 2008

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## LIST of ACRONYMS and ABBREVIATIONS

ACSP	- Albania Child Survival Project
AED	- Academy of Educational Development
AlbRC	- Albanian Red Cross
AmRC	- American Red Cross
ARI	- Acute Respiratory Infection
BCC	- Behavior Change Communication
BCG	- Bacilli Chalmette Guérin
BP	- Blood Pressure
CDD	- Control of Diarrheal Disease
CHC	- Commune Health Center
CHV	- Community Health Volunteers
C-IMCI+	- Community IMCI plus Family Planning
CM	- Commune Mobilizers
CSHGP	- Child Survival and Health Grants Program
CSP	- Child Survival Project
CYP	- Couple Years of Protection
DHC	- District Health Coordinators
DIP	- Detailed Implementation Plan
DTP	- Diphtheria, Tetanus, Pertusis
ECHO	- European Commission Humanitarian Aid Office
EOP	- End of Project
EPI	- Expanded Program on Immunization
FF	- Flexible Fund
FP	- Family Planning
FY	- Fiscal year
GB	- Global Bureau
GH/HIDN	- Global Health/Office of Health, Infectious Disease and Nutrition
GMP	- Growth Monitoring Promotion
GNI	- Gross National Income
GP	- General Practitioner
HBV	- Hepatitis B Vaccine
HDI	- Human Development Index
HFA	- Health Facility Assessment
HII	- Health Insurance Institute
HIS	- Health Information System
HW	- Health Worker
IDD	- Iodine Deficiency Disorder
IEC	- Information, Education, Communication
IMCI	- Integrated Management of Childhood Illness
IMR	- Infant Mortality Rate
INSTAT	- Albanian Institute of Statistics
IPH	- Institute of Public Health
IR	- Intermediate Results
JHU	- Johns Hopkins University

JSI	- John Snow International
KPC	- Knowledge, Practices and Coverage
LAM	- Lacteal Amenorrhoea Method
LBW	- Low Birth Weight
LMIS	- Logistic Management Information System
LOE	- Level of Effort
LOP	- Life of Project
M&E	- Monitoring and Evaluation
MCH	- Mother and child health
MCV	- Measles Containing Vaccine
MD	- Medical Doctor
MICS	- Multi Indicators Cluster Survey
MoH	- Ministry of Health
MOU	- Memorandum of Understanding
NGO	- Non-Governmental Organization
NHQ	- National Headquarters
Ob-Gyn	- Obstetric – Gynecology specialist
OPV	- Oral Polio Vaccine
ORS	- Oral Rehydration Solution
ORT	- Oral Rehydration Treatment
PCV	- Peace Corps Volunteers
PHC	- Partners for Health Reform plus
PHCD	- Primary Health Care Directorate
PHD	- Public Health Directorate
PHR+	- Primary Health Reform+
PPP	- Project Planning Process
PPS	- Population Proportional Size
PRA	- Participatory Rural Appraisal
PVO	- Private Voluntary Organization
QA	- Qualitative Assurance
RA	- Rural Ambulanca
RC	- Red Cross
RH	- Reproductive Health
RHF	- Recommended Home Fluids
SCF	- Save the Children Fund
SDM	- Standard Days Method
SDP	- Service Delivery Point
SE	- South East
SO	- Strategic Objective
STI	- Sexual Transmitting Infection
TAPE	- Technical, Assistance, Planning and Evaluation
TBD	- To be Determined
TFR	- Total Fertility Rate
TOT	- Training of Trainers
U5MR	- Under the age of five Mortality Rate
UM	- Urban Maternity

UNDP - United Nations Development Programs  
UNFPA - United Nations Population Fund  
UNICEF - United Nations Children's fund  
UPA - Urban Pediatric Ambulanca  
URC - University Research Co.  
USAID -United States Agency for International Development  
VAD - Vitamin A Deficiency  
VHE - Volunteer Health Educators  
VHW - Village Health Worker  
VNM - Village Nurse Midwife  
WCC - Women Consultancy Center  
WCR - Women Consultancy Room  
WFP - World Food Program  
WHO - World Health Organization  
WRA - Women of Reproductive Age

## A. Executive Summary –Albania Child Survival Project

**Project Location:** The three districts of the Diber Prefecture, Albania - Diber, Bulqize, and Mat - covering all 6 towns and 279 villages.

**Project Beneficiaries.** Implemented over a five-year period, the ACSP will reach approximately 221,669 people comprised of 28,661 children U5 (including 4,230 infants), and 55,417 women of reproductive age (15-49 years) and 68,717 men (15-59 years).

**Category of original CSHGP application:** Entry.

**Level of funding:** USAID: \$1,099,679 with PVO match: \$1,412,054, totaling \$2,511,733

**Project Duration:** October 1, 2003 through September 30, 2008.

**Problem Statement:** The health status of women and children in Albania has steadily declined since the fall of communism in the early 1990's and throughout the subsequent, turbulent transition period. Infant and U5 mortality rates are ranked among the highest in Europe fueled by highly preventable and treatable diseases such as malnutrition, diarrhea and acute respiratory infection (ARI). Similarly, the national maternal mortality ratio (MMR) is among the highest in Europe. While the MMR was greatly reduced upon the legalization of abortion in 1991, access to modern contraceptive methods is still very limited, especially in rural areas. Abortions are used as a form of birth control, reflected in the high national abortion rate, reported at one abortion per 2.5 live births.<sup>1</sup> Although much emphasis and international investment has occurred in Albania to overhaul the health system in the past ten years, it remains highly fragmented and overly medicalized. USAID, UNICEF, WHO and others have made gains in improving the availability of quality maternal and child health (MCH) services, yet they have largely been at the clinical level and in more urban settings.

**Program Goal, Objectives and Major Strategies:** To increase demand for these improving systems and services, while maintaining a rationale use of the health care system, the AmRC is working through the AlbRC to mobilize communities to take responsibility for their health while improving the skills of first-line health workers. The AlbRC will be responsible for implementing the project with significant technical assistance and oversight by the AmRC.

The **goal** of the ACSP is improved health status of women of childbearing age and children 0-59 months. This will be done through targeted interventions that address the leading causes of U5 mortality and morbidity in the Diber Prefecture - malnutrition, ARI and diarrhea as well as increase access to and utilization of family planning and reproductive health (FP/RH) services for women and men of reproductive age.

The ACSP will focus on three **objectives** and the associated key primary interventions:

1. **Nutrition (30%)** To reduce morbidity and mortality associated malnutrition through breastfeeding promotion, nutrition education, and increased iodized salt consumption.

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<sup>1</sup> Albania National Women Report, United Nations Development Program (UNDP), 1999.

2. **Management of the Sick Child (ARI 20% and CDD 20%):** (40%) To reduce diarrhea and ARI-associated morbidity and mortality through preventive measures (hygiene), prompt and appropriate home-based case management, and recognition of danger signs with appropriate utilization of formal health services.
3. **FP/RH (30%)** To improve RH through appropriate micronutrient supplementation during pregnancy, increased early initiation of prenatal care, and increased awareness, knowledge and utilization of modern family planning methods by couples.

There are three cross-cutting implementation **strategies** that will be used and applied to all technical interventions: 1) *capacity-building to improve access, availability, and quality of services*; 2) *community mobilization to increase demand for, and use of, key services*; and 3) *tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices*. Within a context of an integrated Community Integrated Management of Childhood Illness and Family Planning model, the three cross-cutting implementation strategies will be combined with four high-impact community activities that will be implemented in all interventions: 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups.

**Operations Research:** There are two proposed subjects for operations research. First, a ***Qualitative inquiry (“Grandmother Approach”)***; the study will make inquiries into key household attitudes, beliefs, and practices related to family planning and child health from household decision makers including grandmothers and mothers-in-law. The second study aims to examine the efficacy of male vs. female Volunteer Health Educators at the village level.

**USAID Mission Representatives:** The ACSP objectives and overall strategy have been discussed and negotiated in detail with the USAID Albania Mission located in Tirana. In addition to numerous meetings during 2003-4 on this topic, the USAID Health, Population and Nutrition Officer reviewed and provided comments on earlier conceptual drafts to ensure integration with USAID Mission objectives and key results areas. Key personal involved included: Harry F. Birnholz, Mission Director, Pamela J. Wyville–Staples General Development/Health Officer and Zhaneta Shatri, Health Assistant.

**Main Authors of Document:** The DIP was written by members of the ACSP team, led by the AmRC National Headquarter Senior Regional Associate, Malik Jaffer, and Regional Health Delegate for South East Europe, Karen Z. Waltensperger, with Fabian Cenko, Project Manager; Ermira Brasha, Senior Liaison (M&E) Officer; Gazmend Koduzi, Deputy Program Manager; Artan Isaraj, Technical Officer; Ardiana Peci, AlbRC National Health Coordinator; Nancy Campbell, Regional Finance and Administration Delegate, AmRC/South East Europe; and Geltjana Bulku, Project Assistant and Translator. Jim Ricca, Health Manager of the AmRC Technical Assistance and Program Evaluation (TAPE) Unit and Alice Willard, Senior Monitoring and Evaluation Manager of the TAPE unit provided review and feedback of key documents; as did Suzanne Savage, Regional Head of Delegation (South East Europe); Paul Robinson, AmRC Europe, Central Asia and Middle East Health Officer; and Dr. Gilbert Burnham, Consultant, JHU.

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**B. CSHGP Data Form**

***Child Survival Grants Program Project Summary***

**DIP Submission: Apr-30-2004  
ARC Albania**

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**Project Information:**

<b>Project Description:</b>	This project works through the Albanian Red Cross to mobilize communities to take responsibility for their health while improving the skills of first-line health workers. Targeted interventions will address the leading casues of under-5 mortality and morbidity in Diber Prefecture. The project plans to focus on improvements in nutritional status, management of the sick child and increasing access to and utilization of family planning and reproductive health services.
<b>Partners:</b>	Albania Red Cross, Johns Hopkins University, Ministry of Health, Albania, UNICEF, and University Research Center
<b>Project Location:</b>	The three districts of the Diber Prefecture, Albania - Diber, Bulqize, and Mat - covering all 6 towns and 279 villages.

## Grant Funding Information:

USAID Funding:(US \$)	\$1,099,679	PVO match:(US \$)	\$1,412,054
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## Target Beneficiaries:

Type	Number
infants (0-11 months):	3,760
12-23 month old children:	3,714
24-59 month old children:	12,476
0-59 month old children:	19,950
Women 15-49:	55,417
Estimated Number of Births:	3,872

## Beneficiary Residence:

Urban/Peri-Urban %	Rural %
24%	76%

## General Strategies Planned:

Social Marketing  
Advocacy on Health Policy

## M&E Assessment Strategies:

KPC Survey  
Health Facility Assessment  
Organizational Capacity Assessment with Local Partners  
Organizational Capacity Assessment for your own PVO  
Participatory Rapid Appraisal  
Participatory Learning in Action  
Community-based Monitoring Techniques  
Participatory Evaluation Techniques (for mid-term or final evaluation)

## Behavior Change & Communication (BCC) Strategies:

Social Marketing  
Mass Media  
Interpersonal Communication  
Peer Communication  
Support Groups

## Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
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US HQ (General) CS Project Team	Local NGO	(None Selected)	National MOH Dist. Health System Health Facility Staff Other National Ministry	CHWs
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**Interventions:**


**Acute Respiratory Infection 20 %**

** IMCI Integration
** CHW Training
** HF Training
*** Recognition of ARI Danger Signs

**Control of Diarrheal Diseases 20 %**

** IMCI Integration
** CHW Training
** HF Training
*** Water/Sanitation
*** Hand Washing
*** ORS/Home Fluids
*** Feeding/Breastfeeding
*** Care Seeking


**Nutrition/Micronutrients/Vit A (Combined) 30 %**

** IMCI Integration
** CHW Training
** HF Training
*** Comp. Feed. from 6 mos.

*** Cont. BF up to 24 mos.
*** Growth Monitoring
*** Post Partum
*** Iodized Salt
*** Iron Folate in Pregnancy
<b>Family Planning &amp; Reproductive Health 30 %</b>
** IMCI Integration
** CHW Training
** HF Training
*** Knowledge/Interest
*** FP Logistics
*** Male Reproductive Health
*** Youth FP Promotion
*** Community Involvement
*** Access to Methods
*** Policy

<b>Indicator</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Estimated Percentage</b>	<b>Confidence line</b>
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	72	428	16.8	6.3
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	214	289	74.0	10.2
Percentage of children age 0-23 months whose births were attended by skilled health personnel	563	569	98.9	1.8
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	369	569	64.9	8.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	44	122	36.1	17.2
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	68	83	81.9	16.9

Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	130	177	73.4	13.4
Percentage of children age 12-23 months who received a measles vaccine	180	276	65.2	11.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	523	569	91.9	7.7
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	85	263	32.3	11.6
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	424	569	74.5	7.3
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	178	569	31.3	7.7

**Table 1 - Rapid Catch Indicators**

<b>Sentinel Measure of Child Health and Well-being</b>		
1	Percentage of children <b>aged 0-23 months</b> who are more than 2 standard deviations below the median weight-for-age of the reference population	14.8%
<b>Prevention of Illness/Death</b>		
2	Percentage of children <b>aged 0-23 months</b> who were born at least 24 months after the previous surviving child	74.1%
3	Percentage of children <b>aged 0-23 months</b> whose births were attended by skilled health personnel	98.9%
4	Percentage of <b>mothers with children 0-23 months</b> who received at least 2 TT injections (recall) before the birth of the youngest child	64.8%
5	Percentage of children aged 0-5 months who were exclusively fed breastmilk during the last 24 hours	36.1%
6	Percentage of children <b>aged 6-9 months</b> who received breastmilk and solid or semi-solid foods during the last 24 hours	81.9%
7	Percentage of children <b>aged 12-23 months</b> who received BCG, DTP3, OPV3, vaccine before their first birthday (Fully vaccinated) <sup>2</sup>	73.4%
8	Percentage of children <b>aged 12-23 months</b> vaccinated for measles (confirmed by card or mother's recall) <sup>3</sup>	65.2%
9	Percentage of children <b>aged 0-23 months</b> old who slept under an insecticide-treated bed net the previous night ( <b>in malaria risk areas only</b> )	N/A
10	Percentage of <b>mothers of children aged 0-23 months</b> who cite at least two known ways of reducing the risk of HIV infection	74.5%
11	Percentage of <b>mothers of children aged 0-23 months</b> who report that they wash their hands with soap before food preparation, feeding children, after defecation and attending to a child who has defecated.	31.2%
<b>Management/Treatment of Illness</b>		
12	Percentage of <b>mothers of children aged 0-23 months</b> who know at least 2 signs of childhood illness that indicate the need for treatment	91.9%
13	Percentage of children <b>aged 0-23 months</b> with an illness in the last two weeks who received increased fluids and continued feeding during the illness.	32.3%

<sup>2</sup> Note that this indicator does NOT conform to the Albanian definition of “fully vaccinated”.

<sup>3</sup> Note that measles vaccination is given to children up to 14 months in Albania

### **C. Description of the Detailed Implementation Plan (DIP) Process**

This detailed implementation plan (DIP) for the Albania Child Survival Project (ACSP) is the product of a participatory process of team building, partnering, assessment, analysis, consensus development, and feedback that began prior to October 1, 2003.

**NB:** The ACSP is being implemented jointly by the American Red Cross (AmRC) and the Albanian Red Cross (AlbRC). The membership of the “ACSP team” or the “project team” represents both Red Cross partners. All Albanian national staff are contracted through the AlbRC. Please see Organogram and Management Plan in Annex 8 for structural and functional details.

#### ***Project start-up activities:***

##### **September 2003**

- Translation of project proposal shared with key partners and stakeholders
- Installation of project office in Peshkopi
- Detailed job descriptions developed for national staff positions
- Recruitment and hiring of Project Manager and key project staff
- Initial management orientation and training in Peshkopi
- Pre-KPC survey planning
- Initial briefings with Ministry of Health (MOH), Institute of Public Health (IPH), United Nations Children’s Fund (UNICEF), United States Agency for International Development (USAID), District Public Health Directors, AlbRC Diber Branch Secretary and sub-branch personnel

##### **October 2003**

- Arrival of international team members and KPC Consultant (October 6)
- Presentation and feedback of KPC methodology, tools, and team to MOH and other Tirana stakeholders (e.g., Save the Children, Christian Children’s Fund (CCF), etc.)
- Letter of authorization for conducting the Knowledge, Practice and Coverage (KPC) survey secured from MOH
- Project agreement between American Red Cross and Albanian Red Cross finalized
- Knowledge, practice, and coverage (KPC) survey supervisor training (October 9-11)
- Updates for District Public Health Directors and AlbRC Diber Branch and sub-branches
- KPC interviewer training (October 21-24)
- KPC survey completed (October 27-31)

##### **November 2003**

- Deputy Project Manager hired
- KPC data entry (November 4-December 2)

##### **December**

- KPC data analysis
- KPC preliminary feedback meeting in Peshkopi (20 December) – *see description below*

##### **January 2004**

- KPC analysis continues
- Planning for health facilities assessment (HFA) and DIP
- Community mapping exercise begins

#### **February**

- Arrival of NHQ Senior Associate and HFA Consultant (February 12-13)
- Health facilities assessment (HFA) questionnaire adaptation, logistics planning, and supervisor training (February 15-20)
- HFA surveyor training (February 21-23 )
- HFA carried out (February 24-28)
- ACSP participation in USAID/URC “Improving Primary Health Care Services in Albania” launch meeting in Tirana (February 25-27)
- HFA data entry
- Planning for DIP workshop in Peshkopi
- Community mapping exercise continues

#### **March 2004**

- HFA analysis begins
- DIP workshop in Peshkopi (March 8-9) – *see description below*
- Processing of DIP workshop results
- Community mapping exercise completed at commune level

#### **April 2004**

- Technical Officer hired
- DIP processing and writing
- KPC and HFA report writing

***KPC preliminary feedback meeting:*** On Saturday, 20 December 2003 in Peshkopi, the ACSP team introduced the project to the Diber Prefecture community at-large and presented preliminary key KPC results to an audience of 58 stakeholders. In addition to the dissemination of the KPC results, the meeting provided an opportunity to recognize the contributions of KPC supervisors and interviewers by awarding certificates of appreciation from representatives of the AlbRC and AmRC. The event was positively covered by local print and broadcast media. Participating individuals, institutions, and organizations included the following:

- *Prefectoral Inspector Health and Education*
- *Mat, Bulqize, and Diber District Health Directorates*
- *Institute of Public Health*
- *KPC interviewers (e.g., doctors, nurse midwives, teachers, agricultural extension workers)*
- *Christian Children’s Fund*
- *Coordinator of Diber NGOs*
- *Mayors of Bulqize and Diber*
- *ACTED (NGO)*
- *Dibra Vision (local Danish-funded local government project)*
- *DANIDA*
- *Albania Red Cross volunteers from Diber Prefecture*
- *Local media (TV, print)*
- *American Red Cross Regional Head of Delegation (South East Europe)*

**DIP Stakeholder Workshop:** On 8-9 March 2004, the project held a participatory, field-based, two-day DIP stakeholder workshop in Peshkopi, attended by 47 individuals representing major partners, stakeholders, and constituencies, including “mother leaders”, village nurse midwives (VNMs), and local community leaders. The workshop was positively covered by local television and print media. Annex 9 contains the agenda, objectives and workshop results. Below is an indicative listing of participants:

- *Ministry of Health-Primary Health Care Directorate*
- *Institute of Public Health*
- *Prefectoral Inspector for Health and Education*
- *Mat, Bulqize, and Diber District Health Directorates*
- *Tirana Health Directorate*
- *Christian Children’s Fund (including staff, teachers, and “mother leaders”)*
- *Spanish Red Cross*
- *USAID Mission (Health Specialist)*
- *University Research Corporation (URC) (Advocacy Specialist)*
- *Peace Corps (Peshkopi-based Peace Corps volunteer)*
- *Mayor of Peshkopi*
- *Health providers, including 10 Visiting Nurse Midwives (VNMs)*
- *Local media (TV, print)*

**Planning methods:** In addition to key stakeholder meetings, consultation with USAID/Albania, KPC preliminary results feedback meeting, and DIP workshop described above, other planning methods have included: 1) team consensus-building and planning exercises; 2) review of background documents and secondary sources; and 3) working meetings with MOH, IPH, UNICEF, WHO, and URC, USAID’s bilateral contractor for primary health care reform.

**Number of days spent on DIP preparation:** The DIP was written by members of the ACSP team, led by the AmRC National Headquarters (NHQ) Senior Regional Associate, Malik Jaffer, and Regional Health Delegate for South East Europe, Karen Z. Waltensperger, with Fabian Cenko, Project Manager; Ermira Brasha, Senior Liaison (M&E) Officer; Gazmend Koduzi, Deputy Program Manager; Artan Isaraj, Technical Officer; Ardiana Peci, AlbRC National Health Coordinator; and Geltjana Bulku, Project Assistant and Translator. Jim Ricca, Health Manager of the AmRC Technical Assistance and Program Evaluation (TAPE) Unit and Alice Willard, Senior Monitoring and Evaluation Manager provided review and feedback of key documents; as did Suzanne Savage, Regional Head of Delegation (South East Europe) and Paul Robinson, AmRC Europe, Central Asia and Middle East Health Officer. The DIP represents approximately 110 person days of actual writing, reviewing, and compiling. (This includes writing up, review, and editing of the reports of the KPC, Community Mapping Exercise, and HFA.)

**Planned follow up:** There are several follow-up activities planned following the DIP process.

- **Project Monitoring and Evaluation (M&E) plan:** The project’s M&E plan is still in development. Next steps include the following:
  - AmRC Technical Assistance, Programming and Evaluation (TAPE) Unit will provide technical assistance for M&E tool development and

- monitoring plan to project's Senior Liaison (M&E) Officer (week of May 24, 2004) at AmRC National Headquarters in Washington, DC;
- Senior Liaison (M&E) Officer will participate in "Quality Assurance Management for Developing Countries" course<sup>4</sup> at Johns Hopkins University School of Public Health (June 7-18) in Baltimore, MD;
  - Qualitative inquiry ("Grandmother Approach") to be carried out in August 2004 will inform development and refinement of community monitoring tools;
  - Design of M&E tools will be finalized by October 2004
  - M&E and monitoring plan will be reviewed at M&E workshop to be held in November 2004.
- ***Project advisory group:*** One key recommendation from the DIP workshop held in March 2004 is the formation of an ACSP advisory group that meets with the project team three times a year to review monitoring and evaluation (M&E) data, assess progress, identify problems and solutions, determine priorities for action in the context of the DIP, and make adjustments, as necessary. Participation in the advisory group will include District Public Health Directors, AlbRC Diber Branch Secretary and sub-branch health coordinators, and prefecture authorities, as well as community representation through delegated VNMs and Volunteer Health Educators (VHEs) on a rotational basis. Thrice yearly meetings will allow the advisory group to meet once in Burrell (Mat District), once in Bulqize town (Bulqize District), and once in Peshkopi (Diber District). The first meeting of the project advisory group is scheduled to take place in July 2004.
  - ***Qualitative inquiry ("Grandmother Approach"):*** In August 2004, the project will conduct a qualitative inquiry into key household attitudes, beliefs, and practices related to family planning and child health (e.g., child caring, infant and young child feeding, illness prevention, illness recognition, home care, appropriate care seeking, and treatment compliance). This study will be led by Judi Aubel. The Grandmother Approach will focus on the role of influential senior women and other family decision-makers. Results of this qualitative study will inform development of the Community Integrated Management of Childhood Illness plus Family Planning) C-IMCI+) package (e.g., training curriculum, behavior change strategy, and key messages). It is envisioned that the qualitative inquiry will generate ideas about leveraging wisdom and influence of senior women and exploiting traditional socio-cultural channels for transmitting information (e.g., communication between mother-in-law to daughter-in-law).
  - ***Population-based family-planning survey:*** In August 2004, the project will conduct a second population-based survey for family planning consistent with Flexible Fund requirements. The sampling methodology and implementation of the survey is expected to follow the same methodology that was used during the KPC. A copy of the survey instrument is attached in Annex 10. The survey will be adapted to the

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<sup>4</sup> Course fee and accommodation for this course is being provided through a generous contribution from Prof. Gilbert Burnham at the JHU Bloomberg School of Public Health.

Albanian context and translated prior to use. The project will take advantage of this additional survey opportunity to repeat selected questions from the KPC survey that relate to complementary feeding in order to verify KPC findings and ensure that baseline data accurately reflect actual household practices. A full report of the population based family planning survey will be included in the year one annual project report.

- **USAID/URC “Improving Primary Health Care in Albania” project:** USAID/Albania’s new umbrella health project<sup>5</sup> “*Improving Primary Health Care in Albania*” is being implemented by URC. The ACSP team was represented at URC at the national conference launching the project, held in Tirana February 25-27, 2004. The project’s focus is on health care reform; and its goal is “to improve primary health care nationwide through enhanced *quality, utilization, and integration* in scope and system.” To achieve its expected results, URC will apply a “collaborative methodology” that involves series of technical discussion where best practices and strategies for change are shared and implemented in a structured way in pilot communes. The URC project focuses on health service delivery, health information, health financing, and health advocacy; and any one of these areas may be selected to be tested through the “collaboratives”. Prefectures are being phased into the project in a cascading manner during 2004-5. Diber Prefecture has been prioritized and is expected to enter the process in June 2004. The ACSP team and URC have met together several times and will continue to work closely to ensure that the three districts derive maximum benefit from the collaborative experience. It is, however, too early to determine what particular set of problems and best practices will be addressed in Diber Prefecture, or which communes will be selected to test solutions.
- **Peace Corps Volunteers:** In March 2004, the Peace Corps in Albania took in a new group of Peace Corps Volunteers (PCVs) who will be working in health. These PCVs are currently undergoing three months of pre-placement training and will be assigned to District Public Health Directorates at the district and commune health center level. The ACSP advocated with the District Public Health Directors in Diber Prefecture to submit applications for PCVs to work with the ACSP, and it is possible that one or two volunteers will be placed in Diber District (but not in Mat or Bulqize). Final decisions have yet to be made. The ACSP team has been asked to provide health-related training inputs for the volunteers during their induction period.

#### **D. Revisions from the original application**

**Project site, location, and selection of interventions:** There have been no changes in the project site, location, or selection of interventions.

**Project name:** The name of the project has been changed from the Child Survival and Health Project (CSHP) to the **Albania Child Survival Project (ACSP)**.

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<sup>5</sup> October 2003 – September 2006 with possible 2-year extension

**Project goal and objectives:** The project goal and objectives have been refined, and the set of indicators modified and expanded based on KPC and HFA findings, Flexible Fund requirements, and current Albania MOH policies, norms, and protocols. Targets have been selected or revised taking into consideration KPC results and confidence intervals.

The revised goal of the Albania Child Survival Project (ACSP) is ***improved health status of women of reproductive age and children 0-59 months in Diber Prefecture***. In the original proposal, the project goal was stated as follows: “*The goal of the (project) is to empower individuals, families, communities, and village midwives to improve the health of children U5 and women of reproductive age in Diber, Bulqize, and Mat Districts of the Diber Prefecture through targeted interventions that address the leading causes of childhood deaths (malnutrition, diarrhea, ARI) and increase access to quality FP/RH services.*”

**Number of beneficiaries:** The number of beneficiaries has been modified, based on updated statistics from the prefecture and to conform to Flexible Fund requirements for male beneficiaries. In the original proposal, the total population of the prefecture was estimated at 223,606. The Diber Prefecture Statistical Office estimates the current total population as 221,669. **This includes a beneficiary population of approximately 28,661 children 0-59 months; 55,417 women of reproductive age (15-49 years); and 68,717 men (15-59 years).** In the original proposal, only men 15-49 years were included. The 2004 population growth for Albania is estimated at 0.0%<sup>6</sup> and is expected to decline in the future as a result of out-migration.

**Budget amendment:** Changes in international training costs, international travel plans, indirect cost elements, and procurement plan are reflected in the budget amendment being submitted on revised Forms 424 and 424A accompanied by supporting information on all cost charges. The revised forms and supporting information is submitted in Annex 11.

**Other changes from the original application:** Other changes from the original application include the following:

- **Support for MOH national IMCI strategy:** In order to increase availability and ensure access to key services for sick children, the ACSP will provide resources and organizational support to expand the national IMCI program to all districts of Diber Prefecture, complemented by development and documentation of a community IMCI plus family planning (C-IMCI+) model for Albania.
- **Vitamin A supplementation:** The indicator for routine vitamin A supplementation (VAS) of children 6-59 months has been removed. The decision not to pursue VAS is justified in the technical section on nutrition and micronutrients.

**Changes in the project’s management plan:** The roles and responsibilities of staff contributing to the ACSP have changed and/or been refined from the original proposal. It is envisioned that over the life of the project, the overall day to day management of the project transition from the AmRC to the Albanian Red Cross. This transition is articulated in a full management plan in Annex 8 with Phase I being the current organizational structure, roles and responsibilities and Phase II being the envisioned structure and reporting lines being fully effective in July 2005.

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<sup>6</sup> US Census Bureau 2004.

The proposed changes in the management plan are being discussed with the AlbRC. Below are bullet points relating to the changes in staffing structure.

***The following points all relate to the project's staffing structure:***

- At the community level, the project will train approximately two AlbRC VHEs per village instead of four, as originally proposed. A total of 760 VHE will be trained allowing for more than two volunteers in larger villages. Approximately 60 of these volunteers will be used at the communal health center level to support the work of doctors and nurse. All volunteers will be trained in a six day course on Community Integrated Management of Childhood Illness with Family Planning. This reduction in the volunteer force was considered necessary in order to match the size of villages with the number of volunteers at village, communal and district levels within the context of a budget realignment.
- The cadre of project-paid Community Mobilizers has been reduced from 62 to 36 or one per commune. The role of the CM will continue to remain the same but will also rely on the AlbRC District Health Coordinators for support in supervision, mentoring, and monitoring activities.
- To strengthen AlbRC capacity and ensure sustainability in volunteer management and retention, the three district health supervisors have been re-located to the AlbRC side of the organogram and will report to the AlbRC Diber Branch Secretary.
- The AlbRC National Health Coordinator will be funded at 100% for two years (beginning March 2003) and at 25% for a third year. (Funding was originally proposed at 30% for three years.) This position has been filled; and the incumbent (who has significant previous American Red Cross community-based experience) serves as part of the ACSP team and primary AlbRC counterpart.
- The position of Training/M&E Coordinator was split by function. It was decided to create a Deputy Project Manager position (100% LOE). This post has been filled by a medical doctor undertaking a specialization in public health and experienced in both training and family planning (former JSI employee).
- The M&E function was assumed by the American Red Cross Senior Liaison Officer, a medical graduate with several years of American Red Cross experience, who will devote a total of 80% LOE to the project.
- It was determined that the project would need additional technical resources in child health and IMCI, and the position of Technical Officer was created for the first four years of the project. This position has been filled with a pediatric specialist.
- The position of Project Assistant/Translator will be phased out in August 2004 after completion of the DIP.
- The international position of Regional Health Delegate for South East Europe (budgeted as cost share) is scheduled to be phased out after April 2005.

## **E. DETAILED IMPLEMENTATION PLAN**

In this section, there will be a summary of the baseline assessments and the implementation context. The summary will touch on results of the KPC, HFA, Community Mapping exercise and partner assessment as well as planned studies for August 2004 and operations research. Following the summary is a more detailed discussion of baseline findings by intervention;

namely nutrition and micronutrients, control of diarrheal disease, acute respiratory infection, and family planning.

## ***E.1 - SUMMARY OF BASELINE AND OTHER ASSESSMENTS***

***Current country and implementation context:*** The Republic of Albania, located in South East Europe, borders Montenegro and Kosovo to the northeast, Macedonia to the east, Greece to the south, and the Adriatic Sea to the west. Slightly smaller than the United States State of Maryland, the country covers an area of 26,748 square kilometers, with a population of approximately 3.1 million. The terrain is predominantly mountainous, with central and coastal plains. Albania's geography and history have shaped it into a modern nation with isolated populations, poor infrastructure, and low socio-economic status as reflected by its gross national income (GNI) per capita of \$1,380. Albania ranks 95/151 ("medium human development") on the 2003 Human Development Index (HDI). Life expectancy is 73.4 years (75.85 for women and 69.90 for men); and the adult literacy rate is 85.3%.<sup>7</sup>

To quote from an earlier UNDP report<sup>8</sup> for Albania: "*General health indicators in Albania require careful analysis. Some indicators compare Albania favorably to its European counterparts. Life expectancy is 72.2 years, which is slightly below the average for Western Europe but above that of other countries in transition. This is probably due to people's diet and lifestyle and the climate. But this indicator needs reassessment given the recent increase in deaths by car accident and gunfire, especially among young people*" (p.25).

The ***health status of children*** in Albania has declined steadily since the fall of communism in the early 1990s and throughout the turbulent decade of transition that followed, particularly in the underserved northern region. UNFPA estimates Albania's maternal mortality ratio as 31/100,000<sup>9</sup>. Albania's officially-reported national infant mortality rate (IMR) is 26/1,000, and the under five mortality rates (U5MR) is 30/1,000 (2001).<sup>10</sup> Albania's IMR is nearly double that of the Eastern European average (14/1,000). Diber and Bulqize, two districts of Diber Prefecture, are reported to have the highest rates of infant mortality in the country, but accurate district-level data is unavailable. IPH is currently undertaking a national study of infant mortality, and Diber District is included in the districts being sampled.

The IPH lists the main causes of infant mortality in Albania as respiratory infections, diarrhea, congenital abnormalities, and infectious diseases. Nationally, and in Diber Prefecture, lower respiratory infections (especially pneumonia) and diarrhea are the leading reported causes of under five morbidity and mortality<sup>11</sup>. The District Public Health Directors in Diber Prefecture have registered concern about high neonatal mortality rates in maternities; and this report warrants further investigation and documentation. With a stunting rate of 17% nationwide<sup>12</sup>, malnutrition is an important underlying cause of infant mortality and morbidity.

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<sup>7</sup> Human Development Report. United Nations Development Programme, 2003).

<sup>8</sup> Albania Human Development Report. United Nations Development Programme, 2000.

<sup>9</sup> UNFPA Albania Country Report, 2003.

<sup>10</sup> From State of the World's Children. UNICEF, 2003.

<sup>11</sup> Causes of Death for the Year 1998. MOH/Institute of Statistics/INSTAT, 2000.

<sup>12</sup> Multiple Indicator Cluster Survey. UNICEF, 2000.

**Albania's formal health system:** In 2002, MOH unveiled a *Ten-year Development Strategy of the Albanian Health System*<sup>13</sup> designed to improve health status of the population through increasing availability and access to high quality services. The health system is currently fragmented and in the throes of reform and the government's de-centralization process. The formal healthcare system is administered by MOH, with District Public Health Directorates responsible for health service delivery, health information reporting, and disease surveillance. There are at present no prefecture level health authorities that correspond to current government administrative units, but this is likely to change over the five years of the project.

Through the District Public Health Directorates, MOH employs directly most categories of healthcare providers in the district hospitals, polyclinics, commune health centers, and urban and rural ambulancas (health posts). However, as part of the movement to reform healthcare financing, GPs at the PHC level (e.g., commune health centers) are employed and compensated through the Health Insurance Institute (HII), Albania's public health insurance scheme (funded in part through salaried employee and/or employer contributions) to whom they are accountable. Since its inception in 1995, HII has become the major funder for PHC doctor salaries and drugs. The funding of PHC infrastructure has also changed. Since 1998, funds have been channeled as block grants to local governments from the Ministry of Local Government and Decentralization.

**Administrative divisions in Albania:** Administratively, Albania is currently divided into prefectures, each composed of clusters of three districts. Each of the three districts is divided into local administrative units (e.g., municipalities and communes); and these are further divided into urban towns and rural communes and villages. Figure 1 visually depicts the administrative divisions in Albania. Currently, the country recognizes 12 prefectures, 36 districts, 64 urban municipalities, and 310 communes<sup>14</sup>.

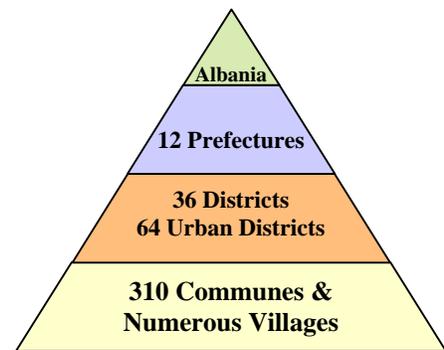


Figure 1

**Diber Prefecture:** The ACSP is being implemented in Diber Prefecture, with a current total population of 221,669<sup>15</sup>. This includes a beneficiary population of approximately 28,661 children 0-59 months; 55,417 women of reproductive age (15-49 years); and 68,717 men (15-59 years). It is anticipated that the population will remain fairly stable throughout the life of the project (LOP), as the official 2004 population growth for Albania is estimated at 0.0% annually<sup>16</sup>, mainly due to out-migration.

Diber Prefecture is an impoverished, rural mountainous area in northeastern Albania spanning 2,356 square kilometers with over 26% of the population living in poverty (*income less than \$2 per day*) and 44% living in extreme poverty (*income less than \$1 per day*)<sup>17</sup>. Over 72% of the

<sup>13</sup> Ministry of Health, Tirana, Albania, 2000-2010.

<sup>14</sup> Assessment of Social and Economic Conditions of District in Albania, UNICEF, December 20, 2000.

<sup>15</sup> Diber Prefecture Statistical Office 2004.

<sup>16</sup> US Census Bureau 2004.

<sup>17</sup> Results of Household Living Conditions Survey, INSTAT, 1998.

active population of this region of Albania is engaged in small-scale private agriculture<sup>18</sup>. Increasing numbers of men from the prefecture, and many women, work abroad as migrant laborers and support families with remittances from outside the country, mostly Greece or Italy. Others seek wage labor opportunities in Tirana and other urban areas in Albania.

Diber Prefecture is composed of the three districts of Diber, Bulqize, and Mat. The ACSP works in all three districts of the prefecture and has its project office in Peshkopi (Diber District), the prefecture seat. Diber is the largest, with 14 communes; Bulqize has 7 communes; and Mat 11; there are total of 279 rural villages. The three main urban areas are Burrel in Mat, Bulqize town, and Peshkopi in Diber.

For the Integrated Management of Childhood Illness (IMCI)/C-IMCI+ strategy, the project will focus its interventions at the village (rural ambulanca) level where approximately 279 VNMs are employed and salaried by MOH, supervised by general practitioners (GPs) at commune health centers under the District Public Health Directorates<sup>19</sup>. The project will also carry out selected activities in support of maternal nutrition and child health in antenatal clinics, maternities, and commune health centers in the prefecture.

***VNMs and rural ambulancas:*** To increase access and availability of quality key services at the community level, the ACSP will focus at the community level where VNMs work out of rural ambulancas, or from their own homes in villages that lack infrastructure. HFA results show that most VNMs have completed a 9-month training course. Many have been working in the same position in the same village for many years, some up to 30 years. For the most part, they know their community and its families very well, as they are neighbors and community residents themselves. In some cases, one nurse midwife serves two villages. In certain isolated rural villages of Mat District with no VNM, community healthcare workers have been trained with a 2-month curriculum by the District Public Health Directorate under a pilot project<sup>20</sup> authorized by the MOH. There are also village where other categories of providers, such as veterinarians, are filling the role. Some large villages have ambulancas staffed by medical doctors (GPs). Through the community mapping exercise, the project has collected detailed information on all human resources at the village level, with names and contact information for the providers, as well as other pertinent information relation to infrastructure, distances, road conditions, transport, etc. ***For purposes of this DIP document, all village-level healthcare workers are referred to as VNMs.***

An important part of the job of the VNM is to immunize children and follow up pregnant and post-partum women; and they maintain registers of all children 0-23 months and mothers in the village. VNMs are supervised by GPs from commune health centers. These GPs are supposed to visit the village at least once a week to follow up patients and supervise the VNMs. However, more often than not, VNMs travel themselves to the commune health center on a monthly basis to hand in their report and receive supervision. The HFA also found that many VNMs are

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<sup>18</sup> Assessment of Social and Economic Conditions of Districts in Albania, UNICEF, December 20, 2000.

<sup>19</sup> This may change in 2005 when the PHC service package is re-structured, at which time VNMs may pass from MOH to HII.

<sup>20</sup> This pilot project was technically assisted by the Department of Community Medicine/Braun School of Public Health, Hebrew University, Jerusalem.

discouraged and have lost their motivation due to difficult working conditions, poor compensation, lack of infrastructure, weak supervision, and few opportunities for professional growth and development. Often, they lack the equipment and supplies necessary to do their jobs. They feel that they are under-valued in the system.

**Baseline assessments:** The ACSP has conducted three baseline assessments: 1) a population-based knowledge, practice, and coverage (KPC) survey; 2) a health facilities assessment; 3) a community mapping exercise in the three districts to collect specific information about community and health systems resources.

**Knowledge, practice, and coverage survey:** The project received technical assistance for the KPC survey from Dr. Gilbert Burnham, Associate Professor, Bloomberg School of Public Health, Johns Hopkins University (JHU) under a task order agreement between AmRC and JHU.

The KPC survey questionnaire was adapted from *KPC 2000+* (MACRO CSTS), with additional complementary feeding questions drawn from *Generating Indicators of Appropriate Feeding of Children 6-23 Months from the KPC 2000+* (International Food Research Policy Research Institute). Local partners and stakeholders were consulted in survey development; and survey questions were compared to UNICEF's Albania 2000 Multiple Cluster Indicator Survey (MICS) to make them as comparable as possible.

A two-stage 30-cluster sampling design was used over all three districts of the prefecture. Each district was considered as a study unit, and the two-stage sampling technique involved a) clusters drawn at random from each districts; and b) children 0-23 months drawn randomly from within each cluster using vaccination rosters maintained by nurse midwives at the village level. The cluster sampling method applied in this survey provides survey findings that are less precise than findings obtained using simple random sampling. This is due to the smaller variance within each cluster in comparison with the variance within the population target. This comes from potential bias of sampling of groups (within the same villages) that are more likely to be similar for some variables of our interest, rather than sampling individuals. A sample of these groups, therefore, may not be as representative of the whole target area (in this case the whole of Diber prefecture) as a sample of randomly selected individuals. In order to avoid this bias when calculating the sample size in order to ensure the same statistical significance, the design effect of 2 is used.

The indicators requiring the largest sample size were those related to stunting. For these, a sample size of 600 was estimated to be satisfactory. The sample size issue was calculated to provide an adequate sample number to demonstrate changes between baseline and endline values with statistical significance over the duration of the project. This sample size ensured statistical significance for all the other indicators when evaluated over time. The resulting sample size was n=569 with two mothers with children refusing to answer questions. The cluster number for each district was the same, although the district populations are quite different. However, this allowed an adequate sample at the district level to make statistical comparisons among them. A weighting procedure was used to calculate the value of each indicator at the prefecture level.

In the first half of October 2003, the project team developed a 3-day curriculum to train six supervisors, who in turn trained 29 interviewers during a 5-day period that included a day of field testing. KPC supervisors comprised members of the project technical team and representatives of the MOH, IPH, Tirana University Hospital, and the former USAID/JSI reproductive health project. In coordination with the AlbRC Diber Branch Secretary, District Public Health Directors in the three districts selected the 29 female interviewers. These interviewers included doctors, nurse midwives, teachers, agricultural extension workers, and AlbRC volunteers.

Teams of four to six interviewers, paired in teams, with one supervisor visited mothers whose children 0-23 months were selected via the random sampling. They interviewed the mothers to gather data on reported practices and use of services for the child sampled. To collect anthropometric data, that child plus all other children 0-59 months in the household were weighed and measured for height using scales and standard height boards following standardized instructions given during training. Reserve households had been identified in the random sampling and were visited if the mother of the child initially selected was found not at home. Only two mothers out of 569 refuse to collaborate (0.4% refusal rate).

Supervisors were responsible to ensure the accuracy of data and checked over questionnaires the same day, as they were completed by the interviewers.

Following initial data entry in November 2003, a second cleaning of the data took place. Data were analyzed using EpiInfo v. 6.04, following recommendations from the *KPC 2000+ Field Guide*. Anthropometric data was analyzed using EPI INFO v 6.04. EPINUT *Anthropometry* was used to calculate the anthropometric data. Indicators were calculated for prefecture and district, and the prefecture level data was weighted to account for differing district population sizes. Key baseline finding of the KPC survey are outlined below and the Rapid Catch indicators are seen in Table 1 above. A full draft report of the KPC is attached in Annex 3.

**Table 2 - Baseline KPC survey findings arranged by ACSP intervention areas**

NUTRITION		
1	Percentage of children 0-59 months <b>moderately to severely underweight</b>	14.8%
2	Percentage of children 0-59 months with <b>moderate to severe wasting</b>	14.8%
3	Percentage of children 0-59 months with <b>moderate to severe stunting</b>	18.6%
4	Percentage of children 6-23 months <b>who received a dose of vitamin A in the last 6 months</b>	3.9%
5	Percentage of children 0-11 months <b>breastfed during the first hour following birth</b>	30.3%
6	Percentage of children 0-5 months <b>exclusively breastfed</b>	34.3%
7	Percentage of children 6-9 months <b>who received breastmilk and solid or semi-solid foods during the last 24 hours</b>	81.9%
8	Percentage of children 0-11 months <b>who received anything by bottle during past 24 hours</b>	32.0%
9	Percentage of children (aged 6-8 months and 9-23 months) that <b>ate at least the minimum recommended number of times yesterday</b>	89.6%
10	Percentage of children 6-23 months who <b>ate meat, organ meat, fish, or poultry yesterday</b>	27.7%
11	Percentage of children aged 6-23 months who <b>ate any animal source food yesterday</b>	91.1%
12	Percentage of household that use <b>iodized salt</b>	50.6%
IMCI (GENERAL / DIARRHEA)		
13	Percentage of children 0-23 months with an illness in the last 2 weeks who were <b>offered the same amount or more food and fluids during the illness</b>	33.0%
14	Percentage of children 0-23 months who were sick in the past 2 weeks and were offered more food and fluid during recovery from the illness	93.9%
15	Percentage of mothers who <b>can cite at least 2 neonatal danger signs</b>	47.8%
16	Percentage of mothers who <b>can cite at least 3 neonatal danger signs</b>	12.5%
17	Percentage of mothers who <b>cited “fast/difficult breathing” as a neonatal danger sign</b>	22.0%
18	Percentage of mothers who <b>can cite at least 2 danger signs in children</b>	89.6%
19	Percentage of mothers who <b>can cite at least 4 danger signs in children</b>	41.9%
20	Percentage of mothers who <b>cited “fast/difficult breathing” as a danger sign in children</b>	8.3%
21	Percentage of children 0-23 months with an illness in the last 2 weeks who were <b>offered the same amount or more food and fluids during the illness</b>	33.0%
22	Percentage of children aged 0-23 months with diarrhea in the last 2 weeks who <b>received oral rehydration solution (ORS) and/or recommended home fluids</b>	16.3%
23	Percentage of mothers with children 0-23 months who <b>can correctly prepare the ORS from package</b>	76.7%
24	Percentage of children 0-23 months <b>with diarrhea in the last 2 weeks who were taken to a health facility for treatment within the first 2 days after the diarrhea started</b>	65.8%
25	Percentage of children 0-23 months with <b>diarrhea in the last 2 weeks whose mother sought outside advice or treatment</b>	54.0%
26	Percentage of mothers who <b>wash hands with soap at ALL appropriate times</b>	31.0%
OTHER – VACCINATION COVERAGE		
27	Percentage of children 0-23 months <b>with vaccination card</b>	69.7%
28	Percentage of children with <b>DPT1</b> recorded on vaccination card	88.7%
29	Percentage of children 14-23 <sup>21</sup> months vaccinated for <b>measles</b> (card or mother’s recall)	70.4%
30	Percentage of children 12-23 months with <b>DPT1 but not DPT3</b> (drop out rate)	8.7%
31	Percentage of children 12-23 months who received BCG, DTP3, OPV3, HBV3 before their first birthday ( <b>fully vaccinated</b> ) <sup>22</sup>	69.7%
OTHER – ANTENATAL CARE		
32	Percentage of mothers who received at <b>least 2 Tetanus Toxoid (TT) injections</b> (recall) before the birth of the youngest child 0-23 months	63.5%
33	Percentage of mothers who had at <b>least one antenatal visit</b> prior to the birth of the youngest child 0-23 months	86.6%
34	Percentage of mothers who had <b>at least 2 antenatal visits</b> prior to the birth of the youngest child 0-23 months	71.6%
35	Percentage of mothers who received their <b>first antenatal visit during first trimester</b> of most recent pregnancy	53.2%
36	Percentage of mothers who <b>received/bought iron or iron/folate supplements</b> during most recent pregnancy	9.6%
FAMILY PLANNING		
37	Percentage of non-pregnant mothers who desire no more children in the next 2 years, or are not sure, who are using a modern method of contraception	12.1%
38	Percentage of children 0-23 months who were <b>born at least 24 months after the previous surviving child</b>	74.4%
39	Percentage of children 0-23 months who were <b>born at least 36 months after the previous surviving child</b>	36.0%

<sup>21</sup> Note that Measles vaccinations are given to children up to 14 months in Albania

<sup>22</sup> Albania immunization schedule = BCG at birth; DPT3+HBV3+OPV3 by 6 months; MCV (measles and rubella) by 14 months

**Health facilities assessment (HFA):** The project team worked again with Prof. Gilbert Burnham from JHU to review and adapt HFA instruments. A total of 10 instruments were adapted for use at health facilities and with healthcare providers at different levels. Work on the instruments was part of the training of the six HFA supervisors that took place in Peshkopi during the period February 15-19, 2004. The supervisors, all medical doctors, had been selected and released from their duties by the District Public Health Directors with concurrence of the Health Insurance Institute (HII). Individual doctors did NOT supervise surveyor teams in their own service areas; and doctors were only selected as supervisors where there was at least one other doctor covering patient load during the time of the assessment. The District Public Health Director of Bulqize was among the supervisors. Table 3 below summarizes the different type of health facilities and the type of health services that were addressed

**Table 3 - Type of health services assessed**

#	Health Facility	Urban/rural	Health services assessed
1	District maternity	Urban	- Maternity services - Family planning services - Maternal health (antenatal & post-partum)
2	Women's Consultancy Centre (WCC)	Urban	- Family planning services - Maternal health (antenatal & post-partum)
3	Urban pediatric health post (ambulanca)	Urban	- Health services for children 0-14 yrs
4	Commune health centers	Rural	- Health services for children 0-14 yrs - Family planning service (if available) - Maternity services (if available) - Maternal health (antenatal & post-partum)
5	Rural ambulanca/ Village nurse midwife	Rural	- Health services for children 0-14 yrs - Family planning services (if available) - Maternal health (antenatal & post-partum)

The training took place during the period 21-23 February, 2004, including a day of field testing. With assistance from the District Public Health Directors, twelve individuals (6 GPs and 6 nurse midwives) were selected as HFA surveyors. The surveyors were divided into six teams, each composed of one GP, one nurse midwife, and one supervisor. From a comprehensive listing of all health facilities in the prefecture, a sample from each category was drawn, as illustrated in Table 4 below.

**Table 4**

#	Types of health facilities	Diber		Mat		Bulqize	
		Available	Selected	Available	Selected	Available	Selected
1	District maternities	1	1	1	1	1	1
2	WCCs	1	1	1	1	1	1
3	Urban Pediatric Ambulancas	3	1	3	1	3	1
4	Commune Health Centers	14	3	11	3	7	3
5	Rural Ambulancas / Villages	141	20	76	17	62	14

For the selection of rural ambulancas (village level), the cluster strategy was adapted to logistic and time constraints. Twelve (12) areas were selected randomly from the entire prefecture (proportional to population size). In each area selected, three to four neighboring villagers were visited. Each team visited at least one health facility per day. The final sample included 21% of rural ambulancas, 25% of commune health centers, 33% of urban pediatric ambulancas, and 100% of maternities.

Supervisors ensured data accuracy by reviewing questionnaires as they were completed. Data entry was performed immediately after data collection was finished. EpiInfo v.6.04 was used for data entry and analyses. The main requirements for the analyses were to generate frequency tabulations for each of the variables of the survey. The small sample sizes do not allow for statistical significance nor comparison among districts. However, the team is confident that HFA results have qualitative value. They have been used to illuminate KPC findings, guide discussion during the DIP workshop, formulate additional questions, and guide priorities for future actions. A summary of key HFA findings is listed below and a full draft report of the HFA is attached in Annex 3.

**Key HFA findings:** Key HFA findings that have informed development of the project design and this DIP include the following:

#### **Availability of Services**

- Where villages lack infrastructure (no ambulanca building), VNMs work out of private homes.
- VNMs do provide outreach, including following up pregnant women and post-partum mothers and newborns.
- Regular and frequent growth monitoring and promotion does not take place at the village level.
- Most Primary Health Center (PHC) providers at commune health centers and village ambulancas have had no training in past 5 years and no specific training in management of childhood illness, nutrition, antenatal care (including maternal nutrition), or family planning.
- FP services exist in all three urban districts at the district level but may not be available at all HCs at the communal level.

#### **Quality of Services**

- Most rural ambulancas lack scales.
- Providers lack counseling skills, and counseling in most areas is inadequate.
- Few providers are unable to cite known danger signs for young infants and children.
- PHC facilities (e.g., rural ambulancas, commune health centers) do not have functioning Oral Rehydration Therapy (ORT) corners.
- Many essential medications (including Oral Rehydration Salts (ORS) sachets and antibiotics) are lacking in village emergency drug boxes.
- Few Maternal Child Health (MCH) and Family Planning (FP) Service Delivery Points (SDPs) have printed health education materials, posters, etc.
- Standard case management protocols are not found in most MCH SDPs.

- Data flows from the village to the commune health center to the district but not back to the village.
- Schedules, records, and registers are frequently incomplete.
- VNMs are de-motivated by lack of professional development opportunities and lack written materials for self-improvement.
- Not unlike the general population, PHC providers are migrating out of Diber Prefecture to other parts of the country or abroad.
- Urban health providers have been trained in FP by JSI in 2001-2. (Total of 6 urban facilities)

**Community mapping exercise:** The project team designed a community mapping exercise to collect and compile key data required for project implementation. This started in January 2004 and to date has been completed down to commune level. Team members have visited each commune of the prefecture (14 in Diber, 11 in Mat, and 7 in Bulqize), spending one or two days in each, visiting health facilities and rural ambulancas in some villages.

The mapping exercise has collected data about the formal health system and community resources in the prefecture. It was conceptualized as a means to collect critical information to facilitate communication, logistics, and planning for training, supervision, monitoring and evaluation. Neither the exercise itself, nor the data collection instruments used, was based on any well-known protocol. Simply, the team agreed on what kind of information was needed and at what levels and developed the necessary data collection instruments. Information was collected about the following:

- Demographics for municipality, commune, and village populations (total population, male/female ratio, cohort births over the past 5 years, number of families, etc.);
- human resources of the formal health system (numbers, names, contact information for GPs, VNMs, health center personnel;
- for VNMs: their duration of service, in-service training, and training topics;
- for health infrastructure: existence and condition of rural ambulancas, existence of rural hospitals/maternalities, pharmacies, family planning SDPs;
- names and contact information (e.g., cell phone numbers) for key community leaders, e.g., head of communes and villages, school directors, teachers, AlbRC volunteers, representatives of local NGO and community-based organizations, religious leaders;
- Presence of popular doctors or other traditional or religious practitioners.

All information collected during the community mapping exercise has been put into a database and into excel and PDF files and is being bound for easy reference for the project team and as a community resource. A short summary of the community mapping exercise finding is attached in Annex 3.

**Partner capacity assessments:** The AlbRC completed a self-assessment for governance in 2001 and conducted nationwide public image surveys (PIS) in 2001 (baseline) and 2003 (follow up). These assessments were funded by the AmRC and technically assisted by AmRC, the Faculty of Social and Psychological Studies at Tirana University, and the Illyricum Fond (Media Institute).

A copy of the PIS can be found in Annex 12. In addition, the AlbRC, with funding from the International Federation of Red Cross and Red Crescent Societies, has completed a number of capacity-building cycles in four districts of Albania using participatory rural appraisal (PRA) techniques and tools to identify problems and weaknesses<sup>23</sup>. No specific capacity assessments of the AlbRC have been carried out in the context of the ACSP.

***Additional baseline assessments to be conducted:*** Before the end of FY 04, the ACSP will conduct two additional baseline assessments: 1) *population-based family planning survey* to conform to Flexible Fund requirements using a sample size consistent with the baseline KPC; and 2) a *qualitative inquiry* (“Grandmother Approach”) into household practices for child health and family planning focusing on the role of senior women and other household decision-makers.

***Population-based family-planning survey:*** In August 2004, the project will conduct a second population-based survey for family planning consistent with Flexible Fund requirements. The sampling methodology and implementation of the survey is expected to follow the same methodology that was used during the KPC. A copy of the survey instrument is attached in Annex 10. The survey will be adapted to the Albanian context and translated prior to use. The project will take advantage of this additional survey opportunity to repeat selected questions from the KPC survey that relate to complementary feeding in order to verify KPC findings and ensure that baseline data accurately reflect actual household practices. A full report of the population based family planning survey will be included in the year one annual project report.

***Qualitative inquiry (“Grandmother Approach”):*** The project has planned a qualitative inquiry (“Grandmother Approach”) for early August 2004. To be led by Judi Aibel/The Grandmother Project, this piece of qualitative research will focus on key household practices for family planning and child health and will serve to 1) analyze and document the role of the mother-in-law and other family decision-makers in promoting the health and well-being of infants and children in Diber Prefecture and recommend strategies for behavior change and sustainability; 2) strengthen the capacity of the AlbRC to conduct qualitative research and collaborate with senior women as key actors in community health programs; 3) adapt a methodological tool that can be shared with other NGOs and PVOs working in Albania; and 4) produce a report that can be published and disseminated as a monograph.

### ***E.1.1 - BASELINE FINDINGS FOR NUTRITION AND MICRONUTRIENTS (30%)***

***Nutritional deficiencies:*** Globally, malnutrition is recognized as the underlying cause of more than half of the 11 million deaths among children 0-59 months annually. More than two-thirds (an estimated 70%) of these child deaths occur in the first two years of life and are commonly associated with inappropriate infant and young child feeding practices. Nutritionally deprived infants and young children who do survive suffer more frequent illness, as well as impaired health, growth, and development throughout life. Improved maternal nutrition can lead to healthier babies; and improved feeding practices in early childhood ensure adequate intakes of energy and nutrients, protecting health and nutritional status. Anthropometric findings from the KPC survey, and behavioral results for infant and young child feeding practices in the prefecture,

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<sup>23</sup> Capacity Building Framework (CD-ROM), International Federation of Red Cross and Red Crescent Societies, Geneva, Version 2002.

reveal that nutritional deficiencies constitute a significant child health problem in the project area and justify the selection of Nutrition and Micronutrients as one of the project's technical interventions at 30% Level of Effort (LOE).

***Anthropometry:*** Stunting is a consequence of sub-optimal intra-uterine nutrition, poor infant and young child feeding practices, micronutrient deficiencies, and repeated infections in early childhood. Results of the baseline population-based KPC survey indicate that 18.6% of *children under five*<sup>24</sup> in Diber Prefecture are stunted (15.8% in Mat, 15.1% in Bulqize, 22.6% in Diber). This prefecture level result is comparable to the countrywide stunting rate of 17% reported in the MICS.

Rates for both underweight and wasting are higher in Diber Prefecture than in Albania as a whole. KPC results show the proportion of children underweight in the prefecture at 15.4%, compared to the UNICEF conducted Albania Multiple Indicator Cluster Survey (MICS) finding of 4% countrywide; and the proportion of children wasted is 14.3%, compared to 4% countrywide.

***Immediate breastfeeding:*** At a behavioral level, the KPC survey reveals sub-optimal breastfeeding practices in the prefecture. Although 90% of births in the prefecture take place in health facilities, and 98% are attended by trained health workers; only 31% of neonates benefit from initiation of breastfeeding within the first hour after delivery. This finding suggests problems with health worker performance, as well as weak demand on the part of mothers to breastfeed immediately. Mothers remain in the maternity on an average of 72 hours following delivery. However, "rooming in" is not commonly practiced (except in certain facilities in Bulqize where MOH and UNICEF have implemented "baby friendly" hospitals as part of the "Safe Motherhood" strategy); and newborns are frequently kept in incubators, separated from their mothers and not able to breastfeed on demand.

***Exclusive breastfeeding:*** KPC results for the prefecture reflect exclusive breastfeeding rates as follows: 64.1% for children 0-1 month; 45.3% for children 0-3 months; 34.3% for children 0-5 months. On a positive note, the 45.3% rate for children 0-3 months in the prefecture is significantly higher than the countrywide rate of 9% reported for this age group reported in the MICS. Attitudes and beliefs relating to breastfeeding practices, on the part of both mothers and mothers-in-law, will be investigated in depth in the qualitative inquiry planned for August 2004.

***Bottle use:*** Thirty-two percent (32%) of children 0-11 months in the prefecture are fed some liquids by bottle, even though only 7.5% of mothers work outside of the home. Maternity facilities do not post "no bottle" signs.

***Continued breastfeeding:*** While 82% of children 6-11 months benefit from continued breastfeeding; 59.7% are still breastfed at 12-17 months; and only 28.2% of children 18-23 months are still breastfed.

***Complementary feeding:*** The project's KPC findings for complementary feeding suggest more positive household behaviors than for breastfeeding. However, given rates for stunting,

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<sup>24</sup> All children 0-59 months in the sampled households were weighed and measured during the KPC survey.

underweight and wasting in the prefecture; and taking into consideration discrepancies with MICS results; the project team is not confident that KPC findings for complementary feeding reflect actual practices at the household level in Diber Prefecture. It is possible that the KPC interviewers did not consistently enforce the 24-hour recall rule for responses; and it is likely that mothers overstated quality, quantity, and frequency of foods given for reasons of pride and socio-cultural expectation. Given this lack of confidence, the project team has taken the decision to re-administer the complementary feeding module (adapted from "*Generating Indicators of Appropriate Feeding of Children 6 through 23 months from the KPC 2000+*" by Mary Arimond and Marie Ruel from the Institute of Food Policy and Research) to a sub-set of survey respondents (those women of reproductive age with children 6-23 months) when the population-based family planning survey is carried out in August 2004. In addition, the project will seek additional information on infant and young child feeding practices and nutritional management of sick children through the qualitative inquiry ("Grandmother Approach") to be undertaken August 2004.

KPC results for complementary feeding are, for the most part, totally incongruent with MICS findings. KPC findings show the proportion of children aged 6-9 months who receive breast milk plus solid or semi-solid foods is 81.9% in contrast to 24% reported in the MICS. The proportion of children 6-8 months and 9-23 months that are fed at least the minimum recommended number of times daily is 89.6%. More than ninety percent (91.1%) of children 6-23 months are given food from animal sources on a daily basis. Eighty-seven percent (87%) are fed dairy products; 35.7% are fed eggs; and 29.7% are fed meat, poultry, or fish.

Given the surprisingly high baseline values obtained for most of the complementary feeding indicators, the project team has selected to track the indicator for "meat, organ meat, fish, and poultry" because these foods are rich in protein, iron, and vitamin A; and because it appears to be an indicator that can be improved over the life of project (LOP). However, even KPC baseline results for this indicator warrant questioning and possible modification. To quote from the UNDP Albanian Human Development Report 2000: "Meagre incomes mean that the majority of households lead simple and thrifty lives. Only 15% of households earn enough to eat meat at least once in two days..." (p.16). This is broken down as 10.8% for rural areas (under 10,000 inhabitants, and 23.5% for more urbanized areas (over 10,000 inhabitants). As noted above, the project will repeat the complementary feeding module during the population-based family planning survey in August 2004. Depending upon results, indicators may be added or modified. A full report will appear in the project's Year I Annual Report.

***Nutritional management during illness:*** The KPC survey (with a sample size of 569) found that half (50.3%) of all children 0-23 months had been ill in the past two weeks. Of these, only a third (33%) had been offered the same amount or more fluid or food during the illness. However, 93.9% had been offered increased food and fluid during recovery from the illness. The KPC survey found that half (50.3%) of all children 0-23 months had been sick in the past two weeks. This is higher than the 15% of children reported to have had diarrhea or some other illness in the previous two weeks prior to the MICS. Of the children who were reported sick in the KPC, only a third (33%) had been offered the same amount or more fluid or food during the illness, compared to the MICS result of 62%. The KPC did however show that 93.9% of children had been offered increased food and fluid during recovery from the illness. Nutritional management

during illness is clearly an area that could be improved and will be a focus of the C-IMCI+ behavior change strategy.

***Use of iodized salt:*** Iodine deficiency decreases child survival, impairs growth and development, and causes enlargement of the thyroid (goiter). Iodine deficiency during pregnancy is associated with spontaneous abortion, low birth weight, and other complications. Children with iodine deficiency disorder (IDD) are at risk of stunting and developmental disorders affecting intelligence, movement, speech, and hearing. A 1993 UNICEF study of Albanian school children showed that 63% displayed some degree of iodine deficiency<sup>25</sup>; and IDD is considered a public health problem in the country. There are no specific IDD rates available for Diber Prefecture. In 2000, UNICEF and MOH signed an accord to address iodine deficiency and promote the use of iodized salt nationally.

Only half of all Diber Prefecture households (50.6%) surveyed in the KPC use iodized salt for cooking and family consumption. This is comparable to the use rate of 47.8% for rural areas reported in the MICS. The project has retained the indicator for use of iodized salt at the household level. HFA results indicate that only a little more than half (60%) of VNMs routinely promote the use of iodized salt in the community.

***Related maternal nutrition:*** The health and nutritional status of young children is closely linked to that of their mothers. Improving infant and young child feeding begins with ensuring the health and nutritional status of women throughout all stages of life, including pregnancy and lactation, to prevent maternal nutritional depletion and closely spaced pregnancies. Given the critical importance of maternal nutrition for good pregnancy outcomes, the project will focus on selected key actions related to maternal nutrition. Synergy with the project's family planning intervention (30% LOE) is further justified.

***Low birth weight (LBW):*** The MICS estimates that approximately 3% of newborns in Albania weigh less than 2,500 grams at birth, a rate thought to be under-estimated. According to MICS findings, prevalence of LBW does not vary much between urban and rural areas or by mother's education. The District Public Health Directors in the prefecture have shared their concerns about high incidence of LBW and high rates for neonatal mortality in maternities. More detailed data and documentation of LBW rates in the districts will be sought to illuminate this problem as the project progresses. While outside the scope of this current project, the AMRC will actively seek external resources and partnerships to address the issue of newborn mortality and improve neonatal care in the prefecture.

***Antenatal nutritional management:*** New MOH guidelines for reproductive health recommend at least four antenatal visits, the first one in the first trimester. A copy of the MOH guidelines is attached in Annex 13. KPC findings show that 86.6% of mothers in the prefecture had at least one antenatal visit during their last pregnancy, and 71.6% had at least two visits. Only about half (53.2%) had their first antenatal visit during the first trimester. Nearly two-third (63.5%) reported having received at least two tetanus toxoid injections before the birth of their youngest

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<sup>25</sup> UNICEF/Albania Newsletter: *Albania's Future*, January-February 2002 figure cited from 1993 UNICEF Cluster Study (more recent data unavailable).

child. Less than 10% (9.6%) of those who received antenatal care were supplemented with iron or iron/folate. Of those that were supplemented, the average duration of supplementation was only 35 days. The HFA found that less than a third (26.53%) of VNMs interviewed could explain the importance of taking iron/folate supplements during pregnancy. (See discussion under “*constraints*” below.)

Of those mothers that had antenatal care, only 21% reported having been counseled on the importance of diet, workload, and rest during pregnancy. This result varies significantly by district: 44.7% in Mat, 11.6% in Bulqize, and 8.2% in Diber. HFA findings show that provider performance could be improved in the areas of tracking trends and giving appropriate feedback for antenatal weight gain and counseling on maternal diet, workload, and rest. Routine post-partum vitamin A supplementation is not currently supported by MOH policies, norms, and protocols (see discussion under constraints below); and only 3.6% of mothers report having been supplemented with vitamin A following most recent delivery. The results of the KPC are congruent with MICS results that indicate about 3% of mothers who gave birth in the year prior to the survey were supplemented with vitamin A within eight weeks of the birth. Pregnant and lactating women should be encouraged to consume foods (animal products, liver) rich in vitamin A and iron.

***Constraints related to optimal infant and young child feeding objectives:*** At the national level, there is weak institutional support for the protection and promotion of exclusive breastfeeding. Albania is a signatory to the International Code of Marketing of Breastmilk Substitutes and has passed enabling legislation for Promotion and Protection of Breastfeeding (Law Nr. 8528, dated 23 September 1999). However, this law is unenforced; and the sale of breastmilk substitutes and feeding paraphernalia (e.g. baby-bottles) is largely unregulated. Products are widely marketed and freely available throughout the country, including Diber Prefecture, without adequate warning labels or consumer guidance. In Diber Prefecture, most maternities are not “baby friendly”, bottle-feeding is not actively discouraged, and HFA findings suggest that health workers do not adequately promote immediate and exclusive breastfeeding to six months. “No bottle” signs are not routinely posted at maternities. The project will respond to this constraint through its behavior change strategy aimed at building health worker capacity in infant and young child feeding; and, at the community level, through promotion of exclusive breastfeeding through the C-IMCI+ high-impact activities (e.g., growth monitoring promotion, pro-active home visiting, young child support groups, and family planning focus groups).

***Constraints related to nutritional rehabilitation:*** Because of budget limitations and poor potential for sustainability, it will not be possible to undertake nutritional rehabilitation as an activity at the community level. Currently, nutritional rehabilitation of severely malnourished children is available through referral to district or Tirana hospitals. Given this constraint, the project will implement frequent and routine growth monitoring promotion (GMP) at the village level and promote pro-active referral and “special attention” follow up for malnourished children referred through the existing system for nutritional rehabilitation. See detailed information in the section for nutrition and micronutrient technical intervention.

***Constraints related to vitamin A supplementation (VAS):*** Widespread vitamin A deficiency (VAD) has not been documented and is not currently considered to be a public health problem in

Albania. In the absence of epidemiological evidence, and with IMR <75/1000 and U5MR <100/1000, universal vitamin A supplementation is not justified. There is no common local term for “night blindness”, thus indicating that results of vitamin A deficiency are not a health issue. For these and other reasons, routine bi-annual vitamin A supplementation has not been adopted as part of the Albania IMCI strategy and is not currently recommended either by UNICEF or MOH. The Albania IMCI protocols recommend vitamin A only for case management of severe malnutrition. To conform to national policy and norms, the project will not promote universal vitamin A supplementation for children 6-59 months. *This is a change from the original proposal.* In support of this decision, KPC findings suggest that children are generally fed complementary foods rich in animal sources. However, the project will undertake to repeat the complementary feeding module in the population-based survey planned for late August 2004. To respond to this constraint, the project will actively promote the consumption of vitamin-A rich foods (e.g., breastmilk, eggs, dairy products, dark green leafy vegetables) and especially meat, organ meat, fish, and poultry, for both pregnant women and children from six months. Post-partum vitamin A is not part of the new MOH guidelines for reproductive health and is not recommended for mothers following delivery. The project will advocate with MOH to allow the introduction of post-partum vitamin A, consistent with international guidelines, to replenish maternal vitamin A stores after delivery and enrich breastmilk, thus benefiting both mother and infant. However, as this is not yet policy, it is not included as a project indicator.

***Constraints related to routine prophylactic antenatal iron/folate supplementation:*** MOH policies, norms, and protocols for routine prophylactic antenatal iron/folate supplementation are in place, but implementation is evolving. (See MOH guidelines for reproductive health in Annex 13) Although routine supplementation with folic acid is recommended to be given at the first antenatal visit (in the first trimester), and routine iron+folic acid supplementation is recommended from the second antenatal visit (second trimester), specific dosages and durations are only prescribed for women with anemia confirmed by laboratory results. MOH has advised the ACSP that no additional authorization is required to implement routine iron/folate supplementation in Diber Prefecture. However, the new guidelines have not been adequately disseminated or operationalized at the district level; and GPs and specialists providing antenatal care do not, as common practice, prescribe or dispense iron/folate supplements except to pregnant women with anemia confirmed by laboratory results. Currently, only in Bulqize District (where MOH and UNICEF put in place some components of “safe motherhood” a few years ago) are pregnant women routinely supplemented with iron/folate free-of-charge. The project has planned and budgeted to train 81 providers in antenatal clinics and maternities in the new guidelines. Moreover, the project team is informed that HII plans in 2005 to introduce an antenatal minimum package that will include iron/folate supplements “free-of-charge.” This is an evolving situation that will benefit from project advocacy, technical assistance and training.

### ***E.1.2. BASELINE FINDINGS FOR CONTROL OF DIARRHEAL DISEASES (CDD) (20%)***

WHO estimates that up to 90% of diarrheal episodes are attributable to three main environmental causes: 1) poor sanitation; 2) poor hygiene; 3) contaminated water and foods. KPC results for water and sanitation in Diber Prefecture reflect conditions that prevail in much of Albania. Fewer than half of the families (42.4%) in the prefecture enjoy water piped into the house. (The MICS reported a little more than 45%.) About a fifth of families (19.7%) get water from a

standpipe in the yard; and another fifth (18.9%) take water from a public standpipe or tap. A little more than half of households in the prefecture (54.4%) have indoor flush toilet systems; 14.5% have outdoor flush systems; and a third (31.1%) use pit latrines. These and the behavioral findings cited below justify the selection of CDD as one of the project's technical interventions at 20% LOE.

A majority (86.6%) of mothers surveyed reported hand washing with soap before food preparation; 73.2% reported hand washing with soap prior to feeding children; and 67.5% reported hand washing with soap following child's defecation. Only 31% of mothers reported hand washing at ALL appropriate times. A significant proportion of infants are exposed to contaminants because of sub-optimal breastfeeding practices: only a third (34.3%) of children 0-5 months are exclusively breastfed; and a third (32%) of children 0-11 months are fed fluids by bottle.

Although three quarters (76.7%) of Diber Prefecture mothers surveyed at baseline were able to correctly prepare oral rehydration solution (ORS) from commercially-available sachets, only 16.3% of children 0-23 months with diarrhea in the last two weeks received oral rehydration therapy (ORT) (e.g., ORS or recommended home fluids (RHF)). This result compares unfavorably with the MICS finding of a national average of 94% of children with diarrhea who received one or more of the recommended home treatments (e.g., ORS or recommended home fluids).

KPC results show that families of greater than half (54%) of children with diarrhea in the last two weeks sought outside treatment. Three quarters (65.8%) of those children taken to health facilities were taken within 48 hours of diarrhea onset. Greater than a third of children with diarrhea (35.6%) received antibiotics from the health facility, pharmacy, or other source; a rate suggesting that simple diarrhea is possibly being treated inappropriately with antibiotics. Antibiotics fall into the category of medications that are supposed to be free for children 0-23 months, and that are subsidized for children 24-59 months. Only medical doctors are authorized to prescribe antibiotics, but they are not usually dispensed at health facilities and must be obtained at pharmacies. Many pharmacists sell antibiotics, as well as other medications, without prescriptions. Families who want or believe they need antibiotics frequently by-pass health facilities and go directly to pharmacies. It is therefore difficult to fully understand antibiotic prescribing practices and use. *Additional qualitative information on this issue will be sought in the qualitative inquiry planned for August 2004.*

At the community level, the HFA showed that less than two-thirds (61.4%) of VNMs have ORS sachets on hand, and none of the commune health centers or rural ambulancas visited had dedicated ORT corners. The HFA asked VNMs for topics of home visits: more than half (52.9% indicated "hand washing" as a topic; and 17.6% indicated "management of diarrhea". The HFA also revealed that only half of the village midwives surveyed (49%) advised mothers to continue breastfeeding during a diarrheal episode.

***The status of measles in Albania:*** As measles is associated with diarrhea, it is useful to review the current status of measles in Albania. After 1992, measles cases were increasing annually and eventually reached approximately 10,000 per year at the end of the decade. During 2000-2002,

the Albania MOH/Institute of Public Health conducted two nationwide campaigns that led to the current “elimination phase” for measles. The first national campaign, carried out in November 2000, vaccinated one million children 1-14 years old, achieving reported 99.7% coverage of that age group. Because vaccination was for both measles and rubella, the first campaign was followed up by a 15-month second nationwide campaign, October 2001-December 2002, that vaccinated nearly half a million women of reproductive age and achieved 96% coverage. In 2003, only 28 suspected cases of measles were reported countrywide, and no cases were laboratory<sup>26</sup> confirmed. Moreover, Albania has been able to achieve relatively high-performance routine vaccination against measles, with 98% national coverage for the first dose (at 12-14 months) and 90% for the second dose (at 5 years). KPC results for Diber Prefecture show 70.4% coverage, confirmed by vaccination card<sup>27</sup> or mother’s recall.

**Constraints related to CDD objectives:** Many mothers and other family decision-makers are unaware that most cases of simple diarrhea can and should be managed with ORT (e.g., ORS, recommended home fluids) and continued feeding and do not require antibiotics. Often family’s by-pass the VNM and health center and go directly to the pharmacy to obtain antibiotics without a prescription (see section on ARI below). To overcome this constraint, the project will focus on communicating and promoting recognition of danger signs and best household practices for management of diarrheal episodes. Rural ambulancas and commune health centers will be assisted to set up “ORT corners”, and the project will provide technical assistance to improve the supply line for ORS sachets at the village ambulanca level.

### **E.1.3. BASELINE FINDINGS FOR ACUTE RESPIRATORY INFECTION (ARI) (20%)**

Acute respiratory infection is one of the most common reasons for child health visits to health facilities nationwide and in Diber Prefecture. Acute lower respiratory infection has been documented as the leading cause of infant mortality in the country<sup>28</sup> and is named as a leading cause of U5 mortality nationwide<sup>29</sup> and in the project area<sup>30</sup>, justifying the selection of ARI as one of the project’s technical interventions at 20% LOE.

**Recognition and care seeking:** At the household level, there is poor recognition of cough with “fast and difficult breathing” as one of the most important danger sign for pneumonia in children under five. Although 89.6% of mothers surveyed at baseline were able to cite at least two danger signs for illness in children, and 41.9% were able to cite four; *only 8.3% were able to cite “fast or difficult breathing” as one of the danger signs.* The KPC findings differ significantly from MICS results that indicate 55% of mothers would take their child to a health facility right away if the child had difficulty breathing. About half of mothers (47.8%) were able to cite at least two known danger signs for newborns; 12.5% were able to cite three; and only 2.8% could cite four neonatal danger signs. For newborns, 22% of mothers cited “fast or difficult breathing” as a danger sign; and more than half (51%) cited “poor feeding”.

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<sup>26</sup> Albania’s national lab is WHO certified for measles

<sup>27</sup> Only 69.7% of mothers were able to produce vaccination cards for their children.

<sup>28</sup> Causes of Death for the Year 1998, MOH/INSTAT, 2000.

<sup>29</sup> UNICEF MICS 2000.

<sup>30</sup> Communications by District Public Health Directors, Diber Prefecture.

“High fever” was the danger sign most commonly cited for children under five by 88.4% of mothers. The MICS reported a similar finding that 85% of mothers would take their child with high fever to a health facility right away. “Vomits everything” was cited by 53.3% of mothers as a danger sign requiring immediate treatment; “not eating or drinking” by 45.8% of mothers; “looks unwell” by 22.6% of mothers; “lethargic or difficult to wake” by 4.6% of mothers.

Prefectural level baseline results show that nearly three quarters (62.8%) of children 0-23 months who experienced cough AND *fast/difficult breathing* in the two weeks prior to the survey were taken to a health facility AND received antibiotics. However, only half (49.4%) of children with cough AND fast/difficult breathing were taken to a health facility for treatment *within 48 hours of illness onset*. Of those children with cough AND fast/difficult breathing treated at a health facility, a majority (82%) received antibiotics. Of those NOT treated at a health facility, 6.5% received antibiotics from other sources (e.g., left-overs, friends).

***Pneumonia standard case management:*** At the primary care (commune health center) level, Albania IMCI guidelines provide health workers with a clear protocol for assessment, classification, and treatment of pneumonia, and counseling about home care. The IMCI algorithm also gives guidance on the pneumonia standard case management of potential treatment failures. However, only health workers in Bulqize District- including 80% of VNMs – have been trained in IMCI, justifying the ACSP’s decision to join forces with MOH and UNICEF to expand IMCI throughout the prefecture.

***Constraints related to access to antibiotics:*** Under Albanian law and MOH policy, only Medical Doctors (MDs) are permitted to prescribe antibiotics. VNMs are supposed to have a small stock of antibiotics (e.g., amoxycilin, penicillin benzoate) on hand as part of their “emergency drug box,” and are authorized to administer a single dose to a child with signs of pneumonia before referral to a commune health center. Notwithstanding, HFA findings indicate that only 15.9% of VNMs sampled (7/44) had any antibiotics available in their emergency drug box. This limitation constitutes a significant barrier to access and availability at the village level and may contribute to treatment delays for children with pneumonia and other lower respiratory infections, particularly in winter when snow and ice and road conditions make travel to the commune health center difficult.

While only MDs are authorized to prescribe antibiotics; and while antibiotics are legally available only by prescription; they are in fact widely obtainable through pharmacies without prescription. Families often by-pass the doctor or health center and go directly to the pharmacy, increasing potential for misuse of antibiotics. This is an issue for health reform, and one that MOH would like to address. The situation is complicated by powerful interests that protect the pharmacy industry and render project-level intervention unwise.

***Behavioral constraints related to ARI:*** Because it is common to bundle children heavily against the cold and strap them into wooden cradles piled with warm covers, it is often difficult for mothers to observe a child’s breathing. Mothers, grandmothers, and household decision-makers need to be sensitized to the gravity of the sign “fast/difficult breathing” in general; and to all danger signs, especially non-specific danger signs (e.g., poor feeding) in the young infant (during

the first two months of life); and the need for prompt and appropriate care seeking within 48 hours of onset of illness.

#### ***E.1.4. BASELINE FINDINGS FOR FAMILY PLANNING (30%)***

As preface to this section on baseline findings for family planning, it is important to appreciate differences between reproductive health status in a South East European country like Albania versus developing countries outside of Europe. To quote the recent national Reproductive Health Survey<sup>31</sup> Preliminary Report: “A key programmatic difference between policy objectives in Albania compared with those in some developing countries is that the emphasis is not on promoting a decline in fertility and population growth, but on bringing about improvements in women’s health through increased availability and improved use of modern contraceptive methods and reduced reliance on abortion.”

***Total fertility rate (TFR):*** The 2002 National Reproductive Health Survey estimates Albania’s TFR at 2.6, “...a bit higher than the rate published by WHO for 2001 (2.4) and the rate of 2.3 published by the UN Population Division (WHO, 2003; UN, 2003). There is no difference in the TFR by urban or rural residence...The TFR is the highest in Europe and higher than the TFR in 10 of the 13 countries in Eastern Europe and the former Soviet Union that have conducted similar Reproductive Health Surveys (CDC and MACRO, 2003).”<sup>32</sup>

***Adequate birth interval:*** KPC findings indicate that 74.4% of the children 0-23 months whose mothers were surveyed were born at least 24 months after the previous surviving child; and 36% were born at least 36 months after the previous surviving child.

***Plans for population-based family planning baseline assessment:*** The AmRC and AlbRC in cooperation with the MOH conducted the ACSP population-based KPC survey in October 2003, prior to dissemination of the *Flexible Fund Guidance for Grantees Program Implementation Plan and Annual Reports FY 2004*. To conform to Flexible Fund requirements, the AmRC has agreed to conduct, and has budgeted, a second population-based baseline survey that is planned for late August 2004. **The population-based findings for family planning detailed below are drawn from the project’s KPC survey carried out in October 2003 that sampled mothers of children 0-23 months and not all women of reproductive age. For the moment, these should be considered proxies for the required Flexible Fund indicators.**

***Contraceptive awareness:*** Contraceptive awareness is generally high in Albania. The national Reproductive Health Survey preliminary results indicate that nearly all women (96%) are aware of at least one family planning method, with 90% aware of at least one *modern* method, and 84% aware of a traditional method. Of the modern methods, the condom was most commonly known (81% of women), followed by the oral pill (68%), and tubal ligation (65%). KPC findings show that 58.1% of mothers surveyed could name at least one source of modern family planning methods.

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<sup>31</sup> Reproductive Health Survey Albania 2002: Preliminary Report. Institute of Public Health, Centers for Disease Control, USAID, December 2003.

<sup>32</sup> Reproductive Health Survey Albania, 2002, Preliminary Report Draft. Institute of Public Health, Division of Reproductive Health, Centers for Disease Control, USAID, December 2003.

Awareness of any method of contraception was also reported by the Reproductive Health Survey to be almost universal among men (98%). However, knowledge of specific methods was more limited, with only the condom (89%) and withdrawal (85%) being known by more than half of men.

***Contraceptive coverage (mothers of children 0-23 months):*** In Diber Prefecture, the proportion of mothers of children 0-23 months not currently pregnant and not desiring another child in the next two years, or not sure, who are using a modern method of contraception is 12.1%. However, this contraceptive coverage rate varies significantly by district. In Mat District, where USAID promoted family planning through the JSI family planning and reproductive health project, the coverage rate is 20.8%. In Bulqize District, it is 8.8%; and in Diber District, 7.4% where the JSI project did not have any FP interventions. These findings are comparable to preliminary results reported by the national Reproductive Health Survey of 11% for urban women and 5% for rural women.

***Use of non-modern methods of contraception:*** Most couples in union depend on non-modern methods of contraception. At the prefectural level, nearly half (49.7%) of mothers of children 0-23 months reported using withdrawal as a method. Again, this varied by district (Mat 35%, Bulqize 45.6%, and Diber 63%). A similar preliminary result is reported in the recent Reproductive Health Survey: "...the reported current practice of contraception is relatively high, at 75% for married women and 77% for married men. However, these rates are almost entirely due to the use of the traditional methods of withdrawal (67% and 72% for married women and men, respectively)" (p.16).

***Use of Lactational amenorrhea method (LAM):*** Although the rate of exclusive breastfeeding for children 0-5 months is 34.3%, only 2.4% of mothers of children 0-5 months (who are not pregnant and do not want another child in the next two years or are not sure) report using lactational amenorrhea method as a method of family planning.

***Inappropriate use of induced abortion as a family planning method:*** The over-reliance on induced abortion as a means of birth prevention in Albania has been well-documented. The Albanian Institute of Statistics (INSTAT) reports 200 abortions per 1,000 live births for the 3-year period 1999-2001<sup>33</sup>. Among the factors frequently cited as contributing to the inappropriate and excessive use of abortion as a family planning method are limited availability of modern contraceptive methods, poor quality of methods available, fears about possible side effects, and easy access to and low cost of induced abortion. No KPC survey respondent cited abortion as a family planning method. This is not surprising, as preliminary results of the recent (2002) national Reproductive Health Survey suggest "severe under-reporting of induced abortions by respondents"...The survey rate of 73 abortions per 1,000 live births is 64% lower than the

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<sup>33</sup> Reproductive Health Survey Albania 2002, Preliminary Report Draft, Institute of Public Health (IPH), Albania Ministry of Health, Institute of Statistics (INSTAT), Tirana, Albania and Division of Reproductive Health, Centers of Disease Control and Prevention (DHR/CDC), Atlanta, Georgia, and United States Agency for International Development (USAID), United Nations Population Fund, Albania (UNFPA) and United Nations Children's Fund (UNICEF).

official data...reported to INSTAT<sup>34</sup>.” The project team recognizes that further investigation needs to take place to get a better understanding of this issue in Diber Prefecture and plans a series of women’s focus groups as part of implementation of the family planning technical intervention.

***Current family planning service access in Diber Prefecture:*** At the present time, 55% of the population of the prefecture lives within 5 kilometers of a family planning service delivery point (SDP). While 5 kilometers is a standard indicator for access, it should be noted that mountainous terrain, poor road infrastructure, lack of public transport, and winter weather conditions constitute significant barriers. Some roads are impassable for 2-3 months of every year. Of the maternal and child health SDPs in the prefecture (including VNMs and rural ambulancas), only 7.8% offer family planning services. The project’s strategy to improve access and availability targets the village-level, where teams of VNMs and VHEs will be trained to increase interest and knowledge at the household level, and access and availability through rural ambulancas.

***Contraceptive commodity supply:*** Under the current agreement between the United Nations Population Fund (UNFPA) and MOH, UNFPA is responsible for purchase, storage, and distribution of all family planning commodity supplies to the district level. MOH manages the system of utilization (LMIS). This agreement goes through 2005 and is expected to be renewed through 2010 when the MOH is supposed to be taking over responsibility for contraceptive commodity supply. HFA findings indicate some stock shortages in family planning products at some SDPs. Strengthening the Logistical Management Information System (LMIS) will improve family planning commodity supply. The LMIS ensures the management, recording, and distribution of contraceptive supplies. It serves to coordinate the activities at the levels of the family planning SDPs, District Public Health Directorates, and the MOH, in collaboration with UNFPA. UNFPA is also developing the central/district warehousing and distribution system, which is expected to increase the availability of reproductive health services and commodities at the PHC level.

***Albania’s Contraceptive Distribution and Logistics Management Information System (LMIS):*** Through the Reproductive Health Law, ratified June 2002, the Government of Albania takes a rights-based approach to reproductive health. A Contraceptive Security Commission has been established under the Chairpersonship of the Vice Minister of Health. The commission is charged with extending the Logistics Management Information System (LMIS) throughout each district of Albania. The overall intent of the LMIS can be summarized as follows: To ensure the supply of the 1) right goods; 2) in the right quantities; 3) in the right condition; 4) in the right place; 5) at the right time; and 6) at the right cost.

***Constraints related to family planning objectives:*** Except for condoms, distribution of family planning products by *non-health* workers is not permitted under MOH policy and Albanian law, and it is unlikely that this prohibition would ever be relaxed. Therefore, it is not considered a

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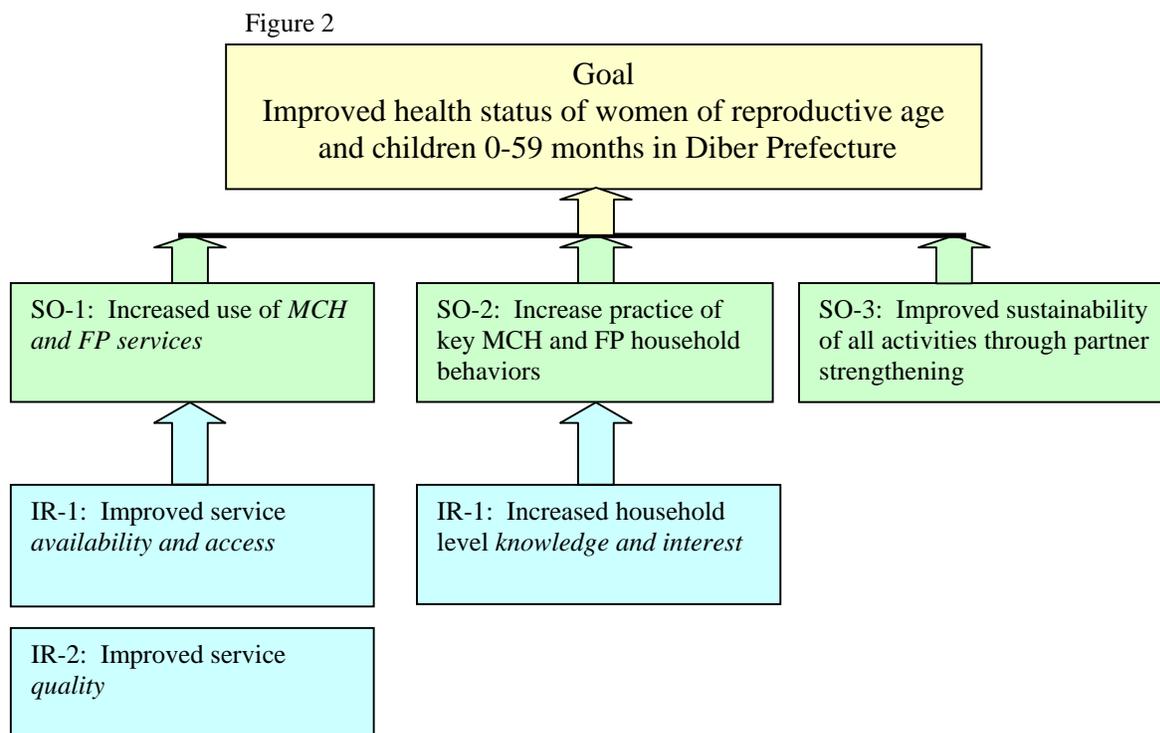
<sup>34</sup> Reproductive Health Survey Albania 2002 Preliminary Report Draft, Institute of Public Health (IPH), Albania Ministry of Health, Institute of Statistics (INSTAT), Tirana, Albania and Division of Reproductive Health, Centers for Disease Control and Prevention (DRH/CDC), Atlanta, Georgia, and United States Agency for International Development (USAID), United Nations Population Fund, Albania (UNFPA) and United Nations Children’s Fund (UNICEF).

sustainable approach to attempt a pilot project for *community-based distribution* of methods by non-health workers. There is, however, no legal barrier to training VNMs to distribute contraceptive methods at the village level, under the supervision of a GP from the commune health center; and this is the approach that the project will promote. Further, it is permitted under Albanian law for health service providers employed by the MOH to offer FP services. The village nurse midwives will be teamed with AlbRC VHEs to increase demand through counseling, education, and promotion of family planning at the household level.

**E.2 - PROGRAM DESCRIPTION BY OBJECTIVE, INTERVENTION, AND ACTIVITIES**

**Project goal and objectives:** The goal of the Albania Child Survival Project (ACSP) is **improved health status of women of reproductive age and children 0-59 months in Diber Prefecture** through the following objectives: 1) *increased use of MCH and FP services*; 2) *improved service availability and access*; 3) *increased service quality*; 4) *increased practice of key MCH and FP household behaviors*; 5) *increased household level knowledge and interest*; and 6) *improved sustainability of all activities through partner strengthening*.

Figure 2 below shows a graphic representation of the project goal and objectives.



**Contribution to USAID/GH/CSHGP Intermediate Results:** The ACSP will contribute to all three of the USAID/GH/CSHGP Intermediate Results.

***IR1: Increased quality of child and maternal health, and nutrition and infectious disease programs implemented by PVOs and their local partners:*** This is the first child survival project awarded to the American Red Cross by USAID/GB/HIDN/CSHGP and is also the first USAID Child Survival Grant for Albania. The project will build AmRC capacity in project design, management, implementation, and monitoring and evaluation. Through joint implementation and quality assurance, this project will enhance the partnership of AmRC and AlbRC in Albania and build the AlbRC capacity to develop a model for C-IMCI+ in Albania. As AlbRC field projects in maternal and child health are often of short duration due to limited funding, this ACSP offers a sustained 5-year opportunity for the AlbRC to test and strengthen systems for volunteer management, quality assurance, monitoring and evaluation, and documentation and dissemination.

***IR2: Increased sustainability of child and maternal health and nutrition and infectious disease programs and interventions initiated by PVOs and their partners:*** The ACSP will strengthen the AlbRC role as auxiliary and facilitator to the formal health system, linking the formal system to the community level through volunteers, increasing demand for and use of key services and behaviors, and empowering families to take responsibility for their own health. Through the “Grandmother Approach,” behavioral sustainability will be ensured through the transmission of health-promoting messages through traditional socio-cultural channels, e.g., from mother-in-law to daughter-in-law.

***IR3: Child and maternal health, and nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested and applied:*** Through the ACSP, AmRC, AlbRC and partners will develop, test, evaluate, document, and disseminate a model C-IMCI+ package for Albania, with replicable behavior change strategies, tool, and messages.

***Technical interventions:*** The project’s four technical interventions - ***Nutrition and Micronutrients (30%); Control of Diarrheal Diseases (20%); Acute Respiratory Infection (20%); Family Planning (30%)*** - were originally selected based on MICS results and need expressed by the Ministry of Health, Institute for Public Health, and District Public Health Directors in Diber, Bulqize, and Mat. These four interventions have now been further justified by stakeholder feedback, community inputs, and baseline assessment findings.

At the level of the formal health system, all interventions will be implemented using existing health personnel, structures, relationships, priorities, and plans; and all conform to MOH policy, norms, and protocols. For the child health interventions, the project will join forces with MOH, UNICEF, and WHO to expand the national IMCI program. This will ensure sustainability at the end of the project. At the community and household level, interventions will be implemented through a comprehensive and integrated C-IMCI+ strategy using AlbRC volunteers and leveraging the role and reputation of the Albanian Red Cross as auxiliary and facilitator to MOH with more than a decade of experience in volunteer recruitment, management, and retention. All project technical interventions are closely linked and mutually reinforcing.

There are three cross-cutting implementation strategies that will be used and applied to all technical interventions: *1) capacity-building to improve access, availability, and quality of*

*services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* These three strategies will be stated in each section of the interventions discussed in the DIP.

Combined with the three cross-cutting implementation strategies are four high-impact community activities: 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups. Again, these four high-impact community activities will be stated in each of the sections of the interventions discussed in the DIP.

***Nutrition and Micronutrients (30%):*** The project recognizes infant and young child feeding as the cornerstone of survival and childhood growth and development and seeks to reduce nutritional deficiencies and improve nutritional status by applying tenets of the Global Strategy for Infant and Young Child Feeding (integrating breastfeeding, complementary feeding, nutritional management of early childhood illness, micronutrient nutrition, and related maternal nutrition) using three cross-cutting implementation strategies: *1) capacity-building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* The formal health system and facility levels will be strengthened through training, monitoring, supervision, technical assistance, and quality assurance for expansion of IMCI in Mat and Diber Districts. This will include the improvement of maternal nutrition services in all three districts of the prefecture with Bulqize District having previously received training in 2002-3. Linking the formal health system with the community, the C-IMCI+ package - implemented by village level teams comprised on VNMs and AlbRC VHEs - will mobilize the community to increase demand and use of key services and improve family practices. C-IMCI+ is implemented by way of four high-impact community activities: 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups.

***Control of Diarrheal Diseases (20%):*** The three cross-cutting implementation strategies will also apply to CDD: *1) capacity-building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* At the community and household levels, this intervention will focus on: 1) prevention of diarrheal episodes through promotion of optimal infant and young child feeding, adequate hand washing, improved food handling and hygiene, and reduction in bottle-feeding; and 2) improved home management of diarrheal episodes through recognition, use of ORT, correct nutritional management (e.g., continued fluids and feeding), and appropriate care seeking. A key message for mothers and families is that many cases, simple diarrhea can be managed at home; and that antibiotics are contra-indicated cases of simple diarrhea. Cases of bloody and persistent diarrhea require immediate and appropriate care seeking. CDD is integrated into the C-IMCI+ package delivered through four high-impact community activities: 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4)

family planning focus groups. At the level of the formal health system, health worker practice will be strengthened through training, monitoring, supervision, and technical assistance for scale-up of IMCI in Mat and Diber Districts. Special attention will be paid, in training and supervision, to appropriate use of antibiotics and promotion of ORT and nutritional management. Commune health centers and village ambulancas will be assisted to install and maintain “ORT corners.”

***Acute Respiratory Infection (20%):*** ARI will be implemented using the three cross-cutting strategies: *1) capacity-building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* At the community level, this intervention will focus on: 1) recognition of danger signs for newborns young infants, and for older children; 2) immediate and appropriate care seeking; and 3) adherence to treatment recommendations (e.g., taking the full course of the antibiotic, returning for follow up). Special attention will be paid to recognition of cough with fast/difficult breathing as a danger sign for ARI, as well as to danger signs for young infants. This intervention is integrated into the C-IMCI+ package delivered through four high impact community activities; 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups. As an integral part of the C-IMCI+ package, the ARI intervention is reinforced through the promotion of optimal infant and young child feeding practices. At the level of the formal health system, health worker practice will be strengthened through training in IMCI standard case management protocols that will improve assessment, classification, treatment, referral, and counseling for childhood pneumonia by health workers. In addition, the project will build capacity of maternity personnel to educate mothers and grandmothers about danger signs in newborns. The project will collaborate closely with the District Public Health Directorates to ensure an adequate supply of drugs and equipment, effective supervision, regular monitoring and evaluation, and appropriate referral.

***Family planning (30%):*** The family planning intervention will be implemented using the three cross-cutting strategies: *1) capacity-building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* At the level of the formal health system, capacity building will focus on training and full implementation of VNMs into FP service delivery and the LMIS in Diber District. This will improve availability and access by increasing the proportion of MCH SDPs that offer family planning services. At the community level, family planning is integrated into the C-IMCI+ package and its four high-impact activities: 1) growth monitoring promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups.

In the 6 day C-IMCI+ curricula, FP topics for VHEs will cover modern methods of contraception, where to obtain contraception, key messages regarding child spacing to young couples, to pregnant women during antenatal period, new mothers during

postpartum period, to youth, and men. The curricula will also introduce and train the VHEs regarding non-commodity methods of contraception such as LAM and SDM.

The project is described by objective, intervention, and activities in relevant sections below, following discussion of the over-arching IMCI/C-IMCI+ strategy that shapes the whole. At the level of the formal health system, the project will join forces with MOH, UNICEF, and WHO to increase use of *key services* for MCH and FP by expanding the national IMCI strategy. Family planning, using the national LMIS, will similarly be extended by incorporating VNMs as full-service family planning providers throughout the three districts of the prefecture. At the community level, all four technical interventions (Nutrition, CDD, ARI, and Family Planning) will be implemented through a strategy of C-IMCI+ designed to increase use of *key household practices* for MCH and FP.

### ***INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI) AND COMMUNITY IMCI PLUS (C-IMCI+)***

***IMCI in Albania and Diber Prefecture:*** The Albania Child Survival Project will implement its three child health interventions (e.g., Nutrition and Micronutrients, Control of Diarrheal Diseases, and Acute Respiratory Infection) within the context of Albania's national IMCI program. This will be achieved by joining forces with MOH, UNICEF, and WHO; and in full conformance to Albania MOH policies, norms, and protocols.

In 2002-3, Bulqize District was one of two national IMCI pilot districts; and a majority of district- and commune-level health workers who treat children in Bulqize have been trained, including approximately 80% of VNMs (n=62). The ACSP has been invited by MOH, UNICEF, and WHO to participate in the National IMCI Coordinating Group. A national IMCI "lessons learned" conference to review the pilot experience is planned for May 2004 and will be organized by WHO in Tirana. A draft copy of the MOU can be seen in Annex 14.

At the project's DIP Stakeholder Workshop, held in Peshkopi in March 2004, one of the top priorities for District Public Health Directors in Diber and Mat Districts was expansion of IMCI training into those two districts. The ACSP has successfully advocated for this expansion with MOH and UNICEF, and an MOU has been drafted. Budgetary and organizational support from the project will ensure that IMCI training is extended to VNMs in Diber and Mat Districts as part of a phased roll out of training. This will increase access to key services for child health and nutrition for the population of the prefecture. It is anticipated that IMCI training will take place in Diber District in late 2004 and in Mat District in 2005, although UNICEF can only commit on a year-to-year basis. In the event that UNICEF is unable to fund IMCI training in Mat in 2005, the project budget will be realigned to fill the gap.

***IMCI protocols:*** Albania IMCI protocols were adapted by MOH with its international partners, UNICEF and WHO in 2000-01 and have been piloted in the Districts of Bulqize and Pogradec. The protocols will be reviewed at the national IMCI "lessons learned" review meeting planned for May 2004.

**IMCI training curriculum:** The Albania IMCI training curriculum was developed by MOH with UNICEF and WHO in 2000-1 and piloted in Bulqize and Pogradec Districts in 2002-03. The training curriculum will also be reviewed in the national “lessons learned” meeting planned for May 2004.

**IMCI trainers:** IMCI trainers have been trained at the national level, as well as at the district level in Bulqize and Pogradec. For roll-out of IMCI in Diber and Mat Districts, training of trainers (TOT) will be funded by UNICEF, with coordination by MOH.

**IMCI training materials:** The project has agreed to share the cost of the IMCI training materials for Diber and Mat with UNICEF. In addition, the districts are currently conducting an inventory of supplies and will be submitting a request to UNICEF for baby and child scales for village ambulancas.

**Sustainability of IMCI:** Albania has officially adopted IMCI as a national strategy but currently depends on external funding from international partners (UNICEF, WHO, the ACSP) for expansion and sustainability. Within the framework of primary health care reform, including healthcare financing reform, it is hoped, but difficult to predict, whether the MOH will be able to scale up IMCI throughout the whole of the country.

**C-IMCI+:** At the community level, to complete roll-out of IMCI, the ACSP centerpiece will be development, documentation, and dissemination of an *Albanian model for community IMCI (C-IMCI+ to include child health and family planning)* that will constitute Albania’s first C-IMCI experience. At the **community and household levels**, the project’s C-IMCI+ strategy will:

- Link the community with the formal health sector;
- Increase community access to information and care about family planning and child health and nutrition;
- Improve recognition of danger signs and appropriate care seeking and referral;
- Improve key household practices for family planning and child health and nutrition;
- Empower mothers, grandmothers, and household decision-makers to take responsibility for family health.

**Village level C-IMCI+ teams:** The project’s C-IMCI+ model is built around village level teams comprising the VNM paired with approximately two trained AlbRC volunteer health educators (VHEs). In total, it is anticipated that approximately 279 VNMs and 700 VHEs will be trained to carry out C-IMCI+ activities at the village level. An additional 60 VHEs will be trained in C-IMCI+ and assigned to health facilities, including maternities and commune health centers.

**Four high-impact activities:** Village C-IMCI+ teams will increase access and availability of key services and promotion of key household practices through four high-impact activities:

- growth monitoring promotion
- pro-active home visiting
- young child support groups
- family planning focus groups

The 60 VHEs placed at maternities and commune health centers will tailor these activities to the facility context, with special attention to essential nutrition actions in maternities and antenatal clinics. The four high-impact activities will be described at greater length in the technical intervention sections that follow.

***C-IMCI+ behavior change and communication approach:*** The project's overall behavior change and communication approach is fully integrated into the C-IMCI+ package and focuses on improving use of key MCH and FP services and household behaviors. At the heart of the project's C-IMCI+ model are the *key family practices* adapted to the Albanian context. They are shown in Table 5 below.

As part of the C-IMCI+ package, VHEs will be trained in interpersonal communication, participatory techniques, and adult learning and teaching; as well as in the key family practices for maternal and child health, recognition of danger signs, and appropriate care seeking. At maternities and commune health centers, VHEs will coordinate with nurse midwives to promote essential actions and key practices for pregnant women, newborns, and children 0-59 months. At the village level, VHEs will team with VNMs to carry out the four high-impact activities. VHEs will reinforce messages through distribution of AlbRC developed and printed materials that will be available to the project. The project team will review and adapt existing and tested educational materials (e.g., posters, brochures, leaflets) developed AlbRC maternal and child health projects over the past several years and currently being used throughout the country. These include materials promoting optimal infant and young child feeding, maternal health and nutrition, family planning and modern contraceptive methods, and use of iodized salt.

*Behavioral sustainability* will be achieved by promoting empowerment through knowledge and action. The project is especially interested in exploiting traditional communication channels, e.g., the transmission of knowledge and practice from mother-in-law to daughter-in-law. This will be explored further in the qualitative inquiry ("Grandmother Approach") planned for August 2004 and documented in a monograph for dissemination. In addition, group-based counseling and support (e.g., young child support groups, family planning focus groups) will help build confidence of individual women, while enabling them to problem solve in a safe learning environment, among friends and neighbors.

Table 5

**KEY COMMUNITY IMCI FAMILY PRACTICES**

**Adapted<sup>35</sup> for Albania**

*(Albania Child Survival Project Emphasis Behaviors in **Bold**)*

For physical growth and mental development

- **Breastfeed infants exclusively to six months.** (*Mothers found to be HIV positive require counseling about possible alternatives to breastfeeding.*)
- **Starting at about six months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to two years or longer.**
- **Ensure that children receive adequate amounts of micronutrients (vitamin A and iron) through their diets.**
- **Use iodized salt for household consumption.**
- Promote mental and social development by responding to a child's needs for care, through talking, playing, and providing a stimulating environment.

For disease prevention

- Take children *as scheduled* to complete a *full course of immunizations* by 14 months<sup>36</sup>.
- **Dispose of feces, including children's feces, safely.**
- **Wash hands with soap after defecation, before preparing meals, and before feeding children.**
- Adopt

For appropriate home care

- **Continue to feed and offer more fluids, including breastmilk to children when they are sick.**
- **Give sick children appropriate home treatment for infections.**
- Take appropriate actions to prevent and manage child injuries and accidents.
- Prevent child abuse and neglect, and take appropriate action when it has occurred.
- Ensure that men actively participate in providing childcare, and are involved in the reproductive health of the family.

For seeking care

- **Recognize when sick children need treatment outside the home and seek care from appropriate providers.**
- **Follow the health worker's advice about treatment, follow-up and referral.**
- Ensure that every pregnant woman has adequate antenatal care. This includes having at least four antenatal visits with an appropriate health care provider, and receiving the recommended doses of the tetanus toxoid vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

***C-IMCI+ training curriculum:*** The C-IMCI+ 6-day training curriculum for VNMs and AlbRC VHEs will be developed by the ACSP team during the period July-October 2004. The C-IMCI+

<sup>35</sup> From "Community IMCI Key Practices". UNICEF, WHO, American Red Cross

<sup>36</sup> Albania schedule = BCG at birth; DPT3+HBV3+OPV3 by 6 months; MCV (measles and rubella) by 14 months.

curriculum will be adapted for the northeast Albania context from existing successful C-IMCI curricula (e.g., BASICS, AMRC Armenia, WHO) and will incorporate best practices for child health and family planning. It will be informed by results of the qualitative inquiry (“Grandmother Approach”) planned for early August 2004. In addition to key family practices and recognition of danger signs, the training curriculum will emphasize the International Red Cross values and principles, teamwork, participatory learning and teaching, adult education techniques, and interpersonal communication. Focus will be on quality performance of the four high impact activities (i.e., growth monitoring promotion, pro-active home visiting, young child support groups, and family planning focus groups). For quality purposes, trainees will learn how to use job aids (e.g., counseling cards) correctly and how to collect and record project data for monitoring and evaluation. Quality will be assured through training pre- and post-tests; and a sample of trainees will be tested 6 months following the training to check for sustained changes in knowledge and practice.

***Training of trainers (TOT) for C-IMCI+:*** The project will train 12 C-IMCI+ trainers, four from each district. This number, which will include the AlbRC District Health Coordinators in each district, will ensure adequate coverage for all trainings planned over the course of two years. The TOT curriculum for C-IMCI+ will be developed by the ACSP team, concurrently with the C-IMCI+ curriculum for VNMs and VHEs.

***C-IMCI+ roll-out:*** The project will initially introduce C-IMCI+ in Bulqize District, where providers have already been trained in IMCI, including approximately 80% of the VNMs. It is planned that C-IMCI+ trainings in Bulqize will start in January 2005. This introduction experience will provide experience and documentation for the C-IMCI+ coordinating workshop that WHO is planning for sometime in 2005. As providers are trained in IMCI in Diber and Mat Districts, (2004-05), C-IMCI+ will be rolled-out in those districts, taking into account lessons learned from the Bulqize experience.

***Sustainability of C-IMCI+:***

Sustainability of the C-IMCI+ is expected through four key areas: implementation by the AlbRC, strengthened AlbRC volunteer management, integration with MOH policies and procedures and increased parental knowledge and practice.

The AlbRC, being an indigenous Albanian organization will not be closing their offices following the program. Rather, the AlbRC has had programming in the prefecture prior to the ACSP and will continue to serve the Albania community in the prefecture following project activities.

Through the project, the AlbRC volunteer management systems will be strengthened. This will take place through training on supervisory mechanisms, a computerized database to track volunteers, a small regular non-monetary incentive system and an enhanced cadre of volunteers that can be utilized beyond health programming. A copy of the current volunteer management guidelines is attached in Annex 15.

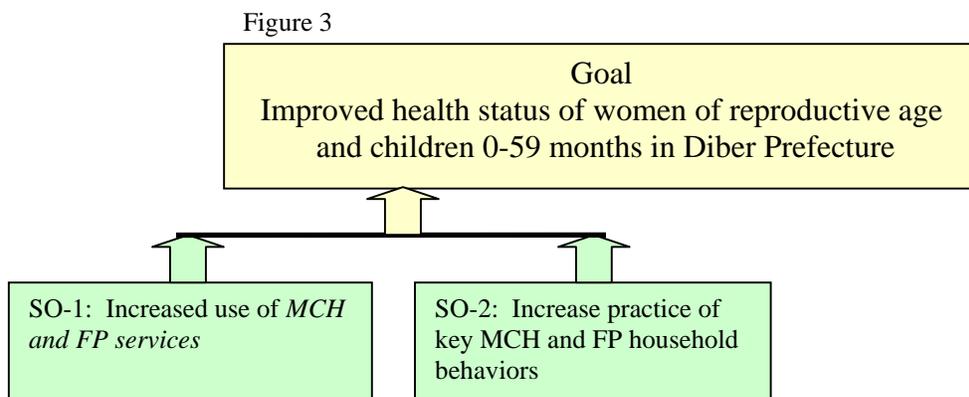
Development of the C-IMCI+ curriculum will be in concert with the MOH with inputs from UNICEF and WHO. The curriculum that is developed should be applicable to other prefectures

of Albania. This valuable tool can be used to expand programming to other parts of the country as well as be used for refresher trainings.

More importantly, the impact of behavior change resides with individuals. Through project interventions, there will be increased parental knowledge and practice resulting in improved health status. A change in an individual's behavior is expected to continue beyond the project cycle.

### ***E.2.1 - NUTRITION AND MICRONUTRIENTS (30%)***

***Objective for nutrition and micronutrients:*** The project's nutrition objective is *improved use of key nutrition services and increased practice of key household behaviors for infant and young child feeding* in Diber Prefecture. The objective is summarized in Figure 3.



**Table 6: Indicators for Nutrition and Micronutrients (30%)**

<b>Goal: Improved health status of women of reproductive age and children 0-59 months in Diber Prefecture</b>	<b>Baseline value</b>	<b>EOP target</b>	<b>Source</b>
% of children 0-59 months who are more than 2 standard deviation below the median height-for-age for the reference population	18.6%	10%	KPC
% of children aged 0-59 months who are more than 2 standard deviation below the median weight for age for the reference population	15.4%	7%	KPC
<b>SO-1: Increased use of MCH services</b>			
% of babies 0-11 months that were breastfed during the first hour after birth	31%	60%	KPC
% of mothers supplemented with iron/folate tablets during last pregnancy	9.6%	30%	KPC
% of villages with functioning C-IMCI+ teams that report data to project M&E system	0%	80%	ACSP M&E
% of village nurse midwives in Diber Prefecture trained in IMCI	18%	75%	MOH/ACSP M&E
% of VHEs using job aids	0%	75%	ACSP M&E
% of village nurse midwives using supervision checklists for VHEs	0%	75%	ACSP M&E
<b>SO-2: Increased practice of key household behaviors</b>			
% of children 0-5 months exclusively breastfed during the last 24 hours	34.3%	60%	KPC
% of children aged 0-11 months who had anything by bottle yesterday	32%	15%	KPC
% of household that use iodized salt	50.6%	75%	KPC
% of children 0-23 months with an illness in the last two weeks who were offered the same amount or more food and fluids during an illness	33%	60%	KPC
% of children aged 6-23 months who ate meat, organ meat, poultry or fish yesterday	29.7%	50%	KPC

**Strategy for Nutrition and Micronutrients:** The ACSP overall approach for this technical intervention recognizes infant and young child feeding (and related maternal nutrition) as the cornerstone of survival and childhood growth and development. The project will apply the Global Strategy for Infant and Young Child Feeding (integrating breastfeeding, complementary feeding, nutritional management of early childhood illness, micronutrient nutrition, and related maternal nutrition) using three cross-cutting implementation strategies: 1) *capacity-building to improve access, availability, and quality of services at facilities (e.g., maternities and community health centers);* 2) *community mobilization and education to increase demand for, and use of, key services;* and 3) *tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices.* Optimal infant and young child feeding practices lead to improved intakes of energy, protein, and micronutrients, improved nutrient absorption and utilization, increased survival, enhanced immune system, better nutritional status, and improved psychomotor development, school readiness, and school performance.

***Capacity-building to improve access, availability, and quality of services at facilities:*** The project will build capacity at all levels – health system/health facility, community, and household.

Through joining forces with MOH, UNICEF, and WHO, the ACSP will improve access and availability to quality nutrition and micronutrient services by expanding the national IMCI program and training health workers in all three districts of the prefecture, down to the level of the VNM. Currently, only providers in Bulqize District have been trained in IMCI (including 80% of VNMs).

Under an MOU to be signed by MOH, UNICEF, WHO, and the Albanian Red Cross the project will provide resources and organizational support to ensure the standard IMCI training of approximately 217 VNMs. In addition, the project will train some 81 providers in maternities, commune health centers, and antenatal clinics in selected essential actions for nutrition and micronutrients. These essential actions include routine prophylactic antenatal iron/folate supplementation; improved counseling for pregnant women in diet, workload, and rest; improved tracking of weights and trends for pregnant women; and immediate and exclusive breastfeeding. To support improved practice in antenatal clinics and maternities, 60 VHEs trained in C-IMCI+ will be teamed with these facilities to promote and support the nutrition and micronutrient intervention, especially in for maternal nutrition and infant and young child feeding.

***Behavior change and communication for Nutrition and Micronutrients:*** The project’s behavior change approach for nutrition and micronutrients is fully integrated into the C-IMCI+ package and focuses on improving both key household practices for infant and young child feeding and related maternal nutrition.

As part of the C-IMCI+ package, VHEs are trained in participatory methods, interpersonal communication and adult learning and teaching. The training will also include key household practices relevant to optimal breastfeeding, complementary feeding, nutritional management of childhood illness, micronutrient nutrition, and related maternal nutrition.

At antenatal clinics and maternities, trained health providers will promote maternal nutrition and optimal infant and young child feeding through enhanced individual counseling for women and their mothers-in-law. Messages will be reinforced through posters and printed materials (e.g., brochures) that mothers can take home with them. VHEs assigned to antenatal clinics and maternities will further reinforce key messages through individual and group counseling, especially visits to new mothers and infants after delivery and before discharge from the maternity. Mothers-in-law and other family members present in the maternity will be engaged in the learning sessions and their supportive roles emphasized.

At health centers and ambulancas, VHEs will coordinate with nurse midwives to promote essential actions and key practices through antenatal and delivery care, routine growth monitoring and promotion, pro-active home visiting, and small child support groups. Posters and printed materials will reinforce messages.

At the village level, and at commune health centers, trained VHEs will counsel new mothers and organize “young child support groups” for mothers and grandmothers. *Behavioral sustainability*

will be achieved by promoting empowerment through knowledge and action and by facilitating transmission of knowledge and practice from mother-in-law to daughter-in-law. Group-based counseling and support helps build confidence of individual women, while enabling them to problem solve in a safe learning environment, among friends and neighbors.

The ACSP will review and adapt existing AlbRC materials developed for other maternal and child health projects and currently being used throughout the country. These include brochures promoting optimal breastfeeding and complementary feeding, maternal health and nutrition, and use of iodized salt.

### ***C-IMCI+ activities for Nutrition and Micronutrients:***

***Growth monitoring promotion (GMP), counseling, and follow-up:*** Village C-IMCI+ teams of VNMs and VHEs will conduct monthly growth monitoring sessions to identify children falling behind in their growth. Children will be weighed, their growth recorded on growth curve cards, trends tracked, and mothers/caretakers given feedback and counseled on infant and young child feeding. VHEs will mobilize mothers and grandmothers in the community to bring children 0-59 months every month for growth monitoring. Focus will be on young children 0-23 months, as this is the age group most vulnerable to nutritional deficiencies. As part of the role of VNMs, they maintain rosters of children 0-23 months, mothers who do not bring their young children for GMP can be actively followed up and encouraged through pro-active home visiting if not brought to the monthly growth monitoring session. GMP sessions, which will take place at the village ambulance or other venue (e.g., school, mosque, church), will offer an opportunity to reinforce positive infant and young child feeding practices and take corrective action when a child is found to be growth faltering. GMP sessions will be animated with participatory activities that promote positive practices, such as recipe exchanges, cooking contests, and problem-solving group discussion involving mothers and grandmothers.

Children who fail to gain weight will be referred to the commune or district level for nutritional rehabilitation, and children returning to the community will be followed-up and monitored through pro-active home visiting conducted by the VNM and VHE.

The project's GMP component meets the criteria for effective growth monitoring by providing *regular* assessment of child growth; *action* for the caretaker to improve nutritional management of the child; *community support*; and *follow up* for the child to review growth and feeding practices over time. Growth monitoring technical skills, counseling, and referral are part of the C-IMCI+ training package for VNMs and VHEs. Quality assurance will be ensured through the use of job aids, supervision tools, and regular M&E by project and commune level personnel.

***Pro-active home visiting (for Nutrition and Micronutrients):*** Using rosters of children 0-23 months currently maintained by VNMs for immunization purposes, VHEs will schedule and conduct pro-active home visits to monitor pregnant and lactating women and children 0-59 months in the village. For pregnant women, VHEs will educate and counsel about diet, rest, and workload; consumption of foods rich in iron and vitamin A;

use of iodized salt; and iron/folate supplementation. For lactating women, VHEs will promote extra snacks and fluid intake; consumption of iron- and vitamin A-rich foods; use of iodized salt; continued supplementation with iron/folate; and exclusive breastfeeding. For children 6-23 months, focus will be on best practices for complementary feeding. Special attention will be accorded to newborns, sick children, growth faltering children, and children who have been counter-referred following nutritional rehabilitation. Depending on circumstances and need, home visits may be thematic in nature; or may focus on current problems and solutions. Pro-active home visiting offers an opportunity for individual counseling and coaching, as well as for distribution of pertinent educational materials.

***Young child support groups (for Nutrition and Micronutrients):*** As a key vehicle for community-level promotion of infant and young child feeding and management of the sick child, young child support groups will be organized by VHEs for pregnant and lactating women and their mothers-in-law. The small groups (4-10 women) will convene with the VHE or VNM facilitator weekly for about one hour at the rural ambulance, a participant's home, or other venue. The groups will focus on pregnancy, neonates, and infants 0-23 months; but, space allowing, they will welcome the participating of any mother of a child 0-59 months. One reason for this is that it will offer the opportunity for more experienced mothers to share their infant and young child feeding challenges and solutions with new mothers. The groups will be designed to allow women to share experiences, information, and resources in a lively and appropriate socio-cultural context. Group sessions will be participatory and thematic, focusing on a different relevant subject every week. In the area of nutrition, focus areas will include:

- *early initiation of breastfeeding within one hour after birth*
- *exclusive breastfeeding for six months*
- *continued breastfeeding for two years or beyond*
- *timely, adequate, safe, and appropriate complementary foods and feeding starting at about six months*
- *nutritional management of childhood illness (e.g., continued feeding and fluids)*
- *related support for maternal health, nutrition, and birth spacing (e.g., LAM as a method of family planning for mothers of infants 0-5 months)*

***Advocacy for Nutrition and Micronutrients:*** The project will play the role of catalyst to government at the national and regional levels, and to communities through its volunteer network, to apply and operationalize the tenets of the Global Strategy for Infant and Young Child Feeding in Diber Prefecture and in Albania. One of the ways it will do this is through the Albanian Red Cross membership and leadership role in the emergent *Albania Forum for Public Health*. Through this and other professional bodies, the ACSP team will seek opportunities to advocate for improved nutrition policies at the national level. This will include a review of progress in national implementation of the International Code of Marketing of Breastmilk Substitutes. Other advocacy needs include: 1) national policies and legislation to protect the breastfeeding rights of working women in accordance with international labor standards; and 2) review of micronutrient policies (e.g., vitamin A) for children under 6-59 months and post-partum women.

Given the elevated rates for stunting, underweight, and wasting found in both MICS and KPC survey, the American Red Cross will, in the course of the project, seek additional partners and resources to facilitate the conduct a PROFILES or similar national assessment for nutrition in Albania. PROFILES, developed by the Academy of Educational Development (AED), is a set of advocacy tools and processes that can raise awareness and priorities for nutrition, build consensus, strengthen communication capacity, target existing resources and leverage new ones, promote coalitions, and develop leadership skills of nutrition advocates.

***Access/Health Related Products (Availability of Drugs, Vaccines, Micronutrients, Equipment) for Nutrition and Micronutrients:*** As mentioned in an earlier section, the matter of adequate supplies of iron/folate supplements for free-of-charge routine prophylactic antenatal distribution will require advocacy and technical assistance. Currently, iron/folate supplements are provided by prescription and obtainable in pharmacies at cost price, consistent with current practice in Albania.

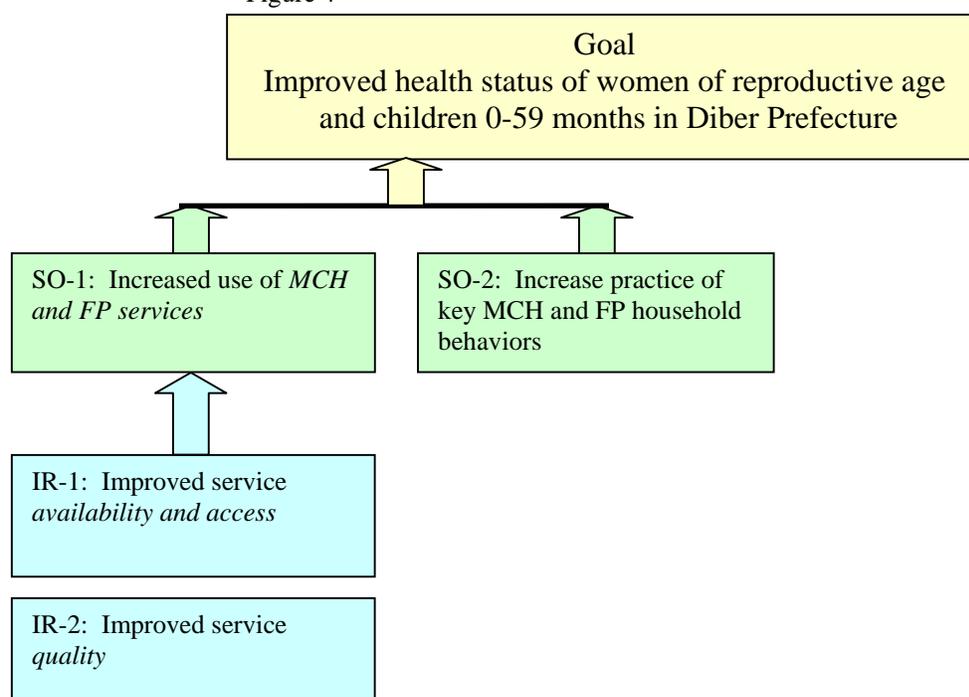
For routine GMP at the village level, the District Public Health Directorates are currently undertaking an inventory of need for scales for infants and children and will submit a request to UNICEF to fill the needs, as required. Height boards, when needed, are available from the ACSP project office in Peshkopi.

***Quality assurance for Nutrition and Micronutrients:*** Quality of health worker performance will be assured through the introduction of checklists for antenatal care and new mothers/new babies. VHEs will use job aids (e.g., counseling cards) in carrying out the four high-impact activities at the community level. VNMs and AlbRC District Health Coordinators will use supervisory checklists for VHEs. To improve knowledge and practice, VNMs and VHEs will receive quarterly project newsletters focusing on important topics related to nutrition and micronutrients. It is anticipated that additional quality assurance tools and mechanisms will be introduced as a result of the Senior Liaison (M&E) Officer's participation in the JHU "Quality Assurance Management for Developing Countries" course in Baltimore in June 2004.

### ***E.2.2 - CONTROL OF DIARRHEAL DISEASES (CDD) (20%)***

***Objective for CDD:*** The project's CDD objective is *improved use of key CDD services and increased practice of key household behaviors for prevention and management of diarrheal episodes in Diber Prefecture*. This is depicted graphically in Figure 4 followed by Table 7 outlining the indicators and targets for the project.

Figure 4

**Table 7: Indicators for Control of Diarrheal Diseases**

<i>SO-1: Increased use of MCH services</i> <i>IR -1: Improved service availability and access</i> <i>IR-2: Improved service quality</i>	<i>Baseline value</i>	<i>Endline target</i>	<i>Source</i>
% of village ambulancas with ORT corners installed and functioning	0%	50%	Community mapping, HFA, ACSP M&E
% of villages with functioning C-IMCI+ teams that report data to project M&E system	0%	80%	ACSP M&E
% of village nurse midwives in Diber Prefecture trained in IMCI	18%	75%	MOH/ACSP M&E
% of VHEs using job aids	0%	75%	ACSP M&E
% of village nurse midwives using supervision checklists for VHEs	0%	75%	ACSP M&E
<i>SO-2: Increased practice of key household behaviors</i>			
% of children aged 0-23 months with an illness in the last two weeks who were offered the same amount or more food or fluids during the illness	33%	60%	KPC
% of children 6-23 months with diarrhea in the past 2 weeks who were treated with ORS or ORT or appropriate home fluid	16.3%	45%	KPC
% of mothers of children aged 0-23 months who wash their hands with soap before food preparation, feeding children, after defecation, and attending to a child who has defecated	31%	50%	KPC

% of mothers who know can cite at least 3 neonatal danger signs	12.5%	25%	KPC
% of mothers who can cite at least 4 danger signs for sick children	41.9%	75%	KPC

**Strategy for CDD:** The CDD intervention is integrated into the project’s IMCI/C-IMCI+ strategy and delivered using the three cross-cutting implementation strategies: 1) *capacity-building to improve access, availability, and quality of services*; 2) *community mobilization to increase demand for, and use of, key services*; and 3) *tailored behavior change communication (BCC) to improve key household behaviors and care-seeking practices*.

**Capacity building to increase access and availability of quality services:** Access and availability of quality services will be increased through expansion of the national IMCI program to Diber and Mat Districts. To date, only health workers in Bulqize District- including 80% of VNMs – have been trained in IMCI. The project will join forces with MOH, UNICEF, and WHO to expand IMCI coverage to the entire prefecture. The project will provide resources and organizational support to ensure that providers in Diber and Mat are trained down to the level of the VNM. Health worker practice will be strengthened through training in IMCI standard case management protocols to improve assessment, classification, treatment, referral, and counseling for diarrheal episodes. During sick child visits, health workers will counsel mothers, mother/caretakers about correct home management of diarrheal episodes and use of ORT, as well as on the importance of continued fluids and feeding during and after illness. Special attention will be paid to appropriate use of antibiotics. The project will collaborate closely with the District Public Health Directorates as IMCI comes on-line in Diber and Mat Districts to ensure an adequate supply of drugs and equipment, effective supervision, regular monitoring and evaluation, and appropriate referral systems. Materials for training will be provided by UNICEF with partial funding from the project.

At the community level, VNMs will improve their clinical management and counseling skills for CDD. Technical assistance will be provided to commune health centers and village ambulancas will be assisted to set up and maintain “ORT corners.”

**Behavior change and communication for CDD:** CDD is integrated into the C-IMCI+ package delivered through the set of high-impact activities, in particular: 1) growth monitoring and promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups.

The project’s behavior change approach for CDD is fully integrated into the C-IMCI+ package and focuses on improving key household practices for prevention of diarrheal episodes through improved hygiene (e.g., hand washing with soap at all appropriate times); optimal infant and young child feeding (e.g., exclusive breastfeeding, adequate complementary feedings); use of ORT and nutritional management; recognition of danger signs and rapid and appropriate care seeking. As part of the C-IMCI+ package, VHEs are trained in participatory methods and interpersonal communication and adult learning and teaching; as well as the key messages relevant to household hygiene, hand washing, infant and young child feeding practices, recognition of danger signs, ORT, rapid and appropriate care seeking, and nutritional

management of childhood illness. It will be emphasized that, while cases of bloody and persistent diarrhea require immediate and appropriate care seeking, most cases of simple diarrhea can be managed at home with ORT and increased fluids and feeding. To the extent possible, VHEs will address their messages to both mothers and grandmothers, using job aids (e.g., counseling cards). Messages will be reinforced through the distribution of AlbRC printed materials (e.g., brochures, leaflets) that mothers can keep and share with other members of the household. The project's behavior change strategy at the community level is centered on the high-impact activities of C-IMCI+:

***Growth monitoring and promotion (GMP), counseling, and follow-up:*** VHEs will mobilize mothers and grandmothers in the community to bring children 0-59 months every month for growth monitoring. GMP sessions will serve as an excellent vehicle for helping mothers and grandmothers make the connection between the child's nutritional status and prevention and correct management of diarrheal episodes. During the sessions, C-IMCI+ teams of midwives and VHEs will disseminate messages about prevention and control of diarrheal disease. Messages will focus on prevention of diarrheal episodes through promotion of optimal infant and young child feeding practices, adequate hand washing with soap at all appropriate times, improved food handling and hygiene; nutritional management of diarrheal episodes (continued fluids and feeding); and proper use of ORT (ORS and recommended home fluids).

As it is part of the role of VNMs to maintain rosters of children 0-23 months, mothers who do not bring their young children for GMP can be actively followed up and encouraged through pro-active home visiting if not brought to the monthly GMP sessions. Children who fail to gain weight will be followed up with pro-active home visits and referred to the commune or district level for nutritional rehabilitation. Children returning to the community following a referral will be followed-up and monitored through pro-active home visiting.

***Pro-active home visiting (for CDD):*** Using rosters of children 0-23 months currently maintained by VNMs for immunization purposes, VHEs will schedule and conduct pro-active home visits to monitor child health and coach and educate mothers, mothers-in-law, and other family members about prevention and management of diarrheal episodes. VHEs will counsel mothers and mothers-in-law and educate them about the relationship between optimal infant and young child feeding practices and the prevention and control of diarrheal disease. Using job aids (e.g., counseling cards), VHEs will promote hand washing with soap at all appropriate times. VHEs will emphasize prevention, use of ORT (e.g., ORS, recommended home fluids), continued feeding and fluids during illness, and catch up feeds during recovery. VHEs will distribute educational printed materials to reinforce the messages.

***Young child support groups (for CDD):*** As a key vehicle for community-level promotion of infant and young child feeding and management of diarrheal episodes, young child support groups will be organized by VHEs mothers of children 0-23 months (and up to 59 months), and their mothers-in-law. The small groups (4-10 women) will convene with the VHE or nurse midwife facilitator weekly for about one hour at the rural

ambulanca, a participant's home, or other venue. More experienced mothers will be encouraged to share challenges and solutions related to diarrhea prevention and management with new mothers and those less experienced. The groups will be designed to allow women to share experiences, information, and resources in a lively and appropriate socio-cultural context. Group sessions will be participatory and thematic, focusing on a different relevant subject every week.

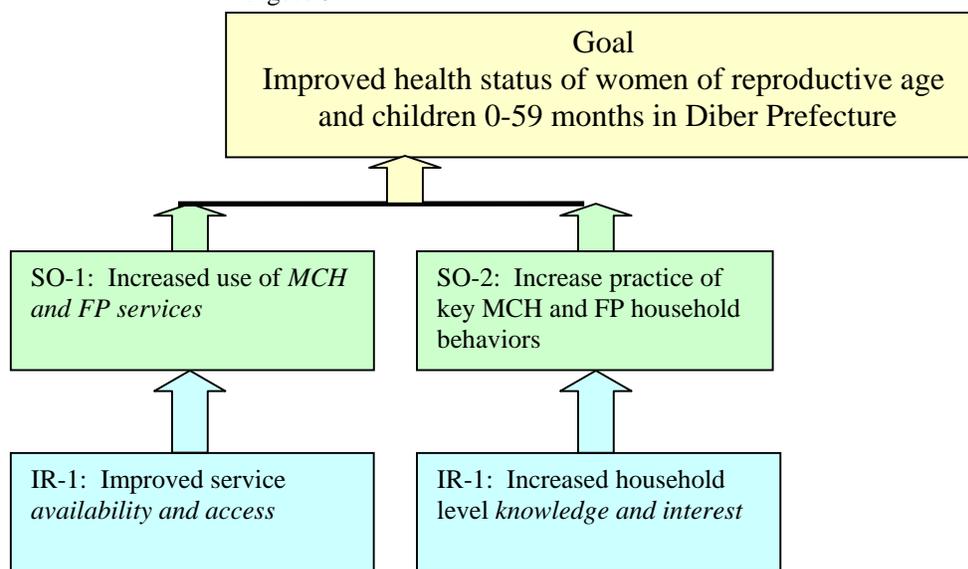
***Access/Health Related Products (Availability of Drugs, Vaccines, Micronutrients, Equipment) for CDD:*** The project will provide technical assistance to commune health centers and VNMs in rural ambulancas to install and maintain ORT corners and to strengthen the supply system for ORS sachets for “emergency drug boxes”.

***Quality Assurance for CDD:*** A simple set of quality assurance tools will be developed for use with IMCI and C-IMCI+. Quality of provider performance will be assured through IMCI algorithms and standard case management protocols and supervisory checklists. VHEs will use job aids (e.g., counseling cards). VNMs and AlbRC District Health Coordinators supervising the activities of VHEs will use supervisory checklists. To improve knowledge and practice, VNMs and VHEs will receive quarterly project newsletters focusing on important topics related to diarrhea prevention and control. It is anticipated that additional quality assurance tools and mechanisms will be developed following the Senior Liaison (M&E) Officer's participation in the JHU “Quality Assurance Management for Developing Countries” course in Baltimore in June 2004.

### ***E.2.3 - ACUTE RESPIRATORY INFECTION (20%)***

***Objective for ARI:*** The project's ARI objective is *increased use of key child health services and increased practice of key household behaviors for management of sick children* in Diber Prefecture. This is graphically depicted in Figure 5 below followed by Table 8 outlining the indicators and targets for the project.

Figure 5

**Table 8: Indicators for Acute Respiratory Infection**

<i>SO1: Increased use of MCH and FP services / IR-1: Improved service availability and access</i>	<i>Baseline value</i>	<i>EOP target</i>	<i>Source</i>
% of children 0-23 months with cough and fast/difficult breathing in the last two weeks taken to a health center who were treated with antibiotics	62.8%	80%	KPC
% of villages with functioning C-IMCI+ teams that report data to project M&E system	0%	80%	ACSP M&E
% of villages nurse midwives in Diber Prefecture trained in IMCI	18%	75%	ACSP M&E
% of VHEs using job aids	0%	75%	ACSP M&E
% of village midwives using supervision checklists for VHEs	0%	75%	ACSP M&E
<i>SO2: Increased practice of key household behaviors / IR-1: Increased household level knowledge and interest</i>			
% of children 0-23 months with cough and fast/difficult breathing in the last two weeks whose family sought treatment within 48 hours of illness onset	50%	75%	KPC
% of mothers who know at least 3 neonatal danger signs	12.5%	25%	KPC
% of mothers who know at least 4 child danger signs	41.9%	75%	KPC
% of mothers that cite fast/difficult breathing as a danger sign for neonates	22%	50%	KPC
% of mothers that cite fast/difficult breathing as a danger sign for children	8.3%	30%	KPC

**Strategy for ARI:** The ARI technical intervention will be implemented through IMCI and C-IMCI+, using the project's three cross-cutting strategies: 1) *capacity-building to improve access,*

*availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication (BCC) to improve key household behaviors and care seeking practices.*

***Capacity building to increase access and availability and quality of services for ARI:*** Access and availability of services will be increased, and quality of provider practice improved, through expansion of the national IMCI program to Diber and Mat Districts. To date, only health workers in Bulqize District, including 80% of VNMs, have been trained in IMCI, justifying the ACSP's decision to join forces with MOH and UNICEF to expand IMCI throughout the prefecture.

Health worker practice will be strengthened through training in IMCI standard case management (SCM) protocols to improve assessment, classification, treatment, referral, and counseling for childhood pneumonia. At the primary care (commune health center) level, Albania IMCI guidelines provide health workers with a clear protocol for assessment, classification, and treatment of pneumonia, and counseling about home care. The IMCI algorithm gives guidance on the pneumonia standard case management of potential treatment failures.

Special attention will be paid to appropriate use of antibiotics. The project will collaborate closely with the District Public Health Directorates as IMCI comes on-line in Diber and Mat Districts to ensure an adequate supply of drugs and equipment, effective supervision, regular monitoring and evaluation, and appropriate referral systems. Materials for training will be provided by UNICEF with partial funding from the project.

***Constraints related to access to antibiotics:*** Under Albanian law and MOH policy, only MDs are permitted to prescribe antibiotics. VNMs are supposed to have a small stock of antibiotics (e.g., amoxicillin, penicillin benzoate) on hand as part of their "emergency drug box," and are authorized to administer a single dose to a child with signs of pneumonia before referral to a commune health center. Notwithstanding, findings from the health facilities assessment indicate that only 15.9% of VNMs sampled (7/44) had any antibiotics available in their emergency drug box. This limitation constitutes a significant barrier to access and availability at the village level and may contribute to treatment delays for children with pneumonia and other lower respiratory infections, particularly in winter when snow and ice and road conditions make travel to the commune health center difficult.

While only medical doctors are legally authorized to prescribe antibiotics; and while antibiotics are legally available only by prescription; they are in fact widely obtainable through pharmacies without prescription. Families often by-pass the doctor or health center and go directly to the pharmacy, increasing potential for misuse of antibiotics. This is an issue for health reform, and one that MOH would like to address. The situation is complicated by powerful interests that protect the pharmacy industry and render project-level intervention unwise.

***Behavior change and communication for ARI:*** VNMs and VHEs are trained in participatory approaches and methods for adult learning and teaching. Their messages are reinforced through use of job aids (e.g., counseling cards) and dissemination of AlbRC printed promotional materials (e.g., brochures, leaflets). At the community level, the behavior change strategy

focuses on key household practices for ARI: 1) recognition of danger signs in young infants and older children; 2) immediate and appropriate care seeking; and 3) adherence to treatment recommendations.

The ARI intervention is reinforced through the promotion of exclusive breastfeeding, appropriate complementary feeding (including promotion of vitamin-A rich foods), and nutritional management of childhood illness. Special attention will be paid to recognition of cough with fast/difficult breathing as a danger sign for ARI, as well as to non-specific danger signs for young infants. VHEs working in maternities will make a special point of visiting new mothers and educating mothers and other family members about the non-specific danger signs for pneumonia in neonates.

The ARI intervention is integrated into the C-IMCI+ behavior change package delivered through four high impact community activities, in particular: 1) growth monitoring and promotion; 2) pro-active home visiting; and 3) young child support groups.

***Growth monitoring and promotion (GMP), counseling, and follow-up:*** VHEs will mobilize mothers and grandmothers in the community to bring children 0-59 months for monthly GMP sessions. GMP sessions will be used as a vehicle to alert mothers and grandmothers to the critical importance of recognition of danger signs and immediate and appropriate care seeking for pneumonia, as well as adherence to treatment prescribed. Participatory techniques (e.g., discussion, story-telling, skits and sketches) will be used to illuminate the role of optimal infant and young child feeding for infection prevention. Appropriate nutritional management of childhood illness will be stressed, with emphasis on continued fluids and feeding, and catch-up feeds during recovery. As it is part of the role of VNMs to maintain rosters of children 0-23 months, and mothers who do not bring their young children for GMP can be actively followed up through pro-active home visiting.

***Pro-active home visiting (for ARI):*** Using rosters of children 0-23 currently maintained by VNMs for immunization purposes, VHEs will schedule and conduct pro-active home visits to monitor child health, identify sick children, and educate about danger signs for young infants and older children and the critical importance of rapid and appropriate care seeking. Using job aids (e.g., counseling cards), VHEs will counsel mothers and mothers-in-law and educate them about the relationship between infectious disease and a child's nutritional status. Special attention will be accorded to newborns, young infants, sick children, growth faltering children, and children who have been counter-referred following nutritional rehabilitation. Depending on circumstances and need, home visits may be thematic in nature; or may focus on current problems and solutions. Pro-active home visiting offers an opportunity for individual counseling and coaching, as well as for distribution of pertinent educational materials.

***Young child support groups (for ARI):*** As a key vehicle for community-level promotion of infant and young child feeding and management of the sick child, young child support groups will be organized by VHEs mothers of children 0-23 months (or up to 59 months) and their mothers-in-law. The small groups (4-10 women) will convene with the VHE or

nurse midwife facilitator weekly for about one hour at the rural ambulance, a participant's home, or other venue. The groups will focus on pregnancy, neonates, and infants 0-23 months; but, space allowing, they will welcome the participating of any mother of a child 0-59 months. This will allow more experienced mothers to share challenges in management of childhood illness with new mothers. The groups will be designed to allow women to share experiences, information, and resources in a lively and appropriate socio-cultural context. Group sessions will be participatory and thematic, focusing on a different relevant subject every week but responsive to immediate needs.

***Behavioral constraints related to ARI:*** Because it is common to bundle children heavily against the cold and strap them into wooden cradles piled with warm covers, it is often difficult for mothers to observe a child's breathing. Mothers, grandmothers, and household decision-makers need to be sensitized to the gravity of the sign "fast/difficult breathing" in general; and to all danger signs, especially in the young infant (during the first two months of life); and the need for prompt and appropriate care seeking within 48 hours of onset of illness.

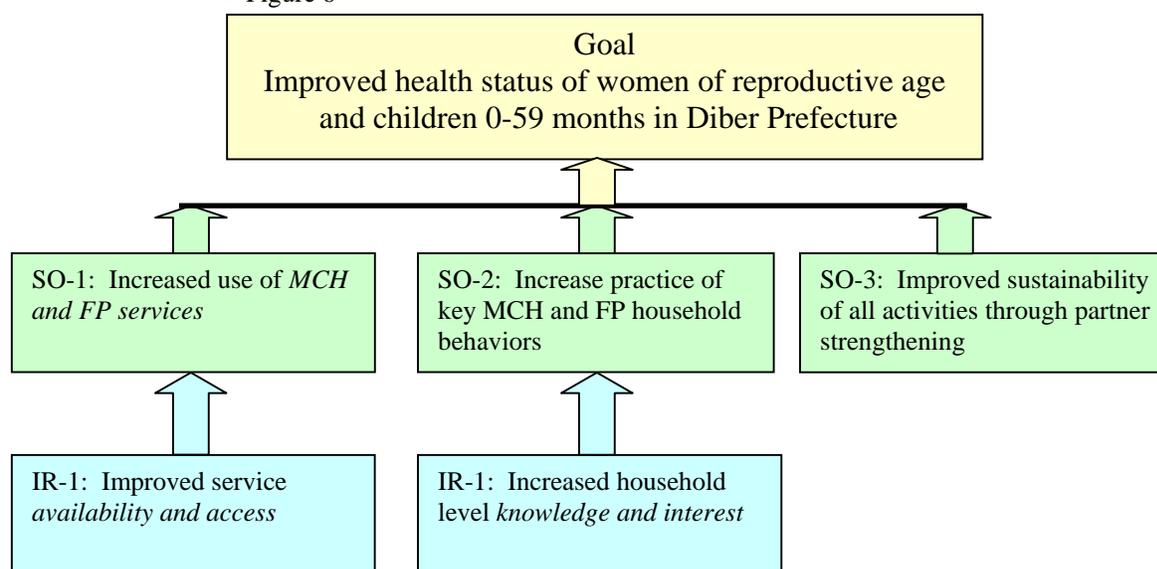
***Quality assurance for ARI:*** Quality assurance of health worker performance will be assured through standard case management protocols, use of simple tools, such as job aids and supervisory checklists. Quality of VHE performance will be assured through the use of job aids (e.g., counseling cards) and other simple tools. VNMs and AlbRC District Health Coordinators supervising VHEs will use supervisory checklists. To improve knowledge and practice, VNMs and VHEs will receive quarterly project newsletters focusing on critical topics related to recognition of danger signs and immediate care seeking, as well as the importance of infant and young child feeding practices. It is anticipated that additional quality assurance tools and mechanisms will be developed following the Senior Liaison (M&E) officer's participation in the JHU "Quality Assurance Management for Developing Countries" course in Baltimore in June 2004.

***Access/Health Related Products for ARI (Availability of Drugs, Vaccines, Micronutrients, Equipment):*** The project has agreed to share the cost of IMCI training materials with UNICEF. This includes devices to time respiratory. Antibiotics are available from pharmacies upon subscription. The project will monitor, advocate, and provide technical assistance to assure the proper supply of emergency antibiotics in VNM "emergency drug boxes".

#### ***E.2.4 - FAMILY PLANNING (30%)***

***Objective for family planning:*** The project's family planning objective is *improved use of key family planning services and increased knowledge and interest in family planning at the household level* in Diber Prefecture. This is graphically depicted in Figure 6 below followed by Table 9 outlining the indicators and targets for the project.

Figure 6

**Table 9: Key Indicators for Family Planning**

<i>SO1: Increased use of MCH and FP services / IR-1: Improved service availability and access</i>	<i>Baseline value</i>	<i>EOP target</i>	<i>Source</i>
Number of CYP distributed by the program to the target population per annum	287 <sup>37</sup>	1,500	HIS/LMIS/ACSP records
% of women 15-49 years who are not pregnant report using a modern FP method	TBD <sup>38</sup>	TBD	FP baseline – KPC/FP endline
<i>Proxy:</i> % of mothers of children 0-23 months who are not pregnant and who do not want another child in the next 2 years or who are not sure and who are using a modern method of contraception	12.1%	25%	KPC
Number of WRAs who report being a ‘new user’ of a modern method of FP per annum	1,099 <sup>39</sup>	4,000	HIS/LMIS
% of respondents of reproductive age who report discussing FP with a health or family planning worker or promoter in the past 12 months	TBD <sup>40</sup>	TBD	FP baseline – KPC/FP endline
% of the population that lives within 5 km of a family planning SDP	55%	80%	Community mapping
% of MCH SDPs in the target area offering FP services	7.8%	60%	HIS/ACSP M&E
% of FP clients who received adequate counseling	TBD <sup>41</sup>	TBD	FP baseline – KPC/FP endline
<i>SO2: Increased practice of key household behaviors / IR-1: Increased household level knowledge and interest</i>	<i>Baseline Value</i>	<i>EOP target</i>	<i>Source</i>

<sup>37</sup> CYP for prefecture (3 districts) for the period July 2002-June 2003 from JSI final report to USAID.

<sup>38</sup> To be collected through population-based FP survey planned for August 2004.

<sup>39</sup> From JSI final report to USAID for period July 2002-June 2003.

<sup>40</sup> To be collected through population-based family planning survey scheduled for August 2004.

<sup>41</sup> To be collected through population-based family planning survey scheduled for August 2004.

% of mothers with infants 0-5 months who report using LAM	2.4%	20%	KPC
% of sexually active respondents who report discussing FP issues with their spouse or sexual partner in the past 12 months	TBD <sup>42</sup>	TBD	FP baseline – KPC/FP endline
% of women of reproductive age who recall hearing a specific FP-related message being promoted by the program	0%	30%	FP baseline – KPC/FP endline
<b><i>SO-3: Improved sustainability of all activities through partner strengthening</i></b>	Baseline value	EOP target	Source
FP program has sustainability plan in place	N	Y	ACSP M&E
FP logistics management information system fully functioning in 3/3 districts at EOP	N	Y	LMIS/ACSP M&E

**Strategy for family planning:** The family planning technical intervention will be implemented using the project’s three cross-cutting strategies: 1) *capacity-building to improve access, availability, and quality of services*; 2) *community mobilization to increase demand for, and use of, key services*; and 3) *tailored behavior change communication (BCC) to improve key household behaviors and care seeking practices*.

**Access and availability of quality family planning services:** The project’s family planning approach will greatly expand access and availability to quality family planning services by increasing the number of MCH service delivery points (SDPs) that provide family planning services and by integrating family planning into antenatal and post partum services. To accomplish this, the project will train 279 VNMs at the village level and integrate them fully into the current family planning service delivery system, including the LMIS. Although not trained in FP, some VNMs already provide counseling and distribute FP methods under the supervision of GPs at commune health centers, and the project will build on this reality. Once trained, VNMs will be able to provide a broader range of family planning services including, adequate counseling, and pro-active referral. Due to legal and policy constraints, it must be noted that VNMs will not be authorized to provide the full range of FP methods and that, at first, their product range may be limited to LAM, standard days method (SDM), condoms, and oral contraceptives. However, the full range of methods is available through full-service family planning SDPs at the commune and district level, and the referral system will be strengthened to serve the needs of users.

To incorporate VNMs into the FP intervention strategy, there will be a phased in approach to the family planning training. The first VNMs will be trained in Mat in March 2005 with VNMs being trained in Diber during April 2005, then in VNMs in Bulqize about one year later during March/April 2006. Concurrent with this training, the project will provide technical assistance to the District Public Health Directorates to strengthen the LMIS and integrate the community level information.

Once trained and integrated into the system, the VNMs will be supervised in family planning (as they are in their other duties) by GPs at the commune health centers and the Inspector of Mother

<sup>42</sup> To be collected through population-based family planning survey scheduled for August 2004.

and Child for the District Public Health Department. GPs and Nurse/Midwives working at the commune health centers in Mat and Bulqize have been trained in FP by the JSI project in 2002. The training was not extended to Diber district during the JSI project. Quality will be assured through the use of job aids (e.g., counseling cards adapted from those already in use designed by JSI) and supervisory check lists. Proper use of the counseling cards will be part of the FP curriculum as well as practical exercises using the cards.

***Training in family planning:*** The family planning training curriculum for VNMs will be adapted from the standard provider curriculum developed by MOH previously with assistance from JSI from a USAID funded project. This will need to be reviewed with MOH following the population-based family planning survey that the project will carry out in August 2004. Trainers will be drawn from trained trainers in Mat and Bulqize Districts, as well as trained trainers at the national level. VNMs will be fully integrated into the LMIS and will be trained to collect community level data and feed it to the district level.

***Behavior change and communication for family planning:*** The project's behavior change approach family planning is integrated into the C-IMCI+ package and focuses on increased use of key family planning services through improved knowledge and interest in family planning at the household level. For the family planning intervention, it is important for the providers and VHEs at the village level to take advantage of every opportunity to stimulate interest. At the commune level, male VHEs will seek out youth and men at cafes, billiard halls, mosques, and other venues where males gather. The project will work with local schools to allow providers and volunteers to talk to health education classes in the middle and secondary schools. The project will provide technical assistance to District Health Directorates to integrate family planning counseling more effectively into antenatal and post-partum services. VHEs assigned to antenatal clinics and maternities will further reinforce key messages through individual and group counseling, especially visits to new mothers and infants after delivery and before discharge from the maternity. Mothers-in-law and visiting family members will also be engaged and informed about the importance of adequate child spacing for maternal and child health and survival. For new mothers, and with their mothers-in-law, information on modern contraceptive methods will be shared with an emphasis on LAM as a modern method of contraception. New mothers will be able to make an informed choice of family planning methods. Post-partum methods available to new mothers will be part of the C-IMCI+ curricula. VHEs will be capable of educating community members about access and availability of modern contraceptive methods. Lively printed materials (e.g., posters, brochures, leaflets) will be adapted or developed and made available in health facilities for women to take home with them to share with their spouses.

As part of the C-IMCI+ package, teams of VHEs and VNMs will be trained in interpersonal communication and adult learning and teaching. At the community level, focus will be on promotion of family planning, education about modern contraceptive methods available, and referral to VNMs and commune health centers. The VHEs will promote LAM and standard days method (SDM) as modern methods of contraception.

At the level of the village and commune health center, trained VHEs will organize family planning focus groups. These groups will be planned jointly with health center staff and VNMs

and will be tailored to the needs of specific “focus” constituencies, e.g., youth, men, married couples. Group-based counseling will encourage users of modern methods of contraception to share experiences with others in a supportive environment. Individuals and couples who prefer to speak to the VHE or the VNM privately and confidentially will be offered opportunities to do so.

***Family planning focus groups:*** Within the context of C-IMCI+, family planning focus groups will serve as a main vehicle for communicating accurate information and promoting family planning and the household and community level. Trained VHEs and VNMs will organize group meetings “focused” on the needs of different constituency groups, e.g., men, youth, women of reproductive age, etc. Family planning focus groups will be held at least twice a month in most villages, as well as at the commune level. These groups will meet in especially selected non-threatening venues that might include private homes, schools, mosques or churches, commune health centers, clubs, cafes, or community organizations. Using participatory techniques and interpersonal communication skills, the VHEs and VNMs will stimulate discussion and questions about the benefits of family planning and modern methods of contraception. For those individuals or couples interested, referrals will be made to the VNM (or the commune health center, in the event that the VNM has not yet completed training and is not integrated into the LMIS).

***Family Planning during (GMP), counseling, and follow-up:*** VHEs will mobilize mothers and grandmothers in the community to bring children 0-59 months for monthly GMP sessions. GMP sessions provide a forum for VNMs and VHEs to promote the benefits of child spacing and family planning in a non-threatening environment and provide information about modern methods of family planning and referral. A special emphasis will be on LAM, reinforced with promotion of exclusive breastfeeding to six months. As GMP is an activity that VNMs and VHEs will probably be carrying out as a team, mothers who express interest in family planning information can be invited aside and counseled in private.

***Pro-active home visiting (for FP):*** VHEs will schedule and conduct pro-active home visits and provide village residents (women of reproductive, men, young people) with confidential counseling and accurate information about family planning, modern methods of contraception, and referrals. Family planning promotion will be reinforced through the use of counseling cards and with lively educational materials developed by the AlbRC and tested in several project sites around the country.

***Young child support groups (for FP):*** Young child support groups will be organized by VHEs mothers of children 0-23 months (or up to 59 months) and their mothers-in-law. The small groups (4-10 women) will convene with the VHE or nurse midwife facilitator weekly for about one hour at the rural ambulanca, a participant’s home, or other venue. The groups will focus on pregnancy, neonates, and infants 0-23 months; but, space allowing, they will welcome the participating of any mother of a child 0-59 months. Young child support groups provide another excellent vehicle for promotion of birth spacing and family planning. Again, a special focus will be on LAM, reinforcing

messages for exclusive breastfeeding to six months and the difference between exclusive breastfeeding and LAM. VHEs will be trained to educate mothers regarding the correct use of LAM as a modern contraceptive method. Printed materials on family planning will also be available. The groups will be designed to allow women to share experiences, information, and resources in a lively and appropriate socio-cultural context. Users of modern methods of contraception will be encouraged to share their experiences with others in the group. The involvement of mothers-in-law in these groups, and in the other high impact activities, will contribute to family support for contraceptive decisions.

***Quality assurance for family planning:*** Quality assurance of health worker performance will be assured through the use of standard tools already developed under the USAID/JSI project and approved by the MOH, including job aids and supervisory checklists. Quality of VHE performance will be assured through the use of job aids (e.g., counseling cards) and other simple tools. VNMs and AlbRC District Health Coordinators supervising VHEs will use supervisory checklists. To improve knowledge and practice, VNMs and VHEs will receive quarterly project newsletters focusing on critical topics related to family planning benefits and modern methods of contraception. It is anticipated that additional quality assurance tools and mechanisms will be developed following the Senior Liaison (M&E) officer's participation in the "Quality Assurance Management for Developing Countries" course in Baltimore in June 2004.

***Contraceptive Distribution and Logistics Management Information System (LMIS):*** Through the Reproductive Health Law, ratified June 2002, the Government of Albania takes a rights-based approach to reproductive health. A Contraceptive Security Commission has been established under the Chairpersonship of the Vice Minister of Health. The commission is charged with extending the Logistics Management Information System (LMIS) throughout each district of Albania. The overall intent of the LMIS can be summarized as follows: To ensure the supply of the 1) right goods; 2) in the right quantities; 3) in the right condition; 4) in the right place; 5) at the right time; and 6) at the right cost.

ARC will interfere in District, commune Health Center (HC) and village ambulanca to expand and strengthen LMIS by providing technical assistance. The Deputy Program Manager of ACSP is a former JSI member, and one of three national LMIS trainers, with expertise in this field. Through technical assistance at the Primary Health Directorate, the ACSP will expand the number of commune HCs that will be supplied with contraceptives. At the commune HC level, the project will assist GPs supervising VNMs, to supply VNMs with contraceptives that can provide to their clients at the village level. Project staff will also work with VNM and GPs at commune HC to encourage correct and timely reporting to local health authorities responsible for FP issues.

***Contraceptive commodity supply:*** Under the current agreement between the United Nations Population Fund (UNFPA) and MOH, UNFPA is responsible for purchase, storage, and distribution of all family planning commodity supplies to the district level. MOH manages the system of utilization (LMIS). This agreement goes through 2005 and is expected to be renewed through 2010 when the MOH is supposed to be taking over responsibility for contraceptive commodity supply. HFA findings indicate some stock shortages in family planning products at some SDPs. Strengthening the Logistical Management Information System (LMIS) will

improve family planning commodity supply. The LMIS ensures the management, recording, and distribution of contraceptive supplies. It serves to coordinate the activities at the levels of the family planning SDPs, District Public Health Directorates, and the MOH, in collaboration with UNFPA. UNFPA is also developing the central/district warehousing and distribution system, which is expected to increase the availability of reproductive health services and commodities at the PHC level.

**Family planning sustainability plan:** Working with the MOH, District Public Health Directorates, and national and international partners (UNFPA), the project will develop a sustainability plan for family planning before EOP.

### ***E.3 MONITORING AND EVALUTION (M&E PLAN)***

The project's M&E plan is still in development. Next steps include the following:

- AmRC TAPE Unit will provide technical assistance for M&E tool development and monitoring plan to project's Senior Liaison (M&E) Officer (week of May 24, 2004) at AmRC NHQ in Washington, DC – focus of TA will be on developing simple tools for capturing key data for tracking progress and measuring results;
- Senior Liaison (M&E) Officer will participate in “Quality Assurance Management for Developing Countries” course<sup>43</sup> at Johns Hopkins University School of Public Health (June 7-18) in Baltimore, MD;
- Qualitative inquiry (“Grandmother Approach”) to be carried out in early August 2004 will inform development and refinement of community monitoring tools;
- Design of M&E tools will be finalized by October 2004;
- M&E and monitoring plan will be reviewed at M&E workshop to be held in November 2004.

**Current disease surveillance and health information system (HIS):** The ACSP seeks to strengthen existing systems and will work with the District Public Health Directorates to build capacity in the community to feed into the existing MOH health information system.

**ALERT:** MOH has an effective (syndrome-based) surveillance system called ALERT, developed to track cases of infectious diseases, including respiratory infection, diarrhea, jaundice, and fever. Each week, community health centers, polyclinics, and hospitals provide information on these and other epidemiological diagnoses to the District Public Health Directorate and IPH, where they are incorporated into the national ALERT system.

A second (disease-based) surveillance system for infectious disease is the 14SH, a monthly report on the occurrence of 73 conditions reported by healthcare facilities, laboratories and doctors. Information from the 14SH feeds a national database. Critics of this system note that some infectious diseases are diagnosed without lab confirmation, as some healthcare facilities do not have adequate lab supplies.

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<sup>43</sup> Course fee and accommodation for this course is being provided through the generosity of Prof. Gilbert Burnham at the JHU Bloomberg School of Public Health.

Data from these surveillance systems are used to follow the epidemiological situation in the country and to evaluate the impact of health interventions. For example, 14SH and ALERT systems indicated a dramatic decrease in the incidence of Rubella measles in the general population, after the 2000-2 national vaccination campaigns that targeted children 1-14 years old and women 15-35 years old.

The project will work with IPH and the District Public Health Directorates to identify ways in which the ALERT system might be strengthened through community-level surveillance.

***Health Information System (HIS):*** The MOH health information system (HIS) is set up to report vital statistical data, maternal and child health (MCH) data, and additional infectious disease surveillance data. VNMs working at the village/rural ambulance level are currently a primary source of this data. These VNMs report MCH data monthly to supervising medical doctor/general practitioners (GPs) at commune health centers. They also submit immunization data that are first checked by the GPs. Following this, the data is submitted directly to District Epidemiologists. The District Epidemiologist compiles and revises all immunization data for the district and sends copies of quarterly immunization reports to the National Expanded Program for Immunization (EPI) Coordinator at IPH and to the District Public Health Director.

For antenatal care, village nurse midwives track pregnant women in their villages and report data for each woman, including mother's name, age, anticipated delivery date, and notes on blood pressure, weight, danger signs, if any, and referral information. The nurse midwives submit reports of number of pregnancies, maternal deaths, antenatal visits, and notes on a monthly basis to the supervising GPs at the commune health centers, who open new records for each pregnancy that include all the above information. The HIS does not currently capture information related to maternal nutrition (e.g., weight gain and trend tracking, whether counseled about diet, workload, and rest), iron/folate supplementation, breastfeeding initiation, or post-partum care. The project will work with the District Public Health Directorates to enhance data capture that include all pertinent information relevant to project indicators.

In the area of child health, village nurse midwives maintain rosters and records of all children 0-23 months in the village. These records include date of birth, growth monitoring (when scales are available), and vaccinations given. VNMs report monthly on number of new births in the village, although a majority of deliveries (90%) take place in health facilities. At the level of the commune health center, GPs keep records of sick child visits by age that are reported to the Health Insurance Institute on a monthly basis. On a quarterly basis, GPs submit birth and mortality data (including whether home or facility), as well as information related to birth defects and pathologies, to Mother and Child Health Inspectors at District Public Health Directorates. The Mother and Child Health Inspectors organize this data by urban and rural classifications and submit it in a quarterly report format to MOH, where it is further compiled with national data and included in the MOH annual report. The HIS system is functional but in need of strengthening and will benefit from incorporation of more comprehensive village-level data.

For family planning (FP), information is tracked through the logistic management information system (LMIS) that is fully operational in Mat and Bulqize, and partially functional in Diber (where there are only three existing FP SDPs). The current LMIS system is set up to track

distribution of modern methods of contraceptives down to the level of the commune health center. In some communes of Mat and Bulqize, GPs are currently giving family planning products to village nurse midwives for distribution at the village level to continuing clients (not new acceptors). New users are referred to the commune health centers. VNMs report to GPs, who maintain records of number of FP visits, number of FP consultation sessions, number of users, and number of FP contraceptive methods supplied at the beginning of the month, and stock available at the end of the month. Confidential client records are kept for acceptors. The Mother and Child Inspector in the District Public Health Directorates receives information from the commune health centers and other family planning SDPs about numbers and kinds of contraceptives distributed, stock available, and number of users, including new acceptors. The Inspectors compile comprehensive reports for the district that are sent to the Maternal and Child Health Department at MOH. The LMIS system is functional but in need of strengthening and will be extended to capture village level activities.

The ACSP will work with the District Health Directorates, IPH, and MOH to strengthen the current HIS and complement it with data collected from the community level rather than building parallel data collection:

- *Maternal care information* - strengthen existing HIS data and provide additional data for maternal nutrition (e.g., weights and tracking of trends, iron/folate supplementation) and post-partum/newborn monitoring at the village level;
- *Young infants and children* - strengthen the existing HIS and complement it with appropriate data on routine growth monitoring promotion; ARI and diarrhea case reports from the village level for inclusion in the ALERT system;
- *Family planning LMIS* – provide technical assistance to the District Public Health Directorates to strengthen and expand the LMIS to Diber District.

Neither the formal health system nor the HIS is organized at present to capture prefecture level information. Prefecture level information will be compiled by the project and shared with the District Health Directorate and prefecture level authorities. As the national de-centralization process continues over the next few years, the project will seek opportunities for the ACSP to have an expanded role in development of a prefecture level HIS system.

***Monitoring project activities:*** In order to enhance local learning, participatory approaches will be used to impart M&E skills and promote the use of data for decision-making at local levels.

Participatory approaches were applied during project start up activities (KPC/HFA baseline assessments; KPC feedback meeting and results review; DIP Workshop and indicators review), where stakeholder input was sought and used for setting priorities, designing strategies, and creating feedback mechanisms. The AlbRC has successfully used needs assessments, Project Planning Process (PPP), and Participatory Rural Appraisal (PRA) approaches in four remote project areas in Albania. These tested PRA methodologies will be adopted and used at community level. It is expected that the qualitative inquiry to be carried out in August 2004 will also add value to the project M&E system and tool development.

In November 2004, the project will organize an M&E workshop to facilitate participatory review of project M&E tools, including supervisory checklists, job aids, and other quality assurance

(QA) instruments to capture household and community level activities. These tools will then be field-tested by the project staff in collaboration with AlbRC district health coordinators and local partners.

The IMCI National Coordination Group (WHO, MoH, UNICEF, Pediatric Cathedra in Faculty of Medicine, Tirana University, and the ACSP team) will provide input and technical assistance in developing tools for monitoring IMCI community and facility based indicators. Teams composed of project staff, AlbRC District Health Coordinators, and representatives of the District PH Directorates, including GPs from commune health centers, will make periodic direct observations of VNM practice in the villages. For that purpose, the existing facility IMCI observation checklist will be adopted to monitor, not only case management of sick children and counseling in facilities, but also outreach activities and counseling on infant and young child feeding, community management of diarrheal episodes, recognition of danger signs, and family planning. For community indicators for key household practices, checklists will be developed by the project team and field-tested.

Additional monitoring tools will be developed following the FP population-based survey and qualitative inquire.

***Data collection/project plans for ongoing assessments:*** Facility-based records for family planning and maternal and child health, and tools developed by the project will be used to obtain monthly and quarterly data.

To collect baseline data for project indicators, a population-based KPC survey was conducted and complemented with a community mapping exercise and health facilities assessments. (These assessments and key findings are described in earlier sections of the DIP.) The project will also carry out a population-based family planning survey in August 2004 to identify knowledge and beliefs with regards to FP. Also, in August 2004, the ACSP will conduct a qualitative study (“Grandmother Approach”) to learn more about key household attitudes, beliefs, and practices related to family planning and child health (e.g., child caring, infant and young child feeding, illness prevention, illness recognition, home care, appropriate care seeking, treatment compliance). This qualitative inquiry will focus on the role of senior women (e.g., mothers-in-law) and other community decision-makers. Results of this qualitative study will inform development of the C-IMCI+ package (e.g., training curriculum, behavior change strategy, and key messages). It is envisioned that the qualitative inquiry will generate ideas for leveraging the wisdom and influence of senior women and exploiting traditional socio-cultural channels for transmitting information (e.g., mother-in-law to daughter-in-law).

At midterm (in Year III of the project), a *participatory midterm evaluation* will be undertaken to review strategies, processes, project data and documentation, and stakeholder input and develop recommendations for improvement. It is envisioned that this will be a participatory evaluation, guided by involving all team members and partners, with significant contributions from end-users and community members in the prefecture.

A final evaluation will be conducted during the last quarter of the project (around August 2008), following population-based endline surveys and health facility assessment. The final evaluation

will review endline values for project indicators, documentation, and other results and assess outcomes and possible impacts generated by the project.

***Process to determine population denominator:*** Equity is an important consideration. VNMs keep up-to-date rosters for all pregnant women 0-23 months and children in the village. Meanwhile, the civil registration office maintains lists of births and deaths, and statistics for the reproductive age population. In addition, the community mapping tools will be used to track number of households and locations in the catchments area. The project intends to train VNMs and VHEs in all villages to ensure C-IMCI+ coverage of the entire target population. Given the small size of most villages in Diber Prefecture, and by using the above mentioned information, it is expected that all beneficiaries will have an opportunity to participate in the project.

***System for data collection/participation in the data collection/how data will be used:*** The VNMs and VHEs will be the first line data collection source through weekly and monthly home-visits and other community based activities. The VNM will have a crucial role in supervising the VHEs information to ensure data quality, and will include the information in the monthly meetings which will be sent to supervising GPs at the commune health centers. AlbRC District Health Coordinators (DHC) will make supervisory visits, visiting each village at least quarterly. The DHC will also participate in monthly meetings at the commune health centers to cross check data provided by the VNMs and VHEs. The Senior Liaison (M&E) Officer and other project staff responsible for technical oversight will review the quality of data and ensure that they are entered regularly in the database to be developed during the first year of the project. Feedback will be provided through the quarterly project newsletter to be distributed to all PHC providers in the districts, as well as to the District Public Health Directorates and key stakeholders. The main counterpart for M&E at district level will be the Mother & Child Inspector who already reviews MCH and FP data. Copies of all reports will be shared and analyzed with district health authorities and GPs during the quarterly meeting. Data will be compiled and organized for presentation at meetings of the Project Advisory Group and will be shared at regular meetings of the IMCI National Coordinating Group (UNICEF, WHO, MOH, Pediatric Cathedra, ACSP). Results from baseline surveys and other studies will be made available to the local and international community.

***Methods that will be used to monitor and improve the performance of health workers, quality and coverage:*** For trainings, simple and participatory pre- and post-tests will be designed and used to assure quality, measure learning, and evaluate teaching. For service delivery, quality will be assured through use of standard protocols and use of tools such as supervisory checklists, job aids, and client satisfaction surveys. The ACSP has requested technical assistance through the AmRC TAPE Unit for development of M&E and QA tools; and the Senior Liaison (M&E) Officer will be participating in the Johns Hopkins University “Quality Assurance Management for Developing Countries” course in June 2004.

***How M&E skills of local staff and partners will be assessed and strengthened:*** The project aims at applying a participatory M&E approach by involving the local partners and health staff in the process. The HFA and KPC baseline surveys were new experiences for both project staff and local partners who were involved in all steps. Results from the surveys and project indicators were discussed during the KPC feedback meeting, DIP workshop, and in one-to-one meetings with stakeholder and partners. The local health officials gave constructive feedbacks and

prioritized project interventions and indicators for themselves. The baseline surveys are anticipated to build a continued collaboration for the ongoing M&E activities.

The AlbRC District Health Coordinators will carry out routine monitoring visits of nurse midwives and VHEs in close collaboration with the GPs from the commune health centers, strengthening the AlbRC capacity to use quality assurance and performance monitoring tools. Participatory approaches used at community level are expected to build the capacity of community to identifying and problem solving.

Also, the FP baseline, midterm evaluation, endline surveys and the final evaluation will ask for close collaboration of partners and meanwhile strengthen their capacity to monitor and analyze data collected.

### ***E.3.1 - OPERATIONS RESEARCH***

***Operations research #1: “Grandmother Approach” qualitative inquiry:*** The C-IMCI+ behavior change and communication approach will be fine-tuned during and following the “Grandmother Approach” qualitative inquiry led by Judi Aubel planned for August 2004. This qualitative inquiry will 1) analyze and document the role of the mother-in-law and other family decision-makers in promoting the health and well-being of infants and children in Diber Prefecture and recommend strategies for influencing their health-related practices; 2) strengthen the capacity of the AlbRC to conduct qualitative research and collaborate with senior women as key actors in community health programs; 3) adapt a methodological tool that can be shared with other NGOs and PVOs working in Albania.

***Operations Research #2: The use of male VHEs at the village level:*** During the recruitment of VHEs, every effort will be made to focus the use of the volunteers in line with the interventions and strategies. Clearly, more women than men will be needed as it is assumed that female VHEs will be able to have more open and freer discussions with other females and females are more often the primary care givers. The same assumption holds true for male VHEs discussing intervention activities with males in the community. The project proposes to select one commune in each district to “monitor” the efficacy of male vs. female volunteers. The project proposes and even 1:1 ratio of female to male volunteer in each village in the selected commune. This may help us to understand the context in which male VHEs can approach community members on topics generally handled by females in the household. There may also be district level differences in community acceptance of education from a member of a different gender.

### ***E.3.2 - PROJECT DOCUMENTATION AND DISSEMINATION***

***Documentation and dissemination:*** The project will document and disseminate results at a number of levels.

***Project Advisory Group:*** For local stakeholders, an important channel for dissemination of data for decision-making will be through thrice-yearly meetings of the project advisory group. This group grew out of a recommendation from the DIP workshop and will meet three times a year to review M&E data, assess progress, identify problems and solutions,

determine priorities for action in the context of the DIP, and make adjustments, as necessary. Membership in the advisory group will include District Public Health Directors, AlbRC Diber Branch Secretary and sub-branch health coordinators, and prefecture authorities, as well as community representation through delegated VNMs and VHEs on a rotational basis. Thrice yearly meetings will allow the advisory group to meet once in Burrell (Mat District), once in Bulqize town, and once in Peshkopi (Diber District). The first meeting of the project advisory group is scheduled to take place in July 2004.

***Dibra Vision website:*** This Peshkopi-based Danish-funded capacity-building project for local governance and community development is establishing an internet website and has invited the ACSP to contribute information about child survival, in general, and its activities and results on a regular basis. There is an internet café with uplinked satellite access at the Cultural Center in Peshkopi and a small internet café in Burrell (Mat District).

***IMCI National Coordination Group:*** As part of the MOU signed by MOH, UNICEF, WHO, and the Albanian Red Cross, the ACSP will participate as a member of the IMCI National Coordination Group that will review national IMCI implementation and provide feedback and technical assistance for developing C-IMCI pilots in other districts (e.g., Elbasan) where IMCI is being implemented. This is a forum where the ACSP project can advocate for further expansion and sustainability of IMCI countrywide and disseminate its experiences for replication. This group will meet 3-4 times per year following the national review meeting scheduled for May 2004.

***Quarterly newsletter for providers:*** One of the findings of the HFA is that VNMs and health workers at the commune level have few opportunities for professional development, including reading materials on topics of interest related to MCH and family planning. The project aims to create, publish, and disseminate on a quarterly basis a 4-6 page newsletter for PHC workers, including VNMs, and VHEs. Each issue will display and explain key M&E information and contain lively, clearly-written articles about important issues and topics relevant to project interventions (e.g., infant and young child feeding, recognition of danger signs, LAM as a method of family planning).

***Monographs:*** The project will identify opportunities to produce and disseminate monographs on topics of interest to the wider child survival community. The first one will be a report of the qualitative inquiry (“Grandmother “Approach”) into household practices for family planning and child health in Diber Prefecture that will take place in August 2004.

***Professional papers and peer-reviewed publications:*** It is one of the ACSP objectives to disseminate results by way at least four professional presentations or publications in peer-reviewed journals over the LOP. The first ACSP paper<sup>44</sup> was presented at the International Conference entitled “Promoting Human Rights and Social Policies for

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<sup>44</sup> Jaffer, M, Waltensperger, KZ Lutz, E, Cenko F, Brasha E, Koduzi G, Ricca J, “Maternal and Child Health Status in Diber Prefecture, Albania”

Children and Women: Monitoring and Achieving the Millennium Development Goals,” organized by the Graduate Program in International Affairs at the New School University and UNICEF, held at the New School in New York April 28-30, 2004. The project has prepared and submitted an abstract for the American Public Health Association conference 2004. Acceptance of abstracts will take place in early June 2004. The project will develop an abstract for a paper to be presented at the first national public health conference to be organized by the Albanian Public Health Forum in January 2005.

### ***E.3.3 - VOLUNTEER RECRUITMENT AND MANAGEMENT***

***Volunteer recruitment and management:*** Volunteer management is a strategic priority of the AlbRC, and the organization is continually looking for ways to maximize volunteer effectiveness. Albanian Red Cross’s strategy for volunteers can be summed up in two simple points:

- Promote volunteering as the best way of mobilizing human solidarity for relieving the pain of people in need;
- Promote volunteering as a method of supporting the emancipation of civil society.

The AlbRC has over 12 years of experience in managing community-based volunteers, and currently has more than 3,000 active volunteers working on various projects and programs in all regions of the country, including approximately 137 in Diber Prefecture. At the district level, VHEs will be co-supervised by village nurse midwives and AlbRC District Health Coordinators, who report to the AlbRC Diber Branch Secretary, ensuring full integration into the AlbRC structure and interface with the formal health system.

In 2002, AlbRC developed *Manuali i Vullnetaritet: Përmbledhje Politikash dhe Udhëzimesh mbi Vullnetarizmin* (Volunteer Manual: Summary of Volunteer Policy and Guidelines, Albanian Red Cross 2003). See Annex 15 for an English translation of the Volunteer’s Manual. The manual provides guidelines and best practices of for recruiting, managing, and retaining volunteers. Volunteers are an essential and indispensable component of the AlbRC, demonstrating community support and involvement by donating time and energy to activities that benefit the community. Volunteers:

- add unique value with their ideas and suggestions;
- contribute time and effort for social change and as an expression of support for their community;
- reduce costs of delivering service to people in need;
- Increase active community participation through families, friends, and associates.

The AlbRC has found that volunteers are much easier to recruit for an active project with very specific responsibilities. The ACSP has already gained a positive reputation and prominent profile in the community through its KPC survey, the results of which were reported to the community and covered in the local media, as well as with local leaders and community members who participated in the DIP workshop.

During the DIP workshop, a working group composed of CCF “mother leaders”, VNMs, ACSP team members, and AlbRC volunteers met to brain-storm criteria for volunteer recruitment for

this project. Also discussed were simple incentives to motivate volunteers and stimulate retention for sustainability. These incentives – that include identification badges, pens, caps and t-shirts printed with key messages, and opportunities for exchange of experiences – have been budgeted (at the approximate value of \$5 per VHE per year). It was recommended that volunteers participate in the selection of the yearly incentive.

The project's C-IMCI+ component will depend on quality services provided by VHEs who will be teamed with VNMs at the village level. As a general rule, the project will seek female volunteers, as females will have best access to young mothers and mothers-in-law in the household. However, the project considers it important to have male volunteers, as well, especially for the family planning intervention, and this will be accomplished in two ways. First, the 60 VHEs assigned to the level of the commune health center will be evenly split between males and females. Second, as operational research, in all the villages of one commune in each district, the project will recruit one male and one female volunteer. This will offer an opportunity to compare and contrast results for child health and family planning and provide valuable lessons as the project unfolds.

Based on lessons learned from past AlbRC projects, VHEs will be recruited using a participatory approach and a cascade process. The project team will visit villages and, in cooperation with the VNM and community leadership, organize community meetings inviting community members to participate and discuss child health and family planning issues, review volunteer recruitment criteria, and nominate two people as VHEs. The recruiting process for a training cycle will take place approximately two weeks prior to commencement of the training.

To ensure that each volunteer becomes sufficiently engaged and feels part of the organization and the project, she/he will receive a copy of her/his job description and will sign an annual agreement with AlbRC. The standard agreement delineates roles and responsibilities of both parties and defines the role of volunteerism in dissemination and protection of the AlbRC image and International Red Cross Fundamental Principles. The AlbRC Branch Secretary will keep a personnel file for each volunteer and reports relevant data to the AlbRC National Volunteer Manager for inclusion in the AlbRC volunteer database. It is envisioned that, during the LOP, this database will become computerized and operationalized at the level of the AlbRC Branch Secretary and can be used as a model for nationwide implementation.

Upon recruitment, volunteers will be informed about their role and duties in the ACSP, the services that they will provide, and the type and dates of trainings that they are expected to attend. In each village, two VHEs will be paired up with VNMs who will lead the village C-IMCI+ team. VHEs and VNMs will be trained together for C-IMCI+ which will promote teamwork and a spirit of mutual support.

In early December 2004, the first C-IMCI+ groups (8 VNMs and 16 VHEs in Bulqize) will be trained in Bulqize where healthcare providers down to the commune level and 80% of VNMs have already been trained in the national IMCI strategy. A plan of activity will be developed each month and the VNM will be in charge of monitoring volunteer activities related to the four high-impact activities (e.g., GMP, young infant support groups, pro-active home visiting, and family planning focus groups). Monitoring and supervisory visits will be performed on a

quarterly basis by AlbRC District Health Coordinators, joined at time by the AlbRC Branch Secretary or sub-branch personnel. Supervisory checklists and other simple and participatory M&E tools and feedback mechanisms will be developed and used to engage volunteers in a positive manner (and not make them feel that they are being “tracked for their mistakes”). This method ensures immediate and constructive feedback to volunteers and is seen as an incentive. Quarterly project newsletters published and distributed to VNMs and VHEs will provide a vehicle for communicating achievements and ideas, lessons learned, as well as educational content about management of child health problems and family planning information. Competitions between villages and shared lessons learned will increase interest in the project.

Strengthening team work of VHEs and VNMs is important to project success and long-term sustainability. The participatory approach in recruiting and retaining volunteers will be refined and documented as an awareness tool to promote unpaid voluntarism and improve community capacity for decision-making and involvement.

#### E.4 - WORKPLAN

**Project Goal:** Improved health status of women of reproductive age and children 0 – 59 months in Dibër Prefecture

**Technical Interventions:** Nutrition and Micronutrients (30%), CDD (20%), ARI (20%), Family Planning (30%)

<b>1. SO-1:</b>	<b>Increased use of MCH and FP services</b>
- IR-1:	<b>Improved service availability and access</b>
- IR-2:	<b>Improved service quality</b>
<b>2. SO-2:</b>	<b>Increased practice of key household behaviors</b>
- IR-1:	<b>Improved household level knowledge and interest</b>
<b>3. SO-3:</b>	<b>Improved sustainability of all activities through partner strengthening</b>

Major Activities:	Time Frames	Personnel Responsible	Benchmarks	Comments/status
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#### NATIONAL LEVEL

##### 1. Collaboration with Ministry of Health:

a. Coordination meetings with IMCI focal point (every two months)	Oct '03 – Sept '08	Program Manager (PM)	Minutes of bi-monthly meetings documented	
b. Coordination meetings with Family Planning/Reproductive Health Department (every two months)	Oct '03 – Sept '08	Technical Officer (TO)		

##### 2. Collaboration with IMCI National Coordinating Group (MOH, UNICEF, WHO, ACSP team)

a. Review Memorandum of Understanding for expansion of IMCI program nationally	Oct '03 - Sept '08	MOH, UNICEF, WHO	MoU reviewed and signed by parties	
b. Participate in bi-annual meetings (twice a year)	Oct '03 – Sept '08	PM&TO of ACSP	Minutes of bi-annual meetings documented	
c. Annual IMCI review meeting	Jun '04 - Sept '08	MOH ACSP WHO UNICEF	-Review meeting carried out -Present the C-IMCI+ Dibër model at the meeting	

<b>3. Collaboration with Albania Public Health Forum (APHF)</b>				
a. Review Memorandum of Understanding of APHF	Dec '04	Program Manager (PM)	MoU reviewed and signed by parties	
b. Participate in meetings and advocacy for C-IMCI+	Mar '04- Sept '08	PM&ACSP Deputy Manager (DPM)	Minutes of meetings and conclusions	
c. Develop and present professional paper(s) at first APHF national meeting	Jan '05	PM & DPM	Paper(s) presented to the APHF meeting	
<b>4. Advocacy for nutrition and micronutrients</b>				
a. Secure external resources for national PROFILES <i>Assessment</i>	Oct '06 – Sept '07	PM&DPM	Marketing document regarding national PROFILES assessment	
b. Review vitamin A policies and protocols	Oct '06 – Sept '07	TO	Protocols reviewed reported	
<b>5. Strengthen AlbRC partner</b>				
a. AlbRC develop 2005 -2009 strategy	Nov '04	AlbRC	AlbRC 2005 -2009 strategy in place	
b. AlbRC assumes 100% of salary of NHC by Feb '07	Mar '04-Mar '07	AlbRC	100% of NHC salary assumed by AlbRC Mar. '04 – Mar. '07	

#### **DISTRICT LEVEL**

1. DIP workshop in Peshkopi	Mar '04	PM DPM M&E	DIP workshop events and results summarized and reported; DIP report	
2. Hire AlbRC District Health Coordinators	May-Jun '04	PM Albanian Red Cross National Health Coordinator (AlbRC NHC)	AlbRC District Health Coordinators hired	

3. Translate DIP summary	Jun '04	PM&DPM	DIP summary translated	
4. Create ACSP Advisory Board:	Jul '04	PM&DPM	ACSP Advisory Board in place	
a. Thrice yearly meetings and project activities review	Aug '04 - Sept '08	PM&DPM	Minutes of thrice yearly meetings documented	
b. Involve advisory board members in project M&E activities (e.g. quarterly supervisory visits)	Aug '04 – Sept '08	PM&DPM	Participation of Advisory Board members reported and recorded	
5. Technical assistance to District PH directorates to improve HIS, supervisory and monitoring skills (improve data collection and ability to work with data):	Oct '03 - Sept '08	PM&DPM	LMIS extended Supervisory and monitoring tools in place	
a. Compile quarterly data reports to share with District PH Directors in quarterly meetings	Feb '05 – Sept '08	PM&DPM	Quarterly reports sent to PHD	
6. Involve District PH Directorates in quarterly monitoring visits of VNMs and VHEs	Jan '05 – Sept '08	PM&DPM	Participation of DPH Directorates reported and recorded	
7. Develop FP sustainability plan	Oct '07 – Sept '08	PM&DPM&TO and DPH Directorates	FP sustainability plan in place and documented	

**FACILITY LEVEL (Village ambulanca/VNMs; Commune Health Center, Maternity, Women Consultancy Center, FP Center):**

1. Revise Family Planning curriculum	Jan '05	DPM FP Dept. of MOH	Family Planning curriculum revision reported	
2. Update FP counseling cards	Jan '05	DPM FP Dept. of MOH	Updated FP counseling cards in place	

3. Train VNMs in FP	-Dibër: Apr '05 - Mat: Mar '05 - Bulqize: Mar-Apr '06	DPM/PM/TO	279 VNMs trained in FP	
4. Train providers in antenatal clinics and maternities in essential actions for nutrition and micronutrients	-Dibër: Feb '05 - Mat: Feb '05 - Bulqize: Feb '06	DPM/TO	81 Providers working in antenatal clinics and maternities trained	
5. Train VNMs in IMCI	- Dibër: Oct-Dec '04 - Mat: Apr-Jun '05	MOH PM TO	217 VNMs trained in IMCI	

#### COMMUNITY/HOUSEHOLD LEVEL:

1. Develop and document C-IMCI+ model	May '04	PM & DPM & TO	C-IMCI+ model developed and documented	
2. Develop C-IMCI+ curriculum	Jun- Jul '04	PM & DPM & TO	C-IMCI+ curriculum developed	
3. Design curriculum for C-IMCI+ TOT	Aug – Sept '04	PM & DPM & TO	Curriculum for C-IMCI+ TOT designed	
4. C-IMCI+ TOT	Nov '05	PM & DPM & TO	12 Trainers trained	
5. Participatory community meetings and recruitment of VHEs	Nov '04 – Sept '08	PM & DPM & TO	VHEs recruited and minutes of meetings recorded	
6. Develop training materials and job aids	Oct '04	DPM & TO	Training materials and job aids developed	
7. C-IMCI+ training of VHEs and VNMs	Dibër	PM & DPM & TO	760 VHEs and 279 VNMs trained in C-IMCI+	
	Mat			
	Bulqize			
8. Operationalize C-IMCI+ at village level (community mobilization):	Jan '05 – Sept '08	PM & DPM & TO	Monthly reports documented	

a. Growth monitoring promotion b. Pro-active home visiting c. Young child support groups d. FP focus group meetings	Jan '05 – Sept '08	VHEs, VNM	-Monthly reports documented -Activities reported	
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## MONITORING & EVALUATION:

### Baseline and endline surveys:

1. KPC survey (baseline)	Oct-Nov '03	PM DPM M&E officer	KPC final report disseminated	
2. KPC feedback meeting in Peshkopi	Dec '03	M&E officer	KPC feedback meeting final report	
3. Community mapping	Dec '03-April '04	ACSP team	Database of community mapping exercise created, reported and used	
4. HFA (Health Facilities Assessment) survey (baseline)	Feb-Mar '04	PM & DPM M&E officer	HFA final report disseminated	
5. M&E Officer participate in QA Management for Developing Countries course at JH University Bloomberg school of PH	Jun '04	M&E Officer	M&E participation at course and Certification	
6. Qualitative Inquiry	Aug '04	PM & DPM & TO M&E officer	Qualitative Inquiry final report	
7. Family planning baseline survey	Aug-Sept '04	PM & DPM & TO M&E officer	Family planning baseline population based survey- final report	
8. Develop QA tools and M&E tools	Oct – Nov '04	M&E Officer	QA tools developed	
9. Develop M&E Plan	Oct – Nov '04	M&E Officer	M&E plan developed	

10. Develop M&E database	Dec '04	M&E Officer and TO	M&N database developed and functioning	
11. M&E Workshop	Nov '04	M&E officer	M&E workshop final report	
12. AlbRC National Volunteer Management database set up in Dibër Local Branch	Sept '04	Dibër Branch Secretary / AlbRC National Volunteer Management Coordinator	National AlbRC Volunteer Management database in Dibër Local Branch set up and functioning	
13. Quarterly monitoring supervisory visits	Jan '05 – Sep '08	District Health Coordinator (DHC) and M&E Officer/ACSP team	Quarterly supervisory checklist filled up	
14. C-IMCI+ teams functioning (monthly data-reporting)	Jan '05 – Sep '08	VHE, VNM, DHC, AlbRC Dibër Branch Secretary and AlbRC NHC	Monthly data reported	
15. Bi-monthly (every two months) update of Volunteer Management database	Jan '05 – Sep '08	AlbRC Dibër branch Secretary, DHC	Database updated	
16. Midterm evaluation	May – Jun '06	ACSP team	Midterm evaluation report	
17. HFA (Health facilities Assessment) survey (endline)	Apr – May '08	ACSP team	HFA final report disseminated	
18. KPC/FP endline survey	Apr -May '08	ACSP team	Population based survey final report disseminated	
17. Final evaluation	Jul-Sept ' 08	ACSP team PHD managers	Final evaluation report	

<b>Documentation/Dissemination</b>				
1. Monograph from Qualitative Inquiry	Dec '04	ACSP team	Monograph report	
2. Develop four papers or published articles	April '04 – Sep '08	ACSP team	Papers published and presented	
3. Develop and distribute quarterly ACSP newsletter	Oct'04- Sept '08	DHC/DPM/TO	At least 4 newsletters distributed to VHEs and VNMs	
4. Operational research on male vs. female volunteers	Jun '08	PM & DPM	Research results reported	

