

**REPORT
KNOWLEDGE, PRACTICES, AND COVERAGE
BASELINE SURVEY IN DIBER PREFECTURE,
ALBANIA 2003**

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KPC SURVEY REPORT
Albania Child Survival Project
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LIST OF ACRONYMS

ACSP	- Albania Child Survival Project
AED	- Academy of Educational Development
AlbRC	- Albanian Red Cross
ARC	- 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 +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
HH	- Household
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 Amenorrhea 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
ORT/ORS	- Oral Rehydration Treatment/Solution
PCV	- Peace Corps Volunteers
PHC	- Partners for Health Reform plus
PHCD	- Primary Health Care Directorate
PHD	- Public Health Directorate
PHR+	- Partnership for Health Reform
PPP	- Project Planning Process
PPS	- Population Proportional Size
PRA	- Participatory Rural Appraisal
PSI	- Public Service International
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

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EXECUTIVE SUMMARY

Introduction The Albanian Red Cross in collaboration with the American Red Cross has launched a five-year USAID centrally funded project in Diber prefecture in the northeastern part of Albania.

ACSP Goal

The Albanian Child Survival Project's (ACSP) goal is to empower individuals, families, communities, and village midwives to improve the health of children U5 and women of reproductive age in the Peshkopi, Bulqiza, and Mat districts of the Diber Prefecture through targeted interventions that address the leading causes of childhood deaths (malnutrition, diarrhea, ARI) and increase the access and utilization of high-quality FP/RH services.

Objectives and Intervention Activities

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

1. **Nutrition** (30 percent) To reduce morbidity and mortality associated malnutrition through breastfeeding promotion, nutrition education, vitamin A supplementation promotion, and increased iodized salt consumption.
2. **Management of the Sick Child:** (40 percent) To reduce diarrheal and ARI-associated morbidity and mortality through prompt and appropriate case management by treating all episodes at home with fluid and dietary management, recognizing danger signs with appropriate referral, and using sanitation measures to prevent diarrhea.
3. **FP/RH** (30 percent) To improve RH through iron supplementation during pregnancy, promoting first prenatal visits during first trimester, and increasing FP knowledge and awareness and use by both men and women.

Program objectives of the proposed interventions

Nutrition (30 percent effort)

1. Increase the percent of children exclusively breastfed up to 6 months from 9 percent to 30 percent
2. Increase the percent of mothers who introduce complementary foods at 6 months from 24 percent to 43 percent.
3. Increase the percent of HH that use iodized salt from 48 percent to 56 percent.
4. Increase the percent of children U5 who received a dose of Vitamin A in the last 6 months from 7 percent to 20 percent.

Management of the sick child (40 percent effort)

1. Increase the percent of children U5 who received increased fluids and continued feeding during an illness during the past 2 weeks from 47 percent to 63 percent.
2. Increase the percent of children U5 who had diarrhea in the past 2 weeks who were treated with ORS or appropriate HH solution from 35 percent to 60 percent.
3. Increase the percent of mothers with children U5 who know at least 2 signs of childhood illness that indicate need for treatment from 60 percent to 72 percent.

FP/RH (30 percent effort)

1. Increase percent of women who do not want a child in the next 2 years who are using modern FP methods from 8 percent to 17 percent.
2. Increase the percent of women who received a prenatal visit during the first trimester from 18 percent to 29 percent.
3. Increase the percent of women taking iron/folate supplements during their last pregnancy from 10 percent to 28 percent.
4. Increase the percent of men who can name at least 2 outlets for obtaining FP services from 25 percent to 63 percent.

Methods The questionnaire used for the KPC survey has been adapted from the KPC 2000+ manual, while the complementary feeding section was drawn from International Food Policy Research Institute (revised September 2, 2003). The survey population were mothers with

children aged 0-23 months (born in the interval from November 1, 2001, until October 31, 2003) living in the prefecture of Diber (in all three districts of this prefecture). The calculation size was based on the expected prevalence drawn from the MICS survey implemented in 2000¹. The survey was conducted with a larger sample size than what is normally recommended for 30 cluster surveys. This was to ensure that enough children are included in the sample size, based on the large number of children that are stunted. As explained from the methodology section below, 600 children 0-23 months belonging to 30 clusters were selected from the whole prefecture--divided equally in all three districts. Thus, 10 clusters (equal 200 children 0-23 months) were selected from each district (each cluster was composed of 20 children 0-23 months). Although the districts differ in total population size, the cluster number per district was not defined PPS (proportional population size). Each district's samples had to be large enough to compare significantly the indicators value among them. Villages and towns made up the sampling list.

First stage: The selection of living areas was done randomly PPS, i.e. the biggest living areas (such as the district center) had more chance to have more than one cluster selected. Ten living areas, relative to ten clusters, were selected randomly in each district.

Second stage: In each living area selected 20 children were selected randomly (5 children were selected as reserve). The sample frame used the list of vaccination records containing all children aged 0-23 months.

During the data collation, every team (composed of two interviewers) was supposed to visit a certain number of children to administer the questionnaire to his/her mother and then to perform the anthropometry measurements of the same child as well as all children 0-5 years found in the household. (Sometimes reserved children were selected because the selected child or the mother was not home.) Only two mothers (out of the total of 569 mothers) refused to respond the questionnaire (refusal rate only 0.4 percent). One supervisor supervised two to three teams/per day, and it was his/her responsibility to ensure the quality control and that the visits of appropriately selected households were made.

Data entry was performed immediately after the data collection using the EpiInfo v. 6.04. The analyses were done using the same software package, while for the calculation of anthropometry indexes used the EPINUT (a module of EpiInfo v.6.04).

Results *The socio-economic and demographic* situation of the households where children 0-23 months were selected is described from:

- Forty-two percent of households had water piped into the house; 54 percent indoor used a flush system
- Two major employment categories of the fathers were migrant worker-31 percent, unemployed 31 percent
- Only 7.5 percent of mothers work outside home and 71 percent of them do administrative work
- More than two third of mothers had completed obligatory school (middle school) and one fourth completed high school.

¹ Multi Indicator Cluster Survey implemented nationwide by UNICEF in Albania in 2000

- In 26 percent of households 1-4 persons slept in the house the previous night, and 70 percent of the households contained 5-10 persons

The age distribution of our sample was 21 percent were 0-5 months; 27 percent were 6-11 months; 25 percent were 12-17 months; and 27 percent were 18-23 months

Immunization: It should be noted that the relative findings, as listed in the result section of the report, was based on the mother's memories—as many did not remember to bring their health cards with them to the health facility.. The vaccination card is not expected a complete record of all the antigens given to the child, due to the frequent fact the mother did not always remember to bring it when the child was brought vaccinated. Additional data, such as from vaccination registers could not be obtained due to time and logistic constraints.

Anthropometry: Stunting is a consequence of sub-optimal intra-uterine nutrition and poor feeding and repeated infections in early childhood. Results of the baseline population-based KPC survey indicate that 18.6 percent of *children under five* in Diber Prefecture are stunted. The proportion of children underweight in the prefecture is 14.3 percent and the proportion of children wasted is 14.3 percent.

Immediate breastfeeding: At a behavioral level, the KPC survey reveals sub-optimal breastfeeding practices in the prefecture. Although 90 percent of births in the prefecture take place in health facilities, and 98 percent are attended by trained health workers; only 31 percent of neonates benefit from the initiation of breastfeeding within the first hour after delivery.

Exclusive breastfeeding: KPC results for the prefecture reflect exclusive breastfeeding rates as follows: 64.1 percent for children 0-1 months; 45.3 percent for children 0-3 months; *34.3 percent for children 0-5 months*. 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.

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

Complementary feeding: KPC findings for complementary feeding suggest more positive household behaviors than for breastfeeding. However, given rates for stunting, underweight and wasting; and given discrepancies with MICS results; the project team is not confident that the KPC findings reflect actual practices at the household level in the 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 the quality, quantity, and frequency of foods given for reasons of pride and socio-cultural expectations.

Nutritional management during illness: The KPC survey (with 569 mothers sampled) found that half (50.3 percent) of all children 0-23 months had been sick in the past two weeks. Of these, only a third (33 percent) had been offered the same amount or more fluid or food during the illness. However, 93.9 percent had been offered increased food and fluid during recovery from

the illness. Of the children who were reported sick in the KPC, only a third (33 percent) had been offered the same amount or more fluid or food during the illness, compared with the MICS result of 62 percent. The KPC did however show that 93.9 percent of children had been offered increased food and fluid during recovery from the illness.

Use of iodized salt: Only half of all Diber Prefecture households (50.6 percent) surveyed in the KPC use iodized salt for cooking and family consumption. But it should be noted the salt samples were used in quick tests that detected the presence for iodine/iodate but not the actual level.

Antenatal and Postpartum Care management: While 86.6 percent of mothers in the prefecture had at least one antenatal visit during most recent pregnancy, less than 10 percent received iron or iron/folate supplementation. Of those that were supplemented, the average duration of iron supplementation was only 35 days. Of those mothers in the prefecture who received antenatal care, only 21 percent reported having been counseled on the importance of diet, workload, and rest during pregnancy. This result varies significantly by district: 44.7 percent in Mat, 11.6 percent in Bulqiza, and 8.2 percent in Diber. Routine post-partum vitamin A supplementation is not currently supported by MOH policies, norms, and protocols; and only 3.6 percent of mothers report having been given supplemented vitamin A following their most recent delivery. Only 20 percent of mothers had postpartum check ups after leaving the hospital. The low rate of knowledge level for neonatal danger signs encountered in mothers has a clear link with the reduction of contact the health workers have with the neonates' mothers (and other parents like grandmothers, etc).

Discussion Many indicators reflect the health of children, especially newborn, that are related with the knowledge level of the communities (their mothers, parents etc). Starting breastfeeding within the first hour after delivery, exclusively breastfeeding, and continuing breastfeeding as recommended should be linked with the health promotion activities from health staff and health volunteers. The high rate of underweight, stunted and wasting conditions shows that the complementary feeding (although the KPC results seems better than expected) needs to be appropriately promoted. Appropriate coverage of the health services as antenatal care is relatively low --30 percent of mothers get their first antenatal visit within the first trimester. The same comment applies to the postpartum visits.

Maternal nutrition during antenatal and postpartum counseling is not amongst the most preferred topics. Iron/folate supplementation, notwithstanding the supporting national policy, was found at a very low level. Vitamin A supplementation both for mother (in the postpartum period) and for children was verified in a very low proportion of our sample.

Stratification of the sample by residency of children's living areas for statistical findings (urban versus rural). This additional analysis helps to target better the problem areas. Health staff in rural areas do not provide adequate coverage of the recommended topics during antenatal and postpartum counseling check ups contrasted to the counseling that urbanmothers receive. These key findings have been found to be similar with other type of assessments such as the countrywide 2000 MICS Survey.

BACKGROUND

The Republic of Albania, located in SE 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 US 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)². Life expectancy is 73.4 years; and the adult literacy rate is 85.3 percent (UNDP Human Development Report 2003).

To quote from an earlier UNDP report (Albania Human Development Report 2000): "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).

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. Currently, the country recognizes 12 prefectures, 36 districts, 64 urban municipalities, and 310 communes³. Over 88 percent of Albanians above 15 years are literate.⁴ The population is largely homogeneous with over 97 percent ethnic Albanians. Approximately 70 percent of the population is Muslim, 20 percent Orthodox Christian, and 10 percent Roman Catholic.⁵ In the Diber prefecture, most inhabitants are Muslim, though religious tolerance is universal. Northern Albania is characterized by a patriarchal society with few freedoms for women, and gender inequalities are common. The family is the key support system, compared to community participation which has weakened after half a century of forced volunteerism. Internal and external migration is a serious issue in the project area. Many women are left alone to fend for their families relying solely on remittances from their husbands working in neighboring Greece and Italy.

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. 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).⁶ Albania's IMR is nearly double that of the Eastern European average (14/1,000). Diber and Bulqiza Districts, two of the districts of Diber Prefecture where the ACSP is being implemented, are reported to have the highest rates of infant mortality in the country, but accurate district-level data is unavailable. Institute of Public Health is undertaking a nation-wide infant mortality assessment, where

² Human Development Report. United Nations Development Programme, 2003.

³ Assessment of Social and Economic Conditions of District in Albania. UNICEF, December 20, 2000.

⁴ Multiple Indicator Cluster Survey Report, Albania; UNICEF, December 4, 2000.

⁵ Health Care Systems in Transition/Albania. European Observatory on Health Care Systems, WHO Regional Office for Europe, 1999.

⁶ From State of the World's Children. UNICEF, 2003.

amongst the districts sampled is Diber district. However, according to the Ministry of Health (MOH)/ Institute of Public Health (IPH), the main causes of infant mortality in Albania are respiratory infections, diarrhea, congenital abnormalities, and infectious diseases. Lower respiratory infections (especially pneumonia) and diarrhea are the leading causes of under five morbidity and mortality nationwide and in Diber Prefecture. The District Public Health Directors in Diber Prefecture have expressed concern about high neonatal mortality rates in maternities; but this report requires further investigation and documentation. Malnutrition, with a stunting rate of 17 percent nationwide⁷, is an important underlying cause of infant mortality and morbidity.

Diber Prefecture is an impoverished, rural mountainous area in northeastern Albania spanning 2,356 square kilometers with over 26 percent of the population living in poverty (*income less than \$2 per day*) and 44 percent living in extreme poverty (*income less than \$1 per day*)⁸. Over 72 percent of the active population of Albania is engaged in the small-scale private agriculture⁹. A large proportion of men in Diber Prefecture are working in Tirana, other urban areas, or outside of the country, mostly in Greece or Italy, and supporting families through remittances.

The health service delivery system is centralized, with District Public Health Directorates at the district level. There is no current prefecture level health authority. The Diber Prefecture is composed of the three districts of Mat, Bulqiza, and Diber. Mat comprises 11 communes; Bulqiza 7; and Diber 14, totaling 32 communes in the Diber Prefecture. There are three main urban centers in the prefecture (Burrel, Bulqiza, and Peshkopi) and 279 villages.

The MOH's national surveillance systems (weekly – syndrome based and monthly – disease based) are functioning in Diber prefecture as well. The periodic reports follow the specific flows for each system starting from the reporting unit and after summarized at epidemiological sector 9 (for each district) are sent to Institute of Public Health where these data are inserted into a nationwide database. Both surveillance systems data are used to follow the epidemiological situation in the prefecture, as part of the country, to evaluate the impact after important interventions and to monitor successes achieved. For instance, the Measles Rubella national campaign for children 1-14 yrs and women 15-35 yrs in 2000-2002 has decreased dramatically the reporting level of measles and rash and fever respectively for disease and syndromic surveillance systems.

The current population of Diber Prefecture is 223,606. The project targets approximately 28,906 children under five years old, 63,453 women of reproductive age (15-49 years), and 68,153 men (15-59 years) in the prefecture. It is anticipated that the population will remain fairly stable throughout the LOP, as the official population growth for Albania is estimated at 0.0 percent per year¹⁰, mainly due to immigration.

⁷ MICS 2000. UNICEF.

⁸ Results of Household Living Conditions Survey, INSTAT, 1998.

⁹ Assessment of Social and Economic Conditions of Districts in Albania, UNICEF, December 20, 2000.

¹⁰ U.S. Census Bureau 2004.

Rapid Catch Indicators – Diber Prefecture

#	INDICATOR	Numerator	Denominator	Prefecture (percent)	CI (percent) Prefecture level
1	<i>Underweight</i> Proportion of children aged 0-5 years who are less than 2 standard deviations below the median weight-for-age of the reference population	95	666	14.8	12.0 – 17.5
2	<i>Adequate birth interval between youngest surviving children</i> Proportion of children aged 0-23 months who were born at least 24 months after the previous surviving child	214	289	74.4	69.3 – 79.5
3	<i>Delivery attended by skilled health personnel</i> Proportion of children aged 0-23 months whose births were attended by skilled health personnel	563	569	98.8	97.9 – 99.7
4	Tetanus toxoid coverage Proportion of mothers who received at least 2 TT injections (recall) before the birth of the youngest child less than 24 months of age	369	569	63.5	59.5 – 67.5
5	Exclusive breastfeeding rate 0-5 months Proportion of children aged 0-5 months who were fed breast milk only during the last 24 hours	44	122	34.3	25.7 – 42.9
6	<i>Complementary feeding rate</i> Proportion of children aged 6-9 months who received breast milk and solid or semi-solid foods during the last 24 hours	68	83	81.9	73.4 – 90.3
7	<i>EPI coverage – Fully vaccinated children</i> Proportion of children aged 12-23 months who received BCG, DPT3, OPV3, vaccine before their first birthday (Fully vaccinated) ¹¹	130	177	72.6	65.9 – 79.3

¹¹ Note that this indicator does NOT conform to the Albanian definition of “fully vaccinated”.

#	INDICATOR	Numerator	Denominator	Prefecture (percent)	CI (percent) Prefecture level
8	<i>Measles vaccination coverage</i> Proportion of children aged 12-23 months vaccinated for measles (confirmed by card or mother's recall) ¹²	180	276	64.2	58.5 – 70.0
9	Malaria risk indicator Proportion of children aged 0-23 months old who slept under an insecticide-treated bed net the previous night (in malaria risk areas only)	N.A.	N.A.	N.A.	N.A.
10	Maternal knowledge of 2 child danger signs Proportion of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that require treatment	523	569	89.6	87.0 – 92.2
11	Increased food and fluid intake during an illness Proportion of children aged 0-23 months with an illness in the last two weeks who were offered the same amount or more food and fluids during the illness	85	263	33.0	27.2 – 38.8
12	<i>HIV/AIDS knowledge and Prevention</i> Proportion of mothers of children aged 0-23 months who cite at least two known ways of reducing the risk of HIV infect.	424	569	74.7	71.1 – 78.4
13	<i>Maternal Hand Washing</i> Proportion 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.	178	569	31.0	27.2 – 34.9

¹² Note that measles vaccination is given in Albania to children 12-14 months old

PROCESS AND PARTNERSHIP BUILDING

KPC pre-implementation process: During September through October 2003, along with ACSP start up activities, the KPC pre-implementation preparations were done. The ARC Senior Associate, ARC Senior Liaison Officer and AlbRC National Health Coordinator held meetings with HQ/local branch AlbRC, USAID Mission, MoH and key stakeholders in Tirana and Diber (UNICEF, IPH, IMCI focal point/MOH and local health officials), in order to share the project proposal (English and Albanian) and inform about the up-coming KPC activities. The MoH provided ARC and AlbRC with a Letter of Permission to implement the ACSP and KPC Survey in Diber Prefecture. Meanwhile, letters were sent to AlbRC, MOH, UNICEF, IPH, Albanian Institute of Statistics (INSTAT), JSI, Faculty of Social Sciences and Faculty of Medicine, informing them in details about the KPC Survey and asking them to assist in recruiting survey supervisors. The list of criteria for KPC supervisors was attached to the letters. IPH, JSI, and the Faculty of Medicine provided three supervisors. Requests for interviewers were sent to the Diber RC local branch and the district PH Directors in Mat, Diber and Bulqiza. The AlbRC Logistic Manager in coordination with ARC Liaison Officer and ARC driver developed the logistic plans and AlbRC provided with four drivers and five vehicles.

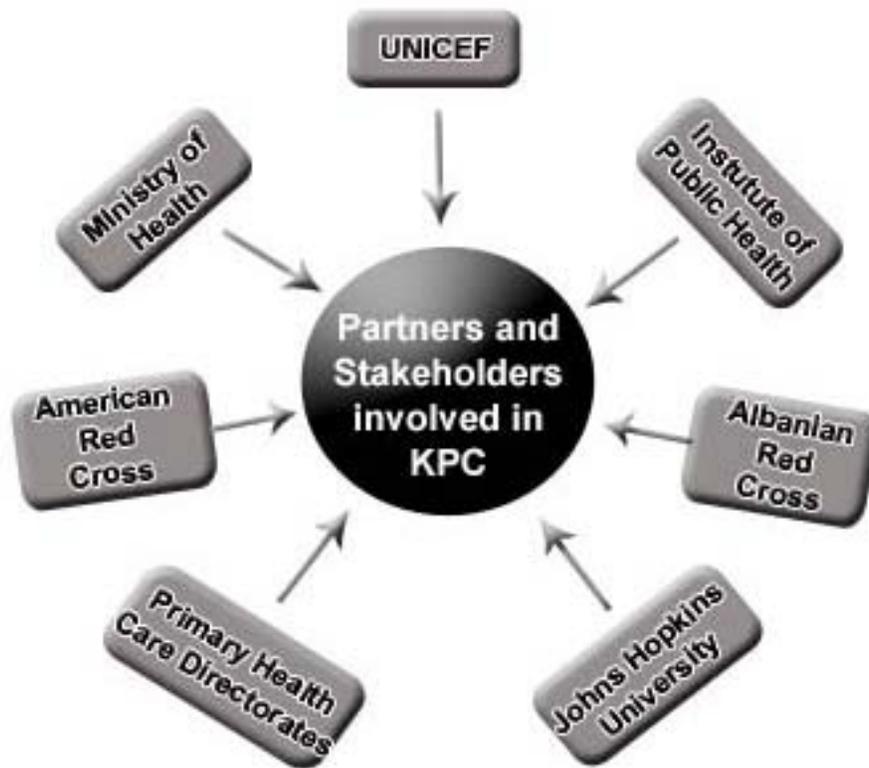
On October 6, 2003, the KPC Coordination Team composed of the JHU Technical Advisor, ARC Senior Associate, ACSP Manager, ARC Regional Health Officer, ARC Liaison Officer, ARC Finance Officer and the AlbRC National Health Coordinator met to discuss the respective roles/responsibilities and to review the survey logistics and management plans.

The KPC Coordinator Team used three days for meeting with stakeholders and partners in Tirana to present and get feedback on KPC methodology and tools. Stakeholders were invited to participate in the training of supervisors. (MOH, USAID/URC, UNICEF, Abt Associates/ PHR+/ Save the Children/Christian Children Funds)

The training of five Supervisors and twenty-nine interviewers was completed with support from Dr. Gilbert Burnham of The Johns Hopkins University, Bloomberg School of Public Health. The interviewers (nurse midwives, GP-s, AlbRC volunteers and community members) were selected by local Red Cross and Health Officials of the PH Directorates. During the training, the draft questionnaire developed by Dr. Burnham was revised by the supervisors and the KPC survey team. Suggestions from Community IMCI focal point /MOH were included in the second draft. The survey team field tested the questionnaire and carried out further modifications to adapt it to the local context. Team members finalized the logistics plan on the last day of the training.

The KPC team traveled to Diber and met with local Albanian Red Cross staff and volunteers (Diber branch secretary, AlbRC Health Coordinators of Diber, Mat and Bulqiza) and local Health Officials (PH Directors Mat, Bulqiza and Diber) to discuss the local partnership, KPC tools and methodology, especially the sampling. The PH Directors provided lists of villages/communes/municipalities, demographic data and contact information. They also facilitated the work of the CS staff to get immunization rosters for children under 23-months old in the selected clusters.

Data Collection: The KPC survey team conducted the interviews from October 27 to 31, 2003. The interviewers conducted 569 interviews in 30 randomly selected clusters. The assistance provided to supervisors and interviewers by the village nurse midwives, who accompanied the teams to find selected households was noteworthy, as it facilitated the data collection. Dr. Burnham developed the EPI info data base and trained the KPC Survey Team on its use.



Data analysis and feedback: The ACSP Deputy Manager and Tirana Office Assistant completed the data entry. They also carried out double entry of a sample of 55 questionnaires that were randomly selected, for data validation. Following preliminary data analysis, the team presented the survey findings at the KPC Feedback Meeting on December 20, 2003 to an audience of 58 stakeholders. This meeting also served as an opportunity to recognize the contributions of KPC supervisors and interviewers who were awarded certificates by representatives of the AlbRC and ARC. The local print and broadcast media covered the event. UNICEF provided salt testing kits for assessing presence of iodine in salt. Dr. Dritan Mema from the University Hospital of Tirana assisted with the process of salt testing, data entry and analysis.

METHOD

Data management and analysis

The KPC Survey Team developed the questionnaire by adopting the generic one in the KPC 2000+ manual, while the complementary feeding section was drawn from International Food Policy Research Institute Report (revised September 2, 2003)

The supervisors checked all questionnaires each day of the interview and at each village to ensure accuracy of data collection, and gave feedback to the interviewers when necessary. A computerized data entry program was developed in EpiInfo v. 6.04 (check file .CHK) to check data for each variable. After the data-entry was completed, another data cleaning was performed ensuring data validation through the double data entry using the specific module of EpiInfo v. 6.04 (VALIDATE DUPLICATE entry). A double entry and analysis of a sample of 55 randomly selected questionnaires showed minor differences among the two entries (due to typos), and thus, were considered not significant enough to warrant a double data-entry of the entire set of questionnaires. Before starting the analysis, each variable was checked for abnormal values or different respondent rates.

Data were analyzed by EpiInfo v. 6.04. Nutritional analysis was performed using *EPINUT anthropometry* (a module in EpiInfo v. 6.04). Through this module, for each anthropometry index (Underweight, Stunted and Wasting) was calculated based on the cut off points on Z-score, Percentiles and Percentage of the Median. Z-scores were used for the determination of those indexes because of 2 major advantages Z-score has: firstly Z-scores allows us to identify a fixed point in the distribution of different indexes and across different ages. Secondly, using the Z-score, useful summary statistics can be calculated from them. On the other hand Z-scores are the statistic recommended for use when reporting results of nutritional assessment.

The age of children was calculated with EpiInfo based on the date of birth, as reported by their mothers, and from the date when the interview was performed.

Sampling Design (Methodology)

The population target for the survey were the mothers with children aged 0-23 months (born in the interval from November 1st 2001 until October 31st 2003) living in the prefecture of Diber (in all three districts of this prefecture). The table shows general data concerning the total population and target population in the target area (following the administrative division). For the assessment of the nutrition status, children aged 0-59 months old, living in the households selected for this survey, were included as well.

District	Diber	Mat	Bulqiza	Prefecture
Total Population	96.774	72.890	52.005	221.669
# of municipalities	1	1	1	3
# of communes	14	11	7	32
# of villages	141	76	62	279
Births per year*	1289	991	896	3176
# of children 24 months	2626	1870	1655	6151

* The average for the last three years birth cohort (2001, 2002 and 2003) has been calculated

Sample size calculation

Because of the Cluster Sampling design applied, in order to determine the appropriate sample size, the formula for simple random sampling was used and then multiplied by two for the design effect:

$$n = g^2 \frac{N * z^2 * p * (1-p)}{d^2 * (N-1) + z^2 * p(1-p)}$$

n= sample size to be determined z= z value (corresponding the confidence interval)

p= expected proportion in the population

d= absolute (desired) precision g= design effect

Specifically for Diber prefecture, over the total population of children 0-23 months (around 6000 children) the consultant from Johns Hopkins University, Dr Gilbert Burnham, calculated the sample size needed to accurately estimate the true prevalence with various margins of error (assuming a design effect equal 2).

ARI

MICS survey = 1.5 percent in past two weeks

With a 2 percent margin of error)

95 percent confidence n=282

99 percent confidence n=486

Assume the true value were 2.5 percent

With a 2 percent margin of error

95 percent confidence n=464

99 percent confidence n = 796

Assume the true value were 3.5 percent

With a 3.5 percent margin of error

95 percent confidence n=210

99 percent confidence n= 364

Diarrhoea

MICS survey = 7 percent in past two weeks

With a 3 percent margin of error

95 percent confidence n=550

99 percent confidence n=942

Assume true value were 5 percent

With a 3 percent margin of error

95 percent confidence n=402

99 percent confidence n=692

Assume true value were 10 percent

With a 3 percent margin of error

95 percent confidence n=760

99 percent confidence n=1394

Use of Modern Contraceptives

MICS survey = 15 percent

With a 3 percent margin of error

95 percent confidence n=1,066

99 percent confidence n=1,807

With a 5 percent margin of error

95 percent confidence n=288

99 percent confidence n=668

With a 7 percent margin of error

95 percent confidence n=200

99 percent confidence n=342

Exclusive breastfeeding

MICS=9 percent

If this were increased to 15 percent, to measure a difference with a cluster survey at

95 percent confidence n=146

99 percent confidence n=250

Correct introduction of weaning foods

MICS=24 percent

If this were increased to 30 percent, to measure a difference with a cluster survey at

95 percent confidence n=394

99 percent confidence n=664

Vitamin A in the past six weeks

MICS=7.4 percent

If this were increased to 15 percent, to measure a difference with a cluster survey at

95 percent confidence n=90

99 percent confidence n=156

Giving the same or increased food and drink to the sick child

MICS=47 percent

If this were increased to 60 percent, to measure a difference with a cluster survey at

95 percent confidence n=132

99 percent confidence n=194

Correct location of ARI treatment

MICS=83 percent

If this were increased to 90 percent, to measure a difference with a cluster survey at

95 percent confidence n=220

99 percent confidence n=380

Changing the underweight status

MICS=14 percent

If this were decreased to 10 percent, to measure a difference with a cluster survey at

95 percent confidence n=572

99 percent confidence n=982

If this were decreased to 9 percent, to measure a difference with a cluster survey at

95 percent confidence n=368

99 percent confidence n=632

If this were decreased to 7 percent, to measure a difference with a cluster survey at

95 percent confidence n=188

99 percent confidence n=324

Changing the level of stunting

MICS=31.7 percent

If this were decreased to 25 percent, to measure a difference with a cluster survey at

95 percent confidence n=368

99 percent confidence n=634

If this were decreased to 22 percent, to measure a difference with a cluster survey at

95 percent confidence n=176

99 percent confidence n=304

If this were decreased to 20 percent, to measure a difference with a cluster survey at

95 percent confidence n=122

99 percent confidence n=210

The results from the Multiple Indicator Cluster Survey (MICS) that UNICEF implemented in Albania in 2000 were used to define the appropriate sample size to demonstrate statistically the differences among districts in the same time and to evaluate changes over time during the project's duration.

The indicators requiring the largest sample size were those relating to stunting. For these a sample size of 600 was estimated to be satisfactory. The sample size issue was calculated to provide an adequate number to demonstrate changes between the baseline and the final survey with statistical significance. This sample size ensured statistical significance for all the other indicators when evaluated in time.

The design used was Two Stage 30-Cluster Sampling Method. Each district was considered as a study unit and the survey was designed, using a two-stage sampling technique; cluster sampling in each district, and simple random sampling for children 0-23 months within each cluster selected during the first stage.

First stage - Selecting clusters from the district

A sampling frame was used the list of all villages for three districts. This list, together with the number of total population by each village (showed as cumulative population column), determined sampling frame. The sampling scheme used for the selection of sampling units from the sampling frame is explained here below:

District	Diber	Mat	Bulqiza
A Total Population	96,774	72,890	52,005
B # of urban centers	1	2	1
C # of villages (rural centers)	141	75	62
D Total living centers (B+C)	142	77	63
E # cluster selected	10	10	10
F # children 0-23 months per each cluster	20	20	20
G Cluster step (A/E)	9,677	7,289	5,200
H starting number (between 1 and G) (<i>randomly chosen</i>)	9,115	2,744	5,054

Each district had 10 clusters with 20 children/cluster = 200 children/district. Within each district the urban and rural clusters were selected based on PPS. The sample of 200 children for each district will ensure statistical significance when the indicators will be compared among districts.

Using the cumulative population information (referred to in the Table above), each cluster was selected. For example the first cluster was in the center where the 9115th person lived, while the next cluster was the one that had $9115 + 9677 = 18,792^{\text{nd}}$ person, and so on.

Second stage - Selecting children 0-23 months from each clusters

To derive the 200 samples per district, each cluster would need to have 20 children 0-23 months of age. A list of all children 0-23 was obtained for each cluster. Immunization records are accurately maintained, and these were used for getting the list of children. For villages with less than the required number of 20 children, a neighboring village was selected. Using the PPS method, each cluster with the list of children were completed, following the random selection of the 20 children using the automatic random number table generated by the EPI 6 software. There were also an additional five children selected to replace those that might not be available at the time of interviews.

Refusal rate from the mothers for participating in the interviews was quite low (2 in 569).

RESULTS AND DISCUSSION

Demographic characteristics of the Sample

Characteristics of the Households

Table 1 below provides selected household characteristics of the survey respondents. Only 42 percent of the household had water piped into the house, with Bulqiza showing the highest percentage (62 percent) and Diber the lowest (43 percent). Yard and public standpipes were found in small numbers (20 percent and 19 percent respectively for the prefecture average). A smaller number of households reported drawing water from springs and boreholes or tubewells (6.5 percent and 12.6 percent prefecture average respectively).

More than half of the households have indoor flush toilet (54.4 percent Prefecture average), Bulqiza having the highest proportion (71 percent). In Diber and Mat the percentage of households with pit latrines is approximately double of those with outdoor flush systems.

The Bulqiza district has the highest proportion of households with indoor flush toilets and piped water in the house

Table 1. Characteristics of the Household

Characteristics	Levels (as percent)				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Source of water					
<i>Piped into the house</i>	31.0	43.4	62.0	42.4	36.2 - 48.5
<i>From standpipe in yard</i>	17.9	22.2	19.3	19.7	12.2 - 27.1
<i>From public standpipe</i>	30.4	8.6	11.8	18.9	10.8 - 26.9
<i>From the spring</i>	3.8	14.6	0.0	6.5	Sample too small
<i>From borehole or tubewell</i>	16.8	11.1	7.0	12.6	4.5 - 20.8
Toilet Type					
<i>Indoor flush system</i>	41.8	59.6	70.6	54.4	48.9 - 59.9
<i>Outdoor flush system</i>	19.0	14.1	6.4	14.5	6.3 - 22.6
<i>Pit latrine</i>	39.1	26.3	23.0	31.1	23.9 - 38.3

One third of all household reported unemployment of the father, while another one third listed the occupation of migrant workers as the primary source of income. See Table 2 below. Mat District had the highest number of unemployment (39 percent), while Diber had the lowest with 30 percent.

Diber (39 percent) reported the highest numbers of migrant workers, while Mat (19 percent) the lowest. Bulqiza had the highest number of of mine and other workers (11 percent) of the three districts mainly because of the presence of a functional mine in that district that provided jobs. This percentage for Mat and Diber is only 1 percent and 0.5 percent respectively.

Seasonal workers (9 percent), private/small businessmen (9 percent) and administrative/clerical job holders (9 percent) made up the other categories of employment.

Table 2. Characteristics of Father's and Mother's employment

Characteristics	Levels (as percent)				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Father's job activity					
Deceased/divorced	0.5	0.0	0.0	0.2	Sample too small
<i>Migrant worker</i>	38.6	19.2	34.8	31.3	24.3 – 38.3
<i>Farmer/agricultural work</i>	3.3	3.0	0.0	2.4	Sample too small
<i>Administrative/clerical</i>	7.6	8.6	11.2	8.8	0.9 – 16.6
<i>Worker/mine laborer</i>	0.5	1.0	11.2	3.2	Sample too small
<i>Other salaried employee</i>	2.2	7.1	4.3	4.3	Sample too small
<i>Seasonal laborer</i>	12.0	8.1	6.4	9.4	1.1 – 17.6
<i>Private/small businessman</i>	5.4	14.1	8.6	9.0	1.2 – 16.8
<i>Unemployed</i>	29.9	38.9	23.5	31.4	24.4 – 38.4
Mother's employment status					
<i>That earn money at work</i>	4.3	10.6	9.1	7.5	5.3 – 9.7
Mother's job activity					
<i>Farmer/agricultural work</i>	0.0	19.0	5.9	7.6	Sample too small
<i>Administrative/clerical</i>	75.0	61.9	76.5	71.0	55.0 – 87.1
<i>Other salaried employee</i>	12.5	9.5	11.8	11.3	Sample too small
<i>Private/small businessman</i>	12.5	9.5	5.9	10.0	Sample too small

The high unemployment rate of fathers correlates with the very low employment status of mothers. In Mat we found that the higher percentage of mothers working outside home to earn money (10.6 percent) compared with 9.1 percent in Bulqiza and only 4.3 percent in Diber district. The administrative/clerical job activity was found to be the most frequent one among the women that were employed; more than two third of all those mothers had a job such Private/small business was found in the same percentage as in the case of the fathers (at the prefecture level), while among the Diber mothers more then twice had these types of jobs compared to those living in Bulqiza district.

Table 3 demonstrates the household number of inhabitants that slept in the house the night before the interview. The number of inhabitants that slept in the previous night in selected households is a standardized question intended to assess the number of household members. The total sub-sample (at district level) if stratified by urban and rural areas, shows that more households have one to four persons who slept the previous night in urban areas versus rural areas--where more households with the number of inhabitants who slept in the house during the previous night was five to ten persons. This was the case for Diber and Bulqiza, while for Mat the percentage of families with respectively one to four and five to ten inhabitants who slept the previous night was very similar if stratified by urban and rural areas. The number of households with more than

10 inhabitants that slept there the previous night for the urban households was zero (0 percent) for all three districts.

Table 3. Characteristics of Household (HH) inhabitants and rooms space

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Inhabitant population in HH					
1-4 persons slept last night	21.2	25.8	34.8	25.9	18.8 – 32.9
5-10 persons slept last night	72.3	71.7	59.9	69.2	64.5 – 73.9
>10 persons slept last night	6.5	2.5	5.3	4.9	Sample too small

The information in table 3 (3/1; 3/2) shows a more traditional family pattern in rural areas, where children, in addition to their parents, usually live with grandmothers, uncles, cousins etc. This is useful information to help better planning during the C-IMCI+ activities from VHE and VNM to approach specific topics in each HH differently in urban and rural areas.

Table 3/1. Characteristics of Household (HH) inhabitants and rooms space in URBAN AREA

Characteristics	Levels (as percent).			
	Diber	Mat	Bulqiza	Prefecture
Inhabitant population in HH				
1-4 persons slept last night	32.5	26.8	46.4	33.9
5-10 persons slept last night	67.5	73.2	53.6	66.1
>10 persons slept last night	0.0	0.0	0.0	0.0

Table 3/2. Characteristics of Household (HH) inhabitants and rooms space in RURAL AREA

Characteristics	Levels (as percent).			
	Diber	Mat	Bulqiza	Prefecture
Inhabitant population in HH				
1-4 persons slept last night	18.1	25.5	29.8	23.2
5-10 persons slept last night	73.6	71.3	62.6	70.3
>10 persons slept last night	8.3	3.2	7.6	6.5

The table 4 shows all the other demographic characteristics of our sample in relation with:

Mother age distribution; ten percent (10 percent) of mothers, at prefecture level, were younger than 20 years, and another 10 percent older then 35 years, while most (80 percent) of the mothers of children 0-23 months were in age group 21-34 years. This distribution was found more or less the same in all three districts.

Number of children per mother; fifty percent (49.9 percent) of the mothers in our sample had only one child (that child was the one enrolled in KPS survey), while the rest of mothers had

more than one living child. Out of this percentage of mothers that had more than one child (51.1 percent) only 4 percent had three or more children. The remaining had only two living children.

Table 4. Characteristics of Mothers, Husbands and Children

Characteristics	Levels (as percent).			
	Diber	Mat	Bulqiza	Prefecture
Mother's age (denominator)				
<21 years	9.8	5.6	11.8	8.9
21-34 years	82.0	80.1	81.2	81.2
35+ years	8.2	14.3	7.0	9.9
Mother's # of biological kids – 1				
1 child	48.9	59.1	39.0	49.9
> 1 child	51.1	40.9	61.0	50.1
Mother's education-denominator				
Elementary	3.3	1.5	3.2	2.7
Secondary	73.9	66.5	66.1	69.6
High	21.7	26.9	27.4	24.8
University	1.1	5.1	3.2	2.9
Child's age (0-23 months)				
0-5 months	20.7	19.7	24.1	21.1
6-11 months	29.9	26.3	21.9	26.8
12-17 months	22.3	21.2	34.2	24.7
18-23 months	27.2	32.8	19.8	27.3
Child's gender (0-23 months)				
Male	50.5	59.1	54.0	54.2
Female	49.5	40.9	46.0	45.8
Next youngest child's age				
< 25 months	41.6	35.7	29.5	37.4
25-36 months	22.5	31.3	28.6	26.8
> 36 months	36.0	31.3	41.9	35.8
Next youngest child's gender				
Male	32.2	33.3	49.5	36.7
Female	67.8	66.7	50.5	63.3
# children ≤ 5 years/household				
HH with only one child ≤ 5 yrs	50.0	58.1	45.5	51.6
HH with two children ≤ 5 yrs	41.3	37.9	44.4	40.9
HH with >2 children ≤ 5 yrs	8.7	4.0	10.2	7.5

Mother's educational level: No mother was illiterate and 73 percent of mothers had finished the obligatory school. Around one third of mothers have finished high school. These percentages are similar in all three districts of the prefecture. The mothers that have a university degree in Mat district are five times more than in the Diber district and almost two times more than the mothers in Bulqiza district.

Children 0-23 months age distribution: Distribution of the sample (children aged 0-23 months), as shown in the table 4, was found to be very similar among different age groups and different districts. The number of children 0-5 months was 25 percent of the total sample, while the percentage of children 0-11 months (first year of life) comprised 47.9 percent of the total sample. Thus, the normal distribution of those age-groups will provide more statistical significance when indicators will be compared among the districts of Diber Prefecture.

Children 0-23 months gender distribution: As was expected, the gender distribution among children 0-23 months was similar (males 54.2 percent and females 45.8 percent).

Next youngest children age distribution: The distribution of the age for the next youngest children, for mothers with more than one child, is related with the family planning issues. At the prefecture level, more than one third of the mothers (37.4 percent) involved in the survey had the next child within 24 months of delivery for the previous living child (as referred to the Rapid Catch Indicators List). Only 35.8 percent of mothers reported having had more than 24 months between the last two live births.

Next youngest children gender distribution: The gender distribution of the next youngest child, in families with more than one child, showed that the number of females were almost twice the number of males.

Childhood Immunization Indicators

Table 5 shows the vaccination coverage based on the findings of the KPC survey. The first indicator is the proportion of children whose mothers were able to show to the interviewer his/her vaccination card. Thus, the source of information used was the vaccination card, if available from the mother and, if not, the mother's recall. For almost all indicators in Table 5, the calculation has been made based only upon the records found in the vaccination card. The vaccine shots that every child has received are usually more than what can be verified from the child's vaccination card. As the immunization program in Albania does not use the record from vaccination cards as a monitoring and data source tool, less efforts have been put into the promotion of vaccination card to mothers and caretakers. The mother's recall has been used as part of the numerator for the coverage estimation only for Measles-Containing Vaccine¹³ (MCV).

¹³ In Albania the MCV is the Measles Rubella vaccine introduced into the national immunization schedule from November 2000.

Table 5 Childhood Immunization Indicators

Indicators	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Possession vaccination card ¹⁴	70.1	67.7	71.7	69.7	65.8 – 73.5
Epi access					
<i>Proportion of children 12-23 months with DPT1 recorded</i>	88.7	83.1	96.6	88.7	83.9 – 93.5
Drop our rate					
<i>Proportion of children 12-23 months with DPT1 but not DPT3 recorded.</i>	7.5	9.2	10.2	8.7	4.5 – 13.0
EPI coverage (liberal criterion)					
<i>Proportion of kids 12-23 months vaccinated with OPV3 before they were 12 months</i>	77.4	70.8	89.9	78.1	71.9 – 84.3
EPI coverage (Alban. adaptation)					
<i>Proportion of kids 14-23 months who received BCG, DTP3, OPV3, HBV3 and MCV before they are 14 months old</i>	59.0	44.6	47.6	51.6	43.1 – 60.1
EPI coverage (Rapid Catch Indicator)					
<i>Proportion of children aged 12-23 months who received BCG, DTP3, OPV3, vaccine before their first birthday</i>	71.7	67.7	81.4	72.6	65.9 – 79.3
MCV coverage (Albanian adaptation)					
<i>Proportion of children 14-23 m vaccinated for measles based on record or mother's recall.</i>	67.6	70.8	75.0	70.4	64.2 – 76.6

The access rate for the Expanded Program on Immunization (EPI) in Albania using DPT1 coverage is at 89 percent at the prefecture level; Bulqiza has the highest DPT1 rate at 97 percent and Mat the lowest 83 percent.

¹⁴ Except when clearly written, the vaccination coverage has been calculated on the recorded found in individual vaccination cards. No further investigation has been done to complete the vaccination records from other data sources.

The Drop Out rate (DPT3 – DPT1) is quite low (9 percent) with Bulqiza showing more than 10 percent. See Table 5 above.

The complete children's immunization coverage as measured by the Rapid Catch indicator is 73 percent, whereas using the Albania adaptation of EPI protocol, this rate considerably drops down to 52 percent. Whether this decrease in EPI performance on complete coverage is due to the inclusion of HBV3 and MCV antigens in the Albania adaptation, and whether the fact that children not 12 to 23 but 14 to 23 months are analyzed in Albania has any influence in this low performance should be further investigated.

The vaccination coverages obtained using the vaccination cards as the only information source, are undercounted if compared with the vaccination rates that were obtained from including additional information from the vaccination registers kept in each ambulanca where the vaccination schedule is administered. Thus, besides addressing the need for improving and maintaining good EPI coverage, the ACSP should increase the card retention rate in the project areas.

Breastfeeding and Child Nutrition Indicators

Breastfeeding practices in the prefecture are far from optimal. Although the proportion of mothers that gave deliveries in a health facility and deliveries attended by skilled health personnel were very high, respectively 90.8 percent and 98.8 percent at prefectural level, the proportion of mothers that put their babies in breast immediately after birth (within 1 h) was only 30 percent. 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 Bulqiza where MOH and UNICEF have implemented "baby friendly" hospitals).

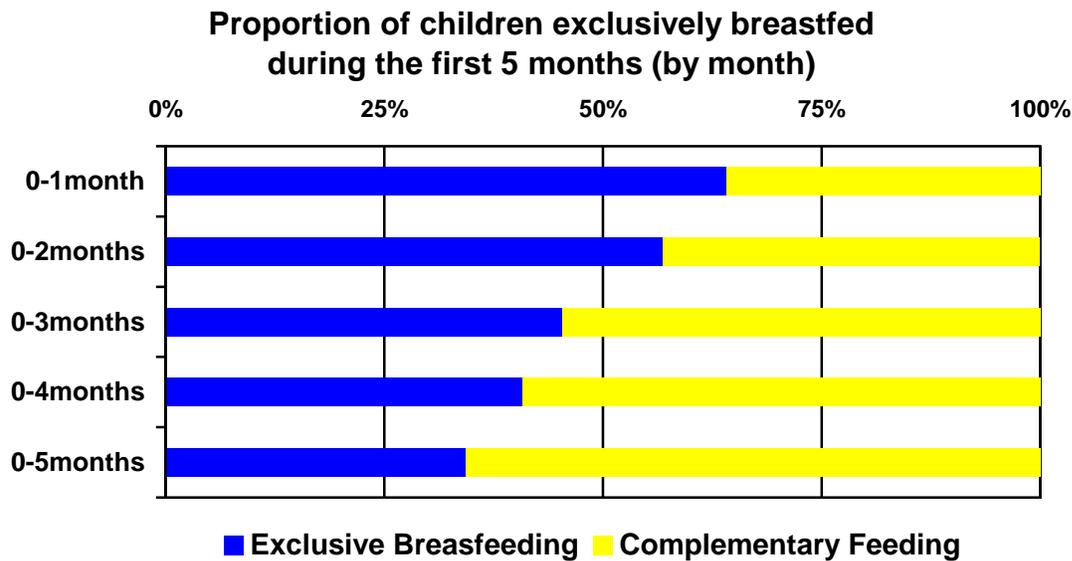
Table 6. Starting Breastfeeding Behavior after Delivery

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Starting Breastfeeding after delivery (denominator)	89	87	86	262	
< 1 st hour after delivery	20.2	32.2	46.5	30.3	20.4 – 40.2
After 1 st h and before 24 th h	51.7	40.2	37.2	44.5	35.2 – 53.9
> 24 hours after delivery	28.1	27.6	16.3	25.2	14.2 – 36.2

Among neonates that lose this opportunity the proportion of children that are put in mother's breast within the first 24 hours after delivery (but after the first hour), in our sample of children 0-11 months (denominator 262 children), is 44.5 percent, while the remaining children (25 percent of the sample) start being breastfed after the first 24 hours (during the second day). Table 6 shows the relative proportions by each district of the prefecture.

Following delivery, only 29 children (5 percent) were not breastfed. The remaining 95 percent of children, at the prefecture level, were exclusively breastfed for variable durations as, shown in the following figure:

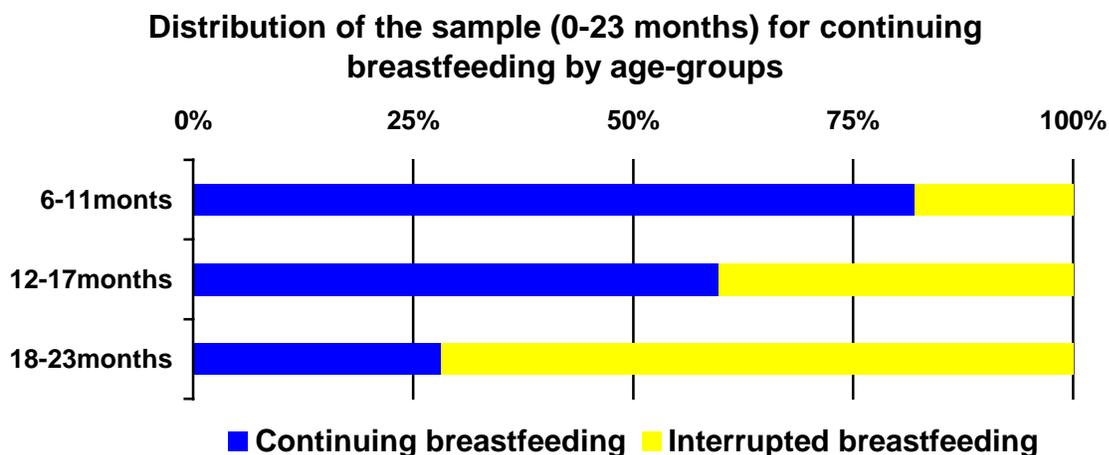
Fig. 1



Based on the findings above, the ACSP should emphasize behavior changes by both the community mothers and women of reproductive age as well as by the service providers in the maternity centers. The focus should be to increase the proportion of newborns that are put to a mother's breast within one hour of birth.

On a positive note, the 45.3 percent rate for children 0-3 months in the prefecture is significantly higher than the countrywide rate of 9 percent found for this age group as 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.

Fig. 2



The prefectural values of these indicators stratified by urban and rural differences should be analyzed to address the appropriate activities for improvements. Table 6 shows the indicator estimations at the prefecture level by residency (urban and rural).

The trend for exclusive breastfeeding in both the urban and rural setting shows a decline from the infant's first month to the fifth month. Comparing the urban and rural sub-samples, we see that in rural areas exclusive breastfeeding is more common and continuing breastfeeding lasts a longer time, but there is no statistical significance among them (that might be verified considering even the confidence interval). The ACSP should design effective behavior change interventions to increase the proportion of infants that are exclusively breastfed for at least until four months of age in both the urban and rural project areas.

The proportion of children aged 6-9 months who receive breast milk plus solid or semi-solid foods is 81.9 percent (Table 2). More than ninety percent (91.1 percent) of children 6-23 months are given food from animal sources daily. Eighty-seven percent (87 percent) are fed dairy products; 35.7 percent are fed eggs; and 29.7 percent are fed meat, poultry, or fish (meat, poultry and fish rate is the only indicator different in all three districts; in Mat district it is almost twice the rate of Diber and Bulqiza district). For all the other indicators concerning the nutritional section, the rates in single districts are similar among them and with the prefecture weighted value.

KPC results for complementary feeding rates are, for the most part, totally incongruent with MICS findings. KPC findings show that the proportion of children aged 6-9 months who receive breast milk plus solid or semi-solid foods is 81.9 percent in contrast to the 24 percent reported in the MICS

Table 6. Starting Breastfeeding Behavior after Delivery

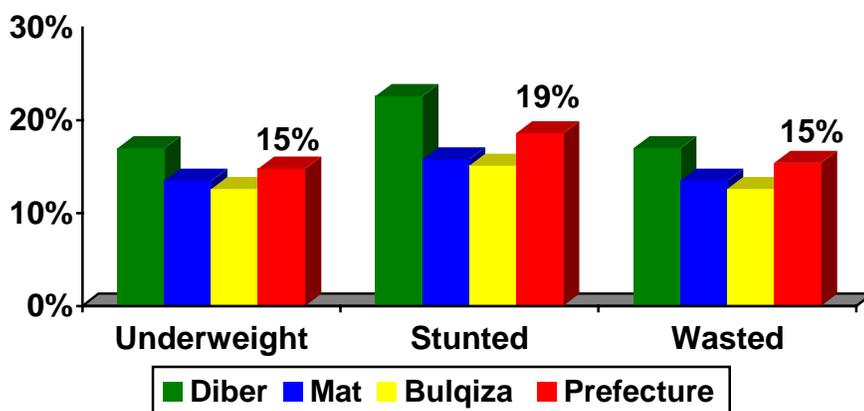
Characteristics	Levels (as percent). – URBAN		Levels (as percent). – RURAL	
	95 percent (CI)	Prefecture URBAN	Prefecture RURAL	95 percent (CI)
Starting Breastfeeding after delivery (denominator)				
< 1 st hour after delivery	10.2 – 30.9	20.6	32.5	25.9 – 39.2
Exclusive breastfeeding				
0 – 1 month	<i>Small sample</i>	20.0	80.9	<i>Small sample</i>
0 – 2 months	10.6 – 73.0	41.8	62.1	44.1 – 80.1
0 – 3 months	6.3 – 55.8	31.0	49.2	34.7 – 63.6
0 – 4 months	9.4 – 49.1	29.2	44.1	31.5 – 56.8
0 – 5 months	5.7 – 35.2	20.5	44.7	34.4 – 55.1
Complementary feeding				
6 – 9 months	60.2 – 95.0	77.6	83.2	73.6 – 92.9
Continuing breastfeeding				
6 – 11 months	56.9 – 89.3	73.1	84.8	77.3 – 92.2
12 – 17 months	36.9 – 67.7	52.3	61.7	53.2 – 70.2
18- 23 months	0.3 – 23.1	11.3	32.6	23.1 – 42.1
Nipple use rate	32.6 – 57.7	45.2	28.7	22.3 – 35.1

It was not possible to undertake an exhaustive nutritional survey within the context of the KPC baseline assessment, and the ACSP might like to consider investigating if complementary food given to children following weaning results in a balanced diet. Thus, 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. Whatever the result of the follow-up survey, a full report will appear in the project's Year I Annual Report in August 2004. Although the findings reported above show largely the intake of protein, adequate portions of carbohydrates, fats, vitamins and minerals need to be added to the weaning diet.

The table below shows the nutritional indicators as estimated from the KPC sample. As explained in the Methodology section, the Z-score cut off points was used for Underweight (weight for age), Stunted (height for age) and wasted (weight for height). The target populations for Fig 3 are children 0-59 months

Fig 3

Distribution of Underweight, Stunted and Wasting by Districts & Prefecture level (children 0-59 months)



As illustrated in Figure 3, the Diber district has the biggest proportion of children who are underweight, stunted, and wasting, while the Mat and Bulqiza districts are similar to each other. If analyzed by residency (urban/rural), the proportion of children Underweight, Stunted and Wasting do not change significantly

Table 6. Distribution of Underweight, Stunted and Wasting by residence area

Characteristics	Levels (as percent). – URBAN		Levels (as percent). – RURAL	
	95 percent (CI)	Prefecture URBAN	Prefecture RURAL	95 percent (CI)
<i>Underweight</i>	7,7 – 19,0	13,3	15,2	12,0 – 18,3
<i>Stunted</i>	12,7 – 25,8	19,2	18,5	15,1 – 21,8
<i>Westing</i>	7,8 – 19,1	13,4	15,8	12,6 – 19,0

The high proportion of chronic malnourished children (that are below the second deviation standard for height for age - Stunted) is similar with what MICS survey (2000) found nationwide. On the other side, the proportion of children in the Underweight and Wasted categories in the KPC survey is very different from what the MICS found nationwide; Underweight and Wasted were 15 percent in KPC population target and 4 percent in MICS (the same age-group population target).

As Wasted indicates acute malnutrition, the category will not serve for monitoring and evaluation of the impact of the project. The high rate of children with an acute illness in the last two weeks might have contributed to the result of Wasting found in all three districts. The high proportion of children with a low weight for age index, given the Stunted rate of the population, reflects past (chronical) and present (acute) undernutrition.

The sample of children 0-23 months has been divided into four age-groups (in a six-month interval). As seen from the Figure 3/1, all growth indexes increase with age and are more significant during the second semester of life when complementary feeding is introduced. On the other hand, the ascending increase in the stunted category shows persistent causes.

Fig 3/1

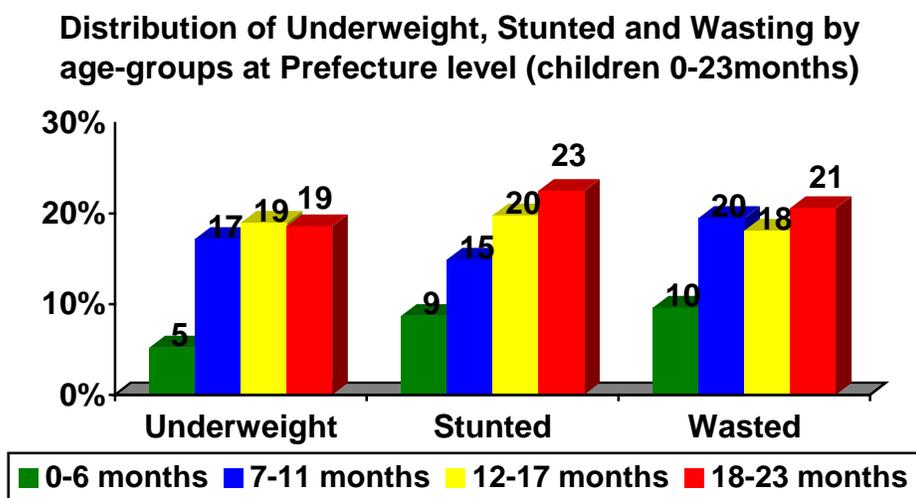


Fig. 3/2

Distribution of Underweight, Stunted and Wasting by age-groups at Prefecture level (children 0-59months)

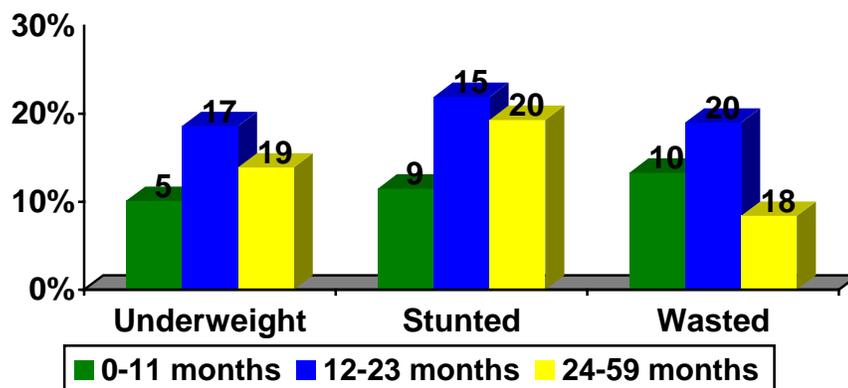


Figure 3/2 shows the distribution of growth indexes by three age groups (0-11 months; 12-23 months and 24-59 months). As shown in the graph, during the second year of life the health status of our sample population became worse, due to the complementary feeding introduced; and acute illness occurring more frequently linked with the parents and health professionals behaviour pattern etc. After the second year of age, underweight and wasting that are more linked with an short-term cause improved much more than those in the stunted group, which shows the persistence of causes.

The ACSP should investigate further the causes of malnutrition, and find ways to improve the state of acute and chronic malnutrition in the project areas.

The salt samples collected during the survey were qualitatively tested for iodine with quick tests that showed the following results (See Table 7).

Table 7

Table 7. Household Salt sample Tested for Iodization

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Salt samples tested (denominator)	187	179	196	562	N.A.
<i>Proportion of households that use iodized salt</i>	33.0	70.9	55.1	50.6	46.4 – 54.8

It appears that only half the number of households surveyed (50.6 percent) used iodized salt at the prefecture level. Only one-third of the households in Diber district use iodized salt. Given the fact that there is high prevalence of goiter in the project area (confirmed from studies conducted by endocrinology clinic of Unniversity Hospital Centre in Tirana and supported by different

NGOs), the ACSP will make efforts to increase the knowledge and practice levels related to the use of iodized salt through VNM and VHE participatory activities. In this context, PSI/UNICEF has supported the Ministry of Health's promotion of iodized salt for domestic consumption.. The rehabilitation of the only salt factory in the country to produce iodized salt, the endorsement of the appropriate legislation for only iodized salt importation, and better coordination with the District Health Authorities to monitor the quality of iodized salt traded, are some of the activities that the project will promote to further expand the health education of the community to increase the demand for iodized salt.

Childhood Illness Indicators.

More than half of the children surveyed experienced an illness in the two weeks before the interviews. Table 8 shows the percentage of mothers who follow the practice of giving food and fluids to sick children during the clinical phase of the disease and during recovery.

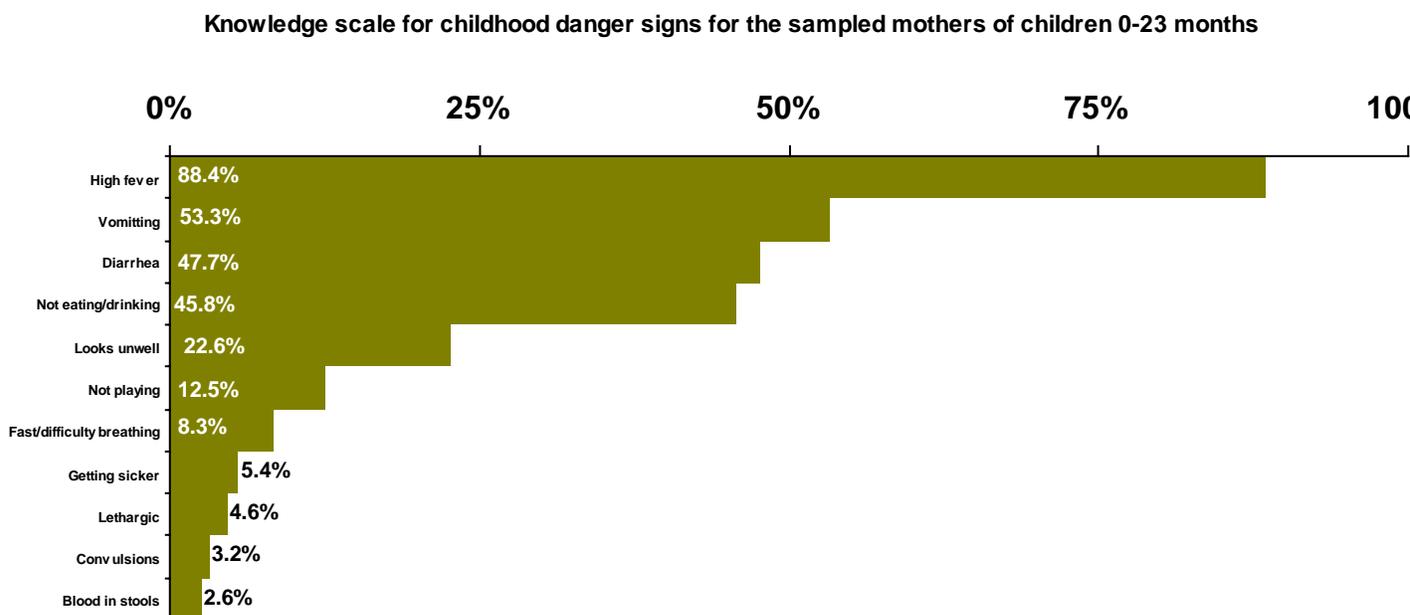
More than 62 percent of the respondents at the prefecture level reported giving increased fluids during a child's illness.. No significant difference among the districts was noted. Less than 50 percent of the sampled households in the prefecture level gave increased food to the sick child. The increased fluids and foods during the recovery from an illness were found to be very high (almost 94 percent). These findings, stratified by residency of the households, will help ACSP refine its behavior change strategies to include increasing children's food and fluid intake during their illnesses and to maintain high food and fluid intake during the recovery phase.

Table 8. Household Behavior for the Sick Children 0-23 months

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Sick child past 2 weeks	65.2	36.4	42.2	50.3	46.1 – 54.5
Increased Fluids during illness	56.9	65.7	66.7	62.1	56.1 – 68.1
Increased Foods during illness	43.2	58.6	44.0	48.5	42.3 – 54.6
Increased Fluids & Food during illness	27.4	41.4	31.6	33.0	27.2 – 38.8
Increased Fluids and Foods when recovering from illness	93.3	95.7	92.3	93.9	90.0 – 96.8

Almost 90 percent of mothers knew at least two danger signs of childhood sickness, while only 41.9 percent knew at least four danger signs.

Among the childhood danger signs, high fever was the best recognized by the mothers. As shown in Fig. 3, "Vomiting", "Diarrhea" and "Not eating/drinking" were the next three signs with the knowledge scale showing 53.3 percent, 47.7 percent and 45.8 percent respectively. Only a small proportion of respondents (less than 10 percent of mothers) knew about "Fast/Difficulty breathing", "Child getting sicker", "Child becoming lethargic", "Convulsions" and "Blood in Stools." This is reflected in the chart below (Fig. 4).

Fig. 4

Control of Diarrheal Disease

The proportion of children that experienced diarrhea during the two weeks just before the survey was 22.5 percent (128 children out of 569). Taking into consideration the cold weather conditions when the data collection took place, the proportion observed was surprisingly higher than usual. Also noteworthy is the fact that the children with diarrhea comprised almost half of all children that were sick during the two weeks before the survey. Thirty-one percent of the mothers reported washing their hand appropriately. Table 9 shows hand washing practices of the mothers interviewed, in relation to food preparation, eating, child feeding, defecation and cleaning child following defecation.

The project might consider including proper hand washing practices as one of the behavior change strategies since less than a third of the surveyed mothers (when all three districts are aggregated at the prefecture level) reported washing their hands at all the times listed in Table 9.

From our sample, 54 percent of children with a diarrheal episode were referred to a health worker. Two thirds (66 percent) of them were referred within two days after the start of a diarrheal episode, and one third (34 percent) were referred to a health worker the third day, or even later. Since a high proportion of the children are seen by a health worker three days or more after the onset of a diarrheal episode, it would be useful for the project to consider this finding when developing health education messages.

Table 9. Maternal Hand washing Behavior

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Hand washing occurred:					
- <i>always</i>	25.0	44.4	23.5	31.0	27.2 – 34.9
- <i>before food preparation</i>	81.5	88.9	93.0	86.6	83.8 – 89.5
- <i>before eating</i>	64.1	78.8	69.0	70.1	66.2 – 73.9
- <i>before feeding children</i>	66.3	84.3	70.6	73.2	69.5 – 77.0
- <i>after defecation</i>	64.1	81.3	56.1	67.9	64.0 – 71.8
- <i>after defecation to a child</i>	60.9	77.3	66.3	67.5	63.6 – 71.5

The inappropriate treatment of diarrheal episodes with antibiotics occurred on 35.6 percent of the sample with variation amongst the three districts. In the Mat district twice the number of children received antibiotics during the diarrheal episode as those in the Diber and Bulqiza districts.

In connection with ORS treatment, 16 percent of children received the oral rehydration solution during their most recent diarrheal episode. The use of ORS or other recommended home made fluids in the Diber district is half of that in the Bulqiza and Mat districts. From Table 10 it can be observed that the percentage of ORS usage is much less than the percentage of mothers who could describe correctly how to prepare the ORS at home. The project needs to explore if this is due to low ORS access in the project areas, or if there may be other factors that influence the low ORS usage. At any rate, the survey revealed a clear need for the project to stress the effectiveness of correct and rapid treatment of diarrhea with oral rehydration solution (ORS) and/or recommended home fluids (RHF).

Table 10. ORS and/or RHF Preparation and Usage Rate for**Children Experiencing Diarrheal Episodes**

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
ORS / RHF u					
<i>Use during diarrhea episode</i>	10.8	19.7	21.5	16.3	11.8 – 20.8
<i>Home Correct preparation</i>	71.7	80.8	80.2	76.7	73.2 – 80.3
<i>Home preparation of ORS/RHF</i>	(#) Urban (percent)		(#) Rural (percent)		Risk
<i>Correct</i>	118	84.5	324	74.3	OR = 18.63 CI [10.66 – 32.90]
<i>Incorrect</i>	19	15.4	108	24.7	

When the prefectural sample is stratified by residency, the proportion of mothers that prepared correctly the ORS package for the home treatment of diarrhea appears more than 18 times higher in the urban area than in the rural areas (CI 10.66 – 32.90). This clearly identifies the need for appropriate ORS-related message dissemination among the rural communities.

Acute Respiratory Infection Control

From Figure 4 it is apparent that only 8 percent of the mothers recognized fast or difficult breathing as a danger sign of childhood illness requiring medical attention. Also, the survey found that about half of the respondents got medical attention for their child with ARI within two days of the onset of the symptoms. The other half sought medical attention on the third day or later. This would indicate the need for the project to design effective messages for care providers to recognize the ARI danger signs, and seek timely medical attention for the sick child. The small sample size does not allow a statistical comparison of this indicator by residency (urban vs. rural).

The percentage of parents who seek timely care (within 48 hours after the onset of illness) when their child is having fast/difficult breathing is expressed in Figure 5.

Figure 5

Proportion of children with ARI that were taken to HF within the next 48 h after the illness onset

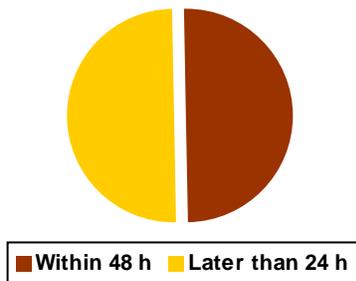
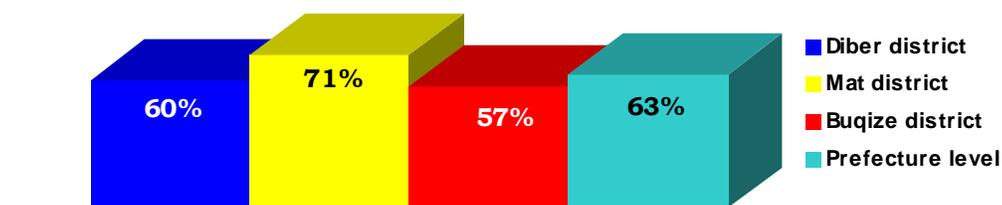


Figure 5 shows the proportion of parents who seek outside advice for their children suffering with ARI with a health worker and the Figure 6 illustrates the proportion of children who were given antibiotics at a health facility. Only half of those children have been visited by a health worker within the next two days after the symptoms started, while the other half was visited the third day or even later. The small sample size does not allow a

statistical comparison of children by residency (urban vs rural).

Figure 6

Proportion of children 0-23 m with cough and fast/difficulty breathing in the last two weeks taken to a Health Facility and were treated with antibiotics



Thus, from 124 children who had fast/difficulty breathing in the two weeks before the survey, 95 of them (76 percent) were taken to a health facility; and of these 95 children, 77 (63 percent) were prescribed antibiotics (63 percent of the total of 124 children), as seen in the chart above in Fig 6.

An inappropriate behavior is the use of antibiotics that have not been prescribed by a health worker but taken from leftover supplies. Thus, 6.5 percent of mothers with ARI children who did not take their children to a health facility are reported to have used antibiotics not prescribed by a health worker. (Table 11). Health messages for the community mothers should include information about the need for medical supervision and advice in giving their children antibiotics—and the dangers of unsupervised use.

Table 11. Inappropriate use of antibiotics for children with ARI

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
ARI care seeking u <i>Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were NOT taken to health facility AND received antibiotics</i>	7.7	5.7	5.4	6.5	2.1 – 10.9

Birth Spacing Indicators

One third of all mothers who desire no more children in the next two years, or are not sure, responded by not using any method of contraception AT ALL. This proportion does not change if stratified by their residency (urban vs. rural), while the proportion of these mothers in Bulqiza district is double of that in the Diber district (see Table 12). Along with this fact, the survey revealed that only 12 percent of these mothers that do use contraceptives utilize a modern method of contraception. The LAM use (Lactational amenorrhea method) was found in 2.4 percent of mothers at prefecture level.

The high level of unmet need, coupled with the very low modern contraceptive use rate, should warrant aggressive resource investment by the project for improving birth spacing knowledge, and practices. The LAM messages, if appropriate, should be considered for health education as well.

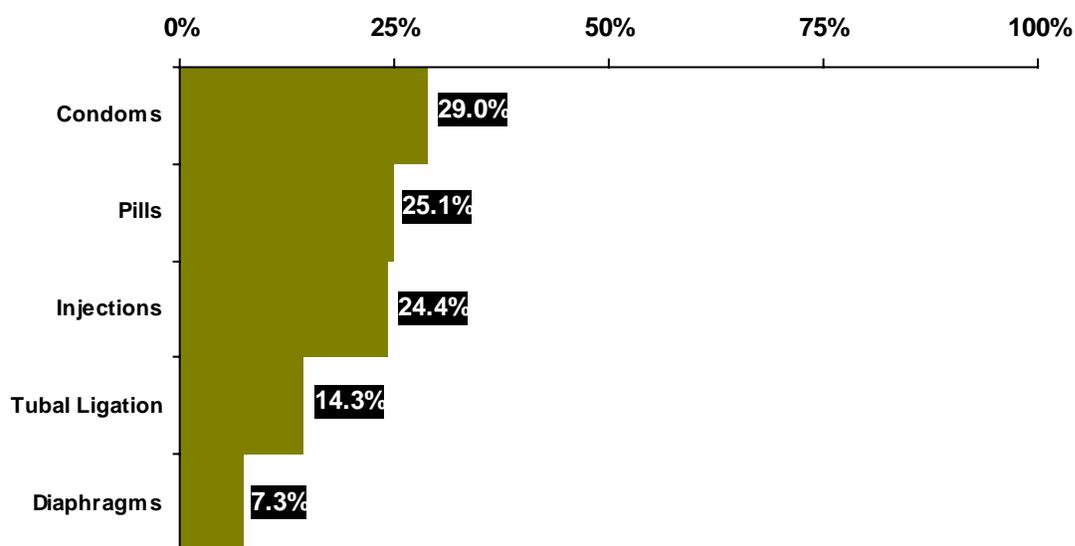
Table 12. Birth Control Methods of Mothers Who Desire No More Children or Are Not Sure,

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
NO type of contraceptive use among mothers who want to limit or space births	23.5	33.8	44.4	33.4	29.2 – 37.6
Modern Method used among mothers who want to limit or space births	7.4	20.8	8.8	12.1	9.2 – 15.0

The proportion of mothers that used any of the modern methods of contraception at the prefecture level was only 12.1 percent. If compared within the prefecture, the Mat district has almost three times more women using such a method when compared with the Diber district. This might be linked with previous family planning activities implemented recently in this area¹⁵. Only 64 women out of 505 women who desired no more children or not sure used any of the modern method of contraception in order to limit or space births. Within this sub-sample, the proportion of usage of each modern method is shown in figure .7

Fig. 7

Usage of modern method of contraceptions for mothers who desire no more children or are not sure.



Indeed, withdrawal is the most frequent contraceptive method used in the whole prefecture. Half of the mothers (49.7 percent) in the area reported to be using this method in order to limit or space births. In Diber district the proportion of mothers that use withdrawal is the highest (63 percent), while the Mat district shows the lowest proportion (35 percent). The Bulqiza district shows 46 percent (see Table 13).

¹⁵ John Snow Family Planning project

Table 13. Family Planning Indicators

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Family Planning Method Usage WITHDRAWAL	63.0	35.0	45.6	49.7	45.2 – 54.1
Knowledge of source of family planning methods	38.6	78.8	65.2	58.1	53.9 – 62.2
Adequate birth interval between youngest surviving children					
<i>Proportion of children aged 0-23 months who were born at least 24 months after the previous surviving child</i>	78.7	69.1	73.7	74.4	69.3 – 79.5
<i>Proportion of children aged 0-23 months who were born at least 36 months after the previous surviving child</i>	35.2	32.1	43.0	36.0	30.3 – 41.6

Counseling activities about modern family planning methods have been analyzed and the results shown in Table 14. Family planning information was disseminated more during postpartum visits than during antenatal visits (38 percent vs. 21.4 percent), but in both types of counseling the proportion of mothers counseled on birth spacing is quite low. There is statistical evidence that the proportion of mothers that live in urban areas and are counseled about birth spacing topics is almost four times more prevalent than in mothers that receive counseling in rural areas (OR=3.85; CI=[2.39 – 6.21] see also information in Table 14).

In the prefecture level around 38 percent of mothers were counseled about family planning. In the Mat district the proportion of mothers counseled is at least three times more than in the Diber and Bulqiza districts. If stratified by the urban and rural samples, the proportion of mothers counseled concerning in urban areas is 2.6 times higher than mothers in rural areas (OR=2.6; CI=[1.28 – 5.32]. (See also information in table 14)

Table 14. Counseling Activities in Relation to Family Planning Topics

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
During antenatal counseling					
<i>Proportion of mothers who received family planning information during a prenatal check-up</i>	10.8	40.6	14.4	21.4	17.8 – 25.1
Risk calculation	(#) Urban (percent)		(#) Rural (percent)		Risk
<i>FP info given</i>	52	42.0	56	14.7	OR = 3.85 CI [2.39 - 6.21]
<i>FP info not given</i>	76	58.0	315	85.3	
During postpartum counseling					
<i>Proportion of mothers who received family planning information during a postpartum check-up</i>	20.0	70.3	26.1	38.0	31.1 – 44.9
Risk calculation	(#) Urban (percent)		(#) Rural (percent)		Risk
<i>FP info given</i>	29	51.4	53	33.0	OR=2.6 CI [1.28 – 5.32]
<i>FP info not given</i>	20	48.6	95	67.0	

Seventy-five percent (75 percent) of mothers interviewed knew at least two risk factors for HIV transmission. This proportion was very similar in single districts, and also among the urban and rural mothers.

Antenatal, Delivery and Postpartum Indicators

Antenatal Indicators

Only 2.1 percent of mothers interviewed during the survey at the prefecture level had health cards, while no mother had such a card/book in the Bulqiza district. Therefore the information concerning the Tetanus Toxoid coverage was obtained from the mothers' recall. The national Albanian schedule for pregnant mothers recommends two doses for each pregnancy. Based on the mothers' recall, 63.5 percent of mothers received two vaccines during their last pregnancy at the prefecture level (see Table 15)

Table 15. Health Card/Book Possession and Tetanus Toxoid Coverage Achieved for Mothers Interviewed

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Proportion of mothers with a maternal card (interviewer confirmed) for the youngest child less than 24 months of age	2.2	3.5	0.0	2.1	0.9 – 3.3
Proportion of mothers who received at least 2 TT injections (recall) before the birth of the youngest child less than 24 months of age	53.8	76.3	63.6	63.5	59.5 – 67.5

The pregnancy-related services provided to pregnant women by the health centers, based on the sample of 569 mothers interviewed, are summarized in Table 16.

Table 16. Coverage of Health Services for the Pregnant Women

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Antenatal Care Coverage	80.4	92.4	89.8	86.6	83.7 – 89.4
Proportion of mothers that had the 1 st antenatal visit during the last trimester of the pregnancy	47.6	59.1	55.2	53.2	47.1 – 59.3
Iron/folate supplementation coverage	9.8	8.6	10.7	9.6	7.1 – 12.1
	Average (in days) duration				
Mean duration of iron/folate supplementation in pregnancy	27	43	38	35	N.A.

Although there seems to be a high proportion of mothers receiving antenatal care (87 percent at the prefecture level with the Mat District reaching 92 percent), the timing of the first ANC visit takes place in within the first trimester of the pregnancy for only around half the mothers interviewed (53 percent). Only 10 percent of mothers reported taking iron/folate supplementation

during their last pregnancy. These findings clearly demonstrate the need for the ACSP to make significant efforts in improving ANC interventions in the project areas.

The proportion of mothers that received iron/folate during their pregnancy was very low (only 9.6 percent) in spite of MoH policies disseminated on this issue¹⁶. The mean duration of iron/folate somministration was much lower than what is recommended from this policy (only 35 days).

HII has planned to introduce within the year 2005 the inclusion of medications given during the pregnancy into the free-of-charge packages. The ACSP should focus on the appropriate education of the health staff to promote the iron/folate therapy for all pregnant women as part of the C-IMCI+ curricula.

Delivery Indicators

About 99 percent of mothers surveyed reported that their child delivery was attended by skilled health personnel at the prefecture level. This high proportion was evidenced in all three districts. The proportion of children aged 0 to 23 months delivered in a health facility was 90.8 percent at the prefecture level, while by single districts it was 91.8 percent, 91.9 percent and 87.2 percent respectively for the Diber, Mat, and Bulqiza districts.

Postpartum and Newborn Care Indicators

The first postpartum contact is done in the health centers, although the KPC indicator defines the first visit as the one that a health staff makes after the mother returns home. In keeping with this KPC definition, the proportion of mothers that had the first postpartum contact was found to be 31.8 percent at prefecture level. This proportion varies quite a lot in single districts.; In the Bulqiza district, the proportion of mothers that had a postpartum visit is more than twice the amount in the Diber district. This means that the neonates, when they are back home from the maternity wards, have the first contact with the health staff very late. This should be considered, along with the geographical constraints of some areas and the supervision performance of the GPs over the VNMs. Th connection should be made of the late postpartum visits with the high neonatal mortality, particularly in the Diber district.

The vitamin A supplementation for the mother during postpartum period was very low. (see table 17).

Table 17. Postpartum Check up Visits and Maternal Vitamin A Supplementation

Characteristics	Levels (as percent).				95 percent (CI) Confidence Limit
	Diber	Mat	Bulqiza	Prefecture	
Proportion of mothers who had at least 1 postpartum check up	19.0	37.4	47.6	31.8	27.9 – 35.7
Proportion of mothers who received vitamin A during the first two months after delivery	3.3	2.5	5.9	3.6	2.1 – 5.2

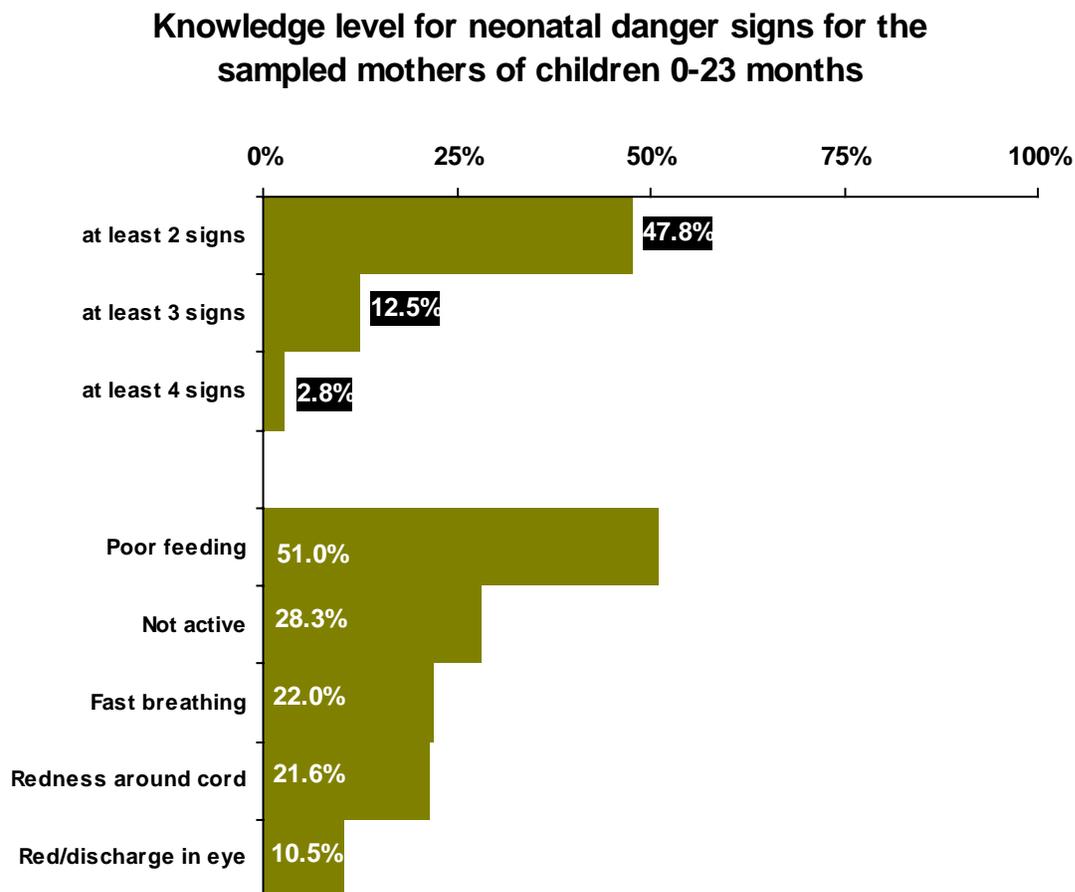
¹⁶ MoH Guideline for Reproductive Health issued on April 11th, 2003

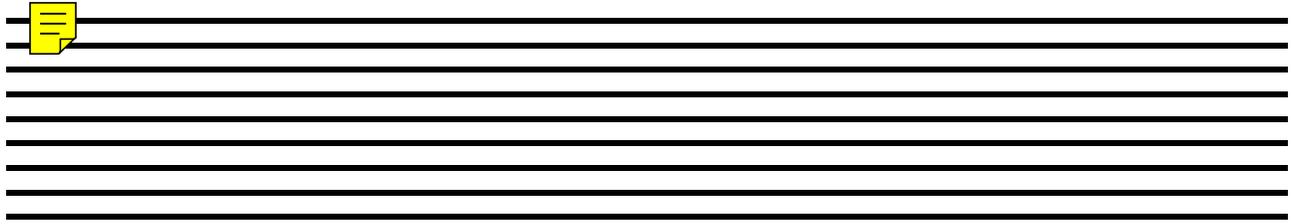
Less than half (48 percent) of mothers know at least two neonatal danger signs at the prefecture level. In the Mat district the proportion of mothers that know at least two neonatal danger signs is more than double than that of the Diber district. The same difference can be observed in the Bulqiza district. This high performance in the Mat district may indicate the success of the previously implemented project activities in these areas (as family planning, etc).

When analyzing the number of mothers who know at least three neonatal danger signs, the proportion of mothers in the prefecture level decreased 12.5 percent--with large differences seen among the three districts(3,8 percent of mothers in Diber, 6,4 percent in Bulqiza and 28,3 percent in Mat district). These findings make clear the urgent need for neonatal health education promotion activities among both the community members as well as the health staff of those areas

Figure 8 shows at the prefecture level the proportion of mothers that know at least two, three, or four neonatal danger signs as well as the proportion of mothers that know each of the five neonatal danger signs separately.

Fig. 8





These findings clearly demonstrate the need for the ACSP to make significant efforts in improving ANC interventions in the project areas.



¹⁷ John Snow Family Planning project

Delivery Indicators

About 99 percent of mothers that were surveyed reported that their child delivery was attended by a skilled health personnel at prefecture level. This high proportion was evidenced in all three districts. The proportion of children aged 0-23 months delivered in a health facility was 90.8 percent at prefecture level, while by single districts it was 91.8 percent, 91.9 percent and 87.2 percent respectively for Diber, Mat and Bulqiza district.

Postpartum and Newborn Care Indicators

The first postpartum contact is done in the health centers, although the KPC indicator defines the first visit as the first one that a health staff makes after the mother returns home. In keeping with this KPC definition the proportion of mothers that had the first postpartum contact was found to be 31.8 percent at prefecture level. This proportion varies quite a lot in single districts; in Bulqiza district proportion of mothers that had a postpartum visit is more than twice of that of the Diber district.

The vitamin A supplementation for the mother during postpartum period, was very low. The absence of an Albanian law to promote the vitamin A supplementation might be considered as major factor why such a indicator is so low in all three district (see tab 17). 

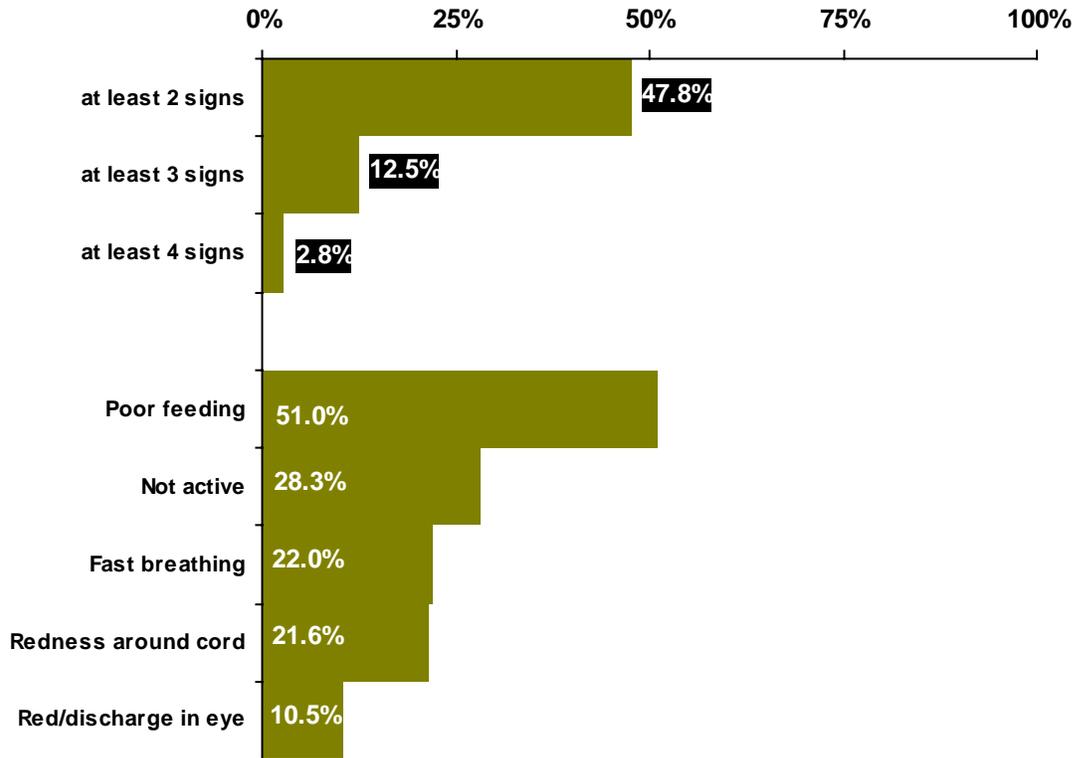
Table 17. Postpartum check up visits and Maternal Vitamin A supplementation

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Proportion of mothers who received vitamin A during the first two months after delivery	3.3	2.5	5.9	3.6	2.1 – 5.2

Less than half (48 percent) of mothers know at least 2 neonatal danger signs at prefecture level. In Mat district the proportion of mothers that know at least 2 neonatal danger signs is more than double than that of the Diber district. The same difference can be observed also in BBulqiza district. This high performance in the Mat district may indicate the success of the previously implemented project activities in these areas (as family planning, IMCI etc).  When analyzing mothers that know at least three neonatal danger signs, in Diber district the proportion of mothers is half of that in Bulqiza district and 7 times less than that in Mat district. These findings make clear the urgent need for neonatal health promotion activities among both the community members and as well as the health staff of those areas (see Figure .8)

Fig. 8 

Knowledge level for neonatal danger signs for the sampled mothers of children 0-23 months



CONCLUSION

The findings of the KPC assessment (October 2003) and the related discussion during the feedback meeting held on December 20th, 2003 with the local stakeholders and partners initiated a process of revising of the project goal, strategic objectives, and indicators of the project proposal. As part of the revising of this proposal during the DIP process and based on other assessments, such as the Health Facility Assessment, Mapping Exercise, and Flexible Fund, requirements for the level of effort the project should spend on Family Planning activities should be increased. The Result Framework annexed here below shows the updated Goal and Strategic Objectives, the new Intermediate Results, and the related activities/indicators. This table displays selected information; results, indicators, measurement methods, baseline values, & end of program targets.

RESULTS FRAMEWORK

<i>Goal, Strategic Objectives (SO), Intermediate Results (IR)</i>		#	Indicator and Source	Method	Baseline Value	EOP Target	Intervention
Goal: Improved health status of women and children 0-59 months	Stunting	1	percent of children aged 0-59 months who are less than 2 standard deviations below the median height-for-age of the reference population	KPC survey	18.6 percent	10 percent	Nut
	Underweight	2	percent of children aged 0-59 months who are less than 2 standard deviations below the median weight-for-age of the reference population	KPC survey	14.8 percent	7 percent	Nut
SO-1: Increased use of MCH and FP services	Couple Years of Protection (CYP): <i>Increased contraceptive distribution measured in CYP</i>	3	Number of CYP distributed by the program to the target population per annum	HIS/ACSP records	287 ¹⁸	1500	FP
	Contraceptive Prevalence: <i>Increased use of modern FP methods by women of reproductive age (WRA)</i> <i>Proxy¹⁹: Increased use of modern FP by mothers of children 0-23 months</i>	4	percent of women 15-45 years who are not pregnant, desire no more children or are not sure who report using a modern FP method percent 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	Baseline FP survey/ endline KPC	²⁰ 12.1 percent	TBD 25 percent	FP

¹⁸ CYP for the prefecture (3 districts) for the period July 2002-June 2003 from JSI final report to USAID.

¹⁹ Proxy until population-based results from FP are available for WRA.

²⁰ To be collected through population-based family planning survey scheduled for August 2004.

	<i>New Acceptors: Increased use of modern family planning methods by WRA who are new users</i>	5	Number of WRAs who report being a 'new user' of a modern method of FP per annum	DHIS/URC/ACSP records	1099 ²¹	4000	FP
	Breastfeeding Initiation	6	percent of babies 0-11 months that were breastfed during the first hour after birth	KPC survey	31 percent	60 percent	Nut
	Maternal Iron Supplementation Coverage	7	percent of mothers supplemented with iron/folate tablets during last pregnancy	KPC Survey	9.6 percent	30 percent	Nut
	Duration of iron/folate supplementation in pregnant women	8	Average (in days) duration of iron or iron folate supplementation in women during the pregnancy of their youngest child 0-23 months	KPC survey	35	75	Nut
	Appropriate Use of Antibiotics	9	percent of children 0-23 with cough and fast/difficult breathing in the last two weeks taken to a health facility who were treated with antibiotics	KPC survey	62.8 percent	80 percent	ARI
IR-1: Improved service <i>availability and access</i>	Increased MCH and FP Access in Communities	10	percent of villages with volunteers trained in C-IMCI+	ACSP records	0 percent	80 percent	Nut/ CDD/ ARI/ FP
		11	percent of respondents of reproductive age who report discussing FP with a health or family planning worker or promoter in the past 12 months	FP baseline/ Endline KPC	²²	TBD	FP
	Service Integration	12	percent of MCH SDPs in the target area offering FP services	HIS	xx	Xx	FP

²¹ CYP for the prefecture (3 districts) for the period July 2002-June 2003 from JSI final report to USAID.

²² To be collected through population-based family planning survey scheduled for August 2004.

IR-2: Improved Service <i>quality</i>	Adequate Counseling	13	percent of FP clients who received adequate counseling	Baseline FP survey/ endline KPC	²³	TBD	FP
	Providers Trained in IMCI	14	percent of village nurse midwives trained in clinical IMCI	ACSP/ MOH records	18 percent	75 percent	Nut/ CDD/ ARI
	Use of QA Tools	15	percent of VHEs using job aids	ACSP M&E system	0 percent	75 percent	Nut/ CDD/ ARI/ FP
		16	percent of village nurse midwives using supervision checklists for VHEs	ACSP M&E system	0 percent	75 percent	Nut/ CDD/ ARI/ FP
SO-2: Increased <i>practice</i> of key household behaviors	LAM Use	17	percent of mothers with infants 0-5 months who report using LAM	KPC survey	2.7 percent	20 percent	FP
	Exclusive Breastfeeding	18	percent of children 0-5 months exclusively breastfed during the last 24 hours	KPC survey	34.3 percent	60 percent	Nut
	Bottle Use Rate	19	percent of children aged 0-11 months who had anything by bottle yesterday	KPC survey	32 percent	15 percent	Nut
	Iodized Salt Consumed in Household	20	percent of households that use iodized salt	KPC Survey	50.6 percent	75 percent	Nut

²³ To be collected through population-based family planning survey scheduled for August 2004.

	Increased Food and Fluid Intake during an Illness	21	percent of children aged 0-23 months with an illness in the last two weeks who were offered the same amount or more food and fluids during the illness	KPC Survey	33 percent	60 percent	Nut/ARI/CDD
	Meat, poultry, fish rate	22	percent of children aged 6-23 months who ate meat, organ meat, poultry or fish yesterday	KPC survey	29.7 percent	50 percent	Nut
	ARI Care Seeking	23	percent of children 0-23 months with cough and fast/difficult breathing in the last two weeks whose family sought treatment with 48 hours of illness onset	KPC survey	50 percent	75 percent	ARI
	ORT Use During a Diarrheal Episode	24	percent of children 6-23 months who had diarrhea in the past 2 weeks who were treated with ORS or ORT or appropriate home available fluid	KPC survey	16.3 percent	45 percent	CDD
	Maternal Hand Washing	25	percent 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.	KPC survey	31 percent	50 percent	CDD
IR-1: Increased household level <i>knowledge and interest</i>	Knowledge and Interest in FP	26	percent of sexually active respondents who report discussing FP issues with their spouse or sexual partner in the past 12 months	Baseline FP survey/ Endline KPC	²⁴	TBD	FP
	Message Recall	27	percent of women of reproductive age who recall hearing a specific FP-related message being promoted by the program	KPC survey	0 percent	30 percent	FP

²⁴ To be collected through population-based family planning survey scheduled for August 2004.

	Knowledge of child danger signs	28	percent of mothers who know 3+ neonatal danger signs	KPC survey	12.5 percent	25 percent	ARI/CDD
		29	percent of mothers who know 4+ danger signs for sick child	KPC survey	41.9 percent	75 percent	ARI/CDD
		30	percent of mothers that cite fast/difficult breathing as a danger sign for neonates	KPC survey	22 percent	50 percent	ARI
		31	percent of mothers that cite fast/difficult breathing as a danger sign for children	KPC survey	8.3 percent	30 percent	ARI
SO-3: Improved <i>sustainability</i> of all activities through partner strengthening	FP Program Sustainability	32	FP program has sustainability plan in place	ACSP records	N	Y	FP
	Partner Strengthening	33	Albanian Red Cross has 2005-2009 strategy in place	AlbRC documentation	N	Y	All
		34	Albanian Red Cross assumes 100 percent of salary of National Health Coordinator by EOP	AlbRC financial records/ AmRC finance reports	N	Y	All
		35	Albanian Red Cross has computerized volunteer data base in place and operational at branch level	AlbRC Documentation	N	Y	All

		36	FP logistics management information system functioning in 3/3 districts at EOP	MOH/ district records	1/3	3/3	FP
	Documentation and dissemination	37	Professional papers or peer-reviewed publications by EOP	ACSP documentation	0	4	All

BIBLIOGRAPHY

- 1 Generating indicators of Appropriate Feeding of Children 6 to 23 months from KPC 2000+. Mary Arimond and Marie T Ruel. International Food Policy Research Institute. Revised September 2, 2003.
- 2 Methodology and Sampling Issues for KPC Survey. November 30, 1999. John Hopkins University, School of Public Health, Department of International Health.
- 3 Multiple Indicator Cluster Survey report (Draft). December 4, 2000. UNICEF - Albania

APPENDIXES

**ALBANIA CHILD SURVIVAL (CS-19)
KPC BASELINE SURVEY**

I. CONSENT FORM**INFORMED CONSENT**

Hello. My name is _____, and I am volunteering with the Albania Red Cross. We are cooperating with the American Red Cross to conduct a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help the Red Cross and the local health authorities to develop a five-year, community-based health project in the Diber prefecture (Diber, Mat, and Bulqiza districts) and to assess whether they are meeting their goal to improve the health of women and children. The survey usually takes 45 minutes to complete.

(READ THE FOLLOWING TWO PARAGRAPHS EXACTLY AS WRITTEN.)

The information you provide will be kept strictly confidential. Your name will not be kept as part of the survey records. Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. If you decide not to participate, it will not make it more difficult to receive health care or other services. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey? If you have any questions in the future, you may contact the project office in Peshkopi at 0218-5320, and we will be happy to answer these for you.

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 — END

II. COVER PAGE

IDENTIFICATION							
1. CLUSTER NUMBER.....	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr> <tr><td style="width: 50%; height: 20px;"></td><td style="width: 50%; height: 20px;"></td></tr> </table>						
2. HOUSEHOLD NUMBER.....							
3. RECORD NUMBER.....							
4.a. DISTRICT_____							
4.b. TOWN/VILLAGE_____							

ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 24 MONTHS OF AGE

5. Interview date Day month <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> 2003	Reschedule interview Day Month ____/____
6. Interviewer's name _____	
7. Supervisor's name _____	

Given name of the mother (not surname) _____	Name of youngest child less than 24 months _____
8. Age of the mother (in years)..... <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	10. Sex of child (1=male, 2=female) <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
9. The highest level of education the mother has completed. Primary school =1 Middle school =2 High School = 3 University = 4	11. Date of Birth Day Month Year <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
12. How many people slept in this house last night?	<input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/>
13. How many rooms (including kitchen) does the house have?	<input style="width: 40px; height: 25px; border: 1px solid black;" type="text"/>

14	<p>What is the main source of water for your household?</p> <p><i>DO NOT READ THE CHOICES. CIRCLE THE NUMBER OF THE MAIN WATER SOURCE. IF OTHER, WRITE IN THE SOURCE.</i></p>	<p>Piped into the house..... 1 A pipe in the yard2 A public standpipe3 Borehole or tubewell4 From a spring.....5 Other _____ 6 (specify)</p>
15	<p>What is the main form of excreta control for your household?</p> <p><i>DO NOT READ THE CHOICES. CIRCLE THE NUMBER OF THE MAIN FORM THE MOTHER SAYS. IF OTHER, WRITE IN THE FORM OF EXCRETA CONTROL.</i></p>	<p>Indoor Flush system 1 Outdoor Flush system.....2 Pit latrine3 Other _____ 4 (specify)</p>
16	<p>Do you work outside of the home to earn money?</p> <p>If yes, what kind of work do you do?</p> <p><i>DO NOT READ CHOICES. CIRCLE ALL MENTIONED.</i></p>	<p>No outside work 1 Farmer/agricultural work2 Professional/administrative/clerkal...3 Factory/mine/laborer4 Other salaried employment.....5 Seasonal Laborer6 Private/small business..... 7 Other _____ 8 (specify)</p>
17	<p>What best describes the main employment status of (NAME'S) FATHER?</p> <p><i>DO NOT READ CHOICES. CIRCLE THE LETTER OF THE TERM THAT BEST MATCHES FATHER'S EMPLOYMENT.</i></p>	<p>Deceased/divorced (not in household).....A Migrant workerB Farmer/agricultural workC Professional/administrative/clerkal...D Factory/mine/laborerE Other salaried employment.....F Seasonal Laborer.....G Private/small business.....H UnemployedI Other _____ J (specify)</p>
18	<p>How many children living in this household are under five years of age?</p>	<p style="text-align: center;"><input type="text"/></p>
19	<p>How many of those children under five are your biological children?</p>	<p style="text-align: center;"><input type="text"/></p>

20	What is the sex and date of birth of your two youngest children? <i>NO AGE LIMITATION FOR SECOND CHILD.</i>	Child #1 (NAME)	Child #2 (next youngest)										
		1 = Male 2 = Female	1 = Male 2 = Female										
		<u>Date of birth</u>	<u>Date of birth</u>										
		Day <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>							Day <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>				
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III. CHILDHOOD IMMUNIZATION

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
21	Has (NAME) ever taken a vitamin A dose like this one? SHOW VITAMIN A CAPSULE.	Yes 1 No..... 2 Don't know 8	2→23 8→23
22	If YES when?	In the past 6 months 1 More than 6 months ago..... 2 Don't remember 8	
23	Do you have a card or health book where (NAME'S) vaccinations are written down? IF YES: May I see it please?	Yes, seen by interviewer 1 Not available/lost/misplaced 2 Never had a card or book 3 Don't know 8	2→26 3→26 8→26
24	(1) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD. (2) WRITE "44" IN DAY= COLUMN IF CARD SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE IS RECORDED		
		Day Month Year	
	BCG (tuberculosis)		
	HEPATITIS B 1		
	HEPATITIS B 2		
	HEPATITIS B 3		
	POLIO 1		
	POLIO 2		
	POLIO 3		
	DPT 1 (three vaccine)		
	DPT 2		
	DPT 3		
	MEASLES/RUBELLA		
25	Has (NAME) received any vaccinations that are not recorded on this card? <i>CIRCLE RESPONSE THE MOTHER GIVES</i>	YES 1 NO..... 2 DON'T KNOW 8	2→28 8→28
<i>If no card is available, then complete the following questions</i>			
26	Did (NAME) ever receive any vaccinations to prevent	YES 1	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	him/her from getting diseases?	NO..... 2 DON'T KNOW..... 8	2→28 8→28
	<i>PLEASE TELL ME IF (NAME) RECEIVED ANY OF THE FOLLOWING VACCINATIONS:</i>		
27A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
27B	Hepatitis B injection in the right thigh?	YES..... 1 NO..... 2 DON'T KNOW..... 8	2→27D 8→27D
27C	How many times was Hepatitis B given?	NUMBER OF TIMES <input type="checkbox"/> DON'T KNOW..... 8	
27D	Polio vaccine, that is, drops in the mouth?	YES..... 1 NO..... 2 DON'T KNOW..... 8	2→27F 8→27F
27E	How many times was the polio vaccine received?	NUMBER OF TIMES <input type="checkbox"/> DON'T KNOW..... 8	
27F	DPT vaccination (<i>“three vaccine” or “vaccine of fever”</i>), that is, an injection given in the left thigh, sometimes at the same time as polio drops (<i>in the mouth</i>)?	YES..... 1 NO..... 2 DON'T KNOW..... 8	2→27H 8→27H
27G	How many times was DPT given?	NUMBER OF TIMES <input type="checkbox"/> DON'T KNOW..... 8	
27H	An injection in thigh to prevent measles or rubella?	YES..... 1 NO..... 2 DON'T KNOW..... 8	

IV. BREASTFEEDING AND INFANT/CHILD NUTRITION

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
28	Did you ever breastfeed (NAME)?	Yes..... 1	2→36
29	How long after birth did you first put (NAME) to the breast?	Immediately (within first hour) after delivery..... 1 After the first hour, but within the first 24 hours..... 2 After 24 hours..... 3	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		Don't remember/Don't know...8	
30	During the first three days after delivery, did you give (NAME) the liquid (colostrum) that came from your breasts?	Yes 1 No..... 2 Don't know 8	
31	During the first three days after delivery , did you give (NAME) anything else (food or drink) before giving him/her breastmilk?	Yes 1 No..... 2 Don't know 8	2→33 8→33
32	What did you give (NAME) during the first 3 days before feeding him/her breastmilk? <i>DO NOT READ THE LIST. CIRCLE THE NUMBERS FOR ALL MENTIONED.</i> <i>Anything else? How about water?</i>	Cow, sheep, or goat milk 1 Plain water 2 Sugar or glucose water..... 3 Fruit juice..... 4 Infant formula 5 Tea/infusions..... 6 Other_____ 7 (specify)	
33	Are you currently breastfeeding (NAME)?	YES 1 NO..... 2	2→35
34	How often do you breastfeed (NAME)? <i>DO NOT READ THE CHOICES. CIRCLE BEST ANSWER.</i>	When the baby wants 1 On a regular schedule.....2 Both.....3 Don't know.....8	1→36 2→36 3→36 8→36
35	For how long did you breastfeed (NAME)? <i>IF LESS THAN ONE MONTH, RECORD "00" MONTHS.</i>	MONTHS <input type="text"/> <input type="text"/>	
36	Now I would like to ask you about the types of liquids [NAME] drank during the last 24 hours . Did [NAME] drink any of the following liquids during the last 24 hours ? <i>READ THE LIST OF LIQUIDS. CIRCLE THE LETTER IF [NAME] DRANK THE LIQUID.</i>	Breastmilk A Plain water..... B Sugar or glucose water..... C Infant formula D Any fresh animal milk such as cow, goat or sheep..... E Powdered or canned animal milk F Yogurt G Fruit juice H Carbonated drinks I Coffee or tea J Soup broth K Syrup -vitamin or mineral supplements L Others_____ M (Specify)	
37	Did (NAME) drink anything from a bottle with a nipple during the last 24 hours ?	Yes.....1 No.....2 Don't know.....8	
38	Now I would like to ask you about the types of food	Any foods made from grain	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<p>(NAME) ate during the last 24 hrs.</p> <p>Did (NAME) eat any of the following foods during the last 24 hours.</p> <p>READ THE LIST OF FOODS. CIRCLE THE LETTER IF (NAME) ATE THE FOOD.</p>	<p>(for example, muhalebi, sultash, pilaf, macaroni, bread, quille).....A</p> <p>Pumpkin, carrots.....B</p> <p>Any other food made from roots (for example, potatoes, beet root).....C</p> <p>Any dark green leafy vegetables (for example, spinach).....D</p> <p>Other fruits and vegetables (for example, bananas, apples, oranges, tomatoes, cucumbers, peppers, egg plants, cabbage, onions)E</p> <p>Any beef, pork, lamb, goat, rabbit, or dried meatF</p> <p>Any chicken, duck, turkey, or other poultryG</p> <p>Any fresh or dried fish, or seafood.....H</p> <p>Any eggs.....I</p> <p>Any foods made from beans or lentils (for example, white beans).....J</p> <p>Any peanuts, chestnuts, cashews, hazel nuts, walnuts.....K</p> <p>Any cheese or yogurtL</p> <p>Any food made with oil, fat, or butter.....M</p> <p>Any organ meats (for example, liver, kidney, heart, others).....N</p>	

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
39	<p>How many times did (NAME) eat during the last 24 hours?</p> <p>THIS INCLUDES ALL MAIN MEALS AND SNACKS SUCH AS FRUITS AND CHEESE.</p> <p>DOES NOT INCLUDE LIQUIDS.</p> <p><i>IF MOTHER ANSWERS SEVEN OR MORE TIMES, RECORD "7"</i></p>	<p>NUMBER OF TIMES <input type="checkbox"/></p> <p>DON'T KNOW = 8</p>	
40	<p>May I take a sample of the salt that is used for cooking?</p> <p><i>ASK THE MOTHER TO PUT ABOUT 30 GRAMS OF SALT IN THE PLASTIC BAG (ABOUT HALF FULL).</i></p> <p><i>LABEL CLEARLY AND COMPLETELY WITH CHILD'S FIRST NAME, CLUSTER NUMBER, AND NAME OF VILLAGE OR TOWN.</i></p>	<p>Yes.....1</p> <p>No (refused).....2</p>	

V. HANDWASHING

41	<p>When do you wash your hands with soap?</p> <p><i>DO NOT READ.</i></p> <p><i>CIRCLE NUMBER FOR ALL ANSWERS GIVEN.</i></p> <p><i>WHEN ELSE?</i></p>	<p>Never..... 1</p> <p>Before/during food preparation...2</p> <p>Before eating.....3</p> <p>Before feeding children..... 4</p> <p>After defecation..... 5</p> <p>After attending to a child who has defecated.....6</p> <p>After shaking hands with people 7</p> <p>Other_____9</p> <p>(specify)</p>	
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VI. CHILDHOOD ILLNESS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
42	<p>Sometimes children get sick and need to receive immediate treatment for illnesses. What are the danger signs that would indicate your child needs immediate treatment?</p> <p><i>DO NOT READ.</i></p> <p><i>CIRCLE ALL LETTERS MENTIONED.</i></p> <p><i>IF MOTHER MENTIONS "COUGH", RECORD AS OTHER, AND ASK "WHAT ELSE."</i></p>	<p>Don't know A</p> <p>Looks unwell B</p> <p>Not playing normally C</p> <p>Crying continuously D</p> <p>Not eating or drinkingE</p> <p>Lethargic or difficult to wake.....F</p> <p>High fever G</p> <p>Fast or difficult breathing..... H</p> <p>Vomits everything..... I</p> <p>Convulsions..... J</p> <p>Blood in the stool K</p> <p>Persistent diarrheaL</p> <p>Getting sicker M</p> <p>OTHER_____N</p> <p>(SPECIFY)</p>	

		OTHER _____ <u>O</u> (SPECIFY)	
		OTHER _____ <u>P</u> (SPECIFY)	
43	Did (NAME) experience any of the following in the past two weeks ? <i>READ TO MOTHER, CIRCLE THE NUMBERS FOR ALL MENTIONED.</i> <i>IF MOTHER IS UNSURE WHAT YOU MEAN BY "DIARRHEA," TELL HER THAT IT MEANS THREE OR MORE WATERY STOOLS ON THE SAME DAY.</i>	Diarrhea..... 1 Blood in stool 2 Cough 3 Difficult breathing 4 Fast breathing/short, quick breaths.... 5 Fever..... 6 Convulsions..... 7 <i>Other illnesses or symptoms (specify)..... 8</i> No illness in the past 2 weeks 9	9→66
44	<i>ASK MOTHER, IF (NAME) WAS SICK IN THE LAST 2 WEEKS.</i> If (NAME) was breastfeeding, when (NAME) was sick in the past 2 weeks , did you breastfeed him/her less than usual, about the same amount, or more than usual?	Child not breastfed 1 Less 2 Same..... 3 More 4 Don't know 8	
45	<i>ASK MOTHER, IF (NAME) WAS SICK IN THE LAST 2 WEEKS.</i> When (NAME) was sick in the past 2 weeks , was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	Less 1 Same..... 2 More 3 Nothing to drink 4 Don't know 8	
46	<i>ASK MOTHER, IF (NAME) WAS SICK IN THE LAST 2 WEEKS.</i> When (NAME) was sick in the past 2 weeks , was he/she offered less than usual to eat, about the same amount, or more than usual to eat?	Less 1 Same..... 2 More 3 Nothing to eat..... 4 Don't know 8	
47	<i>ASK MOTHER, IF (NAME) WAS SICK IN THE LAST 2 WEEKS.</i> During the period when (NAME) was recovering from his or her illness, did you give him/her less than usual to eat or drink, about the same amount, or more than usual to eat or drink?	Less 1 Same..... 2 More 3 Nothing to eat or drink 4 Don't know 8	

VII. ACUTE RESPIRATORY INFECTIONS (ARI)

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
48	Has (NAME) had an illness with a cough at any time during the last two weeks ?	Yes 1 No 2 Don't know 8	2→57 8→57
49	When (NAME) had an illness with a cough in the last two weeks , did he/she have trouble breathing or breathe faster than usual with short, fast breaths?	Yes 1 No 2 Don't know 8	2→57 8→57

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
50	Did you seek advice or treatment outside the home for the cough or fast breathing?	Yes 1 No 2	2→55
51	How long after you noticed (NAME's) cough and fast breathing did you seek treatment?	Same day 1 The following day 2 Two days later 3 Three or more days 4 Don't know/don't remember 8	
52	Where did you FIRST get advice or treatment? <i>DO NOT READ.</i> <i>CIRCLE THE LETTER FOR THE FIRST SOURCE OF ADVICE OR TREATMENT.</i> IF SOURCE IS HOSPITAL, HEALTH CENTER, CLINIC, OR AMBULANCA WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	Hospital A Polyclinic B Health center C Ambulanca D Home visit by village midwife/nurse E Community-based health promoter F Private clinic G Pharmacy H Popular doctor I Religious healer J Friend/relative K Don't know/don't remember L Other _____ M (specify)	
53	Did you obtain advice or treatment for (NAME'S) cough and fast/difficult breathing anywhere else?	Yes 1 No 2	2→55
54	Where did you next obtain advice or treatment? <i>DO NOT READ.</i> <i>CIRCLE THE LETTER FOR THE SECOND SOURCE OF ADVICE OR TREATMENT.</i> IF SOURCE IS HOSPITAL, HEALTH CENTER, CLINIC, OR AMBULANCA, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	Hospital A Polyclinic B Health center C Ambulanca D Home visit by village midwife/nurse E Community-based health promoter F Private clinic G Pharmacy H Popular doctor I Religious healer J Friend/relative K Don't know/don't remember L Other _____ M (specify)	
55	Which medicines were given to (NAME) for cough or difficult breathing? <i>DO NOT READ.</i>	Nothing A Aspirin B Paracetamol C Paracetamol suppositories D	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<i>RECORD ALL MENTIONED.</i>	Analgin..... E Antibiotic tablets/syrup..... F InjectionG IV drip.....H Unknown oral medication (tablets or syrup) I Traditional or home treatment J Don't know/don't rememberK Other _____ M (specify)	K→57
56	Where were these medications obtained? <i>DO NOT READ.</i> <i>CIRCLE ONE LETTER ONLY FOR THE MAIN SOURCE OF MEDICINES FOR THE CHILD.</i>	Hospital.....A Polyclinic B Health center C Ambulanca/village nurse/midwifeD Community-based health promoter.....E Private clinic..... F PharmacyG ShopH Popular doctor..... I Religious healerJ Friend/relative.....K Left-overs or home stock L Don't know/don't remember.....M Other _____ N (specify)	

VIII. DIARRHEA

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
57	Has (NAME) had diarrhea in the last 2 weeks ? <i>IF MOTHER IS UNSURE WHAT YOU MEAN BY "DIARRHEA," TELL HER THAT IT MEANS THREE OR MORE WATERY STOOLS ON THE SAME DAY.</i>	YES1 NO2 DON'T KNOW8	2→66 8→66
58	What was given to (NAME) at home during the diarrhea? DO NOT READ. CIRCLE THE LETTERS OF ALL MENTIONED. Anything else?	NothingA Fluid made from ORS packetB Sugar-Salt Solution C Extra waterD Milk or infant formula..... E Tea/infusions F Rice broth.....G YogurtH Bananas. I Eggs.....J	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		Wool around the waist.....K Aspirin.....L ParacetamolM Analgin.....N Antibiotic tablet/syrup.....O Antidiarrheal medication.....P Unknown oral medication (tablets or syrup)Q Don't know/don't remember.....R Other_____S (Specify)	
59	Did you seek advice or treatment from someone outside of the home for (NAME'S) diarrhea?	Yes 1 No..... 2	2→66
60	How long after you noticed (NAME's) diarrhea did you seek treatment outside of the home?	Same day 1 The following day 2 Two days later..... 3 Three or more days 4	
61	Where did you first go for advice or treatment? <i>DO NOT READ.</i> <i>CIRCLE THE LETTER FOR THE FIRST PLACE OF ADVICE OR TREATMENT OUTSIDE THE HOME.</i> <i>CIRCLE ONE LETTER ONLY.</i> <i>IF SOURCE IS HOSPITAL, HEALTH CENTER, CLINIC, OR AMBULANCA, WRITE THE NAME OF THE PLACE.</i> _____ (name of place)	Hospital A PolyclinicB Health centerC Ambulanca D Home visit by village midwife/nurse.....E Community-based health promoter..... F Private clinic G Pharmacy..... H Popular doctorI Religious healer.....J Friend/relative K Don't know/don't remember.....L Other_____M (specify)	
62	Did you go anywhere else for advice or treatment for (NAME'S) diarrhea?	Yes.....1 No.....2	2→64
63	Where did you go next for advice or treatment? <i>DO NOT READ.</i> <i>CIRCLE THE LETTER FOR THE SECOND PLACE OF ADVICE OR TREATMENT OUTSIDE THE HOME.</i> <i>CIRCLE ONE LETTER ONLY.</i> <i>IF SOURCE IS HOSPITAL, HEALTH CENTER,</i>	Hospital A PolyclinicB Health centerC Ambulanca D Home visit by village midwife/nurse.....E Community-based health promoter..... F Private clinic G Pharmacy..... H Popular doctor.....I	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<p><i>CLINIC, OR AMBULANCA, WRITE THE NAME OF THE PLACE.</i></p> <p>_____</p> <p>(NAME OF PLACE)</p>	Religious healer.....J Friend/relative K Don't know/don't remember.....L Other _____ M (specify)	
64	<p>Which medicines (NOT HOME TREATMENTS) were prescribed or directed to (NAME) for treatment of diarrhea?</p> <p><i>DO NOT READ LIST.</i></p> <p><i>RECORD ALL MENTIONED.</i></p> <p>Anything else?</p>	Nothing A ORS.....B Aspirin.....C Paracetamol..... D Analgine.....E Antibiotic tablets/syrup F Antidiarrheal medication..... G Unknown oral medication (tablets or syrup)H InjectionI IV drip.....J Traditional treatments.....K Don't know/don't remember..L Other_____ M (specify)	L→66
65	<p>Where were these medicines obtained?</p> <p><i>DO NOT READ.</i></p> <p><i>CIRCLE ONE LETTER ONLY FOR THE MAIN SOURCE OF MEDICINES FOR THE CHILD.</i></p>	Hospital A PolyclinicB Health centerC Ambulanca/village nurse/ midwife D Community-based health promoterE Private clinic..... F Pharmacy..... G Shop H Popular doctorI Religious healer.....J Friend/relative K Left-overs or home stockL Don't know/don't remember.....M Other_____ N (specify)	
66	<ul style="list-style-type: none"> • Have you heard of ORS or seen a packet like this? SHOW ORS PACKET • If yes, ask mother to describe ORS preparation for you. • If she says "NO" circle 3 (never heard of or saw ORS). • Once mother has provided a description, record whether she described ORS preparation correctly or incorrectly. <p><i>Circle 1 [correctly] if the mother mentions the following:</i></p>	Described correctly 1 Described incorrectly 2 Never heard of ORS or seen pkt 3	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<ul style="list-style-type: none"> ● Use 1 liter (1 kg) of boiled drinking water if large packet or use 250 ml of boiled drinking water if small packet. ● Use the entire packet. ● Dissolve the powder fully. 		

IX. PRENATAL CARE

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
67	Did you consult with anyone for prenatal care while you were pregnant with (NAME)?	Yes 1 No..... 2	2→72
68	IF YES: Whom did you see? <i>DO NOT READ. RECORD ALL MENTIONED.</i>	Doctor/Ob-gyn 1 Village nurse/midwife2 Nurse 3 Midwife4 Traditional Birth Attendant...5 Community-based health promoter.....6 Other _____ 7 <i>(specify)</i>	
69	Where were these services provided? <i>DO NOT READ. RECORD ALL MENTIONED.</i>	Maternity hospital 1 Women's consultation center.2 Health center 3 Ambulanca 4 Home visit..... 5 Private practice/clinic 6 Other _____ 7 <i>(specify)</i>	
70	When were you first seen for prenatal care? <i>CIRCLE ONLY ONE RESPONSE.</i>	0-3 months1 4-6 months2 7-9 months 3 Don't know/don't remember.....8	
71	How many times did you consult with someone for care during the pregnancy with (NAME)?	Number of times <input type="text"/> <input type="text"/> <i>Don't know=99</i>	
72	Do you have a mother's card/book with a record of your immunizations? <i>IF YES, ASK TO SEE THE CARD.</i>	Yes 1 No..... 2	2→74

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																												
73	From the Mother's card, write down the dates of ALL TT vaccinations recorded on the card.	<table border="1"> <thead> <tr> <th data-bbox="878 310 1000 386">TT dose</th> <th data-bbox="1000 310 1110 386">Day</th> <th data-bbox="1110 310 1227 386">Mont h</th> <th data-bbox="1227 310 1338 386">Year</th> </tr> </thead> <tbody> <tr> <td data-bbox="878 386 1000 428">1</td> <td data-bbox="1000 386 1110 428"></td> <td data-bbox="1110 386 1227 428"></td> <td data-bbox="1227 386 1338 428"></td> </tr> <tr> <td data-bbox="878 428 1000 470">2</td> <td data-bbox="1000 428 1110 470"></td> <td data-bbox="1110 428 1227 470"></td> <td data-bbox="1227 428 1338 470"></td> </tr> <tr> <td data-bbox="878 470 1000 512">3</td> <td data-bbox="1000 470 1110 512"></td> <td data-bbox="1110 470 1227 512"></td> <td data-bbox="1227 470 1338 512"></td> </tr> <tr> <td data-bbox="878 512 1000 554">4</td> <td data-bbox="1000 512 1110 554"></td> <td data-bbox="1110 512 1227 554"></td> <td data-bbox="1227 512 1338 554"></td> </tr> <tr> <td data-bbox="878 554 1000 596">5</td> <td data-bbox="1000 554 1110 596"></td> <td data-bbox="1110 554 1227 596"></td> <td data-bbox="1227 554 1338 596"></td> </tr> <tr> <td data-bbox="878 596 1000 638">6</td> <td data-bbox="1000 596 1110 638"></td> <td data-bbox="1110 596 1227 638"></td> <td data-bbox="1227 596 1338 638"></td> </tr> </tbody> </table>	TT dose	Day	Mont h	Year	1				2				3				4				5				6				
TT dose	Day	Mont h	Year																												
1																															
2																															
3																															
4																															
5																															
6																															
74	How many TT injections did you receive during the pregnancy with (NAME)?..... <input type="checkbox"/> <input type="checkbox"/> IF UNKNOWN=88																														
75	How many TT injections did you receive during all of your pregnancies?..... <input type="checkbox"/> <input type="checkbox"/> IF UNKNOWN=88																														
76	Did you receive a measles/rubella vaccine during the last immunization campaign?	YES 1 NO 2 Don't know/don't remember.. 8																													
77	During your prenatal check, were you counseled on the following topics: READ THIS LIST AND CIRCLE THE LETTER FOR ALL RESPONSES.	NO PRENATAL CHECK ...A Delivery preparations.....B Tetanus toxoid injections....C Taking iron tablets.....D Breastfeeding.....E Importance of child spacing...F Immunization for child.....G Danger signs during pregnancy.....H Maternal nutrition.....I Work, rest and other activities during pregnancyJ NO INFORMATION GIVEN.....K																													

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
78	<p>Now I would like to ask you about when you gave birth to (NAME). Where did you give birth?</p> <p>DO NOT READ LIST.</p> <p><i>IF MOTHER DELIVERED AT MATERNITY HOSPITAL, HEALTH CENTER, CLINIC, OR AMBULANCA, WRITE THE NAME OF THE PLACE.</i></p> <p>_____</p> <p>(NAME OF PLACE)</p>	Maternity hospital 1 Health center 2 Ambulanca 3 Private practice/clinic 4 Own home 5 Other home..... 6 Other_____ 7 (specify)	
79	<p>Who assisted you with (NAME'S) delivery?</p> <p>RECORD ALL MENTIONED.</p>	Doctor/Ob-gyn 1 Nurse 2 Midwife..... 3 Traditional birth attendant. 4 Family member 5 No one..... 6 Other_____ 7 (specify)	

X. IRON SUPPLEMENTATION DURING PREGNANCY

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
80	<p>When you were pregnant with (NAME), did you receive or buy any iron tablets?</p> <p>SHOW IRON TABLETS.</p>	YES 1 NO 2 DON'T KNOW 8	2→82 8→82
81	<p>How many days did you take the iron tablets?</p> <p><i>IF ANSWER IS NOT CLEAR, PROBE FOR APPROXIMATE NUMBER OF DAYS.</i></p>	NUMBER OF DAYS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 888	

XI. POSTPARTUM CARE

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
82	<p>After (NAME'S) birth and <u>after you took (NAME) home</u>, did you have a postpartum consultation?</p>	Yes..... 1 No..... 2 Don't know/don't remember..8	2→86 8→86
83	<p>How many days or weeks after the delivery and after bringing (NAME) home, did the first postpartum consultation take place?</p>	Days after delivery <input type="text"/> <input type="text"/> Weeks after delivery <input type="text"/> <input type="text"/> Don't	

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		know.....88	
84	<p>IF YES, Where did this first postpartum consultation take place?</p> <p>DO NOT READ.</p> <p>CHECK ONLY ONE RESPONSE.</p>	Maternity..... 1 Polyclinic 2 Health Center 3 Ambulanca/village midwife/nurse.....4 Home visit/village midwife/nurse.....5 Women/child consultation center..... 6 Private Practice/Clinic.....7 Other.....8 (specify)	
85	<p>During your postpartum consultation, were you counseled on the following topics:</p> <p>READ THIS LIST AND CIRCLE THE LETTER FOR ALL RESPONSES.</p>	Breastfeeding.....1 Lactational Amenorrhea Method.....2 Family planning 3 Maternal danger signs in the post partum period4 Neonatal danger signs.....5 Immunizations for the child . 6 NO INFORMATION GIVEN.....7	
86	<p>In the first two months after delivery, did you receive a vitamin A dose like this?</p> <p>SHOW VITAMIN A CAPSULE.</p>	Yes.....1 No.....2 Don't know.....8	
87	<p>What are the danger signs that may indicate that a newborn baby is ill and requires immediate treatment?</p> <p>DO NOT READ LIST.</p> <p>CIRCLE ALL MENTIONED.</p>	Poor feeding.....1 Fast breathing.....2 Not active.....3 Redness around the cord.....4 Red/discharge in eye.....5 Other.....6 (SPECIFY) Don't know.....8	

XII. FAMILY PLANNING

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
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NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<p><i>CIRCLE LETTER FOR MAIN METHOD USED.</i></p> <p><i>IF NO, CIRCLE A [NO METHOD]</i></p>	Condom..... F Foam/gelG Tubal ligation (operation)H Vasectomy I Under skin implantsJ Lactational amenorrhea method (exclusive breastfeeding).....K CycleL AbstinenceM Would have abortion.....N Withdrawal.....O Other_____P (specify) Decline to answer..... Z	

XIII. HIV/AIDS/SIDA

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
93	Have you ever heard of an illness called SIDA?	YES 1 NO.....2 Don't know 8	2→95 8→95
94	<p>What can a person do to avoid getting SIDA or the virus that causes SIDA?</p> <p><i>DO NOT READ.</i></p> <p><i>CIRCLE THE LETTER OF ALL METHODS MENTIONED.</i></p>	NothingA Abstain from sexB Use condoms.....C Limit sex to one partner/stay faithful to one partner.....D Limit number of sexual partnersE Avoid sex with prostitutes..... F Avoid sex with persons who have many partnersG Avoid intercourse with persons of the same sexH Avoid sex with persons who inject drugs intravenously I Avoid blood transfusionsJ Avoid injectionsK Avoid sharing razors, bladesL Avoid kissingM Avoid mosquito bitesN Seek protection from popular doctorO Other_____P (specify) Other_____ Q (specify) Don't know Z	

XIV. CHILD ANTHROPOMETRY

95. Ask the mother for permission to weigh and measure (name). If she agrees to let you take (name's) measurements, record the necessary information in the spaces below. If the mother refuses permission to measure (name), record '3' [refused] in column 2. Ask to measure other children in the house under five years of age. Record (name's) measurement in the first row.

1. <i>Name of child</i> MEASURE (NAME) FIRST, THEN MEASURE OTHER CHILDREN IN THE HOUSEHOLD UNDER AGE FIVE YEARS.	2. <i>Result</i> 1 measured 2 not present 3 refused 6 other	3. Sex M/F	4. BIOL OGICAL CHILD? Y/N	5. What is his/her date of birth? Day Month Year			6. Weight	7. Height <i>UNDER 2 YRS LIE DOWN, OVER 2 YRS STANDING</i>
(1)								
(2)								
(3)								
(4)								
(5)								

Remember to thank the mother for her time in answering the questions!

DATA FILE KPC SURVEY

1. Cluster number {Q1}##
 2. Household number {Q2}###
 3. Record number {Q3}<IDNUM>
 4.A.district {Q4-a} #
 4.B.town/village {Q4-b} ##
 5. interview date {Q5}<dd/mm>, 2003
 6. interviewer {Q6} ##
 7. Supervisor {Q7} #
 8. Age of mother {Q8}## years
 9. education {Q9}#
 10. Sex of child {Q10}#
 11. date of birth {Q11}<dd/mm/yyyy>
 12. How many people slept in house last night {Q12}##
 13. Rooms in house {Q13}##
 14. Main source of water {Q14}#
 {Q14-6} other< >
 15. Excreta control {Q15}#
 {Q15-4} other< >
 16. Mother's employment
 IF CIRCLED ENTER NUMBER IF NOT "0"
 1 No outside work.....{Q16-1}#
 2 Farmer/agricultural work.....{Q16-2}#
 3 Professional/admin/clerkal..{Q16-3}#
 4 Factory/mine/laborer.....{Q16-4}#
 5 Other salaried employment....{Q16-5}#
 6 Seasonal laborer.....{Q16-6}#
 7 Private/small business.....{Q16-7}#
 8 Other.....{Q16-8}#
 Specify other {Q16-8b}< >
 17. Father's employment {Q17}<A>
 {Q17-J} other< >
 18. Children in house under 5 {Q18}##
 19. Of these no. mother's biological children {Q19}##
 20. Two youngest children
 child 1
 sex {Q20-1}# DOB {Q20-2}<dd/mm/yyyy>
 child 2
 sex {Q20-3}# DOB {Q20-4}<dd/mm/yyyy>
 21. Ever taken Vitamin A {Q21}#
 22. If vit A taken, when? {Q22}#
 23. Do you have immunization record? {Q23}#
 24. Dates for immunizations
 LEAVE BLANK IF NO DATE RECORDED
 BCG {Q24-a}<dd/mm/yy>
 Hep B1 {Q24-b}<dd/mm/yy>
 Hep B2 {Q24-c}<dd/mm/yy>
 Hep B3 {Q24-d}<dd/mm/yy>
 Polio 1 {Q24-e}<dd/mm/yy>
 Polio 2 {Q24-f}<dd/mm/yy>
 Polio 3 {Q24-g}<dd/mm/yy>
 DPT1 {Q24-h}<dd/mm/yy>
 DPT2 {Q24-i}<dd/mm/yy>
 DPT3 {Q24-j}<dd/mm/yy>
 Meas1/Rubel {Q24-k}<dd/mm/yy>

25. Immun not recorded {Q25}#
26. Ever receive any vaccines? {Q26}#
27. History of immunization
- BCG {Q27-a}#
 - HepB {Q27-b}#
 - HepB no {Q27-c}#
 - Polio {Q27-d}#
 - Polio no {Q27-e}#
 - DPT {Q27-f}#
 - DPT no {Q27-g}#
 - Mea/Rub {Q27-h}#
28. Ever breastfeed? {Q28}#
29. When put to the breast? {Q29}#
30. Gave colostrum? {Q30}#
31. Give anything else to drink? {Q31}#
32. Gave what in 1st 3 days?
- IF CIRCLED ENTER THE NUMBER IF NOT THEN "0"
- 1 cow or goat milk. . . . {Q32-1}#
 - 2 plain water {Q32-2}#
 - 3 sugar/glucose water . . {Q32-3}#
 - 4 fruit juice {Q32-4}#
 - 5 infant formula {Q32-5}#
 - 6 tea/infusion {Q32-6}#
 - 7 other {Q32-7}#
 - specify other {Q32-7b}< >
33. Currently breastfeeding? {Q33}#
34. How often breastfeeding? {Q34}#
35. How long did you breastfeed? {Q35}##
36. Liquids given in past 24 hours
- IF CIRCLED ENTER THE LETTER IF NOT THEN "Z"
- A breastmilk {Q36-a}<A>
 - B plain water {Q36-b}<A>
 - C sugar or glucose water {Q36-c}<A>
 - D infant formula {Q36-d}<A>
 - E fresh milk..... . {Q36-e}<A>
 - F powdered canned milk . {Q36-f}<A>
 - G yogurt. {Q36-g}<A>
 - H fruit juice. {Q36-h}<A>
 - I carbonated drinks . . . {Q36-i}<A>
 - J coffee or tea {Q36-j}<A>
 - K soup broth {Q36-k}<A>
 - L vitamin syrup {Q36-l}<A>
 - M other {Q36-m}<A>
 - {Q36-mb} specify < >
37. Drank from bottle with nipple? {Q37}#
38. Types of food given in past 24 hours
- IF CIRCLED ENTER THE LETTER IF NOT THEN "Z"
- A grains. {Q38-a}<A>
 - B pumpkin carrot.. . {Q38-b}<A>
 - C root foods.. . . . {Q38-c}<A>
 - D dark green leafy . {Q38-d}<A>
 - E other fruits veg . {Q38-e}<A>
 - F meat..... {Q38-f}<A>
 - G poultry. {Q38-g}<A>
 - H fish..... {Q38-h}<A>
 - I eggs... {Q38-i}<A>
 - J legumes... {Q38-j}<A>

- K nuts {Q38-k} <A>
 L cheese/yogurt . . . {Q38-l} <A>
 M fat butter oil {Q38-m} <A>
 N organ meat {Q38-n} <A>
39. Number of feeds in past 24 hrs {Q39}#
40. Cooking salt collected? {Q40}#
41. Hand washing with soap
 IF CIRCLED ENTER THE NUMBER IF NOT THEN "0"
 1 never {Q41-1}#
 2 before/during food prep , , {Q41-2}#
 3 before eating {Q41-3}#
 4 before feeding children . . . {Q41-4}#
 5 after defecation {Q41-5}#
 6 after attending to child def {Q41-6}#
 7 after shaking hands {Q41-7}#
 8 all the time {Q41-8}#
 9 other {Q41-9}#
 specify {Q41-9b} < >
42. Danger signs
 IF CIRCLED ENTER THE LETTER, IF BLANK ENTER Z
 A Don't know {Q42-a} <A>
 B Looks unwell {Q42-b} <A>
 C Not playing normally {Q42-c} <A>
 D Crying continuously {Q42-d} <A>
 E Not eating or drinking . . . {Q42-e} <A>
 F Lethargic, hard to wake . . . {Q42-f} <A>
 G High fever {Q42-g} <A>
 H Fast or difficult breaths . . {Q42-h} <A>
 I Vomits everything {Q42-i} <A>
 J Convulsions {Q42-j} <A>
 K Blood in the stool {Q42-k} <A>
 L persistent diarrhea {Q42-l} <A>
 M getting sicker {Q42-m} <A>
 N other {Q42-n} <A>
 specify {Q42-nb} < >
 O other {Q42-o} <A>
 specify {Q42-ob} < >
 P other {Q42-p} <A>
 specify {Q42-pb} < >
43. Illness in the past two weeks
 IF CIRCLED ENTER THE NUMBER, ENTER "0" FOR BLANK
 1 Diarrhea {Q43-1}#
 2 Blood in the stools {Q43-2}#
 3 Cough {Q43-3}#
 4 Difficult breathing {Q43-4}#
 5 Fast breathing/short quick breaths . . {Q43-5}#
 6 FEVER {Q43-6}#
 7 convulsions {Q43-7}#
 8 Any others {Q43-8}#
 specify {Q43-8b} < >
 9 No illness in the past 2 weeks {Q43-9}#
44. Breastfeeding when ill {Q44}#
45. offer more to drink when ill {Q45}#

46. Offer more to eat when ill {Q46}#
47. Offered more to eat and drinking when recovering {Q47}#
48. cough in past 2 weeks {Q48}#
49. Trouble breathing or breathe faster {Q49}#
50. Seek advice or treatment outside home? {Q50}#
51. Onset of symptoms until treatment {Q51}#
52. First place for treatment {Q52}<A>
 {Q52-b} Hosp or clinic name < >
 {Q52-m} other source of rx < >
53. Did you go anywhere else? {Q53}#
54. Where did you next obtain advice or treatment? {Q54}<A>
 {Q54-b} Hospital or clinic name < >
 {Q54-m} other source of rx < >
55. Which medicines were given?
 IF CIRCLED ENTER THE LETTER, ENTER "Z" IF BLANK
- A Nothing {Q55-a}<A>
 B Aspirin {Q55-b}<A>
 C Paracetamol {Q55-c}<A>
 D Paracetamol supp {Q55-d}<A>
 E Analgine. {Q55-e}<A>
 F Antibiotic tabs/syrup. {Q55-f}<A>
 G Injection {Q55-g}<A>
 H IV drip {Q55-h}<A>
 I unknown oral medicine {Q55-i}<A>
 J traditional or home treatment . {Q55-j}<A>
 K don't know {Q55-k}<A>
 L other {Q55-l}<A>
 specify {Q55-lb}< >
56. Where were meds obtained? {Q56}<A>
 {Q56-N} other source of rx < >
57. Diarrhea in the last 2 weeks? {Q57}#
58. Home treatment for the diarrhea?
 IF CIRCLED ENTER THE LETTER, ENTER "Z" IF BLANK
- A nothing {Q58-a}<A>
 B ORS {Q58-b}<A>
 C Sugar-salt sol {Q58-c}<A>
 D extra water {Q58-d}<A>
 E milk or infant formula. . . {Q58-e}<A>
 F tea/infusions..... {Q58-f}<A>
 G rice broth..... {Q58-g}<A>
 H yohurt. {Q58-h}<A>
 I bananas {Q58-i}<A>

- J eggs.....{Q58-j}<A>
 K wool around waist.....{Q58-k}<A>
 L aspirin.....{Q58-l}<A>
 M paracetamol.....{Q58-m}<A>
 N analgin.....{Q58-n}<A>
 O antibiotic tab/syr.....{Q58-o}<A>
 P anti-diarrheal meds.....{Q58-p}<A>
 Q unknown oral meds.....{Q58-q}<A>
 R don't know/don't remember..{Q58-r}<A>
 S other{Q58-s}<A>
 specify {Q58-s1} < >
59. Advice or treatment outside home? {Q59}#
60. Onset of symptoms until treatment {Q60}#
61. First place for treatment {Q61}<A>
 {Q61-b} Hosp or clinic name < >
 {Q61-m} other source of < >
62. Did you go anywhere else? {Q62}#
63. Where did you go next {Q63}<A>
 {Q63-b} Hosp or clinic name < >
 {Q63-m} other source of tx < >
64. Which medicines were given (not home tx)?
 IF CIRCLED ENTER THE LETTER, ENTER "Z" IF BLANK
 A Nothing{Q64-a}<A>
 B ORS.....{Q64-b}<A>
 C Aspirin.....{Q64-c}<A>
 D Paracetamol.....{Q64-d}<A>
 E Analgin.....{Q64-e}<A>
 F Antibiotic tablets/syrup.....{Q64-f}<A>
 G Antidiarrheal meds.....{Q64-g}<A>
 H Unknown oral meds.....{Q64-h}<A>
 I Injection.....{Q64-i}<A>
 J IV drip.....{Q64-j}<A>
 K Traditional treatment(s).....{Q64-k}<A>
 L don't kno/don't remember.....{Q64-l}<A>
 M other.....{Q64-m}<A>
 specify {Q64-m1}< >
65. Where was the meds obtained? {Q65} <A>
 65-n other source of rx {Q65-n1} < >
66. Mother to describe ORS preparation {Q66} #
67. Did you see anyone for prenatal care while you were pregnant?
 {Q67}#
68. IF YES: Whom did you see?
 IF YES ENTER THE NUMBER. ENTER "0" IF BLANK.
 1 Doctor/OB-GYN.....{Q68-1}#
 2 Village nurse/midwife.....{Q68-2}#
 3 Nurse.....{Q68-3}#
 4 Midwife.....{Q68-4}#

- 5 Traditional birth attendant.....{Q68-5}#
 6 Community-based health promoter...{Q68-6}#
 7 Other.....{Q68-7}#
 Specify {Q68-7b} < >
69. Where were these services provided?
 IF CIRCLED, ENTER THE NUMBER. ENTER "0" IF BLANK.
 1 Maternity hospital.....{Q69-1}#
 2 Women's consultation center.....{Q69-2}#
 3 Health center.....{Q69-3}#
 4 Ambulanca.....{Q69-4}#
 5 Home visit.....{Q69-5}#
 6 Private practice/clinic.....{Q69-6}#
 7 Other.....{Q69-7}#
 Specify {Q69-7b} < >
70. When did the mother first go to health worker for antenatal care? {Q70}#
71. How many times did you see someone for care during the pregnancy? {Q71}##
72. Do you have a card with a record of your immunizations? {Q72}#
73. From the Mother's card from the last pregnancy write down the dates of TT
 LEAVE BLANK IF NO DATE IS RECORDED
 1 {Q73-1} <dd/mm/yyyy>
 2 {Q73-2} <dd/mm/yyyy>
 3 {Q73-3} <dd/mm/yyyy>
 4 {Q73-4} <dd/mm/yyyy>
 5 {Q73-5} <dd/mm/yyyy>
 6 {Q73-6} <dd/mm/yyyy>
74. How many TT injections has she received during the pregnancy?
 {Q74}##
75. How many TT injections has she received during all her pregnancies?
 {Q75}##
76. Measles/rubella vaccine?
 {Q76}#
77. During your prenatal check, were you counselled on the following:
 IF CIRCLED ENTER THE LETTER, ENTER "Z" IF BLANK
 A no prenatal check {Q77-a}<A>
 B delivery preparation {Q77-b}<A>
 C tetanus injections {Q77-c}<A>
 D taking iron tablets {Q77-d}<A>
 E breastfeeding {Q77-e}<A>
 F childhood spacing {Q77-f}<A>
 G child immunization {Q77-g}<A>
 H pregnancy danger signs {Q77-h}<A>
 I maternal nutrition {Q77-i}<A>
 J work & rest during preg {Q77-j}<A>
 K no info given {Q77-k}<A>
78. Where did you give birth? {Q78}#
 {Q78-1b}##
 {Q78-7b} Other place < >

79. Who assisted you with (NAME'S) delivery?
 IF CIRCLED, ENTER THE NUMBER, ENTER "0" IF BLANK
 1 Doctor/ob-gyn.....{Q79-1}#
 2 Nurse.....{Q79-2}#
 3 Midwife.....{Q79-3}#
 4 Traditional birth attend.{Q79-4}#
 5 Family member.....{Q79-5}#
 6 No one.....{Q79-6}#
 7 Other.....{Q79-7}#
 Specify {Q79-7b} < >
80. When you were pregnant with (NAME), did you receive or buy any iron tablets or iron syrup?
 {Q80}#
81. How many days did you take the tablets or syrup? {Q81}###
82. Postpartum consultation? {Q82}#
83. How many days or weeks? {Q83-a}## {Q83-b}## {Q83-c}##
84. Where postpartum consultation? {Q84}#
 specify {Q84-8b} < >
85. Counseled on the following topics?
 IF CIRCLED ENTER THE NUMBER, ENTER 0 IF BLANK.
 1 breastfeeding.....{Q85-1}#
 2 LAM.....{Q85-2}#
 3 family planning.....{Q85-3}#
 4 maternal danger signs.....{Q86-4}#
 5 neonatal danger signs.....{Q85-5}#
 6 child immunizaations.....{Q85-6}#
 7 no information given.....{Q85-7}#
86. Postpartum vitamin A? {Q86}#
87. What are neonatal danger signs?
 IF CIRCLED ENTER NUMBER, ENTER 0 IF BLANK.
 1 poor feeding.....{Q87-1}#
 2 fast breathing.....{Q87-2}#
 3 not active.....{Q87-3}#
 4 redness around cord.....{Q87-4}#
 5 red/discharge in eye.....{Q87-5}#
 6 other.....{Q87-6}#
 specify {Q87-6b} < >
 8 don't know.....{Q87-8}#
88. Heard of family planning methods?
 IF CIRCLED ENTER LETTER, ENTER W IF BLANK.
 A injections.....{Q88-a}<A>
 B pill.....{Q88-b}<A>
 C IUD/spital/coil.....{Q88-c}<A>
 D barrier method/diaphram.....{Q88-d}<A>
 E condom.....{Q88-e}<A>
 F foam/gel.....{Q88-f}<A>
 G tubal ligation.....{Q88-g}<A>


```

    specify {Q94-p1}<
Q other. . . . .{Q94-q}<A>
    specify {Q94-q1}<
Z don't know . . . . .{Q94-z}<A>

```

95. CHILD 1 result {Q95-1a}#; sex {Q95-1b}#; biological {Q95-1c}<Y>; birth date {Q95-1d}<dd/mm/yyyy> weight {Q95-1e}##.# kg; height {Q95-1f}###.#; another child? {Q95-1g}<Y>

CHILD 2 result {Q95-2a}#; sex {Q95-2b}#; biological {Q95-2c}<Y>; birth date {Q95-2d}<dd/mm/yyyy> weight {Q95-2e}##.# kg; height {Q95-2f}###.#cm; another child? {Q95-2g}<Y>

CHILD 3 result {Q95-3a}#; sex {Q95-3b}#; biological {Q95-3c}<Y>; birth date {Q95-3d}<dd/mm/yyyy> weight {Q95-3e}##.# kg; height {Q95-3f}###.#cm; another child? {Q95-3g}<Y>

CHILD 4 result {Q95-4a}#; sex {Q95-4b}#; biological {Q95-4c}<Y>; birth date {Q95-4d}<dd/mm/yyyy> weight {Q95-4e}##.# kg; height {Q95-4f}###.#cm; another child? {Q95-4g}<Y>

CHILD 5 result {Q95-5a}#; sex {Q95-5b}#; biological {Q95-5c}<Y>; birth date {Q95-5d}<dd/mm/yyyy> weight {Q95-5e}##.# kg; height {Q95-5f}###.#cm

END

Questionnaire in Albanian

**PROGRAMI “MBIJETESA E FEMIJEVE”, SHQIPERI (MF-19)
VEZHGIMI “NJOHURI, PRAKTIKE DHE MBULESE VAKSINORE”**

I. Formular per miratim nga nena**KERKIMI I MIRATIMIT NGA NENA BASHKESHOQUERUAR ME INFORMACIONIN PERKATES**

Pershendetje. Une quhem _____, dhe po punoj si vullnetare per Kryqin e Kuq Shqiptar, i cili ne bashkepunim me Kryqin e Kuq Amerikan po ben kete vezhgim. Pjesemarrja juaj ne kete vezhgim eshte shume e rendesishme. Ne kete pyetesor kerkohet informacion mbi shendetin tuaj dhe shendetin e femijes tuaj me te vogel nen 2 vjec. Ky informacion do te ndihmoje Kryqin e Kuq dhe autoritetet shendetesore lokale, per te hartuar nje projekt shendetesor 5-vjeçar ne nivel komuniteti ne te gjithë rrethet e Prefektures se Dibres (Diber, Mat dhe Bulqiza) dhe ne te njejten kohe, ndihmon per te vleresuar arritjet e deritanishme ne permiresimin e shendetit te nenes dhe femijes. Pyetesori pergjithesisht kerkon rreth 45 minuta per t’u plotesuar.

(LEXO SIC SHKRUEHEN DY PARAGRAFET E MEPOSHTME)

Çdo informacion qe do te merret prej jush, do te ruhet ne menyre konfidenciale dhe emri juaj nuk do te permendet gjate analizes se te dhenave. Pjesemarrja ne kete vezhgim nuk eshte e detyrueshme dhe eshte e drejta juaj te mos pergjigjeni per ndonje pyetjeje te vecante ose per te gjithë pyetesorin. Nese vendosni te mos merrni pjese, kjo nuk do te influencoje ne marrjen e sherbimeve shendetesore per te cilat mund te keni nevojë. Megjithate, ne shpresojme qe ju do te merrni pjese ne plotesimin e pyetesorit, sepse mendimet tuaja jane te rendesishme.

A keni ndonje pyetje rreth vezhgimit deri tani? Nese do te keni ndonje pyetje edhe ne te ardhmen, ju mund te kontaktoni me zyren e projektit ne Peshkopi, ne kete numer telefoni 0218 – 5320 dhe do te jemi te gatshem t’ju pergjigjemi pyetjeve tuaja.

Firma e intervistuesit: _____ Data: _____

PERSONI PRANON TE
INTERVISTOHET

PERSONI NUK PRANON TE
1 INTERVISTOHET2 — FUND

II. INFORMACION PARAPRAK

IDENTIFIKIMI											
1. NUMRI I GRUPIMIT	<table border="1"> <tr><td> </td><td> </td></tr> </table>										
2. NUMRI I SHTEPISE											
3. NUMRI I PYETESORIT											
4. a. RRETHI											
4.b. QYTET/FSHAT											

TE GJITHA PYETJET DUHET T'JU DREJTOHEN NENAVE QE KANE FEMIJE NEN MOSHEN 24 MUAJSH

5. Data e intervistimit Dita Muaji	Riplanifikimi intervistes Dita Muaji					
<table border="1"> <tr> <td> </td><td> </td> <td> </td><td> </td> <td>2003</td> </tr> </table>					2003	<p>_____ / _____</p>
				2003		
6. Emri intervistuesit						
7. Emri supervizorit						

Emri i nenes (mos shenoni mbiemrin)		Emri i femijes me te vogel nen 24 muajsh										
_____		_____										
8. Moshja e nenes (ne vjec).....	<table border="1"><tr><td> </td><td> </td></tr></table>			10. Gjinia e femijes (1=mashkull, 2=femer)	<table border="1"><tr><td> </td></tr></table>							
9. Shkollimi qe ka perfunduar nena: Fillor =1 Tetevjecar =2 I mesem = 3 I larte = 4	<table border="1"><tr><td> </td></tr></table>		11. Ditelindja Dita Muaji Viti	<table border="1"> <tr> <td> </td><td> </td> <td> </td><td> </td> <td> </td><td> </td><td> </td><td> </td> </tr> </table>								
12	Sa persona kane fjetur mbreme ne shtepine tuaj?		<table border="1"><tr><td> </td><td> </td></tr></table>									
13	Sa dhoma ka shtepia (numero edhe guzhinen)?		<table border="1"><tr><td> </td><td> </td></tr></table>									

14	<p>Ku e mbush ujin e pijshem per familjen tuaj?</p> <p>MOS LEXONI LISTEN, POR QARKO NUMRIN PER BURIMIN KRYESOR. NESE NENA PERMEND NDONJE QE NUK ESHTE PERFSHIRE NE LISTE, SHENO BURIMIN NE HAPESIREN BOSH PER TJETER.</p>	<p>Çezem brenda ne shtepi..... 1 Çezem ne oborrin e shtepise..... 2 Çezem publike (jashte oborrit)..... 3 Pus 4 Burim 5 Tjeter (percakto) _____ 6</p>	
15	<p>Cila eshte menyra e trajtimit te ujrave te zeza ne shtepine tuaj?</p> <p>MOS LEXO, POR QARKO NUMRIN E MENYRES KRYESORE QE NENA PERMEND. NESE KA TJETER SHENO NE HAPESIREN BOSH</p>	<p>WC brenda ne shtepi (me tubacion).. 1 WC jashte shtepise (me tubacion)..... 2 WC me grope 3 Tjeter (percakto)_____ 4</p>	
16	<p>A punoni diku tjeter pervecse ne shtepi per te siguruar te ardhura per familjen tuaj?</p> <p>Nese po, cfare pune beni?</p> <p>MOS LEXO, POR QARKO TE GJITHA PERGJIGJET E NENES</p>	<p>Nuk punoj diku tjeter..... 1 Fermere/ne bujqesi 2 Nenpunese 3 Fabrike/Miniere/Punetore 4 Pune te tjera me rroge..... 5 Punetore sezonale 6 Aktivitet/biznes privat 7 Tjeter (percakto) _____ 8</p>	
17	<p>Cfare pershkruan me se miri punesimin kryesor te Babait te (emrin e femijes)</p> <p>POR LEXO, QARKO SHKRONJEN QE I PERSHTATET ME SE MIRI PERGJIGJES SE NENES PER PUNESIMIN E BABAIT</p>	<p>Ka vdekur / i divorcuar (nuk jeton ne shtepi) A Migrant B Fermere/ne bujqesi C Nepunes..... D Fabrike/miniere/punetore E Pune te tjera me rroge..... F Punetore sezonal/ditor..... G Aktivitet/biznes privat..... H I papune I Tjeter _____ J</p> <p>(specifiko)</p>	
18	<p>Sa eshte numri i femijeve nen 5 vjec qe jetojne ne kete shtepi?</p>	<input type="text"/>	
19	<p>Sa prej ketyre femijeve nen 5 vjec jane femijet e tu?</p>	<input type="text"/>	
20	<p>Cila eshte gjinia dhe data e lindjes se dy femijeve te tu me te vegjel?</p> <p>SHENO MOSHEN PER FEMIJEN E DYTE, PA KUFIZIM MOSHE</p>	<p>Femija # 1 (me i vogli) 1 = Mashkull 2 = Femer Ditelindja</p> <p>Dita <input type="text"/> <input type="text"/></p> <p>Muaji <input type="text"/> <input type="text"/></p> <p>Viti <input type="text"/> <input type="text"/></p>	<p>Femija nr 2 (i parafundit) 1 = Mashkull 2 =Femer Ditelindja</p> <p>Dita <input type="text"/> <input type="text"/></p> <p>Muaji <input type="text"/> <input type="text"/></p> <p>Viti <input type="text"/> <input type="text"/></p>

Nr	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK
	A KA BERE (EMRI I FEMIJES) NDONJE NGA VAKSINAT E MEPOSHTME:		
27A	Vaksinën BCG (kunder turbekulozit), e cila është një injeksion (gjilpërë) që bëhet në pjesën e sipërme të krahut ose shpatull dhe le një shenjë të përherëshme?	PO 1 JO 2 NUK E DI 8	
27B	Vaksinën kunder Hepatitit B, e cila është një injeksion në kofshën e djathtë?	PO 1 JO 2 NUK E DI 8	2 → 27D 8 → 27D
27C	Sa here ka bërë femija vaksinën kunder Hepatitit B?	NUMRI I HEREVE <input type="checkbox"/> NUK E DI 8	
27D	Po vaksinën kunder poliomelitit e cila merret me pika nga goja?	PO 1 JO 2 NUK E DI 8	2 → 27F 8 → 27F
27E	Sa here e ka bërë femija vaksinën kunder poliomelitit?	NUMRI I HEREVE <input type="checkbox"/> NUK E DI 8	
27F	Vaksinën kunder DTP (tri-vaksina ose vakcina e temperaturës), e cila është një injeksion (gjilpërë) që bëhet në kofshën e majtë, shpesh në të njëjtën kohë me vaksinën (me pika) kunder poliomelitit?	PO 1 JO 2 NUK E DI 8	2 → 27H 8 → 27H
27G	Sa here e ka bërë femija tri-vaksinën (kunder DTP)?	NUMRI I HEREVE <input type="checkbox"/> NUK E DI 8	
27H	Vaksinën kunder Fruthit dhe Rubeoles, e cila është një gjilpërë që bëhet në kofshë?	PO 1 JO 2 NUK E DI 8	

IV. USHQYERJA ME GJI/USHQYERJA NE PERGJITHESI E FEMIJES SE VOGEL

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK:
28	A e keni ushqyer me gji ndonjëherë (EMRIN E FEMIJES)?	PO 1 JO 2	2 → 36
29	Kur e ke vënë në gji (EMRIN E FEMIJES) për herë të parë, pas lindjes?	Menjëherë pas lindjes (Brenda orës së parë) 1 Brenda 24-oreve të para (por jo	

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK:
		oren e pare pas lindjes).....2 Pas 24 oresh3 Nuk me kujtohet/Nuk e di.....8	
30	Gjate tre diteve te para pas lindjes, a i keni dhene kulloshtren (EMRI I FEMIJES)?	Po 1 Jo 2 Nuk e di 8	
31	Gjate tre diteve te para pas lindjes , a i keni dhene (EMRI I FEMIJES) dicka tjeter (per te pire ose ngrene) perpara se t'i fillonit ushqyerjen me gji?	Po 1 Jo 2 Nuk e mbaj mend/Nuk e di 8	2→33 8→33
32	Cfare i keni dhene (EMRI I FEMIJES) gjate 3 diteve te para, perpara se te fillonit ushqyerjen me gji? <i>MOS LEXONI LISTEN PERKRAH, POR QARKO NUMRAT PER TE GJITHA PERGJIGJET QE JEP NENA.</i> <i>Ndonje dicka tjeter?</i> <i>Po uje?</i>	Qumesht lope, delje ose dhie..... 1 Uje i zakonshem..... 2 Uje me sheqer 3 Leng frutash 4 Qumesht kutije per bebe (farmacie)..... 5 Caj/bime mjekesore 6 Tjeter.....7 (specifiko)	
33	A e ushqeni aktualisht me gji (EMRI I FEMIJES)?	PO 1 JO 2	2→35
34	Sa shpesh i jep femijes gji (EMRI I FEMIJES)? <i>MOS LEXONI LISTEN PERKRAH, POR QARKO PERGJIGJEN QE JEP NENA.</i>	Sa here femija do 1 Sipas nje orari te percaktuar.... 2 Te dyja 3 Nuk e di.....8	1→36 2→36 3→36 8→36
35	Per sa kohe e keni ushqyer femijen me gji (EMRI I FEMIJES)? <i>NESE E KA USHQYER ME PAK SE NJE MUAJ, SHENO "00".</i>	MUAJ <input type="text"/> <input type="text"/>	
36	Tani, do te doja t'ju pyesja per llojet e lengjeve qe ka pire (EMRI I FEMIJES) gjate 24-oreve te fundit? A ka pire (EMRI I FEMIJES) ndonje nga keto lengje gjate 24-oreve te fundit? <i>LEXO LISTEN E LENGJEVE.</i> <i>QARKO SHKRONJEN, NESE FEMIJA KA PIRE LENGUN QE T'I PERMEND.</i>	Ushqyerje me gji.....A Uje i zakonshem.....B Uje me sheqer.....C Qumesht kutije per bebe (farmacie).....D Ndonje qumesht te fresket si lope, dhije apo deljeE Qumesht lope, dhije apo delje ne kuti ose pluhurF KosG Leng frutash H Lengje me gazI Kafe ose caj.....J	

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK:
		Leng supeK Vitamine apo elemente minerale ne forme te lengshme.....L Te tjera.....M <i>(Specifiko)</i>	
37	A ka pire (EMRI I FEMIJES) me biberon dje, gjate 24-oreve te fundit ?	Po.....1 Jo.....2 Nuk e di.....8	
38	<p>Tani do te doja t'ju pyesja rreth llojeve te ushqimit qe ka ngrene (EMRI I FEMIJES) gjate 24-oreve te fundit.</p> <p>A ka ngrene (EMRI I FEMIJES) ndonje nga keto ushqime gjate 24-oreve te fundit?</p> <p><i>LEXO LISTEN E USHQIMEVE.</i></p> <p><i>QARKO SHKRONJEN QE I KORESPONDON USHQIMIT, NESE FEMIJA KA NGRENE KETE USHQIM GJATE 24-OREVE TE FUNDIT.</i></p>	<p>Prodhime drithrash (psh. muhalebi, sytlash, pilaf, makarona, buke, qulle).....A</p> <p>Kungull, karrotaB</p> <p>Ndonje produkt qe rriten nen toke (si psh. patate, panxhar).....C</p> <p>Ushqime nga perime me gjethe jeshile (si psh. spinaqi).....D</p> <p>Perime dhe fruta te tjera (si psh. banana, molle, portokalle, domate, kastraveca, spec, patellxhan i zi, laker, qepe).....E</p> <p>Ndonje mish vici, derri, qingji, dhije, lepuri ose mish te thate (pasterma).....F</p> <p>Ndonje mish pule, rose, gjel deti apo shpend tjeter?.....G</p> <p>Ndonje mish peshku te fresket apo te thate, ushqime te tjera liqeni apo deti?.....H</p> <p>Ndonje veze?.....I</p> <p>Ndonje ushqim me fasule apo thjerreza (psh fasule te bardha)J</p>	

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK:
		Geshtenja, lajthi, arra, kikirike?K Djathe ose kos?L Ndonje ushqim te gatuar me vaj, dhjame ose gjalpe?.....M Te brendshme kafshesh (psh. melqi, veshka, zemer etj)N	
39	Sa here ka ngrene (EMRI I FEMIJES) gjate 24-oreve te fundit? PERFSHI TE GJITHA VAKTET KRYESORE DHE NGRENJEN NDERMJET TYRE, SI DHE FRUTAT. <i>NESE NENA PERGJIGJET 7 OSE ME SHUME HERE, SHENO "7"</i>	SA HERE NUK E DI = 8 <input type="checkbox"/>	
40	A mund te marr pak nga kripa qe perdorni per te gatuar? <i>I KERKONI NENES TE MBUSHE DERI NE GJYSEM QESEN PLASTIKE (RRETH 30 GRAM) DHE SHKRUANI QARTE DHE NE MENYRE TE PLOTE EMRIN E FEMIJES, NUMRIN E GRUPIMIT DHE FSHATIT/QYTETIT.</i>	Po1 Jo (refuzoi)2	

V. LARJA E DUARVE

41	Kur i lani duart me sapun? <i>MOS LEXO LISTEN, POR QARKO NUMRIN QE KORRESPONDON PER TE GJITHA PERGJIGJET QE JEP NENA.</i> <i>KUR TJETER?</i>	Asnjehere 1 Perpara/gjate gatimit 2 Perpara se te ha buke 3 Para se te ushqej femijet..... 4 Pas daljes nga banja/jashteqitjes 5 Pasi kam shoqeruar femijen qe ka dale nga banja/per jashteqitje.....6 Pas takimit te duarve me njerez te tjere..... 7 Tjeter 9 (specifiko)	
----	--	--	--

VI. SEMUNDJET E FEMIJERISE

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO TEK:
42	Ndonjehere femijet semuren dhe kane nevojë	Nuk e diA	

	<p>urgjente per trajtim shendetesor. Cilat jane ato shenja te rrezikshme te semundjes, te cilat tregojne se femija juaj duhet te marre mjekim menjehere?</p> <p><i>MOS LEXO POR QARKO VETEM SHKRONJAT QE KORRESPONDOJNE ME TE GJITHA PERGJIGJET QE JEP NENA.</i></p> <p>NESE NENA PERMEND “KOLLA”, ATEHERE SHKRUAJENI NE HAPESIREN BOSH PER “TJETER”, DHE PYESNI NENEN “CFARE TJETER?”. KOLLA, SI SHENJE ME VETE, NUK KONSIDEROHET SI SHENJE E RREZIKSHME.</p>	<p>Nuk duket mire B Nuk luan (ne loje) si zakonisht C Qan vazhdimisht D Nuk ha ose pi E I pergjumur ose ka veshtiresi per t'u zgjuar F Temperature te larte G Frymemarrje e shpejte ose me veshtiresi H Vjell gjithcka I Konvulsione/te dridhura J Jashqitje me gjak K Diarre/heqje bark e vazhdueshme L Keqesohet M TJETER N (SPECIFIKO) TJETER O (SPECIFIKO) TJETER P (SPECIFIKO)</p>	
43	<p>A ka pasur (EMRI I FEMIJES) ndonje nga shenjat e meposhtme, gjate dy javeve te fundit?</p> <p><i>LEXO I LISTEN NENES, DHE QARKO NUMRIN QE I KORRESPONDON TE GJITHA PERGJIGJEVE TE SAJ.</i></p> <p><i>NESE NENA SE KA TE QARTE SE CFARE ESHTË DIARREJA, SHPJEGO SE KUR FEMIJA DEL HOLLE/ BARK TRE OSE ME SHUME HERE NE DITE QUHET DIARRE.</i></p>	<p>Diarre/heqje barku 1 Jashteqitje me gjak 2 Kolle 3 Veshtiresi ne frymemarrje 4 Frymemarrje te shpeshtuar/frymemarrje te shpejte dhe te shkurter 5 Temperature 6 Konvulsione/te dridhura 7 Ndonje semundje apo shenje tjeter 8 (<i>specifiko</i>) 8 S'ka qene semure gjate dy javeve te kaluara 9</p>	9→66
44	<p><i>PYESNI NENEN, NESE (EMRI I FEMIJES) KA QENE SEMURE GJATE DY JAVEVE TE FUNDIT.</i></p> <p>Nese po e ushqen (EMRI I FEMIJES) me gji, dhe (EMRI I FEMIJES) ka qene semure gjate dy javeve te fundit, sa here i jepnit gji - me shpesh se zakonisht, si perhere apo me pak se zakonisht?</p>	<p>Nuk po ushqej me gji 1 Me pak 2 Njelloj si perhere 3 Me shpesh 4 Nuk e di 8</p>	
45	<p><i>PYESNI NENEN, NESE (EMRI I FEMIJES) KA QENE SEMURE GJATE DY JAVEVE TE FUNDIT.</i></p> <p>Kur femija ishte semure gjate dy javeve te fundit, sa here i jepnit per te pire lengje me pak se zakonisht, si perhere, apo me shume se</p>	<p>Me pak 1 Njelloj si perhere 2 Me shume 3 Nuk i jepja asgje per te pire 4 Nuk e di 8</p>	

	zakonisht?		
46	<i>PYESNI NENEN, NESE (EMRI I FEMIJES) KA QENE SEMURE GJATE DY JAVEVE TE FUNDIT.</i> Kur femija ishte semure gjate dy javeve te fundit , sa here i jepnit per te ngrene - me pak se zakonisht, si perhere, apo me shume se zakonisht?	Me pak 1 Njelloj si perhere 2 Me shume 3 Nuk i jepja asgje per te ngrene 4 Nuk e di 8	
47	<i>PYESNI NENEN, NESE (EMRI I FEMIJES) KA QENE SEMURE GJATE DY JAVEVE TE FUNDIT.</i> Gjate periudhes qe (EMRI I FEMIJES) po permiresohet , juve i jepnit me pak se zakonisht per te ngrene ose per te pire, si perhere, apo me shume?	Me pak 1 Njelloj si perhere 2 Me shume 3 Asgje per te pire apo per te ngrene 4 Nuk e di 8	

VII. INFEKSIONET RESPIRATORE AKUTE (IRA)

NR.	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
48	A ka qene semure me kolle (EMRI I FEMIJES), ndonjehere gjate dy javeve te kaluara ?	Po 1 Jo 2 Nuk e di 8	2 → 57 8 → 57
49	Kur (EMRI I FEMIJES) ishte semure me kolle gjate dy javeve te kaluara , a ka patur veshitresi ne frymemarje apo frymemarje te pershpejtuar (frymemarje te shkurtra dhe te shpejta)?	Po 1 Jo 2 Nuk e di 8	2 → 57 8 → 57
50	A kerkuat keshillim apo trajtim shendetesor per kollen apo frymemarjen e shpejte, pervec cfare i keni bere vete ne shtepi?	Po 1 Jo 2	2 → 55
51	Sa kohe pasi i filloi kolla dhe frymemarja e shpejte (EMRI I FEMIJES) kerkuat kontroll shendetesor?	Te njejten dite 1 Te nesermen 2 2 dite me vonë 3 Pas 3 ose me shume 4 Nuk e di/nuk e mbaj mend ... 8	
52	Ku moret per here te pare keshillim apo trajtim shendetesor per femijen tuaj? <i>MOS LEXO, QARKO SHKRONJEN QE I KORRESPONDON PERGJIGJES SE NENES PER VENDIN E PARE KU MORET KESHILLIM APO MJEKIM SHENDETESOR PER FEMIJEN TUAJ.</i>	Spital A Poliklinike B Qender shendetesore C Ambulance D Vizite ne shtepi e mamise/infermjeres se fshatit E Edukatore/promovues shendeti per komunitetin F Klinike private G Farmaci H	

NR.	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
	NESE SHERBIMI SHENDETESOR ESHTË OFRUAR NE SPITAL, QENDER SHENDETESORE, AMBULANCE APO KLINIKE, SHENOJENI ME POSHTE. _____ (EMRI I VENDIT)	Mjek popullor I Sherues fetare..... J Miqte/te afermit K Nuk e di/nuk e mbaj mend... L Te tjere _____ M (specifiko)	
53	A moret diku tjetër keshillim apo mjekim shendetesor kur (EMRI I FEMIJES) kishte kolle dhe veshtiresi ne frymemarrje/frymemartje te shpejte?	Po 1 Jo..... 2	2 → 55
54	Ku moret keshillim apo mjekim shendetesor per here te dyte? <i>MOS LEXO, POR QARKO SHKRONJEN QE I KORRESPONDON PERGJIGJES SE NENES PER VENDIN E DYTE KU MORET KETE SHERBIM.</i> NESE SHERBIMI SHENDETESOR ESHTË OFRUAR NE SPITAL, QENDER SHENDETESORE, AMBULANCE APO KLINIKE, SHENOJENI ME POSHTE. _____ (EMRI I VENDIT)	Spital A Poliklinike B Qender shendetesore C Ambulance D Vizite ne shtepi e mamise/infermjeres se fshatit E Edukatore/promovues shendeti per komunitetin F Klinike private G Farmaci H Mjek popullor I Sherues fetare..... J Miqte/te afermit K Nuk e di/nuk e mbaj mend... L Te tjere _____ M (specifiko)	
55	Cfare ilacesh ju dhane (EMRI I FEMIJES) per kolle dhe veshtiresi ne frymemarrje? <i>MOS LEXONI LISTEN, POR SHENONI TE GJITHA PERGJIGJET QE JEP NENA</i>	Asgje..... A Aspirine B Paracetamol C Paracetamol suposte D Analginë E Antibiotike kokerr/shurup F Injeksion (gjilpëre) G Intravenoze H Ilace nga goja i panjohur (shurup ose kokerr)..... I Trajtim ne shtepi me ilace/menyrë popullore J Nuk e di K Te tjera _____ L (specifiko)	55 → 57
56	Ku i moret ilacet? <i>MOS LEXO LISTEN, POR QARKO VETEM NJE SHKRONIE QE KORRESPONDON ME PERGJIGJEN</i>	Spital..... A Poliklinike B Qender shendetesore C Ambulance/mamija/infermj	

NR.	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
	SHKRONJE QE KORRESPONDON ME PERGJIGJEN E NENES PER VENDIN KRYESOR KU JANE MARRE ILACET E FEMIJES	erja e fshatit D Edukatore/promovues shendeti per komunitetin ..E Klinike private F Farmaci..... G Dyqan H Mjeke popullore I Sherues fetare J Miqte/te afermit..... K Ilace te mbetura nga perdorimi i meparshem.....L Nuk e di/nuk e mbaj mendM Te tjereN (specifiko)	

VIII. DIARREJA

NR	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
57	A ka patur (EMRI I FEMIJES) heqje barku/diarre ne dy javet e fundit? DIARREJA KONSIDEROHET KUR FEMIJA KA DALE BARK, TRE OSE ME SHUME HERE GJATE 24-OREVE.	PO1 JO2 NUK E DI8	2 → 66 2 → 66
58	Cfare i dhate vete (EMRI I FEMIJES) ne shtepi , kur kishte diarre? MOS LEXO, POR QARKO TE GJITHA PERGJIGJET E DHENA. Ndonje gje tjeter?	AsgjeA Lengje te pergatitura me paketat e Trisolit.....B Uje me kripe dhe sheqer.....C Me shume uje se zakonisht ..D Qumesht natyral ose qumesht kutije per bebe/farmacise E Caj/lengje me bime mjekesore F Leng oriziG KosH Banane..... I Veze me rigon J Brez leshiK Aspirine L Paracetamol M AnalgineN Antibiotike kokrra ose shurupO Ilace kunder diarrese P Ilace te panjohura (shurup apo kokrra)Q Nuk e di/Nuk e mbaj mend...R	

NR	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
		Tjeter _____ S (specifiko)	
59	A shkuat per keshillim apo mjekim shendetesor diku tjeter, pervecse cfare i dhate ne shtepi (EMRI I FEMIJES) per t'i ndaluar barkun (diarrene)?	Po 1 Jo 2	2 → 66
60	Sa kohe pasi i filloi diarrea (EMRI I FEMIJES) shkuat per te kerkuar mjekim per te?	Te njeften dite..... 1 Diten e neserme..... 2 Dy dite me pas 3 Tre apo me shume dite me pas 4	
61	Ku shkuat per here te pare per te kerkuar keshillim apo mjekim shendetesor? <i>MOS LEXONI LISTEN, POR QARKONI VETEM NJE SHKRONJE, E CILA I KORRESPONDON PERGJIGJES SE NENES PER VENDIN E PARE KU AJO KA DERGUAR FEMIJEN E SAJ KESHILLIM APO MJEKIM.</i> NESE SHERBIMI SHENDETESOR ESHTË OFRUAR NE SPITAL, QENDER SHENDETESORE, AMBULANCE APO KLINIKE, SHENOJENI ME POSHTE: _____ (EMRI I VENDIT)	Spital A Poliklinike B Qender shendetesore C Ambulance D Vizite ne shtepi e mamise/ infirmjeres se fshatit E Edukatore/promovues shendeti per komunitetin F Klinike private G Farmaci H Mjek popullor I Sherues fetare J Miqte/te afermit K Nuk e di/nuk e mbaj mend ... L Te tjere _____ M (specifiko)	
62	A shkuat diku tjeter per te kerkuar keshillim apo mjekim per femijen tuaj?	Po 1 Jo 2	2 → 64
63	Ku tjeter shkuat per te kerkuar keshillim apo mjekim per femijen tuaj? <i>MOS LEXONI, POR QARKONI VETEM NJE SHKRONJE, E CILA I KORRESPONDON PERGJIGJES SE NENES PER VENDIN E DYTE KU AJO KA DERGUAR FEMIJEN E SAJ</i> NESE SHERBIMI SHENDETESOR ESHTË OFRUAR NE SPITAL, QENDER SHENDETESORE, AMBULANCE APO KLINIKE, SHENOJENI ME POSHTE. _____ (EMRI I VENDIT)	Spital A Poliklinike B Qender shendetesore C Ambulance D Vizite ne shtepi e mamise/ infirmjeres se fshatit E Edukatore/promovues shendeti per komunitetin ... F Klinike private G Farmaci H Mjek popullor I Sherues fetare J Miqte/te afermit K Nuk e di/nuk e mbaj mend ... L Te tjere _____ M	

NR	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
		(specifiko)	
64	<p>Cfare ilacesh ju dhane (EMRI I FEMIJES) per te ndaluar diarrene, pervec atyre qe i keni dhene vete ne shtepi?</p> <p>MOS LEXONI LISTEN, POR QARKONI TE GJITHA PERGJIGJET QE PERMEND NENA.</p> <p>Cfare tjeter?</p>	<p>Asgje A</p> <p>Lengje te pergatitura me paketat e Trisolit.....B</p> <p>AspirineC</p> <p>Paracetamol D</p> <p>AnalginëE</p> <p>Antibiotik kokrra ose shurup F</p> <p>Ilace kunder diarrese G</p> <p>Ilace nga goja qe nuk i di emrin (kokrra ose shurup)... H</p> <p>GjilperaI</p> <p>Injeksione intravenozeJ</p> <p>Mjekim popullor K</p> <p>Nuk e di.....L</p> <p>Tjeter _____ M</p> <p>(specifiko)</p>	L → 66
65	<p>Ku i moret ilacet qe ju dhane femijes?</p> <p>MOS LEXONI, POR QARKONI SHKRONJEN QE I KORRESPONON PERGJIGJES SE NENES PER VENDIN KRYESOR KU JANE MARRE ILACET.</p>	<p>Spital A</p> <p>PoliklinikeB</p> <p>Qender shendetesoreC</p> <p>Ambulance/mamija/infermjerja e fshatit D</p> <p>Edukatore/promovues shendeti per komunitetin.....E</p> <p>Klinike private F</p> <p>Farmaci G</p> <p>Dyqan H</p> <p>Mjeke popullore I</p> <p>Sherues fetareJ</p> <p>Miqte/te afermit..... K</p> <p>Ilace te mbetura nga perdorimi i meparshemL</p> <p>Nuk e di/nuk e mbaj mend ..M</p> <p>Te tjere _____N</p> <p>(specifiko)</p>	
66	<ul style="list-style-type: none"> • A keni degjuar apo pare ndonjehere paketat e trisolit si kjo? TREGOJINI PAKETEN E TRISOLIT • Nese ajo thote “PO”, pyesni nenes te pershkruaje se si pergatitet trisoli. • Nese ajo thote “JO”, qarkoni 3 (Kurre skam pare apo degjuar per trisolin). • Kur nena t’ju tregojte pergatitjen e trisolit, shenoni nese ajo di ta pershkruaje mire apo jo ate. <p><i>Qarkoni 1 [mire] nesenena permend elementet e meposhtme:</i></p> <ul style="list-style-type: none"> • Me duhet 1 liter (1 kg) uje i pijshem per pakon e madhe dhe 250 ml per pakon e vogel 	<p>Pershkruajti mire 1</p> <p>Nuk di ta pershkruaje mire..... 2</p> <p>S’ka degjuar apo pare asnjehere paketa Trisoli 3</p>	

NR	PYETJE DHE SYGJERIME	ALTERNATIVA	KALO
	<ul style="list-style-type: none"> Hedh ne uje te gjitha paketen e Trisolit E perziej ate me ujin derisa te shkrihet plotesisht 		

IX. KUJDESI PARA-LINDJES

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVAT	SKIP
67	A jeni keshilluar/vizituar me ndonje njeri kur ishe shtatezene me (EMRI I FEMIJES)?	Po 1 Jo 2	2→72
68	NESE PO: Tek kush? <i>MOS LEXONI, POR QARKONI TE GJITHA PERGJIGJET QE JEP NENA.</i>	Mjeku/Obseter-Gjinekologu.....1 Infermjerja/Mamija e fshatit.....2 Infermjerja3 Mamija4 “Mamija” popullore.....5 Edukator/Promovues shendeti ne komunitet.....6 Tjeter _____ 7 <i>(Specifiko)</i>	
69	Ku ishit per te marre keto sherbime shendetesore? <i>MOS LEXONI, POR QARKONI TE GJITHA PERGJIGJET QE JEP NENA.</i>	Materniteti 1 Konsultorja e gruas 2 Qender shendetesore 3 Ambulanca 4 Vizita ne shtepi nga nje punonjes shendeti5 Klinika Private 6 Te tjera _____ 7 <i>(specifiko)</i>	
70	Sa muajshe ke qene shtatezane me (EMRI I FEMIJES), kur ke shkuar per here te pare per kontroll para-lindjes? <i>QARKO VETEM NJE PERGJIGJE.</i>	0-3 muajshe 1 4-6 muajshe 2 7-9 muajshe3 Nuk me kujtohet/nuk e di.....8	
71	Sa here keni shkuar per kontroll gjate shtatzanise me (EMRI I FEMIJES)?	Numri i vizitave <input type="text"/> <input type="text"/> <i>Nuk e di=99</i>	
72	A e keni fletoren e nenes/kartelen e vaksinimit, ku shenohen te gjitha vaksinimet qe ben nena? <i>NESE PO, KERKONI QE TE SHIHNI KARTELEN/FLETOREN E NENES</i>	Po 1 Jo 2	2→74

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVAT	SKIP																												
73	Nga fletorja e nenes/kartela e vaksinimit te nenes, kopjoni TE GJITHA datat e vaksinimeve TT (Tetanoz) te shenuara ne te. <table border="1" data-bbox="808 338 1268 667" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>TT dose</th> <th>DITA</th> <th>MUA JI</th> <th>VITI</th> </tr> </thead> <tbody> <tr><td>1</td><td></td><td></td><td></td></tr> <tr><td>2</td><td></td><td></td><td></td></tr> <tr><td>3</td><td></td><td></td><td></td></tr> <tr><td>4</td><td></td><td></td><td></td></tr> <tr><td>5</td><td></td><td></td><td></td></tr> <tr><td>6</td><td></td><td></td><td></td></tr> </tbody> </table>	TT dose	DITA	MUA JI	VITI	1				2				3				4				5				6					
TT dose	DITA	MUA JI	VITI																												
1																															
2																															
3																															
4																															
5																															
6																															
74	Sa injeksione TT (tetanoz) keni bere gjate shtatzanise me (EMRI I FEMIJES)? <table border="1" data-bbox="1138 674 1268 737" style="margin-left: auto; margin-right: auto;"> <tr><td></td><td></td></tr> </table> NESE NUK E DI/MBAN MEND, ATEHERE SHENO 88																														
75	Sa injeksione TT mbani mend te keni bere gjate gjithe shtatezanive? <table border="1" data-bbox="1138 831 1268 894" style="margin-left: auto; margin-right: auto;"> <tr><td></td><td></td></tr> </table> NESE NUK E DI/MBAN MEND, ATEHERE SHENO 88																														
76	A e keni bere vaksinin kunder fruth-rubeoles gjate fushates se fundit te vaksinimit?	PO.....1 JO2 Nuk e di/Nuk e mbaj mend.....8																													
77	Gjate kontrollit para-lindjes, a jeni konsultuar ne sa vijon: LEXO KETE LISTE DHE QARKO SHKRONJAT QE I KORRESPONDOJNE TE GJITHA PERGJIGJEVE TE NENES.	A. ASNJE KONTROLL PARA-LINDJE B. Pergatitje per procesin e lindjes C. Berja e injeksionit kunder Tetanozit D. Marrje tabletash hekuri E. Ushqyerje me gji F. Kur eshte mire te keni femije tjeter pas kesaj shtatezanie G. Vaksinimi i femijes se ardhshem H. Shenjat e rrezikshme qe mund te shfaqen gjate shtatezanise I. Ushqyerja e nenes gjate shtatezanise J. Ngarkesa fizike dhe nevoja per te pushim gjate shtatezanise K. Nuk me eshte dhene asnje informacion																													

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVAT	SKIP
78	Ku e lindet (EMRI I FEMIJES)? NESE NENA KA LINDUR NE MATERNITETI, QENDER SHENDETESORE, AMBULACE APO KLINIKE, SHENOJENI ME POSHTE: _____ (EMRI I VENDIT)	Maternitet 1 Qender shendetesore 2 Ambulance 3 Klinike private 4 Ne shtepi 5 Ne nje shtepi tjeter 6 Qendra te tjera 7 (specifiko)	
79	Kush ju asistoi gjate lindjes se (EMRI I FEMIJES)? QARKO TE GJITHA PERGJIGJET QE JEP NENA.	Obseter-Gjinekologu/Mjeku 1 Infermjerja 2 Mamia 3 "Mami" popullore 4 Te afermit 5 Asnjeri 6 Tjeter 8 (specifiko)	

X. MARRJA SHITESJE E HEKURIT GJATE SHITATZANIZE

Nr.	PYETJE DHE SQARIME	ALTERNATIVAT	KALO
80	Kur ishit shtetezene me (EMRI I FEMIJES), a keni marre apo blere tableta per hekur. <i>TREGONI TABLETAT</i>	PO 1 JO 2 NUK E DI 8	2 → 82 8 → 82
81	Per sa dite i keni marre tableta me hekur? <i>NESE PERGJIGJA NUK ESHT E QARTE, KERKONI QE NENA T'JU THOJE ME PERAFERSI NUMRIN E DITEVE.</i>	NUMRI I DITEVE <input type="text"/> <input type="text"/> <input type="text"/> NUK E DI 888	

XI. KUJDESI PAS LINDJES

Nr.	PYETJE DHE SQARIME	ALTERNATIVA	KALO
82	A keni bere ndonje kontroll pas lindje per shendetin tuaj, pasi lindjet (EMRI I FEMIJES) dhe u <u>kthyet ne shtepi</u> ?	PO 1 JO 2 Nuk e di/nuk e mbaj mend ... 8	2 → 86 8 → 86
83	Sa dite apo jave pas lindjes keni bere kontrollin e pare shendetesor? NESE NENA NUK E DI, ATEHERE SHENO (88)	Numri i diteve <input type="text"/> <input type="text"/> Numri i javeve <input type="text"/> <input type="text"/> Nuk e di/nuk e mbaj mend 88	

Nr.	PYETJE DHE SQARIME	ALTERNATIVA	KALO
84	NESE PO, ku shkuat per kontrollin e pare pas lindjes? MOS LEXONI LISTEN POR QARKONI VETEM VENDIN E PARE, KU SHKOI NENA PER KONTROLL.	Maternitet 1 Poliklinike 2 Qendre Shendetesore 3 Ambulance/mamija apo infirmjerja e fshatit 4 Vizita ne shtepi/mamija/infirmjerja e fshatit..... 5 Kosultorja e gruas/femijes ... 6 Klinike private..... 7 Te tjera _____ 8 (specifiko)	
85	A ju eshte folur per ndonje nga temat e meposhtme gjate kontrollit pas lindjes? LEXO LISTEN DHE QARKO TE GJITHA PERGJIGJET QE JEP NENA.	Ushqyerja me gji 1 Mungesa e menstruacioneve/ciklit gjate ushqyerjes me gji 2 Planifikimi familjar 3 Shenja te rrezikshme te shendetit te nenes, pas lindjes4 Shenja te rrezikshme per femijen e porsalindur 5 Vaksinimi i femijes se porsalindur 6 Nuk me eshte dhene asnje informacion 7	
86	A keni marre ndonje doze vitamine A, gjate dy muajve te pare pas lindjes? TREGO KAPSULEN E VITAMINES A.	Po 1 Jo 2 Nuk e di..... 8	
87	Cilat jane ato shenja te rrezikshme tek femija i porsalindur, qe duhet te keni kujdes dhe tregojne se femija juaj eshte semure dhe ka nevojte per trajtim shendetesor te menjehershem? MOS LEXO, QARKO VETEM SHKRONJAT QE KORRESPONDOJNE ME TE GJITHA PERGJIGJET E NENES	Ushqehet shume pak 1 Frymemarrje te shpejta..... 2 Nuk eshte aktiv 3 Skuqje perreth kerthizes..... 4 Sy te skuqur/te infektuar 5 Te tjera _____ 6 (SPECIFIKO) Nuk e di 8	

XII. PLANIFIKIMI FAMILJAR

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVA	KALO
88	PLANIFIKIMI FAMILJAR DO TE THOTE SE “CDO CIFT, MUND TE VENDOSE KUR DHE SA FEMIJE TE KENE”. A keni degjuar per ndonje nga metodat e meposhtme te planifikimit familjar?	Gjilpera (Injeksione)A KokrraB	

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVA	KALO
	LEXO LISTEN, QARKO TE GJITHA SHKRONJAT QE KORRESPONDOJNE ME METODAT TE CILAT NENA KA DEGJUAR.	Aparat (Spiralja) C Diafragma D Llatiku (Prezervativi) E Xhel F Lidhja e tubave tek femrat ... G Operacioni tek meshkujt (lidhja e tubave) H Ato qe vendosen nen lekure .. I Ushqyerja e plote me gji (ndalimi i menstruacioneve gjate saj) J Cikli menstrual K Mos berja e mardhenjeve seksuale L Terheqja M Refuzon te pergjigjet Z	
89	A dini ndonje vend ku mund te merrni ndonje metode te planifikimit familjar? <i>NESE JO, QARKO "Z" [NUK E DI] NESE PO, PYESNI SE KU?</i> <i>SHENO TE GJITHA, PERGJIGJET QE JEP NENA</i> <i>NESE BURIM ESHTË SPITAL/MATERNITET, QENDER SHENDETSORE, AMBULANCE OSE KLINIKE, SHKRUAJ EMRIN E VENDIT:</i> _____ (EMRI VENDIT)	Maternitet A Poliklinike B Qender Shendetesore C Ambulance D Konsultorja e gruas E Nje shperndares metodash kontraceptive ne komunitet. F Klinike private G Farmaci H Dyqan I Miq/te aferm J Tjeter _____ K <i>(specifiko)</i> Nuk di ndonje vend Z	
90	A jeni aktualisht shtatezene?	Po 1 Jo 2 E pasigurte 3 Refuzon te pergjigjet 9	1 → 93
91	Kur do te deshironit te kishit femijen tjeter? <i>MUNDOHUNI TE KEMBENGULNI PER TE MARRE NJE PERGIGJE PREJ NENES, POR KINI PARASYSH SE SHUME NENA NUK DUAN T'JU PERGJIGJEN PYETJEVE TE TILLA.</i>	Brenda 2 viteve 1 Me shume se 2 vite me vonë 2 Nuk dua te kem femije tjeter 3 Nuk e di se kur 8 Refuzon te pergjigjet 9	
92	A po beni dicka apo po perdorni ndonje metode per te vonuar apo shmangur shtatzanine? <i>MOS LEXONI, QARKONI SHKRONJEN QE I PERKON METODEDE KRYESORE QE PERDOR NENA.</i>	Asnje metode A Injeksione B Kokrra C Spiralja D Diafragma E Prezervativi F	

Nr.	PYETJE DHE SHPJEGIME	ALTERNATIVA	KALO
	NESE JO, QARKONI A [ASNJE METODE]	Xhel.....G Lidhja e tubave tek femrat ...H Operacioni tek meshkujt/vezektomi I Ato qe vendosen nen lekure..J Ushqyerja e plote me gji (ndalimi i menstruacioneve gjate saj)K Cikli menstrual..... L Mos berja e mardhenjeve seksuale M Berja e aborteveN TerheqjaO Te tjera P (specifiko) Refuzon te pergjigjet..... Z	

XIII. HIV/SIDA

Nr.	PYETJE DHE SQARIME	ALTERNATIVA	KALO
93	A keni degjuar ndonjehere per nje semundje e cila quhet SIDA?	Po 1 Jo 2 Nuk e di..... 8	2→95 8→95
94	Cfare mund te beje nje person per te shmangur marrjen e SIDE-s ose virusin qe shkakton SIDA-n? <i>MOS LEXONI LISTEN, POR QARKONI VETEM SHKRONJAT QE KORRESPONDOJNE ME TE GJITHA PERGJIGJET E DHENA NGA NENA.</i>	AsgjeA Shmang marrdheniet seksuale .B Perdor perzevativC Marrdhenie seksuale me nje partner /qendroi besnike partnerit.....D Numer i kufizuar i partnereve seksualeE Shpang marrdheniet seksuale me prostituta F Shmang marrdheniet seksuale me persona qe kane shume partnereG Shmang marrdheniet seksuale me persona te te njejtis seksH Shmang marrdheniet seksuale me persona qe injektojne droge me injeksione intravenoze..... I Shmang transfuzionin e gjakut...J Shmang injeksionetK Shmang perdorimin e perbashket te brisceve te rrojes .L Shmang puthjetM Shmang pickimin e mushkonjaveN	

KPC SURVEY REPORT

Appendix: List of people involved in the KPC and their role

KPC Coordination team:

1. Erika Lutz Sennior Associate, TAPE Unit, ARC International Services
Team Leader
2. Dr. Gilbert Burnham ACSP Technical Consultant, Johns Hopkins University
Bloomberg School of Pulic Health
3. Karen Waltensperger ARC Regional Health Delegate, SEE Region
4. Fabian Cenko ACSP Manager
5. Ermira Brasha ARC Senior Liaison Officer
6. Anila Gjoni ARC Finance Officer

KPC Supervisors:

1. Ermira Brasha ARC Sennior Liaison Officer
2. Fabian Cenko CS Project Manager
3. Geltiana Bulku CS Project Assistant/translater of KPC
Questionnaire
4. Gazment Koduzi KPC Supervisor, Former JSI Field Officer
5. Gazment Bejtja KPC Supervisor/ Chief of non-infection Department
in IPH
6. Ilir Skenduli KPC Supervisor/Tirana University Center, Nene Tereza
Hospital

KPC Interviewers:

1. Valentina Ndreu KPC Interviewer, Nurse/Mat
2. Shqipe Gjoka KPC Interviewer, Doctor Assistant/Mat
3. Aferdita Korsita KPC Interviewer, Stomachologist/Mat
4. Arjana Biba KPC Interviewer, Nurse/Mat
5. Sanie Meta KPC Interviewer, Doctor Assistant/Mat
6. Farie Gjoka KPC Interviewer, Nurse/Mat
7. Merita Heta KPC Interviewer, Nurse/Mat
8. Dallendyshe Gjoka KPC Interviewer, GP/Mat
9. Drita Skura KPC Interviewer, Director of pre-elementary school/Mat
10. Flora Palluci KPC Interviewer, Teacher/Mat
11. Naile Skura KPC Interviewer, Teacher/Mat
12. Halil Stana KPC Interviewer, Epidemiologist/Former Director of PHC
Mat
13. Lavdie Okshtuni KPC Interviewer, Nurse/Bulqiza
14. Nele Hasani KPC Interviewer, Nurse/Bulqiza
15. Festime Kotili KPC Interviewer, Nurse/Bulqiza
16. Zaide Shehu KPC Interviewer, Nurse/Bulqiza
17. Elisabeta Vojka KPC Interviewer, Nurse/Diber
18. Ermira Murati KPC Interviewer, Nurse/Diber
19. Fatime Meta KPC Interviewer, AGRITA NGO-trainer, Diber
20. Servete Kera KPC Interviewer, AGRITA NGO-trainer, Diber
21. Fellenxa Shehu KPC Interviewer, AGRITA NGO-trainer, Diber

KPC SURVEY REPORT

Albania Child Survival Project

October 2003

22.	Bukurie Begu	KPC Interviewer, AGRITA NGO-trainer, Diber
23.	Majlinda Hoxha	KPC Interviewer, AGRITA NGO-trainer, Diber
24.	Sanie Ndreka	KPC Interviewer, Teacher/Diber
25.	Alma Xhediku	KPC Interviewer, Nurse/Diber
26.	Femie Kaziu	KPC Interviewer, Teacher/Diber
27.	Flutura Paci	KPC Interviewer, Doctor Assistant/Diber
28.	Bedrie Ciku	KPC Interviewer, AGRITA NGO-trainer, Diber
29.	Barie Cami	KPC Interviewer, Nurse/Diber

KPC Drivers:

1.	Bashkim Kroqi	Head of Drivers and KPC logistic/CS Driver
2.	Mustafa Reka	CS Driver
3.	Arjan Karaj	AlbRC Drivers
4.	Roland Shani	AlbRC Drivers
5.	Sinan Gori	AlbRC Drivers
6.	Thoma Tasho	AlbRC Drivers

Appendix: Training schedule for Supervisors and Interviewers

Training schedule for Supervisors

First day

1. **Overview of the Child Survival project**
 - Partnerships: USAID, AmRC, Alb RC, MoH, Prefectures
 - Purposes: why this is being done
 - Timelines
 - Goals and objectives and interventions
 - Implementation approaches
 - Results expected: what changes we expect to make
 - Monitoring and evaluation
 - How we will know that these changes are being made or have been made?
 - Monitoring mechanisms
 - Mid term and final evaluation
 - KPC & DIP process
 - Expected outputs and outcomes

2. Role of USAID in the Child Survival Project

3. The KPC survey (overview)

4. **KPC – Preimplementation/Implementation/Post implementation**
5. **Review of available information (national and local)**
6. **Review of the data required**
7. Data recording methods
 - a. Quality control
 - i. check list
 - ii. checking individual questionnaires by interviewers
 - iii. checking individual questionnaires by supervisors
 - b. Role of the supervisors
 - a. Oversees selection of households
 - b. Observations of interviews
 - c. Regular checks on the skip patterns
 - d. Assistance with technical problems
 - e. *Maintaining the quality*
 - c. Other activities
 - a. Anthropometrics
 - b. Salt testing
 - d. Field testing the questionnaire by the supervisors

Second day of Training

1. Draft KPC Questionnaire review

2. Sampling methods

- a. Sample size: why size matters
- b. the methods of sampling available
 - a. theoretical advantages of one over another
 - b. practical reasons for selection of one
- c. the cluster sampling methods developed
 - a. (1st stage) selection of clusters in the three districts
this can be done now
 - b. (2nd stage) selection of households-methods to be used establish a methods:
 - c. (3rd stage) which child within the household
- d. use of long and short forms (if we decide to do this)
- e. the sampling protocol-the sacred writ of sampling

Third day of Training

Logistics for carrying out the survey



KPC Survey, Training of Interviewers

Agenda October 21, 2003

Overview of Red Cross/Albanian and American RC	10:30
Overview of CSHP	11:00
Overview of KPC Survey	11:30
Coffee break	12:00
Role of the Interviewers and Supervisors	12:15
How to find household	12:30
Dreka	13:00
Consent form	14:30
Ethical and technical aspects of interviewing	14:45
General overview of keeping records while interviewing mothers	15:00
Coffee break	15:15

Agenda-October 22

- 1-Questionnaire review
- 2-Role playing

Agenda-October 23

- 1-Questionnaire review
- 2-Role playing

Agenda-October 24

- 1-Questionnaire review
- 2-Role playing

Agenda-October 25

- 1-Field testing
- 2-Feedback and discussions from the field test

KPC Indicators
Albania Child Survival Project

CHILDHOOD IMMUNIZATION INDICATORS

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>Possession of vaccination card</i> Proportion of children aged 0-23 months with vaccination card	$\frac{\text{No. of children with response= 1 for Q.23}}{\text{Total no. of children aged 0-23 months}} \times 100$	70.1	67.7	71.7	69.7	65.8 - 73.5
2 <i>EPI access</i> Proportion of children aged 12-23 months with DTP1 recorded on the vaccination card	$\frac{\text{No. of children aged 12-23 months with DTP1 vaccine (card-confirmed, Q.23)}}{\text{Total no. of children aged 12-23 months with cards}} \times 100$	88.7	83.1	96.6	88.7	83.9 - 93.5
3 <i>Measles vaccination coverage</i> Proportion of children aged 12-23 months vaccinated for measles (confirmed by card or mother's recall)	$\frac{\text{No. of children age 12-23 months who received measles vaccine according to Q.24 OR with response=1 for Q. 27H}}{\text{Total no. of children aged 12-23 months}} \times 100$	59.3	69.3	66.3	64.2	58.5 - 70.0
4 <i>Measles (rubella) vaccination coverage (Albania adaptation)</i> Proportion of children aged 14-23 months vaccinated for measles (confirmed by card or mother's recall)	$\frac{\text{No. of children age 14-23 months who received measles vaccine according to Q.24 OR with response=1 for Q. 27H}}{\text{Total no. of children aged 12-23 months}} \times 100$	67.6	70.8	75.0	70.4	64.2 - 76.6
5 <i>Drop out rate</i> Proportion of children aged 12-23 months with DTP1 but not DTP3 (recorded on card)	$\frac{(\text{No. of children age 12-23 months who received DTP1 [Q.24]} - \text{No. of children aged 12-23 months who received DTP3 [Q.24]})}{\text{Total no. of children aged 12-23 months with cards who received DTP1 (Q.24)}} \times 100$	7.5	9.2	10.2	8.7	4.5 - 13.0
6 <i>EPI coverage I (Rapid Catch Indicator)</i> Proportion of children aged 12-23 months who received BCG, DTP3, OPV3, vaccine before their first birthday (Fully vaccinated)	$\frac{\text{No. of children aged 12-23 months with BCG, DTP3, and OPV3 (card-confirmed, Q.24) before first birthday}}{\text{Total no. of children aged 12-23 months with cards}} \times 100$	71.7	67.7	81.4	72.6	65.9 - 79.3
7 <i>EPI coverage I (Albania adaptation for HBV3)</i> Proportion of children aged 12-23 months who received BCG, DTP3, OPV3, HBV3 vaccine before their first birthday (Fully vaccinated)	$\frac{\text{No. of children aged 12-23 months with BCG, DTP3, OPV3, and HBV3 (card-confirmed, Q.24) before first birthday}}{\text{Total no. of children aged 12-23 months with cards}} \times 100$	67.9	66.2	78.0	69.7	62.8 - 76.6

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
8 <i>EPI coverage I (Albania adaptation for measles at 14 months)</i> Proportion of children aged 14-23 months who received BCG, DTP3, OPV3, HB3 and measles vaccine before their first birthday (Fully vaccinated)	$\frac{\text{No. of children aged 14-23 months with BCG, DTP3, OPV3, HBV3 and Measles (card-confirmed, Q.24) before they had 14 months old}}{\text{Total no. of children aged 14-23 months with cards}} \times 100$	59.0	44.6	47.6	51.6	43.1 – 60.1
9 <i>EPI coverage (liberal criterion)</i> Proportion of children aged 12-23 months that were vaccinated with OPV3 before they were 12 months old	$\frac{\text{No. of children aged 12-23 months with OPV3 before age 12 months (card-confirmed, Q.24)}}{\text{Total no. of children aged 12-23 months with cards}} \times 100$	77.4	70.8	89.8	78.1	71.9 – 84.3

BREASTFEEDING AND CHILD NUTRITION INDICATORS

	INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Vitamin A coverage</i> Proportion of children aged 6-23 months who received a vitamin A dose in the last six months	$\frac{\text{No. of children aged 6-23 months with response=1 for Q.21 AND response=1 for Q.22}}{\text{Total no. of children aged 6-23 months}} \times 100$	3.6	2.6	6.1	3.9	2.0 – 5.7
2	<i>Breastfeeding initiation</i> Proportion of children aged 0-11 months that were breastfed during the first hour after birth	$\frac{\text{No. of children with response=1 for Q.29}}{\text{Total no. of children aged 0-11 months}} \times 100$	20.2	32.2	46.5	30.3	24.6 – 36.0
3	<i>Exclusive breastfeeding rate 0-1 month</i> Proportion of children aged 0-1 months who were fed breastmilk only during the last 24 hours	$\frac{\text{No. of children aged 0-1 months with response= A AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-1 months}} \times 100$	60.0	58.3	80.0	64.1	43.7 – 84.6
4	<i>Exclusive breastfeeding rate 0-2 months</i> Proportion of children aged 0-2 months who were fed breastmilk only during the last 24 hours	$\frac{\text{No. of children aged 0-2 months with response= A AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-2 months}} \times 100$	50.0	61.1	63.6	56.9	41.0 – 72.7
5	<i>Exclusive breastfeeding rate 0-3 months</i> Proportion of children aged 0-3 months who were fed breastmilk only during the last 24 hours	$\frac{\text{No. of children aged 0-3 months with response= A AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-3 months}} \times 100$	33.3	50.0	61.1	45.3	32.7 – 58.0
6	<i>Exclusive breastfeeding rate 0-4 months</i> Proportion of children aged 0-4 months who were fed breastmilk only during the last 24 hours	$\frac{\text{No. of children aged 0-4 months with response= A AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-4 months}} \times 100$	32.0	44.8	51.7	40.8	30.1 – 51.6
7	<i>Exclusive breastfeeding rate 0-5 months</i> Proportion of children aged 0-5 months who were fed breastmilk only during the last 24 hours	$\frac{\text{No. of children aged 0-5 months with response= A AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-5 months}} \times 100$	28.9	35.9	42.2	34.3	25.7 – 42.9

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
8 <i>Breastmilk + plain water.</i> Proportion of children aged 0-5 months fed with breastmilk and plain water only during the last 24 hours	No. of children aged 0-5 months with response= A, and B AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38 $\frac{\text{No. of children aged 0-5 months with response= A, and B AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. children age 0-5 months}} \times 100$	7.9	2.6	0.0	4.3	0.6 – 8.0
9 <i>Breastmilk + plain water + glucose water</i> Proportion of children aged 0-5 months fed with breastmilk, glucose water and plain water only during the last 24 hours	No. of children aged 0-5 months with response= A and B and C AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38 $\frac{\text{No. of children aged 0-5 months with response= A and B and C AND no other responses (B through M left blank) for Q. 36 AND no responses checked (A through N left blank) for Q.38}}{\text{Total no. of children age 0-5 months}} \times 100$	7.9	2.6	0.0	4.3	0.6 – 8.0
10 <i>Complementary feeding rate</i> Proportion of children aged 6-9 months who received breastmilk and solid or semi-solid foods during the last 24 hours	No. of children aged 6-9 months with response=A for Q.36 AND any of responses A through N for Q.38 $\frac{\text{No. of children aged 6-9 months with response=A for Q.36 AND any of responses A through N for Q.38}}{\text{Total no. of children age 6-9 months}} \times 100$	81.8	81.5	82.6	81.9	73.4 – 90.3
11 <i>Continued breastfeeding 6-11 months</i> Proportion of children aged 6-11 months who are still breastfeeding	No. of children aged 6-11 months with response=1 for Q.33 $\frac{\text{No. of children aged 6-11 months with response=1 for Q.33}}{\text{Total no. of children aged 6-11 months}} \times 100$	70.8	86.4	96.8	82.0	75.1 – 89.0
12 <i>Continued breastfeeding 12-17 months</i> Proportion of children aged 12-17 months who are still breastfeeding	No. of children aged 12-17 months with response=1 for Q.33 $\frac{\text{No. of children aged 12-17 months with response=1 for Q.33}}{\text{Total no. of children aged 12-17 months}} \times 100$	53.8	66.7	60.9	59.7	52.2 – 67.2
13 <i>Continued breastfeeding 18-23 months</i> Proportion of children aged 18-23 months who are still breastfeeding	No. of children aged 18-23 months with response=1 for Q.33 $\frac{\text{No. of children aged 18-23 months with response=1 for Q.33}}{\text{Total no. of children aged 18-23 months}} \times 100$	33.3	30.4	15.6	28.2	20.2 – 36.2
14 <i>Bottle use rate</i> Proportion of children aged 0-11 months who had anything by bottle yesterday	No. of children aged 0-11 months with response=1 for Q.37 $\frac{\text{No. of children aged 0-11 months with response=1 for Q.37}}{\text{Total no. of children aged 0-11 months}} \times 100$	34.8	37.5	18.8	32.0	26.2 – 37.7
15 <i>Frequency of feeding</i> Proportion of children (aged 6-8 and 9-23 months) that ate at least the minimum recommended number of times yesterday	No. of children aged 6-8 months with response of 2 or more for Q.39 + No. of children aged 9-23 months with response of 3 or more for Q.39 $\frac{\text{No. of children aged 6-8 months with response of 2 or more for Q.39 + No. of children aged 9-23 months with response of 3 or more for Q.39}}{\text{Total no. of children aged 6-23 months}} \times 100$	84.9	90.7	97.0	89.6	86.7 – 92.6

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
16 <i>Meat, poultry, fish rate</i> Proportion of children aged 6-23 months who ate yesterday meat, organ meat, poultry or fish yesterday	No. of children aged 6-23 months with any of responses F or G or H or N for Q.38 _____ x 100 Total no. of children aged 6-23 months	25.9	42.2	18.9	29.7	25.2 – 34.1
17 <i>Egg rate</i> Proportion of children aged 6-23 months who ate egg yesterday	No. of children aged 6-23 months with response I for Q.38 _____ x 100 Total no. of children aged 6-23 months	32.4	38.4	37.9	35.7	31.0 – 40.3
18 <i>Dairy rate</i> Proportion of children aged 6-23 months who had dairy yesterday	No. of children aged 6-23 months with response E or F or G for Q.36 or response L for Q.38 _____ x 100 Total no. of children aged 6-23 months	87.8	88.1	84.1	87.0	83.7 – 90.3
19 <i>Non-breastfed dairy rate</i> Proportion of children aged 6-23 months not breastfed who had dairy yesterday	No. of children aged 6-23 months with either response=2 for Q.28 or response=2 for Q.33 AND response E or F or G for Q.36 or response L for Q.38 _____ x 100 Total of kids aged 6-23 m with resp 2 for Q.38 or Q33	93.3	95.7	92.3	93.9	90.9 – 96.8
20 <i>Breastfed dairy rate</i> Proportion of children aged 6-23 months breastfed who had dairy yesterday	No. of children aged 6-23 months with either response=1 for Q.28 or response=1 for Q.33 AND response E or F or G for Q.36 or response L for Q.38 _____ x 100 Total no. of kids aged 6-23 m with respon 1 for Q.33	80.0	79.8	77.9	79.4	74.2 – 84.6
21 <i>Animal source food rate</i> Proportion of children aged 6-23 months who ate any animal source food yesterday	No. of children aged 6-23 months with response E or F or G for Q.36 or any of responses F, G, H, I, L or N for Q.38 _____ x 100 Total no. of children aged 6-23 months	90.6	93.4	88.6	91.1	88.3 – 93.8

INDICATOR		FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Iodized salt consumed in household</i> Proportion of households that used iodized salt	$\frac{\text{No. of samples taken in households that reacted positively with Quick Tests for iodized salt}}{\text{Total no. samples taken in each household as response=1 for Q.40}} \times 100$	33.0	70.9	55.1	50.6	46.4 – 54.8
22	<i>Underweight</i> Proportion of children aged 0-5 YEARS who are less than 2 standard deviations below the median weight-for-age of the reference population	$\frac{\text{No of children aged 0-5 YEARS who are less than 2 standard deviations below the median weight-for-age of the reference population as showed in Q.95}}{\text{No of children 0-5 YEARS whose data related to sex, agte and weight are taken in Q.95}} \times 100$	17.0	13.5	12.6	14.8	12.0 – 17.5
23	<i>Stunted</i> Proportion of children aged 0-5 YEARS who are less than 2 standard deviations below the median hight-for-age of the reference population	$\frac{\text{No of children aged 0-5 YEARS who are less than 2 standard deviations below the median height-for-age of the reference population as showed in Q.95}}{\text{No of children 0-5 YEARS whose data related to sex, agte and height are taken in Q.95 as response=1 for Q.40}} \times 100$	22.6	15.8	15.1	18.6	15.6 – 21.6
24	<i>Wasting</i> Proportion of children aged 0-5 YEARS who are less than 2 standard deviations below the median weight -for-height of the reference population	$\frac{\text{No of children aged 0-5 YEARS who are less than 2 standard deviations below the median weight-for-height of the reference population as showed in Q.95}}{\text{No of children 0-5 YEARS whose data related to sex, agte and height are taken in Q.95 as response=1 for Q.40}} \times 100$	17.0	13.5	12.6	14.8	12.0 – 17.5

MATERNAL AND NEWBORN CARE**Antenatal Care Indicators**

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>Maternal health card possession</i> Proportion of mothers with a maternal card (interviewer confirmed) for the youngest child less than 24 months of age	$\frac{\text{No. mothers with response= 1 for Q.72}}{\text{Total no. of mothers with children less than 24 months of age}} \times 100$	2.2	3.5	0.0	2.1	0.9 – 3.3
2 <i>Tetanus toxoid coverage</i> Proportion of mothers who received at least 2 TT injections (recall) before the birth of the youngest child less than 24 months of age	$\frac{\text{No. of mothers with at least 2 recorded dates before (NAME'S) date of birth (Q.74)}}{\text{Total no. of mothers with children less than 24 months of age}} \times 100$	53.8	76.3	63.6	63.5	59.5 – 67.5
3 <i>Antenatal care coverage</i> Proportion of mothers who had at least one antenatal visit prior to the birth of her youngest child less than 24 months of age	$\frac{\text{No. of mothers with response 1 for Q.67}}{\text{Total no. of mothers with children less than 24 months of age}} \times 100$	80.4	92.4	89.8	86.6	83.7 – 89.4
4 <i>Number of antenatal visit per pregnancy</i> Proportion of mothers who received more than 2 visits during the pregnancy of her youngest kid aged 0-23 months	$\frac{\text{No. of mothers with response >2 (exclude 99) per Q. 71}}{\text{Total no. of mothers with response 1 for Q.67}} \times 100$	57.9	80.4	84.8	71.6	67.5 – 75.8
5 <i>Timing of the first antenatal visit</i> Distribution of mothers who received their first antenatal visit during the first trimester of pregnancy.	$\frac{\text{No. of mothers with response 1 per Q.70}}{\text{Total no. of mothers with response 1 for Q.67}} \times 100$	47.6	59.1	55.2	53.2	47.1 – 59.3
6 <i>Iron supplementation coverage</i> Proportion of mothers who received/bought iron supplements while pregnant with the youngest child less than 24 months of age	$\frac{\text{No. of mothers with response=1 for Q.80}}{\text{Total no. of mothers with children less than 24 months of age}} \times 100$	9.8	8.6	10.7	9.6	7.1 – 12.1
7 <i>Duration of Iron/folate Supplementation in Pregnant Women</i> Average (<i>in days</i>) duration of iron/folate supplementation in women during the pregnancy of their youngest child less than 24 months of age	$\frac{\Sigma \text{ of days as responses in Q. 81 (exclude 888)}}{\text{Total no. of mothers with response 1 per Q.80}} \times 100$	27	43	38	35	

	INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
8	<i>Antenatal counseling on DIET</i> Proportion of mothers that were counseled about diet during pregnancy during antenatal visits	$\frac{\text{No. of children with response= I for Q.77I}}{\text{Total no. of children aged 0-23 months with response=Z for Q.77.A}} \times 100$	13.9	62.3	35.9	35.0	30.7 - 39.3
9	<i>Antenatal counseling on WORKLOAD, REST</i> Proportion of mothers that were counseled about their workload and rest during pregnancy during antenatal visits	$\frac{\text{No. of children with response= J for Q.77J}}{\text{Total no. of children aged 0-23 months with response=Z for Q.77.A}} \times 100$	17.1	57.9	21.0	31.4	27.3 - 35.6
10	Antenatal counseling on <i>DIET AND WORKLOAD, REST</i> Proportion of mothers that were counseled about their diet AND workload, rest during pregnancy during antenatal visits	$\frac{\text{No. of children with response= I for Q.77I AND response=J for Q.77J}}{\text{Total no. of children aged 0-23 months with response=Z for Q.77.A}} \times 100$	8.2	44.7	11.6	21.0	17.3 - 24.6

Delivery Care Indicators

	INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Delivery attended by skilled health personnel</i> Proportion of children aged 0-23 months whose births were attended by skilled health personnel	$\frac{\text{No. of mothers with response=1 OR 2 OR 3 for Q.79}}{\text{Total no. of children less than 24 months of age}} \times 100$	98.4	99.0	99.5	98.8	97.9 - 99.7
2	<i>Delivery in a health facility</i> Proportion of children aged 0-23 months delivered in a health facility	$\frac{\text{No. of mothers with response=1 OR 2 OR 3 OR 4 for Q.80}}{\text{Total no. of children less than 24 months of age}} \times 100$	91.8	91.9	87.2	90.8	88.3 - 93.2

Postpartum and Newborn Care Indicators

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulgiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>Postpartum contact</i> Proportion of mothers who had at least one postpartum check up	$\frac{\text{No. of mothers with response= 1 for Q.82}}{\text{Total no. of mothers with children less than 24 months}} \times 100$	19.0	37.4	47.6	31.8	27.9 – 35.7
2 <i>Knowledge of 2 neonatal danger signs</i> Proportion of mothers able to report at least two known neonatal danger signs	$\frac{\text{No. of mothers with at least two responses= 1 through 5 for Q.87}}{\text{Total no. of mothers with children less than 24 months}} \times 100$	30.4	71.7	46.5	47.8	43.6 – 52.0
2 <i>Knowledge of 3 neonatal danger signs</i> Proportion of mothers able to report at least two known neonatal danger signs	$\frac{\text{No. of mothers with at least three responses= 1 through 5 for Q.87}}{\text{Total no. of mothers with children less than 24 months}} \times 100$	3.8	28.3	6.4	12.5	9.7 – 15.2
2 <i>Knowledge of 4 neonatal danger signs</i> Proportion of mothers able to report at least two known neonatal danger signs	$\frac{\text{No. of mothers with at least four responses= 1 through 5 for Q.87}}{\text{Total no. of mothers with children less than 24 months}} \times 100$	1.1	7.1	0.0	2.8	1.4 – 4.2
2/1 Knowledge of neonatal danger sign - 1 Proportion of mothers of kids aged 0-23 months who know as neonatal danger sign – POOR FEEDING	$\frac{\text{No. of mothers who response = 1 for Q. 871}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	38.6	59.6	62.0	51.0	46.8 – 55.2
2/2 Knowledge of neonatal danger sign - 2 Proportion of mothers of kids aged 0-23 months who know as neonatal danger sign – FAST BREATHING	$\frac{\text{No. of mothers who response = 1 for Q. 872}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	10.3	41.9	15.8	22.0	18.5 – 25.5
2/3 Knowledge of neonatal danger sign – 3 Proportion of mothers of kids aged 0-23 months who know as neonatal danger sign – NOT ACTIVE	$\frac{\text{No. of mothers who response = 1 for Q. 873}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	23.4	41.9	18.5	28.3	24.5 – 32.1
2/4 Knowledge of neonatal danger sign – 4 Proportion of mothers of kids aged 0-23 months who know as neonatal danger sign – REDNESS AROUND CORD	$\frac{\text{No. of mothers who response = 1 for Q. 874}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	11.4	35.9	20.7	21.6	18.2 – 25.1

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
2/5 <i>Knowledge of neonatal danger sign – 5</i> Proportion of mothers of kids aged 0-23 months who know as neonatal danger sign – RED/DISHARGE IN EYE	$\frac{\text{No. of mothers who response = 1 for Q. 875}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	3.3	18.2	13.0	10.5	7.9 – 13.0
3 <i>Maternal vitamin A supplementation</i> Proportion of mothers who received vitamin A during the first two months after delivery	$\frac{\text{No. of mothers with response= 1 Q.86}}{\text{Total no. of mothers with children less than 24 months}} \times 100$	3.3	2.5	5.9	3.6	2.1 – 5.2

FAMILY PLANNING INDICATORS

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulgqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>NOT-Contraceptive use among mothers who want to limit or space births</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are NOT using any method of contraception AT ALL	$\frac{\text{Total no. of mothers with response=A for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	23.5	33.8	44.4	33.4	29.2 – 37.6
2 <i>Contraceptive use among mothers who want to limit or space births – LACTATIONAL AMENORRHEA METHOD</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using a modern method of contraception	$\frac{\text{Total no. of mothers with response=K for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	0.0	5.4	2.6	2.4	Too small sample
3 <i>Contraceptive use among mothers who want to limit or space births</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using a modern method of contraception	$\frac{\text{Total no. of mothers with response=B through J for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	7.4	20.8	8.8	12.1	9.2 – 15.0
3.1 <i>Contraceptive use among mothers who want to limit or space births - INJECTIONS</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using INJECTIONS as a modern method of contraception	$\frac{\text{Total no. of mothers with response=B for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	8.3	57.9	7.1	24.4	13.6 – 35.1
3.2 <i>Contraceptive use among mothers who want to limit or space births - PILLS</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using PILLS as a modern method of contraception	$\frac{\text{Total no. of mothers with response=C for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	16.7	23.7	42.9	25.1	14.3 – 36.0
3.3 <i>Contraceptive use among mothers who want to limit or space births – DIAPHRAGMS as BARRIER METHOD</i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using DIAPHRAGMS as a modern method of contraception	$\frac{\text{Total no. of mothers with response=E for Q.92}}{\text{Total no.of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	16.7	0	0	7.3	0.8 – 13.8

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
3.4 <i>Contraceptive use among mothers who want to limit or space births - <u>CONDOMS</u></i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using <u>CONDOMS</u> as a modern method of contraception	$\frac{\text{Total no. of mothers with response=F for Q.92}}{\text{Total no. of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	33.3	18.4	35.7	29.0	17.6 – 40.3
3.5 <i>Contraceptive use among mothers who want to limit or space births – <u>TUBAL LIGATION</u></i> Proportion of non pregnant mothers who desire no more children in the next two years, or are not sure, who are using <u>TUBAL LIGATION</u> as a method of contraception	$\frac{\text{Total no. of mothers with response=H for Q.92}}{\text{Total no. of mothers with response=2 for Q.90 AND responses=2,3 or 8 for Q.91}} \times 100$	25.0	0	14.3	14.3	5.5 – 23.0
4 <i>Family Planning Method Usage – <u>Withdrawal</u></i> Proportion of mothers who report <u>Withdrawal</u> as the current family planning method being used	$\frac{\text{No. of mothers with responses= O for Q.92}}{\text{Total no. of mothers with responses to Q.92}} \times 100$	63.0	35.0	45.6	49.7	45.2 – 54.1
5 <i>Knowledge of sources of family planning methods</i> Proportion of mothers who report at least one place where she can obtain a method of family planning	$\frac{\text{No. of mothers with responses= A through K for Q.89}}{\text{Total no. of mothers with responses to Q.89}} \times 100$	38.6	78.8	65.2	58.1	53.9 – 62.2
6 <i>Adequate birth interval between youngest surviving children</i> Proportion of children aged 0-23 months who were born at least 24 months after the previous surviving child	$\frac{\text{No. of children aged 0-23 months whose date of birth is at least 24 months after the birth of the previous surviving child}}{\text{Total no. of children aged 0-23 months who have an older sibling}} \times 100$	78.7	69.1	73.7	74.4	69.3 – 79.5
7 <i>Adequate birth interval between youngest surviving children</i> Proportion of children aged 0-23 months who were born at least 36 months after the previous surviving child	$\frac{\text{No. of children aged 0-23 months whose date of birth is at least 36 months after the birth of the previous surviving child}}{\text{Total no. of children aged 0-23 months who have an older sibling}} \times 100$	35.2	32.1	43.0	36.0	30.3 – 41.6
8 <i>Provision of family planning information during a prenatal check-up</i> Proportion of mothers who received family planning information during a prenatal check-up	$\frac{\text{No. of mothers with response= F for Q.77}}{\text{Total no. of mothers with responses B through K for Q.77}} \times 100$	10.8	40.6	14.4	21.4	17.8 – 25.1

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
9 <i>Provision of child spacing information during a postpartum check-up</i> Proportion of mothers who received family planning information during a postpartum check-up	$\frac{\text{No. of mothers with response= 3 for Q.85}}{\text{Total no. of mothers with responses to Q. 85}} \times 100$	20.0	70.3	26.1	38.0	31.1 – 44.9
10 <i>HIV/AIDS knowledge and Prevention</i> <i>Proportion of mothers of children aged 0-23 mths who cite at least two known ways of reducing the risk of HIV infect.</i>	$\frac{\text{No. of mothers who report at least two of the Ways how to prevent AIDS listed in responses B through O of Q. 94}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	75.0	75.8	72.7	74.7	71.1 – 78.4

CHILDHOOD ILLNESS INDICATORS

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>Maternal knowledge of 2 child danger signs</i> Proportion of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that require treatment	$\frac{\text{No. of mothers who report at least two of the signs listed in responses B through M of Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	77.7	99.5	97.9	89.6	87.0 – 92.2
2 <i>Maternal knowledge of 3 child danger signs</i> Proportion of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that require treatment	$\frac{\text{No. of mothers who report at least three of the signs listed in responses B through M of Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	48.9	91.4	85.6	71.5	67.7 – 75.3
3 <i>Maternal knowledge of 4 child danger signs</i> Proportion of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that require treatment	$\frac{\text{No. of mothers who report at least four of the signs listed in responses B through M of Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	19.6	68.7	46.0	41.9	37.8 – 46.1
3/1 <i>Maternal knowledge of child danger signs – 1</i> Proportion of mothers of kids aged 0-23 months who know as sign of illness that require treatment – LOOKS UNWELL	$\frac{\text{No. of mothers who response = B for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	11.4	30.3	32.6	22.6	19.1 – 26.1
3/2 <i>Maternal knowledge of child danger signs – 2</i> Proportion of mothers of kids aged 0-23 months who know as sign of illness – NOT PLAY NORMALLY	$\frac{\text{No. of mothers who response = C for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	6.5	21.7	10.7	12.5	9.7 – 15.3
3/3 <i>Maternal knowledge of child danger signs – 3</i> Proportion of mothers of kids aged 0-23 months who know as sign of illness – CRYING CONTINUOUSLY	$\frac{\text{No. of mothers who response = D for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	32.1	55.1	47.1	43.1	39.0 – 47.3
3/4 <i>Maternal knowledge of child danger signs – 4</i> Proportion of mothers of kids aged 0-23 months who know as sign of illness – NOT EATING OR DRINKING	$\frac{\text{No. of mothers who response = E for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	29.3	65.2	49.2	45.8	41.6 – 50.0

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
3/5 Maternal knowledge of child danger signs – 5 Proportion of mothers of kids aged 0-23 months who know as sign of illness – LETHARGIC or HARD TO WAKE	$\frac{\text{No. of mothers who response = F for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	3.3	8.1	2.1	4.6	2.8 – 6.3
3/6 Maternal knowledge of child danger signs – 6 Proportion of mothers of kids aged 0-23 months who know as sign of illness – HIGH FEVER	$\frac{\text{No. of mothers who response = G for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	81.0	96.5	90.9	88.4	85.7 – 91.1
3/7 Maternal knowledge of child danger signs – 7 Proportion of mothers of kids aged 0-23 months who know as sign of illness – FAST or DIFFICULTY BREATHING	$\frac{\text{No. of mothers who response = H for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	3.8	17.2	4.3	8.3	6.0 – 10.6
3/8 Maternal knowledge of child danger signs – 8 Proportion of mothers of kids aged 0-23 months who know as sign of illness – VOMITS EVERYTHING	$\frac{\text{No. of mothers who response = I for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	38.0	70.7	57.2	53.3	49.1 – 57.5
3/9 Maternal knowledge of child danger signs – 9 Proportion of mothers of kids aged 0-23 months who know as sign of illness that require treatment – CONVULSIONS	$\frac{\text{No. of mothers who response = J for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	3.3	5.1	0.5	3.2	1.7 – 4.7
3/10 Maternal knowledge of child danger signs – 10 Proportion of mothers of kids aged 0-23 months who know as sign of illness that require treatment – BLOOD IN STOOL	$\frac{\text{No. of mothers who response = K for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	2.7	4.0	0.5	2.6	1.3 – 4.0
3/11 Maternal knowledge of child danger signs – 11 Proportion of mothers of kids aged 0-23 months who know as sign of illness – PERSISTENT DIARRHEA	$\frac{\text{No. of mothers who response = L for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	33.7	64.1	50.8	47.7	43.5 – 51.9
3/12 Maternal knowledge of child danger signs – 12 Proportion of mothers of kids aged 0-23 months who know as sign of illness that require treatment – GETTING SICKER	$\frac{\text{No. of mothers who response = M for Q. 42}}{\text{Total no. of mothers of children aged 0-23 months}} \times 100$	3.3	12.1	0.0	5.4	3.5 – 7.3
4 Child sickness in past two weeks Proportion of children aged 0-23 months who had an illness in the past two weeks	$\frac{\text{No. of children 0-23 months with response 1 to 8 for Q. 43}}{\text{Total no. of children aged 0-23 months}} \times 100$	65.2	36.4	42.2	50.3	46.1 – 54.5

INDICATOR	FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
5 Increased fluids intake during an illness Proportion of children aged 0-23 months with an illness in the last two weeks who were offered more fluids during the illness	$\frac{\text{No. of children with response= 4 for Q.44 or response=3 for Q.45}}{\text{No. of children with response 1 to 8 for Q.43}} \times 100$	56.9	65.7	66.7	62.1	56.1 – 68.1
6 Increased food intake during an illness Proportion of children aged 0-23 months with an illness in the last two weeks who were offered the same amount or more food during the illness	$\frac{\text{No. of children with response=2 or 3 for Q.46}}{\text{No. of children with responses 1 to 8 for Q.43}} \times 100$	43.2	58.6	44.0	48.5	42.3 – 54.6
7 Increased food and fluid intake during an illness Proportion of children aged 0-23 months with an illness in the last two weeks who were offered the same amount or more food and fluids during the illness	$\frac{\text{No. of children with response=2 or 3 for Q.46 AND with response= 4 for Q.44 or response=3 for Q.45}}{\text{No. of children with responses 1 to 8 for Q.43}} \times 100$	27.4	41.4	31.6	33.0	27.2 – 38.8
8 Increased food and fluid intake when recovering from an illness Proportion of children aged 0-23 months who were sick in the past two weeks and were offered more food and fluid when recovering from the illness	$\frac{\text{No. of children with response=2 or 3 for Q.47}}{\text{No. of children with responses 1 to 8 for Q.43}} \times 100$	93.3	95.7	92.3	93.9	90.0 – 96.8

Acute Respiratory Infection Indicator

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 ARI care seeking 1 Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were taken to health facility OR received antibiotics from another source	$\frac{\text{No. of children with response=A, B, C, D, E, or G for Q.52 or Q.54 -OR- with response= F for Q.55}}{\text{No. of children with response=1 for Q. 48 and Q 49}} \times 100$	76.9	91.4	83.8	83.3	76.6 – 90.0
2 ARI care seeking 2 Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were taken to health facility AND received antibiotics	$\frac{\text{No. of children with response=A, B, C, D, E, or G for Q.52 or Q.54 -AND- with response= F for Q.55}}{\text{No. of children with response=1 for Q. 48 and Q 49}} \times 100$	59.6	71.4	56.8	62.8	54.1 – 71.5
3 ARI care seeking 3 Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were taken to health facility THAT received antibiotics	$\frac{\text{No. of children with response= F for Q.55}}{\text{No. of children with response=1 for Q. 48 and Q 49 AND A, B, C, D, E, or G for Q.52 or Q.54}} \times 100$	86.1	83.3	72.4	82.0	74.1 – 89.9
4 ARI care seeking 4 Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were NOT taken to health facility AND received antibiotics	$\frac{\text{No. of children with response=2 for Q.50 AND =F for Q.55 and response= F, H, I, J, K, for Q.52}}{\text{No. of children with response=1 for Q. 48 and Q 49}} \times 100$	7.7	5.7	5.4	6.5	2.1 – 10.9
5 ARI care seeking delay Proportion of children aged 0-23 months with cough and fast/difficulty breathing in the last two weeks who were taken to health facility for treatment within the next two days	$\frac{\text{No of children with response=1 and 2 for Q.51}}{\text{No. of children with response=1 for Q. 48 and Q 49}} \times 100$	44.4	56.7	48.3	49.4	39.1 – 59.6

Diarrhea Indicators

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>ORT use during a diarrhea episode</i> Proportion of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids (RHF)	$\frac{\text{No. of children with responses B or C for Q.58}}{\text{No. of children with responses to Q.58}} \times 100$	10.8	19.7	21.5	16.3	11.8 – 20.8
2 <i>Diarrhea care seeking delay</i> Proportion of children aged 0-23 months with diarrhea in the last two weeks who were taken to health facility for treatment within the first two days after the diarrhea started.	$\frac{\text{No of children with response=1 and 2 for Q.60}}{\text{No. of children with response=1 for Q. 57}} \times 100$	56.5	66.7	81.8	65.8	54.1 – 77.5
3 <i>Care seeking for diarrhea</i> Proportion of children aged 0-23 months with diarrhea last two weeks whose mother sought outside advice or treatment	$\frac{\text{No. of children with response= 1 for Q.59}}{\text{No. of children with responses to Q.59}} \times 100$	42.9	70.0	52.4	54.0	45.2 – 62.8
4 <i>Antibiotic consumption during Diarrhea episode</i> Proportion of children aged 0-23 months with diarrhea in the last two weeks who received antibiotics	$\frac{\text{No. of children with response= O for Q.58 OR O, I for Q.64}}{\text{No. of children with response=1 to Q.57}} \times 100$	28.6	53.3	23.8	35.6	27.1 – 44.1
5 <i>Maternal competency in ORS preparation</i> Proportion of mothers that have children from 0-23 months who can correctly prepare the ORS from package.	$\frac{\text{No. of mothers with response= 1 for Q.66}}{\text{Total no. of mothers with responses to Q.66}} \times 100$	71.7	80.8	80.2	76.7	73.2 – 80.3
6 <i>Maternal Hand Washing</i> Proportion 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.	$\frac{\text{No. of mothers with responses 2 through 6 Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	25.0	44.4	23.5	31.0	27.2 – 34.9
6/1 <i>Maternal Hand Washing Before Food Preparation</i> Proportion of mothers of children aged 0-23 months who wash their hands with soap before food preparation	$\frac{\text{No. of mothers with response 2 for Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	81.5	88.9	93.0	86.6	83.8 – 89.5

INDICATOR		FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
6/2	<i>Maternal Hand Washing Before Eating</i> Proportion of mothers of children aged 0-23 months who wash their hands with soap before eating	$\frac{\text{No. of mothers with response 3 for Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	64.1	78.8	69.0	70.1	66.2 – 73.9
6/3	<i>Maternal Hand Washing Before Feeding Children</i> Proportion of mothers of children aged 0-23 months who wash their hands with soap before feeding children	$\frac{\text{No. of mothers with response 4 for Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	66.3	84.3	70.6	73.2	69.5 – 77.0
6/4	<i>Maternal Hand Washing After Defecation</i> Proportion of mothers of children aged 0-23 months who wash their hands with soap after defecation	$\frac{\text{No. of mothers with response 5 for Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	64.1	81.3	56.1	67.9	64.0 - 71.8
6/5	<i>Maternal Hand Washing After Defecation to a Child</i> Proportion of mothers of children aged 0-23 months who wash their hands with soap after attending to a child who has defecated	$\frac{\text{No. of mothers with response 6 for Q.41}}{\text{Total no. of mothers with responses to Q.41}} \times 100$	60.9	77.3	66.3	67.5	63.6 – 71.5

DEMOGRAPHIC INDICATORS

Household sanitation

INDICATOR		FORMULA	Diber (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Water piped into the house</i> Proportion of households whose main source of water is Piped into the house	$\frac{\text{No. of mothers with response= 1 for Q.14}}{\text{Total no. of mothers with responses to Q.14}} \times 100$	31.0	43.4	62.0	42.4	36.2 – 48.5
2	<i>Water from standpipe in yard</i> Proportion of households whose main source of water is a standpipe in the yard	$\frac{\text{No. of mothers with response= 2 for Q.14}}{\text{Total no. of mothers with responses to Q.14}} \times 100$	17.9	22.2	19.3	19.7	12.2 – 27.1
3	<i>Water from public standpipe</i> Proportion of households whose main source of water is a Public Standpipe	$\frac{\text{No. of mothers with response= 3 for Q.14}}{\text{Total no. of mothers with responses to Q.14}} \times 100$	30.4	8.6	11.8	18.9	10.8 – 26.9
4	<i>Water from the spring</i> Proportion of households whose main source of water is from the Spring	$\frac{\text{No. of mothers with response= 5 for Q.15}}{\text{Total no. of mothers with responses to Q.15}} \times 100$	3.8	14.6	0.0	6.5	Too small sample
5	<i>Water from borehole or tubewell</i> Proportion of households whose main source of water is borehole or tubewell	$\frac{\text{No. of mothers with response= 4 for Q.14}}{\text{Total no. of mothers with responses to Q.14}} \times 100$	16.8	11.1	7.0	12.6	4.5 – 20.8
1	<i>Indoor flush system</i> Proportion of households with indoor flush system	$\frac{\text{No. of mothers with response= 1 for Q.15}}{\text{Total no. of mothers with responses to Q.15}} \times 100$	41.8	59.6	70.6	54.4	48.9 – 59.9
2	<i>Outdoor flush system</i> Proportion of households with outdoor flush system	$\frac{\text{No. of mothers with response= 2 for Q.15}}{\text{Total no. of mothers with responses to Q.15}} \times 100$	19.0	14.1	6.4	14.5	6.3 – 22.6
3	<i>Pit latrine</i> Proportion of households with pit latrine	$\frac{\text{No. of mothers with response= 3 for Q.15}}{\text{Total no. of mothers with responses to Q.15}} \times 100$	39.1	26.3	23.0	31.1	23.9 – 38.3

Father's employment

INDICATOR		FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	Proportion of households whose family's father is deceased/divorced (not in household)	$\frac{\text{No. of mothers with response= A for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	0.5	0.0	0.0	0.2	Too small sample
2	Proportion of households whose family's father is a migrant worker	$\frac{\text{No. of mothers with response= B for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	38.6	19.2	34.8	31.3	24.3 – 38.3
3	Proportion of households whose family's father is a farmer/agricultural worker	$\frac{\text{No. of mothers with response= C for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	3.3	3.0	0.0	2.4	Too small sample
4	Proportion of households whose family's father is a professional/administrative/clerical	$\frac{\text{No. of mothers with response= D for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	7.6	8.6	11.2	8.8	0.9 – 16.6
5	Proportion of households whose family's father is factory a worker/miner/laborer	$\frac{\text{No. of mothers with response= E for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	0.5	1.0	11.2	3.2	Too small sample
6	Proportion of households whose family's father is other salaried employee	$\frac{\text{No. of mothers with response= F for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	2.2	7.1	4.3	4.3	Too small sample
7	Proportion of households whose family's father is a seasonal laborer	$\frac{\text{No. of mothers with response= G for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	12.0	8.1	6.4	9.4	1.1 – 17.6
8	Proportion of households whose family's father is a private/small businessman	$\frac{\text{No. of mothers with response= H for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	5.4	14.1	8.6	9.0	1.2 – 16.8
9	Proportion of households whose family's FATHER is unemployed	$\frac{\text{No. of mothers with response= I for Q.17}}{\text{Total no. of mothers with responses to Q.17}} \times 100$	29.9	38.9	23.5	31.4	24.4 – 38.4

Mother's employment

INDICATOR		FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Mother's employment status</i> Proportion of mothers that mother work outside the home to earn money	$\frac{\text{No. of mothers with no response= 1 and any response from 2 to 8 for Q.16}}{\text{Total no. of mothers with responses to Q.16}} \times 100$	4.3	10.6	9.1	7.5	5.3 – 9.7
2	Mother's job activity Farmer/agricultural work	$\frac{\text{No. of mothers with response= 2 for Q.16}}{\text{Total no. of mothers with responses to Q.16}} \times 100$	0.0	19.0	5.9	7.6	Too small sample
3	Mother's job activity Professional/administrative/clerical	$\frac{\text{No. of mothers with response= 3 for Q.16}}{\text{Total no. of mothers with responses to Q.16}} \times 100$	75.0	61.9	76.5	71.0	55.0 – 87.1
4	Mother's job activity Other salaried employment	$\frac{\text{No. of mothers with response= 5 for Q.16}}{\text{Total no. of mothers with responses to Q.16}} \times 100$	12.5	9.5	11.8	11.3	Too small sample
5	Mother's job activity Works in a private/small business	$\frac{\text{No. of mothers with response= 7 for Q.16}}{\text{Total no. of mothers with responses to Q.16}} \times 100$	12.5	9.5	5.9	10.0	Too small sample

Family members in household

INDICATOR		FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1	<i>Inhabitant population of the household</i> Proportion of households where 1-4 persons slept last night	$\frac{\text{No. of mothers with response = 1 till 4 for Q.12}}{\text{Total no. of mothers with responses to Q.12}} \times 100$	21.2	25.8	34.8	25.9	18.8 – 32.9
2	<i>Inhabitant population of the household</i> Proportion of households where 5-10 persons slept last night	$\frac{\text{No. of mothers with response = 5 till 10 for Q.12}}{\text{Total no. of mothers with responses to Q.12}} \times 100$	72.3	71.7	59.9	69.2	64.5 – 73.9
3	<i>Inhabitant population of the household</i> Proportion of households where >10 persons slept last night	$\frac{\text{No. of mothers with response > 10 for Q.12}}{\text{Total no. of mothers with responses to Q.12}} \times 100$	6.5	2.5	5.3	4.9	Too small sample
4	<i>Number of rooms in the household</i> Proportion of households with 1-3 rooms (kitchen included).	$\frac{\text{No. of mothers with response = 1 till 3 for Q.13}}{\text{Total no. of mothers with responses to Q.13}} \times 100$	60.9	66.7	63.6	63.4	58.4 – 68.5
5	<i>Number of rooms in the household</i> Proportion of households with 4-6 rooms (kitchen included)	$\frac{\text{No. of mothers with response = 4 till 6 for Q.13}}{\text{Total no. of mothers with responses to Q.13}} \times 100$	37.5	30.3	33.7	34.2	27.4 – 41.1
6	<i>Number of rooms in the household</i> Proportion of households with > 6 rooms (kitchen included).	$\frac{\text{No. of mothers with response > 6 for Q.13}}{\text{Total no. of mothers with responses to Q.13}} \times 100$	1.6	3.0	2.7	2.3	Too small sample

Mother's Demographics

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 <i>Educational level of mother</i> Proportion of mothers who finished elementary school	$\frac{\text{No. of mothers with response=1 for Q.9}}{\text{Total no. of mothers with responses to Q.9}} \times 100$	3.3	1.5	3.2	2.7	Too small sample
2 <i>Educational level of mother</i> Proportion of mothers who finished secondary school	$\frac{\text{No. of mothers with response=1 for Q.9}}{\text{Total no. of mothers with responses to Q.9}} \times 100$	73.9	66.5	66.1	69.6	65.0 – 74.3
3 <i>Educational level of mother</i> Proportion of mothers who finished high school	$\frac{\text{No. of mothers with response=1 for Q.9}}{\text{Total no. of mothers with responses to Q.9}} \times 100$	21.7	26.9	27.4	24.8	17.6 – 32.0
4 Educational level of mother Proportion of mothers who finished university	$\frac{\text{No. of mothers with response=1 for Q.9}}{\text{Total no. of mothers with responses to Q.9}} \times 100$	1.1	5.1	3.2	2.9	Too small sample
5 <i>Age group of mothers</i> Proportion of mothers aged 17-20 years old	$\frac{\text{No. of mothers with response=17 till 20 for Q.8}}{\text{Total no. of mothers with responses to Q.8}} \times 100$	9.8	5.6	11.8	8.9	0.9 – 16.9
6 <i>Age group of mothers</i> Proportion of mothers aged 21-34 years old	$\frac{\text{No. of mothers with response=21 till 34 for Q.8}}{\text{Total no. of mothers with responses to Q.8}} \times 100$	82.0	80.1	81.2	81.2	77.5 – 84.8
7 <i>Age Group of mothers</i> Proportion of mothers >older than 34 years old	$\frac{\text{No. of mothers with response > 34 for Q.8}}{\text{Total no. of mothers with responses to Q.8}} \times 100$	8.2	14.3	7.0	9.9	1.9 – 17.9
8 <i>Number of children per sampled mothers</i> Proportion of mothers with only <u>one child</u>	$\frac{\text{No. of mothers with no response for Q.203 AND Q.204}}{\text{Total no. of mothers with children 0-23 months}} \times 100$	48.9	59.1	39.0	49.9	44.0 – 55.9
9 <i>Number of children per sampled mothers</i> Proportion of mothers with <u>more than one child</u>	$\frac{\text{No. of mothers with any response for Q.203 AND Q.204}}{\text{Total no. of mothers with children 0-23 months}} \times 100$	51.1	40.9	61.0	50.1	44.2 – 55.9

Children's Demographics

INDICATOR	FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
1 Number distribution of children under 5 years per household Proportion of households with only one child	$\frac{\text{No. of mothers with response} = 1 \text{ for Q.18}}{\text{Total no. of mothers with responses to Q.18}} \times 100$	50.0	58.1	45.5	51.6	45.7 – 57.4
2 Number distribution of children under 5 years per household Proportion of households with two children	$\frac{\text{No. of mothers with response} = 2 \text{ for Q.18}}{\text{Total no. of mothers with responses to Q.18}} \times 100$	41.3	37.9	44.4	40.9	34.5 – 47.3
3 Number distribution of children under 5 years per household Proportion of households with more than two children	$\frac{\text{No. of mothers with response} > 2 \text{ for Q.18}}{\text{Total no. of mothers with responses to Q.18}} \times 100$	8.7	4.0	10.2	7.5	Too small sample
4 Number distribution of biological children under 5 years per household Proportion of households with only one biological child.	$\frac{\text{No. of mothers with response} = 1 \text{ for Q.19}}{\text{Total no. of mothers with responses to Q.19}} \times 100$	54.9	61.6	50.3	56.0	50.4 – 61.6
5 Number distribution of biological children under 5 years per household Proportion of households with two biological children	$\frac{\text{No. of mothers with response} = 2 \text{ for Q.19}}{\text{Total no. of mothers with responses to Q.19}} \times 100$	40.2	35.4	45.5	39.8	33.4 – 46.3
6 Number distribution of biological children under 5 years per household Proportion of households with more than two biological children	$\frac{\text{No. of mothers with response} > 2 \text{ for Q.19}}{\text{Total no. of mothers with responses to Q.19}} \times 100$	4.9	3.0	4.3	4.1	Too small sample
7 <i>Gender distribution of 0-23 months children</i> Proportion of males for children 0-23 months	$\frac{\text{No. of mothers with response} = 1 \text{ for Q.201}}{\text{Total no. of mothers with responses to Q.201}} \times 100$	50.5	59.1	54.0	54.2	48.5 – 59.8
8 <i>Gender distribution of 0-23 months children</i> Proportion of females for children 0-23 months	$\frac{\text{No. of mothers with response} = 2 \text{ for Q.201}}{\text{Total no. of mothers with responses to Q.201}} \times 100$	49.5	40.9	46.0	45.8	39.6 – 52.0
9 <i>Gender distribution of the next youngest children</i> Proportion of males for the next youngest children	$\frac{\text{No. of mothers with response} = 1 \text{ for Q.203}}{\text{Total no. of mothers with responses to Q.203}} \times 100$	32.2	33.3	49.5	36.7	27.4 – 45.9

INDICATOR		FORMULA	Dibër (%)	Mat (%)	Bulqiza (%)	Prefecture (%)	CI (%) Prefecture level
10	<i>Gender distribution of the next youngest children</i> Proportion of Female for the next youngest children	$\frac{\text{No. of mothers with response = 2 for Q.203}}{\text{Total no. of mothers with responses to Q.203}} \times 100$	67.8	66.7	50.5	63.3	55.9 – 70.8
11	<i>Age group distribution of next youngest child</i> Proportion of households with the next youngest child less than 25 months old.	$\frac{\text{No. of mothers with response < 25 months for Q.204}}{\text{Total no. of mothers with responses to Q.204}} \times 100$	41.6	37.5	29.5	37.4	27.6 – 47.2
12	<i>Age group distribution of next youngest child</i> Proportion of households with the next youngest children from 25 months to 36 months old.	$\frac{\text{No. of mothers with response from 25 to 36 months for Q.204}}{\text{Total no. of mothers with responses to Q.204}} \times 100$	22.5	31.3	28.6	26.8	16.6 – 37.0
13	<i>Age group distribution of next youngest child</i> Proportion of households with the next youngest child older than 36 months old.	$\frac{\text{No. of mothers with response > 36 months for Q.204}}{\text{Total no. of mothers with responses to Q.204}} \times 100$	36.0	31.3	41.9	35.8	26.3 – 45.3

ANNEX 1

Response to Application Debriefing

RESPONSE TO APPLICATION COMMENTS (*Questions appear in italics*)

Budget Information

“One major oversight is that the PVO did not feel it appropriate to budget for travel of national staff, either internally in Albania, regionally, or to the US, such as project manager coming to the DIP mini-university, and other events.” (p.1)

Travel costs: This oversight has been addressed in the comprehensive budget amendment being submitted with the DIP. Project Manager, Fabian Cenko, and Senior Liaison (M&E) Officer¹, Ermira Brasha, will both participate in the DIP Mini-University.

“The budget does not include costs related to training (other than supplies). Also, it would be nice to include other media equipment (e.g., video and/or digital camera) in the proposed list of equipment. Such equipment can be used to facilitate the sharing of innovations and lessons learned with others, as well as provide a visual record of trainings or important workshops. (Given the high turnover in most organizations, video footage from workshops could be used to train/orient new staff, for example.)” (p.1)

Training costs: Training costs have been detailed in the budget amendment. With regard to the recommendation of media equipment, the project does have digital cameras available for use. While the recommendation to purchase a video camcorder is sound and compelling, it has not been possible to include such equipment in our amended budget at the present time. However, should additional cost share funds be raised, a video camcorder and multi-media video projector are on the “wish list.”

“Other important field staff (e.g., a community liaison, guard, accountant/logistics person) do not appear to be included in the estimated budget.” (p.1)

Budgeted staff: Please refer to budget amendment and updated Organogram. The project has an administrative/finance officer in Tirana and a cashier/bookkeeper in the Peshkopi office. There is no need for a guard in Tirana, as the American Red Cross (ARC) office is located in a secure building with a reception desk that controls ingress and egress. In Peshkopi, guard services are included in office rent.

Community liaison functions: Community liaison, as a function, is integrated into the project design, through partnership with the Albanian Red Cross (AlbRC), specifically through the Diber Branch Secretary, the AlbRC sub-branches at district level, and the project’s District Health Coordinators who oversee the work of the VHEs. Please see updated Organogram in Annex 8.

Executive Summary and Overall Application

“The statement ‘with an approved extension’ is unclear since this is an entry level application.” (p.2)

“Approved extension”: This was in reference to the possibility of a CS-24 cost extension.

Description of the PVO Applicant

“It would have been nice to read more about the applicant’s capacity with respect to nutrition and reproductive health, as well as its experience in applying some of the state-of-the-art strategies noted in the application (e.g., TIPS, community-based distribution program, the BEHAVE framework).” (p.2)

¹ The Senior Liaison (M&E) Officer will be able to participate in the DIP Mini-University as she will be participating in the Quality Assurance Management for Developing Countries course at Johns Hopkins Bloomberg School of Public Health (with non-project funding) during that same time period.

Recent ARC experience in nutrition and IMCI: The ARC and the Armenian Red Cross Society (ARCS) recently carried out a short-term project to improve health status of mothers and children under five by targeting maternal and child health and nutrition knowledge and practices in the Martuni Region. The Red Cross partners applied a community-IMCI strategy in Gegharkunik *marz* and carried out a community-based peer health education and mass media campaign. ARCS field officers (previously trained in clinical IMCI by Ministry of Health specialists) trained 387 Community Health Volunteers (CHVs) from 16 villages of Martuni region. These CHVs counseled and educated approximately 5,000 caretakers of children under 5 in their communities on key nutrition and health practices, including breastfeeding, control of diarrheal diseases, acute respiratory infection, hygiene practices, recognition of danger signs, and appropriate referral. The program also developed and distributed IMCI campaign products via several local and national media. The intervention in Martuni region lasted for approximately seven months (from mid-April 2003 to late November 2003). ARC contracted the American University of Armenia’s Center for Health Services Research and Development to support its evaluation component by conducting baseline and final surveys in the project area. The analysis documented statistically significant improvements in many of the unfavorable areas noted in the baseline and documented the positive impacts on women’s knowledge and practices attributable to the campaign: 1) exclusive breastfeeding practice increased 30% (from 16.7% to 48.1%); 2) maternal awareness of child danger signs (at least 2) increased 30% (from 35% to 65%); 3) knowledge of HIV risk reduction increased 28.5% (from 19% to 47.5%); 4) awareness of AIDS increased 10% (from 85% to 94%); 5) physician attended deliveries increased 15% (from 63.7% to 78.3%); 6) home deliveries declined 7% (from 16.3% to 9%). This evaluation documented the significant and substantial short-term impact of the IMCI program and the effectiveness of community-based approach for improving maternal and child health related knowledge and practices in rural areas of Armenia. In addition to the above, the ARC has recent experience using the BEHAVE framework and applying TIPS to the adaptation of the IMCI food box and feeding recommendations for Nagorno Karabakh (2000).

Situational Analysis

“The assumption on page 6 that the 8.3% contraceptive prevalence is due to low availability was not supported by other reasons.” (p.2)

Contraception prevalence: The project’s KPC survey results bear out the assumption that contraceptive prevalence rate (12.1% among mothers of children 0-23 months for the prefecture) is due, in part, to low availability. Although 55% of the population in Diber Prefecture lives within 5 km of a FP service delivery point (SDP), access is limited by road conditions, weather, and lack of public transportation. Other reasons include lack of accurate information about family planning, socio-cultural barriers, familial economic constraints, and over-reliance on withdrawal and abortion as methods. In Mat District, where USAID contractor John Snow International (JSI) worked with the district health directorate to increase access and availability through training, logistic management support, and information campaigns, the contraceptive prevalence rate is significantly higher than the other two districts:

Mat District	20.7%
Bulqize District	8.7%
Diber District	7.4%
Prefecture	12.1%

“A more detailed discussion as to how synergies would work between ARC, SCF², WFP and ECHO would have been beneficial, as it isn’t clear how ARC will work in relation to these others. Also, a more detailed discussion as to why the socio-economic situation may have a negative impact on the health status of women and children, including how behavior and accessibility will affect the project implementation would have been useful. In addition, a more detailed discussion of how the proposed project fits into the USAID/Albania

² Note that Save the Children in Albania is led by Save the Children Norway and not Save the Children Fund UK (SCF).

strategy would have been good. Finally, constraints to achieving success were not addressed in any detail in this application.” (p.2)

Synergy with partners: In the process of detailed implementation planning, the Red Cross partners have collaborated with a variety of stakeholders, including the Ministry of Health (MOH) and district health District Public Health Directorates; UNICEF and WHO; USAID and University Research Corporation (URC), its bi-lateral health contractor; the Peace Corps; and local NGOs/PVOs (e.g., Christian Children’s Fund and AGRITA, a local NGO providing agricultural extension services) active in the implementation zone. Neither ECHO nor WFP is currently operational in the prefecture. Save the Children works in Diber District with a Cluster School project designed to strengthen primary education for children 6-14 years. The ACSP will seek opportunities to collaborate with Save the Children to engage youth, especially as the project develops its family planning intervention. In addition, Italian Cooperation is in the process of renovating the Peshkopi Polyclinic. Please also see DIP sections relevant to synergy with partners and collaborators.

Socio-economic situation: Albania is the poorest country in Europe, with gross national income (GNI) per capita of \$1,380. Albania ranks 95/151 (“medium human development”) on the Human Development Index (HDI)³. Life expectancy is 73.4 years (75.85 for women and 69.90 for men); and the adult literacy rate is 85.3%.

The *health status of women and children* has steadily declined during the turbulent decade of transition following the fall of communism in the early 1990s. The 1989 unemployment rate of 10% more than doubled (23%) by 2001⁴. The underserved northeast region is among the most economically strained regions of the country, disadvantaged in terms of infrastructure and human capacity. At the household level, many male heads of family work as migrant laborers in Italy, Greece, and other countries, sending back support through remittances. Many families are re-locating to Tirana and other urban areas to seek employment opportunities. Indeed, it was found during the KPC survey and HFA that many health workers and village nurse midwives are also seeking employment opportunities elsewhere in the country. Albania’s once rigidly organized health system, while still highly centralized, has become fragmented. In the north of the country, the situation is exacerbated by interruption of investments, uncontrolled internal migration of health care providers, and general economic collapse. Infrastructure is crumbling, and families often by-pass the primary health care (commune health center) level to seek more specialized services at Diber Regional Hospital or Tirana University Hospital. Services that were once free under Communism now require an under-the-table payment. The country is in the process of reforming the health care system, assisted in part by USAID through its bi-lateral primary health care reform project being led by URC. The Red Cross partners have advocated with URC and USAID to prioritize Diber Prefecture districts for implementation of the bi-lateral project’s consensus-building action-oriented “collaboratives” process and will be cooperating with URC and the District Public Health Directorates on the family planning intervention.

Fit with USAID/Albania strategy: The ACSP supports USAID/Albania’s Strategic Objective *Improved Selected Primary Health Care Services in Selected Sites*. “The public health system in Albania remains the least developed in Central and Eastern Europe. While there has been some progress, the health delivery system continues to emphasize curative services over primary and preventive care and suffers from poor planning, weak management capacity, and insufficient infrastructural investment. Abortion continues to be the primary method of birth control for many Albanian women. This strategic objective aims to increase the efficiency and lower the cost of health services to reduce the social investment required to maintain a healthy population and to bolster the productive capacity of Albania’s people.”⁵

³ Human Development Report. United Nations Development Programme, 2003.

⁴ INSTAT, 2002.

⁵ USAID/Albania Annual Report 2002.

Constraints to achieving success:

Constraints related to nutrition and micronutrient objectives: 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”, and HFA findings suggest that health workers do not actively promote immediate and exclusive breastfeeding to six months. Maternities do not post “no bottle” signs. The project will respond to this constraint through capacity-building (training and mentoring) for maternity personnel and information and education delivered by VHEs assigned to facilities.

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. In response to this constraint, the project will implement frequent and routine growth monitoring 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.

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”. 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 further support of this decision, KPC findings suggest that children are generally fed complementary foods rich in animal sources. To respond to this constraint, the project will promote the consumption of vitamin-A rich foods (e.g., breastmilk, eggs, dairy products, dark green leafy vegetables) and especially meat, fish, and poultry, for both pregnant women and children from six months. In addition, MOH guidelines for reproductive health do not provide for post-partum vitamin A supplementation, but the project will continue to advocate for this important micronutrient intervention 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.

MOH policies, norms, and protocols for routine prophylactic antenatal iron/folate supplementation are in place, but implementation is evolving. 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 to introduce in 2005 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.

Constraints related to control of diarrheal diseases: Many mothers and other family decision-makers do not understand 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 families by-pass the village nurse midwife 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.

Constraints related to ARI: 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., amoxicilin, 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.

Constraints related to family planning: Distribution of family planning methods 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 sustainable approach to attempt a pilot project for *community-based distribution* of methods by non-health workers. There is, however, no legal barrier to nurse midwives distributing contraceptive methods at the village level, and this is the approach that the project will promote through systems design, training, and supervision.

Constraints to achieving success are detailed in the DIP.

“Information on issues such as the following would have provided the reviewer with a deeper understanding of potential factors than can affect program effectiveness: family structure (e.g., nuclear or with in-laws?); social networks; differences (e.g., in terms of fertility behavior, women’s status) by religion; the relation between gender (e.g., p. 12 mentions that husbands prefer sons) and child health outcomes.” (p.3)

Family structure, religion, gender: In fact, the proposal did provide information about multi-generational families residing together in large households. “In the Diber Prefecture, most inhabitants are Muslim, though religious tolerance is universal. Northern Albania is characterized by a patriarchal society with few freedoms for women, and gender inequalities are common. The family is the key support system, compared to community participation which has weakened after half a century of forced volunteerism.” Religion is not a divisive characteristic of northern Albanian society. There are few differences in household practice among the different religions. Although it is true that traditional culture prizes boy children more highly than girls, the Institute of Public Health has found no gender disparities in vaccination coverage or other key indicators. A recent nationwide Reproductive Health Survey (2001) carried out by Institute of Public Health, the Centers for Disease Control, and others did not identify any differences in fertility behavior among

different religious affiliations. The ACSP will be carrying out a qualitative inquiry into household attitudes, beliefs, and practices related to health, nutrition, and family planning using a “grandmother approach” and will explore gender attitudes in depth. This is tentatively planned for late July/early August 2004 and will be led by Dr. Judi Aibel/The Grandmother Project.

Program Strategy and Interventions

“Although attention was paid to male involvement, it is not clear that measuring increase in men who can name at least 2 outlets gets at changing their attitudes toward FP – this may be in the negative sense. There is an assumption that the “doctor knows best” needs to be changed – it is not clear what is meant by this and may not work in a positive way if you want people to actually do what the “Dr. says.” Although it is laudable to address some issues through the family unit to deal with husband’s misfounded beliefs, this strategy may also not allow women to speak openly and freely. A combination approach might be more useful.” (p.4)

Family planning indicators: Family planning indicators have been modified, refined, and brought into line with Flexible Fund requirements.

Medical model: Albania’s highly centralized health care system reflects its Communist past and tends to be “medicalized” and disempowering, emphasizing curative services over prevention and home management. The end-users of health care services could benefit from freely available and accurate health information to inform choices and should know their rights and responsibilities as consumers. The project strives to build respect for the formal health system and its providers by improving quality, increasing access and availability, and educating consumers to become partners in their own care. The PRA approach will be a helpful tool to involve community and health workers in identifying problems and problem solving.

Addressing issues through the family unit: A combination approach will indeed be taken, as suggested. The project will carry out a qualitative inquiry focusing on the role of influential senior women (e.g., grandmothers, mothers-in-law) and other household decision-makers that will inform message construction and curriculum development for the training of volunteers. Female VHEs and VNMs will network with women at the household level through pro-active home visiting and young child support groups. At the commune level, male volunteers (including youth) will network with men around family planning.

“Growth monitoring might have been included under (nutrition) intervention. On p.18, the applicant states that women “feared the side effects of contraception” and “would never use contraception”. However, abortion is used excessively and the application does not recognize this contradiction.” (p.4)

Growth monitoring: Growth monitoring promotion has been included under the nutrition and micronutrient intervention. Village C-IMCI+ teams (VHEs and VNMs) 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 counseling on infant and young child feeding. Referrals will be made for nutritional rehabilitation, as needed; and counter-referrals will be actively followed up and monitored at the household level. Focus will be on young children 0-23 months, as this is the age group most vulnerable to nutritional deficiencies. See the DIP for additional detail on this key activity.

Inappropriate use of abortion as method of family planning: It is true that there is a high reliance on induced abortion as a means of birth prevention in Albania. 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 corresponds to the preliminary results of the recent (2002) national Reproductive Health Survey that suggest “severe under-reporting of induced abortions by respondents”...The survey rate of 73 abortions per 1,000 live births is 62% lower than the official data of 196 per 1,000 live births reported to INSTAT⁶.” The project team recognizes that further investigation needs to take place and plans women’s focus groups on this issue as part of implementation of the family planning technical intervention. Notwithstanding, the dangers of induced abortion will be included in family planning messages promoted by the project.

“Program strategies should better address the constraints which may be encountered in the implementation area. Also, how the partner AlbRC will be able to sustain activities post-project needs to be further developed. No mention was made of what SCF and USAID are doing in the project area, if anything. More detail should have been provided in the FP component regarding supply and flow of FP commodities. Although it was mentioned in other places and was referred to indirectly in this section, a more appreciative discussion of MOH policy and how this proposed project fits into it, or is approved of by the MOH could have been made.” (p.4)

Constraints: See section above.

Supply of family planning commodities: 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. 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.

Strengthening of the partner AlbRC: The development and implementation of the C-IMCI+ model will strengthen the relationship between the MOH and the AlbRC and enhance the Red Cross image and reputation as a key facilitating partner for community-based initiatives in the public health system. Moreover, the ACSP and its C-IMCI+ component will further strengthen and refine the AlbRC system of volunteer management. See detail in section below.

Volunteer management: AlbRC has developed a sustainable system of volunteer management. See detail in section below.

⁶ 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).

Collaboration with URC Primary Health Care Reform Project: Diber Prefecture will be one of the first prefectures to be included in the USAID/URC bi-lateral primary health care strengthening project. The ACSP team is actively collaborating with the URC project team and will participate in the “collaborative” process planned to be initiated in May 2004. ARC and AlbRC were represented at the URC launch meeting in February 2004. Both USAID and URC sent representatives to the ACSP DIP workshop in Peshkopi in March. Additional detail may be found in the DIP narrative.

Conformity to MOH policies, norms, and protocols: The project conforms to MOH policies, norms, and protocols for IMCI and family planning and works proactively to support and promote the national IMCI strategy and to increase access and availability of family planning services. The ACSP project is authorized by the MOH through signed MOUs with the AlbRC. (Consistent with the Red Cross Fundamental Principal of “Unity,” only one Red Cross Society may be operational in a country. Accordingly, the ARC operates in Albania under the auspices of the AlbRC.)

“For some objectives, the difference between the baseline and the target is not that large. Although, the project should not be overly ambitious, please consider the margin of error associated with your assessment tools and their ability to detect the magnitude of differences that you have indicated for each objective.” (p.4)

Measuring change: This is an excellent point. Indeed, indicators and targets have been revised and refined, based on KPC and HFA results and taking confidence intervals into consideration.

“Further attention should be paid to how the project will manage the cadre of VHEs and CMs, and promote the use of routinely collected information for improved project management. The Care Group Methodology (which has been employed successfully by World Relief in Asia and Africa) might be worthwhile to explore. See CS Connections, Issue 1 (available at www.childsurvival.com) for more information on this approach.

Volunteer management: As AlbRC volunteers, the VHEs will be recruited and managed in accordance with existing and published policies and practices of the AlbRC. (See *Manuali i Vullnetaritet: Përmbledhje Politikash dhe Udhëzimesh mbi Vullnetarizmin* - Volunteer Manual: Summary of Volunteer Policy and Guidelines, Albanian Red Cross 2003). 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. The cadre of paid Community Mobilizers has been reduced to 36 for reasons of lack of potential sustainability and budget realignment. *This is a change from the original proposal.* See revised Organogram in Annex 8.

Care group methodology: The project team feels that developing the C-IMCI+ package to complement the national IMCI strategy and managing VHEs within the existing AlbRC context are the most viable and efficient approaches for achieving and sustaining objectives.

“There is a lot of reference to mass media and IEC materials. As a reminder, the ideal is a behavior change approach that entrails empowerment, not just information dissemination.” (p.5)

Behavior change approach: Behavioral sustainability will be achieved by promoting empowerment through knowledge and action. Culturally appropriate mass media and IEC materials will be developed/adapted and used judiciously as an adjunct to other interpersonal/traditional communication strategies (e.g., the transmission of knowledge and practice from mother-in-law to daughter-in-law). The project will review

and re-print IEC materials (e.g., posters, brochures) that have been tested and used by the AlbRC in other of its maternal and child health promotion projects in Albania. See relevant DIP sections for more detail on the behavior change approach.

“The training and quality of care discussions for each technical area are too biased toward adherence to clinical protocols. The applicant should pay more attention to counseling and interpersonal/communication skills of providers.” (p.5)

Provider interpersonal communication skills: The C-IMCI+ training curricula for providers (VNMs, VHEs) will focus on the development of effective teamwork, interpersonal/communication skills, and participatory learning and teaching, consistent with adult education methodology.

“Job aids have proven to be very useful in helping workers (both at the facility and community levels) adhere to performance standards. The applicant should explore/adapt existing job aids (such as those developed by the Quality Assurance Project).” (p.5)

Job aids for quality assurance: Job aids will be adapted as part of M&E. The project’s M&E officer will be participating in the course *Quality Assurance Management for Developing Countries* at Johns Hopkins in June 2004.

“With respect to the nutrition component, the prevention orientation is admirable, but are there also plans for nutrition rehabilitation? What about growth monitoring and promotion or deworming?” (p.5)

Nutritional rehabilitation: Although nurse midwives and VHEs will not carry out nutritional rehabilitation at the village level, they will focus on promoting optimal infant and young child feeding through pro-active home visiting and young child support groups. Routine growth monitoring promotion will permit early identification of mildly and moderately malnourished children. Children who are growth faltering will be closely monitored and given special attention through counseling at the household level. As needed, children with moderate or severe malnutrition will be referred to district or Tirana hospitals where nutritional rehabilitation services are available. VNMs and VHEs will perform close follow up and monitoring of children counter-referred following nutritional rehabilitation. With regard to routine de-worming of children, this is not included in the current Albania IMCI protocols and not considered a sustainable activity in the current context. However, the project will continue to advocate for the introduction of routine de-worming of children (and pregnant women, consistent with international guidelines).

“With respect to IMCI, the applicant should pay attention to facilitating linkages between the community and the formal health system. Experience has shown that the integration of facility-based IMCI with household/community IMCI is what truly makes the difference.” (p.5)

Linkages with formal health system: It is indeed on the main aims of the project to promote strong and effective linkages between the community and the formal health system. The project’s C-IMCI+ package will be developed and implemented in tandem with MOH clinical IMCI package through the health facilities. At the community level, linkages will be facilitated by the formation in each rural village of a 3-person team (nurse/midwife + two AlbRC volunteers). At selected commune health centers and maternities, additional VHEs will be integrated into the service delivery teams.

The parallel training of health workers in clinical IMCI and C-IMCI+ teams at the village level will be mutually reinforcing, ensuring standards and accurate information on both sides.

“Before embarking on any of the proposed activities, the reviewers strongly recommend getting a better sense of traditional methods of information dissemination, community mobilization, and social and

behavioral change. The Grandmothers Approach, which has been applied by Christian Children's Fund in a number of contexts, might be worthwhile to explore for the proposed project.” (p.5)

“Grandmothers approach”: In fact, the so-called “Grandmothers Approach” was originally developed by Dr. Judi Aubel in Laos (with UNICEF) and has been applied by Aubel and others in a variety of countries and settings, including Christian Children's Fund in Senegal, Helen Keller International in Mali, Project HOPE in Uzbekistan, World Vision in southern Senegal, and others. Indeed, we are planning to engage Judi Aubel/The Grandmother Project to lead a qualitative inquiry into household practices for child health and family planning and the role of senior women and other household decision-makers. This qualitative piece, to be carried out in August 2004, will inform VHE curriculum development and C-IMCI+ strategy for information dissemination, community mobilization, and behavioral change.

“The applicant is encouraged to address missed opportunities for family planning promotion and service provision (e.g., when a mother brings her child for immunization), as well as better service integration (e.g., STI control and family planning) in order to meet its reproductive health objectives.” (p.5)

Missed opportunities for family planning: The family planning intervention is designed to take advantage of all opportunities, including child immunization. At the village level, routine immunization is the responsibility of the village nurse midwives. The project will be training village nurse midwives as part of the family planning intervention.

Organizational Development

“The reviewers recommend identifying separate capacity-building objectives for the applicant and its local partner. Page 14 mentions community sustainability as a strategy. This is not really a strategy per se. Other dimensions of sustainability (e.g., financial issues, management capacity, the use of data for decision-making) should also be addressed.” (p.5)

Sustainability: The project has identified separate capacity-building and sustainability objectives and indicators relating to MOH and AlbRC partners. Multiple dimensions of sustainability are addressed in the DIP.

Performance Monitoring and Evaluation

“The use of midwives as the primary data collectors may have implications operationally. It is not clear that the midwives are agreeable to serve in this role. Applicant should be aware of the populations addressed in the KPC.” (p.6)

Village nurse midwives: The nurse midwives in Diber Prefecture have been engaged in the project and, by all accounts, are willing, and even keen, to serve in this role. Ten village nurse midwives were selected to participate in the DIP workshop in Peshkopi and contributed ideas and feedback to the plan. Nurse midwives from commune health centers were also represented in the cadres of interviewers for the KPC survey and HFA. The village nurse midwives currently maintain village rosters of pregnant women and children 0-23 months which will form the basis for and enhanced HIS and monitoring and evaluation of community-level activities. In general, the nurse midwives at the village-level are gratified that the project will facilitate their training in IMCI and C-IMCI+. Sorry, we cannot respond to the second sentence of this reviewer's comment as the meaning is unclear.

“Although triangulation of data from different sources is certainly encouraged, there is concern that the applicant has proposed way too many M&E activities. In developing the M&E plan, please consider the time frame, relevance to project management, as well as the human resources and other budgetary

implications. Please consider how the data can be shared with the community, and the role that the community can play in a) monitoring its own status and b) developing its own solutions.” (p.6)

“Data for decision-making”: The project’s M&E plan has been revised and will continue to be refined. We agree that “data for decision-making” can empower communities and are building in feedback mechanisms appropriate to the socio-cultural context.

“The indicators presented in the Program Monitoring Matrix are consistent with the proposed objectives; however, there may be a need to identify additional indicators related to quality of care, community participation for monitoring quality.” (p.6)

Project indicators: We have revised and expanded the project’s set of indicators and have included indicators for quality of care, community participation, and sustainability.

“Please consider the logistics in collecting information from different target groups. For example, children U5 (as noted in the vitamin A and IMCI indicators) are not conventional targets of a KPC survey. For the family planning/reproductive health indicators, specify whether you are targeting women of reproductive age or mothers of young children (U2? U5?). Also, the data needed for the indicator related to men’s knowledge of family planning outlets can be collected using parallel sampling in a KPC survey. Finally, a more sensitive indicator of men’s attitudes should be identified (e.g., given men’s perceptions of women who want to use family planning, an indicator related to men’s acceptance of family planning use seems appropriate.)” (p.6)

Vitamin A and family planning indicators: With regard to vitamin A, the project team has taken the decision not to include routine bi-annual vitamin A supplementation as part of its nutrition intervention. This change is justified above and in the relevant section of the DIP. For the family planning intervention, the project will target women of reproductive age (15-49 years), as well as men (15-59). We have revised the family planning indicators, in part to bring them into line with Flexible Fund (FP/FF) requirements. Please refer to the technical sections of the DIP for justification of changes in the beneficiaries, targets, and indicators. We will measure change and impact using both population-based data from the KPC survey (for 0-23 months); the planned FP/FF survey (WRA, men, etc.); and through tracking of service data collected through the MOH district HIS.

Management Plan

“Although a good attempt was made to define roles at each RC level (table, pg. 27), it appears to be a cumbersome structure and it is not clear how they will work together or what “technical assistance” will be provided from regional to national to community level.” (p.7)

Partner roles and responsibilities: Please refer to revised Organogram and description of management structure in DIP for clarification of structural and functional relationships. A revised management plan is summarized in the DIP and elaborated in Annex 8.

Collaboration with USAID Field Missions

N/A (There were no comments or recommendations)

ANNEX 2

Response to Final Evaluation Recommendations

NOT APPLICABLE

ANNEX 3

Report of Baseline Assessments

- Draft Knowledge, Practice and Coverage Report
- Draft Health Facility Assessment
- Community Mapping

MAPPING EXERCISE SUMMARY NARRATIVE REPORT

Mapping exercise started on the beginning of January 2004 and was performed in all communes of Diber prefecture (respective 14 communes in Diber district, 11 commune in Mat district and 7 communes in Bulqize district). The tool included forms to be filled in commune level (see annex 1) and village level (see annex 2). All communes of the prefecture were visited with one/two days field visits. For each commune visited, one form for commune level was filled; while from all villages of that commune 2-3 selected villages were filled up relative forms. The selection was done based on the logistic facilities of that area. Mapping exercise has been conceptualized as a tool to collect general information that will help during the implementation phase for the planned activities. Many of that information gathered during this exercise will facilitate all logistic issues during the field activities. The conception of the forms, the collection process and other practical issues we dealt during the mapping exercise were not based on any well-known protocol. Simply, the team discussed over all kind of information we will be interested to know, through all levels, which will help a better planning process and defining some feasible and cost effective models, and include that in a form adapted for commune level and village level. Those two levels represent different stages for both administrative division and formal health system. Information selected in the two forms covered data about the following topics:

- Commune and village demographic data was taken from the commune statistic office (population number, male/female ratio, cohort births for the last 5 years, number of families etc)
- Commune and village health data was taken from personal contact with the head of the doctors/nurses of the health center:
 - Related to health workers (number of GP, nurses/midwives, their duration of the work time, trainings done and the relative topics)
 - Related to the health structures/buildings (number of villages with ambulanca/building, existence of a rural hospital/maternity, pharmacy, family planning center etc)
- Contact information with key persons in commune and village level as head of commune/village, director and teachers of any school, Albanian Red Cross volunteers, representatives of different NGOs operating in the area.
- Other useful information linked with our project like the availability of the health staff the whole time in the area (is GP/nurse/midwife living there), presence of Traditional Healer or Popular Doctors etc.

All information developed and collected during mapping exercise is available for the project team in a easy consulting format (excel and PDF formats)

ANNEX 4

Agreements

- **Memorandum of Understanding between the American National Red Cross and Albania Red Cross Society (English and Albanian)**
- **Albania Child Survival Project Agreement between American National Red Cross and Albania Red Cross Society**
- **Approval for Implementation of Child Survival Project, Ministry of Health Albania (English and Albanian)**
- **Approval of Albania Child Survival Project, District Public Health Directorates of Diber, Mat and Bulqize (English and Albanian)**

MEMORANDUM OF UNDERSTANDING
between
the Albanian Red Cross
and
The American National Red Cross
concerning
Program Collaboration

1. Introduction

The purpose of this Memorandum of Understanding (MoU) is to maximize the cooperation and coordination of The American National Red Cross (hereafter: American Red Cross) and the Albanian Red Cross (hereafter: Albanian Red Cross) (collectively "the Parties") to ensure the commitment by the Parties to work effectively and in an efficient manner in the following areas : Primary Health Care; Food Security; Tracing and Red Cross Messages; Emergency Response; Organizational Development and Blood Services for cooperation and knowledge transfer (i.e., "Programs"). The Parties intend, but do not commit, to enter into separate project agreements, in substantially the same form as attached hereto as Attachment A and made a part hereof ("Project Agreement"), to implement projects in support of Programs ("Projects"). For purposes of this MoU, it is understood and agreed that Project Agreements will not be required for emergency disaster relief services provided by one Party to the other.

2. Term of the MoU

- 2.1 This MoU comes into effect upon the date on which the last signatory signs the MoU and will remain in effect until December 31, 2005, unless this MOU is terminated in accordance with Section 2.3 or the Parties mutually agree in writing to extend the term of this MoU by execution of an amendment.
- 2.2 This MoU will be reviewed on an annual basis by both Parties. Representatives of American Red Cross and Albanian Red Cross will jointly evaluate the progress of this MoU and revise and develop new initiatives or goals as appropriate.
- 2.3 It is understood by both Parties that this MoU may be terminated at any time with thirty (30) calendar days prior written notice from either Party to the other. In the event of such termination, neither Party will have any liability to the other Party except as specifically set forth in a properly executed Project Agreement.

3. General Provisions

- 3.1 This MoU is intended to provide the overall framework for collaboration between the Parties with regard to the Programs and Projects. No commitment is made to enter into any Project Agreement in support of a Program or Project.
- 3.2 The terms and intent of this MoU can only be modified by execution of a written amendment signed by both Parties.
- 3.3 Each Party to this MoU is a separate and independent organization. As such, each Party retains its own identity in providing services, and each Party is responsible for establishing its own policies and procedures.
- 3.4 This MoU does not create a legally binding partnership or a joint venture, and neither party has the authority to bind the other. The Parties agree to enter into separate Project Agreements for the implementation of any Programs or Projects hereunder. Nothing in this MoU is to be construed as a binding commitment by either Party to enter into any Project Agreements. No work may be performed in support of any Program or Project prior to the execution of a Project Agreement between the the two Parties.

4. Methods of Cooperation

To assure proper cooperation between American Red Cross and Albanian Red Cross, both organizations agree to the following:

- 4.1 A close liaison will be maintained between American Red Cross national headquarters and the Albanian Red Cross national headquarters.
- 4.2 American Red Cross and Albanian Red Cross will encourage participation and coordination among their respective internal departments.
- 4.3 Chapters, branches and other administrative units of each Party will be encouraged to engage in training initiatives and technical exchanges as appropriate upon execution of a Project Agreement entered into through the Parties' respective national headquarters.
- 4.4 American Red Cross and Albanian Red Cross will make every effort, through their information offices, to keep the public informed of their cooperative efforts. All press releases and similar documents related to this MOU and/or the Programs or Projects under it must be approved in writing by both Parties prior to release.

4.5 American Red Cross and Albanian Red Cross will actively seek ways for this MoU to complement existing cooperative efforts and determine other areas or services within their respective organizations where cooperation and support may be mutually beneficial.

4.6 American Red Cross and Albanian Red Cross agree that any expenses incurred as a result of cooperation or collaboration under the terms of this MoU will be apportioned as mutually agreed upon in a properly executed Project Agreement.

4.7 American Red Cross and Albanian Red Cross may pursue the joint development of training or technical curriculum, materials or information for implementation or in support of a Project or Program and may distribute or publish such curriculum, materials or information in accordance with a properly executed Project Agreement specifically setting forth all rights and responsibilities related thereto, including any and all limitations on the use of proprietary information.

5. The Role and Responsibilities of the American National Red Cross

The role of American Red Cross is to seek opportunities for cooperation and coordination with the Albanian Red Cross. In support of this objective, and when agreed to by the Parties, American Red Cross will:

5.1 Provide resources as agreed upon by the Parties in a properly executed Project Agreement. Such resources shall be in the form of services, funds, or delegate(s), according to the specific needs of the Program(s) or Project(s) as set forth in detail in the Project Agreement.

5.2 Upon the request of Albanian Red Cross, provide assistance and support as available, necessary and as mutually agreed upon the Parties in the event of a natural disaster.

6. The Role and Responsibilities of the Albanian Red Cross

The role of Albanian Red Cross is to seek opportunities for cooperation and coordination with American Red Cross. In support of this objective, and when agreed to by the Parties, Albanian Red Cross will:

6.1 Provide administrative support to American Red Cross delegate(s) in a properly executed Project Agreement.

6.2 Provide, through its good relations with the relevant national and local authorities, administrative and other support to the American Red Cross delegate(s) to allow the achievement of its objectives.

6.3 Ensure that the American Red Cross activities are coordinated with other non-governmental organizations (NGOs) to enhance effectiveness and avoid duplication.

7. U.S. Government Donors

In the event the United States Government provides federal funds to American Red Cross in support of Program or Project ("Award"), communication with U.S. Government Donors will be conducted as indicated in the Award. American Red Cross shall endeavor to secure funding from U.S. Government donors when such action is appropriate in support of a Project Agreement.

Any applicable U.S. Government Regulations that apply to a Program or Project shall be provided to the Albanian Red Cross for review to ensure the ability of Albanian Red Cross to comply with such regulations prior to American Red Cross accepting the Award. If such requirements are acceptable to Albanian Red Cross, and American Red Cross accepts the Award, then the U.S. Government Regulations shall be attached to and become an integral part of the Project Agreement.

8. Financial Support

In the event that either Party provides financial support to the other pursuant to a Project Agreement, the following terms shall apply:

8.1 The Party providing funds ("Funding Party") agrees to make funds available electronically for deposit directly into Receiving Party's ("Receiving Party") bank account. Funds will be provided in strict accordance with the terms of the Project Agreement.

8.2 The Receiving Party agrees to provide financial accounting support as set forth in the Project Agreement in accordance with the following mechanism: The Receiving Party agrees to:

8.2.1 Verify and book all Project related expenses to a segregated account(s) or coding to be opened for the Project.

8.2.2 Only make charges to the Project that are actual expenditures within the line-items and limits contained in the agreed upon budget (Annex 2 to the Project Agreement), with the exception of flat rates identified within the budget;

8.2.3 Ensure timely payment of all expenses incurred in furtherance of the Project Agreement provided the expenses are in-line with the agreed upon budget.

8.2.4 Submit a monthly Project specific financial report directly to the Funding Party. The report may be used for Project monitoring.

8.2.5 Prepare and submit quarterly financial printouts to the Funding Party within thirty (30) calendar days of the close of the calendar quarter.

8.2.6 Prepare and submit a quarterly cash flow statement or summary to accompany the quarterly financial printouts, listing total cash receipts and expenditures for the Project to date.

8.2.7 Interest amounts up to USD 100.00 per fiscal year received on funds advanced for program expenses may be retained by the Receiving Party for administrative expenses. Interest accrued in excess of USD 100.00 must be returned to the Funding Party.

8.3 In the event that the Project Agreement provides for reimbursement of expenses:

8.3.1 The Receiving Party will issue an invoice, which shall include wire transfer instructions for payment, relevant to the quarter for the validated amounts.

8.3.2 The Funding Party will remit payment so that funds are paid within thirty (30) calendar days of the receipt of an approved invoice.

8.4 Upon expiration or termination of a Project Agreement, a final invoice will be submitted. Balances due will be reimbursed as detailed above. Any outstanding advance or surplus funds held by Receiving Party will be reconciled and remitted to the Funding Party.

8.4.1 The availability of funds in support of a Program or Project is subject to the terms and conditions of the Project Agreement. Specific dates for implementation and financial reporting will be detailed therein.

8.4.2 Requests by an Receiving Party to extend due dates shall be submitted in writing to the Funding Party, not less than thirty (30) calendar days prior to the due date and confirmed by a written amendment to the Project Agreement.

9. Audit

- 9.1 Annual audits must be conducted by the Receiving Party according to the Receiving Party's standard procedures. Additional Project-specific audits may be conducted locally as described in the Project Agreement.
- 9.2 The Receiving Party must obtain an annual audit by an independent Certified Public Accountant, or appropriate counterpart, of the funds advanced or claimed for reimbursement under the terms of a Project Agreement.
- 9.3 The Receiving Party must ensure that appropriate corrective action is taken within six (6) months if there are any audit findings related to the Project or Program and must specify the contact person responsible for the corrective actions and the anticipated completion date.
- 9.4 A copy of all Project and/or Program audit reports will be forwarded to the Funding Party as designated in the Project Agreement. The Funding Party also reserves the right to conduct internal and independent audits of the Project within the term of the Project Agreement and/or the following twelve (12) months.
- 9.5 All financial and programmatic records pertinent to the Project must be retained and reasonably accessible for three (3) full fiscal years from the date of submission of the final financial reports, or such other period of time as may be required by law, rule or regulation.
- 9.6 The Funding Party, in consultation with the Receiving Party, reserves the right to conduct or facilitate external reviews of the Project's progress. The Funding Party will make every effort to ensure that any such reviews or evaluations take place at a time convenient to the Receiving Party's staff and to include the Receiving Party in the process.

10. Final Provisions

- 10.1 The Parties agree to consult each other as soon as possible to resolve any difficulty in implementing the terms of this MoU or any Project Agreement. The Parties will refer disputes to an independent arbitrator for resolution of such matters.
- 10.2 If any circumstance beyond the reasonable control and without the fault of a Party occur that delay or render impossible the performance of that Party's obligations under this MoU or any Project Agreement on the dates provided ("Force Majeure Event"), such obligation shall be postponed for such time as such performance necessarily has had to be suspended or delayed on account thereof, provided such Party shall notify the other Party in writing as soon as practicable. In such event, the Parties shall meet promptly to determine an equitable solution to the effects of any such Force Majeure Event, provided that such Party who fails to perform because of a Force Majeure Event will, upon the cessation of the Force Majeure Event, take all reasonable steps within its power to resume with the least possible delay compliance with its obligations. Force Majeure Events shall include, without limitation, war, revolution, invasion, terrorism, strikes, insurrection, riots, mob violence, sabotage or other civil disorders, acts of God, limitations imposed by exchange control regulations or foreign investment regulations or similar regulations, laws, regulations, directives or rules of any government or governmental agency, any inordinate and unanticipated delays in regulatory review or governmental approval process that are within the sole control of such government or governmental agency, and any delay or failure in manufacture, production or supply by third parties of any goods or services.
- 10.3 In the event of a conflict between this MOU and any Project Agreement executed hereunder the terms of the Project Agreement shall govern. In the event of a conflict between an American Red Cross or Albanian Red Cross Program or Project description and a Project Agreement, the terms of the Project Agreement shall govern.
- 10.4 This MOU is issued in two (2) language versions, English and Albanian; in the event of a conflict between the versions, the English version shall govern.

11. Notices.

All notices, reports and other correspondence shall be delivered to the Parties at the addresses set forth below, unless otherwise provided for herein or unless notice is provided otherwise:

The American National Red Cross
International Services
431 18th Street, NW
Washington, DC 20006
Attention: Gerald Jones, Vice President International Services

Copy to: The American National Red Cross
Office of General Counsel
430 17th Street, N.W.
Washington, DC 20006

The Albanian Red Cross

Tirana
REPUBLIC OF ALBANIA
Attention:

It is with the intent of furthering the parties' purpose of alleviating human suffering and assisting people that we enter into this MoU. We hereby acknowledge our mutual respect and support for each other's skills and capacity to serve those in need, locally and globally.


Mr. Gerald Jones
Vice President
The American National Red Cross


Prof. Dr. Shyqir Subashi
President
Albanian Red Cross

December 2, 2002
Date

Date

**Memorandum Mirëkuptimi
ndërmjet
Kryqit të Kuq Shqiptar dhe Kryqit të Kuq Amerikan
për Programin Bashkëpunues**

1. Hyrje

Qëllimi i këtij Memorandumi Mirëkuptimi (MM) është rritja e bashkëpunimit dhe koordinimit ndërmjet Kryqit të Kuq Amerikan (më poshtë: KKA) dhe Kryqin e Kuq Shqiptar (më poshtë: KKSJ) (të dy sëbashku "Palët"), garantimi i angazhimit të Palëve për të punuar me efikasitet dhe në mënyrë frytëdhënëse në fushën e Kujdesit Primar Sëëndetësor, Sigurimit të Ushqimit, Kërkimit dhe Mesazheve të Kryqit të Kuq, Përgjigjes ndaj situatave emergjente, Zhvillimit Organizativ dhe Dburimit të gjakut, bashkëpunimit dhe shkëmbimit të informacionit ("Programet"). Palët synojnë, por ky MM nuk i detyron, të zhvillojnë marrëveshje të veçanta për Projektmarëveshje të ngjashme në formë me materialin bashkëngjitur si Lidhja A, dhe të zbatojnë projekte në mbështetje të Programeve (Projekteve). Nëpërmjet këtij Memorandumi kuptohet dhe pranohet se nuk do të kërkohet hartimi i një Projektmarëveshje për ndihmën e dhënë në raste fatkeqësish nga njëra apo tjetra palë.

2. Kushtet Memorandumi të Mirëkuptimit (MM)

- 2.1. MM bën në fuqi nga data kur nënshkruhet nga të dyja Palët dhe është i vlefshëm deri më 31 dhjetor 2005, me përjashtim të rastit kur MM bëhet i pavlefshëm sipas Sectionin 2.3 ose kur të dyja Palët biben dakort reciprokisht me shkrim që të zgjasin afatin e këtij MM nëpërmjet zbatimit të një amendamenti.
- 2.2. MM rishikohet çdo vit nga të dyja Palët. Përfaqësuesit e KKA dhe KKSJ do të vlerësojnë së bashku ecurinë e këtij MM si dhe do të rishikojnë e zhvillojnë iniciativa dhe qëllime të reja që i përshtaten të dyja palëve.
- 2.3. Të dyja Palët pranojnë se ky MM mund të përfundojë në çdo kohë me kusht që njëra apo tjetra Palë, të njoftojë Palën tjetër me shkrim, mundësisht 30 ditë kalendarike përpara datës së përfundimit. Në një rast të tillë, Palët nuk mbajnë përgjegjësi ndaj njëra tjetrës, me përjashtim të rasteve të përcaktuara paraprakisht në një Projektmarëveshje të zbatuar në mënyrë korrekte.

3. Klauzolat të Përgjithshme

- 3.1. MM ka për qëllim të sigurojë kornizën e përgjithshme të bashkëpunimit ndërmjet Palëve në lidhje me Programet dhe Projektet. Asnjë angazhim nuk

mund të të ndërmerret në mbështetje të ndonjë Programi apo Projekti, bazuar në ndonjë Projekt Marrëveshje.

- 3.2. Afatet dhe synimet e këtij MM mund të ndryshohen vetëm në se zbatohet një amendament me shkrim, i nënshkruar nga të dyja Palët.
- 3.3. Në këtë MM, çdonjëra Palë është një organizatë e veçantë dhe e pavarur. Si e tillë, secila Palë ruan identitetin e saj në shërbimet e ofruara dhe secila Palë është përgjegjëse për vendosjen e ligjeve dhe procedurave të veta.
- 3.4. Ky MM nuk krijon një partneritet juridikish të kushtëzuar apo një ndërmarrje të përbashkët, dhe asnjëra Palë nuk ka të drejtë të kushtëzojë Palën tjetër. Palët bien dakort të kenë Projektmarrëveshje të veçanta për zbatimin e ndonjë Programi apo Projekti. MM nuk duhet të interpretohet si një angazhim i detyrueshëm i Palëve për të marrë pjesë në ndonjë Projektmarrëveshje. Asnjë veprim nuk duhet marrë në mbështetje të ndonjë Programi apo Projekti nëse nuk është realizuar përfunduar një Projektmarrëveshje ndërmjet Palëve.

4. Mënyrat e Bashkëpunimit

Për të garantuar një bashkëpunim të frytshëm ndërmjet KKA dhe KKSH të dy organizatat bien dakort si më poshte vijon:

- 4.1. Ndërmjet Selive qendrore të KKA dhe KKSH do të vendoset një lidhje e ngushtë.
- 4.2. KKA dhe KKSH do të nxisin pjesëmarrjen dhe koordinim ndërmjet departamenteve të secilës organizatë.
- 4.3. Nëndegët, Degët dhe njësitë e tjera administrative të Palëve përkatëse do të nxiten për t'u angazhuar sipas rastit në iniciativat trajnuese dhe në shkëmbimin e eksperiencës teknike me qëllim realizimin e Projektmarrëveshjes, që është pranuar paraprakisht nga selitë përkatëse kombëtare të të dyja Palëve.
- 4.4. KKA dhe KKSH do të bëjnë të gjitha përpjekjet e mundshme që nëpërmjet zyrave të tyre të informimit, të vënë në dijeni publikum e gjerë për bashkëpunimin ndërmjet tyre. Të gjitha shkrimet për shtyp apo dokumente të ngjashme, lidhur me këtë MM ose/dhe me Programet apo Projektet bazuar në të (MM), duhet të aprovohen me shkrim nga të dy Palët përpara se të shkojnë për botim.
- 4.5. KKA dhe KKSH do të kërkojnë të gjitha mënyrat që ky MM të plotësojë përpjekjet aktuale ndërmjet tyre dhe të përcaktojë fusha dhe shërbime të

tjera brenda organizatave përkatëse, ku bashkëpunimi dhe përkrahja mund të jenë me dobi reciproke.

- 4.6 . KKA dhe KKSH bien dakort që të gjitha shpenzimet, rezultat i bashkëpunimit ndërmjet tyre në kushtet e këtij MM të përpjestohen siç është rënë dakort nga të dy Palët në Projekt marrëveshje.
- 4.7 . KKA dhe KKSH mund të ndjekin zhvillimin e trajnimeve dhe të programeve teknike të përbashkëta, materialet dhe informacionin për zbatim, ose mbështetje të një Projekt / Programi dhe mund të shpërndajnë apo të publikojnë programe, materiale apo informacione të tilla në lidhje me një Projekt marrëveshje, duke marrë parasysh në mënyrë specifike të gjitha të drejtat dhe përgjegjësitë në lidhje me to, përfshirë këtu dhe të gjitha kufizimet gjatë përdorimit të informacionit që është në zotërim të tyre.

5. Roli dhe përgjegjësitë e Kryqit të Kuq Amerikan

Roli i KKA është të gjejë mundësi bashkëpunimi dhe koordinimi me KKSH. Në mbështetje të këtij objekti dhe me marrëveshje të të dy Palëve, KKA do të ndërmarrë veprimet e mëposhtme :

- 5.1. Të sigurojë burime, siç është rënë dakort ndërmjet Paleve bazuar në Projekt marrëveshje. Këto burime duhet të jenë në formën e shërbimeve, fondeve apo delegatëve, në varësi të kërkesave specifike të Programeve apo Projekteve, siç janë përcaktuar paraprakisht në mënyrë të detajuar në Projekt marrëveshje.
- 5.2 Në varësi të kërkesave të KKSH, do të sigurojë ndihmë dhe përkrahje sipas mundësi, të nevojshme gjatë katastrofave natyrore, siç dhe është rënë dakort në marrëveshje dypalëshe. .

6. Roli dhe përgjegjësitë e Kryqit të Kuq Shqiptar

Roli i KKSH është të gjejë mundësi bashkëpunimi dhe koordinimi me KKA. Në mbështetje të këtij objekti dhe me marrëveshje të të dyja Palëve, KKSH do të ndërmarrë veprimet e më poshtme:

6. 1. Në pajtim me Projekt marrëveshjen, të sigurojë përkrahje administrative delegatëve të KKA.
 - 6.1. Njëpërmjet marrëdhënieve të tija të mira me autoritetet përkatëse lokale dhe kombëtare, të sigurojë përkrahje administrative dhe çdo mbështetje tjetër për të cilat mund të kenë nevojë delegatët e KKA, me qëllim që ata të përmbushin objektivat e tyre.

- 6.2. Të garantojë koordinimin e aktiviteteve të KKA me organizatat e tjera jo qeveritare (OJQ), në mënyrë që të rritet efektiviteti dhe të shmangët dublimi.

7. Donatorët e Qeverisë së Shteteve të Bashkuara

Në rastin kur Qeveria e Shteteve të Bashkuara siguron fonde shtetërore për KKA, si përkrahje për Programet apo Projektet ("Fituesit"), komunikimi me Donatorët e Qeverisë të Shteteve të Bashkuara do të zhvillohet ashtu siç është përcaktuar në Projekt. KKA duhet të përpiqet të sigurojë fonde nga donatorët e Qeverisë të Shteteve të Bashkuara, atëherë kur një ndërmarrje e tillë është në mbështetje të Projektmarrëveshjes.

Çdo Rregullorë e Qeverisë të Shteteve të Bashkuara që i adresohet Programit apo Projektit, do t'i paraqitet KKSJH për rishikim në mënyrë që të sigurohet mundësia që ka KKSJH për tu përshatur me rregulla të tilla përpara se KKA të miratojë Vendimin. Nëse KKSJH i konsideron këto rregulla si të pranueshme dhe nëse KKA miraton Vendimin, atëherë Rregulloret e Qeverisë të Shteteve të Bashkuara do t'i bashkangjiten dhe do të bëhen pjesë integrale e Projektmarrëveshjes.

8. Përkrahja Financiare

Në rast se ndonjëra nga Palët siguron përkrahje financiare për Palën tjetër gjatë një Projektmarrëveshje, atëherë do të zbatohen këto kushte:

- 8.1. Pala e cila siguron fonde (Pala Financuese), bie dakort që të kryejë elektronikisht transferetën bankare në Llogarinë Bankare të Palës Përfutuese. Fondet do të sigurohen duke respektuar rigorozisht kushtet e Projektmarrëveshjes.
- 8.2. Pala Përfutuese bie dakort të sigurojë mbështetje financiare siç është përcaktuar më parë në Projektmarrëveshje duke ndjekur hapat që vijojnë:
 - 8.2.1. Të verifikojë dhe regjistrojë të gjitha shpenzimet lidhur me Projektin në një Llogari të veçantë apo kod të hapur veçmas për Projektin.
 - 8.2.2. Të kryejë shpenzime lidhur me Projektin, shpenzime që janë brenda kufijve të caktuar sipas buxhetit të miratuar (Shtojca 2 e Projektmarrëveshjes), me përjashtim të tarifave fikse të identifikuara brenda buxhetit.
 - 8.2.3. Të kryejë në kohë të gjitha pagesat e shpenzimeve të parashikuara në Projektmarrëveshjen e dhënë duke u siguruar që shpenzimet janë në përputhje me buxhetin e parashikuar paraprakisht.

- 8.2.4. T'i paraqesë Palës Financuese një raport financiar mujor të Projektit. Raporti mund të përdoret për monitorimin e Projektit.
- 8.2.5. Të përgatisë dhe t'i paraqesë Palës Financuese raporte tre mujore me shkrim brenda 30 ditë kalendarike para se të mbarojë tremujori kalendarik.
- 8.2.6. Deri në këtë datë, të përgatisë dhe të paraqesë gjendjen e arkës (rrjedhjen e parave) ose një përmbledhje që të shoqërojë dokumentet e printuara tri mujore financiare, listën e të gjithë mandat pagesave, si dhe shpenzimet e tjera në lidhje me Projektin.
- 8.2.7. Shumat e interesit vjetor bankar deri me 100.00 USD të marra paraprakisht nga fondet për shpenzimet e programit mund të përdoren nga Pala Përfutuese për shpenzime administrative. Interesat e përfuturara mbi shumën 100.00 USD duhet t'i kthehen Palës Financuese.
- 8.3. Në rastet kur Projektmarrëveshja siguron rimbursimin e shpenzimeve:
- 8.3.1. Pala Përfutuese duhet të sigurojë një faturë, e cila duhet të përmbajë udhëzimet e transferitës bankare për pagesën, në përshtatje me shumat e vlefshme për tremujorin përkatës.
- 8.3.2. Pala Financuese do të dërgojë pagesën në mënyrë që fondet të paguhen brenda 30 ditë kalendarike nga marrja e fatures së miratuar.
- 8.4. Para mbarimit apo ndërprerjes së Projektmarrëveshjes do të paraqitet një faturë përfundimtare. Balanca përkatëse do të rimbursohet si më lart. Çdo paradhënie madhore apo fonde të tepërta të mbajtura nga Pala Përfutuese do t'i kthehen Palës Financuese.
- 8.4.1. Fondet që do të jenë të vlefshme për të mbështetur Programin apo Projektin janë subjekt i kushteve të Projektmarrëveshjes. Po këtu do të specifikohen edhe datat për implementimin dhe raportimin financiar.
- 8.4.2. Kërkesat e Palës Pranuese për të shtyrë datat përkatëse duhet t'i paraqiten me shkrim Palës Financuese, jo më para se 30 ditë kalendarike përpara datës së caktuar. Kjo duhet të konfirmohet me një amendament bashkëngjitur Projektmarrëveshjes.

9. Auditimi

- 9.1. Auditimi vjetor duhet të drejtohet nga Pala Përfutuese, në pajtueshmëri me procedurat standarde të tij. Audite plotësuese më specifike të Projektit mund të drejtohen lokalisht siç dhe është përshkruar në Projektmarrëveshje.
- 9.2. Pala Përfutuese duhet të sigurojë një Agjensi Publike të autorizuar, ose një Agjensi homologe vendase, për të kryer një audit vjetor të fondeve të paradhëna apo kërkesave për rimbursim në bazë të kushteve të Projektmarrëveshjes.
- 9.3. Në rast se kontrolli financiar ka evidentuar ndonjë gabim në lidhje me Projektin apo Programin, Pala Përfutuese duhet të garantojë marrjen e veprimit korrigjues brenda 6 muajve dhe të përcaktojë personin e kontaktit, që do të jetë përgjegjës për veprimin korrigjues, si dhe afatet e parashikuar të përfundimit të detyrës.
- 9.4. Kopje të të gjitha raporteve të auditimit të Projekteve apo Programeve do t'i përcillen Palës Financuese, siç është përcaktuar në Projektmarrëveshje. Pala Financuese, gjithashtu ka të drejtën të drejtojë audite të brendshme dhe të pavarura për Projektet brenda kushteve të Projektmarrëveshjes dhe / ose atij për 12 muajt e ardhshëm.
- 9.5. Të gjitha dosjet financiare dhe programore që i përkasin Projektit, duhet të ruhen mirë dhe të jenë lehtësisht të përdorshme për 3 vite të plota financiare që nga data e paraqitjes së raporteve përfundimtare financiare, ose për atë kohë sa mund të jetë përcaktuar nga ligji, rregullat dhe rregulloret e vendosura.
- 9.6. Pala Financuese, në konsultim me Palën Përfutuese, ruan të drejtën të drejtojë apo të lehtësojë vëzhgimin nga jashtë të ecurisë së Projektit. Pala Financuese duhet të bëjë të gjitha përpjekjet për të siguruar që çdo analizë apo vlerësim i tillë bëhet në një kohë të përshtatshme për personelin e Palës pritëse duke e përfshirë këtë të fundit në proces.

10. Klauzola përfundimtare

- 10.1. Palët bien dakort të konsultojnë njëra tjetrën sa më parë që të jetë e mundur me qëllim që të zgjidhin në mënyrë miqësore çdo vështirësi që mund të shfaqet gjatë zbatimit të kushteve të kësaj MM apo të çdo lloj Projektmarrëveshjeje tjetër. Në rast mosmarrëveshjes, Palët i drejtohen një gjykatësi të pavarur për zgjidhjen e çështjes.
- 10.2. Nëse paraqiten raste jashtë kontrollit të arsytuar dhe jo për faj të Palës për të përmbushur këto afate apo që bëjnë të pamundur arritjen e rezultateve që

janë detyrime për Palën bazuar në MM apo në çdo lloj tjetër projektarrëveshje sipas datave të parashikuara ("nga Forca madhore"), afati i përmbushjes së detyrimeve të tilla do të shtybet për aq kohë sa nuk është mundur të realizohet, dhe Pala përgjegjëse duhet të njoftojë me shkrim Palën tjetër mundësisht sa më shpejt që të jetë e mundur. Në raste të tilla, Palët e interesuara duhet të takohen sa më shpejt që të jetë e mundur me qëllim që t'i japin një zgjidhje të drejtë pasojave të një Forcë të tillë Madhore, ç'ka nënkupton që Pala që nuk ka mundur të kryejë detyrimin për shkak të veprimit të këtyre Forcave, me ndërprerjen e veprimit të këtyre Forcave Madhore, do të ndërmarret të gjithë hapat e nevojshëm brenda mundësive të saja, për të rifilluar plotësimin e detyrimeve sa më shpejt. Në Forcat Madhore duhen përfshirë pa kufizime, lufta, revolucioni, pushtimi, terrori, greva, kryengritjet, rebelimet, dhuna e bandave keqbërëse, sabotimet ose trazira të tjera civile, forcat natyrore, kufizimet e imponuara nga ndryshimi i rregullave të kontrollit ose rregullat në lidhje me investimet e huaja apo rregulla të ngjashme, ligjet, vendimet, urdhëresat ose rregullat e cilësdo qeveri ose agjencie qeveritare, të gjitha vonesat e paparashikuara apo të tepërta në kontrollin e rregullta apo proceset miratuese nga ana e qeverisë dhe që janë vetëm nën kontrollin e një qeverie të tillë apo agjencie qeveritare, dhe çdo vonesë ose dështim në fabrikimin, prodhimin ose furnizimin me mall apo me shërbime të tjera nga persona të tretë.

- 10.3. Në rast mosmarrëveshjeje midis MM dhe një Projektarrëveshjeje, do të merren si prioritare kushtet e Projektarrëveshjes. Në rast të ndonjë mosmarrëveshjeje midis KKA dhe KKSJH në lidhje me përshkrimin e një Programi ose Projekti dhe një Projektarrëveshjeje, atëherë do të jenë prioritare kushtet e Projektarrëveshjes.
- 10.4. Ky MM do të firmoset në anglisht dhe shqip, në rast mosmarrëveshjeje me përkthimin, do të merret për bazë versioni në gjuhën angleze.

11. Shënime

Të gjitha njoftimet, raportet dhe letërkëmbimet e tjera duhet t'i dorëzohen të dy Palëve në adresat përkatëse, të shënuara si më poshtë:

The American National Red Cross
International Services
431 18th Street, N.E.
Washington, DC 20006
Attention: Gerald Jones, Vice President International Services
Kopje të dokumentave në adresën:
The American National Red Cross
Office of General Counsel
430 17th Street, N.E.
Washington, DC 20006

Kryqi i Kuq Shqiptar
(Adresa)
Sheshi Karl Topia
Rruga Muhamet Gjollësia

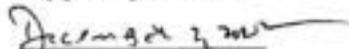
Tiranë
Shqipëri

Kjo MM ka si qëllim që të erisë me tej synimet e palëve në përpjekjet e tyre për të lehtësuar vuajtjet njerëzore, dhe për të ndihmuar njerëzit në nevojë. Në këtë mënyrë ne bëjmë të njohur respektin tonë të ndërsjellë dhe mbështetjen tonë ndaj aftësive dhe kapaciteteve të njeri tjetrit për t'iu ardhur në ndihmë atyre që janë në nevojë në nivel lokal dhe global.



Mr. Gerald Jones
Zëvendës President

Kryqi i Kuq Amerikan


Datë

Prof. Dr. Shyqyri Subashi
President

Kryqi i Kuq Shqiptar

Datë

Project Agreement No. 1
issued under
MEMORANDUM OF UNDERSTANDING
between
Albanian Red Cross Society
and
American National Red Cross
concerning
ALBANIA CHILD SURVIVAL AND HEALTH PROGRAM

This Project Agreement, effective as of September 22, 2003, is entered into between The American National Red Cross ("AmCross") and the Albanian Red Cross Society ("AlbRC") (collectively, the "Parties") pursuant to the Memorandum of Understanding ("MoU") dated December 3, 2002.

The terms and conditions contained in the MoU apply to this Project Agreement ("PA") as if they were included herein and are made an integral part of this Project Agreement.

1. Project Description

USAID has awarded a cooperative agreement to AmCross to implement a Child Survival and Health Program ("Program") in Albania in accordance with the USAID Grant Award No. GHS-A-00-03-00007-00 ("Award"). Activities will include but are not limited to the following: collecting baseline and qualitative data to inform Program strategies, revising Program goals, objectives, indicators as needed, strategizing on major interventions, planning critical Program tasks and activities, prioritizing planned activities.

Under this cooperative agreement and pursuant to this PA, AmCross will collaborate with AlbRC for the purpose of implementing this Program, in accordance with the program budget ("Budget") as set forth in Annex 1. The AlbRC is considered a subrecipient of USAID funding and agrees to follow all terms and conditions that apply as described in this PA and all attached Annexes, hereto and made an integral part hereof. AmCross will provide technical support to the AlbRC and oversight for the Program in accordance with the Program Description as set forth in Annex 2.

The purpose of this PA is to specify the roles and responsibilities of AmCross and the AlbRC for the implementation of the Program to ensure the commitment by the Parties to working effectively and in an efficient manner towards the implementation of the Program in the interests of the direct beneficiaries of the Program.

2. Period of Agreement

This PA forms an integral part of the AlbRC MoU and covers the period from September 22, 2003 until September 30, 2008; or the end date of the USAID program whichever occurs last.

3. Responsibilities of the AlbRC

The AlbRC will:

3.1 Provide assistance to AmCross with the development of the detailed implementation plan ("DIP") for the Program according to the USAID guidance for DIPs for private voluntary organizations Child Survival and Health Programs (Annex 3).

3.2 Work with AmCross on the knowledge, practice, coverage ("KPC") survey; train interviewers; compile data; print AmCross approved educational materials; coordinate and implement the training and activities involved in the Program implementation as set forth in the Program Description.

3.3 Select, recruit and hire appropriate qualified staff and volunteers as identified in the Program Description and with input from AmCross, including, but not limited to the AlbRC Liaison Officer. All staff will be hired through the AlbRC and will become employees of the AlbRC. Such staff will at all times be employees of AlbRC. As such, AlbRC agrees to comply with all labor laws, pay all appropriate local taxes and comply with all other applicable laws, rules and regulations.

3.4 Organize the mobilization of AlbRC volunteer staff in the Diber Prefecture, namely the AlbRC Branch Secretary for the Diber Prefecture and the AlbRC Sub-branch Health Coordinators for the Peshkopi, Mat, and Bulqize districts, to participate in education, dissemination of AmCross material on regarding the three core objectives: nutrition, management of the sick child and family planning/reproductive health

3.5 Maintain a record of all time spent by AlbRC staff members working on the Program by completing time sheets (Annex 4). These time sheets must be available for on-site verification by AmCross or USAID personnel. Time sheets will be maintained in appropriate offices (e.g. Tirana or Peshkopi), and will be verified by the Program Manager and Regional Health Delegate.

3.6 Coordinate and participate in quarterly Program Advisory Board meetings at the national, regional, and district level.

3.7 Provide, through its good relations with the relevant national and local authorities, administrative and other support to the Program to allow the achievement of Program objectives.

3.8 Take part in the mid-term evaluation, final evaluation, operation research activities, and training workshops for the Program, as agreed upon by the Parties.

3.9 AlbRC will sign all necessary contracts and, in coordination with AmCross, administer them. AlbRC will retain sole liability for all contracts and sole responsibility for ensuring that all contracts comply with local laws, rules and regulations.

3.10 Perform all necessary procedures for the importation or purchase of material goods and furniture needed for the Project and be reimbursed for all related costs.

3.11 Perform all necessary procedures for the importation or purchase/lease and the registration of vehicles needed for the Project and be reimbursed for all related cost.

3.12 Vehicles provided for the Program will only be used for Program purposes in accordance with written procedures established by AmCross and agreed to by AlbRC.

3.13 In the event of police involvement, AlbRC will be the primary point of contact and keep AmCross informed of all developments.

3.14 Ensure that the Program is coordinated with other non-governmental organizations (NGOs) to enhance effectiveness and avoid duplication of effort.

3.15 Provide office space to AmCross as needed for the provision of technical assistance.

3.16 When requested by USAID, periodically brief USAID Mission representative in Albania. All significant contacts with USAID must be conducted with the knowledge of the AmCross Regional Health Delegate.

3.17 Provide program narrative and numerical reports of all Program activities on a quarterly basis to AmCross Regional Health Delegate. The quarterly reports are due by the 15th day of the month following the end of the quarter. The quarters are defined by the US Government and are as follows:

1. January 1 through March 30
2. April 1 through June 30
3. July 1 through September 30
4. October 1 through December 31

Therefore, quarterly reports are due on the 15th day of April, July, October and January. Reports will be provided by AlbRC staff dedicated to the Child Survival program.

Provide monthly financial reporting according to AmCross guidelines and formats based on the forms contained in [Annex 5](#) (Monthly Statement of Cash), [Annex 6](#) (Monthly Statement of Expenses), [Annex 7](#) (Monthly Summary of Expenses), and [Annex 8](#) (Two Month Forecast/Cash Request). These guidelines include having these monthly financial reports (with supporting documentation or receipts) available for on-site verification by AmCross representatives including the Regional Finance Delegate based in Sofia and USAID. Financial reports will be provided by AlbRC staff dedicated to the Child Survival program.

4. Responsibilities of AmCross

The role of AmCross is to provide funding and appropriate resources to support implementation of the Program and to ensure appropriate monitoring and evaluation of the Program.

AmCross will:

4.1 Provide consultants as needed for the KPC survey, detailed implementation plan, and monitoring and evaluation activities as described in the Program proposal.

4.2 Provide the services of an AmCross Regional Health Delegate to provide technical support, coordination and guidance for the Program.

4.3 Provide the services of a Regional Finance Delegate based in the AmCross regional office in Bulgaria for oversight of financial disbursements, monitoring of expenditures, and follow up on financial quarterly reporting.

4.4 Provide other technical assistance ("TA") required and/or requested by the AlbRC and any necessary TA for implementation of the activities and for compliance with USG regulations. Other TA may be provided based on AmCross assessments and AlbRC requests.

4.5 AmCross, on behalf of and in coordination with AlbRC, will reimburse for staff expenses for staff that are dedicated to the Child Survival program.

5. Budget

5.1 AlbRC will ensure that all funds provided by AmCross under this Program are used solely for Program activities in strict accordance with the Budget.

5.2 AmCross will reimburse the AlbRC for all properly documented expenses incurred on behalf of the Program based on the approval of AmCross. AlbRC should seek approval from AmCross prior to incurring such expenses.

5.3 Following the signing of this PA, funding will only be advanced following approval by AmCross of AlbRC's expenses for approved Program expenditures.

6. Financial Support and Reporting Requirements

AmCross will:

6.1 Make funds available electronically for deposit directly into an AlbRC bank account.

6.2 Ensure timely reimbursement of all properly documented AlbRC expenses incurred on behalf of the Program provided the expenses are allowable and in-line with the Budget.

6.3 Verify that the charges incurred and documented by AlbRC have supporting documentation according to standard provisions and USAID Regulations.

6.4 Reimburse AlbRC for all expenses related to the import of AmCross goods or materials (e.g. customs duty, etc.).

The AlbRC will:

6.5 Any funding advanced to AlbRC for Child Survival program must be maintained in a financial management system that allows Program finances to be reported separately from other AlbRC finances. Such funds reported on in an accurate, complete and separate disclosure (income and expenses).

6.6 Participate in quarterly finance visits and provide AmCross personnel with information and support necessary to conduct said visits.

6.7 Prepare financial reports that include, i) copies of invoices (with English translation), and ii) bank advices of funds received (including exchange rate).

6.8 Ensure that AlbRC staff dedicated to the Child Survival program will submit a final financial report within forty-five (45) days of the expiration or termination of this PA.

6.9 AlBRC shall only retain funds for allowable expenses.

6.10 Submit financial invoices on a monthly basis to request reimbursement.

7. Audit

7.1 A copy of all financial audits related to this Program will be forwarded to AmCross Headquarters. USAID and AmCross reserve the right to conduct or facilitate internal and independent audits of the Program and to have access to program related records and financial statements. Verification and review of the documentation, internal controls, and accounting systems are necessary in order for AmCross to practice its due diligence in assuring the allowability of related costs and the completeness of required documentation.

7.2 All financial and programmatic records pertinent to the Program shall be retained and reasonably accessible for a minimum of seven (7) years from the date of submission of AmCross's final financial reports to USAID, or such longer period of time as required by law, rule, or regulation.

8. Program Reporting

8.1 AmCross, in consultation with the AlBRC, reserves the right to conduct or facilitate external reviews of the Program's progress. AmCross will make every effort to ensure that any such reviews or evaluations take place at a time convenient to the AlBRC staff and to include the AlBRC in the process.

9. US Government Rules and Regulations

9.1 The US Government rules and regulations pertaining to the Program are set forth in the following publications: A-110 (Standard Provisions for Non-US, Non-Governmental Recipients), A-122 (Cost Principles) and A-133 (Audit Compliance Standards) are set forth in Annexes 9-11 and must be adhered to by all Parties throughout the term of this PA.

9.2 Pursuant to the EXECUTIVE ORDER ON TERRORISM FINANCING the AlBRC certifies that it will not provide material support or resources to any individual or entity that it knows, or has reason to know, is an individual or entity that advocates, plans, sponsors, engages in, or has engaged in terrorist activity, including but not limited to the individuals and entities listed in the E. O 13224 EXECUTIVE ORDER ON TERRORISM FINANCING VERIFICATION and other such individuals and entities that may be later designated by the United States under any of the following authorities: § 219 of the Immigration and Nationality Act, as amended (8 U.S.C. § 1189), the International Emergency Economic Powers Act (50 U.S.C. § 1701 et seq.), the National Emergencies Act (50 U.S.C. § 1601 et seq.), or § 212(a)(3)(B) of the Immigration and Nationality Act, as amended by the USA Patriot Act of 2001, Pub. L. 107-56 (October 26, 2001) (8 U.S.C. §1182). The AlBRC further agrees that it will not provide material support or resources to any individual or entity that it knows, or has reason to know, is acting as an agent for any individual or entity that advocates, plans, sponsors, engages in, or has engaged in, terrorist activity, or that has been so designated, or will immediately cease such support if an entity is so designated after the date of the referenced agreement. "Material support and resources" includes currency or other financial securities, financial services, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

9.3 AlbRC agrees to complete an Executive Order verification on their behalf for each vendor or contractor receiving funds under this PA. AlbRC agrees to provide a copy of the completed verifications to the AmCross Finance Delegate. Executive Order verification can be completed at the following website: [<http://www.ustreas.gov/offices/enforcement/ofac/sdn/index.html>].

10. Final provisions

10.1 The Parties agree to consult each other as soon as possible to resolve any difficulty in implementing the terms of this PA and, if necessary, the Parties may ask an independent arbiter for support in resolving such matters.

10.2 If AmCross wishes to end its association with the Program, then it must give five (5) days prior written notice to the AlbRC.

10.3 If any party has materially failed to comply with the terms and conditions of this PA, either party may suspend the program, terminate the agreement, or take such actions or remedies as may be legally available and appropriate in the circumstances. Notification and conditions of said suspension or termination will be provided in writing.

10.4 AlbRC agrees to indemnify, defend and hold AmCross, its governors, directors, officers, employees, volunteers and agents harmless from and against any damage, claim, liability and expense that is incurred by or may be asserted or claimed against AmCross as a result of the negligent or willful acts, errors or omissions of AlbRC, its directors, officers, employees, agents, contractors and subcontractors as a result of (1) the implementation and performance by AlbRC of the Program, (2) any breach or violation by AlbRC of any of the terms and provisions of this Project Agreement or its Annexes; or (3) due to a failure of AlbRC, to comply with any laws, regulations, standards or rules. In no event shall these indemnifications of AmCross by AlbRC apply to the extent and proportion such losses are caused by the negligence or willful misconduct of AmCross, or the actions of an AlbRC employee, whose salary is reimbursed by AmCross, who took such action at the express direction of AmCross.

This Section Indemnification shall survive the expiration or other termination of this Project Agreement indefinitely.

For any technical or programmatic questions, please contact the American National Red Cross Desk at wards@usa.redcross.org

For any financial or compliance questions, please contact the American National Red Cross Regional Finance Delegate at arc.campbell@redcross.org.

Attachments: The following attachments are hereby made an integral part of this PA:

- Annex 1 Budget
- Annex 2 Program Description
- Annex 3 USAID guidance for Detailed Implementation Plans
- Annex 4 Timesheet Format
- Annex 5 Monthly Statement of Cash
- Annex 6 Monthly Statement of Expenses
- Annex 7 Monthly Summary of Expenses
- Annex 8 Two Month Forecast/Cash Request

Annex 9 A-110 Standard Provisions for Non-US, Non-Governmental Recipients
Annex 10 A-122 Cost Principals
Annex 11 A-133 Audit Compliance Standards

IN WITNESS WHEREOF, the Parties hereto, acting through their duly authorized officers, have executed this agreement as of the date first above written.

Signatories:

The Albanian Red Cross Society

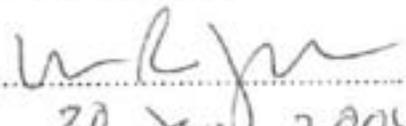
Signature: 

Date: 22.12.03

Name: Prof. Dr. Shyqyri SUBASHI

Position: President

The American National Red Cross

Signature: 

Date: 20 Jan 2004

Name: Gerald R. Jones

Position: Vice President, International Services



REPUBLIC OF ALBANIA

MINISTRY OF HEALTH

Directory of Primary Health Care

Address: Blv. "Bajram CURRI", Tirana – Albania, Tel/Fax.: + 355 364671

No _____ Prot.

Tirana, October 3, 2003

To: Miss ERMIRA BRASHA
Senior Liaison Officer, American Red Cross in Albania
Address: Doro Center, Rr. "Muhamet Gjollesha" (pranë IKF "Vojo Kushi")

TIRANA

Object: Approval for the implementation of CS project

After analyzing the materials presented by you about the project, including reasons of why the selection of Diber prefecture as target area, and after we also got the feedback and comments from interested sectors within our directory, we approve the implementation of the presented project interventions.

In the future meetings, more details with regards to project implementation and steps to be undertaken will be worked out.

Thank you for the collaboration

Director

Agim SHEHI



REPUBLIKA E SHQIPERISE
MINISTRIA E SHENDETTESISE
/ Drejtoria e Kujdesit Shendetesor Paresor/

Adresa: Blv. " Bajram CURRI " Tirana – Albania, Tel/fax. + 355 364671

Nr. 100 Prot.

Tirane, me 3 . 10 . 2003

Per: Zj. ERMIRA BRASHA

Perfaqesuese e Delegacionit te Kryqit te Kuq Amerikan ne Shqiperi
Qendra "Doro" Rr "Muhamet Gjollsha" (prane IFK "Vojo Kusli")

T I R A N E

OBJEKTI: Miratim i projektit te paraqitur nga ana juaj.

Pasi analizuam materialin e paraqitur nga ju per arsyet e perzgjedhjes si zone target Prefekturen e Dibres dhe morem komentet e sektoreve te interesuar prane drejtorise tone, miratojme projektin e paraqitur.

Ne takimin e ardhshem ku ju do te prezantoni ne menyre te detajuar edhe nepermjet eksperteve te huaj pikat kyçe te zbatimit te projektit, ne do te shfrytezojme rastin per te sqaruar çdo element qe ka nevojë per me shume informacion.

Faleminderit per bashkepunimin.

DREJTORI

Agim BIEHI

Approval of the “Albanian Child Survival Project”

The Public Health Directorate _____, based on the Ministry of Health document, dated 3rd of October 2003 hereby approves the request of Albanian Red Cross and the American Red Cross to implement the “Albanian Child Survival Project”

As previously discussed in our on-going communications, and based on objectives of this project, we underline once more our interest in your intervention fields as:

- Maternal and child nutrition;
- Integrated Management of Childhood Illness (disease diarrhea control and acute respiratory infectious);
- Family planning.

The collaboration with other partners (UNICEF, WHO, URC etc) to plan activities connected with the above mentioned intervention fields will provide synergy and coordination that will be in the interest of the community needs. At this point, it is important to mention the contribution of this project to train the health workers in the villages according to the strategies of the Ministry of Health- Integrated Management of Childhood Illness (IMCI), training of the health volunteers in community IMCI and family planning topics.

We hope during the implementation phase of this project, our continuous collaboration will be led by the reciprocal interest towards improving the health of children and the entire community.

DATE ___ / 04 / 2003

DISTRICT PUBLIC HEALTH DIRECTOR

MIRATIMI I PROJEKTTIT "MBIJETESA E FËMIJËVE"

Nga Drejtoria e Shëndetit Publik Diber, në vijim të shkresës së Ministrisë së Shëndetësisë, në datën 3 Tetor 2003, miratohet kërkesa e Kryqit të Kuq Shqiptar dhe Kryqit të Kuq Amerikan për Zbatimin e Projektit të Shëndetit "Mbijetesa e Fëmijëve".

Në bazë të komunikimeve të vazhdueshme të deritanishme dhe objektivave të këtij projekti, nënvízojmë interesin tonë për fushat tuaja të ndërhyrjes:

- Ushqyerja e nënës dhe fëmijës;
- Menaxhimi i Integruar i Sëmundjeve të Fëmijërisë
(Diarreja dhe Infeksionet respiratore akute);
- Planifikim familjar.

Bashkëpunimi edhe me partnerë të tjerë si UNICEF, OBSH, URC etj. për planifikimin e aktiviteteve në lidhje me fushat e mësipërme të ndërhyrjes, do të sigurojnë një sinergjizëm dhe koordinim i cili do të jetë në interes të nevojave të komunitetit. Në këtë kuadër vlen të theksohet kontributi i këtij projekti për trajnimin e stafit shëndetësor të fshatrave sipas strategjisë së Ministrisë së Shëndetësisë – Integrimi i Menaxhuar i Sëmundjeve të Fëmijërisë (MISF), trajnimi i vullnetarëve të shëndetit sipas komponentit komunitar të MISF-it dhe planifikimit familjar.

Shpresojmë që gjatë fazës së zbatimit të këtij projekti, bashkëpunimi ynë i vazhdueshëm do të udhëhiqet nga interesi i dyanshëm për përmirësimin e shëndetit të fëmijëve dhe të gjithë komunitetit.

DIBER 15 / 04 / 2003

DREJTORIA E SHËNDETTIT PUBLIK



Dr. Mustafa NDREKA

MIRATIMI I PROJEKTIT “MBIJETESA E FËMIJËVE”

Nga Drejtoria e Shëndetit Publik Bulqizë, në vijim të shkresës së Ministrisë së Shëndetësisë, në datën 3 Tetor 2003, miratohet kërkesa e Kryqit të Kuq Shqiptar dhe Kryqit të Kuq Amerikan për Zbatimin e Projektit të Shëndetit “Mbijetesa e Fëmijëve”.

Në bazë të komunikimeve të vazhdueshme të deritanishme dhe objektivave të këtij projekti, nënvízojmë interesin tonë për fushat tuaja të ndërhyrjes:

- Ushqyerja e nënës dhe fëmijës;
- Menaxhimi i Integruar i Sëmundjeve të Fëmijërisë
(Diarreja dhe Infeksionet respiratore akute);
- Planifikim familjar.

Bashkëpunimi edhe me partnerë të tjerë si UNICEF, OBSH, URC etj. për planifikimin e aktiviteteve në lidhje me fushat e mësipërme të ndërhyrjes, do të sigurojnë një sinergjizëm dhe koordinim i cili do të jetë në interes të nevojave të komunitetit. Në këtë kuadër vlen të theksohet kontributi i këtij projekti për trajnimin e stafit shëndetësor të fshatrave sipas strategjisë së Ministrisë së Shëndetësisë – Integrimi i Menaxhuar i Sëmundjeve të Fëmijërisë (MISF), trajnimi i vullnetarëve të shëndetit sipas komponentit komunitar të MISF-it dhe planifikimit familjar.

Shpresojmë që gjatë fazës së zbatimit të këtij projekti, bashkëpunimi ynë i vazhdueshëm do të udhëhiqet nga interesi i dyanshëm për përmirësimin e shëndetit të fëmijëve dhe të gjithë komunitetit.

BULQIZË 15 / 04 / 2003

DREJTORI I SHËNDETTIT PUBLIK

Dr. Blendj GURRA



MIRATIMI I PROJEKTIT "MBIJETESA E FËMIJËVE"

Nga Drejtoria e Shëndetit Publik Mat, në vijim të shkresës së Ministrisë së Shëndetësisë, në datën 3 Tetor 2003, miratohet kërkesa e Kryqit të Kuq Shqiptar dhe Kryqit të Kuq Amerikan për Zbatimin e Projektit të Shëndetit "Mbijetesa e Fëmijëve".

Në bazë të komunikimeve të vazhdueshme të deritanishme dhe objektivave të këtij projekti, nënvizojmë interesin tonë për fushat tuaja të ndërhyrjes:

- Ushqyerja e nënës dhe fëmijës;
- Menaxhimi i Integruar i Sëmundjeve të Fëmijërisë
(Diarreja dhe Infeksionet respiratore akute);
- Planifikim familjar.

Bashkëpunimi edhe me partnerë të tjerë si UNICEF, OBSH, URC etj. për planifikimin e aktiviteteve në lidhje me fushat e mësipërme të ndërhyrjes, do të sigurojnë një sinergjizëm dhe koordinim i cili do të jetë në interes të nevojave të komunitetit. Në këtë kuadër vlen të theksohet kontributi i këtij projekti për trajnimin e stafit shëndetësor të fshatrave sipas strategjisë së Ministrisë së Shëndetësisë – Integrimi i Menaxhuar i Sëmundjeve të Fëmijërisë (MISF), trajnimi i vullnetarëve të shëndetit sipas komponentit komunitar të MISF-it dhe planifikimit familjar.

Shpresojmë që gjatë fazës së zbatimit të këtij projekti, bashkëpunimi ynë i vazhdueshëm do të udhëhiqet nga interesi i dyanshëm për përmirësimin e shëndetit të fëmijëve dhe të gjithë komunitetit.

MAT 15 / 04 / 2003

DREJTORI I SHËNDETTIT PUBLIK



Dr. Nasan CENI

ANNEX 5

Summary of Hiring Status

Resumes/CVs and Job Descriptions of Key Personnel

SUMMARY OF PROJECT FUNDED STAFF AND HIRING STATUS

NAME	POSITION	HIRING STATUS
Fabian Cenko	Project Manager	Hired
Gazimend Koduzi	Deputy Project Manager	Hired
Ermira Brasha	Senior Liaison Officer (M&E)	Hired
Artan Isaraj	Technical Officer	Hired
Geltina Bulku	Project Assistant	Hired
Anila Gjoni	Albania Finance Officer	Hired
Teuta Nazari	Office Manager	Hired
Alketa Kuka	Cashier/Receptionist	Hired
Bashkim Kroqi	Driver	Hired
Mustafa Reka	Driver	Hired
Ardiana Peci	AlbRC National Coordinator-ACSP	Hired
OPEN	AlbRC District Health Coordinator-Diber	Recruitment June 2004
OPEN	AlbRC District Health Coordinator-Mat	Recruitment June 2004
OPEN	AlbRC District Health Coordinator-Bulqize	Recruitment June 2004
OPEN	AlbRC Community Mobilizers-All districts	Rolling beginning August 2004
OPEN	AlbRC Volunteer Health Educators-All districts	Rolling beginning August 2004

James Ricca, MD, MPH
Senior Health Advisor, International Services

<i>Summary</i>	Jim Ricca is a community health specialist and family practice physician with 13 years relevant experience, including 10 years post-graduate experience, 5 ½ in the international setting, 4 of which was in international assignments. Significant training and experience in Maternal and Child Health, Reproductive Health, HIV/AIDS, IMCI, monitoring, evaluating, managing, and advising health and development projects in the Americas, Africa, Europe and former Soviet Union.
Relevant Professional Experience	<p><i>Senior Health Advisor, International Services, American Red Cross, Jan. 2003 – Present</i></p> <p>Health Delegate - Honduras, International Services, American Red Cross, April 1999 – December 2002</p> <p><i>Director of Community Projects and Assistant Professor, Department of Family Medicine, Georgetown University School of Medicine, Feb. 1997 – Jan. 1999</i></p> <p>Clinical Preceptor, Department of Family Medicine, Georgetown University School of Medicine, July 1996 – Jan. 1997</p> <p><i>Staff Physician, Department of Internal Medicine, Kaiser Permanente, Kensington, Maryland, July 1996 – Jan. 1997</i></p> <p>Family Physician, Gerald family Care Associates, Washington, DC, Aug. 1995 – May 1996</p> <p>Emergency Medicine Physician, Bowie Health Center, Dec. 1994 – July 1995</p> <p>Laboratory Technician, Department of Pharmacology, Harvard Medical School, Feb. 1985 – May 1987</p> <p>Laboratory Technician, Department of Biophysics, University of Pennsylvania, Jan. 1983 – Dec. 1983</p>
Language and Computer Skills	<p>English mother tongue. Fluent in Spanish.</p> <p>Windows 2000 & XP, MS Office, EpiInfo 6.0 & 2000</p>
Education	<p><i>Johns Hopkins School of Public Health, 1994-1995. Master of Public Health, with concentration in International Health awarded May 1995.</i></p> <p>Georgetown University Residency in Family Medicine, 1991-1994. Board certified in Family Medicine July 1994. Recertified July 2000.</p> <p>University of California at Los Angeles, School of Medicine, 1987-1991. Doctor of Medicine awarded May 1991.</p> <p>Yale University, 1979-1984. Bachelor of Science with honors in Molecular Biophysics and Biochemistry awarded May 1984.</p>

Malik Jaffer, MPH

Senior Regional Associate, International Services

<i>Summary</i>	Malik Jaffer is a community health specialist with experience in Africa, Asia, the Middle East and Europe. In addition to his technical experience, his strengths are in program management, finance, donor relations and communications within the non-profit and private sectors.
Relevant Professional Experience	<p><i>Senior Regional Associate, International Services, American Red Cross, July 2001 – Present.</i> Current responsibility for South East Europe developing and implementing relief and development programs. Spent 60%+ time in field operation in the last 36 months</p> <p><i>Senior Regional Associate/Operations Lead, International Services, American Red Cross, October 2001 to November 2003</i> for the White House initiative “America’s Fund for Afghan Children”.</p> <p><i>Assistant Regional Director for Asia and the Middle East, Project HOPE, August 2000 to July 2001.</i> Managed regional portfolio in health programs and established HQ/Field operational procedures.</p> <p><i>Country Manager, Aga Khan Foundation Tanzania, July 1998-August 2000.</i> Managed country portfolio of health, educations and NGO capacity building programs. Appointed by President Mkapa to Steering Committee for the World Bank \$50,000,000 Social Action Fund.</p>
Language and Computer Skills	<p>Fluent English and basic verbal skills in French, Kiswahili, Urdu, Gujrati and Kachi.</p> <p>Windows 2000 & XP, MS Office, SPSS</p>
Education	<p>Masters in Business Administration in Executive Management (MBA), Frederick Taylor University, Administration (in process)</p> <p>Master in Public Health (MPH) Boston University School of Public Health (1998)</p> <p>Certificate: Health Care in Developing Countries, Boston University School of Public Health (1997)</p> <p>Certificate: Financing of Health Care in Developing Countries, Boston University School of Public Health (1996)</p> <p>Bachelor of Science, Health Science with emphasis in Community Health Education, San Diego State University (1996)</p> <p>Associate of Science, General, Grossmont College (1995)</p>

Karen Z. Waltensperger, M.A., M.P.H.
Regional Health Delegate SE Europe

<i>Summary</i>	Karen Z. Waltensperger is an international maternal and child health professional with 25+ years of experience developing, managing, implementing, monitoring, evaluating, and advising community health programs in the field, including 11 years in sub-Saharan Africa.
Relevant Professional Experience	<p>Regional Health Delegate SE Europe, American Red Cross International Services, based in Tirana, Albania (from September 2003).</p> <p>Country Director/Mali, Helen Keller International, Bamako, Mali (August 2001-August 2003).</p> <p>Country Representative/Mozambique, Pathfinder International, Maputo, Mozambique (June 1999-July 2000).</p> <p>Africa Regional Health Advisor, Save the Children US, based in Maputo, Mozambique (November 1997-June 1999).</p> <p>Health Program Manager/Mozambique, Save the Children US, Xai-Xai, Mozambique (July 1994-November 1997).</p> <p>Co-Director and Research Officer, Health Systems Development Unit, Department of Community Health, University of the Witwatersrand School of Medicine, based in Acornhoek, South Africa (February 1993-July 1994).</p> <p>Health Educator Advisor, Mozambique Health Committee, Chimoio, Mozambique (July 1992-January 1993).</p> <p>Director/Project EPIC, Department of Community Medicine, Wayne State University School of Medicine, Detroit, Michigan (May 1986-May 1991).</p>
Language and Computer Skills	<p>English mother tongue. Working knowledge of French and Portuguese. Some German and Polish. High school Russian.</p> <p>Windows 2000 & XP, MS Office, EpiInfo 6.0 & 2000</p>
Education	<p>Post-graduate (doctoral) coursework in applied medical anthropology, Wayne State University (1986-89).</p> <p>Master in Public Health (M.P.H.), University of Michigan School of Public Health, Ann Arbor, Michigan (1986).</p> <p>Master of Arts in Education (M.A.), University of Michigan, Ann Arbor, Michigan (1974).</p> <p>Bachelor of Arts in Anthropology and East European Studies, Wayne State University, Detroit, Michigan (1972).</p>



Fabian CENKO, M.D., M.P.H.
Project Manager – Albania Child Survival Project

<i>Summary</i>	Fabian Cenko has nine years of experience researching, planning, implementing, and evaluating public health. Prior to joining the Albania Child Survival Project as Project Manager, he spearheaded the Albania Expanded Program on Immunization (EPI) at the Institute of Public Health in Tirana and also served as a technical advisor for a community-based maternal and child health project in nine districts in northeast Albania during the Kosovo crisis. He has published on infant and young child feeding practices and iron deficiency anemia in mothers in Albania. As a WHO consultant, Dr.Cenko has conducted two successful national immunization assessments in Moldova and Georgia. He completed his medical specialization in public health, a second M.D., and Master of Public Health (MPH) degree in Italy.
Relevant Professional Experience	Project Manager, Albania Child Survival Project, Albanian Red Cross, Peshkopi, Albania (from October 2003). National EPI Coordinator, Institute of Public Health, Ministry of Health, Tirana, Albania (January 2001-September 2003). Technical Health Coordinator, Sant'Egidio (Italian NGO), Tirana, Albania (March 1998-September 2003). District Medical Officer, Ministry of Health, Kurbin, Albania (August 1994-October 1995).
Language and Computer Skills	Native speaker of Albanian. Excellent English and Italian. Windows 2000 & XP, MS Office, EpiInfo 6.0, SPSS
Education	Regional Flagship Course on Health Reform and Immunization, Budapest, Hungary (April 2002). European Program Intervention Epidemiology Training (EPIET), Veyrier du Lac, France (September-October 2001). Doctor of Medicine (M.D.), Tor Vergata University, Rome, Italy (2001). Master of Public Health (M.P.H.), Tor Vergata University, Rome, Italy (2000). Post-doctoral studies in Public Health, Tor Vergata University, Rome, Italy (1999). Doctor of Medicine (M.D.), Faculty of Medicine, University of Tirana, Tirana, Albania (1994).

Position Title:	Manager, Albania Child Survival and Health Program (CSHP)
Reports To:	Regional Health Delegate
Location:	Tirana/Peshkopi, Albania

Position Summary: The CSHP Manager has overall field responsibility for the CSHP providing management and support to the field teams in community organizing, training, supervision, monitoring and evaluation, and administrative activities. The Manager coordinates and manages relationships with key field stakeholders including USAID, Ministry of Health (MoH), UNICEF, and Albanian RC.

Major Responsibilities:

1. Manages work plans of program staff.
2. Facilitates quarterly CSHP Advisory Board meetings with key stakeholders
3. Participates in baseline, mid-term, and final evaluations.
4. Coordinates the completion and submission of monthly and quarterly narrative and financial reports, annual performance reports, mid-term evaluation report, and final evaluation report according to USAID and ARC guidelines.
5. Develops and implements Detailed Implementation Plan (DIP)
6. Manages vendor relationships and associated contracts and workplans
7. Makes regular field visits within Diber Prefecture to supervise project staff and monitor CSHP activities
8. Participates in quarterly CSHP Board meetings at Prefecture level.
9. Involves the Albania Red Cross National Health Coordinator, Branch Secretary, and Sub-branch Health Coordinators in CSHP planning, training, and implementation.
10. Develops detailed 6 month work plan within 30 days of starting position; update monthly

Scope: Responsible for line management of program staff and indirect management of [1,454] persons including Community Mobilizers [62], Volunteer Health Educators [1,112], Midwives/Nurses [278] and Drivers [1]. With HQ and RHD, manages an overall budget of \$1.7 million.

Key Qualifications:

- Academic degree in a health-related field, MD or MPH preferred
- At least 5 years of experience with child survival and/or health education-related activities
- At least 5 years experience in training, planning, management and supervisory skills
- Proven ability to work in a highly interactive team setting
- Proficiency in spoken and written English
- Computer skills in Windows 2000, Word, Excel and related software



Gazmend KODUZI, M.D.

Deputy Project Manager – Albania Child Survival Project

Summary

Gazmend Koduzi joined the Albania Child Survival Project as Deputy Project Manager following work as a Field Officer in family planning and women's reproductive health with John Snow International under a contract with USAID. Previously, he worked with the Albanian Red Cross, where he coordinated its first aid program, and with an American Red Cross project for community-based volunteer health educators. Dr. Koduzi is currently undertaking his medical specialty training in public health through the Faculty of Medicine at University of Tirana. He is a certified first aid instructor and judge (Albanian Red Cross) and a trainer of trainers in family planning (John Snow International).

Relevant
Professional
Experience

Deputy Project Manager – Albania Child Survival Project, Albanian Red Cross (November 2003 – present).
Supervisor (KPC Survey) – Albanian Child Survival Project, Albanian Red Cross (October 2003).
Field Officer – Family Planning and Women's Reproductive Health, John Snow International, Tirana, Albania (July 2002 – September 2003).
Medical Officer and Shelter Manager – Anti-Trafficking Project, International Organization for Migration, Tirana, Albania (June-July 2002).
Coordinator of First Aid Program, Albanian Red Cross, Tirana, Albania (January 2002 – June 2002).
Project Coordinator for Volunteer Health Educators, Albanian Red Cross, Tirana, Albania (July 2001 – December 2001).
Medical Officer, Emergency Center, University of Kamza, Tirana, Albania (March 2000-July 2001).
Family Doctor, District of Lushnja, Albania (March 1995 – March 2000).

Language and
Computer
Skills

Native speaker of Albanian. Excellent English. Some Greek.
Windows XP, MS Office.

Education

Currently enrolled in medical specialization in Public Health, Faculty of Medicine, University of Tirana, Albania.
Doctor of Medicine (M.D.), Faculty of Medicine, University of Tirana, Tirana, Albania (1994).

Position Title:	Deputy Manager, Albania Child Survival and Health Program (CSHP)
Reports To:	CSHP Manager
Location:	Peshkopi, Albania

Position Summary: Technical position that serves as program leader in the absence of the CSHP Manager. Provides backstopping support to the CSHP Manager in the areas of program supervision, administration, reporting and work plan management

Major Responsibilities:

1. Provides backstopping support to CSHP Manager and assumes Manager role in his/her absence
2. Assists the CSHP Manager to organize quarterly CSHP Board Meetings at the Prefecture level
3. Participates in the mid-term and final evaluations.
4. Coordinates and consolidates monthly , quarterly, and annual reporting inputs of T&M Officer, District Supervisors for CSHP Manager
5. Makes regular field visits within Diber Prefecture to supervise project staff and monitor CSHP activities
6. Identify certified MOH facilitators to conduct clinical IMCI/Safe Motherhood/Family Planning training and refresher courses for midwives as needed
7. In coordination with T&M Officer, UNICEF and MOH, develop all training curriculum for implementation by District Health Supervisors, CMs and VHEs
8. Supports District Health Supervisors and Communities in the selection of Community Mobilizers and Volunteer Health Educators
9. Develop detailed 6 month work plan within 30 days of starting position; update monthly

Scope: Supervises T&M Officer, District Supervisor (3) and 1454 persons, including 62 Community Mobilizers and provides Management Backstopping support to team of 7 persons. Assists CSHP Manager in the management of overall CS program and administration.

Key Qualifications:

- Academic degree in a health-related field, M.D or nurse with MPH preferred
- At least 3 years of experience with child survival and/or health education-related activities
- Demonstrated experience in training, planning, management and supervisory skills
- At least 3 years health management experience required
- Proven ability to work in a highly interactive team setting
- Proficiency in spoken and written English
- Computer skills in Windows 2000, Word, Excel and related software



Ermira BRASHA, M.D.

*Senior Liaison (M&E) Officer
Albania Child Survival Project*

Summary

Ermira Brasha, a medical graduate, has worked with the American Red Cross in Albania for four years and served as Organizational Development Officer and Senior Liaison Officer for management, business development, and stakeholder relations before joining the Albania Child Survival Project (ACSP) as M&E Officer in October 2004. Dr. Brasha provided overall leadership during ACSP proposal development and pre-implementation. As Organizational Development Officer (August 2000-September 2002), she managed a baseline survey of the “Public Image of the Red Cross in Albania,” was point person for development of the “Albanian Red Cross Branch Profiles,” an interactive database on CD, and assisted in the creation of a marketing plan and donor mapping exercise.

Relevant
Professional
Experience

Senior Liaison (M&E) Officer, Albania Child Survival Project, Albanian Red Cross, Tirana, Albania (from December 2003).
Senior Liaison Officer, American Red Cross, Tirana, Albania (September 2002-December 2003).
Organizational Development Officer, American Red Cross, Tirana, Albania (August 2000-September 2002).
Program Development Coordinator, Albanian National Health Organization (NGO), Tirana, Albania (September 2001-September 2002).
Nurse Trainer, Regional Hospital Kukes, Albania (June 1999-September 1999).

Language and
Computer
Skills

Native speaker of Albanian. Excellent English.
Windows 2000 & XP, MS Office 2000, Internet Explorer 5.5

Education

Licensed Physiotherapist, Physical Education and Sports Academy, Tirana, Albania (2001).
Doctor of Medicine (M.D.), Faculty of Medicine, University of Tirana, Tirana, Albania (2000).

Position Title:	American Red Cross Senior Liaison Officer
Reports To:	Regional Health Delegate SE Europe (RHD)/Head of Regional Delegation (HoRD), SE Europe
Location:	Tirana, Albania

Position Summary: The AmRC Senior Liaison Officer (SLO) is responsible for overall leadership of the Albania country team, including oversight of bilateral projects with Albanian Red Cross, USAID, and others; as well as management of the Monitoring & Evaluation component of the USAID-funded Child Survival and Health Project (CSHP). The SLO is responsible for maintaining effective and mutually-productive relationships with Albanian Red Cross, AmRC donors, international organizations, and other partners and stakeholders. As a key member of the CSHP team, the SLO takes the lead in project M&E, including developing a tracking system for process and outcome indicators and quality assurance monitoring tools and preparation of routine reports. In addition, the SLO may provide technical assistance and managerial support to regional activities of the Regional Delegation for SE Europe as requested.

Major Responsibilities:

1. Represents AmRC interests to other Red Cross partners, USAID, international organizations, and other stakeholders;
2. conducts needs assessments and explore and identify funding opportunities in areas of strategic importance to both AlbRC and AmRC;
3. develops concept papers and project proposals adhering to AmRC requirements;
4. manages the M&E component of the USAID-funded CSHP including developing a tracking system for process and outcome indicators and quality assessment monitoring tools and producing routine analytical reports;
5. participates in project assessments (e.g., baseline KPC survey, health facility assessment);
6. participates in the DIP process with Consultant and other local stakeholders
7. monitors the CSHP results framework, ensuring achievement of output and objective level results
8. develops appropriate monitoring and quality assurance tools for each level of CSHP project and other
9. identifies certified MOH facilitators to conduct clinical IMCI/Safe Motherhood/Family Planning training and refresher courses for midwives as needed;
10. serves as primary counterpart for CSHP mid-term and final evaluations with support from Regional Health Delegate, External Evaluator/Consultants, CSHP Manager and CSHP team;
11. submits bi-weekly reports for Albania country office and contributes qualitative and quantitative input for monthly, quarterly and other reports as necessary;
12. provides regional technical assistance and managerial support, as requested.

Scope: Does not supervise staff directly but collaborates closely with RHD, HoRD, CSHP Manager and Deputy Manager, and Finance Officer in the implementation and development of AmRC projects and activities.

Key Qualifications:

- 3-5 years experience with international organizations in project planning; assessment, and successful proposal writing;
- experience in public health (government, municipal or NGO);
- experience in quantitative and qualitative research methodologies, including population-based surveys, focus group discussions, etc.;
- experience in development and management of databases;
- fluent in English (written and spoken);
- excellent interpersonal communication skills.



Ardiana PEÇI, M.D.

*Albanian Red Cross National Health Coordinator
Albania Child Survival Project*

<i>Summary</i>	Ardiana Peci is the Albanian Red Cross National Health Coordinator and principal national society counterpart for the Albania Child Survival Project. She is a medical graduate with previous Red Cross experience, including responsibility for social mobilization during the national measles rubella immunization campaign and oversight of a project that trained and managed volunteer health educators (VHEs). She has designed VHE curricula for infant and young child feeding, sexual and reproductive health, and household hygiene. Dr. Peci has also worked for Relief International, an international organization. She completed her medical specialization in Microbiology.
Relevant Professional Experience	National Health Coordinator, Albanian Red Cross, Tirana, Albania (from March 2004). Medical Microbiologist, Laboratory Center BIOS, Tirana, Albania (September 2003-March 2004). Program Officer (Health), American Red Cross, Tirana, Albania (March 2000-March 2002). Medical Coordinator, Relief International, Korca, Albania (April 1999-October 1999).
Language and Computer Skills	Native speaker of Albanian. Excellent English. Fair Italian. Windows 2000 & XP, MS Office 2000, Internet Explorer 5.5
Education	Medical specialization in Microbiology, HUC Mother Teresa Laboratory, Tirana, Albania (2000-2003). English language exam, Faculty of Foreign Languages, University of Tirana, Tirana, Albania (1998). Doctor of Medicine (M.D.), Faculty of Medicine, University of Tirana, Tirana, Albania (1995).

Position Title:	Albanian Red Cross National Coordinator (Child Survival and Health Project)
Reports to:	Albanian Red Cross Head of Health Program
Location:	Tirana, Albania

Position Summary: Under the supervision of the Albanian Red Cross (AlbRC) Head of Health Programs, the National Coordinator serves as key counterpart and coordinates the overall relationship with the American Red Cross (AmRC) for implementation of the USAID-funded Child Survival and Health Project (CSHP) in Diber Prefecture. Participates as a team member in planning, implementation, monitoring, and evaluation activities and facilitates the role of AlbRC volunteers and staff in project implementation at HQ and Diber Branch (including Diber, Mat and Bulqize sub-branches) levels in accordance with AlbRC policies and procedures. Applies lessons learned/tools from the CSHP to other AlbRC health projects and assists the National Society in identifying funding sources for other maternal and child health and related activities to build the AlbRC health portfolio.

Major Responsibilities:

1. Provide leadership, training, and guidance to all CSHP-related staff with supervisory responsibilities in key supervision and performance evaluation practices based on AlbRC policies, protocols and previous experiences.
2. Provide assistance to American Red Cross in establishing and maintaining relationships with Albanian Red Cross and key stakeholders in Tirana and outlying areas.
3. Provide assistance in organizing quarterly CSHP Advisory Board meetings and takes active role in participation.
4. Participate in weekly or bi-weekly meetings with CSHP team to discuss CSHP developments.
5. Assist CSHP staff in developing training curricula
6. Applies lessons learned/tools to other AlbRC projects,
7. Supervise sub-branch staff and volunteers and ensures monthly reports from sub-branch coordinators for inclusion in AlbRC monthly report.
8. Prepare all required reports by Albanian Red Cross to NHQ Head of Health Department.
9. Assist in the marketing of the CSHP to internal and external stakeholders, including information on CSHP activities in the monthly bulletin of AlbRC.
10. Provides overall guidance and assistance in the development of various community mobilization, monitoring and evaluation (M&E) materials, and tools ensuring AlbRC standards are maintained.
11. Assist Albanian Red Cross Head of Programs to identify other resources with a specific focus on health

Scope:

As the key counterpart to the AmRC with regard to the CSHP, facilitate/establish relations with field staff and volunteers.

Key Qualifications:

- Academic degree in a health-related field, MD or MPH preferred
- At least 3 years of relevant experience in maternal and child health. Public Health experience preferred.
- At least 3 years experience in training, planning, M&E, management
- Supervisory skills
- Experience in writing proposals and concept papers for grants
- Proven ability to work in a highly interactive team setting
- Computer skills in Windows 2000, Word, Excel and related software
- Excellent spoken and written skills in English
- Availability to travel outside of Tirana (approximately 40% of time)



Anila GJONI

Finance and Administrative Officer – Albania Child Survival Project

Summary

Anile Joni is Finance and Administrative Officer for the Albania Child Survival Project and has been working with the American Red Cross in Albania since August 2002. Previously, she has worked for other international organizations, including the International Catholic Migration Commission (ICMC) and German Caritas. Ms. Joni has completed trainings in Participatory Rural Appraisal, Monitoring and Evaluation, Financial Management, and USAID Rules and Regulations for Finance and Grant Compliance (Association of PVO Financial Managers, Istanbul, Turkey, 2003). She holds a Bachelor of Civil Engineering degree from University of Tirana and is currently pursuing a second degree in Economics.

Relevant Professional Experience

Finance and Administrative Officer - Albania Child Survival Project, American Red Cross/Albanian Red Cross (August 2004 - present).
Finance Assistant, International Catholic Migration Commission (ICMC), Korca, Albania (January 2002-July 2002).
Office and Finance Administrator, German Caritas in Albania (April 1999-October 2001).
Office and Finance Administrator, “Emigrant Shipyard” Newspaper, June 1998-April 1999.

Language and Computer Skills

Native speaker of Albanian. Excellent English and Italian. Some German.
MS Office 2000, AUTOCAD, Waken.

Education

Currently enrolled in Bachelor of Economics and Agricultural Policy degree program, University of Kamza, Tirana, Albania.
Bachelor of Civil Engineering, University of Tirana, Tirana, Albania (1998).

Position Title: Finance / Administration Officer

Reports to: Regional Finance Delegate

Location: Tirana, Albania

Grade: 4

Position Summary:

Ensure in financial and administrative policies and procedures are administered appropriately.

Major Responsibilities:

- 1) Administer petty cash in line with established procedures.
- 2) Verify validity of documentation submitted for processing; input data and verify; produce relevant reports, reconcile output with supporting documents; process corrections as instructed.
- 3) Prepare end-of-month closure including compilation of Monthly Financial Report for submission to NHQ.
- 4) Prepare monthly Bars for Project Manager and RFD.
- 5) Compile VAT invoices and prepare VAT report.
- 6) Receive and process monthly cell phone bills according to established financial policy and procedures.
- 7) Ensure up-to-date national staff personnel files.
- 8) Ensure smooth functioning of the office premises.
- 9) Maintain and track all American RC contracts and ensure compliance of contracts by both parties.
- 10) Coordinate all contracts with ARC Regional Delegation office. Assist with procurement; work with known suppliers to determine best value, and prepare 'CBAs'.
- 11) Act as focal point with suppliers to ensure delivery and validity of goods/services, and follow-up as needed for returns or exchanges.
- 12) Ensure that all delegates and national staff are trained on and follow ARC procurement and purchasing policies.
- 13) Perform semi-annual updating of Fixed Asset Register.
- 14) Assist delegation in identifying staff training needs. Assist in training new staff.
- 15) Provide oral and written translation as required.
- 16) Other duties as required.

Scope:

As the key counterpart between ARC Tirana office and ARC regional office on financial and administrative issues. Support the ARC sub-office in Peshkopi on financial issues and administrative issues.

Key Qualifications:

- University required, degree in Accounting, Business or Economics preferred
- 1 – 2 years of similar experience preferably with a humanitarian organization
- MS Office required
- advanced Excel skills
- knowledge of Quicken a plus
- Fluent in English and Albanian, regional languages a plus
- Self-motivated, hard working, organizational skills, exhibits good judgment and common sense.

Professional Relations:

Knowledge of American Red Cross:

- Be aware of the delegations objectives and activities.
- Understands all principles and all three components of the Red Cross Movement.
- Be aware of the security rules and situation in the field at all times.



Artan ISARAJ, M.D.

Technical Officer – Albania Child Survival Project

Summary

Artan Isaraj, a Pediatrician, joined the Albania Child Survival Project as Technical Officer for child health, bringing with him experience from other international organizations, including International Medical Corps (IMC) and Norwegian People's Aid (NPA). He is a graduate of the Faculty of Medicine at University of Tirana where he also completed his specialization in pediatrics. Since 1999, Dr. Isaraj has been a member of the Organizing Committee, computer designer, and secretary of the French-Albanian Pediatric Conference organized by the Albanian Pediatric Society.

Relevant
Professional
Experience

Technical Officer - Albania Child Survival Project, Albanian Red Cross (April 2004 – present).
Supervisor (Health Facilities Assessment) – Albanian Child Survival Project, Albanian Red Cross (February - March 2003).
Pediatrician, Department of Pediatrics, Mother Teresa University Hospital Center, Tirana, Albania (1999-2004).
Physician/Trainer, International Medical Corps (IMC), Kukes, Albania (August 1999 – February 2000).
Physician, Norwegian People's Aid (NPA), Durrës, Albania (April – June 1999).
General Practitioner, Hospital of Kucova, Albania (1998-1999).

Language and
Computer
Skills

Native speaker of Albanian. Excellent English and Italian. Good Greek.
MS Office, Adobe Photoshop 6.0, Adobe PageMaker 6.5, CorelDraw 9, Corel PhotoPaint 9, Macromedia Flash 4, EpiInfo 6 & 2000, SPSS, 3DStudio Max.

Education

Medical specialization in Pediatrics, Faculty of Medicine, University of Tirana, Albania (January 1999 – January 2003).
Doctor of Medicine (M.D.), Faculty of Medicine, University of Tirana, Tirana, Albania (1997).

Position Title:	Technical Officer, Albania Child Survival Project
Reports To:	ACSP Manager
Location:	Peshkopi, Albania

Position Summary: The Technical Officer (TO) takes the lead in the design and implementation of all IMCI and FP curricula. He/she is responsible for the overall coordination & management of IMCI, Community-IMCI+ and FP trainings and; provides support to ACS Project Manager,

Major Responsibilities:

1. Participate in the DIP process with Consultant and other local stakeholders;
2. Develop IMCI and Community-IMCI+ training curricula for TOT and C-IMCI/FP in coordination with ACSP team, IMCI National Coordination Group and MOH;
3. Identify certified MOH facilitators to conduct clinical IMCI/Family Planning trainings;
4. Train Albania Red Cross District Health Coordinators and local trainers of trainers midwives, and others as needed in C-IMCI and FP;
5. Support Albania Red Cross District Health Coordinators and communities in the selection of CMs and VHEs;
6. Makes regular field visits within Diber Prefecture to monitor ACSP activities;
7. Assist the M&E in developing monitoring and quality assurance tools for each level of project hierarchy.

Scope: Does not have any direct line supervision of staff, but works closely with Albanian Red Cross District Health Coordinators, VNMs, CMs (60) and VHEs (760) in the implementation of training curriculum.

Key Qualifications:

- Academic degree in a health-related field, M.D or nurse with MPH preferred
- Experience in developing and implementing training curriculum and familiarity with peer learning methodologies
- Experience in database development and management including Epi-info, Stata or related software
- Proven ability to work in a highly interactive team setting
- Computer skills in Windows 2000, Word, Excel and related software
- English fluency (written and verbal)



Job Description

Albanian Red Cross ACSP Community Mobilizers

Position Title:	Albania Red Cross Community Mobilizer (CM), Albania Child Survival Project
Reports To:	Albania Red Cross District Health Coordinator
Location:	_____ (Commune) _____ (District), Diber Prefecture

Position Summary: The CM has overall responsibility for community outreach and involvement as well as for the supervision of volunteer networks in their respective commune. He/she is responsible for facilitating the recruitment, selection and, most importantly, retention of the Volunteer Health Educator network.

Major Responsibilities:

1. Protect and promote the Albanian Red Cross Image & Fundamental Principles;
2. Recruit, coach and manage the VHEs;
3. Identify and provide appropriate volunteer incentives;
4. Assist in the training of VHEs in all IMCI+ curriculum;
5. Assist in the development of VHEs and VNMs outreach work monitoring tools;
6. Supervise and monitor the four high impact IMCI+ activities performed by the VHEs and VNMs: young child support groups; proactive home visits; growth monitoring and FP focus groups;
7. Liaise with commune Health Center staff;
8. Meet with village midwives during monthly vaccination outreach visits;
9. Assist in community-level data collection and analysis;
10. Facilitate the monitoring visits of Albanian Red Cross District Health Coordinators;
11. Conduct client satisfaction surveys;
12. Review the VHE and VNMs monthly ACSP activity logs;
13. Coordinate community meetings;
14. Prepare monthly data reports to the District Health Coordinators.

Scope:

CMs have direct line supervision of approximately 27 VHEs in a designated commune in the implementation of IMCI+ training curricula and IMCI+ activities.

Key Qualifications:

Community Mobilizers are required to live in the commune where they work. Criteria for selection will be determined during baseline participatory discussions with village members.



Albania Child Survival Project

Position Title:	AlbRC District Health Coordinator (DHC)
Reports To:	AlbRC Branch Secretary of Diber
Location:	<i>District, Diber Prefecture (1 Each in Diber, Mat and Bulqize Districts)</i>

Position Summary: As a member of the Albanian Child Survival Project (ACSP) team, the DHC is responsible of the oversight of the project in their district for managing, monitoring and supervising AlbRC volunteer health educators (VHEs) working at the commune and village level. The DHC assists ACSP Manager to establish and maintain positive relationships with local authorities and District PH Directorates.

Major Responsibilities:

1. Facilitate partnerships with local officials including health officials, community leaders, stakeholders and AlbRC VHEs;
2. Recruit, manage, and supervise AlbRC VHEs;
3. Make quarterly supervisory visits to each CS VHE in the district;
4. Assist M&E Officer in data collection and interpretation for ACSP;
5. Train VHE and VNM in C-IMCI+
6. Assist ACSP technical staff to organize IMCI training of village nurses midwives (VNM);
7. Assist District Directorates of Public Health conducting follow-up visits at commune health centers as needed;
8. Uses project tools and methods to strengthen VHE performance and assure quality;
9. Prepare and submit monthly and quarterly report for the ACSP to Diber Branch Secretary and ACSP Manager.

Qualifications:

- 1 Field experience in health, social work, education, community development or related areas;
- 2 Experience in managing volunteers;

Additional skills preferred:

- a) good communication skills;
- b) willing to travel within and out of the district;
- c) Computer literacy (Word, Excel, Email);

Scope: Supervise Volunteer Health Educators in District.



Job Description
Albanian Red Cross ACSP Volunteer Health Educators

Position Title:	Albania Red Cross Volunteer Health Educator (VHE), Albania Child Survival Project (ACSP)
Reports To:	Albania Red Cross District Health Coordinator
Location:	-----Village-----Commune-----District

Position Summary: VHEs are the first line implementers of community IMCI+ model, empowering community to take responsibilities for family health. VHEs working in teams with nurse midwives in village level, as well as in selected health facilities: promote key CS health messages, carry out four high impact activities and facilitate the direct link of community with formal health system. In accordance with Albanian Red Cross policies and regulations, VHEs protect and promote good image for the organization.

Major Responsibilities:

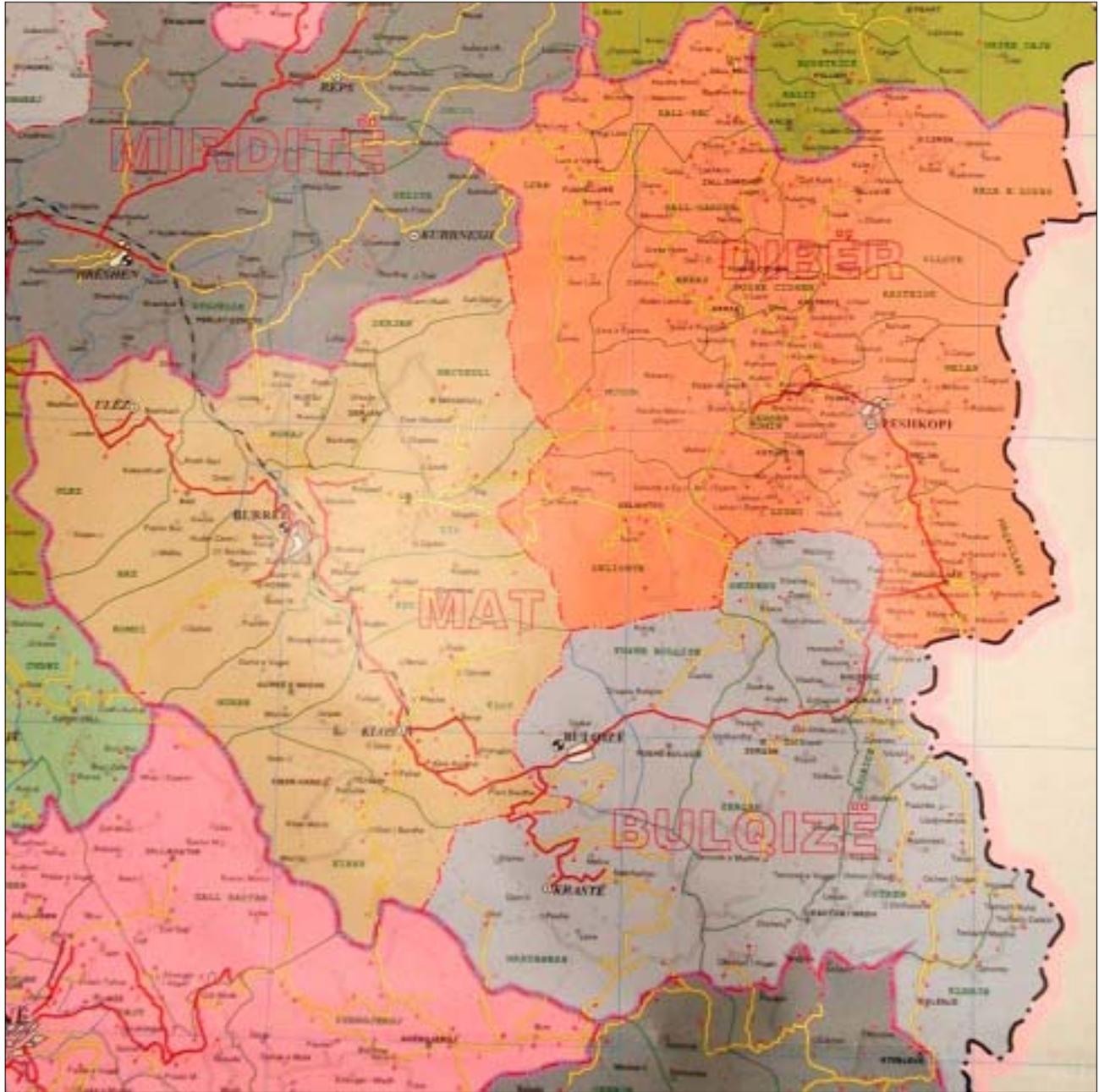
1. Protects and promotes the Albanian Red Cross Image & Fundamental Principles;
2. Organizes the community to become active in the ACSP
3. Facilitates and carries out four high impact activities: young child support groups; pro-active home visits; growth monitoring and FP focus groups;
4. Participates in monthly immunization outreach sessions;
5. Undertakes data collection and submit data form on weekly and monthly basis to VNM;
6. Prepares monthly reports to the ACSP District Health Coordinator;
7. Participates in the Albanian Red Cross trainings in the framework of ACSP;

Requirements:

- Strong interpersonal and communication skills
- Experience in conducting community outreach activities
- Experience in working with local community
- Ability to work in team
- Time available to volunteer
- Volunteer experience with AlbRC or other local organizations
- High school education preferred

ANNEX 6

Map of Diber Prefecture



ANNEX 7

RAPID CATCH Summary

Rapid Catch Indicators

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

⁷ Note that this indicator does NOT conform to the Albanian definition of "fully vaccinated".

⁸ Note that measles vaccination is given to children up to 14 months in Albania

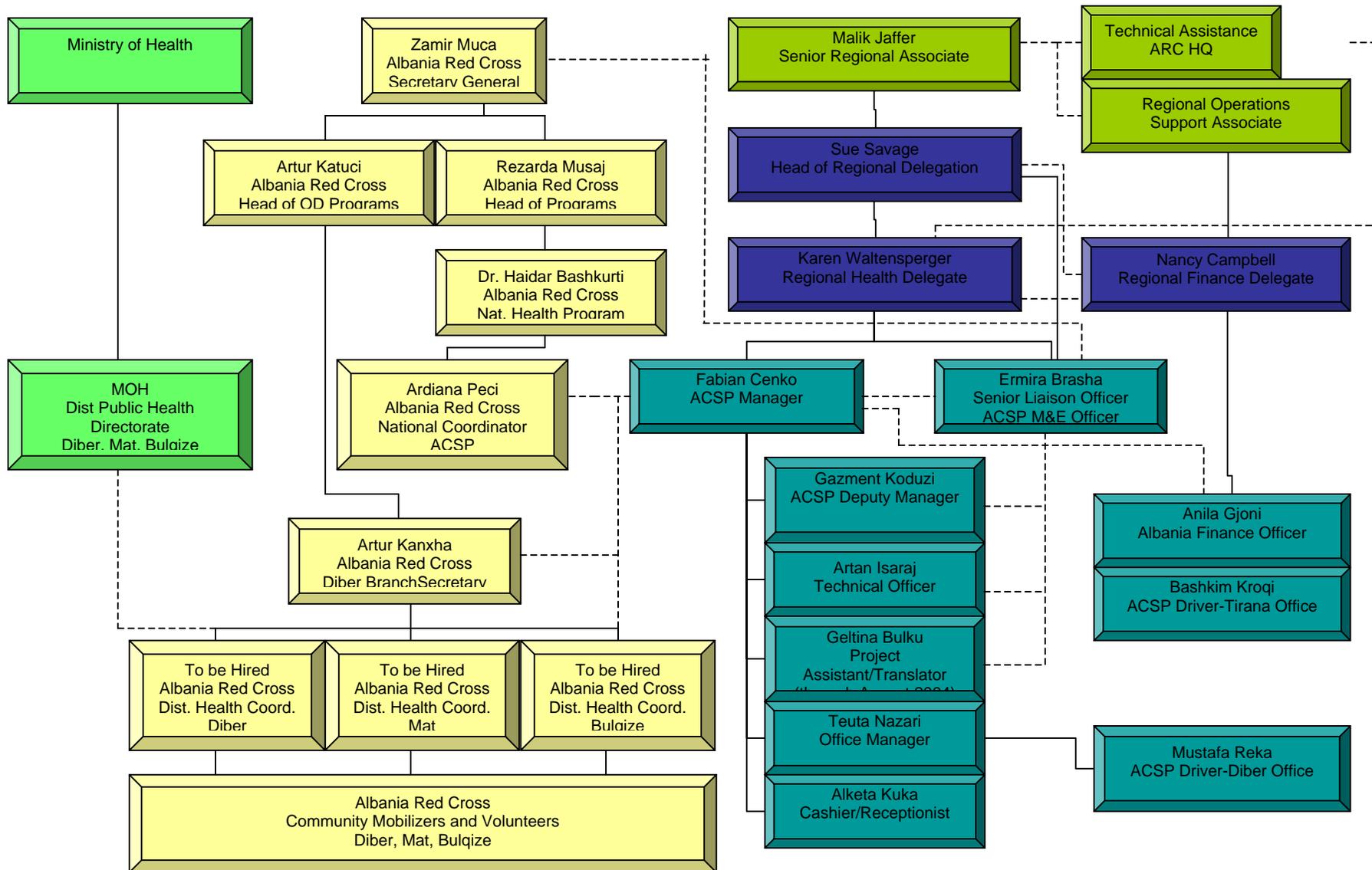
ANNEX 8

Organizational Structure Phase I

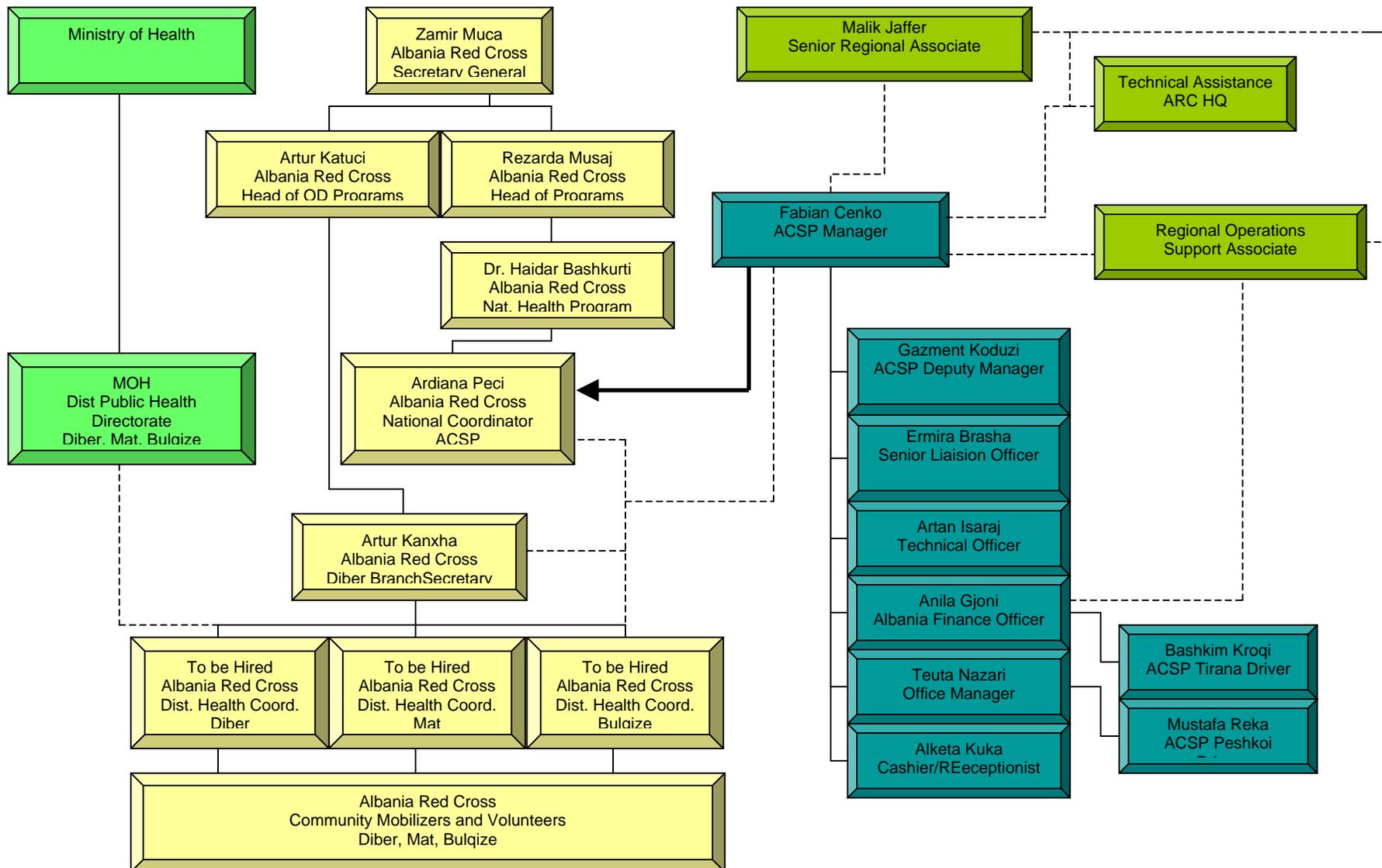
Organizational Structure Phase II

Management Plan

American Red Cross Albania Child Survival Project (ACSP) Phase I



American Red Cross Albania Child Survival Project (ACSP) Phase II (Proposed July 2005)



MANAGEMENT STRUCTURE

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 below 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. The current draft and details are being discussed with the AlbRC.

Skills Transfer: AmRC NHQ in Washington, DC will ensure transfer of skills, information, TA, and lessons-learned with the field program through several mechanisms. A combination of visits from AmRC NHQ will visit the ACSP field site at least once a year to share information gained from CORE updates and cross cutting technical sessions. These visits will include management, financial and technical skill sets from the desk officer, senior health advisor, M&E manager and the regional operations support associate. The NHQ Senior Health Advisor will also send technical updates and reports to the regional and field ACSP staff, and will keep abreast of regional technical training opportunities for field participation. ACSP field experiences will be shared with AmRC NHQ through brown bag sessions, quarterly IRD health sector reviews, and biweekly reports.

A. Management Structure Phase I (Please refer to organizational structure)

Headquarters: AmRC NHQ International Services Division (ISD) staff will administer the ACSP with assistance from the AmRC regional delegation in Bulgaria and the AmRC country office in Albania. Dr. James Ricca, TAPE Senior Health Advisor based in Washington, DC will be the key person at NHQ for providing overall technical and management backstopping for the ACSP and will serve as the main point of contact with USAID. The Europe, Central Asia and Middle East (EuCAME) Regional Operations Associate will provide financial oversight for the ACSP in coordination with the AmRC Regional Finance and Administration Delegate based in Bulgaria and the Country Finance Officer in Albania (see financial management section). The Senior Regional Associate responsible for South East Europe will assist the Health Manager as needed to fulfill ACSP administrative and reporting requirements. The TAPE Unit has assigned three technical staff to the project, Dr. James Ricca, Senior Health Advisor, Dr. Alice Willard, Manager M&E and Tom Carmody, OD Project Manager, to provide Technical Assistance (TA) to the ACSP in survey methodology, indicator measurement, data analysis, and OD tools. Dr. Gil Burnham, from JHU Division of International Health has also provided TA in baseline research methodology and monitoring systems during the JPC and the HFA.

Region: In addition to NHQ support, the AmRC regional delegation in Sofia, Bulgaria will provide management and technical oversight under the guidance of the TAPE Senior Health Advisor. This decentralized approach will enhance communication between the field staff and NHQ, increase technical support and skills transfer to the field, and facilitate problem solving. The Head of Regional Delegation (HORD) reports to the Senior Regional Associate and will provide technical and management assistance to the ACSP as needed. The Regional Finance and Administration Delegate will provide training and guidance to the ACSP ensuring all financial and administrative systems adhere to USAID requirements. The Delegate will also work in close collaboration with the Albania Finance Officer. The AmRC Regional Health Delegate, based in Tirana began work in October 2003 and has been providing intensive TA to the ACSP to ensure achievement of project objectives and indicators and monitor compliance with USAID performance and financial management requirements.

Country: The AmRC country delegation in Tirana will provide administrative and financial assistance to the ACSP. The Liaison Officer who reports 50% to the Regional Health Delegate

and 50% to the HORD plays a critical role in organizing regular ACSP Advisory Board meetings in Tirana with AlbRC, AmRC, USAID Mission, URC, SCF, PHR, CCF, AIHA, WFP, UNICEF, MOH, community representatives, and other key stakeholders to monitor ACSP progress, discuss synergies, and lessons learned. The Country Finance Officer will provide financial management for the ACSP and report to the Regional Finance and Administration Delegate. The AlbRC National Coordinator –ACSP will participate in the Advisory Board meetings and will assist the ACSP Manager in establishing relationships with key stakeholders in the field. The AlbRC National Coordinator--ACSP reports to the AlbRC National Health Program Coordinator who in turn reports to the Head of Programs based in the Tirana NHQ AlbRC office.

Prefecture: Daily ACSP management will be the responsibility of Dr. Fabian Cenko, ACSP Manager who will be based in the ACSP office in Peshkopi town, Diber District, Albania. Prior to joining the ACSP, Dr. Cenko spearheaded the Albania Expanded Program on Immunization (EPI) at the Institute of Public Health in Tirana and also served as a technical advisor for a community-based maternal and child health project in nine districts in northeast Albania during the Kosovo crisis. He has published papers on infant and young child feeding practices and iron deficiency anemia in mothers in Albania. The ACSP Manager will be the key person for managing the ACSP in the field and will formally report to the Regional Health Delegate allowing for more efficient communication and decision-making due to the proximity of both field-based positions; however ultimate authority will rest with the TAPE Health Manager. The ACSP Manager will be assisted by Dr. Gazimend Koduzi, Deputy Manager, a health professional with project management experience. Prior to working with the ACSP, Dr. Koduzi was a Field Officer in family planning and women's reproductive health with John Snow International under a contract with USAID. Dr. Koduzi will bring to bear his experience working with JSI on the Albania Family Planning Program during his tenure with the ACSP. In addition to his responsibilities of assisting the Project Manager, Dr. Koduzi will also lead the FP technical interventions. The training and monitoring role as outlined in the proposal has been split into two functions; namely, M&E and training. The senior liaison officer will spend her time working on M&E issues and on AmRC operations with AlbRC and other stakeholders. Rather than adding a training officer, the ACSP team opted to add a technical officer with specialized pediatric knowledge. By doing so, it is expected that the Deputy Manager and the Technical Officer will also be responsible for leading training in their respective fields of expertise. The ACSP Manager will organize thrice annual ACSP Advisory Board meetings with the MOH Head of Prefecture, AlbRC Branch Secretary, Prefecture administrative leaders, community representatives, NGOs, and key stakeholders to report on ACSP progress in the three districts, discuss any problems, and share lessons learned. Holding the meetings annually will allow for each district in the prefecture to hold the meeting once annually.

District: *AlbRC District Health Coordinators* will supervise the CMs, the VHEs and implement M&E and training activities under the guidance of the M&E Officer and will assist the Directorates of PHC in conducting IMCI/C-IMCI+ follow-up visits at health centers as needed. The District Health Coordinators will report to the AlbRC Diber Branch Secretary and coordinate closely with the AlbRC National Coordinator-ACSP. The District Health Coordinators will also hold tri-annual ACSP District Advisory Board meetings with AlbRC, district authorities, community representatives, and other key stakeholders will facilitate collaboration and provide an opportunity to discuss CHSP activities, issues, and lessons-learned. District Health Coordinators will have an indirect line of communication with the ACSP Manager. A job description of the District Health Coordinator is attached in Annex 5. It is expected that recruitment and hiring of the three District Health Coordinators will take place in summer 2004 and that they will be instrumental during the implementation of the population based family planning survey.

Commune and village: At the village level, the primary link to community participation is in the VNMs. The VNM will be instrumental in implementing the behavior change strategy and will also be responsible for some of the project data collection. In order to expand the role and scope of the VNMs, the project intends to train 760 VHEs. Approximately two volunteers will be used in each village and about 60 VHEs will be used at the commune level. Although the VHE will directly report to the AlbRC District Health Coordinator, it is expected that the VNM will direct the day to day schedules of the VHE and that the VNM and VHEs will adopt a united and cohesive work schedule that serves the community as outlined in detail in the intervention sections above. The VHEs will be drawn from their own villages and will be working with the VNM from their village. A copy of the job description of the VHE is enclosed in Annex 5. There will be 36 community mobilizers, one in each commune. Community mobilizers will be AlbRC volunteers that will be trained in and will be paid a small stipend to coach and manage the volunteer networks in each commune. The recruitment of the volunteers will begin in late summer 2004 and continue in rolling phases tied to the training schedules outlined in the intervention sections above.

B. Human Resource Management

The table below shows the distribution of project staff by organization, structural level and hiring status. **Key personnel** responsible for technical backstopping the ACSP from NHQ Washington and in the field are in **bold**.

Supervision: The AmRC Regional Health Delegate and AlbRC Head of Programs will co-facilitate a training workshop for all ACSP-related staff on supervisory responsibilities in key supervision and performance evaluation practices based on previous RC experiences.

Supervisions of VHEs: District Health Coordinators will directly supervise the 36 commune level CMs and indirectly supervise the VHEs. District Health Coordinators will also review completed surveys such as the participant satisfaction survey and the pre-post tests; District Health Coordinators will follow-up with the Project Manager and the AlbRC National Coordinator-ACSP with poor and 'perfect' feedback

VHE supervision by VNMs will follow a similar model as outlined above. Further, the day to day work of the VHE will be directed by the VNM. This model of supervision is an updated version of the one employed in the previously successful, AmRC/ AlbRC VHE Project. The VHEs will implement pre-and-post tests during their community education sessions. These will capture knowledge and awareness changes in addition to client satisfaction, and more importantly community recommendations for future session topics; since community education sessions are only one activity performed, the VHEs will complete daily activity logs, summarizing them on a weekly basis for the VNMs. These logs will capture frequency of various outreach activities, i.e. education sessions, HH visits, general beneficiary profile information (enough for random follow-up by District Health Supervisors and ACSP staff) as well as challenges encountered.

Supervisions of VNMs: The doctor in charge of the communal health center meet, monitor and supervise VNMs on a monthly basis at a minimum. These regular exchanges frequently bring together a number of VNM from different village allowing for an exchange of issues related to the implementation of the project and updates on MOH policies. The AlbRC District Health Coordinators will attend communal level meetings.

Program Staffing: Project staff have all been recruited and hired. The recruitment of the AlbRC District Health Coordinators and VHEs will be facilitated by the Diber Branch Secretary in consultation with the ACSP Manager using previously successful recruitment models from the AlbRC VHE Project. These outreach and recruitment models ensure gender and ethnic diversity

via local community boards responsible for recruitment and screening; final staffing decisions will be made by joint teams representing local communities, AlbRC and AmRC. As mentioned above, the VHEs will be drawn from their respective villages. The recruitment of the AlbRC District Health Coordinators will take place during the summer of 2004 and is anticipated that they will play a significant role during the implementation of the population based family planning survey. The recruitment of the VHE will begin in late summer 2004 and be phased in according to the training schedule and implementation timeline of the project interventions.

Recruitment Issues: The on-going motivation and retention of the VHEs could be a significant challenge to the ACSP. This will be addressed in part by ensuring a reasonable catchment area, staggered trainings to ensure the timely application of new skills and through the provision of minor non-monetary incentives; the later will include t-shirts with the program title and donor logos, name badges, educational/training aids, and certificates of completion of trainings. All were successfully used in previous AmRC-supported MCH programs in Albania.

Management Structure Phase II: In phase II of the management plan, gradually transitioning between October 2004 through July 2005, the ACSP is proposing greater reliance on the AlbRC structures with greater support from AmRC NHQ while simultaneously reducing the AmRC regional presence.

It is envisioned at the regional level that the HORD will phase out responsibilities in October 2004. Between April 2004 and October 2004, a revised reporting structure will be developed and negotiated with the AlbRC and the appropriate skills, capacities and systems will need to be developed. This should be implemented in light of the Regional Health Delegate completing her work in April 2005 and also transition her responsibility to the AlbRC. The Regional Finance and Administration Delegate will be phasing out at the end of July 2005 to ensure a smooth transition of AmRC fiscal year budget cycles.

The reduction of the AmRC staff at the regional level is possible because of the capacities of the project team and the AlbRC structures. Key systems will need to be strengthened and/or developed to ensure an accurate management and financial compliance. There will be systems and procedures in place for greater involvement from the AmRC NHQ desk and technical staff.

By transitioning greater responsibility to the AlbRC for the day to day management of the project, the AmRC is relying on an already existing framework of the AlbRC and foresees a greater likelihood of sustainability of project activities and capacities. This proposed transition will also help to strengthen the program management capacities of the AlbRC. Please refer to organizational structure Phase II above.

List of Persons Contributing to Achieving ACSP Results

Position FTE/ <i>Financial Responsibility</i>	Primary Responsibilities	Reports To:	Experience/Training
AmRC NHQ Support to ACSP - Washington, DC			
James Ricca , TAPE Health Advisor: 15% (<i>ACSP budget</i>)	Overall ACSP technical, administrative and financial oversight; grant management, report writing	Director TAPE	MD, MPH, 10+ years public & international program experience; experience with maternal and child programs
Malik Jaffer, Senior Regional Associate, EuCAME FTE: 10% (<i>ACSP budget</i>)	Manages project portfolio in SEE; facilitate communication with field at country and regional levels	Regional Manager, EuCAME	BS, MPH in International Health, 9 years work experience in international development in Central Europe, Asia, Africa and the Middle East/Afghanistan.
Regional Operations Associate, EuCAME FTE: 15% (<i>ACSP budget</i>)	Business oversight, grant compliance and financial reporting. Technical support to Regional Finance Coordinator.	Title, Finance	Expected to be hired in May 2004. Will have skills in financial management and knowledge of USG rules and regulations.
Alice Willard, TAPE, M&E Manager FTE: 10% (<i>ACSP budget</i>)	Coordinate w/JHU to conduct M&E, operations research, quantitative & qualitative research	Director TAPE	
Tom Carmody, OD Manager, TAPE FTE: 10% (<i>ACSP budget</i>)	TA for OD and operations research	Director TAPE	14 years development experience in 10+ countries including Albania; 5 years experience w/USAID projects
Regional Support to ACSP – Sofia, Bulgaria			
Suzanne Savage, HORD FTE: 10 % year 1 only (<i>ACSP budget</i>)	Planning, evaluation, and reporting oversight and support	Senior Regional Associate EuCAME	MA in International Relations, 10 years research and development experience in 18 countries
Karen Waltensperger Reg. Health Delegate FTE: 30% year 1; 15% year 2; (<i>ACSP budget</i>)	Public health technical support and backstopping; based in Tirana first year of project to work with the ACSP Manager	HORD	MA, MPH with 25+ years developing, managing and implementing development program with 11+ years in Sub-Saharan Africa
Nancy Campbell, Regional Finance Delegate FTE: 10 % Year 1& 2(<i>ACSP budget</i>)	Field oversight and backstopping in finance, administration and logistics. Technical support to Tirana based Finance Officer.	Regional Operations Associate, EuCAME	BS in Business Administration; MA in International Development, 7+ years experience in NGO financial, administrative, logistical, and program management
Country Support to ACSP – Tirana, Albania			
Dr. Haidar AlbRC National Health Coordinator FTE: 30%	Management and coordination support to ACSP Manager, branch staff and community volunteers	AlbRC Head of Programs	MD, 30 + years as pediatrician in N. Albania, 10 + years managing AlbRC health projects, trained in data analysis, conducted first national midwifery training
Ardiana Peci AlbRC National Coordinator-ACSP FTE: 100 % Year 1 & 2; 25% Year 3 (<i>ACSP budget</i>)	Primary counterpart between project and AlbRC. Provides oversight of project activities and assists with ensuring program goals are in line with AlbRC strategies.	AlbRC National Health Coordinator	MD with experience in social mobilization and designing of VHE curriculum. Has prior experience working for international NGOs including AmRC
Dr. Emira Brasha AmRC Liaison Officer (ACSP M&E) FTE: 100% (<i>ACSP budget</i>)	Coordinate ACSP quarterly board meetings at the national level, and maintain communications between AmRC and stakeholders. Oversight of ACSP M&E.	50% Reg. Health Delegate and 50% HORD	MD, managed AmRC OD program for two years; conducted training course for 80 nurses in northern Albania
Anila Gjoni AmRC Finance Officer FTE: 100% (<i>ACSP budget</i>)	Provides day-to-day project financial management	Regional Finance Coordinator	3+ years finance and office administration experience for international NGOs
Bashkim Kroqi ACSP Driver FTE: 100% (<i>ACSP budget</i>)	Provide transportation for ACSP coordination meetings and field visits	ACSP Deputy Manager	Professional driver for ministry officials, 2+ as AmRC OD driver
Prefecture support to ACSP – Peshkopi, Diber prefecture			
Dr. Fabian Cenko ACSP Manager FTE: 100% (<i>ACSP budget</i>)	Overall field level project responsibility and oversight; coordinates with USAID, MOH, & key local stakeholders	Regional Health Coordinator	MD, Spearheaded the national program on EPI and has written 2 publications
Dr. Gazimend Koduzi ACSP Deputy Mgr. (1) FTE: 100% (<i>ACSP budget</i>)	Provides backstopping support to Project Manager and lead on coordination and training of FP	ACSP Manager	MD, currently pursuing a Master in Public Health. Previous work as field officer for JSI FP program in

	intervention		Albania
Dr. Artan Isaraj ACSP Technical Officer (1) FTE: 100% years 1-4 (<i>ACSP budget</i>)	Responsible for overall coordination of training activities and monitors project objectives and indicators	ACSP Manager	MD with specialization in Pediatrics. Previous experience with International Medical Corps and Norwegian People's Aid.
Teuta Nazari Office Manager FTE: 100% (<i>ACSP budget</i>)	Responsible for running Peshkopi office. Provides administrative and logistical support.	ACSP Manager	Experience with Danish NGO working as Office Manager and providing administrative support
Alketa Kuka Cashier/Receptionist FTE: 100% (<i>ACSP budget</i>)	Responsible for managing the day to day finances of the project office. Provides administrative support.	ACSP Manager	Degree in Economics and last two years as Chief of office (gov't) providing financial support to low income citizen
Mustafa Reka (1) Driver FTE: 100% (<i>ACSP budget</i>)	Provides logistical support as needed	ACSP Manager	Experienced driver, professional and dependable
District level support to ACSP – Peshkopi, Bulqize, Mat districts			
AlbRC District Health Coordinators (3) 1 based in Bulqize 1 based in Mat 1 based in Diber FTE: 100% (<i>ACSP budget</i>)	Part of the AlbRC structure; coordinate with District Public Health Directorates to build partnerships with local leaders, MOH, community, stakeholders, and AlbRC; coordinate regular ACSP Board Meetings and supervise VHEs	AlbRC Branch Secretary	Expected hiring in summer 2004
Commune level support to ACSP			
ACSP CMs (36) 1 per commune x 36 communes FTE: 100% (<i>ACSP transport</i>)	Volunteers who promote key messages through counseling, health education sessions, mass media campaigns, household visits and liaise with health centers.	AlbRC District Health Coordinators	Expected phased in recruitment starting summer 2004
Village level support to ACSP			
VHEs (760) 2.5 per village x 279 villages FTE: 40% (<i>Volunteers</i>)	Volunteers who promote key messages through counseling, health education sessions, mass media campaigns, household visits and liaise with VNMs.	AlbRC District Health Coordinators and VNMs	Expected phased in recruitment starting summer 2004
Midwives/Nurses (278) 1 per village x 278 villages FTE: 100% (<i>MOH salary</i>)	Counsel mothers on FP methods, conduct antenatal visits, promote key messages during immunization visits, advise mothers on home based management of childhood illness and signs for referral	GPs	Limited training, administer routine immunizations for children and pregnant women and conduct antenatal visits

ANNEX 9

DIP Stakeholder Workshop

- **Agenda**
- **Objectives**
- **Presentations**
- **Workshop Results Summary**

**Albania Child Survival Project (ACSP)
Detailed Implementation Planning (DIP) Workshop - Agenda
8-9 March 2004**

MONDAY, 8 March

FACILITATORS

09h30	Registration	Teuta Mazari, Anila Gjoni
10h00	Welcome and Introductions	Dr. Fabian Cenko
10h15	Albania Red Cross	AlbRC Representative
10h30	ACSP (PowerPoint presentation)	Karen Waltensperger Gazmend Koduzi
11h10	Questions	Facilitators at tables
11h20	Responses to questions	Dr. Gazmend Koduzi Karen Waltensperger
11h30	<i>Small group exercise #1 – Technical areas (includes coffee break)</i>	
	Nutrition	A - Dr. Ermira Brasha B - Dr. Fabian Cenko
	ARI + diarrhea (IMCI)	A - Dr. Blendi Gura B - Dr. Artan Isaraj
	Family Planning	A - Dr. Gazmend Koduzi B - Dr. Halil Stana
13h30	Lunch	
15h00	Small groups report back	Dr. Gazmend Koduzi
16h00	<i>Small group exercise #2 – District priorities (includes coffee break)</i>	
	Diber District	Dr. Mustafa Ndreka Dr. Fabian Cenko
	Mat District	Dr. Halil Stana Dr. Gazmend Koduzi
	Bulqize District	Dr. Blendi Gura Dr. Ermira Brasha
17h00	End of day	

ACSP DIP Workshop Day 2

TUESDAY, 9 March

FACILITATORS

09h00	Review of Workshop Day 1	Dr. Fabian Cenko
09h15	Small groups report back	Dr. Gazmend Koduzi
10h00	<i>Small group exercise #3 - Partnerships and collaboration</i>	
	Project advisory mechanisms	Dr. Ermira Brasha
	Volunteer recruitment and retention	Plejada Gugashi Dr. Halil Stana
	Alignment and synergy with partners	Karen Waltensperger Dr. Fabian Cenko
	Village nurse/midwives focus group	Dr. Gazmend Koduzi
11h30	Coffee break	
12h00	Small groups report back	Dr. Gazmend Koduzi
13h00	Questions and next steps	Dr. Fabian Cenko
13h45	End of day	
13h45	Administrative matters	Alketa Kuka, Anila Gjoni

Albania Child Survival Project
DIP Workshop
Peshkopi, Albania
March 8-9, 2004

Objectives

1. Stakeholder knowledge of Albania Child Survival Project increased.
2. Stakeholders engaged in implementation design.
3. Intervention strategies (activities) recommended.
4. Intervention priorities by district recommended.
5. Project advisory mechanisms recommended.
6. Volunteer recruitment and retention guidelines recommended.
7. Partner roles and synergies identified.
8. Village level nurse/midwives engaged.

**Projekti “Mbijetesa e Fëmijëve” në Shqipëri (PMFSH)
Axhenda e Seminarit mbi Planin e Detajuar të Zbatimit (PDZ)
8-9 Mars 2004**

8 Mars, e Hënë

DREJTUESIT/LEHTËSUESIT

9 ³⁰	Regjistrimi	Teuta Mazari, Anila Gjoni
10 ⁰⁰	Mirëseardhja dhe Prezantimi	Dr. Fabian Cenko
10 ¹⁵	Kryqi Kuq Shqiptar	Eugen Junuzi, KKSH
10 ³⁰	PMFSH (Prezantim-Power Point)	Karen Waltensperger
11 ¹⁰	Pyetje	Lehtësuesit nëpër tavolina
11 ²⁰	Përgjigjet e pyetjeve	Dr. Fabian Cenko/Karen Waltensperger
11 ³⁰	<i>Grupi punës, ushtrimi Nr.1- Temat e diskutimit (përfshihet edhe pushimi i kafesë)</i>	
	Ushqyerja	A - Dr. Ermira Brasha B - Dr. Fabian Cenko
	Sëm, Respiratore+Diarrea (MISF)	A - Dr. Blendi Gura B - Dr. Artan Isaraj
	Planifikimi Familjar	A - Dr. Gazmend Koduzi B - Dr. Halil Stana
13 ³⁰	Dreka	
15 ⁰⁰	Raportimi i grupeve të punës	Dr. Gazmend Koduzi
16 ⁰⁰	<i>Grupi i punës, ushtrimi Nr.2- Prioritetet sipas Rretheve (përfshihet edhe pushimi kafesë)</i>	
	Rrethi Dibër	Dr. Mustafa Ndreka Dr. Fabian Cenko
	Rrethi Mat	Dr. Halil Stana Dr. Gazmend Koduzi
	Rrethi Bulqizë	Dr. Blendi Gura Dr. Ermira Brasha
17 ⁰⁰	Fundi i ditës së parë	

Dita e dytë

9 Mars, e Martë

DREJTUESIT/LEHTËSUESIT

09 ⁰⁰	Prezantimi i Ditës së I-rë të Seminarit	Dr. Fabian Cenko
09 ¹⁵	Raportimi i grupeve të punës	Dr. Gazmend Koduzi
10 ⁰⁰	<i>Grupi punës, ushtrimi Nr.3 – Partneriteti dhe bashkëpunimi</i>	
	Mekanizmat këshillimore të Projektit	Dr.Ermira Brasha
	Rekrutimi dhe mbajtja e vullnetarëve	Plejada Gugashi Dr. Halil Stana
	Bashkëpunimi/sinergjizimi me partnerët	Karen Waltensperger Dr. Fabian Cenko
	Grupi i fokusuar në infermjere/mami të fshatit	Dr. Gazmend Koduzi
11 ³⁰	Pushimi i kafesë	
12 ⁰⁰	Raportimi i grupeve të punës	Dr.Gazmend Koduzi
13 ⁰⁰	Pyetje dhe hapat në vijim	Dr. Fabian Cenko
13⁴⁵	Fundi i ditës së dytë	
13 ⁴⁵	Çështjet administrative	Alketa Kuka, Anila Gjoni

Projekti “Mbijetesa e Femijeve ne Shqiperi”
Seminari Plani i Detajuar i Zbatimit
Peshkopi, Shqiperi
8-9 Mars, 2004

Objektivat

- 1 Rritja e njohurive te aktoreve te ndryshem te Programit te Mbijeteses se Femijeve ne Shqiperi
- 2 Angazhimi i aktoreve te ndryshem, ne fazen e projektimit
- 3 Rekomandimi I strategjive te nderhyrjes (aktivitetet)
- 4 Prioritetet e nderhyrjes, te rekomanduara nga rrethi
- 5 Rekomandimi mekanizmave keshillimor te Projektit
- 6 Rekomandimi Direktivave te rekrutimit dhe mbajties se Vullnetareve
- 7 Rolet dhe sinergjite e partnereve te percaktuara
- 8 Angazhimi I Infermiereve/mamive ne nivel fshati

List of Participants and Facilitators DIP Workshop, 8-9 March 2003

Facilitators:

1. Malik Jaffer Senior Regional Associate, Central Asia & Middle East Europe
2. Karen Waltensperger ARC Regional Health Delegate
3. Fabian Cenko ACSP Manager
4. Gazmend Koduzi ACSP Deputy Manager
5. Artan Isaraj ACSP Technical Officer
6. Ermira Brasha ARC Senior Liaison Officer
7. Blendi Gurra Director of Public Health, Bulqiza District
8. Halil Stana Epidemiologist in Tirana Public Health Directorate

Participants:

1. Zhaneta Shatri USAID Health Specialist
2. Dorina Tocaj USAID/URC Advocacy Officer
3. Erol Come Head of Primary Health Care Department, MoH
4. Gazmend Bejtja Chief of Chronic Diseases Department, IPH

Red Cross Partners:

5. Hajdar Bashkurti Head of Health Department, AlbRC
6. Ardiana Peci AlbRC CS National Health Coordinator
7. Eugen Jonuzi Branch Development Coordinator, AlbRC
8. Carmen Isasi Head of Delegation, Spanish RC/Albania
9. Valbona Halili Project Officer, Spanish RC
10. Entela Noka Project Officer, Spanish RC

Representatives from local governmental/health authorities and community:

11. Rasim Skura Chairman of Diber Branch, AlbRC
12. Fitim Dani Mat Subbranch Administrator
13. Hamit Lumi Diber Prefecture General Secretary
14. Mustafa Ndreka Director of PH, Diber
15. Dilaver Corja PHC Director
16. Flutura Paci Nurse/KPC Interviewer, Peshkopi
17. Anife Hysa Midwife, Slllove Health Center
18. Gjile Mirku Nurse Midwife, Peshkopi
19. Flora Muca Nurse Midwife, Maqellare Health Centre
20. Lulzime Pilafi CCF Project Coordinator
21. Hanke Shehu "Mother and child garden" office administrator, CCF
22. Peme Cibaku Midwife, CCF project
23. Marjana Cibaku "Mother and child garden" administrator, CCF
24. Flutura Bulku "Mother and child garden" administrator, CCF
25. Manushaqe Reka "Mother and child garden" administrator, CCF
26. Sabrie Vranici "Mother and child garden" administrator, CCF
27. Lindita Gjoni Midwife, CCF project
28. Meliha Rama "Mother and child garden" administrator, CCF

- | | |
|-----------------------|--|
| 29. Vjollca Nacufi | “Mother Leader, CCF project |
| 30. Gani Korsita | PHC Director, Mat |
| 31. Marie Lala | Head of health promotion Department, Mat |
| 32. Zana Diku | Midwife, Suc Health Center |
| 33. Sanie Meta | Doctor Assistant/AlbRC First Aid Coordinator |
| 34. Dallendyshe Gjoka | GP/KPC & HFA Interviewer |
| 35. Hamza Truka | Village Nurse, Bulqiza |
| 36. Bihane Sallaku | Village Nurse Midwife, Bulqiza |
| 37. Fatmira Hasa | Village Nurse Midwife, Bulqiza |
| 38. Mite Okshtuni | Head of PHC, Bulqiza |
| 39. Sabrie Toska | Mother and Child Inspector, Bulqiza |
| 40. Elvana Istrefi | Mother and Child Inspector in Diber Prefecture |
| 41. Zyra Hysa | Doctor, Diber |
| 42. Robbie | Peace Corps Volunteer |
| 43. Sarie Liksala | Nurse Midwife, Burrel |
| 44. Bakushe Kadria | Nurse, Burrel |

American Red Cross and ACSP Staff:

- | | |
|--------------------|--------------------------------|
| 45. Nancy Campbell | ARC Regional Finance Delegate |
| 46. Anila Gjoni | Finance Officer, Tirana Office |
| 47. Alketa Kuka | Cashier/Receptionist |
| 48. Getjana Bulku | Project Assistant |
| 49. Teuta Mazari | Office Manager |

Working Group Assignment
DIP Workshop, November 8-9, Peshkopi

WORKING GROUP #1 FAMILY PLANING-A	
*1	Gazmend Koduzi
2	Zhanetra Shatri
3	Mother and Child Inspector, Diber
4	Zane Dike
5	Nurse Midwife/Bulqiza
6	Flutura Paci
7	Peme Cibaku
8	Plejada Gugashi
9	Meliha Rama
10	Hamdie Beqiri

WORKING GROUP #1 FAMILY PLANING-B	
*1	Halil Stana
2	Dorina Tocaj
3	Marie Lala
4	Farie Gjoka
5	Infermjere/Mami Bulqiza
6	Anife Hysa
7	Mite Okshtuni
8	Vjollca Nacufi
9	Carmen Isasi
10	Valbona Halili

WORKING GROUP #1 NUTRITION-A	
*1	Mira Brasha
2	Roland Keta
3	Mynyr Myftari
4	Entela Noka
5	Eugen Jonuzi
6	Mustafa Ndreka
7	Nurse/midwife/Maqellare
8	Hanke Shehu
9	Manushaqe Reka
10	Nazmije Koci

WORKING GROUP #1 NUTRITION-B	
*1	Fabian Cenko
2	Iilir Klosi
3	Erol Come
4	Sabri Toska
5	Rasim Skura
6	Gjile Mirku
7	Lulzime Pilafi
8	Marjana Cibaku
9	Lindita Gjoni
10	Evisa Pertafi

WORKING GROUP #2 NUTRITION-A	
*1	Mira Brasha
2	Roland Keta
3	Mynyr Myftari
4	Entela Noka
5	Eugen Jonuzi
6	Mustafa Ndreka
7	Nurse/midwife/Maqellare
8	Hanke Shehu
9	Manushaqe Reka
10	Nazmije Koci

WORKING GROUP #2 NUTRITION-B	
*1	Fabian Cenko
2	Ilir Klosi
3	Erol Come
4	Sabri Toska
5	Rasim Skura
6	Gjile Mirku
7	Lulzime Pilafi
8	Marjana Cibaku
9	Lindita Gjoni
10	Evisa Pertafi

WORKING GROUP #3 IRA/CDD (IMCI)-A	
*1	Artan Isaraj
2	Rezarta Musaj
3	Hajdar Bashkurti
4	Dilaver Corja
5	Peme Cibaku
6	Sabrie Vranici
7	Dallendyshe Gjoka
8	Hasan Ceni
9	Sanie Meta
10	Nurse/midwife Bulqiza

WORKING GROUP #3 IRA/CDD (IMCI)-B	
*1	Blendi Gura
2	Ardiana Peci
3	Gazmend Bejtja
4	Linda Spahiu
5	Flutura Bulku
6	Meliha Rama
7	Skender Lleshi
8	Gani Korsita
9	Roland Keta
10	Marjana Bukli

WORKING GROUP #2 DISTRICT PRIORITY-DIBËR	
*1	Mustafa Ndreka
*2	Fabian Cenko
3	Vjollca Nacufi
4	Meliha Rama
5	Ilir Klosi
6	Dilaver Corja
7	Flutura Paci
8	Anife Hysa
9	Gjile Mirku
10	Maqellare/Mami dhe infermjere
11	Lulzime Pilafi
12	Hanke Shehu
13	Peme Cibaku
14	Marjana Cibaku
15	Flutura Bulku
16	Manushaqe Reka
17	Sabrie Vranici
18	Lindita Gjoni

WORKING GROUP #2 DISTRICT PRIORITY-MAT	
*1	Halil Stana
*2	Gazmend Koduzi
3	Rasim Skura
4	Skender Lleshi
5	Gani Korsita
6	Marie Lala
7	Eugen Jonuzi
8	Zane Dika
9	Sanie Meta
10	Faje Gjoke
11	Dallendyshe Gjoka
12	Zhaneta Shatri
13	Gazmend Bejtja
14	Karmen Isasi
15	Valbona Halili
16	Hajdar Bashkurti

WORKING GROUP #2 DISTRICT PRIORITY-BULQIZË	
*1	Blendi Gurra
*2	Mira Brasha
3	Mynyr Myftari
4	Entela Noka
5	Infermjere/Mami Bulqize
6	Infermjere/Mami Bulqize
7	Infermjere/Mami Bulqize
8	Dorina Tocaj
9	Artan Isaraj
10	Mite Okshtuni
11	Ardiana Peci
12	Sabri Toska

WORKING GROUP #3 RECRUITMENT AND RETENSION OF VOLUNTEERS	
*1	Halil Stana
*2	Eugen Jonuzi
3	Vjollca Nasufi
4	Valbona Halili
5	Dallendyshe Gjoka
6	Rasim Skura
7	Manushaqe Ndreka
8	Mynyr Myftari
9	Gani Korsita
10	Meliha Rama
11	Hanke Shehu
12	Flutura Bulku

WORKING GROUP #3 ADVISORY MECHANISMS FOR THE PROJECT	
*1	Mira Brasha
2	Ardiana Peci
3	Sabri Toska
4	Iilir Kroshi
5	Mustafa Ndreka
6	Dilaver Corja
7	Marie Lala
8	Blendi Gurra
9	Lulzime Pilafi
10	Marjana Cibaku
11	Sabrie Vranici

WORKING GROUP #3 COLABORATION AND SYNERGY WITH PARTNERS	
*1	Fabian Cenko
*2	Karen Waltensperger
3	Linda Spahiu
4	Zhaneta Shatri
5	Dorina Toci
6	Marjana Bukli
7	Carmen Isasi
8	Gazmend Bejtja
9	Erol Come

WORKING GROUP #3 NURSE MIDWIFE FOCUS GROUP	
*1	Sanie Meta
*2	Gazmend Koduzi
3	Hajdar Bashkurti
4	Flutura Paci
5	Anife Hysa
6	Gjyle Mirku
7	Maqellare Infermjere/Mami
8	Peme Cibaku
9	Lindita Gjoni
10	Artan Isaraj
11	Zane Dika
12	Faja Gjoka
13	Mami/Infermjere Bulqiza
14	Mite Okshuni
15	Mami/Infermjere Bulqiza
16	Mami/Infermjere Bulqiza

WORKSHOP
- DETAILED IMPLEMENTATION
PLAN
PRESENTATION OF THE
SMALL GROUPS

Intervention fields: Nutrition
Group - A

- Strategies in HEALTH FACILITIES level:
 - 1. Free distribution of iron/folate and vitamin A (Maternity/Health Centre)
 - 2. Training of health workers (maternity and health centre) including awareness on importance of iodized salt usage
 - 3. Providing adequate equipments
 - Barriers
 - 1. Lack of vitamin A and iron/folate available in facilities
 - 2. Negligence and abuse by the health staff

Intervention Field: Nutrition

Group - A

- Strategies in NURSE/MIDWIFE level:
 - 1. Training of the nurses/midwives on nutrition and how to work with the community
 - 2. Facilitate/engage roles and responsibilities of RC Health Volunteers
 - 3. Mother-support training in Nutrition
 - Barriers:
 - 1. Lack of nurses/midwives
 - 2. Uncontrolled demographic population movements

Intervention Field : Nutrition

Group - A

- Strategies in HOUSEHOLD/COMMUNITY level:
 - 1. Providing trainings to special target groups (grandmothers/mothers in-law, men, new mothers)
 - 2. Providing promotional materials (leaflets, posters, etc)
 - 3. Household visits/and family counseling and free distribution of iron for new mothers
- Barriers
 - 1. Village is overspread and big distance house to house
 - 2. Lack of money, tradition, women are overloaded with house and field works

Intervention Field: Nutrition

Group - B

- Strategies in HEALTH INSTITUTIONS level:
 - 1. Supplementation of vitamin A for children 6-11 months
 - 2. Immediate breastfeeding in health facility
 - 3. Treatment and daily follow-up for pregnant women's diet (iron + acid folic)
- Barriers
 - 1. Lack of Vitamin A
 - 2. No adequate follow-up of the child nutrition by health worker in consulting mother and child centre
 - 3. Financial barriers for providing micronutrient/nutrient's supplementation

Intervention Field : Nutrition

Group - B

- Strategies for NURSES/MIDWIVES level:
 - 1. Identification of pregnant women within first 3-months of pregnancy
 - 2. Raising Awareness of grandmothers/grandfathers
 - 3. Consulting new mothers on delivery/postnatal

Barriers:

- 1. Cultural barriers
- 2. Usage of old-fashioned nutrition methods within the family
- 3. Partly informed or out-dated knowledge of midwives
- 4. Lack of information-education-communication
- 5. Lack of budget to be managed by urban/rural ambulance

Intervention Field: ARI & Diarrhea (IMCI) – Group A

- Strategies in HEALTH INSTITUTIONS level:
 - 1. Improvement of health service infrastructure
 - 2. Training of health personnel
 - 3. Develop/Produce and distribution of Health related information

Barriers:

- 1. Lack of minimum professional knowledge of health staff
- 2. Inadequate infrastructure
- 3. Lack of records/other information with regards to health facilities
- 4. Local authorities (including health authorities) do not support the program implementation

Intervention Field: IRA & Diarrhea (IMCI) – Group A

- Strategies for NURSES/MIDWIVES level:
 - 1. Professional trainings
 - 2. Equipments and supplies
 - 3. Monitoring and follow-up of health workers knowledge trend
 - 4. Proper diagnose and treatment protocols

Barriers:

- 1. Lack of awareness for the CS project and/or neglected
- 2. Poor Health Service's infrastructure
- 3. Lack of minimal required professional knowledge of health professionals

Intervention Field: ARI & Diarrhea

(IMCI) – Group A

- Strategies in HOUSEHOLD/COMMUNITY level:
 - 1. Dissemination of health messages through media (TV Spots, TV talks, etc.)
 - 2. Develop materials to target specific groups
 - 3. Provide ORS packages for free
 - 4. Develop and distribute leaflets/posters in visible places
- Barriers:
 - 1. Poor health service's infrastructure
 - 2. Economic and social problems
 - 3. Ignore of issues with regards to health
 - 4. Habits/Tradition

Intervention Field: ARI & Diarrhea

(IMCI) – Group B

- Strategies in HEALTH INSTITUTIONS level:
 - 1. Training of health personnel with up to date health related topics (IMCI)
 - 2. Organize continuous one to one/group health talks with pregnant women and mothers with regards to CDD/ARI
 - 3. ORT corner
- Barriers:
 - 1. Lack of professional and ongoing trainings
 - 2. Lack of working conditions and most needed equipment and supplies

Intervention Field: Family Planning – Group A

- Strategjitë që mund të zbatohen në nivel
INSTITUCIONE SHENDETESORE
 - 1. Providing health facilities with contraception methods
 - 2. Promoting FP during pregnancy visits (Women consultancy centre)
 - 3. Continues professional trainings for health staff
- **Barriers:**
 - 1. Insufficient availability with contraception methods
 - 2. Lack of health personnel

Intervention Field: Family Planning – Group A

- **Strategies for NURSES/MIDWIVES level:**
 - 1. Training, professional grow-up of nurses/midwives in village level
 - 2. Promotion of FP during prenatal and postnatal follow-up
 - 3. Appropriate provision with contraception methods and health information
- **Barriers:**
 - 1. Too far from the FP service providers
 - 2. Lack of training for appropriate counseling and contraception's side effects

Intervention Field: Family Planning – Group A

- Strategies in HOUSEHOLD/COMMUNITY level:
 - 1. Target group's training
 - 2. Couple counseling for FP
 - 3. Training of Health Community Workers in villages with no health personnel
- Barriers:
 - 1. Wrong beliefs for FP and side effects
 - 2. Health workers do not respect the privacy of clients

Intervention Field: Family Planning – Group B

- Strategies in HEALTH INSTITUTIONS level:
 - 1. Appropriate health education, dissemination of information, counseling of all women of reproductive age
 - 2. Develop health information materials
 - 3. Counseling and providing with different contraception methods
 - 4. Continues development of informative bulletins
- Barriers:
 - 1. Lack of health information materials
 - 2. Lack of contraceptive methods
 - 3. Infrastructure

Intervention Field: Family Planning – Group B

- Strategies for NURSES/MIDWIVES level:
 - 1. Counseling of all women of reproductive age on modern FP methods
 - 2. Provide information and referrals
 - 3. Dissemination of information materials with regards to FP
- Barriers
 - 1. Lack of materials
 - 2. Lack of FP facilities

Intervention Field: Family Planning – Group B

- Strategies in HOUSEHOLD/COMMUNITY level:
 - 1. Couple counseling methodology
 - 2. Youth focus group meetings and trainings about FP
 - 3. Men focus group meetings and trainings about FP
- Barriers
 - 1. Lack of motivation to work
 - 2. Old mind sets and beliefs while discussing FP and contraception methods

PRIORITIES IN MAT

- Family Planning
- Nutrition
- IRA/KSD

Town level

1. Training of health worker (family doctor and nurse) in such topics as FP+IRA/KSD
2. Provision with informative materials
3. Provision with contraceptive and relative kancelarite
4. Educative work with the youth of the high schools
5. Collaboration with Mass Medias (Awareness spots and informing conversations)

5. Educative work with pregnant women in the women consultation center and the family doctor during pre-natal care
6. Advice before abortion (it's a moment when the wife and the husband are together with the doctor)
7. Supervision of the activities related with FP.

Village level

1. Training of the midwife/nurse in the village
2. Training of the AIRC volunteers as educative volunteers, in those places where there is no medical staff
3. Use of positive models by the community that have been using FP methods for a long time, regularly and without side effects (peers education)
4. Youth education

5. Training of the teachers who teach
“Edukata shendetesor”
5. Providing the staff with informing materials
6. Provision with contraceptives
7. Working with mothers who have lots of children and who live under very low economical level
8. Supervision and LMIS
9. Promoting work on FP with pregnant women during pre-natal visits and post-natal follow-up.

- Time of intervention
As soon as the project starts to be implemented in the field
- How it will be intervened?
Primary Health Directorate and the medical staff of Mat district, will support/help according to their possibilities the staff of the “Child Survival in Albania” Project, to implement all the planed interventions providing meeting rooms/training places/halls, health workers, their time, etc.

PRIORITIES IN BULQIZE DISTRICT

IMCI

20% training of the untrained staff

Refreshing courses

Community

NUTRITION

Training in health centers' level

Training of the health workers

Maternity/Health Center

FAMILY PLANNING

Consultation worker / Village midwife

Community

COLLABORATION AND SYNERGY

- **URC/USAID**
 - Packets for the community
 - Materials preparation + Testing
- **UNICEF**
 - Preparing and testing of the IMCI models
- **PUBLIC HEALTH INSTITUTE**
 - Surveying
 - Health Information System-Unification of the systems with PHI/MoH
(Chronic Diseases with URC)

COLLABORATION AND SYNERGY

- LOCAL HEALTH AUTHORITIES
 - Packets for the community
 - Materials preparation + Testing
- The interest of the community on IMCI is higher than on Family Planning
 - Volunteers
- SPANISH RED CROSS
 - Development projects on women through the AIRC.
 - Organizational development / Capacities Development

COLLABORATION AND SYNERGY

- PEACE CORPS
 - Health Volunteers in Diber district
- NURSE/ MIDWIVES IN VILLAGE LEVEL
 - Replacing after leaving the work (retirement or resigning)
 - New nurses who have completed a 9-month course

PARTNERITETI DHE BASHKEPUNIMI

- URC/USAID
 - Paketen e komunitetit
 - Materiale per zhvillim + Testime
- UNICEF
 - Zhvillon + testim modelesh te MISF-per komunitetin
- INSTITUTE I SHENDETIT PUBLIK
 - Survejance
 - Sistemi shendetesor i informacionit-Unifikimin e sistemit Drejtoria e Shendetit Publik/MSH (Semundjet kronike/URC)

PARTNERITY AND COLLABORATION

- Autoritetet locale
 - Interesti per MISF-in eshte me I madhe se per PF
 - Voluntare
- KK Spanjoll
 - Projekte zhvillimi per gratene bashkepunim me KKSH
 - Zhvillim organizativ/Rritje kapacitetesh

PARTNERITY AND COLLABORATION

- PEACE CORPS
 - Health volunteer in Dibra Prefecture
- NURSES/MIDWIVES
 - (REPLACEMENT)
 - Requested by the Village leaders (Bulqize)
 - 9-month courses

FOCUS ON NURSES/MIDWIVES VILLAGE LEVEL

- How has the Midwives/Nurses role changed during the 13-last years?
 - There is less interest for the work
 - It is more informed
 - It is increased the inters of the community
 - Neglecting in fulfilling the tasks
 - There is less supervision in each level
 - It is increased the interest of the community for services

FOCUS ON NURSES/MIDWIVES VILLAGE LEVEL

- What are the difficulties they face during their daily work
 - Lack of infrastructure (consulting room, ambulance)
 - Lack of technical materials (working materials/equipments)
 - Need of now-days professional information
 - Big distance of the working place from the dwelling places
 - Material motivation (low salary)
 - Big demography movement of the community
 - Community mentality
 - Provision with drugs (iron, acid folic, contraceptives, ORS etc.)
 - Lack of informative materials for the community

FOCUS ON NURSES/MIDWIVES VILLAGE LEVEL

- How do you see/imagine your position 5-years later?
 - To work in a consulting office well equipped
 - Better salary
 - Better knowledge level (trained)
 - Increase the service towards the community
 - Healthy community
- Would you like to advice the community on FP?
 - YES
- Would you like to provide contraceptives to the community?
 - YES, if provided with contraceptives

CONSULTING MECHANISMS OF THE PROJECT

- Setting up consulting board in different levels:
 - - Village level (the board meets once a month):
Composition: health volunteer of RC/Village leader/nurse/midwife/active teacher /others
 - Commune Level (the board meets once a month):
Composition: Doctor of the HC/Representative from the villages boards /Nurses and midwives/ RC volunterr/ Head of the Commune.

CONSULTING MECHANISMS OF THE PROJECT

- District level (board meets once each 3 months):
Composition: Mother-child Instructor/Obstetric, Genecology Chef / Pediatric chef/ Primary Health Directorate/ Responsible person on FP/ RC/ community representatives/ Women NGO
- Prefecture Level (board meets once each 4-months):
Composition: PHD of the three districts/ Primary Health Directorate/ Health Pergjegjes for the Prefecture/ Women Organisation/ Coordinator of the local organizations/ RC/ Peace Corps
- National Level (board meets once each 4-months):
Composition: AIRC/AmRC/MoH+PHD/IMCI including UNICEF/MoH/WHO/representatives of the prefecture board

VOLUNTEER RECRUITMENT AND RETENTION

- Which are the easiest ways on volunteer recruitment?
 - a-awareness of the community on the importance of the project
 - b-Intervention in the high schools in order to recruit volunteers or teachers
- c-Selection of the people who have free time and desire to be involved in the project
- d-Awareness through media/ TV. Spots
- e-Involvement and the estimation of the volunteer's work

VOLUNTEER RECRUITMENT AND RETENTION

- How can the men be involved in the project as volunteers?
 - a-Informing and awarning them on the impact of the project
 - b-Awareness of men through their wives
 - c-Collaboration with the village leader
 - d-Operating in those places where there are more males including even meeting with parents at schools and kinder-gardens.

VOLUNTEER RECRUITMENT AND RETENTION

- How can be monitored the work done by the volunteers?
 - a-Compiling the activities plan for thevolunteers
 - b- Having regular meetings with the volunteers
 - c- The volunteers present verifying materials on their work through, e.g photos/video,etc.
 - d-Through the community by completing special questionnaires

VOLUNTEER RECRUITMENT AND RETENTION

- Volunteer's qualities ?

Humanism/Voluntarism/Be active/Knows the Community Problems/ At least with High school Level/ respected by the community/ High moral/ motivated/trustful/ communicative abilities/ listener/age-especially over 35 years-old.
- Is it possible to have volunteers for a 5-year-time? YES, if it is found the right way of selection and age criteria

VOLUNTEER RECRUITMENT AND RETENTION

- Which are the way in motivation the volunteers:
 - a-Charging concrete responsibilities to them
 - b-Involving them in different topic training
 - c-Providing Certificates on their work done and training participation
 - d-Evaluation of their work through medias etc.
 - e-Entertaining activities
 - f-Shirts/T-shirts/bags/hats/ ID cards...RC logos

VOLUNTEER RECRUITMENT AND RETENTION

- What trainings must the health volunteers' complete/follow:
 - a-Communicative abilities
 - b-Health as . FP/Nutrition/diarrhea/ARI etc.
 - c-Training on AIRC/Principles
 - d-Course on first aid

ANNEX 10

Population Based Family Planning Survey

USAID OFFICE OF POPULATION AND REPRODUCTIVE HEALTH
 FLEXIBLE FUND FAMILY PLANNING SURVEY
 WOMAN'S QUESTIONNAIRE
REVISED VERSION FEBRUARY 19, 2004

IDENTIFICATION																								
PLACE NAME _____	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																							
CLUSTER NUMBER																								
HOUSEHOLD NUMBER																								
RECORD NUMBER																								
REGION																								
URBAN/RURAL (URBAN = 1, RURAL =2)																								
NAME OF HEAD OF HOUSEHOLD _____																								
NAME OF WOMAN _____																								
INTERVIEWER VISITS																								
	1	2	FINAL VISIT																					
DATE			DAY <input style="width: 20px;" type="text"/>																					
INTERVIEWER'S NAME			MONTH <input style="width: 20px;" type="text"/>																					
NEXT VISIT:			YEAR <input style="width: 20px;" type="text"/>																					
DATE			<input style="width: 20px;" type="text"/>																					
TIME																								
RESULT CODE	<input style="width: 20px; height: 20px;" type="checkbox"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>	<input style="width: 20px; height: 20px;" type="checkbox"/>																					
RESULT CODES: 1 = COMPLETED 2 = NOT AT HOME 3 = POSTPONED 4 = REFUSED 5 = PARTLY COMPLETED 6 = INCAPACITATED																								
SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY																					
NAME_	NAME																							
DATE	DATE																							
<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>																					

SECTION 1: RESPONDENTS BACKGROUND

INTRODUCTION AND INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a survey about the health of women and children. We would very much appreciate your participation in this survey. I would like to ask you about your health and family life. This information will help the government Ministry of Health and other organizations to plan local health services. This survey will take about ___ to ___ minutes to complete. Whatever information you provide to (NAME OF ORGANIZATION) will remain confidential. We will not pass on your name or the information you provide to any other parties. We will contact you again only if we have a question (or questions) that need(s) to be clarified.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

Signature of interviewer: _____ Date: _____
(day, month, year)

CIRCLE ONE:

RESPONDENT DOES NOT AGREE TO INTERVIEW.....1 → END; DO NOT INTERVIEW WOMAN

RESPONDENT AGREES TO INTERVIEW.....2 → BEGIN INTERVIEW

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME	HOUR..... [][] MINUTES..... [][]	
102	How old were you at your last birthday? COMPARE AND CORRECT 102 AND 103 IF INCONSISTENT	AGE IN COMPLETED YEARS..... [][][]	
103	Have you ever attended school?	YES.....1 NO.....2	→ 107
104	What is the highest level of school you attended: primary, secondary, or higher?	PRIMARY.....1 SECONDARY.....2 HIGHER.....3	
105	What is the highest grade or year you completed at that level?	GRADE..... [][]	
106	CHECK 104: HIGHEST LEVEL OF SCHOOL: PRIMARY (CODE 1) <input type="checkbox"/> ↓	SECONDARY OR HIGHER (CODE 2) <input type="checkbox"/> ⇒	→ 108

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
107	<p>Now I would like to you to read this sentence to me.</p> <p>SHOW CARD TO RESPONDENT</p> <p>IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE:</p> <p>Can you read any part fo the sentence to me?</p> <p>NOTE: EACH CARD SHOULD HAVE FOUR SMIPLE SENTENCES (FOR EXAMPLE, "PARENTS LOVE THEIR CHILDREN", "THE CHILD IS READING A BOOK", ETC)</p>	<p>CANNOT READ AT ALL.....1</p> <p>ABLE TO READ ONLY PARTS.....2</p> <p>ABLE TO READ WHOLE SENTENCES.....3</p> <p>NO CARD WITH REQUIRED LANGUAGE.....4</p> <p>BLIND/VISUALLY IMPAIRED.....5</p>	
108	COUNTRY-SPECIFIC QUESTION ON RELIGION (OPTIONAL)		
109	COUNTRY-SPECIFIC QUESTION ON ETHNICITY (OPTIONAL)		

PROCEED TO NEXT SECTION→

SECTION 2: REPRODUCTION AND CHILD SPACING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES.....1 NO.....2	→ 206																
202	How many children have you given birth to? Include any children born alive, including those who cried or showed signs of life but did not survive.	TOTAL NUMBER OF CHILDREN EVER BORN ALIVE..... <input type="text"/>																	
203	How many children living in this household are under five years of age?	NONE.....0 ONE CHILD.....1 TWO CHILDREN.....2 THREE OR MORE.....3	→ 206																
204	How many of those children are your biological children?	ONE CHILD.....1 TWO CHILDREN.....2 THREE OR MORE.....3	→ 206																
205	What is the sex and date of birth of your two youngest children?	<table border="1"> <thead> <tr> <th>YOUNGEST CHILD</th> <th>SECOND YOUNGEST CHILD</th> </tr> </thead> <tbody> <tr> <td align="center"><u>SEX</u></td> <td align="center"><u>SEX</u></td> </tr> <tr> <td>MALE.....1</td> <td>MALE.....1</td> </tr> <tr> <td>FEMALE.....2</td> <td>FEMALE.....2</td> </tr> <tr> <td align="center"><u>DATE OF BIRTH</u></td> <td align="center"><u>DATE OF BIRTH</u></td> </tr> <tr> <td>DAY <input type="text"/></td> <td>DAY <input type="text"/></td> </tr> <tr> <td>MONTH <input type="text"/></td> <td>MONTH <input type="text"/></td> </tr> <tr> <td>YEAR <input type="text"/></td> <td>YEAR <input type="text"/></td> </tr> </tbody> </table>	YOUNGEST CHILD	SECOND YOUNGEST CHILD	<u>SEX</u>	<u>SEX</u>	MALE.....1	MALE.....1	FEMALE.....2	FEMALE.....2	<u>DATE OF BIRTH</u>	<u>DATE OF BIRTH</u>	DAY <input type="text"/>	DAY <input type="text"/>	MONTH <input type="text"/>	MONTH <input type="text"/>	YEAR <input type="text"/>	YEAR <input type="text"/>	
YOUNGEST CHILD	SECOND YOUNGEST CHILD																		
<u>SEX</u>	<u>SEX</u>																		
MALE.....1	MALE.....1																		
FEMALE.....2	FEMALE.....2																		
<u>DATE OF BIRTH</u>	<u>DATE OF BIRTH</u>																		
DAY <input type="text"/>	DAY <input type="text"/>																		
MONTH <input type="text"/>	MONTH <input type="text"/>																		
YEAR <input type="text"/>	YEAR <input type="text"/>																		
207	From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant if she has sexual relations?	YES.....1 NO.....2 DON'T KNOW.....3	→ 209 → 209																
208	Is this time just before her period, during her period, right after her period has ended, or halfway between her two periods?	JUST BEFORE HER PERIOD BEGINS.....1 DURING HER PERIOD.....2 RIGHT AFTER HER PERIOD HAS ENDED.....3 HALFWAY BETWEEN TWO PERIODS.....4 OTHER.....5 (SPECIFY) DON'T KNOW.....8																	
209	In the past 12 months, have you experienced a miscarriage or a pregnancy termination?	YES.....1 NO.....2 DON'T KNOW/ REFUSED.....3																	

PROCEED TO NEXT SECTION →

SECTION 3: KNOWLEDGE AND EVER USE OF CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
<p>Now I would like to talk about family planning—the various ways or methods that a couple can use to delay or avoid a pregnancy.</p> <p>ASK THE QUESTION 301 (FIRST COLUMN):</p> <p>Which ways have you heard about?</p> <p>FOR EACH METHOD LISTED MENTIONED SPONTANEOUSLY, CIRCLE “1” (YES) IN THE COLUMN 301 TO INDICATE THAT WOMAN HAS HEARD OF METHOD. THEN PROCEED DOWN THE LIST OF METHODS, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE “1” IN COLUMN 301 IF THE METHOD IS RECOGNIZED, AND CODE “2” IF NOT RECOGNIZED.</p> <p>THEN, FOR EACH METHOD WITH CODE “1” IN COLUMN 301, ASK BOTH QUESTIONS 302 AND 303 “DO YOU KNOW OF A PLACE YOU COULD OBTAIN (METHOD)?” AND “HAVE YOU EVER USED (METHOD)?” FOR BOTH THESE QUESTIONS, CODE “1” IF THE ANSWER IS “YES” AND CODE “2” IF THE ANSWER IS “NO”.</p>					
	METHOD	301	302	303	
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?	
A	FEMALE STERILIZATION Women can have an operation to avoid having any more children	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	
B	MALE STERILIZATION Men can have an operation to avoid having any more children	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	
C	PILL Women can take a pill every day to avoid becoming pregnant	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	
D	IUD Women can have a loop or coil placed inside them by a doctor or nurse	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	
E	INJECTABLES Women can have an injection by a health provider which stops them from becoming pregnant for one or more months	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	
F	IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2	

	METHOD	301	302	303
	Which ways have you heard about? PROBE: Have you heard of (METHOD)?		Do you know where to obtain (METHOD)?	Have you ever used (METHOD)?
G	CONDOM Men can put a rubber sheath on their penis before sexual intercourse	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
H	FEMALE CONDOM Women can place a sheath in their vagina before sexual intercourse	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
I	DIAPHRAGM Women can place a thin flexible disk in their vagina before intercourse	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
J	FOAM OR JELLY Women can place a suppository, jelly, or cream in their vagina before intercourse	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
K	LACTATIONAL AMENORRHEA (LAM) Up to 6 months after childbirth, a woman can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
L	STANDARD DAYS METHOD A woman who is sexually active abstains (or uses a condom) on days 8 through day 19 each menstrual cycle	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
M	RHYTHM OR PERIODIC ABSTINENCE Every month that a woman is sexually active can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
N	WITHDRAWAL Men can be careful and pull out before climax	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
O	EMERGENCY CONTRACEPTION Women can take pills up to three days after sexual intercourse to avoid becoming pregnant	YES.....1 → NO.....2	YES.....1 NO.....2	YES.....1 NO.....2
P	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES.....1 → (SPECIFY)..... NO.....2	YES.....1 NO.....2	YES.....1 NO.....2

PROCEED TO NEXT SECTION →

SECTION 4: ACCESS TO FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	<p>Now I would like to ask you about family planning services in your community.</p> <p>Do you know of a place where you could obtain a method of family planning?</p> <p>IF NO, CIRCLE "Z" [DON'T KNOW]</p> <p>IF YES, ASK "Where is that?" ¹</p> <p>PROBE: "Are there any other places where you could obtain a method?"</p> <p>RECORD ALL MENTIONED.</p> <p>IF A SOURCE IS A HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE.</p> <p align="center">_____</p> <p align="center">(NAME OF PLACE)</p>	<p>PUBLIC SECTOR:</p> <p>GOVT. HOSPITAL.....A</p> <p>GOVT. HEALTH CENTER.....B</p> <p>FAMILY PLANNING CLINIC.....C</p> <p>MOBILE CLINIC..... D</p> <p>FIELDWORKER..... E</p> <p>OTHER PUBLIC.....F</p> <p>PRIVATE MEDICAL SECTOR:</p> <p>PRIVATE HOSP./CLINIC.....G</p> <p>PHARMACY..... H</p> <p>PRIVATE DOCTOR.....I</p> <p>MOBILE CLINIC.....J</p> <p>FIELDWORKER.....K</p> <p>OTHER PRIVATE MEDICAL.....L</p> <p>OTHER SOURCE:</p> <p>SHOP.....M</p> <p>CHURCH..... N</p> <p>FRIEND/RELATIVE.....O</p> <p>DON'T KNOW.....Z</p>	<p align="right">→ 501</p>
402	<p>How far away from your home is the place you can obtain a method of family planning: 5 kms or less or more than 5 kms?</p>	<p>5 KMS OR LESS1</p> <p>MORE THAN 5 KMS.....2</p> <p>DON'T KNOW..... 3</p>	
403	<p>How long does it take you to get to the place where you can obtain a method of family planning?</p>	<p>LESS THAN 1 HOUR..... 1</p> <p>1 HOUR UP TO TWO HOURS.....2</p> <p>2 HOURS UP TO 4 HOURS.....3</p> <p>MORE THAN 4 HOURS.....4</p>	

PROCEED TO NEXT SECTION →

SECTION 5: DESIRE FOR FUTURE CHILDREN

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Are you currently pregnant?	YES.....1 NO.....2 UNSURE8	→ 801
502	Do you want to have a/another child?	YES.....1 NO.....2 DON'T KNOW.....8	→ 504 → 504
503	When do you want to have your next child?	WITHIN 2 YEARS.....1 MORE THAN 2 YEARS FROM NOW.....2 UNSURE WHEN..... 8	
504	CHECK QUESTION 303A: WOMAN NOT STERILIZED <input type="checkbox"/> ↓ (CODE 2) PROCEED TO NEXT SECTION	WOMAN STERILIZED <input type="checkbox"/> ⇒ (CODE 1)	→ 602

SECTION 6: CURRENT USE OF FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES.....1 NO.....2	→ 606
602	Which method are you (or your husband/ partner) using? IF WOMAN IS STERILIZED, CIRCLE A. IF MORE THAN ONE METHOD IS MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD ON LIST	FEMALE STERILIZATION.....A MALE STERILIZATION.....B PILL.....C IUD.....D INJECTABLES.....E IMPLANTS.....F CONDOM.....G FEMALE CONDOM.....H DIAPHRAGM.....I FOAM/JELLY.....J LACTATIONAL AMEN. METHOD.....K STANDARD DAYS METHOD.....L PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS).....M WITHDRAWAL.....N OTHER.....X (SPECIFY)	
603	For how long have you (or your husband/partner) been using (CURRENT METHOD) now without stopping? PROBE: In what month and year did you start using (CURRENT METHOD) continuously? IF STERILIZED, ASK: In what month and year was the sterilization performed?	MONTH..... <input type="text"/> <input type="text"/> YEAR..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW.....Z	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
604	<p>Where did you obtain (CURRENT METHOD) when you started using it?</p> <p>IF THE WOMAN OR HER HUSBAND/PARTNER WAS STERILIZED, ASK:</p> <p>Where were you (your partner) sterilized?</p> <p>IF THE WOMAN IS USING LAM OR THE STANDARD DAYS METHOD, ASK:</p> <p>Where did you learn to use your method?</p>	<p>PUBLIC SECTOR:</p> <p>GOVT. HOSPITAL.....A</p> <p>GOVT. HEALTH CENTER.....B</p> <p>FAMILY PLANNING CLINIC.....C</p> <p>MOBILE CLINIC..... D</p> <p>FIELDWORKER..... E</p> <p>OTHER PUBLIC.....F</p> <p>_____</p> <p>(SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR:</p> <p>PRIVATE HOSP./CLINIC.....G</p> <p>PHARMACY..... H</p> <p>PRIVATE DOCTOR.....I</p> <p>MOBILE CLINIC.....J</p> <p>FIELDWORKER.....K</p> <p>OTHER PRIVATE MEDICAL.....L</p> <p>_____</p> <p>(SPECIFY)</p> <p>OTHER SOURCE:</p> <p>SHOP.....M</p> <p>CHURCH..... N</p> <p>FRIEND/RELATIVE.....O</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....Z</p>	
605	<p>Before using (CURRENT METHOD), did you ever use another method of family planning?</p>	<p>YES.....1</p> <p>NO..... 2</p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
606	CHECK 501: NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓ (CODE 2)	PREGNANT <input type="checkbox"/> ⇒ (CODE 1)	→ 801
607	You have indicated that you are not using a method of family planning. Can you please tell me the reason you are not using a method? RECORD ALL MENTIONED	NOT MARRIED.....A FERTILITY-RELATED REASONS NOT HAVING SEX.....B INFREQUENT SEXC MENOPAUSAL/HYSTERECTOMY...D SUBFECUND/INFECUND.....E POSTPARTUM AMENORRHEIC.....F BREASTFEEDING.....G FATALISTIC.....H OPPOSED TO USE RESPONDENT OPPOSED.....I HUSBAND/PARTNER OPPOSED....J OTHERS OPPOSED.....K RELIGIOUS PROHIBITION.....L LACK OF KNOWLEDGE KNOWS NO METHOD.....M KNOWS NO SOURCE.....N METHOD-RELATED REASONS HEALTH CONCERNS.....O FEAR OF SIDE EFFECTS..... P LACK OF ACCESS/TOO FAR.....Q COSTS TOO MUCH.....R INCONVENIENT TO USE.....S INTERFERES WITH BODY'S NORMAL PROCESSES..... T OTHER _____ X (SPECIFY) _____ _____	

PROCEED TO NEXT SECTION →

SECTION 7: QUALITY OF COUNSELING FOR CURRENT USERS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	<p>CHECK 602 (CURRENT METHOD).</p> <p>CIRCLE METHOD CODE.</p> <p>IF MORE THAN ONE METHOD USED, CIRCLE CODE FOR HIGHEST ON LIST</p> <p>IF NO METHOD CURRENTLY USED, CIRCLE Z</p>	<p>FEMALE STERILIZATION.....A</p> <p>MALE STERILIZATION.....B</p> <p>PILL.....C</p> <p>IUD.....D</p> <p>INJECTABLES.....E</p> <p>IMPLANTS.....F</p> <p>CONDOM.....G</p> <p>FEMALE CONDOM.....H</p> <p>DIAPHRAGM.....I</p> <p>FOAM/JELLY.....J</p> <p>LACTATIONAL AMEN. METHOD.....K</p> <p>STANDARD DAYS METHOD.....L</p> <p>PERIODIC ABSTINENCE (OTHER THAN STANDARD DAYS).....M</p> <p>WITHDRAWAL.....N</p> <p>OTHER.....X (SPECIFY)</p> <p>NO METHOD.....Z</p>	<p>→ 702</p> <p>→ 703</p> <p>→ 704</p> <p>→ 704</p> <p>→ 704</p> <p>→ 704</p> <p>→ 708</p> <p>→ 801</p> <p>→ 801</p> <p>→ 801</p> <p>→ 801</p>
702	<p>Before your sterilization, were you told that you would not have any (more) children because of your operation?</p>	<p>YES.....1</p> <p>NO.....2</p>	<p>→ 704</p> <p>→ 704</p>
703	<p>Before the sterilization operation, was your husband (or partner) told that he would not be able to have any (more) children because of the operation?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....3</p>	<p>→ 801</p> <p>→ 801</p> <p>→ 801</p>
704	<p>At the time you first started to use (CURRENT METHOD), were you told about side effects or problems you might have with the method?</p> <p>IF STERILIZED, ASK: At the time you were sterilized, were you told about side effects or problems you might have with the operation?</p>	<p>YES.....1</p> <p>NO.....2</p>	<p>→ 706</p>
705	<p>Were you <u>ever</u> told by a health or family planning worker about side effects or problems you might have with the method?</p>	<p>YES.....1</p> <p>NO.....2</p>	
706	<p>Were you told what to do if you experienced side effects or problems?</p>	<p>YES.....1</p> <p>NO.....2</p>	
707	<p>Were you told when you should return for follow-up (or when someone should be back to see you?)</p>	<p>YES.....1</p> <p>NO.....2</p>	

708	When you obtained (CURRENT METHOD) from (SOURCE OF METHOD) were you told about other methods of family planning that you could use? IF USING LAM OR STANDARD DAYS METHOD, ASK: "When you first learned (METHOD) were you told about other methods of family planning that you could use?"	YES.....1 NO.....2	→ 801
709	Were you <u>ever</u> told by a health or family planning worker about other methods of family planning that you could use?	YES.....1 NO.....2	

PROCEED TO NEXT SECTION→

SECTION 8: DIFFUSION OF FAMILY PLANNING MESSAGES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	In the past 12 months, have you discussed family planning with your husband or partner, friends, neighbors, or relatives?	YES.....1 NO.....2	→ 803
802	With whom? Anyone else? RECORD ALL PERSONS MENTIONED	HUSBAND/PARTNER.....A MOTHER.....B FATHER.....C SISTER(S).....D BROTHER(S).....E DAUGHTER.....F SON.....G MOTHER-IN-LAW.....H FRIENDS/NEIGHBORS.....I OTHER.....J	
803	In the past 12 months, have you discussed the number of children that you want with your husband or partner?	YES.....1 NO.....2 DOES NOT HAVE HUSAND/PART...3	
804	In the past 12 months, were you visited by a community health worker or promoter who talked to you about family planning?	YES.....1 NO.....2	
805	In the past 12 months, have you visited a health facility for care for yourself (or your child?)	YES.....1 NO.....2	→ 807
806	Did any staff member at the health facility speak to you about family planning methods?	YES.....1 NO.....2	
807	In the past month, have you seen or heard any messages about family planning from the following? RADIO NEWSPAPER..... TELEVISION..... HEALTH FAIR.....	YES 1 1 1 1 NO 2 2 2 2	

PROCEED TO THE NEXT SECTION→

SECTION 9: POSTPARTUM FAMILY PLANNING

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
901	<p>CHECK 204: DOES WOMAN HAVE A LIVING (BIOLOGICAL) CHILD?</p> <p align="center">YES (CODE 1)</p> <p align="center"><input type="checkbox"/></p> <p align="center">↓</p>	<p align="center">NO (CODE 2)</p> <p align="center"><input type="checkbox"/> ⇒</p>	→ 1001								
902	<p>CHECK 205: AGE OF YOUNGEST LIVING CHILD:</p> <p align="center">LESS THAN 12 MONTHS:</p> <p align="center"><input type="checkbox"/></p> <p align="center">↓</p> <p align="center">(CODE 1)</p>	<p align="center">12 MONTHS OR OLDER:</p> <p align="center"><input type="checkbox"/> ⇒</p> <p align="center">(CODE 2)</p>	→ 1001								
903	<p>Now I would like to ask a few questions about the time while you were pregnant with your youngest child.</p> <p>Did you see anyone for prenatal care while you were pregnant with (NAME)?</p> <p>IF YES, Whom did you see?</p> <p>Anyone else?</p> <p>PROBE FOR THE TYPE OF PERSON AND CIRCLE ALL PERSONS MENTIONED.</p>	<p>HEALTH PROFESSIONAL</p> <p>DOCTOR.....A</p> <p>NURSE/MIDWIFE.....B</p> <p>AUXILIARY NURSE.....C</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT.....D</p> <p>COMMUNITY HEALTH WORKER.....E</p> <p>OTHER_____ F (SPECIFY)</p> <p>NO ONE..... Z</p>	→ 905								
904	<p>During your prenatal check, were you counseled on the following?</p> <p>Breastfeeding?</p> <p>Lactational Amenorrhea Method?</p> <p>Family planning?</p>	<table border="0"> <tr> <td><u>YES</u></td> <td><u>NO</u></td> </tr> <tr> <td>1</td> <td>2</td> </tr> <tr> <td>1</td> <td>2</td> </tr> <tr> <td>1</td> <td>2</td> </tr> </table>	<u>YES</u>	<u>NO</u>	1	2	1	2	1	2	
<u>YES</u>	<u>NO</u>										
1	2										
1	2										
1	2										
905	<p>After the birth of (NAME) did anyone check on your health?</p>	<p>HEALTH PROFESSIONAL</p> <p>DOCTOR.....A</p> <p>NURSE/MIDWIFE.....B</p> <p>AUXILIARY NURSE.....C</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT.....D</p> <p>COMMUNITY HEALTH WORKER...E</p> <p>OTHER_____ F</p>									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
		(SPECIFY) NO ONE..... Z	→ 907								
906	During your postpartum check, were you counseled on the following? Breastfeeding? Lactational Amenorrhea Method? Family planning?	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><u>YES</u></td> <td style="text-align: center;"><u>NO</u></td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </table>	<u>YES</u>	<u>NO</u>	1	2	1	2	1	2	
<u>YES</u>	<u>NO</u>										
1	2										
1	2										
1	2										
907	After (NAME) was born, did you start to use a method of family planning?	YES.....1 NO.....2	→ 909								
908	Did you start to use the method within the first 6 weeks of after the first 6 weeks following (NAME's) birth?	6 WEEKS OR EARLIER.....1 7 WEEKS OR LATER.....2 DON'T KNOW.....3									
909	CHECK AGE OF YOUNGEST CHILD (SEE 205) CHILD LESS THAN 6 MONTHS <input type="checkbox"/> ↓ YES (CODE 1)	CHILD 6 MONTHS OR MORE <input type="checkbox"/> ⇒ NO (CODE 2)	→ 1001								
910	Did you ever breastfeed (NAME?)	YES.....1 NO.....2	→ 1001								
911	Are you still breastfeeding (NAME?)	YES.....1 NO.....2	→ 1001								
912	Did (NAME) receive any liquids yesterday during the day or at night besides breastmilk?	YES.....1 NO.....2	→ 1001								
913	Did (NAME) eat solid, semi-solid or soft foods yesterday during the day or at night?	YES.....1 NO.....2	→ 1001								
914	When did your last menstrual period start? DO NOT COUNT BLEEDING WITHIN THE FIRST 6 WEEKS POSTPARTUM _____	DAYS AGO.....1_ <input type="text"/> <input type="text"/> WEEKS AGO2 <input type="text"/> <input type="text"/> MONTHS AGO.....3 <input type="text"/> <input type="text"/> BEFORE BIRTH OF (NAME)...4 HAS HAD HYSTERECTOMY..6									

PROCEED TO NEXT SECTION →

SECTION 10: SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100 1	<p>I have a few more questions that I would like to ask you. Some of them ask about personal and sensitive subjects, so I want to remind you that you do not have to answer any question that you do not want to.</p> <p>Now I would like to ask you some questions about sexual activity in order to gain a better understanding of some family life issues.</p> <p>Are you currently married or living with a man?</p>	YES, CURRENTLY MARRIED.....1 YES, LIVING WITH A MAN.....2 NO, NOT IN UNION.....3	
100 2	<p>When was the last time you had sexual intercourse?</p> <p>RECORD 'YEARS AGO' ONLY IF LAST INTERCOURSE WAS ONE OR MORE YEARS AGO. IF 12 MONTHS OR MORE, RECORD ANSWER IN YEARS</p>	DAYS AGO.....1 <input type="text"/> <input type="text"/> WEEKS AGO.....2 <input type="text"/> <input type="text"/> MONTHS AGO.....3 <input type="text"/> <input type="text"/> YEARS AGO.....4 <input type="text"/> <input type="text"/>	
100 3	<p>What is your relationship to the man with whom you last had sex?</p> <p>IF MAN IS BOYFRIEND OR FIANCE, ASK "Was your boyfriend/fiance living with you when you last had sex?"</p> <p>IF YES, CIRCLE '1' IF NO, CIRCLE '2'</p>	SPOUSE/COHABITATING PARTNER.....1 MAN IS BOYFRIEND/FIANCE.....2 OTHER FRIEND.....3 CASUAL AQUAINTANCE.....4 RELATIVE.....5 OTHER.....6	
100 4	<p>The last time you had sex, was a condom used?</p>	YES.....1 NO2	→ 1101
100 5	<p>What was the main reason a condom was used on that occasion?</p>	TO PREVENT STIS/HIV..... 1 TO PREVENT PREGNANCY.....2 TO PREVENT BOTH STIS/HIV AND PREGNANCY.....3 DOESN'T TRUST PARTNER/ PARTNER HAS OTHER PARTNERS..4 PARTNER INSISTED.....5 OTHER 6 DON'T KNOW.....7 REFUSED TO ANSWER.....8	

PROCEED TO NEXT SECTION →

SECTION 11: HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1101	Have you ever heard of an illness called AIDS <i>(or the local term for AIDS)</i> ?	YES 1 NO 2	→ END
1102	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES 1 NO 2 DON'T KNOW 8	→ 1104 → 1104
1103	<p>What can a person do?</p> <p>Anything else?</p> <p>RECORD ALL MENTIONED.</p>	<p>ABSTAIN FROM SEX A</p> <p>USE CONDOMS B</p> <p>LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER ... C</p> <p>LIMIT NUMBER OF SEXUAL PARTNERS..... D</p> <p>AVOID SEX WITH PROSTITUTES..... E</p> <p>AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS.....F</p> <p>AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY . G</p> <p>AVOID CONTACT WITH CONTAMINATED BODY FLUIDS (BLOOD, SECRETIONS, ETC.) H</p> <p>AVOID UNNECESSARY INJECTIONS/ INJECTIONS BY TRADITIONAL HEALERS AND NON HEALTH PROFESSIONALS.....I</p> <p>AVOID GETTING TATOOS J</p> <p>AVOID SHARING RAZORS, BLADES.. K</p> <p>FOR MEN, AVOID HAVING SEX WITH OTHER MEN..... L</p> <p>AVOID KISSING..... M</p> <p>AVOID MOSQUITO BITES N</p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		SEEK PROTECTION FROM TRADITIONAL HEALER Q OTHER X DON'T KNOW Z	
1104	Can the virus that causes AIDS be transmitted from a mother to a child? During pregnancy? During delivery? During breastfeeding?	<p style="text-align: right;"><u>YES NO DK</u></p> DURING PREGNANCY 1 2 8 DURING DELIVERY 1 2 8 DURING BREASTFEEDING 1 2 8	
1105	If a mother is infected with the AIDS virus, is there any way to avoid transmission to the baby?	YES 1 NO 2 DON'T KNOW 8	
1106	Can a person who has AIDS be cured?	YES 1 NO 2 DON'T KNOW 8	
1107	RECORD THE TIME	HOUR [][] MINUTES [][]	

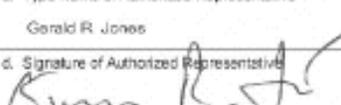
ANNEX 11

SF 424 and SF 424A

Budget Notes

**APPLICATION FOR
FEDERAL ASSISTANCE**

OMB Approval No 0948-0043

1. TYPE OF SUBMISSION Application: <input type="checkbox"/> Construction <input checked="" type="checkbox"/> Non-Construction Preapplication: <input type="checkbox"/> Construction <input type="checkbox"/> Non-Construction		2. DATE SUBMITTED 30 APRIL 2004	Applicant Identifier
3. DATE RECEIVED BY STATE		State Application Identifier	
4. DATE RECEIVED BY FEDERAL AGENCY		Federal Identifier	
5. APPLICANT INFORMATION			
Legal Name: The American National Red Cross		Organizational Unit: International Services	
Address (give city, country, state, and zip code) 2025 E Street, NW, 3rd floor Washington, DC 20008		Name and telephone number of the person to be contacted on matters involving application (give area code) Malik Jaffer, Regional Senior Associate, Europe, Central Asia & Middle East (202) 303-6049	
6. EMPLOYER IDENTIFICATION NUMBER (EIN): 53 - 0196605		7. TYPE OF APPLICANT (enter appropriate letter in box) <input type="checkbox"/> N	
8. TYPE OF APPLICATION <input type="checkbox"/> New <input type="checkbox"/> Continuation <input checked="" type="checkbox"/> Revision If Revision, enter appropriate letter(s) in box(es) <input type="checkbox"/> E A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration E. Other (specify): BUDGET REVISION		A. State H. Independent School District B. County I. State Controlled Institution of Higher Learning C. Municipal K. Indian Tribe D. Township L. Individual E. Interstate M. Profit Organization F. Intermunicipal N. Other (specify): NGO/PVO G. Special District	
9. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER TITLE: N/A		9. NAME OF FEDERAL AGENCY US Agency For International Development	
12. AREAS AFFECTED BY PROJECT (cities, countries, states, etc.) DIBER PREFECTURE, ALBANIA		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: CHILD SURVIVAL IN ALBANIA ---GHS-1-00-03-00007-00	
13. PROPOSED PROJECT: Start Date: 10/1/2003 End Date: 9/30/2008		14. CONGRESSIONAL DISTRICTS OF: a. Applicant b. Project	
15. ESTIMATED FUNDING: a. Federal \$1,099,679 b. Applicant \$1,412,064 c. State \$0.00 d. Local \$0.00 e. Other \$0.00 f. Program Income \$0.00 g. TOTAL \$2,511,733		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS? a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS REVIEW ON Date _____ b. NO <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372 <input type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT? <input type="checkbox"/> Yes If "Yes," attach an explanation <input checked="" type="checkbox"/> No		18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL CO	
a. Type Name of Authorized Representative Gerald R. Jones		b. Title Vice President, International Services	c. Telephone Number (202) 303-6270
d. Signature of Authorized Representative 		e. Date Signed 30 April 2004	

Standard Form 424A

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Headquarters	NA	NA	NA	77,653	236,621	314,274
2. Field	NA	NA	NA	1,022,027	1,175,433	2,197,459
3. NA	NA	NA	NA	NA	NA	NA
4. NA	NA	NA	NA	NA	NA	NA
5. TOTALS	NA	NA	NA	1,099,679	1,412,054	2,511,733
SECTION B - BUDGET CATEGORIES						
6. Object Class Categories	USAID PROGRAM		RECIPIENT FUNDS		TOTAL	
	(1) Federal	(2) Non-Federal	{3}	{4}	{5}	
a. Personnel (1)	730,198	184,854	NA	NA	915,052	
b. Fringe Benefits (1)	14,016	75,645	NA	NA	89,661	
c. Travel (1)	0	231,852	NA	NA	231,852	
d. Equipment (3)	0	117,000	NA	NA	117,000	
e. Supplies (3)	0	161,607	NA	NA	161,607	
f. Contractual (3)	0	165,455	NA	NA	165,455	
g. Construction (N/A)	0	0	NA	NA	0	
h. Other (1), (2)	330,737	333,991	NA	NA	664,728	
i. Total Direct Charges (sum of 6a-6h)	1,074,951	1,270,404	NA	NA	2,345,355	
j. Indirect Charges (4)	24,728	141,650	NA	NA	166,378	
k. TOTALS (sum of 6i and 6 j)	1,099,679	1,412,054	NA	NA	2,511,733	
7. Program Income						

Standard Form 424A (cont'd.)

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program		(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8.	Headquarters	236,621	NA	0	236,621
9.	Field	1,175,433	NA	0	1,175,433
10.	NA	NA	NA	NA	NA
11.	NA	NA	NA	NA	NA
12.	TOTAL (sum of lines 8-11)	1,412,054	NA	0	1,412,054

SECTION D - FORECASTED CASH NEEDS

		Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13.	Federal	130,214	32,554	32,554	32,554	32,554
14.	Non-Federal	NA	NA	NA	NA	NA
15.	TOTAL (sum of lines 13 and 14)	130,214	32,554	32,554	32,554	32,554

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR LIFE OF THE PROJECT

(a) Grant Program	Future Funding Periods (Years)					(g) TOTALS	
	(b) First	(c) Second	(d) Third	(e) Fourth	(f) Fifth		
16.	Federal	130,214	359,343	259,246	179,670	171,205	1,099,679
17.	NA	NA	NA	NA	NA	NA	NA
18.	NA	NA	NA	NA	NA	NA	NA
19.	NA	NA	NA	NA	NA	NA	NA
20.	TOTAL(sum of lines 16-19)	130,214	359,343	259,246	179,670	171,205	1,099,679

SECTION F - OTHER BUDGET INFORMATION

21.	Direct Charges:	1,074,951	22.	Indirect
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	Costs:
23. Remarks:	base= 56,199 total indirect = 24,728

Albania Child Survival and Health Program
Albania Child Survival and Health Program
October 1, 2003 - September 30, 2008

PERSONNEL:

			Year 1	Year 2	Year 3	Year 4	Year 5	
ARC NHQ Personnel:		FTE	Rate	Rate	Rate	Rate	Rate	
Regional Desk Officer	10%	Count	1	37,350	58,470	61,400	64,470	66,850
Regional Operations Associate	15%		1	52,033	58,473	61,393	64,467	66,870
Health Officer	15%		1	40,753	63,787	66,980	70,327	72,925
Monitoring & Evaluation Specialist	10%		1	40,750	63,790	66,980	70,330	72,920
Organizational Development Manager	10%		1	40,750	63,790	66,980	70,330	72,920

			Year 1	Year 2	Year 3	Year 4	Year 5	
Field Personnel:		FTE	Rate	Rate	Rate	Rate	Rate	
SEE Head of Regional Delegation	10%	Count	1	40,750	5,250	-	-	-
SEE Regional Health Coordinator	30%		1	68,715	68,718	-	-	-
SEE Regional Finance Coordinator	10%		1	62,510	44,628	-	-	-
Local Staff:								
AlbRC National Health Coordinator	75%		1	5,194	9,238	10,160	-	-
AmCross Albania Liaison Officer	100%		1	8,400	14,940	15,687	15,876	17,295
AmCross Albania Financial Officer	100%		1	6,692	11,902	12,498	13,122	13,778
Driver - Tirana	100%		1	5,187	9,225	9,686	10,171	10,680
CSHP Manager	100%		1	11,963	21,277	22,341	23,458	24,631
CSHP Deputy Manager	100%		1	9,688	17,231	18,092	18,997	19,947
CSHP Technical Officer	100%		1	8,365	14,878	15,622	16,402	-
Translator / Assistant - Peshkopi	100%		1	4,256	-	-	-	-
Driver - Peshkopi	100%		1	3,717	6,611	6,941	7,289	7,653
Office Manager - Peshkopi	100%		1	4,256	7,570	7,948	8,345	8,763
Cashier / Receptionist - Peshkopi	100%		1	4,256	7,570	7,948	8,345	8,763
YTD Actuals	100%		1	25,415				
CSHP District Health Supervisors	100%		3	1,824	7,570	7,948	8,345	8,763

RATES:

ARC Fringe Benefit rate	23.50%
ARC NICRA rate - offsite	44.00%
ARC Overhead rate	11.15%

TRAVEL:**ARC NHQ International Travel**

	Year 1	Year 2	Year 3	Year 4	Year 5
Washington/Tirana RT	1,442	1,470	1,544	1,621	1,702
Regional Travel	-	420	-	463	-

Lodging:

price per night	61	50	53	55	58
number of nights	50	20	20	20	30

Meals & Incidentals

price per night	75	47	50	52	55
number of nights	50	20	20	20	30

ARC Field Staff International Travel

Albania - Washington DC	1,400	1,470	-	-	1,702
Regional Travel	350	420	441	463	-

Lodging:

price per night	150	86	125	-	182
number of nights	43	30	11	-	10

Meals & Incidentals

price per night	70	45	92	-	85
number of nights	43	30	11	-	10

ARC National Staff Domestic Travel

lodging and per diem	63	325	535	562	590	622
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PROFESSIONAL SERVICES:

Monitoring & Evaluation:

Baseline Assessments

- KPC survey

* Consultant

* Field Costs

- Health Facilities Assessment

* Consultant

* Field Costs

Population Survey - Family Planning

Grandmother Qualitative Inquiry

Mid-Term Evaluation (consultant included)

Final Assessments

KPC, Family Planning & Health Facilities (no consultant)

Final Evaluation (consultant included)

		Year 1	Year 2	Year 3	Year 4	Year 5	
	16,000	16,000					
	15,619	15,619					
	16,000	16,000					
	13,000	13,000					
	13,000	13,000					
	16,000	16,000					
	\$ 16,000.00			16,000			
	\$ 20,000.00					20,000	
	\$ 16,000.00					16,000	
		89,619	-	16,000	-	36,000	141,619

Auditing:

Audit Fees

2

\$ 10,000

	0	10,000	0	0	10,000
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Legal:

Legal Fees

	164	255	268	281	295
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Translating / Interpreting:

Translating / Interpreting Fees

	900	630	331	347	365
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PROGRAM COSTS:

Health Intervention Activities:

340,422

Annual Percentage Allocation

Total by

3,000

203,709

100,674

16,433

16,606

340,422

% of Interven

Intervention

Year 1

Year 2

Year 3

Year 4

Year 5

Totals

Nutrition

30.00%

102,127

900

61,113

30,202

4,930

4,982

102,127

Diarrhea/ARI

40.00%

136,169

1,200

81,484

40,270

6,573

6,642

136,169

Reproductive Health/Family Planning

30.00%

102,127

900

61,113

30,202

4,930

4,982

102,127

Subtotal Health Interventions

100.00%

340,422

3,000

203,709

100,674

16,433

16,606

340,422

Activities per Intervention:**Nutrition**

		% of total	Year 1	Year 2	Year 3	Year 4	Year 5	
Training Supplies	\$ 36,788	30%	2207.28	2207.28	2207.28	2207.28	2207.28	11036.4
Office Supplies	\$ 19,215	30%	1152.9	1152.9	1152.9	1152.9	1152.9	5,765
Copying Printing Costs	\$ 66,468	30%	3988.08	3988.08	3988.08	3988.08	3988.08	19,940
Subtotal Nutrition			7348.26	7348.26	7348.26	7348.26	7348.26	

Diarrhea/ARI

		% of total						
Training Supplies		40%	2943.04	2943.04	2943.04	2943.04	2943.04	14715.2
Office Supplies		40%	1537.2	1537.2	1537.2	1537.2	1537.2	7,686
Copying Printing Costs		40%	5317.44	5317.44	5317.44	5317.44	5317.44	26,587
Subtotal Diarrhea / ARI			9797.68	9,798	9,798	9,798	9,798	

Reproductive Health/Family Planning

		% of total						
Training Supplies		30%	2207.28	2207.28	2207.28	2207.28	2206.28	11036.4
Office Supplies		30%	1152.9	1152.9	1152.9	1152.9	1152.9	5,765
Copying Printing Costs		30%	3,988	3,988	3,988	3,988	3,988	19,940
Subtotal Reproductive Health / Family Planning			7,348	7,348	7,348	7,348	7,347	

EQUIPMENT:**Computers:**

Computers	8	2,220.00	8,880	-	8,880	-	-
Office Furnishings & Equipment stabilizers, fax, copier, printers, cell phones, etc.	1	Year	10,789	630	695	1,807	795
Equipment Maintenance Rate		0.00	1,186	1,186	1,186	1,186	1,186

Vehicles:

	Count						
Lease payments:							
Land Cruiser/Patrol	2	11,700	23,400	year			
Fuel and maintenance		2	10,200	16,585	17,414	18,285	19,199
Insurance	2		112	-	-	-	-

ALBANIA ADMINISTRATIVE COSTS:

	Count		<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Year 5</u>
Other Consumables	1	Year	1,104	1,276	1,340	1,407	1,475
Bank Fees			596	893	938	985	1,033
Telephone (local + fax)			7,246	7,655	8,037	8,439	8,861
Internet			5,034	5,817	6,108	6,414	6,735
Cell Phone			10,998	11,482	12,056	12,659	13,901
Office Rent Cost Share			17,359	18,822	16,522	17,372	19,373
Courier (DHL,FedEx,UPS)			590	911	957	1,005	1,103
Casual Labor			819	-	-	-	-

Albania Child Survival and Health Program

Country: Albania
 Donor 1: USAID
 Donor 2: American Red Cross
 Period: October 1, 2003 - September 30, 2008
 NHQ Account String: 062-36200-72-xxxx-xxxx-0411
 RFAC: M/COP-03-002 FY-2003

	Year 1			Year 2			Year 3			Year 4			Year 5			Total		
	Total	USAID	AmRC	Total	USAID	AmRC												
NHQ & Field Costs																		
Personnel	159,604	116,917	42,687	205,699	156,386	49,313	181,939	152,356	29,583	187,772	156,710	31,062	180,037	147,830	32,208	915,052	730,198	184,854
Benefits/Allowances	42,121	4,113	38,008	18,927	3,110	15,817	9,116	2,164	6,952	9,572	2,272	7,299	9,926	2,357	7,570	89,661	14,016	75,645
Travel	47,008	0	47,008	44,611	0	44,611	44,685	0	44,685	43,484	0	43,484	52,064	0	52,064	231,852	0	231,852
Equipment	23,400	0	23,400	23,400	0	23,400	23,400	0	23,400	23,400	0	23,400	23,400	0	23,400	117,000	0	117,000
Supplies	45,327	0	45,327	26,400	0	26,400	35,409	0	35,409	27,708	0	27,708	26,762	0	26,762	161,607	0	161,607
Contractual	90,683	0	90,683	10,885	0	10,885	16,599	0	16,599	628	0	628	46,660	0	46,660	165,455	0	165,455
Other Direct Costs	58,204	3,000	55,204	268,260	194,025	74,235	165,092	100,674	64,418	83,978	16,433	67,545	89,196	16,605	72,591	664,728	130,737	333,991
NCRA	44,353	6,185	38,168	33,903	5,623	28,280	28,699	4,052	24,647	26,680	4,255	22,426	33,542	4,413	29,130	166,278	24,728	141,650
Grand Total	510,700	130,214	380,485	631,284	359,343	271,941	504,938	289,246	245,692	403,222	179,670	223,552	461,588	171,205	290,384	2,511,733	1,099,679	1,412,054

FIVE-YEAR TOTAL 2,511,733

ANNEX 12

Albania Red Cross Public Image Survey

PUBLIC IMAGE SURVEY OF THE ALBANIAN RED CROSS

JUNE, 2003



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1. INTRODUCTION

In summer 2000, the Albanian Red Cross (AlbRC) asked the American Red Cross in Albania (AmRC) to coordinate a nationwide Public Image Survey (PIS) as one of the Strategy 2000-2004 objectives. In October 2000, the ARC Information Coordinator, the American Red Cross Organizational Development Team (OD Team) and the Albanian Institute for Social and Psychological Studies (ISPS), at the University of Tirana began collaboration on this project.

As a result of the different stakeholder meetings, seven areas of interest were identified:

- Public opinion about humanitarian organizations
- Public opinion about Red Cross activities
- Knowledge of history, symbols and activities of Red Cross
- Participation of citizens in the Red Cross activities
- Public Image about the Red Cross
- Geographical spread of the Red Cross activities

AlbRC leadership, American Red Cross, the Institute of Social Studies and ICRC met to analyze the results and findings. Overall, this resulted in a common interpretation by the stakeholders involved and results presented in the publication “**Public Image Survey of the Red Cross in Albania 2001**”.

The PIS 2001 served as a baseline assessment of the public image of Albanian Red Cross in 2001. As such, it provided a measurement of the degree of knowledge as well as positive and negative views of the organization at that moment. Based on the recommendations of the PIS and respecting the *Strategy 2000-2004*, a repetition of this survey was carried out in June 2003, in order to not only measure changes in the public image of ARC, but also to measure the impact of the Strategy on the constituency of the Albanian Red Cross.

PIS 2001, was a learning process for all participants and it paved the way for the implementation of the Public Image Survey 2003, which was coordinated by the team work of American Red Cross, Albanian Red Cross and the media institute “Illyricum Fond” (IF).

2. SURVEY OBJECTIVES

The 2003 PIS Survey objectives were slightly modified over the PIS 2001 baseline based on lessons learned and interests of the stakeholders involved. However, the majority of the survey remained the same as the baseline to allow for comparison of the two data sets.

- Identify public awareness of humanitarian organizations in Albania
- Identify public perception of humanitarian needs in Albania
- Identify public awareness of the activities of Albanian Red Cross
- Identify public historical giving trends
- Identify public intent to give to charities

3. *METHODOLOGY OF SURVEY*

Journalists/Survey supervisors of Illyricum Fond were trained on Red Cross topics, vocabulary as well as survey methodology. After the first draft of the questionnaire was developed, a pilot test was carried out in Kamez Municipality and based on the analysis of the results, the final questionnaire was completed.

Based on the INSTAT 2001 official data on demographic characteristics of the population, a random sampling to urban and rural areas in proportion to the percentage of population in 12 prefectures and 36 districts was made. 1200 questionnaires were given to persons aged 16-70 years old regardless of gender or education levels during the first two weeks of June 2003. The data was double entered by IF data controllers and analysts in order to ensure quality control.

The first draft survey report was prepared by IF and presented to Albanian and American Red Cross for final compilation and review. The final product of the PIS 2003 contains not only the results, but changes based on the comparative information from the PIS baseline in 2001. This report also contains recommendations for the AlbRC to continue to improve its service delivery.

4. *NARRATIVE SUMMARY REPORT*

This report summarizes the most significant outcomes of the Public Image Survey 2003 and makes a comparative analysis of the outcomes of the two surveys (baseline and final). The analysis presented reflects the joint interpretation conducted by the Albanian Red Cross, American Red Cross, International Committee of the Red Cross, as well as Illyricum Fund.

A. Public awareness of humanitarian organizations in Albania

Humanitarian organizations in general

As in the baseline survey, the **Red Cross**⁹ ranks first (35%) regarding public opinion about the most active organizations in Albania, followed by Sorros foundation (17%), but it no longer enjoys the same commanding lead as it did in the baseline PIS. This might be explained by the return of AlbRC to normal activities after the Kosovo crisis and by the departure of several delegations of sister Red Cross societies from Albania.

RC and Albanian RC

There is a considerable increase in the knowledge of the Red Cross. Compared to 11.4 % of the interviewees who had 'good or very good' knowledge about the Red Cross in the past, 27% today have 'good or very good' knowledge. If this result is combined with the percentage of those who have 'little knowledge', the figure reaches 53%, which is fairly better compared with the figure 38% in the baseline survey. When asked about the knowledge of the Albanian Red Cross specifically, the results were very close to the ones for the Red Cross in general, which indicates that Albanian Red Cross is still conceived as an integrated part of the RD/RC Movement. However, additional efforts could be undertaken to further promote the National Society.

⁹ The baseline survey did not differentiate between the various Red Cross organizations (AlbRC, AmRC, ICRC, Federation etc.). The survey just referred to 'Red Cross'. The follow-up survey again used the generic term 'Red Cross', but a few additional questions were added specifically citing 'Albanian Red Cross', given the reduced presence of the other Red Cross organizations during the previous year.

Approximately 61% of those surveyed consider Red Cross to be a non-governmental humanitarian organization, 20% of the interviewees, as a world-wide movement, and 10% of the interviewees as a movement which intervenes in warfare and emergency situations. Most importantly however, unlike the previous image, where 11% of the interviewees considered the Red Cross to be a governmental organization, today only 4% feel this way.

When asked to describe the RC, the words most often selected were ‘useful’ and ‘trustworthy’ (65% in total). This figure is indicative of the credibility that the Red Cross enjoys among the public at large

There is a considerable decrease in the figures related to the notion ‘international’ (14%) compared to the PIS 2001 (44%), which could be explained through withdrawal of International Federation and most of the Sister societies from Albania. The notion "symbol" ranges almost 3 times lower compared to the baseline survey. Meanwhile, the symbol of Red Crescent is recognized by 2% of the respondents as separate from the RC, which indicates that AlbRC should expand its activities regarding the recognition of emblem. None of the words describing the fundamental principles of the Movement are amongst the most frequently used by the people who try to describe the Red Cross. Therefore, in future campaigns, AlbRC may want to consider additional dissemination of the Fundamental Principles.

Public perception of humanitarian needs in Albania

While asked about the most pressing needs in national and local level, the respondents refer to the following targets:

Health Care services	20%
Support to elderly	13%
Employment assistance	13%
Trafficking victims	12-13%

While two of them, public health care and support to elderly are two of the AlbRC core areas of beneficiary’s groups. Meanwhile, due to the transitional situation of Albania during the last decade, AlbRC was mostly focused on relief operations rather than development aid. The need for services such as support to trafficking victims and employment assistance indicates that AlbRC should consider to enlarge the beneficiary group during the planning of Strategy 2004-10, if not through direct services, may be thought advocacy.

Public awareness of the activities of Albanian Red Cross

When asked where they felt the main activities of the AlbRC were currently focused, those surveyed responded as follows:

Public health	26 %
Disaster preparedness and response	21 %
First aid	19 %
Promotion of blood donation	16%
Tracing	6 %

Compared to the former survey, the results are more consistent with where the activities of the AlbRC are actually focused with the exception of blood donation. The promotion of blood donation continues to enjoy a high level in people's consideration of Red Cross activities, in spite of the fact that AlbRC has not carried out many activities in this area.

The tracing program despite of being a relatively new program, (i.e. two years old), has witnessed a considerable increase in recognition (6%), whereas social activities, promotion of humanitarian values (including landmine and UXO awareness), and other youth activities have an insignificant percentage (i.e. 2% or less). Following a downsizing in Red Cross work with refugees and displaced persons, this activity has also scored lower than the baseline survey.

The increase in public awareness of AlbRC health and emergency response activities could be attributed to their high level of engagement during the 2001-2002 devastating floods and harsh winter snow storms.

Willingness to support (financially and materially) the Albanian Red Cross

Public historical giving trends/public intent to give to charities

As in the baseline, the general public remains largely unwilling to donate or contribute to the AlbRC. However, compared to the former baseline, (38% versus 18.3%), there is an increase in the number of individuals contributing to AlbRC, but they are still outnumbered by those who have not contributed. Although not asked in the baseline, the follow-up PIS questioned the public about their willingness to support the Albanian Red Cross in the future. About 63% of the interviewees answered positively with respect to the financial and material support to the AlbRC. They expressed their willingness to focus their contribution mainly to groups of children in need (44.5%), victims of trafficking (14.1%) and a part of them to disadvantaged women and the elderly. **The discrepancy between the numbers of persons who have contributed historically and those willing to contribute strongly suggests that AlbRC must make greater efforts to ask the general public for assistance as well as provide them with different ways to contribute to the organization.**

Although the general public indicated a willingness to volunteer for the AlbRC, this willingness is lower than those wanting to make a monetary contribution. This is not an anomaly, but rather can be attributed to the undeveloped 'volunteer' attitude in Albania largely based on historical practices during the former Communist system. In examining age differences, the over-50 group appears to be the least interested to become RC volunteers. This indicator is consistent with the current profile of volunteers supporting the AlbRC.

Red Cross is closely related to humanism and universality. Its image is crystallized among all age-groups and all genders in society. Thus, every group is enabled to create a good image of the Red Cross in particular. Such a fact may be used to establish a particular Red Cross image during special campaigns addressed to specific age-groups.

Confidence in the utilization of resources

The level of trust of the Albanian Red Cross has increased somewhat compared to the baseline survey. In the baseline, 29.5 % of people thought that nothing or very little went to its targeted

destination, whereas in 2003, only 20.5 % of the public feels that way. The majority or 62.83 % of the population believes that AlbRC assistance mostly or entirely goes to its proper destination.

Interestingly, the majority of persons (or 72% of the above 20.5%) who think that assistance does not go to the proper target population, primarily blame local government employees rather than Red Cross staff. This is an evident improvement indicator of ARC credibility in local level, although still a lot remains to be achieved with respect to this issue.

Information

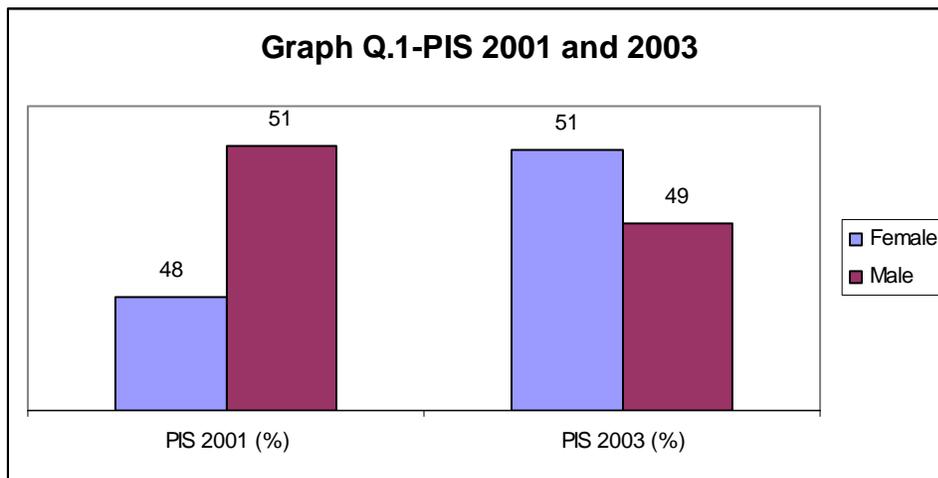
The public's main source of information about Red Cross remains television and radio, at 44%. However, there is a perceptible increase in newspapers and magazines as information sources (24% compared to 7% of the previous survey). The most important fact is that the level of information coming from humanitarian activities and information campaigns has increased (23% versus 7%). In addition, given the fact that the survey indicates a good image of Albanian RC, and a positive giving trend of the general public, the development of a media plan by combining media and public campaigns, should be considered during AlbRC's fundraising campaigns and volunteer recruitment drives.

5. ANALYSIS

Frequencies by gender and age

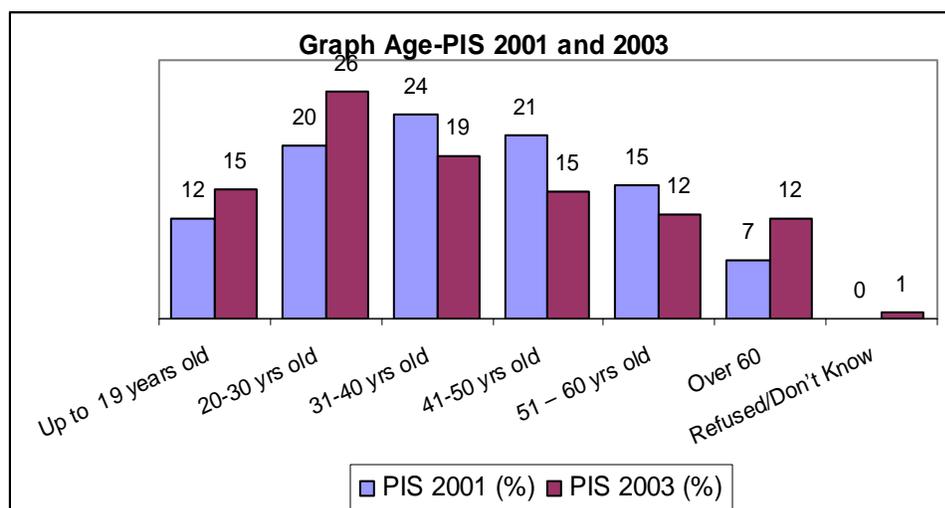
Gender

		PIS 2001 (%)	PIS 2003 (%)
Valid	Female	47,6	50,7
	Male	51,1	49,3
	Total	98,7	100
Missing	System	1,3	0
Total		100,00	100,00



Age

	PIS 2001 (%)	PIS 2003 (%)
Valid		
Up to 19 years old	11,6	14,9
20-30 yrs old	20,0	26,4
31-40 yrs old	23,7	18,9
41-50 yrs old	21,3	14,8
51 – 60 yrs old	15,4	12,2
Over 60	6,8	11,5
Refused/Don't Know	0	0,8
Total	98,8	99,4
Missing		
System	1,2	0,6
Total	100,0	100,0

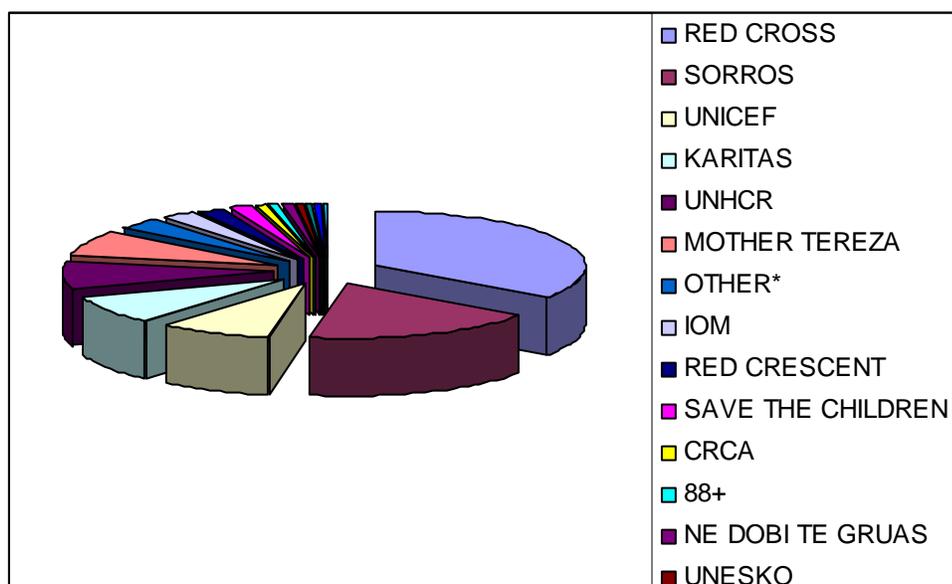


5. In your opinion which are the three most active humanitarian organizations in Albania?

	PIS 2003 (%)
Valid	
RED CROSS	35,1
SORROS	17,5
UNICEF	8,7
KARITAS	8,7
UNHCR	8,1
MOTHER TEREZA	7,5
OTHER*	3,5
IOM	2,6
RED CRESCENT	2,0
SAVE THE CHILDREN	1,7
CRCA	1,0
88+	0,8
NE DOBI TE GRUAS	0,8
UNESKO	0,5
ADRA	0,5
CACRA	0,5

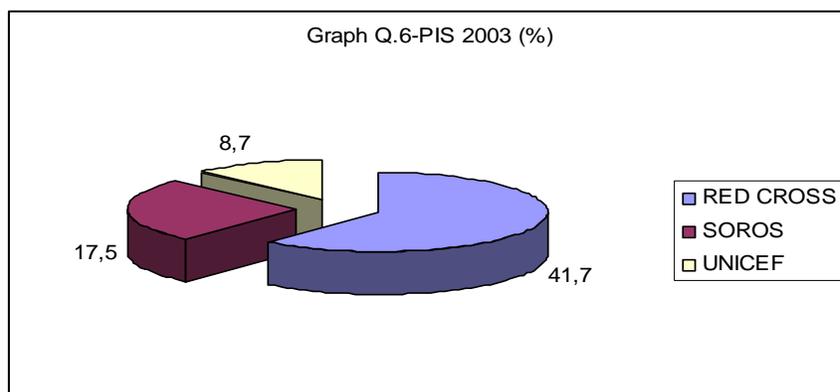
WHAM	0,4
Total	100,0

*ps: METEOR, KISHA KATOLIKE, ICMC, CRS, KESHILLI I ZOJES SE MIRE

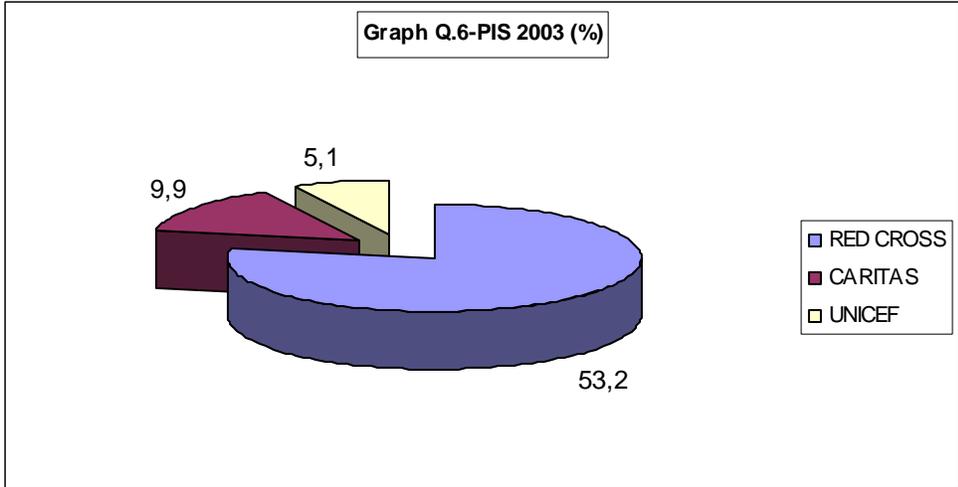


6. In your opinion which are the three most active humanitarian organizations in your DISTRICT?

	PIS 2003 (%)
RED CROSS	35,1
SOROS	17,5
UNICEF	8,7

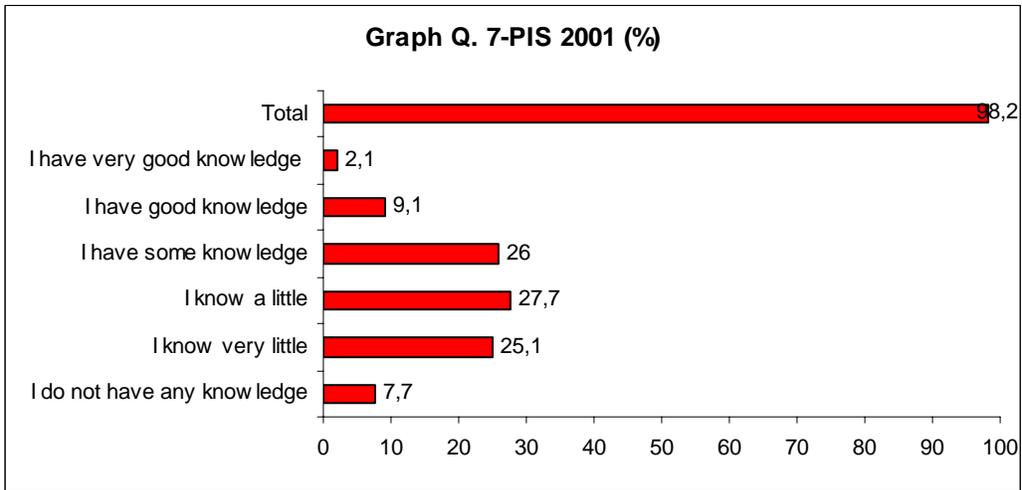


	PIS 2001 (%)
RED CROSS	53,2
CARITAS	9,9
UNICEF	5,1



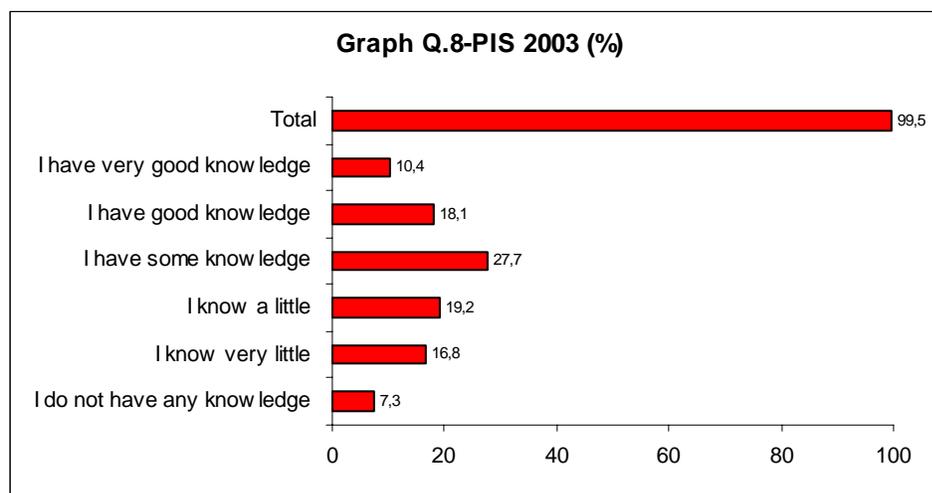
7. How much knowledge do you have about the Red Cross in general?

	PIS 2001 (%)	PIS 2003 (%)
Valid I do not have any knowledge	7,7	8,0
I know very little	25,1	17,8
I know a little	27,7	20,7
I have some knowledge	26,0	26,1
I have good knowledge	9,1	17,4
I have very good knowledge	2,1	9,8
Total	98,2	99,8
Missing System	2,4	0,3
Total	100	100,0



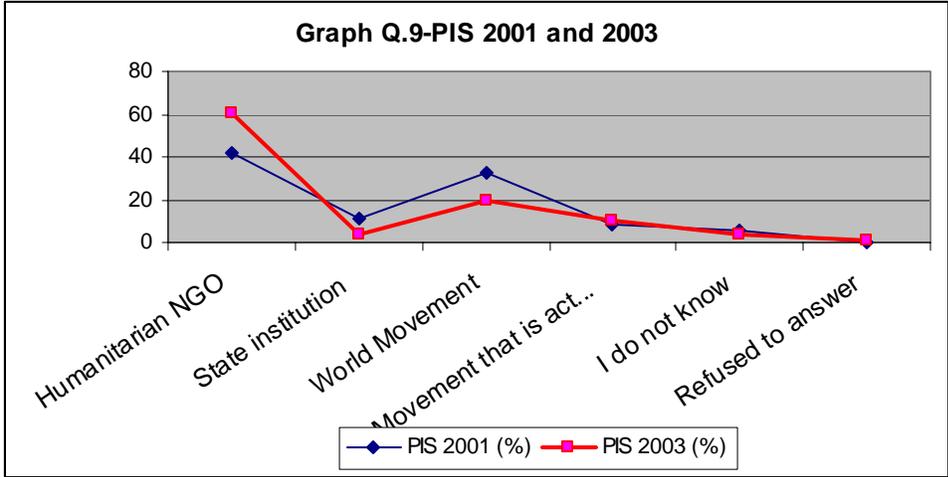
8. How much knowledge do you have about the Albanian Red Cross?

		Percent 2003
Valid	I do not have any knowledge	7,3
	I know very little	16,8
	I know a little	19,2
	I have some knowledge	27,7
	I have good knowledge	18,1
	I have very good knowledge	10,4
	Total	99,5
Missing	0,5	
Total		100,0



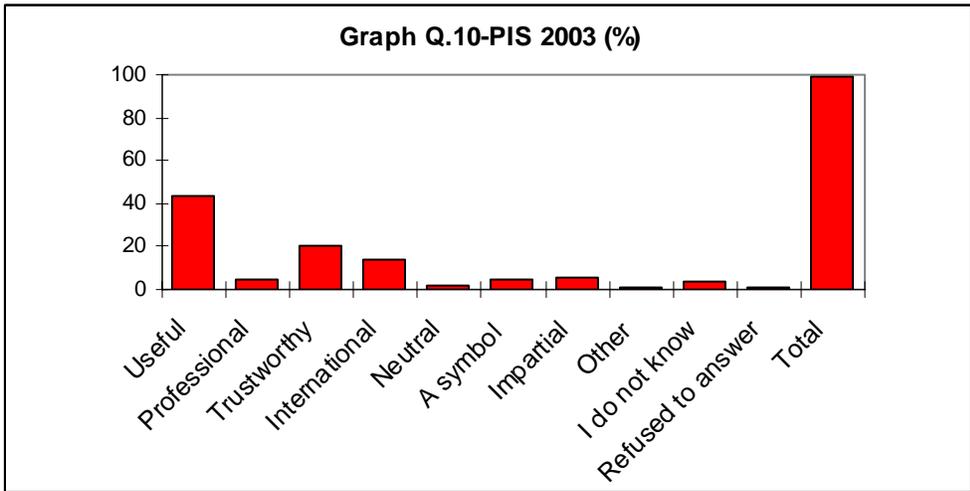
9. What do you think “Red Cross” is?

		PIS 2001 (%)	PIS 2003 (%)
Valid	Humanitarian NGO	41,6	60,9
	State institution	11,0	3,8
	World Movement	32,1	19,8
	Movement that is active only in the case of the war and emergencies	8,8	10,4
	I do not know	5,2	3,9
	Refused to answer	0,3	1,0
	Total	99,0	99,8
	Missing	1,0	0,2
Total	100,0	100,0	



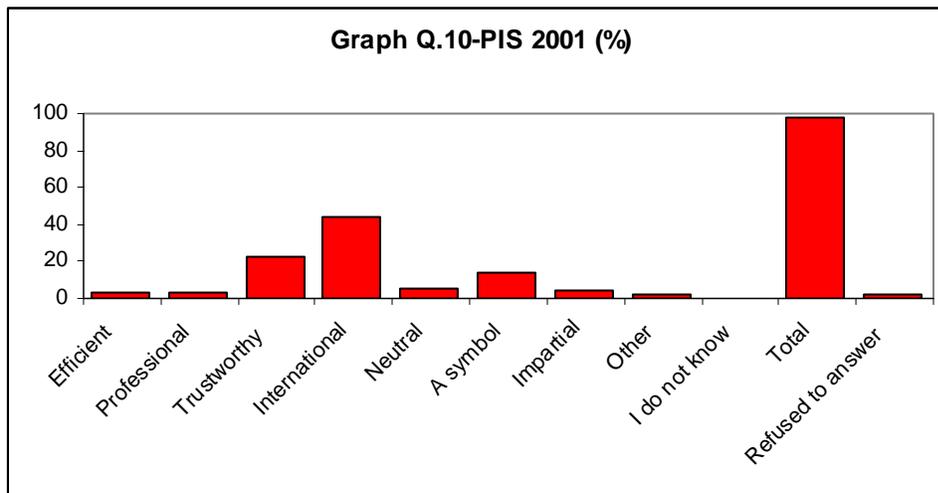
10. What is the first word coming to your mind when “Red Cross” is mentioned?

		PIS 2003 (%)
Valid	Useful	43,4
	Professional	5,0
	Trustworthy	20,8
	International	13,8
	Neutral	1,6
	A symbol	4,7
	Impartial	5,3
	Other	0,5
	I do not know	3,3
	Refused to answer	1,2
	Total	99,5
	Missing	0,5
	Total	100,00



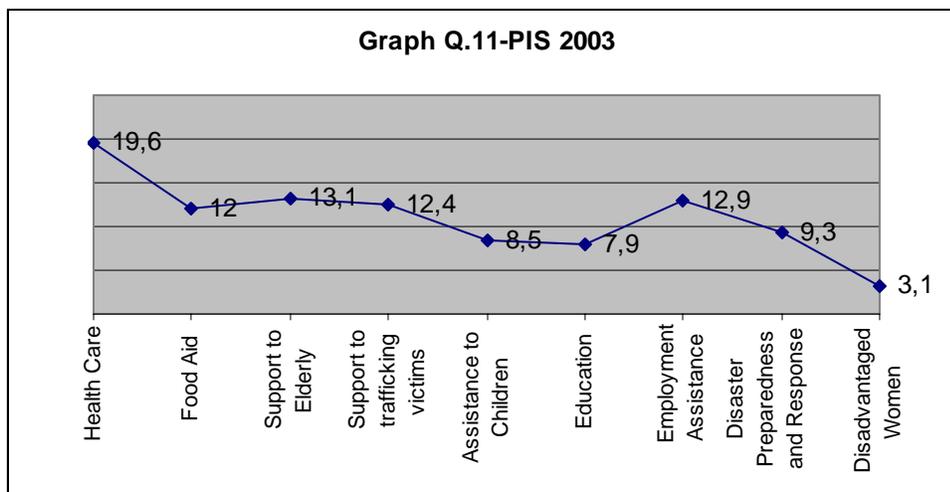
Q. 10 PIS 2001

		PIS 2001
Valid	Efficient	3,4
	Professional	2,7
	Trustworthy	22,4
	International	43,6
	Neutral	5,3
	A symbol	14,2
	Impartial	4,4
	Other	2,6
	I do not know	0,1
	Total	98,3
Total	100,00	



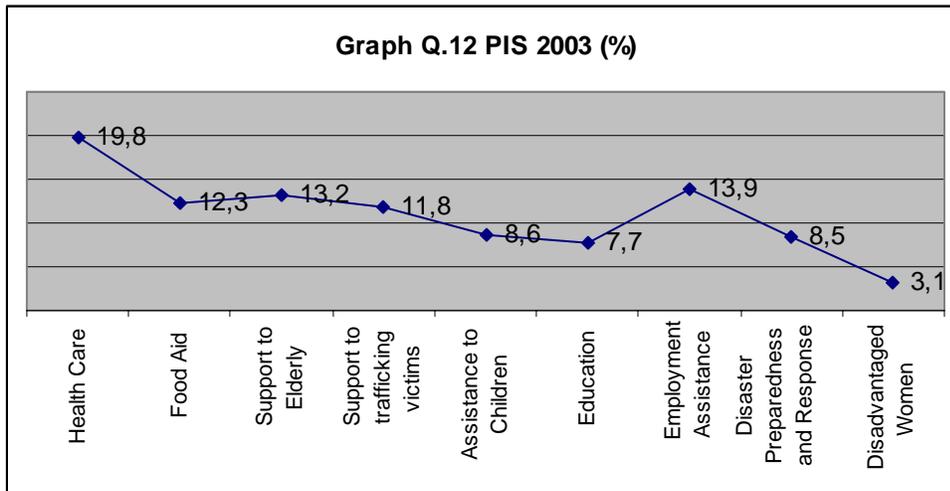
11. What are the three most pressing needs in ALBANIA that could be addressed by a humanitarian organization?

	PIS 2003 (%)
Valid	
Health Care	19,6
Food Aid	12,0
Support to Elderly	13,1
Support to trafficking victims	12,4
Assistance to Children	8,5
Education	7,9
Employment Assistance	12,9
Disaster Preparedness and Response	9,3
Disadvantaged Women	3,1
Other	0,1
I don't know	0,2
Refused to answer	0,1
Total	99,1
Missing	0,9
Total	100,0



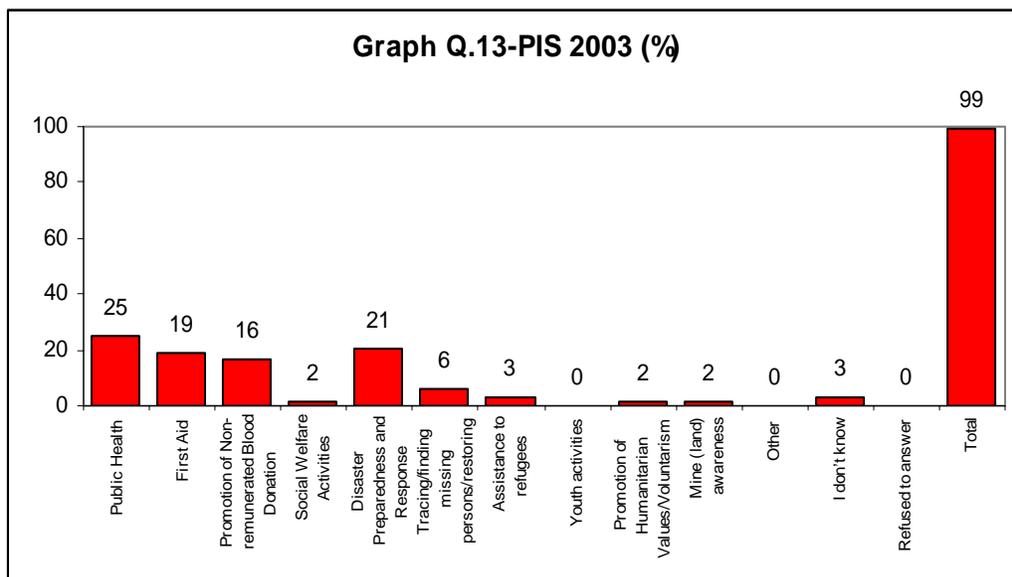
12. What are the three most pressing needs in YOUR DISTRICT that could be addressed by a humanitarian organization?

	PIS 2003 (%)
Valid Health Care	19,8
Food Aid	12,3
Support to Elderly	13,2
Support to trafficking victims	11,8
Assistance to Children	8,6
Education	7,7
Employment Assistance	13,9
Disaster Preparedness and Response	8,5
Disadvantaged Women	3,1
Other	0,1
I don't know	0,3
Refused to answer	0,1
Total	99,3
Missing	0,8
Total	100,0

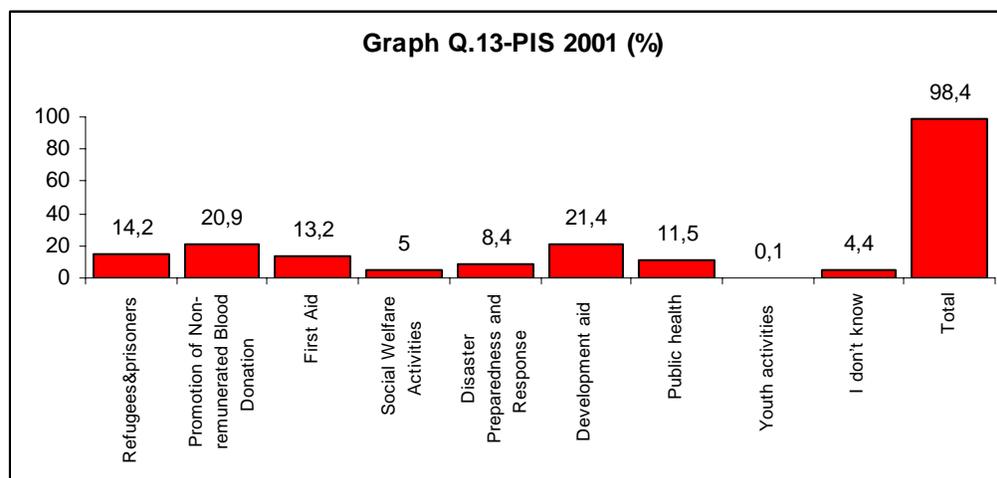


13. Where do you think the activity of the Albanian Red Cross is currently mainly focused?

		PIS 2003 (%)	
Valid	Public Health	25,3	
	First Aid	18,8	
	Promotion of Non-remunerated Blood Donation	16,3	
	Social Welfare Activities	1,7	
	Disaster Preparedness and Response	20,8	
	Tracing/finding missing persons/restoring family links	6,3	
	Assistance to refugees	3,3	
	Youth activities	0,3	
	Promotion of Humanitarian Values/Voluntarism	1,7	
	Mine (land) awareness	1,8	
	Other	0,0	
	I don't know	2,8	
	Refused to answer	0,3	
	Total	99,2	
	Missing	System	0,8
	Total		100,00

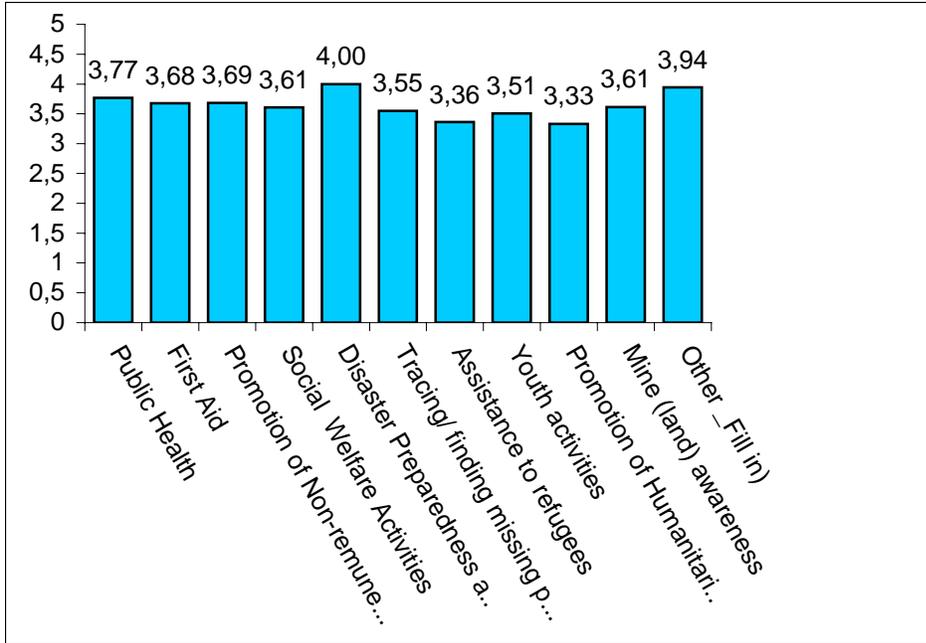


		PIS 2001 (%)
Valid	Refugees&prisoners	14,2
	Promotion of Non-remunerated Blood Donation	20,9
	First Aid	13,2
	Social Welfare Activities	5,0
	Disaster Preparedness and Response	8,4
	Development aid	21,4
	Public health	11,5
	Youth activities	0,1
	I don't know	4,4
	Total	98,4
Missing	System	1,6
Total		100,00



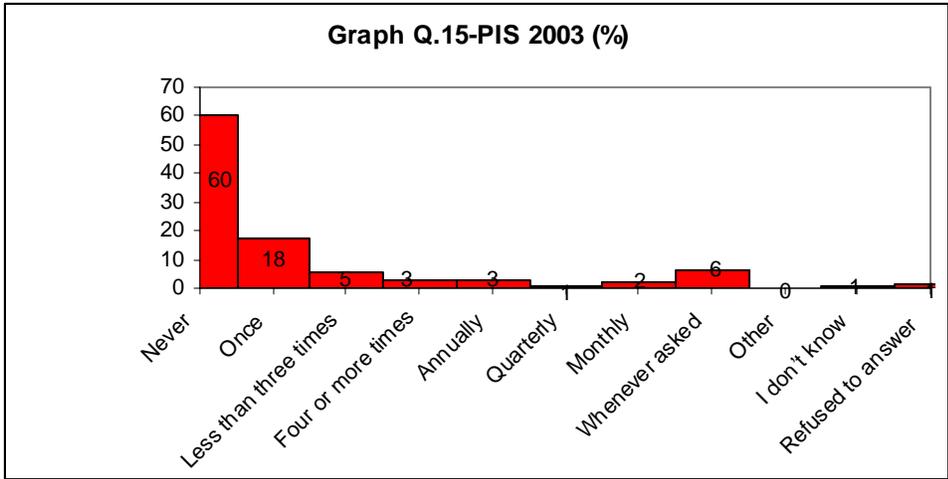
14. Evaluate starting from (1) to (5), the activity intensity of the “Albanian Red Cross” in each of the following areas:

Graph Q.14

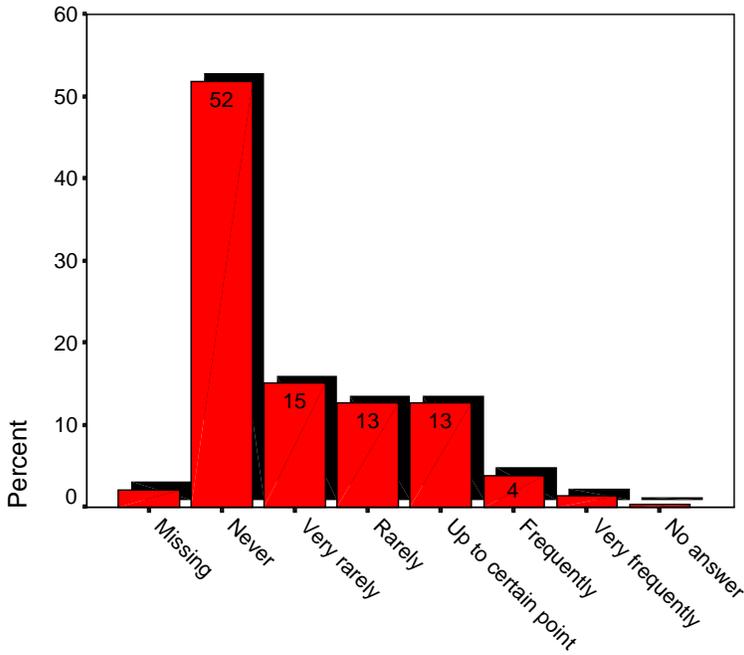


15. Have you ever given a financial contribution to the “Albanian Red Cross”?

		PIS 2003 (%)
Valid	Never	60,4
	Once	17,5
	Less than three times	5,3
	Four or more times	2,7
	Annually	2,6
	Quarterly	1,0
	Monthly	2,2
	Whenever asked	6,0
	Other	0,1
	I don't know	1,0
	Refused to answer	1,1
Total		99,8
Missing	System	0,3
Total		100,0

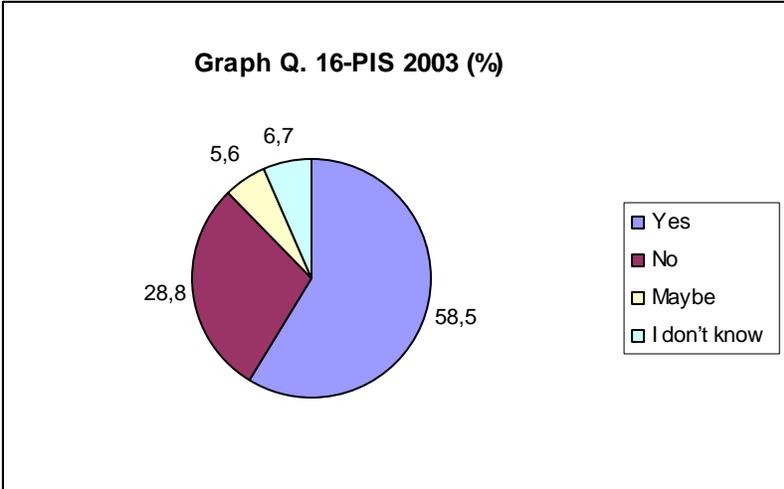


Graph PIS 2001



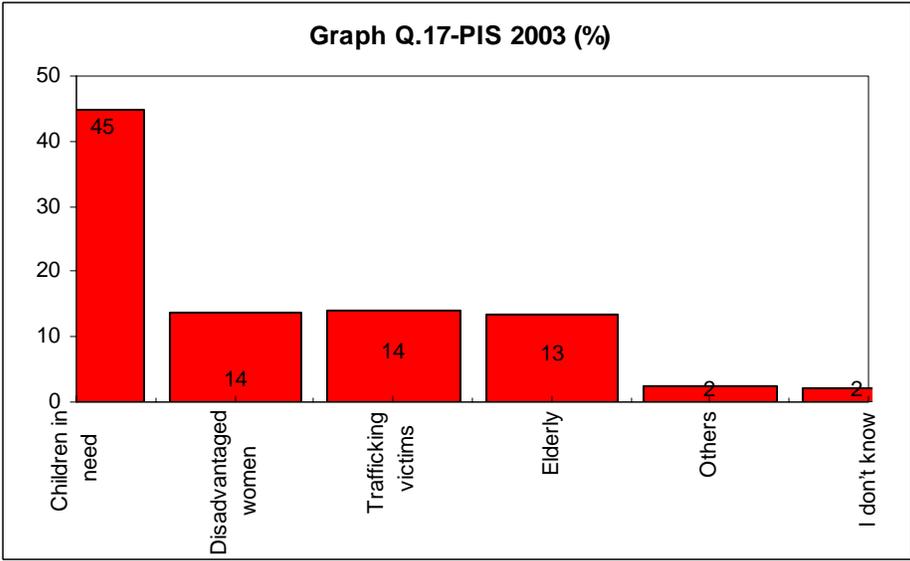
16. Could you consider making a financial contribution to the “Albanian Red Cross” in the future?

		PIS 2003 (%)
Valid	Yes	58,5
	No	28,8
	Maybe	5,6
	I don't know	6,7
	Total	99,5
Missing	System	0,5
Total		100,00



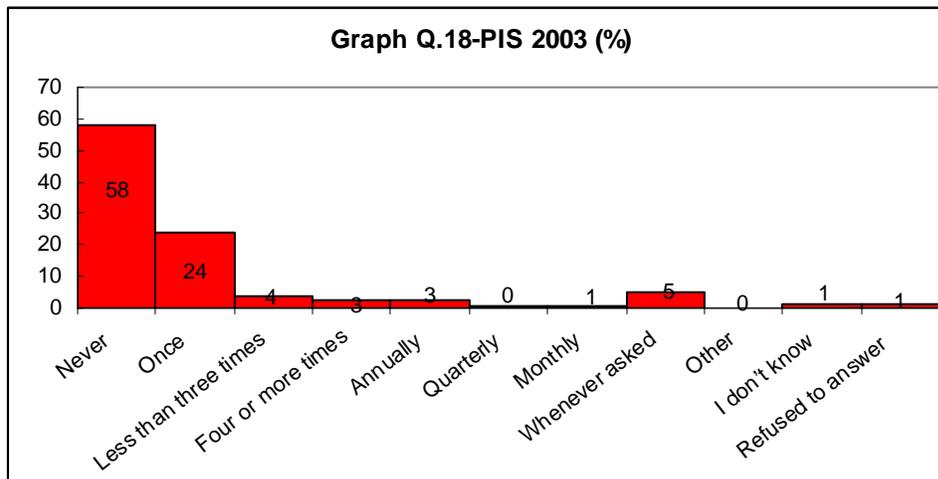
17. What specific cause would you make financial contribution for to “Albanian Red Cross” (Choose one):

		PIS 2003 (%)
Valid	Children in need (orphans, Handicap etc	44,8
	Disadvantaged women	13,8
	Trafficking victims	14,1
	Elderly	13,3
	Others	2,4
	I don't know	2,1
	Refused to answer	0,6
Missing	System	9,0
	Total	100,0



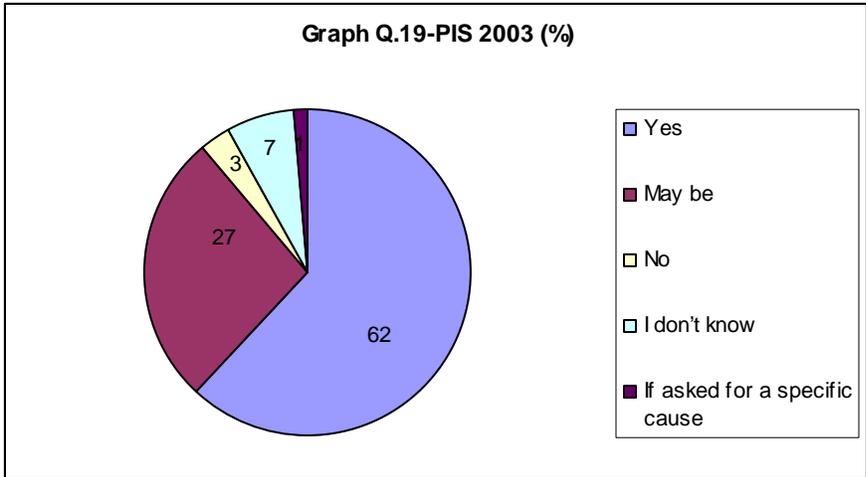
18. Have you ever donated items to the “Albanian Red Cross” (clothes, food, blankets etc.)?

		PIS 2003 (%)
Valid	Never	58,2
	Once	23,8
	Less than three times	3,8
	Four or more times	2,7
	Annually	2,5
	Quarterly	0,4
	Monthly	0,9
	Whenever asked	4,8
	Other	0,1
	I don't know	1,3
	Refused to answer	1,2
	Total	99,7
	Missing	System
Total		100,0



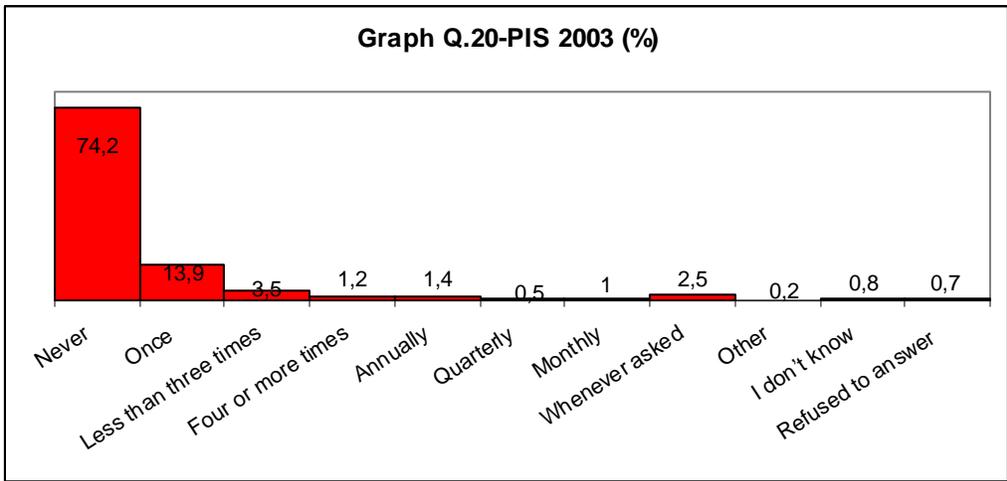
19. Would you consider donating items to the “Albanian Red Cross” in the future?

		PIS 2003 (%)
Valid	Yes	61,8
	May be	26,7
	No	3,1
	I don't know	6,6
	If asked for a specific cause	1,4
	Total	99,6
Missing	System	0,4
Total		100,0



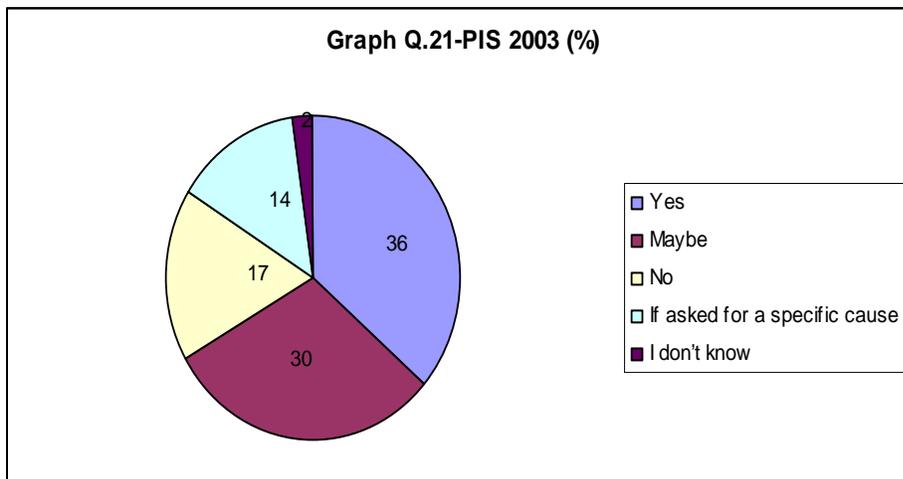
20. Have you ever volunteered your time for the “Albanian Red Cross”?

		PIS 2003 (%)
Valid	Never	74,2
	Once	13,9
	Less than three times	3,5
	Four or more times	1,2
	Annually	1,4
	Quarterly	0,5
	Monthly	1,0
	Whenever asked	2,5
	Other	0,2
	I don't know	0,8
	Refused to answer	0,7
	Total	99,8
	Missing	System
Total		100,0



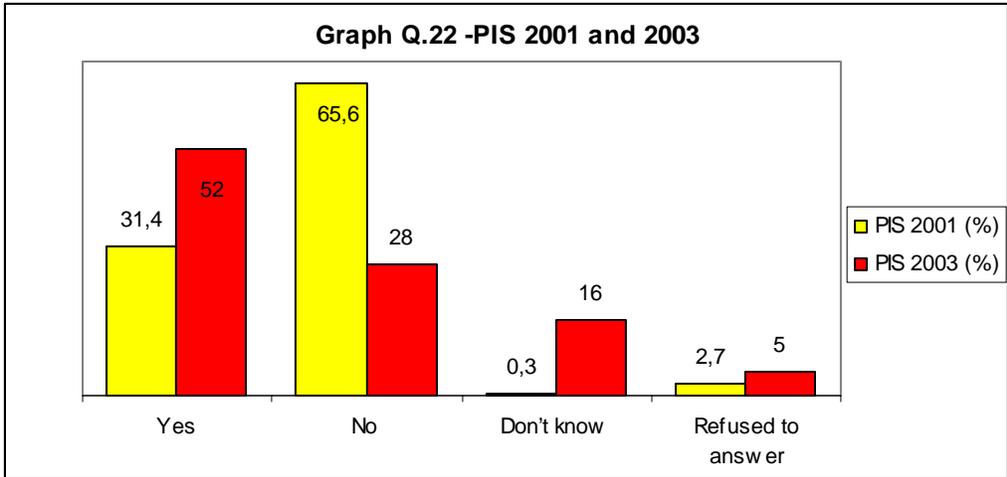
21. Would you consider volunteering your time for the “Albanian Red Cross” in the future?

		PIS 2003 (%)
Valid	Yes	36,0
	Maybe	30,1
	No	17,1
	If asked for a specific cause	13,8
	I don't know	2,1
	Total	99,1
Missing	System	0,9
	Total	100,0



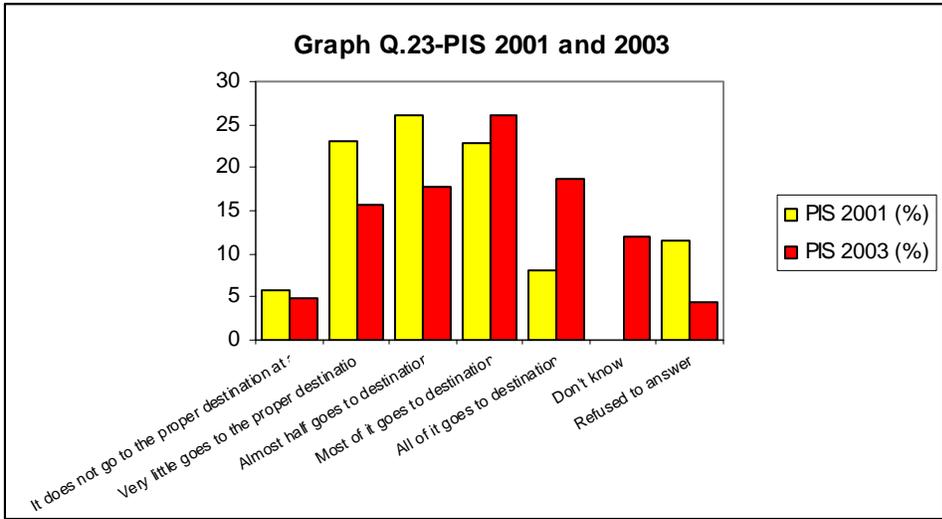
22. Have you or your relatives/friends benefited from or received “Red Cross” aid or assistance in the past?

		PIS 2001 (%)	PIS 2003 (%)
Valid	Yes	31,4	51,5
	No	65,6	27,6
	Don't know	0,3	16
	Refused to answer	2,7	4,6
	Total	97,3	99,7
Missing	System	0	0,33
	Total	100	100



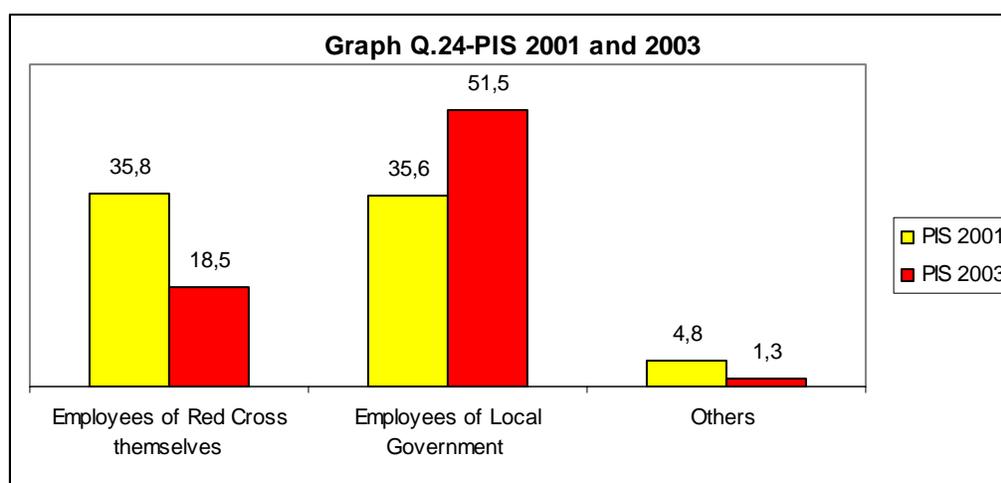
23. Do you think that the contributions and aid given to this organization is going to the proper destination or?

	Percent PIS 2001	Percent PIS 2003
Valid		
It does not go to the proper destination at all	5,7	4,8
Very little goes to the proper destination	23,0	15,8
Almost half goes to destination	26,1	17,8
Most of it goes to destination	22,8	26,1
All of it goes to destination	8,0	18,6
Don't know	0,0	12,0
Refused to answer	11,6	4,4
Total	97,1	99,3
Missing		
System	2,9	0,7
Total	100,0	100,0



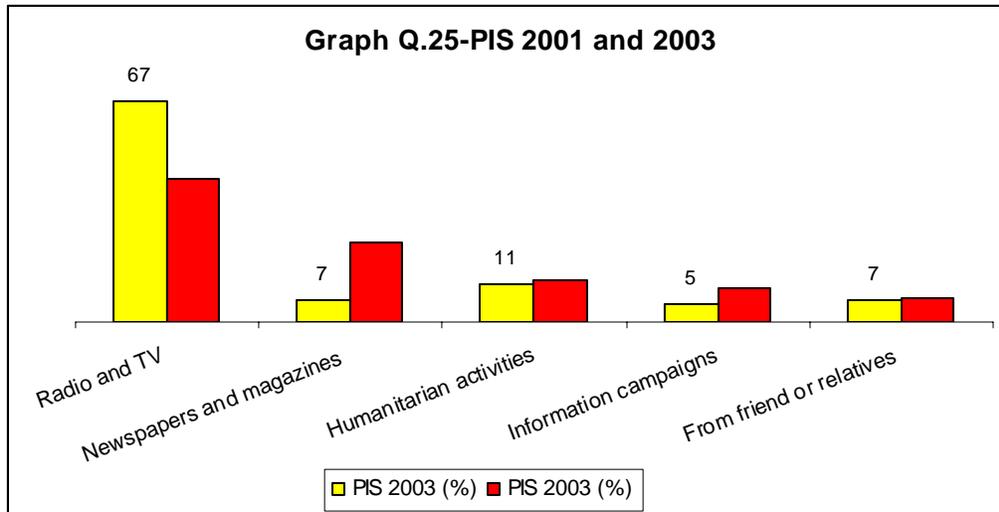
24. Who is responsible of aid not going to its proper destination?

		Percent PIS 2001	Percent PIS 2003
Valid	Employees of Red Cross themselves	35,8	18,5
	Employees of Local Government	35,6	51,5
	Others	4,8	1,3
	Total	76,1	71,3
Missing	System	23,9	28,7
Total		100,0	100,0



25. Where do you normally get your information about the "Albanian Red Cross"?

		PIS 2003 (%)	PIS 2003 (%)
Valid	Radio and TV	66,9	43,5
	Newspapers and magazines	6,8	23,8
	Humanitarian activities	11,2	12,8
	Information campaigns	5,4	10,5
	From friend or relatives	6,6	7,5
	Other	-	0,0
	Don't know	-	0,5
	Refused to answer	0,2	0,2
	Total	97,1	98,9
Missing	System	2,9	1,1
Total		100,0	100,0



6. APPENDICES

Appendix 1

Questionnaire

Questionnaire NO. _____

1. General data before interviewing:

This part should be completed by the interviewee before the interview.

The Interviewee ID#: _____

Residence: _____ coded according selected cities

Date of interview: DD/MM/Y

Start hour: _____: _____ Finish Hour: _____: _____

Interviewee ID#: _____

2. Survey Objectives:

- Identify public awareness of humanitarian organizations in Albania
- Identify public perception of humanitarian needs in Albania
- Identify public awareness of the activities of Albanian Red Cross
- Identify public historical giving trends
- Identify public intent to give to charities

3. Introducing to interviewee

We are journalists from Illyricum Fond. We are undertaking a survey all over Albania. The purpose of this survey is to identify the perceptions and attitudes of Albanians on charities and the work they do in different areas. All information offered from you will be strictly confidential. Your name will not be mentioned in the survey. This survey will only take 35 minutes. Do I have your permission to give you this survey? (If no, thank them for their time and chose next respondent)

(if Yes) We would be grateful, if you would spend the time on answering our questions and filling out this questionnaire.

Please try to be as precise as you can in your answers. If you are not comfortable in answering a question, for any reason, we would prefer that you say that you do not want to answer. This would be valued more than an incorrect answer.

4. Background information (only one person should be answering the questionnaire)

Gender	Female (0)	Male (1)		
Write answer				
Age	up to 19 yrs old (1)	20-30 yrs old (2)	31-40 yrs old (3)	41-50 yrs old (4)
Write answer				
Age	51 – 60 yrs old (5)	Over 60 (6)	Refused/Don't Know (7)	
Write answer				

A. Identify public awareness of humanitarian organizations in Albania

5. In your opinion which are the three most active humanitarian organizations in Albania?

1. _____
2. _____
3. _____
4. No humanitarian organizations
5. Do not know

6. In your opinion which are the three most active humanitarian organizations in your DISTRICT?

1. _____
2. _____
3. _____
4. No humanitarian organizations
5. Do not know

7. How much knowledge do you have about the Red Cross in general?

- I do not have any knowledge (0) / _____ /
- I know very little (1) / _____ /
- I know a little (2) / _____ /
- I have some knowledge (3) / _____ /
- I have good knowledge (4) / _____ /
- I have very good knowledge (5) / _____ /

8. How much knowledge do you have about the Albanian Red Cross?

- I do not have any knowledge (0) / _____ /
- I know very little (1) / _____ /
- I know a little (2) / _____ /
- I have some knowledge (3) / _____ /
- I have good knowledge (4) / _____ /
- I have very good knowledge (5) / _____ /

9. What do you think “Red Cross” is?

- Humanitarian NGO (1) / ____ /
- State institution (2) / ____ /
- World Movement (3) / ____ /
- Movement that is active only in the case of the war and emergencies (4) / ____ /
- I do not know (99) / ____ /
- Refused to answer (88) / ____ /

10. What is the first word coming to your mind when “Red Cross” is mentioned?

- Useful* (1) / ____ /
- Professional* (2) / ____ /
- Trustworthy* (3) / ____ /
- International* (4) / ____ /
- Neutral* (5) / ____ /
- A symbol* (6) / ____ /
- Impartial* (7) / ____ /
- Other* (8) / _____ / (fill in)
- I do not know (99) / ____ /
- Refused to answer (88) / ____ /

B. Identify public perception of humanitarian needs in Albania

11. What are the three most pressing needs in ALBANIA that could be addressed by a humanitarian organization?

- Health Care (1) / ____ /
- Food Aid (2) / ____ /
- Support to Elderly (3) / ____ /
- Support to trafficking victims (4) / ____ /
- Assistance to Children (5) / ____ /
- Education (6) / ____ /
- Employment Assistance (7) / ____ /
- Disaster Preparedness and Response (8) / ____ /
- Disadvantaged Women (9) / ____ /
- Other (10) Fill in _____ / ____ /
- I don't know (99) / ____ /
- Refused to answer (88) / ____ /

12. What are the *three* most pressing needs in YOUR DISTRICT that could be addressed by a humanitarian organization?

- | | |
|--|----------|
| Health Care (1) | / ____ / |
| Food Aid (2) | / ____ / |
| Support to Elderly (3) | / ____ / |
| Support to trafficking victims (4) | / ____ / |
| Assistance to Children (5) | / ____ / |
| Education (6) | / ____ / |
| Employment Assistance (7) | / ____ / |
| Disaster Preparedness and Response (8) | / ____ / |
| Disadvantaged Women (9) | / ____ / |
| Other (10) Fill In _____ | / ____ / |
| I don't know (99) | / ____ / |
| Refused to answer (88) | / ____ / |

C. Identify public awareness of the activities of Albanian Red Cross

13. Where do you think the activity of the Albanian Red Cross is currently mainly focused? (Choose one)

- | | |
|--|----------|
| Public Health (1) | / ____ / |
| First Aid (2) | / ____ / |
| Promotion of Non-remunerated Blood Donation (3) | / ____ / |
| Social Welfare Activities (4) | / ____ / |
| Disaster Preparedness and Response (5) | / ____ / |
| Tracing/finding missing persons/restoring family links (6) | / ____ / |
| Assistance to refugees (7) | / ____ / |
| Youth activities (8) | / ____ / |
| Promotion of Humanitarian Values/Voluntarism (9) | / ____ / |
| Mine (land) awareness (10) | / ____ / |
| Other (11) Fill In _____ | / ____ / |
| I don't know (99) | / ____ / |
| Refused to answer (88) | / ____ / |

14. Evaluate starting from 0 to 5, the activity intensity of the “Albanian Red Cross” in each of the following areas:

<i>Answer Key</i>		
	<i>(0)=I have no idea</i>	<i>(4)=High</i>
	<i>(1)=Very low</i>	<i>(5)=Very high</i>
	<i>(2)=Low</i>	<i>(88)=Refused to answer</i>
	(3)=Medium	
	Activity Area	Evaluation
1	Public Health	(0) (1) (2) (3) (4) (5) (88)
2	First Aid	(0) (1) (2) (3) (4) (5) (88)
3	Promotion of Non-remunerated Blood Donation	(0) (1) (2) (3) (4) (5) (88)
4	Social Welfare Activities	(0) (1) (2) (3) (4) (5) (88)
5	Disaster Preparedness and Response	(0) (1) (2) (3) (4) (5) (88)
6	Tracing/ finding missing persons/restoring family links	(0) (1) (2) (3) (4) (5) (88)
7	Assistance to refugees	(0) (1) (2) (3) (4) (5) (88)
8	Youth activities	(0) (1) (2) (3) (4) (5) (88)
9	Promotion of Humanitarian Values/Voluntarism	(0) (1) (2) (3) (4) (5) (88)
10	Mine (land) awareness	(0) (1) (2) (3) (4) (5) (88)
11	Other _____ (Fill in)	(0) (1) (2) (3) (4) (5) (88)

D. Identify public historical giving trends

E. Identify public intent to give to charities

15. Have you ever given a financial contribution to the “Albanian Red Cross”?

- Never (1) / _____ /
- Once (2) / _____ /
- Less than three times (3) / _____ /
- Four or more times (4) / _____ /
- Annually (5) / _____ /
- Quarterly (6) / _____ /
- Monthly (7) / _____ /
- Whenever asked (8) / _____ /
- Other (9) Fill In _____ / _____ /
- I don't know (99) / _____ /
- Refused to answer (88) / _____ /

16. Would you consider making a **financial contribution** to the “**Albanian Red Cross**” in the future?
- Yes (1) / _____ /
- No (2) / _____ /
- Maybe (3) / _____ /
- I don't know (99) / _____ /

If the answer is (1) or (3) pass to question 18

17. What specific cause would you make financial contribution for to “**Albanian Red Cross**” (Choose one):
- Children in need (orphanages, Handicap etc) (1) / _____ /
- Disadvantaged women (2) / _____ /
- Trafficking victims (3) / _____ /
- Elderly (4) / _____ /
- Others (5) Fill in _____ / _____ /
- I don't know (99) / _____ /
- Refused to answer (88) / _____ /

18. Have you ever **donated items** to the “**Albanian Red Cross**” (clothes, food, blankets etc.)?
- Never (1) / _____ /
- Once (2) / _____ /
- Less than three times (3) / _____ /
- Four or more times (4) / _____ /
- Annually (5) / _____ /
- Quarterly (6) / _____ /
- Monthly (7) / _____ /
- Whenever asked (8) / _____ /
- Other (9) Fill In _____ / _____ /
- I don't know (99) / _____ /
- Refused to answer (88) / _____ /

19. Would you consider **donating items** to the “**Albanian Red Cross**” in the future?
- Yes (1) / _____ /
- May be (2) / _____ /
- No (3) / _____ /
- I don't know (99) / _____ /
- If asked for a specific cause _____(for example) (4) / _____ /

20. Have you ever **volunteered your time** for the “**Albanian Red Cross**”?
- Never (1) / _____ /
- Once (2) / _____ /
- Less than three times (3) / _____ /
- Four or more times (4) / _____ /
- Annually (5) / _____ /
- Quarterly (6) / _____ /

Monthly (7) / _____ /
 Whenever asked (8) / _____ /
 Other (9) Fill In _____ / _____ /
 I don't know (99) / _____ /
 Refused to answer (88) / _____ /

21. Would you consider **volunteering your time** for the **“Albanian Red Cross”** in the future?
 Yes (1) / _____ /
 Maybe (2) / _____ /
 No (3) / _____ /
 If asked for a specific cause (for example) _____ (4) / _____ /

22. Have you or your relatives/friends benefited from or received “Red Cross” aid or assistance in the past?

Yes (1) / _____ /
 No (2) / _____ /
 Don't know (99) / _____ /
 Refused to answer (88) / _____ /

23. Do you think that the contributions and aid given to this organization is going to the proper destination or?

It does not go to the proper destination at all (1) / _____ /
 Very little goes to the proper destination (2) / _____ / Almost half
 goes to destination (3) / _____ /
 Most of it goes to destination (4) / _____ /
 All of it goes to destination (5) / _____ /
 Don't know (99) / _____ / Refused to
 answer (88) / _____ /

If the answer is (5) or (88), pass to question 25

24. Who is responsible of Aid not going to its proper destination?

Employees of Red Cross themselves (0) / _____ /
 Employees of Local Government (1) / _____ /
 Others (2) _____ (specify)

25. Where do you normally get your information about the **“Albanian Red Cross”**?
 (select top **two** choices):

Radio (1) / _____ /
 TV (2) / _____ /
 Newspapers (3) / _____ /
 Magazines (4) / _____ /
 Humanitarian activities (5) / _____ /
 Information campaigns (6) / _____ /
 From friend or relatives (7) / _____ /

Other (specify) (8) _____ / _____ /
 Don't know (99) _____ / _____ /
 Refused to answer (88) _____ / _____ /

Thank you for your time!

Appendix 2 INSTAT Population Data/Number of interviews

	District	No. of families						Interviews		
		Total	%	Urban	% urban	Rural	% rural	Total	Urban	Rural
1	Berat	29502	4,0%	11839	40,1%	17663	59,9%	49	20	29
2	Bulqize	9035	1,2%	2194	24,3%	6841	75,7%	15	4	11
3	Delvine	3195	0,4%	1126	35,2%	2069	64,8%	5	2	3
4	Devoll	8038	1,1%	1622	20,2%	6416	79,8%	13	3	10
5	Diber	17389	2,4%	3139	18,1%	14250	81,9%	29	6	23
6	Durres	45039	6,2%	29260	65,0%	15779	35,0%	74	48	26
7	Elbasan	53399	7,3%	24489	45,9%	28910	54,1%	88	40	48
8	Fier	47597	6,5%	19740	41,5%	27857	58,5%	78	32	46
9	Gramsh	7610	1,0%	2478	32,6%	5132	67,4%	13	5	8
10	Gjirokaster	14034	1,9%	6152	43,8%	7882	56,2%	23	10	13
11	Has	3788	0,5%	630	16,6%	3158	83,4%	6	1	5
12	Kavaje	18736	2,6%	7213	38,5%	11523	61,5%	31	12	19
13	Kolonje	4258	0,6%	1921	45,1%	2337	54,9%	7	3	4
14	Korce	35378	4,9%	16085	45,5%	19293	54,5%	58	26	32
15	Kruje	14548	2,0%	4569	31,4%	9979	68,6%	24	8	16
16	Kucove	8618	1,2%	4719	54,8%	3899	45,2%	14	8	6
17	Kukes	13016	1,8%	3444	26,5%	9572	73,5%	21	6	15
18	Kurbin	12845	1,8%	5823	45,3%	7022	54,7%	21	9	12
19	Lezhe	15742	2,2%	4116	26,1%	11626	73,9%	26	7	19
20	Librazhd	15320	2,1%	2769	18,1%	12551	81,9%	25	5	20
21	Lushnje	31987	4,4%	9603	30,0%	22384	70,0%	53	16	37
22	M.Madhe	9037	1,2%	939	10,4%	8098	89,6%	15	2	13
23	Mallakaster	8771	1,2%	2137	24,4%	6634	75,6%	14	3	11
24	Mat	13522	1,9%	3252	24,0%	10270	76,0%	22	5	17
25	Mirdite	8164	1,1%	2213	27,1%	5951	72,9%	13	3	10
26	Peqin	7015	1,0%	1724	24,6%	5291	75,4%	12	3	9
27	Permet	6408	0,9%	2618	40,9%	3790	59,1%	11	5	6
28	Pogradec	16923	2,3%	6016	35,5%	10907	64,5%	28	10	18
29	Puke	7596	1,0%	1364	18,0%	6232	82,0%	13	3	10
30	Sarande	9837	1,4%	3928	39,9%	5909	60,1%	16	6	10

31	Skrapar	6906	0,9%	3324	48,1%	3582	51,9%	11	5	6
32	Shkoder	46083	6,3%	22424	48,7%	23659	51,3%	76	37	39
33	Tepelene	7563	1,0%	2877	38,0%	4686	62,0%	12	4	8
34	Tirane	129045	17,7%	92509	71,7%	36536	28,3%	213	152	60
35	Tropoje	6222	0,9%	1678	27,0%	4544	73,0%	10	3	7
36	Vlore	36475	5,0%	21952	60,2%	14523	39,8%	60	36	24
Albania		728641	100,0%	331886	45,5%	396755	54,5%	1200	547	653

Appendix 3 Acronym List

AlbRC	Albanian Red Cross
AmRC	American Red Cross
ICRC	International Committee of Red Cross
IFRC	International Federation of Red Cross/Red Crescent
PIS	Public Image Survey
OD Team	Organizational Development Team
ISPS	Institute for Social and Psychological Studies
IF	Illyricum Fond
Q.	Question

ANNEX 13

MOH Reproductive Health Policy

**REPUBLIC OF ALBANIA
MINISTRY OF HEALTH
THE CABINET**

Boulevard "Bajram Curri" Tirana, ALBANIA, Tel/FAX +355 (0)4 329437

No. 1295 Prot.

Tirana, 14/04/2003

MANUAL NO. 146, DT 11/04/2003

**Based on the law no. 8876, date 04/04/2992 " Reproductive Health"
and especially based on the articles 14, 21, 24, 25 of this law**

INSTRUCT

1. All the public or non-public health institutions that offer mother and child health care in the Primary Health Care have to obey to the rule on the approved reproductive health services no 147, on the model-record on pregnancy follow-up, on the women-advisory centre, on the pregnancy follow-up record, on the model-card on physical growth and development follow-up and on the child health card.
2. The content of the above-mentioned documents will be reviewed every 5 years by the Ministry of Health
3. The Public Health Directorate of a certain district has to provide the above-mentioned documentations to all the institutions that offer health care towards the pregnant women and stimulate physical growth and mental development.
4. It will be provided free-of-charge services to all the pregnant women during pregnancy, delivery and postpartum follow-up while in mother and child health care institutions.
5. During the antenatal period the follow-up of the pregnant women will be done as follows:
 - a. The consulting-centre's doctor of the family doctor, in the villages, has to provide minimum **4 antenatal** free-of-charge visits, to all the pregnant women, necessary to prevent, discover and manage the possible complications and to refer them in the proper time when needed

- b. In those cases, when the woman is identified to have one of the following problems will be checked by the doctor within often intervals of time, depending on the presented problem.
 - stillbirth or neonatal death
 - anamnesis, more than 3 spontaneous abortions
 - the youngest child weights less than 2500 g
 - the youngest child weights more than 4500 g
 - during last pregnancy: hospitalised because of hypertension or pre-eclampsia / eclampsia
 - previous surgical interventions in the reproductive tract (myomectomy, cutting out of septum, biopsy, classic CS, serklazh of coolum)

If the present pregnancy is:

- gemelare pregnancy, diagnostic or doubtful
- age, less than 16
- age, more than 40
- izo-immunisation Rh(-) during the present pregnancy or previous pregnancy
- vaginal haemorrhage
- pelvic mass
- blood diastolic pressure more than 90mmHg

In case there are seen other diseases during examining the pregnant women:

-diabetes mellitus insulin-dependent
 -affections/diseases of the urine-system
 -signs of drugs abuse, alcohol and tobacco
 -other medical problems or pulmonary system diseases, blood diseases, chronic diseases of other organs, etc.

- The first visit will be provided within the first trimester of pregnancy. In the case of a normal pregnancy the examinations provided during this period of time will be:
 - clinic examination
 - check-up for anaemia signs through measuring the haemoglobin
 - obstetrical examination to find out the age of pregnancy
 - gynaecologic examination (that might be postpone till the second visit)
 - measuring of the blood tension
- the measurement of height and weight (determining the height index, BMI)
- performing the test of syphilis, toxoplasmosis, German measles , and cytomegalovirus
- finding the symptoms and evaluations on STD through the examination of the vaginal secretions
- performing the urine test
- determination of the blood group and Rh test
- Doing TT immunization
- giving folic acid

- referring if needed to a higher health level

⇒ **d.** The second antenatal visit will be provided within the 22-26 week of pregnancy. If during this visit the pregnancy is found to be normal and it is not identified any of the presented problems the following examinations will be performed:

- Clinic examination for anaemia
- Obstetrical examination to evaluate the pregnancy age, uterine height, FHR
- Measurement of Blood pressure
- Woman's weight
- Urine test for presence of proteins in urine
- The tests to determine the blood glucose level and urine glucose presence
- Iron/ folic acid provision

⇒ **e.** The third antenatal visit will be provided within the 30-32 week of pregnancy. During this visit the woman must be evaluated if there **is a hypertension in the pregnancy, pre-eclampsia and any irregularity on foetal growth.** Meanwhile **the evaluation of the premature risk** and the following examinations will be performed:

- All following-up controls same as in the second pre-natal visit
- Clinic examination on anaemia (Hb test is required)
- TT immunization (second shot)
- informing the woman on the possible time of delivery
- informing and advising the woman about the breastfeeding importance and preparations for happening this
- giving information to the woman about possible delivery plan

⇒ **f.** The forth-antenatal visit will be performed over the 38 week of pregnancy. During this visit must be identified **misinterpretation** and to **refer the case to the second level health care closed to the foreseen day of delivery** also to recommend the woman to get the mother card with her when time to deliver.

During this visit if the pregnancy presents normal the woman must complete the following examinations:

- all following-up controls same as during the second and third visits
- to identify presentation part of body (leg, transversal etc.) and referring on determination of the final time of delivery

5. During pregnancy **three free of charge ultrasound examinations** will be provided to the woman during this period of time.

- First examination from 8-11 week of amenorrhea (to identify the number of foetuses, vitality of foetus, gestational age, accompanying pathologies, early screening of some anomalies as anencephaly, omfalocoele, renal policistoze, nanizem and cardiopatya)

- Second examination from 19-22 week of amenorrhea (screening of foetal abnormality, the evaluation of foetal growth, location the morphology of placenta, amniotic liquid volume, diagnosing the death of one of the twins in cases of multiple pregnancies)
- Third examination over the 32 week of amenorrhea (to determine foetal presentation, foetal growth, foetal abnormality of later diagnose, location, the morphology and the biometric of placenta, amniotic liquid volume, the abnormality of umbilical cord)

6. During normal pregnancy, must be provided a vaginal examination at the end of first pregnancy term, or could be postponed until on the second trimester of pregnancy term.

7. All following-up controls and examinations will be described on the following-up pregnant woman record and on her own pregnant woman notebook.

8. During the period time of delivery, for all normal pregnancies that are provided in the local maternities at Health Centre in the village/or in the house under medical assistance, must complete the following instructions:

9. During the delivery activity, the medical staff that follows-up the delivery must complete the followings:

- ⇒ **a-**Fast evaluation of general health status of woman, considering vital signs (pulse, BP, respiration, fever)
- ⇒ **b-** to evaluate the foetus status considering :
- ⇒
 - hearing immediately FHR after each contraction
 - counting FHR/minute or at least in every 30 minutes during the active phase and in every 5 minute during the second period;
- If FHR are alternated (less than 100 or more than 180 beatings/min) it led to suspect for the fetal suffer and it must be referred immediately.
- If the membranes are cracked and amniotic fluid is colored it should be referred immediately.
 - c. To provide supporting care during the labor and delivery as:
 - To encourage and support the woman, that during labor and delivery process, she should have near a person who is selected by her.
 - To help the person who is selected by the woman to give her/his adequate assistance to the woman during the delivery process.
 - To take care about the woman and her environment's hygiene through:
 - Cleaning up the perineo-vulvare area before each examination;
 - Hand-washing with soap before and after each examination of woman;
 - Insuring cleanness of the antenatal area and delivery room.
 - To encourage the woman to move freely.

- To support her to find a comfortable position during delivery
- To encourage the woman to eat and drink according to her needs.
- To know and to practice the respiratory techniques during labor.
- To help the woman during the delivery if she is anxious, scared or have pain, through the information given on delivery progress, as well as to understand her feelings

10. The vaginal examination should be realized at least once in each 4 hours during the first phase of labor and after the ruin of the membranes. The data should be writing down on partograf.

11. During the second phase of labor the vaginal examinations must be done every 1-hour.

12. If during the whole delivery activity, the FHR are alternated (less than 100 or more than 180 beatings/min) it led to suspect for fetal detres and the woman must immediately be referred to:

13. During the labour must be evaluated the general status of the woman:

- If the woman pulse is intensifying she might be dehydrate or have pains. To be assured appropriate oral rehydration or by I.V.
- If the woman has a lower BP, suspect for haemorrhage and refer

14. Immediately after delivery

- Clean up and dry the child, cover up (his/her first bath must be hold over later, 2-6 hour after birth) and evaluate the child for the breath, heart rate, delivery weight, defect/ delivering trauma.
- If during this evaluation the child is classified with health problems than refer urgently
- In case that the child does not have health problem put on the mother belly in order to provide skin to skin contact and early breastfeed.

15. During the third period of delivery

⇒ **a-** To provide the active management through:

- Immediately giving the oxytocin 10 unite IM. If there is no oxytocin provide ergometrine 0.2 mg IM (if woman has no high TA, pre-eclampsia, eclampsia).
- Check the umbilical cordon
- Massaging uterus

⇒ **b.** Check carefully to be sure that placenta is all out. If one of the mother part is missing or the membranes are turn up including the vein, must be suspected for remaining placenta fragments.

16. At the end of the third phase of delivering woman must be carefully examined and fix any damages of vagina or coolum or to sew up episiotomy.

17. The medical staff that assists on woman delivery at local maternity and/or at house, must provide health care to the newborn, the following:

- Checking-up the respiratory and the colour of the baby in every 5 minute.
- Observe if the child might be cyanotic or does have respiratory difficulty (less than 30 or more than 60 respiratory per minute) and **refer** to the maternity.
- Checking up the warmth through touching the child's legs in every 15 minute
 - If the child's legs seems cold must check axillaries temperature
 - If child's temperature is under 36.5 grade Celsius the child must warmed-over.
 - Checking the cordon if there is any haemorrhage, in every 15 minute. If there is any haemorrhage on the cordon tie again more tightly.
 - Apply to the child's eyes the silver nitrate solution 1%, or iodine solution 2.5% or tetracycline pomade 1%.
 - Cleaning the child's skin from mekoniumi or blood.
 - Foster the early breastfeed when the child is ready
 - Do not practice force to the child to breastfeed.
 - Avoiding to separate mother from the child as much as it is possible.
Do not let both mother and child unaccompanied.
 - Be sure about the primary routine care to newborn baby.
 - Vaccinate the child, hepatitis vaccine and referring after leaving the delivering house or maternity for BCG vaccine according to the MoH instructions.
 - If there is any problem of health to the child, transfer the child to the neonatology ward for a good medical care as fast as possible.

18. All women after birth, during postpartum period must be follow- up by medical staffs, which cover the antenatal and postpartum woman care, the following instructions:

- ⇒ **a-** postpartum period includes the period from the first day of birth to the 60th day.
- ⇒ **b-** Postpartum check-up must be provided necessarily on 3rd, 8th and 40th day after delivery. If the delivery is by caesarean, it is needed an additional visit within 8-15 days.
- ⇒ **c-** The woman must be checked-up and advised for:
 - Pulse, BP
 - Fever
 - Anaemia
 - Breast check-up and lactation management and referring for any problem
 - Pelvic examination, uterus involution check-up for any possible infection to the genital tract
 - Check-up the status of vulvae-vaginal, the lohje character.
 - The urination and defecation.
 - The discussion with mother on contraceptive, after the delivery

19. all women must pay attention and evaluate the anemia caused by the lack of iron, through the controls in village/town women consulting centers and health centers as following:

A. The preconceiving period

- To push the teenage girls and reproductive women to eat the nutrient, which are rich with iron and food that raise the absorption of iron in organism.
- All women that have poor diets with iron, which are base of Ferro-deficiency anemia, must provide an iron supplementation.
- Starting from the adolescence, the all non pregnant women must be screened during the routine health examinations on anemia problem in each 5-10 years during their reproductive age.
- Every year must be screened the women that have lack of iron (long menstruation's period or others blood losses, taking few iron or having former Ferro-deficiency anemia).
- The teenage girls and women that have had the anemia must be given the iron orally 60-120mg/day for 2-3 months. Also they should be advised on lack of iron how to remedy it through diets.
- If the anemia after the 4 weeks hasn't be changed, even those cases have been treated with supplements of iron and if doesn't exist any other reason they must recommended for a specialized treatment.

B. The antenatal period

- To push women to eat food, which is rich with iron and with that kind of nutrient that raise the absorption of iron in organism.
- The pregnant women that have had the poor diets with iron are objects of danger for increase of Ferro-deficiency anemia, so taking the supplement of iron by these women is its necessary.
- The treatment of those women will start with small doze of iron 30mg/day in the first prenatal visit.
- If the level of hemoglobin is less than 9.0g/dL or if the hematocritis is less than 27.0% the patient should be referred to the specialist doctor for the anemia during the pregnancy, and for the other following examination.
- The pregnant women that have anemia (the level of hemoglobin is less than 9.0g/dL and/or the hematocritis is less than 27.0%) the iron will be given them orally in these dozes 60-120mg/day, and women are advised to eat the rich nutriment with products that contain iron.
- During this treatment, in case of:
 - After 4 weeks, the anemia is not improved (the woman remains anemic during the pregnancy and the concentration of Hb doesn't increase with 1g/dL from previous level or hematocritis with 3%) the woman should go to the specialist.
 - The concentration of Hb becomes normal during the pregnancy, the dozes of iron decreases in to 30mg/day.

- During the second and third quarters of pregnancy, if the level is higher than 15.0g/dl or hematocrit is more than 45.0%, evaluate the woman for possible complication of pregnancy related to the decreased volume (insufficient) of blood.

C. In postpartum period

- the women who have huge possibility to be anemic should be screened 4-6 weeks after delivery for anemia using the concentration of hemoglobin or hematocrit test
 - all women with dangerous factor which influence for the continuation of the anemia in third quarters (enormous loss of blood during the delivery, delivery with many fetus) should be treated and follow-up for the Ferro-deficiency anemia equally as non pregnant women.
 - If the woman after delivery doesn't have dangerous factor for the anemia it is advised only for a healthy nutrition.
20. All children aged 0-6 years old will be checked-up free for their development and well-being.
21. It is obligatory that the doctor of village/town health center should make these visits even when the health of child is fine. The visits serve for check-up and control of the child normal development and social environment when he/she lives and respectively:
- a. The visit of first week after delivery.
 - b. The second visit during the second week after delivery
 - c. A visit by the end of first month
 - d. A monthly visit till the ninth month
 - e. A visit in twelfth month
 - f. A quarterly visit from 12-14 months age
 - g. A visit in each six month in the age 2 till 6 years old

Each visit of child will be recorded in record of child consultancy room or in personal book of child health.

21. Children of age 0-6 years, must also be checked by the nurse in charge as follows:

- During the first month, a check between the 3rd and 5th day after leaving the maternity (doctor check-up) and another visit during the 3rd week (doctor visit)
- Age 1-12 months, must see the doctor once a month.

22. During these child check visits, the following must be taken into consideration:

- A. The first visit must be done by the Consultation Centre's doctor, necessarily into the household between the third and the fifth day after leaving the maternity.
- B. During the same month the development and child physical growth will be examined, according to the instructions/determinations of the Consult' card.

- C. When the child is 9-months old, a full examination on the physical growth and psychomotor development will be provided to the child.
- D. At the end of the second year, another full examination on the physical growth and psychomotor development will be provided to the child.
- E. At the end of the third year, another full examination on the physical growth and psychomotor development will be provided to the child.

23. During the first check the doctor must see:

- The general picture/view of the child
- Weight, height, head perimeter
- Different organs examination
- Native anomalies
- Sight
- Hearing
- New-born baby reflects
- Way of nutrition
- Slipping position
- Child vaccination
- Hygiene-sanitary and social-economic conditions of the family where the child with grow-up

24. During the check up visits from 1-18 months the child might be examined on:

- The general status of the child
- Weight, height, head perimeter
- Way of nutrition
- Hearing, sight
- Slipping position
- Vitamins and supplementary received through iron
- Promoter, cognitive and social development

25. A full balance of the physical and psychosocial will be done to the child when she/he is 9-months, describing.

- Weight, height, head perimeter
- Breastfeeding and supplementary feeding/nutrition situation
- Listening, sight
- Motor development, behaviour, speaking
- Social conditions where the child grows up
- Vaccination
- Vitamins and complementary food

26. Next month the child will be checked on:

- Weight, height
- Nutritional situation
- Psychosocial/sensorial development
- Economic-social condition where the child lives

27. When it is noticed no reaction against noises or this happens after a long time or there are difficulties, etc, the child needs to see the doctor immediately.

It is advised to send the 6-year child, before starting school, to the specialist in order to check the child-listening ability.

28. In case the consultation's doctor notices sight anomalies during the visit he/she refers the child to the oculist.

It is advised to send the 6-year child, before starting school, to the specialist in order to check the child-sight ability and meanwhile to see if he/she is developing normally.

29. In case the consultation's doctor notices walking or moving combination anomalies, etc, even after first months of birth, he/she must refer the child to the neurology or Chiro-practitioner.

30. If during the check on psychological problems, the consultation's doctor notices lack of affection, no family care, problems or hard family difficulties, etc., he/she must ask the care of the social worker in case this is part of the public health care structure.

31. Premature children and under-weight newborn children must see the consultation's doctor once a week after leaving the maternity. Their further follow-up must be done in the same way as the underfed children.

32. All the undernourished and underfed children must be treated/followed-up as follows:

- a. The children who are undernourished in a light level will see the doctor each 2 weeks, no difference of age until reaching the normal weight.
- b. The children who are undernourished and underfed kind of medium and severe levels will see the doctor each week, no age difference until reaching the normal weight.
- c. The children who suffer from Rachitic must see the doctor 2-3 times a month no matter how old the child is/there are no limits of age. This contingent of children must see the doctor of the consultation centre in order to determine correct the psychomotor development parameters.

33. For the premature children and under-weight newborn babies the following scheme must be followed by the nurse in charge:

- a. The nurse in charge must check the premature children and those born under-weight during the first month after leaving the maternity once a week, through doctor's visits. Their further follow-up will be same as underfed children.

- b. The nurses in charge will follow-up the children who are underfed according to the underfed grade.
 - The nurse in charge will check the child who is underfed in a light level once each 2 weeks, through doctor visits, even the child is wealthy until the weight normality.
 - The nurse in charge will check the child who is underfed in a medium and severe level once each 2 weeks, through doctor visits, even the child is wealthy until the weight normality.
- c. The nurse in charge must check the child with Rachitic, 2-3 times a month (during time when child is seeing the doctor).

34. When the child is 6 years old, before starting school, a full physic and psycho-emotional must be provided to him/her.

35. Non public health services that will be provided with licence by the Ministry of Health to serve as women and child consulting centres are obligated to follow these Guide/Manual/Instructions and Rules on the Reproductive Health Service of the Primary Health Care.

36. This manual is effective from now on

MINISTER

Mustafa XHANI



**REPUBLIKA E SHQIPERISE
MINISTRIA E SHENDETESISE
KABINETI**

Bulevardi "Bajram Curri" Tirana, ALBANIA, Tel/FAX +355 4 329437

Nr 1285 Prot.

Tirane, 14.4.2003

UDHEZIM NR 146 Dt 11.04.2003

Ne mbeshtetje te ligjit nr 8876 date 4.04.2002 "Per Shendetin Riprodhues" dhe ne veçanti te neneve 14, 21, 24, 25 te ketij ligji

U. DHEZOJ

1. Te gjitha institucionet shendetesore publike dhe jo publike qe ofrojne kujdes shendetesor per nenen dhe femijen ne Kujdesin Shendetesor Paresor do te zbatojne rregulloren e sherbimeve te shendetit riprodhues te miratuar nr 147, kartelen tip te ndjekjes se gruas shtatzete, te keshillimores se gruas, fletoren per ndjekjen e gruas shtatzene, kartelen tip per ndjekjen e rritjes dhe zhvillimit te femijes te keshillimores se femijes, dhe fletoren per shendetin e femijes.
2. Permbatja e dokumentacionit te pershkruar me lart do te rivleresohet çdo 5 vjet nga Ministria e Shendetesise
3. Drejtoria e Shendetit Publik te rrethit duhet te siguroje furnizimin dokumentacionin e mesiperm e te gjitha institucioneve qe ofrojne kujdes shendetesor per gruan shtatzane dhe per mirerritjen e zhvillimin e femijes me
4. Te gjithë grave shtatzana do t'ju sigurohet falas ndjekja shendetesore gjate shtatzanise, lindjes dhe pas lindjes ne institucionet shendetesore te kujdesit per nenen dhe femijen
5. Gjate periudhes antenatale per ndjekjen e gruas shtatzane do te veprohet si me poshte:

⇒ **a.** Te gjitha grave shtatzana do ti kryhen falas nga mjeku i keshillimore se gruas ne qytet dhe mjeku i familjes ne fshat minimumi **4 vizita para lindjes** (antenatale) te domosdoshme per te parandaluar, zbuluar, manaxhuar komplikacionet e mundeshme si dhe kur nevojitet t'i referojne ato ne kohen e duhur

⇒ **b.** Ne ato raste kur gruaja shtatzane identifikohet me nje nga problemet e meposhteme do te kontrollohet nga mjeku me intervale me te shpeshta sipas llojit te problemit te paraqitur.

- feto-morto ose vdekje neonatale
- anamneze me me shume se 3 aborte spontane
- femija i fundit me peshe me te ulet se 2500 g
- femija i fundit me peshe me te madhe se 4500g
- shtatzania e fundit: shtruar ne spital me hipertension ose preeklampsi/eklampsi
- nderhyrjet kirurgjikale te mepareshme ne traktin riprodhues (myomiectomi, heqje e septumit, biopsi, CS klasike, serklazh i kolumit)

Ne se shtatzania ne vazhdim eshte:

- shtatzani gemelare e diagnostikuar ose e dyshuar
- mosha me pak se 16 vjec
- mosha me shume se 40 vjec
- izoimunizim Rh(-) ne shtatzanine ne vazhdim ose ne shtatzanite e meparshme
- hemoragji vaginale
- mase pelvike
- presion diastolik me shume se 90 mmHg

Ne se gruaja shtatzane paraqet semundje te tjera:

- diabet mellitus insulino-vartes
- semundje te sistemit urinar
- semundje te sistemit kardiovaskular
- te dhena per marrjen e drogave, alkolit, duhanit
- ndonje problem tjetër mjekesor, ose semundje te sistemit pulmonar, semundjet e gjakut, semundje kronike te organeve te tjera, etj.

⇒ **c.** Vizita e pare do te kryhet brenda tremujorit te pare te shtatzanise. Ne rast te nje shtatzanie normale ekzaminimet qe do te kryeje gruaja ne kete periudhe kohore jane:

- ekzaminimi klinik,
- vleresimi per anemi nepermjet matjes se hemoglobines
- ekzaminimi obstetrikal per vleresimin e moshes se shtatzanise
- ekzaminimi gjinekologjik (i cili edhe mund te shtyhet deri per viziten e dyte)
- matja e tensionit te gjakut

- matja e gjatesise dhe peshes (percaktimi i indeksit te mases trupore,BMI)
- kryerja e testit per sifiliz, toxoplazmoze, rubeole, citomegalovirus
- zbulimi i simptomave dhe vleresimi per SST nepermjet ekzaminimit te sekrecioneve vaginale
- kryerja e testit te urines
- percaktimi i grupit te gjakut dhe rhezusit
- imunizimi antitetanik
- dhenia e acidit folik
- referimi ne rast nevoje ne nje nivel me te larte kujdesi

⇒ **d.** Vizita e dyte e kontrollit do te kryhet brenda javes se 22 - 26-te te shtatzanise. Gjate kesaj vizite ne se shtatzania vazhdon te zhvillohet normalisht dhe nuk identifikohet asnje nga problemet e paraqitura do te kryhen:

- ekzaminimi klinik per anemi
- ekzaminimi obstetrikal per vleresimin e moshes se shtatzanise, lartesis se uterine , RZF
- matja e TA
- pesha e gruas
- testi i urines per proteinuri
- testet per percaktimin e glicemise dhe glukozurise
- jepet acid folik + hekur

⇒ **e.** Vizita e trete kryhet brenda javes se 30 - 32-te te shtatzanise. Gjate kesaj vizite duhet te vleresohet gruaja ne se eshte mbivendosur **hipertensioni ne shtatzani, preeklampsia dhe çrregullimet e rritjes se fetusit.**

Gjithashtu do te kryhet **vleresimi per rrezikun e lindjes para kohe** si dhe do te kryhen keto ekzaminime:

- te gjitha kontrollet qe kryhen ne viziten e dyte
- ekzaminimi klinik per anemi (kerkohet testi i Hb)
- imunizimi antitetanik (doza e dyte)
- i jepet gruas informacion per planin e mundshem te lindjes
- informohet dhe keshillohet gruaja per rendesine dhe masat qe duhen marre per ushqyerjen me gji

⇒ **f.** Vizita e katert do te kryhet mbi javen e 38-te te shtatzanise. Gjate kesaj vizite duhet te identifikohen **malprezentacionet** dhe te **planifikohet per referimin e rastit ne nivelin e dyte te kujdesit shendetesor ne afersi te dites se parashikuar per lindje** si dhe t'i rekomandohet gruas te marre me vete Fletoren e ndjekjes se shtatzanise kur shkon per te lindur

Ne kete vizite nese shtatzania vazhdon te zhvillohet normalisht gruaja do te kryeje ekzaminimet e meposhtme:

- te gjitha kontrollet qe kryhen ne viziten e dyte dhe te trete
- identifikimin e prezantimit (podalik, transvers etj.) si dhe referimi nper percaktimin e planit perfundimtar te lindjes

5. Gjate shtatzanise, gruaja do te kryeje **falas 3 ekzaminime ekografike** ne keto periudha kohore

- ekzaminimi i pare nga java e 8-11-te e amenorese (per te identifikuar numrin e fetuseve, vitalitetin e fetusit, moshen e shtatzanise, patologjite shoqeruese, depistimin e parakoheshem te disa anomalive si anencefali, omfalocelle, polikistoze renale, nanizem dhe kardiopati)
- ekzaminimi i dyte nga java e 19-22-te e amenorese (per depistimin e keqformimeve fetale, vleresimin e rritjes fetale, lokalizimin dhe morfologjine e placentes, vellimin e lengut amniotik, diagnozen e vdekjes se njerit prej binjakeve ne rastet e shtatzanise multiple)
- ekzaminimi i trete mbi javen e 32-te te amenorese (per te percaktuar prezantimin fetal, rritjen fetale, diagnozen e vone te keqformimeve fetale, lokalizimin, morfologjine dhe biometrine e placentes, sasine e lengut amniotik, anomalite e kordonit umbilikal)

6. Gjate shtatzanise normale duhet te kryhet nje ekzaminim vaginal ne fund te tremujorit te pare te shtatzanise, ose mund te shtyhet deri ne tremujorin e dyte te shtatzanise.

7. Te gjitha vizitat e kontrollit dhe ekzaminimet e kryera do te pershkruhen ne kartelen e ndjekjes se gruas shtatzene dhe ne fletoren personale te ndjekjes se shtatzanise

8. Gjate periudhe se lindjes, per te gjitha lindjet normale qe kryhen ne shtepite e lindjes ne fshat dhe/ose ne shtepi me asistencë mjeksore, duhet te zbatohen udhezimet si me poshte

9. Gjate aktivitetit te lindjes personeli qe ndjek lindjen duhet te kryej

⇒ a. Nje vleresim te shpejte te gjendjes se pergjitheshme te gruas perfshire shenjat vitale (pulsi, TA, respiracioni, temperatura)

⇒ b. Te vleresoje gjendjen e fetusit duke:

- degjuar RZF menjehere pas cdo kontraksioni
- numeruar RZF per nje minute te plote ose te pakten cdo 30 minuta gjate fazes aktive dhe cdo 5 minuta gjate stadiit te dyte;

- nese RZF alterohen (me pak se 100 ose me shume se 180 rrahje ne min)) duhet dyshuar per vuajtje fetale dhe referuar menjehere.
- nese membranat jane te plasura dhe lengu amniotik eshte i ngjyrosur duhet referuar menjehere:

⇒ c. Te ofroje kujdes mbeshtetes gjate aktivitetit te lindjes dhe lindjes duke:

- nxitur dhe mbeshtetur gruan qe gjate aktivitetit te lindjes dhe lindjes te kete prane nje person te zgjedhur prej saj
- ndihmuar shoqeruesin e zgjedhur nga gruaja te jape mbeshtetjen adekuate gjate aktivitetit te lindjes dhe lindjes
- kujdesur per higjenen e gruas dhe te ambientit te saj nepermjet:
 - larjes se fushes perineo - vulvare perpara cdo ekzaminimi ;
 - larjes se duarve me sapun perpara dhe pas cdo ekzaminimi te gruas
 - sigurimit te pastertise se ambientit te paralindjes dhe te dhome se lindjes.
- inkurajuar gruan te levize lirshem;
- mbeshtetur zgjedhjen e gruas per pozicionin me te preferuar prej saj ne lindje.
- nxitur gruan te ushqehet dhe te pije lengje sipas nevojave qe ajo ka.
- njohur dhe zbatuar teknikat e frymemarjes per aktivitetin e lindjes dhe lindjen.
- ndihmuar gruan ne lindje ne se eshte ne ankth, e frikesuar ose me dhimbje duke dhene informacion lidhur me progresin e aktivitetit te lindjes si dhe duke kuptuar ndjenjat e saj

10. Ekzaminimi vaginal duhet te kryhet se paku nje here çdo 4 ore ne fazen e pare te lindjes dhe pas plasjes se membranave. Te plotesohen te dhenat ne partograf.

11. Gjate fazes se dyte te aktivitetit te lindjes kryhen çdo 1 ore ekzaminimet vaginale.

12. Gjate gjithë periudhes kohore te aktivitetit te lindjes nese RZF-te alterohen (me pak se 100 ose me shume se 180 rrahje ne min) dyshohet per detres fetal dhe menjehere referohet gruaja:

13. Gjate gjithë periudhes kohore te aktivitetit te lindjes duhet te vleresohet gjendja e pergjitheshme e gruas:

- Nese pulsi i gruas eshte duke u rritur ajo mund te jete e dehidratuar ose me dhimbje. Te sigurohet hidrimi i pershtatshem nga goja ose me rruge IV.
- Ne se gruaja ka ulje te TA dysho per hemoragji dhe referoje

14. Menjehere pas lindjes

- Fshije dhe thaje teresisht femijen, mbeshtille mire (banjo e pare e tij te shtyhet per nje periudhe te mevonshme 2-6 ore pas lindjes) dhe vlereso foshnjen per frymemarrjen, rrahjet e zemres, peshen e lindjes, defekte/trauma te lindjes
- Ne se gjate ketij vleresimi femija klasifikohet me probleme shendetesore duhet te referohet urgjentisht.
- Ne rast se foshnja nuk paraqet probleme te vendoset ne barkun e nenes, duke siguruar kontaktin lekure me lekure dhe ushqyerjen e hershme me gji.

15. Gjate stadiit te trete te lindjes

⇒ a. te kryhet menaxhimi aktiv duke:

- dhene menjehere oxytocinen 10 unite IM. Ne se oxytocina nuk disponohet, jepet ergometrine 0,2 mg IM (ne rast se gruaja nuk ka TA te rritur, preeklampsi, eklampsi).
- kontrolluar terheqjen e kordonit umbilikal;
- masazhuar uterusin.

⇒ b. te kontrollohet me kujdes placenta per tu siguruar qe asnje pjese e saj nuk mungon. Ne se mungon ndonje pjese e siperfaqes amtare, ose membranat jane te kthyera me gjithë vaza, te dyshohet per mbetje te fragmenteve placentare.

16. Ne fund te fazes se trete te lindjes te ekzaminohet gruaja me kujdes dhe riparohet ndonje demtim i kolumit ose vagines, apo te suturohet epiziotomia

17. Per foshnjen e porsalindur personeli i cili asiston gruan ne lindje ne shtepite e lindjes dhe/ose ne shtepi duhet te ofroje kujdesin per te porsalindurin e shendoshe duke:

- Kontrolluar cdo 5 minuta frymemarrjen dhe ngjyren e femijes
- Vezhguar ne se femija behet cianotik ose ka veshtiresi ne frymemarrje (me pak se 30 ose me shume se 60 frymemarrje ne minute) dhe **REFERUAR** ato ne maternitetin e rrethit.
- Kontrolluar ngrohtesine nepermjet prekjes se kembave te femijes cdo 15 minuta;

- nese kembet e femijes ndihen te ftohta duhet kontrolluar temperatura aksillare;
- ne se temperatura e femijes eshte me poshte se 36.5 grade celsius ringrohet femija .
- Kontrolluar kordonim per hemoragji çdo 15 minuta. Ne se nga kordoni rrjedh gjak rilidhet kordoni me i shtrenguar.
- Aplikuar per syte e femijes solucion nitrat argjenti 1 %, ose solucion providone-jod 2.5%, ose pomade tetracikline 1 %.
- Pastruar lekuren nga mekoniumi ose nga gjaku
- Nxitur fillimin e ushqyerjes se hershme me gji kur femija duket se eshte gati
- Mos ushtruar force tek femija per ta vendosur ne gji.
- Menjanuar ndarjen e nenes prej femijes sa here te jete e mundur. Mos e lini nenen dhe femijen te pashoqeruar asnje here.
- Siguruar kujdesin fillestar rutine per te porsalindurin;
- Vaksinuar femijen me vaksinën kunder Hepatitit B dhe duke e referuar ate pas daljes nga shtepia e lindjes ne maternitetin e rrethit per vaksinën e BCG simbas udhezimeve te Ministrise se Shendetesise per kete çeshtje.
- Transferuar femijen ne sherbimin neonatologjise te spitalit te rrethit ne se ai paraqet probleme ne nje sherbim te pershtatshem per kujdes per te porsalindurin (maternitetin e rrethit) sa me shpejt te jete e mundur.

18. Te gjitha grate pas lindjes gjate periudhes puerperale do te kontrollohen detyrimisht nga personeli shendetesor qe mbulon kujdesin per gruan gjate dhe pas shtatzanise ne qytet dhe ne fshat sipas udhezimeve te meposhteme:

⇒ **a**-Periudha puerperale perfshin nje periudhe kohore nga dita e pare e lindjes deri ne ditën e 60-te te saj .

⇒ **b**-Kontrolli i gruas ne periudhen e paslindjes te kryhet detyrimisht ne ditën e trete, te tete dhe ditën e dyzet pas lindjes. Ne se lindja kryhet me seksio cesarea mund te nevojitet nje vizite shtese brenda 8 - 15 ditesh.

⇒ **c**-Gruaja duhet te kontrollohet dhe keshillohet per :

- pulsin, TA
- temperaturën
- anemine
- kontrollin e gjirit dhe manaxhimin e laktacionit si dhe referimin e ne rast se ka probleme
- ekzaminimin pelvik, kontrollin per involucionin e uterusit per infeksione te mundeshme te traktit genital

- kontrollin e gjendjes vulvo-vaginale, karakterin e lohjeve
- urinimin dhe defekimin
- diskutimin pas lindjes me nenen per kontracepsionin me metoda te pershtatshme .

19. Per te gjitha grate konsultori i gruas ne qytet dhe ne qendren shendetesore te fshatit duhet te ndjeke dhe vleresoje anemine nga mungesa e hekurit si me poshte:

A. Ne periudhen prekonceptionale

- Te nxise vajzat adoleshente dhe grate e moshes riprodhuese te ushqehen me ushqim te pasur me hekur dhe me ushqime qe rrisin absorbimin e hekurit
- Te gjitha grate te cilat marrin dieta te varfera me hekur qe jane me rrezik me te rritur per anemine ferro- deficitare tu jepet hekur shtese
- Duke filluar nga adoleshenca te depistohen te gjitha grate joshtatzane gjate ekzaminimeve shendetesore rutine per anemi çdo 5-10 vjet gjate viteve te tyre te moshes riprodhuese.
- Te depistohen cdo vit grate qe kane patur faktor rreziku per mungesa me hekur (menstruacione te zgjatura ose humbje te tjera te gjakut, marrje e paket e hekurit, ose nje diagnoze e meparshme per anemi ferro – deficitare).
- Te trajtohen vajzat adoleshente dhe grate qe kane pasur anemi duke i dhene nga goja hekur **60 – 120 mg/ ne dite per 2-3 muaj**. Gjithashtu te keshillohen ato rreth korrigjimit te mungeses se hekurit nepermjet dietes.
- Ne se pas 4 javesh trajtimi me hekur anemia nuk korrigohet nepermjet dhenies se shtesave me hekur dhe ne mungeses te arsyeve te tjera duhet te referohen rastet per kujdes me te specializuar.

B. Ne periudhen antenatale

- Te nxitet gruaja shtatzane qe te ushqehet me ushqime te pasura me hekur dhe ushqime qe rrisin absorbimin e hekurit
- Grate shtatzane, dietat e te cilave jane te varfera me hekur kane rrezik te rritur per te zhvilluar anemi ferro – deficitare, prandaj dhenia e hekurit shtese per keto gra eshte e detyrueshme
- Ne keto gra trajtimi do te fillohet me doze te ulet shtese te hekurit 30 mg/ ne dite ne viziten e pare prenatale
- Ne se koncentrimi i Hemoglobines eshte me pak se 9.0 g/dL ose Hematokriti eshte me pak se 27.0 % pacienti referohet tek mjeku specialist per anemi gjate shtatzanise dhe per vleresim te metejshem.
- Ne grate shtatzane ku mjeku percakton anemi (perqendrimi i Hb eshte me pak se 9.0 g/dL dhe/ose Hematokriti eshte me pak se 27.0 %) hekuri do te jepet nga goja ne doza 60 – 120 mg/ ne dite dhe te

keshillohet gruaja shtatzane per nje ushqyerje te pasur me produkte qe permbajne hekur.

- Gjate ketij trajtimi ne rast se :
 - pas 4 javesh, anemia nuk korigjohet (gruaja qendron anemike gjate shtatzanise dhe koncentrimi i Hb nuk rritet me 1 g/dL nga niveli i meparshem ose hematokriti prej 3 %) gruaja duhet te referohet tek specialisti.
 - perqendrimi i Hb behet normal per fazen e shtatzanise, ulet doza e hekurit ne 30 mg/ne dite.
- Gjate tremujorit te dyte dhe te trete te shtatzanise, ne se perqendrimi i Hb eshte me i madh se 15.0 g/dl ose hematokriti eshte me shume se 45.0 %, vleresojte gruan per komplikacione te mundeshme te shtatzanise te lidhura me volumin e ulur (te pamjaftueshem)te gjakut

C. Ne periudhen pas lindjes

- Grate qe kane rrezik te rritur per anemi duhet te depistohen 4-6 jave pas lindjes per anemi duke perdorur perqendrimin e Hemoglobines ose testin e hematokritit.
- Te gjitha grate me faktore rreziku qe ndikojne per vazhdimin e anemise ne tremujorin e trete (humbje e theksuar e gjakut gjate lindjes, lindje me shume fetuse) te trajtohen dhe ndiqen per anemi ferro – deficitare njelloj si grate jo shtatzana.
- Ne se gruaja pas lindjes nuk ka faktore te pranishem rreziku per anemi te keshillohet vetem per nje ushqyerje te shendeteshme.

20. Te gjithe femijet e moshes 0-6 vjeç do te ndiqen dhe kontrollohen falas per mirerritjen dhe zhvillimin e tyre.

21. Keto vizita te behen te detyrimsht nga mjeku i keshillimores se qytetit dhe/ose mjeku i qendres shendetesore ne fshat edhe kur gjendja shendetesore e femijes paraqitet e mire. Ato sherbejne per ndjekjen dhe kontrollin e zhvillimit normal te femijes dhe te ambientit social ku ai ndodhet dhe perkatesisht:

- vizita e javes se pare pas lindjes
 - vizita e dyte brenda javes se dyte pas lindjes
 - nje vizite ne fund te muajit te pare
 - nga nje vizite ne muaj deri ne muajin e 9-te
 - nje vizite ne muajin e 12-te
 - nga nje vizite ne çdo tre muaj gjate moshes 12-24 muajsh
 - nga nje vizite ne çdo gjashte muaj ne moshen 2-6 vjeç
- Çdo vizite e femijes do te plotesohet ne kartelen e keshillimores se femijes dhe fletoren personale te shendetit te femijes.

21. Femijet e moshes 0-6 vjeç duhet gjithashtu te vizitohen edhe nga infermierja e patronazhit si me poshte

→ Ne muajin e pare, nje vizite ndermjet dites se trete dhe te peste pas daljes se femijes nga materniteti (ndermjet vizitave te mjekut) dhe nje vizite ne javen e trete (ndermjet vizitave te mjekut)

• → Nga mosha 1-12 muaj te kryeje nje vizite ne çdo muaj (ndermjet vizites se mjekut).

22. Gjate ketyre vizitave te kontrollit te femijes duhet qe:

→ a. Vizita e parë të bëhet nga mjeku i keshillimores, detyrimisht në banesë nga dita e tretë në ditën e peste të daljes nga materniteti.

→ b. Ne muajt ne vazhdim behet kontrolli i zhvillimit dhe rritjes se femijes siç eshte percaktuar ne kartelen e Konsultorit.

→ c. Ne muajin e 9-te behet nje ekzaminim i plote i zhvillimit fizik dhe psikomotor te femijes.

→ d. Ne fund te vitit te dyte behet nje ekzaminim tjeter i plote i zhvillimit fizik dhe psikomotor te femijes.

→ e. Ne fund te vitit te trete behet nje ekzaminim tjeter i plote i zhvillimit fizik dhe psikomotor te femijes.

23. Gjate vizites se pare te kontrollit mjeku duhet te vleresoje

- Gjendjen e pergjitheshme te femijes
- Peshen, gjatesine, perimetrin e kokes
- Ekzaminimin e organeve te ndryshme
- Anomali te lindura
- Shikimin
- Degjimin
- Reflekset e te porsalindurit
- Menyren e ushqyerjes
- Pozicionin e fjetjes
- Anomali te lindura
- Vaksininimin
- Kushtet higjieno-sanitare dhe social-ekonomike ku rritet femija

24. Gjate vizitave te kontrollit nga muaji 1-8-te femija duhet te kontrollohet per:

- Gjendjen e pergjitheshme
- Peshen, gjatesine, perimetrin e kokes
- Menyren e ushqyerjes
- Degjimin shikimin
- Pozicionin e fjetjes

- Vitaminat dhe shtesat e marra ne hekur
- Zhvillimin psikomotor, konjitiv dhe social te tij

25. Ne muajin e 9-te femijes do t'i behet nje bilanc i plote i zhvillimit fizik dhe psikosocial duke pershkruar

- Peshen, gjatesine, perimetrin e kokes
- Ushqyerja me gji dhe ushqyerjen perplotesuese/gjendjen nutricionale
- Degjimin, shikimin
- Zhvillimin motor, sjelljen, te folurit
- Kushtet sociale ku rritet femija
- Vaksinimi
- Vitaminat dhe shtesat e tjera

26. Ne muajt ne vazhdim femija do te kontrollohet per:

- Peshen, gjatesine
- Gjendjen nutricionale
- Zhvillimin psikosocial/sensorial
- Kushtet ekonomiko-sociale te ambientit ku ndodhet femija

27. Ne rast se veren mungesa te reagimit ndaj zhurmave, vonese apo veshtiresi etj, femija te konsultohet tek specialisti otojater.

Keshillohet kontrolli i degjimit tek specialisti gjate vitit te gjashte te jetes para se femija te filloje shkollën.

28. Në rast se mjeku i keshillimores gjate vizites per depistimin e çrregullimeve te shikimit veren anomali të ndryshme, apo çrregullime të sjelljes vizuale të konsultohet femija nga specialisti okulist.

Keshillohet kontrolli i shikimit tek specialisti gjate vitit të 6-të të jetës perpara se femija të futet në shkolle edhe në se ai ka një zhvillim normal.

29. Në rast se mjeku i keshillimores gjate vizites per depistimin e çrregullimeve neuromotore veren pranine e reflekseve te porsalindurit edhe pas muajve të parë të jetës, çrregullime të ecjes, te koordinimit të lëvizjeve etj duhet te dergohet per konsultë me specialistin neurolog si dhe ortoped.

30. Në rast se mjeku i keshillimores se femijes gjate vizites per depistimin e çrregullimeve psikologjike (ambjenti afektiv, social, neuropsikologjik) veren se ka mungesë të afeksionit, kujdesit familjar, probleme apo vështirësi të forta familjare etj të kërkoje ndërhyrjen edhe te punonjësit social ne rast se ky i fundit eshte pjese e struktures se kujdesit shendetesor publik.

31. Fëmijët prematurë dhe ato të lindur me peshe të ulët në muajin e parë pas daljes nga materniteti të vizitohen një herë në javë nga mjeku i keshillimores. Ndjekja e mëtejshme e tyre të bëhet sipas ndjekjes së fëmijëve me nenushqyerje.

32. Te gjithë femijet me kequshqyerje dhe nenushqyerje duhet të ndiqen si me poshte.

⇒ **a.** Fëmija me kequshqyerje të lehtë do të vizitohet çdo 2 javë pavarësisht nga mosha deri në arritjen e peshës normale.

⇒ **b.** Fëmija me kequshqyerje dhe nenushqyerje të lehtë dhe të rënda do të vizitohet çdo javë, pavarësisht nga mosha deri në normalizimin e peshës.

⇒ **c.** Fëmijët e sëmurë me Rakit të vizitohen 2-3 herë në muaj pamvarësisht nga mosha që ai ka. Ky kontigjent fëmijësh është e domosdoshme të vizitohet në keshillimoren e fëmijëve të qytetit për përcaktim të saktë të parametrave të zhvillimit psiko-motor.

33. Për femijet premature dhe ato të lindur me peshe të ulët duhet të ndiqet skema e mëposhteme nga infermierja e patronazhit:

⇒ **a.** Fëmijët prematurë dhe ato të lindur me peshe të ulët në muajin e parë pas daljes nga materniteti vizitohen nga infermierja e patronazhit 1 herë në javë ndërmjet vizitave të mjekut. Ndjekja e mëtejshme e tyre të bëhet sipas ndjekjes së fëmijëve me nenushqyerje.

⇒ **b.** Ndjekja nga ana e infermieres së patronazhit e fëmijëve me nenushqyerje do të bëhet sipas shkallëve të nenushqyerjes.

- Fëmija me nenushqyerje të lehtë do të shikohet nga infermierja e patronazhit çdo 2 javë ndërmjet vizitave të mjekut pavarësisht nga gjendja e mirë shëndetësore që ai mund të ketë deri në fitimin e peshës normale.
- Fëmija me nenushqyerje të lehtë dhe të rënda do të shikohet nga infermierja e patronazhit çdo 2 javë pavarësisht nga mosha deri në normalizimin e peshës (ndërmjet vizitave të mjekut)

⇒ **c.** Fëmija i sëmurë me Rakit të shikohet 2-3 herë në muaj nga infermierja e patronazhit (ndërmjet vizitave të mjekut).

34. Gjatë vitit të gjashtë të jetes, kur femija është në prag të jetes shkollorë, bëhet perseri ekzaminimi i plotë i zhvillimit fizik dhe psikoemocional të femijes

35. Sherbimet shendetesore jo publike qe do te licensohen nga Ministria e Shendetesis per te kryer aktivitetet e keshillimores se gruas dhe femijes jane te detyruara te zbatojne kete Udhezim si dhe Rregulloren e Sherbimeve te Shendetit riprodhues ne Kujdesin Shendetesor Paresor.

36. Ky udhezim hyn ne fuqi menjehere

MINISTRI

MUSTAFA XHANI

A handwritten signature in black ink, appearing to be 'MX', is written over a circular official stamp. The stamp contains some illegible text around its perimeter.

ANNEX 14

**Draft MOU Between
Albanian Red Cross, UNICEF, WHO and UNICEF**

MEMORANDUM of UNDERSTANDING

between

WORLD HEALTH ORGANIZATION,

UNICEF, THE UNITED NATIONS CHILDREN'S FUND,

ALBANIAN RED CROSS

and

MINISTRY OF HEALTH

**FOR THE IMPLEMENTATION OF INTEGRATED
MANAGEMENT OF CHILDHOOD ILLNESSES STRATEGY
2004-2005**

DATED _____

THIS MEMORANDUM OF UNDERSTANDING REGARDING THE IMPLEMENTATION OF THE "INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES" NATIONAL PROGRAM ACTIVITIES IS SIGNED ON **June ____**, 2004

AMONG: WHO, UNICEF, THE UNITED NATIONS CHILDREN'S FUND ("UNICEF"), ALBANIAN RED CROSS (AlbRC)

AND THE MINISTRY OF HEALTH, REPUBLIC OF ALBANIA

WHEREAS:

- A. UNICEF, in accordance with its Charter and Mission statement, works with governments, civil society organizations and other organizations around the world, including Albania, to advance children's rights to survival, protection, development and participation and is guided by the Convention on the Rights of the Child;
- B. Pursuant to a basic Cooperation Agreement dated (23.07.93) and a master Plan of Operation agreed to on (11.05.96), UNICEF and the above mentioned government institutions work together to develop and facilitate the implementation of programmes designed to assist the children and women of Albania and those programmes are realized within the context of the Country Programme for Albania developed by UNICEF in collaboration with the Government and approved by the UNICEF Executive Board.
- C. WHO
- D. AlbRC, in conformity with the Fundamental Principles of the Red Cross Movement, strives to improve the life and dignity of people in need and to contribute towards the improvement of health status of mother and child through the provision of public health information and education. Pursuant to the Letter of Permission of Ministry of Health, dated 3-th of October 2003, Albanian Red Cross will implement the Albania Child Survival Project in Dibra Prefecture which aims at improved health status of women and children 0-59 months old, guided by the IMCI National Program.
- E. Parties have agreed to collaborate in the activities for the implementation of IMCI in the framework of the IMCI expansion phase in order to expand IMCI geographical coverage and activities initially *in three prefectures Korça, Elbasan, Dibra* and to introduce IMCI in the pediatrics curriculum at faculty and postgraduate level aiming to prepare skillful health professionals to prevent and manage the children illnesses in an effective and integrated manner; to improve health workers practices at both the first and referral level, and to improve health worker interaction with families and communities.

NOW THEREFORE THE PARTIES hereby agree as follows:

- 1) To join efforts in the expansion of IMCI in three prefectures

For this purpose:

UNICEF will provide the technical and financial support for the activities foreseen by the plan of activities attached to this memorandum for the year 2004 in the development of training of trainers and six 10- day-training IMCI course; production of IMCI training sets for all course;

preparation of report on "Evaluation of the output, outcome, process and impact of the IMCI in two-pilot districts"; arrangement of IMCI review meeting; introduction of IMCI in the pediatrics curriculum at faculty and postgraduate level during 2004;

WHO will organize the IMCI review meeting; partner in the development of the community component of IMCI with the AlbRC and organize the workshop on Improving Family and Community Practices in Child Health in March 2005; development, adapt and introduce IMCI clinical guidelines - Adaptation of the referral care guidelines (during 2004, 2005);

Albanian Red Cross: Through the implementation of the USAID and American Red Cross funded Albania Child Survival Project in Dibra Prefecture, will provide technical and financial support for:

- 10-days IMCI training of 230 village nurses midwives, respectively 149 in Dibra district and 81 in Mat district during 2004-2006. Albanian Red Cross will cover expenses of per diem, accommodation, transport costs and 100 IMCI training sets for participants and facilitators;
- Will work closely with WHO and other parties as of this Memorandum of Understanding to develop the community IMCI package during 2004-2005;
- TOT training of 12 trainers for Community IMCI in 2005;
- Will train and cover all costs for training of 590 Volunteer Health Educators and 280 village nurses midwives in c-IMCI in 2005-2006;
- Participate in all IMCI meeting organized by the Ministry of Health and share information and lessons learned during the Albania Child Survival Project implementation.

Ministry of Health will coordinate through all actors; will collaborate in a continuous way with each of them facilitating the process and providing the sustainable rationale endorsement and support of health structures at central and district level.

ANNEX 15

Albania Red Cross Volunteer's Manual



VOLUNTEER'S MANUAL

SUMMARY OF POLICIES AND GUIDELINES ON VOLUNTARISM

CONTENTS:

POLICIES

1. Introduction
2. The Policy for Volunteer Management
3. Youth Policy
4. Policy of representation
5. Conflict of interests
6. Harassments Policy

THE VOLUNTEER IN AlbRC

1. The Definition of the AlbRC Volunteer
2. The rights and responsibilities of the volunteer towards AlbRC
3. The rights and responsibilities of AlbRC towards volunteers
4. Code of conduct of the AlbRC volunteer
5. The relationship volunteer-beneficiary

GUIDELINES

1. Volunteer's Management structure
2. The management of the AlbRC volunteers and members
3. Volunteer's role in disasters
4. Summary of different techniques for recruiting new volunteers
5. Job description of volunteer
6. The employee as volunteer
7. New job vacancies
8. Agreements in between the AlbRC and its volunteers
9. Instructions for training cycle

POLICIES

THE VOLUNTEERS MANAGEMENT SUBCOMMISSION

Volunteers Manual is designed by the Volunteers Management Sub-Commission. The Sub-Commission is composed of representatives of AlbRC governance and management. The commission is responsible for designing; monitoring/supervision and proper implementation of Voluntarism Guidelines and Policies Manual; and provides recommendations for future changes as needed.

APROVEMENT

The policies developed by Volunteers Management Sub-Commission are submitted to the Policies Commission nearby the AlbRC Steering Council. Final revision is made by the Steering Council. Thereafter, the Steering Council approves the additional policies, which are submitted for the final approval to the General Assembly.

IMPLEMENTATION

The policies and guidelines of Volunteer's Manual should be implemented and respected by all AlbRC structures that are working with volunteers. All staff and volunteers of AlbRC have the responsibility and authority for implementation and use of this Manual.

RESPONSIBILITIES

Volunteers Management Sub-Commission is responsible for:

- The supervision of proper implementation of Manual guidelines and policies;
- Revision and development of new policies; guarantees that all policies and procedures are revised and reconfirmed at least once in 2 years;
- Presentation of policies to the Policy's Commission.

The Policies Commission and the Organizational Development Department is responsible for:

- Appointing the members of Volunteers Management Sub-Commission;
- Supporting the activities of Volunteers Management Sub-Commission;
- Presentation the policies to the Steering Council;
- Communicating the revised and new policies.

The initiative to revise or develop new policies

If a volunteer or employee considers that a new policy is needed to be developed, or if an existing policy should be revised, than the person should send a suggestion to the Organizational Development Department in AlbRC Headquarters, through his/her supervisor. The suggestions will be assessed by the Development Department before they will be presented to Volunteers Management Sub-Commission. If the suggestion will be considered as appropriate, the approval process of policies will start.

DISEMINATION OF THE MANUAL

This Manual will be available for all volunteers and staff. All volunteers and staff should use the Manual as reference.

POLICY OF VOLUNTEERS MANAGEMENT (The VII General Assembly - Tirana, October 2003)

The AlbRC fulfills its humanitarian mission based on voluntary contributions without interests, which are offered by the members of organization. Therefore, AlbRC considers the volunteerism, as the foundation of all its humanitarian activities. The Volunteerism is one out of the 7-Fundamental Principles of the International Red Cross/Red Crescent Movement, where AlbRC adheres.

In conformity with the 7-Fundamental Principles of the International Red Cross/Red Crescent Movement, AlbRC:

1. Promotes Volunteerism to motivate and mobilize the strength of humanitarian solidarity, aiming at alleviating the suffer of vulnerable people;
2. Promotes Volunteerism as approach to support emancipation of civil society;
3. Considers as *volunteer*, every individual who led by his/her willingness, accomplishes voluntary work to contribute in improvement of life of vulnerable people, without material or financial profit; respects the Fundamental Principles of the International Red Cross/Crescent Movement and the National Society;
4. Recognizes and values volunteerism as a way for creating the stand-by volunteer network, which is active in disasters cases;
5. Recruits the volunteers in conformity with the Organization's Statute;
6. Ensure appropriate trainings for volunteers in order to raise their capacities to perform with professionalism their undertaken responsibilities;
7. Ensure all facilities to enable volunteers to know and understand volunteerism in the AlbRC context, as well as ensure the implementation of the all volunteer's guidelines and policies of the organization.
8. Provides the safe and supportive working environment to fulfill in appropriate way the needs of volunteers.

POLICY OF YOUTH (The General VII Assembly - Tirana, October 2003)

Albania Red Cross considers crucial the involvement of youth in its humanitarian activities because of the explicit and strength that it gives to the development civil society. The humanitarian mission of the International Red Cross/Crescent Movement in general and AlbRC in particular, in preventing and alleviate the human suffer is an engagement through which the youth volunteers can identify themselves.

As above, AlbRC:

1. Emphasizes the necessity to stimulate and encourage the involvement of youth in presenting the humanitarian values of the International Red Cross/Crescent Movement because of:
 - Youth are the most active part of the society;
 - Youth represent a wide group of the Albania community;
 - Youth are very sensitive towards most concerning problems for the general population and are willing to help, given the characteristics of this target as idealistic, energetic, and desire to change the world for a better place to live.
2. Encourages and motivates humanitarian spirit of youth, aiming at involving them in all activities of the organization in accordance with its strategic directions;
3. The AlbRC welcome as Youth Volunteers all individuals (boys and girls) aged 16 – 25 years old, but also considering those under 16 year old as future members and volunteers;
4. Provides training curriculum for youth volunteers;
5. Motivates the youth volunteers to be involved in elected organs and therefore to the important decisions-making process;
6. Gives priority to activities with students of high schools and university's youth volunteers;
7. Promotes the collaboration with participating national societies and youth structures within the Movement, as well as with other youth organizations with humanitarian mission in country.

***POLICY FOR REPRESENTATION OF YOUTH AND WOMEN (The General VII
Assembly - Tiranë, October 2003)***

AlbRC aims at having diversity of representation from all civil society groups in its structures without regional, formation, religious, racial, professional, age, and gender etc, differentiations. AlbRC considers as very important that, while carrying over the organization's activities, representation in its forums or the beneficiary's groups from different programmers, to have right proportion of participation, especially with regards to the women and youth.

As above, AlbRC:

- I. FOR YOUTH :
 1. Promote the work with youth because:
 - A) Young generation represents a wide group of population in Albania;
 - B) Are opened-minded, active, with broad interests, trended to be committed to the humanitarian mission of organization.
 2. Encourages the youth engagement in humanitarian activities of organization, creating the youth core groups at schools and universities.
 3. Considers the youth as active volunteers in its activities and on the other hand as beneficiaries (through the implementation of programs etc.);
 4. Encourages election of youth in governing forums of organization in conformity with its internal Statute, Rules and Regulations. The age of youth representatives in governing forums is from 16 to 36 years old.

II. FOR WOMEN:

1. Encourages the representation of women in all governing levels of organization;
2. Takes special attention with regards to respecting equality of gender and beneficiaries from programs;
3. Considering the women's vulnerability during conflicts or disasters situation, AlbRC pays special attention and encourages specific assistance to this target in such cases when possible.

THE CONFLICT OF INTERESTS FOR THE VOLUNTEERS

The aim of AlbRC policies for conflict of interests is to set up standard Code of Conduct, applicable for members or volunteers at both levels, Governance and Management. Developing the Code of Conduct is essential in order to have the public trust, to protect the integrity of the Organization and to promote its humanitarian goals. The governance and management members or volunteers are demanded to act for the better of the Organization, and as so, it is necessary to have some standards with regards to conflict of interests.

CONFLICT OF INTERESTS' FOR VOLUNTEERS

1. It is considered as "Conflict the interests" only in the cases when the interests of one person or group of AlbRC, are against the interests of the Organization;
2. The social or political engagement of the volunteer should not create conflicts with interests of the Organization;
3. Volunteers should not have monetary interests during their RC activities;
4. When a volunteer has material interests (personally or with a company or person who has the contract or proposed contract with AlbRC), he/she should submit in written the level of interest;
5. Volunteers should not disseminate, discuss or profit from the confidential information provided when untaken his/her duties with AlbRC, which should not be shared with the general public in general;
6. The volunteer has not the right to vote or participate in discussions about any Contract he/she has material or financial interest on;
7. The volunteer should not undertake the spoke person role on behalf of AlbRC, with representatives of governmental instances, media or specific official to give comments on AlbRC activities, except those cases when they are authorized.

THE POLICY FOR HARASSMENTS

- AlbRC commits to provide a working environment which is without provocations; which stimulates self-esteem and respects each person's dignity. The aim is to provide an understanding and collaborating climate and mutual respect for the better of all AlbRC members without tolerating the provocative and harassing behaviors.

- This policy deals with complains for harassments in working environment, according to the following definitions:

Harassment:

The notion “harassment ” in this policy, referrers to every equivocal behavior, comment or demonstration that provokes an intimate, not social, insulting moment based on racial, nationality, language, financial status, religion, gender, sexual orientation, disability status or what ever kind of discrimination, which is prohibited by a specific legislation.

The sexual harassment:

The sexual harassment means each behaviors, comment, gesture, or sexual contact from one person to the other, whether it is only one or continuous incident that:

- a) As consequence, it is expected to cause insults, discomfort or humiliation of the volunteer (or employee);
- b) As consequence, can be perceived by the volunteer (or employee) as an attempt of sexual nature to involve him/her in preferable projects, special trainings, trainings abroad etc.

Working place:

This policy is developed to cover the harassments that could be happened at working place. The working place context means *‘every location where volunteers perform the activities of AlbRC’*.

APPLICATION OF THE POLICY

The complains for harassments will be accepted and inspected confidentially in conformity with procedures;

- The harassment caused by an employee/volunteer is considered as a serious insult and if it is proved as true, the provocateur will be subject of an immediate disciplinary reprisal;
- Accusation on purpose towards someone which is proved as false will also be considered as serious insult and subject for disciplinary reprisal.

RESPONSIBILITIES

1. Head of programs are responsible to terminate the harassments in working place when are in known;
2. The Personnel Office will save and archive confidentially the number, form of these claims, the results from reviewing of the case and what kind of disciplinary reprisal carried out.

PROCEDURES FOR HARASSMENTS

General:

Red Cross will inform all volunteers about this policy.

Children:

The volunteers and beneficiaries of Red Cross can include children, thus this policy will be applicable also for them.

A child, his/her parent or caretaker can present complains in conformity with this policy.

FIRST STEP

The volunteers, who consider themselves as a subject of harassment, are encouraged to make it known to the harasser that such behavior is not well-perceived.

SECOND STEP

If the conflict resolution is impossible or fails with the first step attempt, a volunteer could complain in writing or verbally to his/her supervisor, who should inform both parties about the rights and responsibilities and should make efforts to solve the claims without further formal inquiry.

Referring to circumstances, the supervisor can undertake actions to avoid parties working together as needed, until complain will be solved out.

THIRD STEP

If it is not possible to resolve the case based on the above steps, than the complainant should be presenting a written and signed claim for a formal inquiry. The claim should include details with regards to the actions of the suspected person towards the complainant such as: dates, time, place, a description of the behavior, identification of each attitude and information related to the case etc.

The reviewer of the harassment case:

1. Will ensure a neutral inquiry, in an appropriate manner with regards to time and confidentiality;
2. Will request a written claim by the complainant, which will be presented to the suspect;
3. Will query the complainant as well any other witnesses if it is necessary
4. Will query the suspected person;
5. Will let every individual that is under the process know about his/her rights to be presented by another person chosen by him/her;
6. Will keep informed all parties during the inquiring process;
7. Will prepare a written report on the complainant's claims, the answer of the suspect, testimonies of any witnesses and conclusions.

In consultation with Secretariat and Personnel Office, disciplinary reprisals such as advises, written warning, suspension or dismissal can be undertaken.

THE VOLUNTEERS IN ALBRC

THE DEFINITION FOR ALBRC VOLUNTEER

Albanian Red Cross volunteer:

Is considered each individual, who lead by his/her will, carries out voluntary work and contributes to improve the life of people in need.

Every kind of voluntary work is performed without any material or financial profit, respecting the 7-Fundamental Principles of Red Cross/Red Crescent Movement.

THE RIGHTS AND RESPONSIBILITIES OF AlbRC VOLUNTEER-s

The rights:

- To share ideas, feedbacks and suggestions for changes;
 - To participate in the Red Cross activities for which he/she has the necessary capacities and he/she is trained on;
 - To participate in designing and implementing different projects;
 - To get acknowledgment and recognition for his/her work;
 - To get performance evaluations based on objective criteria for his/her work and takes appropriate orientations and the necessary training to perform his/her duties;
-
- To receive reimbursements for the in-pocket expenses during the ALBRC activities, in conformity with financial policies of the organization;
 - To elect and to be elected.

Responsibilities:

- To maintain the AlbRC image;
- To know and respect the Fundamental Principles of the Red Cross/Red Crescent Movement;
- To follow the volunteer's job description;
- To maintain the confidentiality of activities;
- To report about his/her work;
- To respect the Code of Conduct as of AlbRC standards;
- To inform in due time in case of resignation.

THE RIGHTS AND RESPONSABILITIES OF THE AlbRC

The rights:

- To expect the collaboration and commitment of volunteers;
- To determine and assign appropriate tasks for each volunteer;
- To determine the Code of Conduct to be followed by the volunteers;
- To engage the volunteers in accordance with their capacities and tasks that should be fulfilled;
- To discharge a volunteer who does not act in conformity with the key documents of Red Cross (statute, policies, regulation, and Code of Conduct).

The responsibilities:

- To enhance knowledge and capacities of volunteers through trainings, aiming at increased professionalism;
- To provide the necessary support and orientations to volunteers and evaluate their performance;
- To give reference letter or personal references when it is necessary and requested by their employer or for further education development;
- To pay special attention to ensure secure conditions for volunteers to accomplish their duties;
- To inform volunteers for the professional growth while working with the Red Cross;
- To reimburse the pocket expenses of volunteers while carrying out the Albanian Red Cross activities in conformity with financial policies of the organization.

CODE OF CONDUCT FOR VOLUNTEER

Albania Red Cross anticipates its volunteers to perform with high professional standards, as well as conduct appropriate behaviors in relation with other individuals. Those behaviors that negatively influence the AlbRC activities and image can not be admitted or tolerated. The volunteers are requested to know the Code of Conduct once they get involved in the AlbRC activities.

The Fundamental Principles of Red Cross/Crescent Movement, the Albanian Red Cross Emblem and Mission, and the Humanitarian Values make up the philosophy and the foundation of the Albanian Red Cross work with vulnerable people.

The volunteers are expected to participate, organize and promote dissemination of the Fundamental Principles of Red Cross/Crescent Movement, Mission and Humanitarian Values of AlbRC.

The volunteers should realize that they can always be perceived as Red Cross representatives, even while carrying over their day-to-day activities. When the daily activities of a volunteer negatively influence the work of other RC staff, volunteers, clients and the Organization itself or can jeopardizes and/or damages the reputation of Red Cross, they can be causes for disciplinary reprisals.

The volunteers should:

- Respect and promote respect for the Albania Red Cross;
- Respect usage of the AlbRC Emblem and prevent its misuse;
- Act accordingly to the laws and rules of the state;
- Accepts to work without financial profits;
- Refuses all kind of financial and material gifts, promises to provide gifts or other advantages while representing the Red Cross;

- Ensure that his/her attitudes are in conformity with fundamental documents of Red Cross: statute, rules and policies;
- Manage carefully the funds and equipments under his/her responsibility and be accountable to report on funds and equipments used;
- Collaborate, support and respect the AlbRC staff;
- Promote and fulfill his/her responsibilities.

ALBRC should:

- Promote and respect the rights of volunteers;
- Inform and provide volunteers with a copy on their *Rights and Responsibilities*.

Abusive and violent behaviors

- AlbRC will not tolerate any kind of violence or other abusive behaviors from any employee or volunteer towards other individuals.

Representing and speaking on behalf of Albanian Red Cross

The AlbRC acknowledges and appreciates the contribution and role of volunteers in presenting the Image of the organization in the general public and mass media, which have a crucial role in building up respect and support for the RC.

Volunteers will be spokespersons on behalf of the organization only in case they fulfill the conditions if:

- It is describe in the job description
- Asked by AlbRC
- Authorized by AlbRC

Personal performance and dressing code:

- The AlbRC has the responsibility to provide volunteers with uniforms and RC signs for use during the RC activities. The volunteer should maintain his/her uniform with the AlbRC emblem in it if carrying out RC activities. The volunteers should put appropriate dress and personal outfit which suits to the purpose of their tasks;
- The volunteers, when on duty, should not wear caps, t-shirts, pins which reflect symbols of any other organization (political, religious etc.) because it would jeopardize the conformity of AlbRC with the Fundamental Principal of Neutrality.

Utilization of the AlbRC properties

1. Information

It is necessary that the information, equipments and properties of the RC to be used only for the RC purposes and in an effective way. Documents, materials and publications developed for the AlbRC activities are property of the organization and the authorship could not be taken by anybody else.

2. Usage of the equipments

The equipments of AlbRC will be used only for AlbRC purposes. Use of the AlbRC equipment for private interests will be done only if provided with a written authorization or towards a payment when appropriate (for example: making

photocopies or interurban phone calls, using of training spaces etc.).

All properties of the AlbRC, including equipments and documents, should not be taken by the volunteers without the approval of the person in charge. The volunteer will be responsible for the use and maintenance of them until they will be returned to AlbRC offices. When materials and equipments of AlbRC will be taken by a volunteer, the hand-over procedures should be applied.

THE RELATIONSHIP VOLUNTEER-BENEFICIARY

The relationship volunteer-beneficiary of Red Cross signifies the unique positioning of the volunteer while performing his role and authority during the service delivery.

During the service delivery, the volunteers should:

- Realize that because of their vulnerability, beneficiaries become dependent on volunteers who offer assistance. Creation of personal relations beyond the professional relationship volunteer-beneficiary is not in favor of each parties or Red Cross itself;
- Take in special consideration the fundamental principles of the humanism, impartiality and neutrality;
- Treat the beneficiaries with respect and dignity;
- Act on behave of the Red Cross and in accordance with internal rules of the organization while giving humanitarian assistance.
- Respect the feedback of beneficiaries;
- Respect the property of the beneficiary.

GUIDELINES

STRUCTURE OF VOLUNTEER MANAGEMENT

A. Information

Each volunteer who adheres to Red Cross for the first time should be provided with information about the Organization within a month after being engaged in a position, but not later than three months. The information must include the following elements:

-
- ✓ History of Red Cross and Red Crescent Movement;
 - ✓ IFRC& ICRC;
 - ✓ The fundamental principles of Red Cross and Red Crescent Movement;
 - ✓ Emblem;
 - ✓ Convent of Geneva and additional protocols;
 - ✓ Mission and Humanitarian Values

-
- ✓ The structure of AlbRC
 - ✓ Volunteer's Manual

- ✓ Programs and services
 - ✓ Presentation of the working place/environment
 - ✓ Necessary trainings /training's possibilities
-

The necessary information can be provided through one of the following methods: group presentation, one-to-one conversations, reading materials or Internet. The person in charge of the volunteer management is responsible providing volunteers with all information needed with regards to volunteer policies and ensures that he/she has a copy or summary of all AlbRC policies.

B. Trainings

The volunteers have the right to be provided with information and to be trained on the project where they will be engaged/involved (refer to the training system).

C. Engagements

AlbRC should encourage, motivate and stimulate the participation of the volunteers according to their skills and trainings provided.

D. Data on the volunteer

Red Cross collects keeps and uses data and information on the volunteer in order to fulfill to be used for the purposes of the Organization and ensures the confidentiality of this information. Each AlbRC branch is responsible to collect, keep and use in an appropriate way the data for its volunteers. The information included in the personal file of each volunteer it then entered in database.

The volunteer's card should contain:

- ✓ Agreement, signed by the volunteer (see Annex)
- ✓ Personal file
- ✓ ID number
- ✓ Copy of the driving-license (if required)
- ✓ Job description

Information on the volunteer's health status

- ✓ The information on the volunteer's health is required only in case it is needed as of the category of his specific responsibilities/engagements with RC. If required, this information must be added in the Volunteer's Card
 - Medical Reference by the specialist
 - Health card

E. Confidentiality

All volunteer's cards are confidential and access to this information can be done only if authorized by the personnel staff. The person in charge of Volunteer Management and the Branch Secretary must keep the Volunteer's Cards. The Volunteer's cards can be taken only in

case the volunteer leave one sub-branch to another AlbRC sub-branch. The volunteer's cards are property of the AlbRC.

MANAGEMENT OF THE AlbRC MEMBERS

Introduction

Voluntarism is one of the Fundamental Principles of Red Cross/Red Crescent Movement. The work of the Albanian Red Cross is founded by the volunteer's engagement and unpaid voluntarism (active members); and on financial contribution of members (passive members).

All Albanian citizens, apart from the ethnicity, race, gender, society level, religion, political side, etc, who respect the Fundamental Principles of Red Cross and Red Crescent Movement have the right to join the AlbRC.

DIFFERENCES IN MEMBERSHIP

When an individual adheres in AlbRC, he/she should decide to be as one of the following forms of membership:

1. Active member
2. Passive member

An active member is a volunteer who not only pays the yearly membership fee to the Organization, but also actively participates in fulfilling the Mission of Albanian Red Cross, in a part time or full-time commitment and is registered as such by the Branch Council.

A passive member is an individual who supports the Red Cross activity by paying the yearly membership fee set and approved by the General Assembly.

Honor Member Title can be given by the Steering Committee to a person who has provided extraordinary services for the National Society.

MEMBERSHIP CRITERIA

Member of the Albanian Red Cross can become individuals who:

- Accepts the Fundamental Principles of the International Movements of the Red Cross and the Red Crescent;
- Pays the annual fee to the Organization;
- Joins one of the AlbRC branches/sub-branches.

THE RIGHTS OF MEMBERS

The active and passive members have the right to:

- Vote;
- Elect and be elected. Employee of the AlbRC cannot be elected;
- Be represented in the Assembly of the branch;
- Express his/her opinion, to represent proposals in order to progress the development of the Organization;
- Participate during the elections of governance boards in the sub-branches where he/she is registered;
- Be informed by the sub-branch on all activities and services of the Red Cross and to get information-dissemination materials;

RESPONSIBILITIES OF THE ACTIVE AND PASSIVE MEMBERS

- To know, follow and disseminate the Fundamental Principles of Red Cross and Red Crescent Movement;
- To promote the Mission of AlbRC;
- To know and respect the status;
- To work for improving the image of the Organization.

THE MEMBERSHIP REQUIREMENT CAN BE REFUSED WHEN:

- When the prestige and the image of the AlbRC is threatened by this member;
- The new member does not respect the Fundamental Principles of Red Cross and Red Crescent Movement.

DISMISSAL OF MEMEBERSHIP MERIT

The membership merit is dismissed when the person:

- Doesn't pay the membership-fee until the end of calendar year;
- He/she is called dismissed from the Branch because:
 - a- serious violation of Fundamental Principles of the RC Movement have been noticed;
 - b- his/her actions threaten the image of AlbRC.

Each member dismissed has the right to present and appeal request nearby the Steering Committee, who has the final decision making authority.

The Steering Committee set up a procedure for reviewing the request in order to ensure the neutrality of the decision.

Management of members in different levels of the AlbRC

The membership in the AlbRC is provided with a membership card. The membership card is effectual for a period of 1 year. During the time as a member, the person can become familiar with the Status, Strategy, Policies of the AlbRC and the Principles of RC Movements.

a) active members

- In general, the active members are in the sub-branch level;
- Under branch level, the active members are part of governance boards;
- The administration of the Personal Files and data entry of all files in database for the active members (volunteers) is under the responsibility of the branch.

b) passive members

- The sub-branch and branch are in charge of the management of members;
- Data-entry for the passive members is the responsibility of branch.

The Sub-branch is responsible to:

- Find members;
- Maintain the annual membership's registers;
- Collect and transfer the collected income from membership-fees in the Branch bank account.

The Branch is responsible to:

- Administer and provide Membership Cards as needed for each sub-branch;
- Maintain the database and pull out information for the generalities and other relevant information (name, last name, age, gender/sex, address etc) of the members;
- Manage the collected funds through memberships and transfer them to the Finance Department at AlbRC headquarters.

SPECIAL RULES ON MEMBERSHIP

- Passive members confirm their membership in the AlbRC contributing the amount of 100-lek a year;
- Membership's contribution is transferred to the bank account of the Branch;
- The membership is effectual only for the contribution period. The passive members receive the membership's certificate after paying the fee;
- All the data needed, must be entered in the membership's certificate during the time of membership. This membership's certificate must be signed by the Head of Branch. Except the above-mentioned rights of the membership in the AlbRC, the membership's certificate creates to the member the possibility to easily take part/participate in educative activities organized by AlbRC (e.g. he/she might participate in such courses as First Aid for free or paying a reduced cost);
- Heads of institutions, governmental or private, are not allowed to be involved in membership campaigns.

ROLE OF VOLUNTEER IN DIZASTERS

A. Engagement of volunteers during disasters

The Albanian Red Cross has stated in its policy that will respond in all cases of humanitarian catastrophes. The AlbRC volunteers are the human resources who will provide services and humanitarian assistance in such cases and AlbRC should support their work.

The AlbRC has stated through written policies that will provide the necessary support to the volunteers for fulfill their responsibilities as asked. If in emergency situations, the volunteers are asked to work out of the normal circumstances than, the following guidelines should be followed.

B. Definition for emergency situation

An emergency situation starts at the moment when it is officially announced as such, until another notification declares the termination of it. The announcements can be informed by the national or local governmental authorities and the Albanian Red Cross Leadership.

C. Guidelines for sharing roles and responsibilities in disaster situations

During the disaster and armed conflict situations, the normal duty practices are cancelled. The volunteers who are engaged to provide humanitarian assistance are expected to work during long time intervals (beyond the normal time), including night and weekends as needed.

During emergency cases, the Volunteer Management Coordinator should take special attention to the management of time that human resources commit, in order to avoid health problems as a consequence of overdoing work. If the Volunteer Management Coordinator realizes that the health of the volunteer could be threatened, he/she might apply changes on time or kind of activities the human resources are engaged at when possible.

The following instructions could be helpful to plan the volunteers' engagement in emergency cases or humanitarian operations:

- After each interval (5 hours intensive engagement), the volunteers must apply at least half an hour break for meal. The additional break must be 10-15 minutes after each interval of 5 hours engagement;
- Each shift will be no longer than 12 hours;
- A break of 10 hours must be applied, between two shifts during the time of the engagement of a volunteer;
- The Red Cross must apply 24 hours service within 24 hours to the persons in need;
- Total number of duty hours must not be more than 60 hours a week or 120 hours during the two first weeks of the emergency response;
- 1 day holiday is obligatory after a non stop period of 6 days.

D. Reimbursement of the volunteers in emergency cases

In the cases when an emergency is announced by the national authorities and AlbRC, the volunteers who will be engaged will be reimbursed by the Organization for their expenses (transport, food), in accordance with the financial policies of Albanian RC.

SUMMARY OF DIFFERENT TECHNIQUES FOR RECRUITING VOLUNTEERS

The first step for recruitment volunteers is to set up criteria of what kind of attributes or skills this person should have to satisfy your requirements. Once the criteria have been set up, different techniques can be used to further the process:

PERSONAL CONTACTS

Use your personal contacts or those of other staff and volunteers.

Organize meetings, parties and invite people you know. Personal contacts stimulate the enthusiasm of the existing volunteers, so that this method is one of the most effective recruiting methods. It is also one of the most overspread methods. But this recruiting method has its negative sides, too. Through personal contacts you might recruit people with a lot of things in common and this is not worth if you would like to engage/include/involve people of different origins, gender/sex and age.

MASS MEDIA – PUBLICIZING

Means you have to pay for information on TV, radio or newspaper. This method is very important when specific messages to a wider audience need to be disseminated. It rather serves to inform on the organization than to stimulate people to be engaged as volunteers. Paying for the advertisement, gives the possibility to have control over the message given and time when it will be in disseminated in order to reach a broader audience.

If approached in appropriate way, most of radio or TV stations can give information for free. If your local stations would accept only announcements against a payment, insist in finding local sponsors. The announcement might end with – “This announcement of the AlbRC was sponsored by x Sponsor. This statement serves as an advertisement for the sponsor company.

RADIO TALKS

Some radios transmit programs free of charge, where you can listen to someone talking on the important of being a volunteer. Meet the journalist in advance and clarify your position and why you would like to take part in the radio talk, so that the interviewer can have enough time to prepare the appropriate questions.

SPECIAL PUBLICATIONS

Identify where you will advertise your announcement (newspapers of a schools, university, professional magazines and newspapers that are regularly published and distributed in your community) taking into consideration that the reader can be potential target for recruiting volunteers. Observe what kind of stories they publicize and what kind of services they announce. Select those that you think have more to do with your goal, your branch or sub-branch.

Prepare materials, as printed announcements, short articles and photos. Contact the publisher/editor in a face-to-face meeting or through telephone. Provide answers to questions such as; to whom do the stories have to be sent to, time-limits, photo-standards (dimensions, number), what kind of letters, stile, addresses, title, etc.

PRESS-RELEASE

A good press-release must be short, exclusively one page. The press-release is an information channel used to inform about an event already happened or expected to happen. Put the date in your press-release, so that the presenter knows how old the information is.

The first paragraph must give replies for such questions as who/what/where/when and if possible why and how. Use short sentences and paragraphs.

Give correct and full information. Give details of the dates and places. Think over the changes that happen inside and outside the Organization. List all things which might be new for the public.

1. Try to connect those developments in your organization with an event that has happened recently or is expected to happen.
2. Keep in mind to include the role of the volunteers in telling stories.

LETTER TO EDITORS

Most of the newspapers have a space for letter sent in their address. An article that can be sent to a newspaper must be a response to a situation or event which recently happened in your community, where your branch or sub-branch assisted. When you write such a letter, you have to keep in mind that the role of your organization is to improve the life of the community. Writing about voluntarism is a very often theme of the newspaper article. The volunteers write on what encourages them to contribute for the community. These letters must be sincere and they must reflect a real concern and enthusiasm on their duty. The readers of these rubrics might be engaged with the humanitarian activity of Red Cross in the future.

Find the proper volunteer who would write the article whose story would encourage and motivate more people to be involved.

FAIRS

Fairs can be an effective communication way due to the big audience. This makes the people stop, see, promote their interests and obtain information. The fairs are organized in such a way to make the participants interested and ask for more information.

RECRUITMENT IN THE STREET

The idea is to “move” your office in the street e.g. to put out a table, two chairs, an informing board on different needs for volunteers and some registration forms. You can explain your need in details, to the people who pass by and express interests on the board information.

RECRUITMENT IN THE VEHICLE

It is an idea more or less similar with the recruitment in the street. This time you move your ‘office’ into a vehicle, that might be smartened up with signs and emblems of the Red Cross and you might drive around different areas/places where a vast number of people lives and you express the goals or activity etc. of the organization with a megaphone.

VOLUNTEER JOB DESCRIPTION

To develop the job description of a new volunteer or an existing volunteer, the following must be taken into consideration:

- Think on what are the actual volunteers doing and what are their roles;
- Think of the position of a new volunteer, roles and responsibilities you expect him/her to fulfill;
- Discuss with the volunteer on the activities he/she wants to be involved and why;
- Think about the necessary training for that position.

HOW THE JOB DESCRIPTION COULD BE USED:

- To ensure that each individual has a definition for his work with Red Cross. The word “volunteer” it’s a category which is not a title. Determine a title that reflects the tasks to be performed and also could be attractive for the volunteer to facilitate the recruiting process;
- Make a short description of the project/program to the volunteer;
- Determine the responsibilities of the duties to be performed by the volunteer. The aim is to make it clear to the volunteer of what do you expect from him/her;
- Define objectives and expected results so that both, the volunteer and you know when the work has been successfully accomplished;
- Include a description on the training and supervision of the volunteer;
- Include reporting in the Job Description-what should report, reporting format and how often;
- Discuss what is the hours in a week or month and how long you expect the volunteer to work for a specific RC project;
- Include a description of the necessary qualifications and interpersonal skills needed;
- It is also worth to write a section on the volunteer’s advantages.

Last thing; don’t be afraid to mention your needs. It’s good to have such volunteers with perspective, who know in advance what is really needed to archive the best results. It is better to know from the beginning if the volunteer is able to take the responsibility to do a certain work or not, in order not to create problems afterwards.

Refresh the description of the volunteers’ position in such a way to reflect correctly the work the volunteers perform for your branch or sub-branch.

<i>POSITION TITLE</i>
PROJECT DESCRIPTION
LIST OF VOLUNTEERS RESPONSIBILITIES /LIST OF TASKS

<i>EXPECTED ACHIVEMENTS/GOALS</i>
<i>TRAINING & SUPPORTING PLAN</i>
<i>REPORTING</i>
<i>INVOLVEMENT ON TIME</i>
NEEDED QUALIFICATIONS
BENEFITS/ADVANTAGES:

THE EMPLOYEE AS VOLUNTEER

The employees of the Albanian Red Cross (both, those who work part-time or full-time) cannot participate/take part in the governance role, consultant role or politics procedures compile within the Rd Cross.

However, the employees can play the role of the volunteer as offering services, such roles that are out of the aim of their paid job within the Red Cross and are provided as overtime.

Former-employees are not aloud to serve in the governance role, consultants role or politics compilers, until a period of 2 year has past from their resignation, retirement, or the expiration of the contract. They might be encouraged to work as volunteers offering services each time.

JOB VACANCY

ANNOUNCEMENT FOR A VOLUNTEER-COORDINANTOR POSITION

It is a good managing practice to stars the selection process for the volunteer-coordinator by a suitable announcement. Interior or exterior announcement for a job vacancy it's a practice applied by the Red Cross.

The elements included in the announcement must include adequate information to attract the proper applicants and to encourage self-exception of the others at the same time.

The following elements for a certain position must be included in the announcement:

- title of the position
- department and/or the program
- location
- description of the position
- benefits
- qualifications

- engagement in time
- deadline
- information on the ways of contacts
- other information

JOB VACANCY ANNOUNCEMENT

In the cases when the announcement on job vacancy is announced in accordance with the Personnel Memorandum, the volunteers must be considered as internal candidates.

AGREEMENT
Between
AlbRC SOCIETY and the VOLUNTEER

The volunteer is familiar with the Fundamental Principles of the Red Cross Movement and has read the instructions on the volunteers. The volunteer commits to act in conformity with the AlbRC policies and regulations Code of conduct. New volunteers must be provided with the basic information on the Red Cross.

By signing this contract, the volunteer agrees to treat confidentiality the information taken while accomplishing his/her duties with Red Cross. The agreement is effective for 1 year and it is renovated automatically if the volunteer has been active at least 6 months before the contract expires.

The volunteer agrees to become a member of the Red Cross Branch and she/he will be registered in *database* program on AlbRC volunteers.

Date Signature of the volunteer

Date Signature of the Branch's Secretary

Information on the volunteer:

Name-Surname:		
Address:		
Sub-Branch		
Branch		
Tel home:	Tel office:	Mob:
Project/Program:		
<input type="checkbox"/> First aid <input type="checkbox"/> Disaster <input type="checkbox"/> Social <input type="checkbox"/> Fundraising		

- | |
|--|
| <ul style="list-style-type: none">❑ Information-Dissemination❑ Management of volunteers❑ Health❑ Tracing Agency❑ Mine awareness project❑ AIDS/HIV project |
| Notes: |

INSTRUCTION ON THE TRAINING SYSTEM

Training system of the Albanian Red Cross ensure that each volunteer or employee provides information with regards to fundamental documents of the AlbRC.

Moreover the Albanian Red Cross:

- will use in a rational way and will unify the existing training sources;
- will increase the professionalism and will improve the way of guiding training.

1) ORGANIZATION

1.1. Criteria to be a trainer of the AlbRC

- 1.1.1 To be an active trainer of AlbRC, the person first must receive/get knowledge on the module “Methodology and didactic”. TOT training on this topic, must be directed by somebody with pedagogy experience and selected by the Secretariat.
- 1.1.2 The trainer must know well/ have good knowledge the history/on history, tasks, strategies and how is the Albanian Red Cross organized, before attending the training.
- 1.1.3 Except the module “Methodology and didactic”, a trainer must be trained in the specialized field.
- 1.1.4. The permission to have the right to be a trainer of the branch or the sub-branch will be given by the relevant Program Coordinator in collaboration with the Branch Secretary.

1.2 Participants are provided with certificates

- 1.2.1. The certificates for the training participants in national level, will be given by the Program Coordinator, signed by the General Secretary.
- 1.2.2. Certificates for the participants on the training organized within the branch, will be given by the branch, signed by the Branch Secretary.

1.3. Responsibilities

- 1.3.1. Within the Secretary, Heads of the Departments are responsible for the manual’s innovation and a good training system.
- 1.3.2. Within the Branch, the Secretaries are responsible in implementing all the training offered by the Albanian Red Cross.
- 1.3.3. Within the Sub-branches, the trainers are responsible in offering training for which they have the permission to organize. They have to report to their Sub-branch and Branch, to the Secretary.

2) TARGET GROUPS

To further develop/improve these instructions, we have to consider that there are three different groups we will work with.

2.1. Volunteers

- in different fields, per example:
 - Health, disaster, first aid, etc.
- in different levels
 - Sub-branch, Branch, Secretariat.

2.2. Paid staff

- in different fields

2.3. Audience

- in general fields, e.g:
 - Course on fund raising (e.g. tailoring, computer, and shoemakers' courses)
 - Other courses of the AlbRC (e.g., how to educate and take care of children, service mother child, first aid).

3) CONTENTS OF THE TRAINING PROGRAM

3.1. All the trainings provided by the trainers must have the same logic and content, changeless for all the Sub-branches.

3.2. The content of the training topics (determined in the Red Cross manuals) will be composed by the Secretariat's staff with the support of the specialists (Red Cross staff or other person).

3.3. Structure:

-For all kind of training offered by the AlbRC, manuals will be compiled, including the exact title of the sort of training (seminary, course, training, etc).

-The manual contents the training's topic with a certain recommendation on the time needed and the methodology

3.4 Division in base and additional modules

Kinds of trainings are divided in:

3.4.1 Base modules (First Aid, knowledge of the Red Cross)

3.4.2 Additional modules, focused on the work's field as: Social, Health, First Aid, Volunteers' Management, etc.

3.5. Methodology and didactic

Each module and sub-module includes the following chapter:

-General: Aim of learning and content

-Information for the referee

-Knowledge-information on the topic

-Practice instructions for the leader

-Practice instructions for the participants

-Material with information for the participants

-During each training topic, different suitable methods must be used as: (materials in papers, discussions, group work, video, exercises, other materials to be seen, etc.)

PERSONAL FILE

To Mr/Mrs _____

Photo space:

A) Personal data

Surname	
Name	
Address	City/Town Street
Date of birth	
Place of birth	
Point of contact in case of emergency	For example: parents, wife, husband
Telephone (Home)	
Telephone (Work)	
Mobile phone (cell)	
Tel&fax	
e-mail	
Profession	Studies Employees as.....
Actual job location	
Other knowledge	Computer Foreign language Other

B) Additional information on the person (facultative)

Civil status	Married / single / divorced/
Married to	
Children	Born
Limits for health reasons (e.g.. not adequate sight)	

C) Internal information on the Red Cross

Belongs to the sub-branch	
Belongs to the branch	
Position in the AlbRC	<p>Volunteer of:</p> <ol style="list-style-type: none"> 1. First aid 2. Disasters 2. Social 3. Research agency 4. Health 5. Management of volunteers <p>Team leader:</p> <ol style="list-style-type: none"> 1. First aid 2. Disasters 3. Social 4. Research agency 5. Health 6. Management of volunteers 7. etc. <p>Coordinator</p> <ol style="list-style-type: none"> 1. First aid 2. Disasters 3. Social 4. Resurch agency 5. Health 6. Volunteers management 7. etc <p>Instructor of first aid</p> <p>Other</p>
Participants in the seminaries of the Red Cross	<ol style="list-style-type: none"> a) How to act during disasters case b) Leader of youth c) First aid d) Instructor of first aid e) Social Program
Participant in seminaries organized by	Specify

other NGO-s.	
Available in case of disasters	Yes/No Planned in the emergency group
Membership in AlbRC	Where When Transfer to the other branches
Medals / Honors	Where What for
Taking over	Uniform First aid box Other (describe)
Interested in the following fields	<ul style="list-style-type: none"> - social - disaster - health - management of/managing volunteers - fund collection - first aid - other
Groups she prefers to work with	<ul style="list-style-type: none"> - No preference - Teenagers - Office staff - Adults - Children - Elders - Disabled people - Other
Availability	<ul style="list-style-type: none"> - I am flexible - Prefer weekends - Prefer during the week days - In the morning - In the afternoon - Other
Your Hobby	