American Red Cross

Mid-Term Evaluation

October 31, 2005

Albania Child Survival Project

Diber Prefecture, Albania
(Districts of Diber, Bulqize, and Mat)
October 1, 2003 – September 30, 2008

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American Red Cross
Albania Child Survival Project

Mid-term Evaluation

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ACRONYMS

ACSP	Albania Child Survival Project
AFPP	Albania Family Planning Project
AlbRC	Albania Red Cross
AmRC	American Red Cross
ARI	Acute respiratory infection
BCC	Behavior change communication
CHS	Community Health Specialist
CDD	Control of Diarrheal Disease
C-IMCI	Community - integrated management of childhood illness
C-IMCI+	Community Integrated Management of Childhood Illnesses
CM	Commune Mobilizer
CPR	Contraceptive Prevalence Rate
CSHGP	Child Survival and Health Grants Program
CSTSG	Child Survival and Technical Support Group
CYP	Couple Year Protection
DHC	District Health Coordinators
DIP	Detailed implementation plan
EBF	Exclusive breast feeding
FP	Family planning
GMHP	Growth monitoring and health promotion
HFA	Health facility assessment
HMIS	Health management information system
HPO	Health Program Officer
HW	Health worker
IEC	Information, education, and communication
IMCI	Integrated management of childhood illness
IPH	Institute of Public Health
IR	Immediate result
IUD	Intrauterine devices
JSI	John Snow Inc.
KPC	Knowledge, practice and coverage
LAM	Lactational amenorrhea method
LMIS	Logistics management information system
M&E	Monitoring and evaluation
MCH	Maternal and child health
MoH	Ministry of Health
MTE	Midterm evaluation
NGO	Non-Governmental organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy

PA	Project agreement
PDP	Performance development plan
PMP	Performance monitoring plan
PVO	Private voluntary organization
SDM	Standard days method
SDP	Service delivery point
SO	Strategic objective
TB	Tuberculosis
TOT	Training of trainers
UNDP	United Nations Development Program
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	United States Agency for International Development
VAS	Vitamin A supplementation
VHE	Village health educator
VHT	Village health team
VNM	Village nurse midwife
WCC	Women Consultancy Center
WHO	World Health Organization
WRA	Women of reproductive age

A. Executive summary

The Albanian Child Survival Project (ACSP) is implemented by the American Red Cross (AmRC) in partnership with the Albanian Red Cross (AlbRC). This collaborative initiative is designed to mobilize communities to take action to improve their members'own health, while improving access to and quality of key services in the formal health system. The project is located in the three districts of the Diber prefecture (Bulqize, Diber, Mat), which are located in an impoverished, rural area of the Balkan Mountains in northeast Albania, near the Macedonian border.

The goal of ACSP is ***improved health status of women of reproductive age and children 0-59 months in the Diber prefecture.*** The project staff works in collaboration with a broad coalition of Ministry of Health (MoH), personnel, collaborating and cooperative organizations, and volunteers to pursue project objectives and to leverage the impact of collaborative activities.

This project is assisting the Albania MoH to roll out the nationally approved MOH strategy of Integrated Management of Childhood Illness (IMCI), and also to provide family planning (FP) training for VNMs in the Diber prefecture. The project seeks to establish, field test, and finalize the C-ICMI+ protocol in the country (and is the single NGO in Albania focused on the C-ICMI strategy). The addition of the family planning component (the "+") of the C-IMCI+ curriculum is unique to this project. The project focuses on improving skills of first-line health workers to improve health at the community level.

The mid-term evaluation (MTE) affirmed that ACSP had accomplished the following:

- Introduced community-IMCI into the Diber prefecture as an augmentation of the clinical IMCI approach that has been adopted by the Ministry of Health,
- Created a model of community-based services through engagement of MoH providers (village nurse midwives [VNM]) and community volunteers (village health educators [VHEs]) in a collaborative effort to promote behavior change related to high-impact health issues (growth monitoring and promotion; control of diarrheal disease, prevention, and treatment of acute respiratory infection; and family planning),
- Expanded family planning access and quality, through training of new service providers, introduction of supportive supervision strategies, expansion of community consciousness about method mix (e.g., emphasis on lactational amenorrhea and standard days methods),
- Took action to build administrative, financial, and volunteer management capacity of the Albanian Red Cross (local project partner) at both the national and the Diber branch levels to enhance sustainability of activities in post-project years.

ASCP has made satisfactory progress toward achieving its training objectives. Village health teams have been established in each of the three districts of the prefecture. Two of the three districts now have a VHT functioning in the majority of villages. Training has been recently initiated in the third district. The number of family planning providers has been markedly expanded. A pilot project is currently being implemented that will extend the number of service delivery points to the community level. The project had worked collaboratively with other NGOs to create a complementary interface between the provider training and service objectives of each project.

Project beneficiaries offer testimony to support the finding that the majority of health messages are being transmitted effectively. End-of-project targets for improvements in health indicators are likely to be attained for most focus areas.

There is less evidence of progress toward attainment of project targets related to control of diarrheal disease and prevention and treatment of acute respiratory infection. The ASCP needs to find ways (including the engagement of appropriate government ministries and community leaders) to address community behaviors related to disposal of waste products (including disposable diapers) and similar environmental water and sanitation practices. The ASCP also needs to engage proactively with MoH personnel and other NGOs involved in health sector reform and family planning to correct the current conflicts that make it difficult (if not illegal) for VHNs to act according to IMCI and reproductive health guidelines (specifically, the stocking of drug boxes and the administration of antibiotics). Results of the Health Facility Assessment and these MTE findings should be shared more broadly with other agencies and personnel who could act upon them. They could then address certain constraints that limit the ability of project beneficiaries to act upon their new learning (e.g., facility health provider attitudes about immediate breastfeeding, uninterrupted availability of FP commodities) and to encourage others to take action on maternal/neonatal best practices that are outside the scope of ACSP activities (e.g, prenatal nutrition and vitamin supplementation(.

The capacity-building activities and strategies in which the ASCP has engaged have two primary objectives:

- Creation of a *model* of community-based action for health (the VHT, engaged at the household and community level) that can be replicated throughout the country, and
- Strengthen the management abilities (administrative, finance, volunteer recruitment, and coordination) of the local partner, the Albanian Red Cross, to provide a nexus for dissemination of that model.

The ASCP has initiated several supportive supervision strategies that are designed to strengthen the capacity of VHTs to evaluate their work and to use both qualitative and quantitative feedback to identify the need for change. The intention is that both community and VHT members will be their own best advocates for quality improvement. The project has also initiated the transfer of administrative responsibility for various aspects of the ACSP workplan to the AlbRC, so that there is the benefit of time, over the remaining life of the project, to prove the necessary and appropriate supervision and support.

Albanian Red Cross administration (national and district branches) are presently challenged in their capacity to sustain the current level of ACSP activities. However, there are other MoH and NGO offices/agencies that could appropriately share (or accept) selected tasks (e.g., IMCI and FP). This would allow the AlbRC to focus on C-IMCI, building from its strengths in community-based volunteerism. This coalition of interested stakeholders will serve to enhance the potential for long-term sustainability of the scope of ASCP interests. ASCP personnel have already initiated discussions and actions to promote consideration of such a plan.

A list of conclusions and recommendations resulting from this mid-term evaluation is presented. The ASCP response to these recommendations and an action plan follow.

Recommendations related to nutrition findings

- Increase the educational activities conducted with facility birth providers (particularly nurses and nurse-midwives) to promote their support of immediate breastfeeding

- Enhance the message about the importance of iron and folate for pregnant and postpartum mothers.

Recommendations related to control of diarrheal disease finding

- The project needs to take a leadership role in educating the communities about the water and sanitation impact of community practices related to the disposal of feces, and disposable diapers. This role can include engagement of other NGOs (e.g., URC's health reform project) in directing the attention of public health authorities about this environmental issue.

- The educational message about distinction between simple and severe cases of diarrhea and when to seek a higher level of care needs to be strengthened.

- The educational message about the proper timing and method of hand washing needs to be enhanced.

Recommendation related to acute respiratory infection findings

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to the stocking of the VNM drug boxes, specifically, the availability of antibiotics for the first dose in treatment of ARI.

Recommendations related to family planning

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of the VNM drug boxes, specifically, the availability of FP commodities at service delivery points.

- The FP message must be augmented clearly to indicate that the free contraceptive supplies distributed by MoH are of good quality (i.e., comparable to supplies that can be obtained from private suppliers).

- Specific strategies and messages should be developed to target men; a more progressive influential male could be selected to help with FP service promotion.

- The project should work with other NGOs engaged in FP promotion to develop negotiation tools for women, which would help them openly discuss the use of various FP methods with their husbands.

- The lactational amenorrhea method (LAM) message needs to be clarified and stressed--in particular, the criteria for election of the method need to be amplified.

Recommendations related to cross-cutting findings

- Develop and distribute more information/leaflets to support the four high-impact activities and secure or develop additional take home materials that address different topics to stimulate the interest of project families in learning about broader health interests.

- Try different learning approaches (role play or drama) during support group activities to ensure that women are more engaged in learning and are not passive listeners. Mix practice and theory (e.g., cooking demonstration, preparation of ORS, hand washing). Develop competitions between communes/villages.

- Use the periodic meetings (already occurring) to hold a special session on a health topic that has been identified by the VHTs. This is to serve as an additional educational opportunity and incentive.

- The project should target more remote families that are not accessing health services due to distance barriers.

- Develop a simple tool or form that can be used to identify families in each neighborhood (e.g.,registry system) to confirm full participation.

Recommendations related to behavior change communication

- A FP education program and materials should be developed, specifically targeted toward and focused on men, which incorporate the understandings gleaned from project experiences.

- Project staff should assertively pursue the acquisition or development of additional educational materials, specifically seeking to secure materials developed by other organizations that address project-related messages as well as materials that focus on other health topics

- Project staff should maximize their interactions with JSI to learn from and expand upon the behavior change communication (BCC) component of the family planning expansion project on which JSI and ACSP are partnering in Diber District. Staff can then evaluate the potential for expansion of these BCC activities in the other ACSP districts.

Recommendations related to PVO capacity building

- AlbRC/ACSP should receive on-the-job or external training in project management responsibilities (including but not limited to human resources and financial management), and fundraising.

- Sources of external support/consultation for IT should be identified for the Diber field office.

- The AmRC program manager should begin planning for a mechanism to provide on-site or at-a-distance support to the country-based staff for implementaton at the end-of -project KPC study.

Recommendations related to building capacity of the Albania Red Cross project partner

- The AmRC and ACSP project staff should assist the AlbRC Diber Branch to develop a strategic plan, in the interest of promoting sustainability following the conclusion of the project. The plan should address features such as (but not limited to) the following:

    - a fundraising plan that addresses the reduction/elimination of the inherited Diber branch debt;
    - a common organization chart that integrates responsibilities for both ACSP project and AlbRC activities'
    - a practical budget that can be sustained without external funds;
    - specific activities to increase the membership; and,
    - support and engagement with the MoH and similar governance structures.

- Develop strategies to integrate the ACSP Project Team (based in Tirana) into the activities of the AlbRC headquarters offices and the Diber branch. This could include increasing the time and presence of each Tirana project staff in the Diber office and integrating ACSP project and AlbRC HQ finance and reporting systems.

- ACSP staff should look for training and other professional development opportunities (both regional and at-a-distance), in which project staff (as a priority) and volunteers (if possible) could engage. These trainings should focus particularly on women and young children's health issues and financial and human resource management.

- ACSP staff should conduct quarterly VHT training sessions. Periodic training sessions on health topics that have been identified by the VHTs as important complements to their C-IMCI+ training (e.g., injection procedures, HIV/AIDS, drug use, and treating children with high fever) will serve as an additional educational opportunity and motivation to continue with the project. It will also address a consistent request from the VHTs for further health education on different health issues.

- Facilitate exchange visits for VHEs and VNMs to visit other VHTs within Diber prefecture as a motivational and learning opportunity. These visits should be facilitated

by project personnel with structured agendas to allow strong performing VHTs to work with and mentor weaker VHTs by sharing best practices and lessons learned.

- Organize activities to bring district- and prefecture-level VHTs together to demonstrate their competence in key project messages through friendly competitions. These events, similar to the AlbRCs' first aid competitions, could be extended to the branch level. Friendly competitions serve to share best practices among VHTs, recognize high performing volunteers, and build teamwork between VHTs from different communities.

- Review the incentives, recognition, and job aids for volunteers. Project staff should interview experienced VHEs and VNMs to assess the most valued combination of incentives, recognition activities, and job aids to be implemented. A carefully designed package of incentives (e.g., lunch money, transportation money, training opportunities); recognition events (inclusion in newsletters, public ceremonies, special awards for top volunteer performers, a piece of clothing [e.g., hat, shirt]) and job aids (paper, pens, informational leaflets, Red Cross identification) will keep retention levels high and volunteers motivated.

- Develop strategies further to integrate the project VHTs and the Red Cross volunteer network. Although the different volunteers have different activities, all identify themselves as Red Cross volunteers. Recruit more than two volunteers in each village.

- Budget additional project funds to provide modest expense reimbursement to VHEs when they host project-related meetings in their own homes.

Recommendation related to health facilities strengthening

- ACSP staff should engage hospital birth attendants, and newborn and child health providers (both doctors and nurses) in dialogue about the mandates of MoH Reproductive Health Guidelines, IMCI and C-ICMI recommendations that are related to maternal health in the antenatal, postnatal, and postpartum periods and the recommendations related to newborn, infant, and child nutrition to promote appropriate and more effective integration of health beliefs and practices.

- ACSP staff should identify the appropriate representative/office within the MoH and transfer the information gleaned from the HFA and from this MTE, so that the data are available for uses beyond the purposes and life of the ACSP project.

Recommendation related to staff training

- ACSP administrators should regularly query all staff about their perceptions of need for additional training related to their project responsibilities. Administrators should be proactive in assisting staff to identify sources for this training and should assist staff to identify resources, including ACSP budget resources, to pay for this.

Recommendation related to budget

- Work with AmRC headquarters finance staff to develop a volunteer tracking system to capture cost-share information. Train Alb Red Cross finance personnel on this process, as a capacity-building exercise to demonstrate an alternative cost-sharing methodology.

Recommendations related to technical assistance

- AmRC headquarters program officer should explore ways and means to provide support to ACSP staff for planning and implementation of the end of project KPC survey. This could be addressed through involving staff in KPC training courses or facilitating on-line study opportunities.

- AmRC headquarters staff and ACSP country-based staff should regularly consult with AlbRC staff at the national office and the Diber branch levels to discuss all issues related to the transition and assumption of program responsibilities and to offer technical assistance and support for any need that is identified.

PVO's responses to the MTE evaluation recommendations

Please see section II.A for PVO's Action Plan.

Revised work plan reflecting how the PVO will address recommendations from the MTE

Please see section II.B for the Action Plan table reflecting the work plan for carrying out response to recommendations.

B. Assessment of the progress made toward achievement of program objectives.

1. Technical approach

a. Project overview: program objectives, location, intervention mix, and general program strategy.

The Albanian Child Survival Project (ACSP) is implemented by the American Red Cross (AmRC) in partnership with the Albanian Red Cross (AlbRC). This collaborative initiative is designed to mobilize communities to take action to improve their own health, while improving access to and quality of key services in the formal health system.

The project is located in the three districts of the Diber prefecture (Bulqize, Diber, Mat), which are located in an impoverished, rural, mountainous area in northeast Albania. The Diber prefecture is located high in the Balkan Mountains, near the Macedonian border. The districts are administratively organized into communes, which are aggregates of village communities. The Diber district is the largest, with 14 communes; Bulqize has 7 communes, and Mat has 11. The prefecture has a total of 279 rural villages. ACSP has its project office is Peshkopi (Diber district), which is the site of the prefecture seat. See Figure 1 for a map of the Diber prefecture..

The goal of ACSP is ***improved health status of women of reproductive age and children 0-59 months in the Diber prefecture.*** The project staff works in collaboration with a broad coalition of Ministry of Health (MoH), personnel, collaborating and cooperative organizations, and volunteers to pursue project objectives and to leverage the impact of collaborative activities, including:

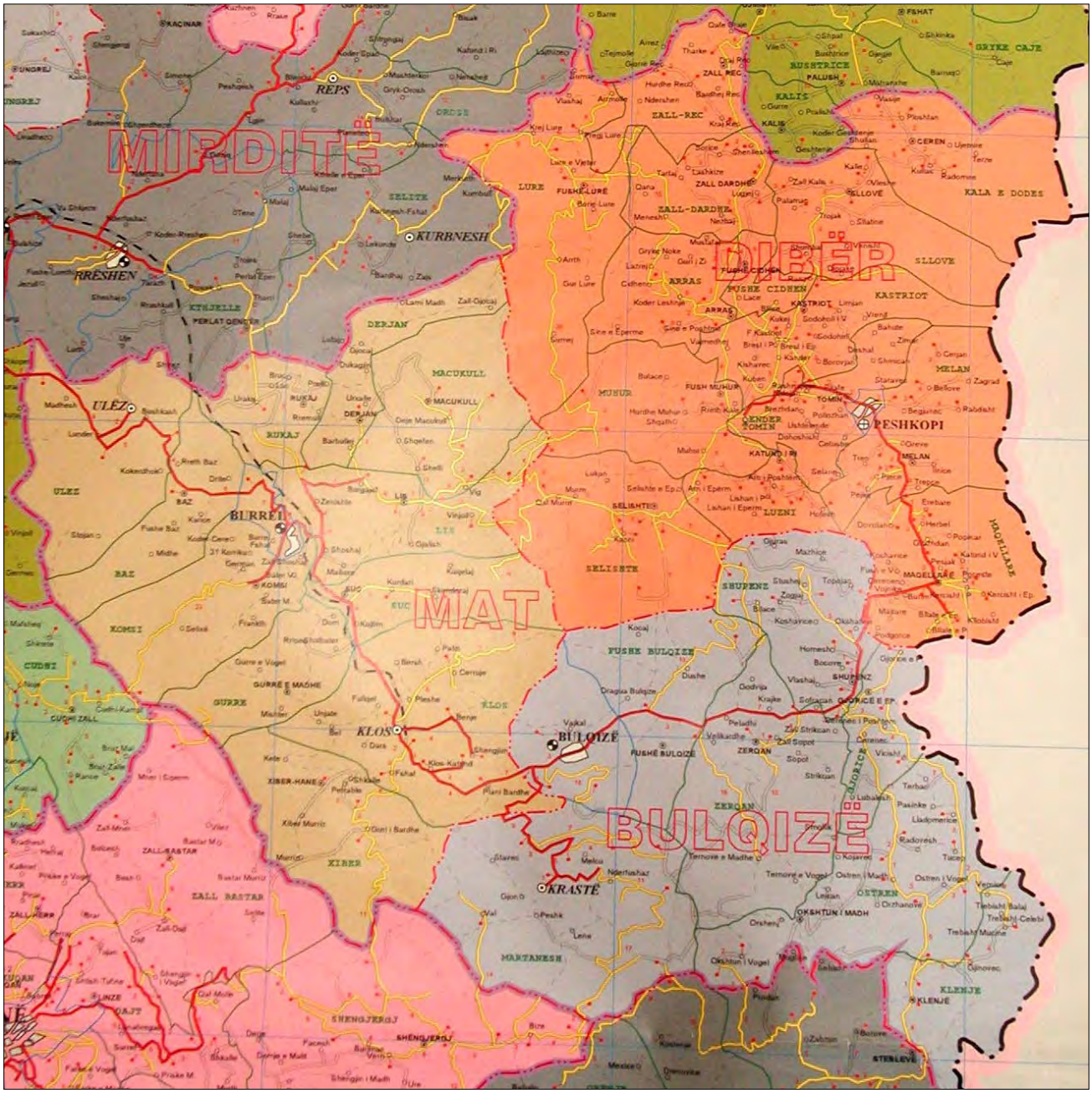
- Ministry of Health, Institute for Public Health (IPH)
- Albania Red Cross (AlbRC)
- Other Non-Governmental Organizations (NGO) and agencies (e.g., UNICEF, URC, JSI [see acronym list])
- District health staff
- Volunteer village health teams (VHT), e.g., the village nurse midwife [VNM] and community-based volunteer village health educators [VHE].

This project is assisting the Albania MoH to roll out the nationally approved MoH strategy of Integrated Management of Childhood Illness (IMCI) and also to provide family planning training for VNMs in the Diber prefecture. The project seeks to establish, field-test and finalize the C-ICMI+ protocol in the country (and is the single NGO in Albania focused on the C-ICMI strategy). The addition of the family planning component (the "+") of the C-IMCI+ curriculum is unique to this project. The project focuses on improving skills of first-line health workers to improve health at the community level.

The ACSP works to achieve six project objectives:
1) Iincreased use of maternal and child health (MCH) and FP services,
2) Iimproved service availability and access,
3) Increased service quality,
4) Increased practice of key MCH and FP household behaviors,

5) Increased household level knowledge and interest, and
6) Improved sustainability of all activities through partner strengthening.

FIGURE 1:Map of Diber Prefecture



The project employs three cross-cutting implementation strategies, applied to all technical interventions:

a) Capacity building to improve access, availability, and quality of services,
b) Community mobilization to increase demand for, and use of, key services, and
c) Tailored behavior change communication to improve key household behaviors and care-seeking practices.

These strategies are pursued through the use of four high-impact community activities:

a) Community-based growth monitoring and promotion,
b) Proactive home visiting,
c) Young child support groups, and
d) Family planning focus groups.

The technical interventions and level of efforts for the project are:

- Nutrition and micronutrients (30 percent)
- Control of diarrheal diseases (20 percent)
- Acute respiratory infection (20 percent)
- Family planning (30 percent)

b. Progress by intervention area.

ACSP has been implemented in successive stages, with progressive implementation of project activities in the three prefecture districts. Therefore, this mid-term evaluation report will be organized by technical intervention area and by district. This will afford the opportunity to reflect on the degree to which progress toward project benchmarks has been accomplished in appropriate proportion to the stage of implementation of project interventions in the various districts.

Figure 2 offers graphic representation of the project goal and objectives. The project's four key technical interventions are addressed via Strategic Objectives (SO) 1 and 2, and the three intermediate results that are linked to these objectives. Minor changes from activities proposed in the Detailed Implementation Plan (those either already implemented, and those proposed at the time of MTE) are discussed in Appendix A. Figure 3 presents the project activity timeline for all training activities.

Progress toward targets established for this ACSP were assessed at mid-term through a participatory evaluation process that involved a broad coalition of project team members, stakeholders, and project beneficiaries. Qualitative methodologies were used for the purpose. Full details of the process and participants is provided in Appendix B, C (C.a., C.b..), and D (D.a.., D. b.). A review of project monitoring reports was conducted to verify quantitative progress toward training and service targets (Appendix E).The quantitative Knowledge, Practice and Coverage (KPC) survey was not repeated.

It is particularly important to note that the majority of focus group participants were also members of active or current support groups that were formed through project activities. The

views of community members who are not presently engaged in project activities are underrepresented.

Figure 2: Strategic objectives

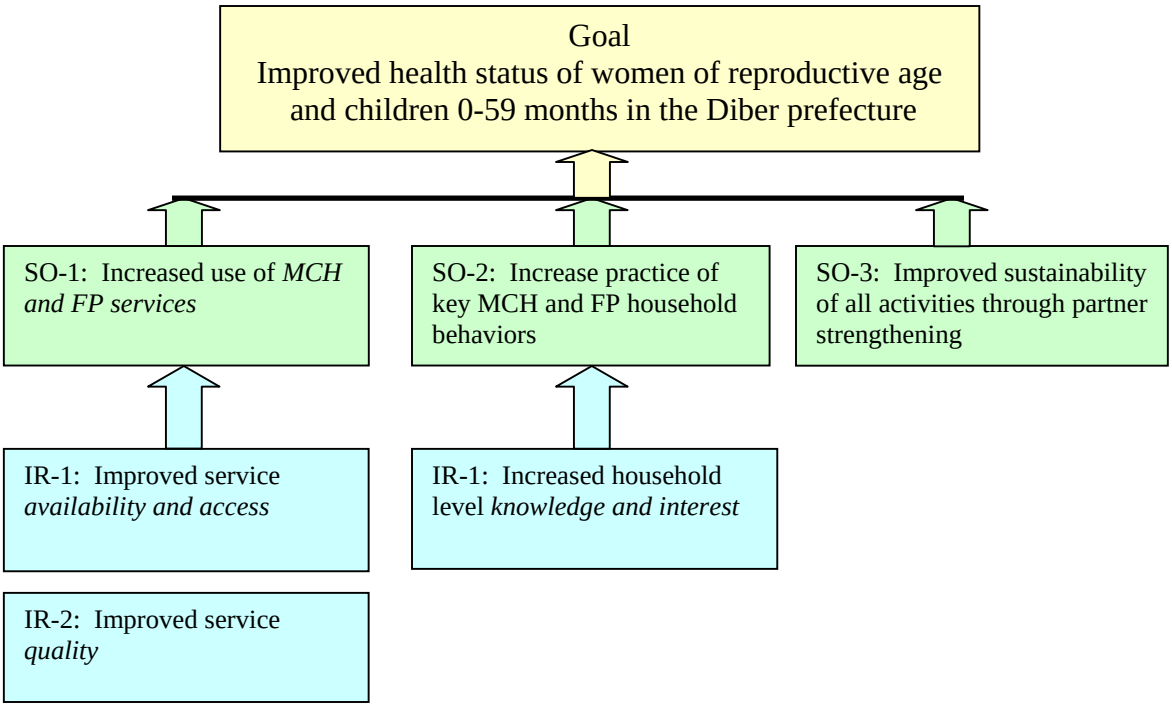


Figure 3: ACS Project Activity Timeline

Activity/ Training	Status	Project Year 1 (10/1/03 – 9/30/04)												Project Year 2 (10/1/04 – 9/30/05)												Project Year 3 (10/1/05 – 9/30/06)											
		O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S
DIP	Scheduled						■	■																													
	occurred						✓	✓																													
KPC survey	Scheduled		■																																		
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HFA survey	Scheduled					■																															
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FP survey	Scheduled											■	■																								
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Grandmother quality. study	Scheduled											■	■																								
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IMCI	scheduled													■	■	■	■																				
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Note: The information about "scheduled activities" is taken from the main project's documents (DIP and Annual reports)

b.1. Nutrition and micronutrients (30%)

The *activities* proposed by ACSP to address improvement in the status of maternal, infant, and child nutrition are linked to SO 1 and SO 2. They include the following.

- Conduct clinical IMCI training for all VNMs at health center/post levels (Note that this activity was to be conducted only in the Diber district, as the MoH had already conducted this activity in Bulqize in 2002).
- Adapt a community IMCI curriculum based on the WHO and UNICEF standard curriculum model that reflected an emphasis on the nutritional issues and significant gaps in household knowledge and practices that emerged as a priority during the project's KPC survey.
- Develop training materials and job aids to accompany the C-IMCI+ curriculum.
- Prepare C-IMCI+ trainers (VNMs and VHEs) to deliver the C-IMCI+ curriculum, using participatory methods, interpersonal communication and adult learning methods.
- Train providers in antenatal clinics and maternities in essential actions for nutrition and micronutrients (improved routine prophylactic antenatal iron/folate supplementation; improved nutritional counseling, rest and workload for pregnant women; improved tracking of weight and trends for pregnant women; and promotion of immediate and exclusive breastfeeding).
- Prepare VNMs to offer enhanced individual counseling for women and their mothers-in-law during prenatal care services.
- Apply the Global Strategy for Infant and Young Child Feeding within the context of all training materials, and as the primary nutritional message to be delivered by VNMs and VHCs (integrating breastfeeding, complementary feeding, nutritional management of early childhood illness, micronutrient nutrition, and related maternal nutrition).
- Develop posters and printed materials (brochures) to reinforce nutritional messages.
- Mobilize mothers and grandmothers to attend monthly growth monitoring promotion activities (weigh babies, complete growth monitoring charts, track trends, and provide tailored nutrition counseling and feedback).
- Maintain a roster of children whose growth has not been monitored and conduct proactive home visits to assess nutrition and growth.
- Organize young child support groups for mothers, grandmothers, future mothers and other caregivers.
- Advocate with the MoH to include iron/folate supplements for pregnant women within their free drug formulary.
- Ensure the supply of weight scales at village levels (health posts) and update knowledge on correct use of scales in the context of growth monitoring and health promotion (GMHP).
- Promote quality of health worker performance through the introduction of checklists that support the supervision system that will be developed and implemented.

The original proposal included the plan to promote Vitamin A supplementation (VAS). However, this was modified at the time of the preparation of the DIP. The Albanian IMCI protocol recommends that Vitamin A supplementation occur in only severe case management of malnutrition. The project decided not to promote Vitamin A to conform to national policy and norms. The revised plan was to review Vitamin A policies and protocols with the MoH and UNICEF because UNICEF is the MoH's main collaborative partner for the clinical IMCI national strategy.

Thirteen *indicators* were established to monitor the progress toward end-of-project targets that were established for this nutrition and micronutrient intervention. These include nine indicators for which baseline data were collected during the KPC survey and are indicated by asterisk:

- Weight for height *
- Weight for age *
- Breastfeeding during the first hour after birth *
- Exclusive breastfeeding (EBF) rate (age 0-5 months) *
- Bottle feeding (age 0-11 months) *
- Iron/folate supplementation during pregnancy *
- Use of iodized salt *
- Provision of food and fluids during an illness episode (age 0-23 months) *
- Inclusion of meat, organ meat, poultry or fish in the diet (age 5-23 months) *
- Villages with functioning C-IMCI+ teams, reporting data to the project M&E system
- VNMs in the Diber prefecture trained in IMCI
- VHE's use of job aids
- VNMs use of supervision checklists for VHEs. (*No longer applicable. See discussion below*.)

Findings for Bulqize District

Training and supervision of health providers: A total of 41 village health teams were trained in the Bulqize district in C-IMCI+. This included 122 persons, including 44 VNMs and 78 VHEs. Training started in April 2005 and was completed in November 2005. During the training sessions, a few promising participants were approached to become trainers for future groups. This identification process served to replace other trainers, previously identified, who did not perform as well as expected. Three individuals from the health sector and the Red Cross Movement were also trained to become trainers of C-IMCI+.

The MoH had previously conducted IMCI training in Bulqize; therefore the ACSP had not targeted IMCI training for this district. The project has considered conducting this training in the near future to provide training for staff that has been newly hired over the last three years. (The last MoH training had been conducted three years ago.).

VHTs conduct household visits primarily for growth monitoring activities, in addition to family planning and health education. Additionally, the VHTs use any opportunity or contact with their neighbors to share health education messages. Examples of such opportunities include: daily collection of water at the common water source, market days, casual contact in paths and roads, family celebrations, working in the fields, gathering wood, etc. This informality is often driven by a lack of acceptable meeting places, such as a local health post or clinic. It also results in meeting by serendipity, rather than by design. There is presently no method or strategy to identify all families who reside in the target community.

To date, the VHTs have conducted 401 home visits, 891 young child support groups, and 654 family planning focus groups. These activities were conducted using behavior change communication materials and strategies, such as handouts, leaflets, cue cards and other job aids. Growth monitoring activities have also been initiated; 363 sessions have been conducted.

Supervisory strategy: The supervisory strategy that has been established for the volunteer staff (VHNs and VHEs) of the ACSP is described below. **Please note** that this cross-cutting supervisory strategy is designed to promote the quality improvement of ACSP activities for three of the four ACSP interventions (nutrition, control of diarrheal disease, acute respiratory infection), in each of the three districts of the Diber prefecture in which ACSP operates. The information presented below will not be repeated in subsequent sections of this narrative (b.2, b.3, and by district). The supervisory strategy is also applicable

to the family planning intervention, but is further augmented for that particular activity. That information will be presented in section I.B.3.

Please note also that VHTs were designed to work as a team and run activities together, therefore VNMs do not have the responsibility to supervise their VHE counterparts. Accordingly, the indicator "VNMs use of supervision checklists for VHEs" was removed from the project's performance monitoring plan (PMP) (Appendix A).

The three district health coordinators (DHC) are the primary supervisors for the VHTs. They conduct site-based visits to consult with VHT members about the progress of their work, to offer support for VHT efforts, to review project monitoring data, and to address constraints and barriers to effective implementation of project tasks. These supervisory visits are not typically scheduled, but do occur with regularity. (Note that project activities have only recently been initiated in the Mat district. However, the supervision system is planned to follow this same model.) (Appendix F). Project staff has developed supervisory tools to monitor and improve the quality of both VHE and VNM activities (Appendix G, H). (Note that feedback and suggestions for improvement are an integral component of this checklist.)

DHCs are assisted in this role by commune mobilizers (CM). CMs are project volunteers (VNMs or VHEs) who have been identified by the project as being particularly effective in performance of their project activities. They have therefore been asked to accept additional responsibilities that include supervision of VHT members, in concert with the DHC. They also facilitate the flow of project monitoring data. Additional information about the role and function of the CM is included in the description of the supervisory system (Appendix F).

The position of community health specialist (CHS) was recently created and will serve in all three project districts. This individual will provide direction supervision of, and support to, DHC, and any other project staff or volunteer who could benefit by the skills that this individual will bring to the project. The position is presently being advertised. The CHS job description is included as Appendix I.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators (KPC rapid catch and similar indicators). These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNMs and VHEs serving the project in the Bulqize district:

- Participants' responses related to breastfeeding and maternal nutrition were largely in line with project messages. When asked to name topics discussed with VHEs, the first items consistently mentioned were child feeding and the importance of breastfeeding.
- Many mothers mentioned that beginning breastfeeding immediately after birth was new and different information to them. Previously, the practice was to wait for the mother to recover (from 3 hours to 3 days) before beginning breastfeeding. This can be challenging for mothers using maternity centers as the resident nurses are sometimes unwilling to bring the newborn child to the mother immediately after birth (within the first hour).
- However, some mothers responded that they give their children water and chamomile tea before the sixth month of age.
- All women emphasized the importance of giving fluids (e.g., fruit juice, water) to children when complementary feeding was initiated.
- Mothers were largely able to identify nutritious foods for their children but some were sometimes unable to purchase these foods for their children.

- Another group of women expressed that, while they could identify nutritious foods, the distances required to travel to the markets to purchase these foods was prohibitive. In the words of one mother: "*It is not important just to fill the stomach of the child but to know what you are giving the child is nutritious."*
- Fruits and vegetables were consistently mentioned as the most nutritious types of food available. Meat was infrequently mentioned; however, further discussion highlighted that livestock and poultry was often available and part of the family's diet. Only two women mentioned grains or cereals, but this might have been due to a problem with translation of the terms ("cereal," "grain") into the Albanian language.
- Growth monitoring is now being accomplished. VNMs noted that they did not have scales or growth monitoring charts prior to the project.
- VNM/VHE respondents noted that there had been no occasion to recommend referral of malnourished or under-weight children. There were no cases documented.
- Some mothers reported that after receiving information from the VHTs, they began to grow carrots for the first time.
- All women interviewed clearly understood the importance of using iodized salt. "Black salt" was used primarily to preserve food, such as pickles and dry meat.
- The project information was largely new to the mothers. They acknowledged that practices have changed.
- A grandmother noted that "*we used to feed the child with what we had, but now we are getting used to the new ways."*
- A VHE, when comparing a current pregnancy to a previous one, commented that she had changed her eating pattern to reflect her new knowledge. Now, after learning the project's messages, she ate smaller portions.

Findings for Diber District

Training and supervision of health providers: The MoH protocol states that 80 percent of VNMs in a district should be trained before IMCI is considered to have been established and ready for implementation. The MoH and UNICEF conducted the clinical IMCI training for family doctors at the health center level. ACSP project staff worked closely with the MoH to ensure that family doctors were given this training as a priority before initiation of ACSP training activities for VNMs. This ensured that a "higher order" supervisory strategy (i.e., supervision provided by a more highly trained health provider) could be pursued. ACSP conducted ICMI training in Diber district from December 2004 through June 2005. There were 134 VNMs trained during that period of time, exceeding the MoH target (80% = 105).

C-IMCI+:training was conducted for VNMs and VHEs in Diber district between July 2005 and April 2006. This training resulted in coverage for 93 Villages (1 VHT per village) in 12 communes of the Diber district. A total of 282 individuals (104 VNMs + 178 VHEs) were trained. The original project proposal indicated that a larger number of villages (102) would be covered by this C-IMCI+ strategy. However, after discussion with the AmRC Program and Technical Officers and with concurrence of officials from the Child Survival and Health Grants Program of the United States Agency for International Development (CSHGP/USAID), this number was reduced in order to enable an increase in the quality of supervision in villages where VHTs were already implementing the intervention.

Community level activities were initiated in a limited number of villages in July 2005. These include, to date, 1,866 young child support groups, 1,280 growth monitoring promotion, 1,456 family planning support groups and 1,104 proactive home visits. The strategy used to identify families who reside in this district is similar to that described for Bulqize, i.e., the recommendation of those known by others (a

"snowball sampling" strategy). There is, therefore, no way to ensure that all families are being reached by the project interventions.

Progress toward learning objectives. The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age and among the VNM and VHEs serving the project in Diber district:

- VHT members noted that the primary target for their health messages was the mother who, in turn, often spoke to other women. Those most eager to learn are women who have already benefited from the program or those who have spoken with women who had already been engaged in learning or counseling.
- Women noted that they had not previously known of importance of breast feeding in the first hour of life, but that they now know that breastfeeding helps to build the immune system of the child.
- Women stated that they had learned about exclusive breast feeding and the nutritional value of colostrum for the infant. VHEs and VNMs noted that this topic was one of the primary messages that they delivered during growth monitoring sessions.
- One woman offered a comparison between the health experience of her children who had not been exclusively breastfed and her current child, who was. She noted that a child who had been breastfed for only two months had become ill at an earlier age and for longer periods of time in comparison to her children who were breastfed for longer periods.
- Women spoke of changed behaviors with respect to complementary feeding. Their previous practice was to use flour and water, but now they know to use more variety. They also begin feedings with smooth or liquid foods and gradually built up to solids.
- Women reported new learning about the importance of vegetables (beans, carrots, spinach, potatoes), fruit (bananas), fish, eggs and meat. They now know the importance of protein (fish, eggs and meat). Prior practice favored pudding, yogurt, and sugar as a primary food choice.
- The quantity and quality of food were also noted as important factors in child nutrition.
- Grandmothers were also open to new learning. They were willing to listen to information provided by the VNM or VHE, either directly or through discussions with their daughters-in-law who passed the information along. The information was considered to be valid because it came from a knowledgeable person.
- Mixed information was received concerning the use of iodized salt. Two groups of women interviewed gave conflicting information. All women participating in one focus group acknowledged their use of the product; but only a minority of women in a second focus group also reported its use. (This may have been the result of a translation error, as women in this group were able to describe the correct type of packaging, and color of the label of the iodized salt product that is sold in the market.)
- Women received nutrition counseling during pre-natal visits. Some learned about iron. All received information on vitamins in general.(*However*, commodity supply was sometimes a problem, and this is outside the scope of project activity.)
- VHEs and VNMs reported that a primary focus of their activities was child weighing sessions and teaching about exclusive breastfeeding.

Findings for Mat District

Training and supervision of health providers: Activities were initiated in Mat district in the second year of the project (June 2005). Family planning training activities were the first project events. A total of 87 VNMs were engaged in a two-day FP training. An additional 18 VNMS, who worked at the health center level, were provided an additional one-day training in the Standard Days Method.

Clinical IMCI training was completed for all VNMs. (The total number of VNMs in MAT is 89). There was at least one trained VNM at each health center or health post by the conclusion of the project's second year. Ninety percent of all VNMs at the health post level have been trained by the ACSP project. The clinical IMCI training for family doctors at the health center level was conducted by the MoH and UNICEF. ACSP project staff worked closed with the MoH to ensure that family doctors were given priority training before ACSP training activities for VNMs took place in order that the "higher order" supervisory strategy (previously noted) could be pursued.

The MoH is responsible for conducting all followup and supervision of trained doctors and nurses. The MoH's supervision module was only recently completed (June 2006). No followup or direct supervision had occurred at the time of the MTE (July 2006). Nevertheless, the project's monitoring data document the fact that trained family doctors and nurses are using some counseling component of the clinical IMCI protocol (especially for nutrition and care seeking), but they are not making use of the complete protocol. These data also document that the majority of nurses do not have access to basic equipment, supplies, and essential drugs at the health center/health post level.

The community IMCI trainings were started in late May 2006. Two training sessions included 46 VHT members, including 16 VNMs and 30 VHEs from 12 villages in 3 communes. Four C-IMCI+ trainers have been trained in a training of trainers (TOT) session conducted in December, 2004. One additional individual, who had demonstrated initiative and interest, was also trained was during the first VNM/VHE training session and joined the second training session as a trainer.

Initial community-level activities were initiated in a limited number of villages in June 2006. At the time of the MTE, 22 young child support groups, 24 growth monitoring and promotion sessions, 12 proactive home visits and 14 family planning focus groups had been conducted. Job aids developed by the ACSP were provided to VHEs and VNMs in all districts. In the Mat district, some of these were provided to VHT members at the end of the C-IMCI+ training. The project plans to distribute additional materials during forthcoming supervisory visits. The project distributed nutrition leaflets (developed by the project with UNICEF funding) to every household with children under 5.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNM and VHEs serving the project in Mat district. *It is important to note* that these findings were elicited after only one month of C-IMCI+ project activity in the Mat district and among only a very few families who had been contacted for participation in project activities.

- Women reported that they had participated in support group discussions or had received individual counseling about growth monitoring and nutritional counseling (immediate and exclusive breastfeeding, and complementary feeding);
- New knowledge or practices that were introduced during these sessions included immediate and exclusive breastfeeding and complementary feeding. Women reported that they were now aware of the benefits of immediate breastfeeding (protection of the newborn from infection and promotion of the bonding process). They also reported that their previous practices for newborn feeding included the use of water and teas for children aged 0-6 months. However, some mothers reported that birth providers in the facilities did not support their request for immediate breastfeeding.
- New knowledge related to complementary feeding included the value of using different types of food and the use of home-cooked food instead of processed foods.

- Foods that are available and given to children included: meat (3-4 days a week); cereal/grains (2 times a day); and fruit (daily). Garden vegetables (e.g., eggplant, spinach, tomatoes, potatoes) were also noted, although this was reported as a newer practice.
- Grandmothers stated that they like the new practices and realize the importance for their grandchildren's health and development.
- Women understood the value of iodized salt, and a high use rate was reported.
- Women who had received antenatal care in the recent short-term reported that the following topics were included in their antenatal counseling: nutritional counseling, discussion about life style changes and for some (but not all) the importance of taking vitamins including iron and folate. (*Note again* the challenge to commodity supply.)
- VHEs and VNMs described how to conduct a growth monitoring session and how often they need to do a session; explained target groups and topics discussed for young child support groups, and emphasized proactive home visits.
- Weight scales were delivered to 14 VHTs at the end of the community IMCI training.
- A proactive growth monitoring visit program had been initiated in at least one village, and 18 home visits had been conducted at the time of the MTE.
- VHEs and VNMs expressed a high level of interest in their information dissemination activities; they feel welcomed into homes for visits.
- Women and volunteers want to see more printed materials about nutrition and other project topics for background information.

Constraints, concerns or limitations:

- Women commented that repetitive messages were not as appreciated as receiving new and different information would be. Women consistently requested additional information on new and different topics.
- The project does not have an activity related to supply of vitamins and iron. Women may not be able to act on their new information about the importance of these supplements in pregnancy and the postpartum period. Commodity supply is the responsibility of the MoH; Project staff need to work in collaboration with MoH to draw emphasis to this fact.
- Some mothers noted that the long distances they were required to travel in order to reach to project informational sessions limited their opportunity to participate in group sessions. Lack of available time and other family-related barriers were also mentioned. At the same time, these mothers expressed an interest in participating in project activities.
- The project has not developed or implemented any formal strategy to verify that all families that reside in the community are being reached with project interventions. A community "mapping" exercise conducted at baseline provided population data. However, it is very likely that changes in the community profile are occurring (in- or out-migration). It is particularly difficult to track these changes given the wide scattering of residences in the hard-to-access geographic regions of the prefecture.

Overall summary of progress toward target for nutrition interventions.

Thirteen indicators were established for the nutrition intervention. Nine of these indicators will be measured at end of project through the KPC survey. Qualitative and anecdotal information suggest that satisfactory progress is being made to transmit the messages related to infant and young child feeding. The majority of women know about the importance of EBF, complementary feeding with a variety of foods and feeding during and after illness but, have a desire for additional information. A lack of household income is typically the barrier for

integrating more nutritious foods in their diets. The nutrition messages are being promoted, but immediate breastfeeding promotion can be strengthened. More emphasis needs to be placed on iron and folate supplementation after delivery. However The MoH shares the responsibility for the supply side of this issue. *Therefore, it is appropriate to amend the target for this specific indicator or to remove it from the PMP*. The project is on track with the implementation of growth monitoring and health promotion sessions (Appendix E.), and responsive proactive home visiting is also well documented.

Recommendations related to nutrition findings

- Increase the educational activities conducted with facility birth providers (particularly nurses and nurse-midwives) to promote their support of immediate breastfeeding

- Enhance the message about the importance of iron and folate for pregnant and postpartum mothers.

b.2. Control of diarrheal disease (20%)

The *activities* proposed by the ACSP to address improvement in the control of diarrheal diseases are linked to SO 1 and its two intermediate results (IR-1, IR-2) and also to SO 2. They include the following:

- Train VNMs in the IMCI protocol for standard case management to correctly assess, classify, treat, refer, and counsel for diarrheal episodes.
- Train VHTs to counsel mothers and caretakers about the home management of dirrahea and use of oral rehydration therapy (ORT) as well as the importance of continued feeding and fluids during and after an episode. Special attention would be paid to the appropriate use of antibiotics.
- Provide technical assistance to health centers and posts to set up and maintain ORT corners and include ORT in emergency drug boxes.
- Target health education messages about improved preventive practices so that there is a focus on hygiene (hand washing with soap at all appropriate times) optimal infant and child young feeding (exclusive breastfeeding, adequate complementary feeding, use of ORT and nutritional management), recognition of danger signs, and appropriate care-seeking.
- Target improved management practices so that there is a focus on appropriate use of ORT at household level, recognition of danger signs and care-seeking.
- Develop job aids that can be used by VHTs as they address their messages to mothers and grandmothers.
- Reinforce BCC messages through the distribution of AlbRC printed materials (brochures and leaflets) that can be kept and shared with other household members.
- Encourage more experienced mothers to share challenges and solutions related to diarrhea prevention and management with new mothers and those less experienced.

Seven *indicators* were established to monitor the progress toward end-of-project targets that were established for this control of diarrheal disease intervention. These include three indicators for which baseline data were collected during the KPC survey, and are indicated by asterisk:

- Children with illness who were offered fluids during illness (age 0-23 months) *
- Children with diarrhea treated with oral rehydration solution (ORS) or ORT or other fluids (age 6-23 months) *

- Hand washing *
- Establishment of ORT corners
- Villages with functioning C-IMCI+ teams, reporting data to the project M&E system
- VNMs in the Diber prefecture trained in IMCI
- VHE's use of job aids
- VNMs use of supervision checklists for VHEs. (*No longer applicable – see section b.1.)*

VHT members noted that diarrhea is one of the most common problems in target areas. Typical practice, prior to implementation of C-IMCI+, was to encourage women to go directly to doctors or health facilities rather than treat the child at home.

Nevertheless, the importance of promoting ORT corners decreased as the project's focus shifted to education in preparation of ORT. The intention of the ORT corners was to create a central location in which caretakers could be instructed in the proper technique for ORS preparation and administration. The ACSP project reconsidered the establishment of ORT corners primarily because a majority of the villages did not have a functioning health post where this ORT corner was to have been established. Secondly, ORS sachets were readily available from a variety of vendors in the community at an affordable price. (Tresol is the brand name of the product available in Albania.) Third, Young Child Support Group sessions conducted by VHTs educate mothers on how to prepare and administer ORS.

A recently completed Doer/Non-doer study of mothers of children under age 5 was conducted to investigate six behaviors related to all the ACSP project objectives. One of these behaviors addressed ORT usage during an episode of diarrhea. Results of this study confirmed that "lack of knowledge" of how to prepare the ORT solution was ***not*** associated with the status of non-doer and, therefore, did not represent a barrier to effective use of the solution in time of need. For these three reasons, the ACSP elected to remove the indicator concerning establishment of ORT corners from its PMP (Appendix A).

Findings for Bulqize District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in C-ICMI+ were reported in section b.1. The supervisory strategy also appears in that section.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNM and VHEs serving the project in the Bulqize district:

- Mothers were consistently able to identify the majority of the symptoms of diarrhea. The sign "increase in thirst" was not often mentioned.
- Most, *but not all*, mothers stated that they would refer a child exhibiting danger signs to the VNM. Several mentioned taking a sick child directly to the hospital
- Mothers who had received training from VHTs mentioned the importance of continuation of breastfeeding upon onset of diarrhea, rather than stopping or reducing breastfeeding and giving the sick child other fluids. This finding was contrary to previously common practices identified in the "Grandmother Study" (reported in section b.1.c.)
- Nearly all mothers said they would give a sick child ORS and were familiar with good preparation practice. Some mothers noted that they would use ORS only after the child vomits.

- Mothers identified the following as diarrhea prevention measures: breastfeeding during the first 6 months, hand washing, good hygiene practices, replacement of fluids, and adherence to prescription and treatment plan from nurse or doctor.
- The majority of mothers commented that the sick child should be served freshly prepared food in smaller quantities and more frequently.
- Proper disposal of feces (including disposable diapers) was *not* mentioned. When prompted, women reported a common community practice of throwing diapers into the river or stream, or placing them in a local (above ground) dump site.

Findings for Diber District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in IMCI and C-ICMI+ are reported in section b.1. The supervisory strategy also appears in that section.

Project staff in Diber district proposed development of a project newsletter as an additional strategy to maintain communication among project team members and project beneficiaries. This activity has not yet been initiated. However, project staff have reproduced and shared other relevant BCC materials with beneficiaries, such as a booklet "A Letter to Mama" covering treatment and care of diarrhea. The newsletter will be produced at the end of the third year of the project. Currently, project staff members are collecting suggestions from VHTs regarding the content and format of the newsletter, including anecdotes from the field and highlighting the work of successful VHTs.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age and among the VNM and VHEs serving the project in Diber district:

- Women who received training on how to diagnose and treat diarrheal disease stated that the information was provided in a different form from what they previously knew. Grandmothers had different information than that being taught by the VNMs and VHEs, but they were willing to accept the new information.
- Women participants were asked to list the danger signs of diarrhea, as they are noted in the C-IMCI+ curriculum. Women named six or seven of the signs, without prompting. Findings about appropriate care seeking were mixed; some mothers were unclear about the distinction of a severe case.
- Hand washing and proper disposal of feces were *not* mentioned spontaneously. Hand washing was noted only after prompting. Women reported that they threw diapers into community dump sites or into rivers and streams.
- Women had correct information about feeding during illness episodes.
- Women were able to cite the recommendations for home treatment of diarrhea, and the use of ORT.

Findings for Mat District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in IMCI and C-ICMI+ were reported in section b.1. The supervisory strategy also appears in that section.

Project team members distributed leaflets (developed by the project, with UNICEF funding) to every household with children under 5 that focused on prevention and home care for diarrhea. This was intended to promote better interpersonal communication between project volunteers and program beneficiaries.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNM and VHEs serving the project in the Mat District. Additional data were obtained from interviews of community leaders and health providers:

- A majority of women were able to correctly list the majority of the danger signs diarrhea, and particularly of severe diarrhea, noted in the C-IMCI+ curriculum.
- Participants knew about preventive measures such as hand washing as a preventive measure, but did not specify the recommendations concerning when to wash hands.
- Community leaders were especially concerned about the access to safe drinking water (availability of chlorine).
- Some women did not seem to understand the difference between a simple and severe case of diarrhea with respect to the need for further care seeking..
- Some women described how to prepare and administer ORT for simple diarrhea; also women understood the importance of continued fluids and feeding during and after episode.

Constraints, concerns or limitations: Several doctors spoke about a very heavy personal workload and stated that they did not see the value of completing the IMCI protocol for simple cases. This workload may increase if caretakers do not have a clear understanding of when it is appropriate to seek care. Health centers that are centrally located would bear a greater adverse impact (higher increase in workload) if care-seeking for diarrhea is not appropriately related to the severity of the illness episode.

Overall summary of progress toward target for control of diarrheal disease interventions

Seven indicators were established for the control of diarrheal disease intervention. Three of these indicators will be measured at the end of project through the KPC survey. Qualitative and anecdotal information suggests that satisfactory progress is being made to transmit the messages related to control of diarrheal disease. There is a mixed level of knowledge of the symptoms of simple diarrhea and the danger signs of more serious disease. There is also a mixed level of knowledge about when it is necessary to seek a higher level of care. The proper use and preparation of ORS is well understood. The intention to establish ORT corners was deleted from the project work plan, with sufficient and compelling justification.

At the same time, there is a lesser degree of awareness, and behavior, about preventive measures. Families need to express a clearer understanding about the proper method of hand washing, and the times when hand washing is a particularly critical preventive measure (cooking, changing diapers). Individual behaviors and community practices related to the proper disposal of feces (and disposable diapers containing fecal material) is of particular concern.

Recommendations related to control of diarrheal disease finding

- The project needs to take a leadership role in educating the communities about the water and sanitation impact of community practices related to the disposal of feces and disposable diapers. This role can include engagement of other NGOs (e.g., URC's health reform project) in directing attention of public health authorities about this environmental issue.

- The educational message about distinction between simple and severe cases of diarrhea, and when to seek a higher level of care needs to be strengthened.

- The educational message about proper timing and method of hand washing needs to be enhanced.

- The educational message about the distinction between simple and severe cases of diarrhea and when to seek a higher level of care needs to be strengthened.

b.3. Acute respiratory infection (20%)

The *activities* proposed by the ACSP to address improvement in the control of acute respiratory infection (ARI) are linked to both SO1 and SO2 and also to SO1, IR-1 and SO 2, IR-1. They include the following:

- Train VNMs in IMCI protocol in standard case management to correctly assess, classify, treat, refer, and counsel for ARI.
- Pay special attention during training to the topic of the use of antibiotics (addressing misuse, premature interruption of treatment duration, use of left-over medications, etc.).
- Promote understanding of prevention measures. Include the promotion of full immunization, education about danger signs, and critical importance of rapid and appropriate care seeking.
- Promote understanding of danger signs in the young infant (within first 2 months of life) and the need for appropriate care seeking within 48 hours of onset of illness.
- Advocate the importance of maintaining the proper supply of emergency antibiotics in VNM emergency drug boxes.

Ten *indicators* were established to monitor the progress toward end-of-project targets that were established for this intervention focused on identification and treatment of acute respiratory infection. These include six indicators for which baseline data were collected during the KPC survey and are indicated by asterisk:

- Children with cough and fast/difficult breathing treated with antibiotics at health center (age 0-23 months) *
- Appropriate care seeking for cough and fast/difficult breathing (age 0-23 months) *
- Knowledge of neonatal danger signs *
- Knowledge of child danger signs *
- Knowledge of fast/difficult breathing as a danger sign for neonates *
- Knowledge of fast/difficult breathing as a danger sign for children *
- Villages with functioning C-IMCI+ teams, reporting data to the project M&E system
- VNMs in Diber prefecture trained in IMCI
- VHE's use of job aids
- VNMs use of supervision checklists for VHEs. (*No longer applicable – see section b.1.)*

Findings for Bulqize District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in C-ICMI were reported in section b.1. The supervisory strategy is also described in that section.

Project team members distributed UNICEF leaflets to every household with children under 5 that focused on ARI danger signs and care-seeking practices. This was a similar strategy used for the control of diarrhea intervention and was intended to promote better interpersonal communication between project volunteers and program beneficiaries.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNM and VHEs serving the project in Bulqize District.

- Common symptoms of ARI identified by a majority of mothers included: high temperature, coughing, sweating, child looks unwell, difficult breathing, noise while breathing, irritability and no appetite. Symptoms not commonly mentioned were lethargy and not eating and drinking. Mothers said that they would seek help from nurses and or doctors if these signs were exhibited. (*It is important to note* that the focus group discussions, in general, centered on the child and that danger signs in the newborn were not explicitly elicited.)
- Mothers commented that, if a prescription and/or a treatment plan were outlined by a doctor, they would certainly follow it and also do a follow-up visit.
- VNMs noted their responsibility for administering a first dose of antibiotic prior to referral of severe cases, but pointed to a lack of drug boxes and/or antibiotic supply as a constraint.

Findings for Diber District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in ICMI and C-ICMI were reported in section b.1. The supervisory strategy is also described in that section.

VHT members noted that ARI was one of the most common problems in the communities of Diber District. Project team members distributed the same UNICEF leaflets (see Bulqize district) to every household with children under 5 that focused on ARI danger signs and care-seeking practices.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNM and VHEs serving the project in Diber District.

- Women stated that they had learned how to reduce a child's elevated temperature by using tepid bath water.
- Women were consistently able to name all the C-IMCI+ designated signs of ARI (but again, knowledge about danger signs in the neonate was not specifically elicited.)
- All focus group participants responded correctly to the C-IMCI+ recommendations concerning care of children with ARI, e.g., timing of care-seeking, sick child referral, and following the recommended duration of treatment.

Findings for Mat District

Training and supervision of health providers: The numbers of VNMs and VHTs trained in ICMI and C-ICMI were reported in section b.1, where the supervisory strategy is also delineated. The project distributed UNICEF leaflets to every household with children under 5 that focused on ARI danger signs and care-seeking practices.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age and among the VNM and VHEs serving the project in Mat District.

- Women recognized the majority most of the C-IMCI+ designated danger signs of ARI (at least for the child).
- Women recognized the importance of completing the full course of treatment of antibiotics. They mentioned that an incomplete dose can lead to re-occurrence of infection.

Constraints, concerns or limitations: The C-IMCI curriculum emphasizes that the first-level health care provider (in this case, the VNM at community level) should dispense a first dose of antibiotic, prior to referral of the child to the next level of care. The C-IMCI approach has been formally adopted by the MoH for country-wide implementation, and the approach has been fully implemented throughout the Diber prefecture. Nevertheless, the current MoH guideline states that nurses are prohibited from prescribing and dispensing antibiotic medications. This policy "disconnect" is acknowledged at MoH levels, but the MoH has only recently begun deliberations about ways to resolve it. This leads, in turn, to the practical effect that drug boxes are not stocked with this "first dose" of antibiotics; therefore first-level providers have no opportunity to implement the C-IMCI action that has been taught and recommended.

The focus group interview guidelines were not sufficiently detailed to prompt the distinction between infants and children with respect to danger signs (neonatal danger signs in general and fast/difficult breathing as a specific danger sign in neonates). Therefore, findings from this MTE do not provide sufficient information to gauge whether the neonatal message is being well transmitted or well received (two of six project indicators). ASCP project personnel report that the Albania IMCI protocol adapted and approved by the MoH does not cover the first week of life (0 -7 days), although the Trainer's Guide does present this information. ASCP project personnel should seek additional information concerning this issue, and perhaps, reconsider the two EOP targets set for the neonate, in light of the findings.

Overall summary of progress toward target for prevention and treatment of acute respiratory infection.

Ten indicators were established for the acute respiratory disease intervention. Six of these indicators will be measured at end of project through the KPC survey. Qualitative and anecdotal information suggests that satisfactory progress is being made to transmit the messages related to prevention and treatment of acute respiratory infection, *at least with respect to the child*. (MTE findings with respect to the neonate are insufficient.) Women know the majority of the symptoms and danger signs as well as appropriate care practices. They consistently mentioned the need to carefully follow the treatment plan as prescribed by their doctor as well as a follow-up visit. First-level care providers (VNMs) are well aware of their responsibilities under the C-IMCI curriculum to provide the first dose of antibiotic, prior to referral of severe cases. However, there is often no drug box at the care facility or the box is not stocked with the appropriate medications.

The ACSP has also made satisfactory progress toward objectives related to training of IMCI and C-IMCI+ teams, and use of job aids. The number of young child support groups conducted by these teams is well documented, and on target. (See Appendix E.)

Recommendation related to acute respiratory infection findings

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of the VNM drug boxes; specifically, the availability of antibiotics for the first dose in treatment of ARI.

b.4. Family planning (30%)

The *activities* proposed by the ACSP to promote adoption of modern methods of family planning are linked to all three of the SOs, and also to SO 1, IR-1 and SO 2, IR-1. They include the following:

- Expand the access and availability of quality FP services by increasing the number of service delivery points and integrating FP into antenatal and post partum services.
- Train VNMs and VHEs at the village level in promotion of FP services and integrate VNMs fully in the FP delivery service and logistics management information system (LMIS).
- Develop training curriculum and job aids for the Standard Days Method (SDM).
- Replicate the counseling cards that were developed by JSI and approved by the MoH as a job aid for delivering FP services.
- Develop study protocol that introduces SDM as a new modern FP method.
- Recruit male VHEs to seek out youth and men at cafes, billiard halls, mosques, and other venues where males gather.
- Work in local schools to provide health education classes in middle and high schools.
- Engage mothers-in-law and other family members to inform them about the importance of child spacing.
- Inform new mothers and mothers-in-law about FP methods, and, in particular, LAM as a modern method.
- Develop lively printed materials (posters, brochures, leaflets) for women to share with their partners.

Twelve *indicators* were established to monitor the progress toward end-of-project targets that were established for this control of family planning promotion intervention. These include eight indicators for which baseline data were collected during the KPC and/or Family Planning surveys, and are indicated by asterisk:

- Couple year protection provided to target population
- Use of modern FP methods (age 15-49) *
- New users of modern methods of FP*
- Discussion of FP with health or FP provider*
- Residence within 5 KM of a FP service delivery point (SDP)*
- MCH SDPs offering FP services
- FP clients receiving adequate counseling*

- Use of lactational amenorrhea method of FP by mothers with infants (age 0-5 months) *
- Discussion of FP issues with spouse or sexual partner *
- Dissemination of FP messages *
- Sustainability plan developed for FP programming
- Functioning logistics management information system

The addition of the family planning component of the C-IMCI+ curriculum is unique to this project. All VNMs and VHEs have been trained in the LAM and SDM methodologies. *Additional, expanded, discussion of Family Planning can be found in Section 3 of this report.* The information presented below provides brief information to provide evidence of linkage with project indicators for the FP intervention.

Currently, ACSP is involved in an expansion of FP in the Diber prefecture (all three districts) at the health post level. It is the case, in a majority of district communities, that a trained FP service provider is located in the community, but does not have access to contraceptive supplies, or supervision, that are essential to the provision of high-quality FP services (essential components of the definition of the indicator of a service delivery point).

The expansion project seeks to craft a functioning FP service delivery point at the village level. Project staff will coordinate with JSI to design supervisory methodology and the report forms. The supervisory team will be made up of the MoH focal point for FP; one MoH monitoring and evaluation (M&E) staff member; and one additional person proposed by the public health director. URC is concurrently conducting a community awareness project in five prefectures, including the Diber prefecture. ACSP and JSI are presently engaged in discussion about modifying existing reporting forms so that there is close correlation with information presently required by the MoH LMIS and to avoid the provider burden of duplication of paperwork, recording, and reporting.

The Logistics Management Information System for contraceptive supply and resupply was built by JSI for the MoH, and is currently maintained by the government. The MoH works through the Institute of Public Health to handle the storage and distribution of all FP commodity supplies to the district level. The United Nations Family Panning Association (UNFPA) is responsible for procuring and purchasing of all FP commodities. The MoH is taking responsibility for the contraceptive supply budget in phases, assuming 100 percent of the cost by 2010.

Findings for Bulqize District

Training and supervision of health providers: The ACSP activities in Bulqize district included provision of FP training in all villages and also for new staff hired at the health centers since the end of the first phase of the JSI initiative. A total of 35 VNMs (both health center and village level staff) received the 2-day training (April 2006). A majority (22) of these same VNMs also participated in the one-day training on SDM. Health center nurses trained on SDM have received numerous on-the-job training and visits from project staff.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNMs and VHEs serving the project in Bulqize District, from site visits to health center FP service delivery sites, and interviews with FP providers.

- All women were able to identify several family planning methods.

- Women consistently commented that they have chosen and used family planning methods without the knowledge of their husbands.
- Not all women were aware that these methods were available at no charge. However, several commented that "free supplies" from the government must indicate that the medicine must be out of date or of lesser quality.
- Some noted that while family planning products were available through the government service point, they obtained their family planning methods from the local drugstore or pharmacy. Others noted that young people specifically went to their local drugstore or pharmacy to preserve an element of anonymity.
- A recent "stock-out" of certain family planning supplies in the district has forced women to alter their family planning methods, in particular, injectable contraception (Depo-Provera).
- Very few women indicated that they would trust the LAM method. At the same time, few were able to list more than one of the three criteria of successfully following the LAM method. Two women commented that they actually got pregnant while using the method.
- Similar to LAM, only two women (both were family planning providers) said they use SDM. Most women, while aware of the recently introduced cycle beads, did not express a need for the beads to track their cycle. Others commented that the pill or Depo-Provera were preferred, due to less attention required to follow the method.
- VHT members expressed their willingness to elect the SDM method for personal use.
- Most sites had displayed family planning materials, most commonly with pamphlets from USAID's SEATS project. The ACSP project's SDM brochure was also visibly displayed and available in sufficient quantity.
- A common comment from FP provider staff was that they had noted a decrease in the rate of abortions as well as the number of births.

Findings for Diber District

Training and supervision of health providers: JSI began FP training for family doctors and health providers at the health center level in May 2005. This was the second phase of this JSI project, which had the goal of expanding FP provider training at the hospital and health center level in 16 districts, including the Diber district, which had not been included in the first project phase. ACSP extended this training to the village level through the provision of additional two-day FP training activities. JSI and ACSP coordinated schedules so that hospital/health center staff received training, which were then followed by ACSP activities. This created the provider pool from which FP supervisors could be drawn. (Supervisors are named in the introduction to this section). A total of 104 VNMs were trained in FP (December 2005 and April 2006). Thirty one of these VNMs also participated in a one-day training on the SDM. These VNMs were all health center staff (i.e., not village level providers). In addition, health center nurses have received numerous on-the-job visits and training from ACSP project staff.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age and among the VNM and VHEs serving the project in Bulqize district. Additional information was obtained from interviews with FP service providers, FP supervisors, and women who were current FP users, including the standard days method.

Two groups of women of reproductive age (WRA) were interviewed in this district. They were asked to discuss their knowledge of various methods of contraception, efficacy, side effects, and where to obtain contraceptive supplies.

- Women were at various levels of understanding about aspects related to oral contraceptive methods.
- Women who did know all of the methods available to them also knew how to use them effectively and where to obtain them.
- Women knew where to obtain contraceptive supplies and that they were free of charge. *However, they also commented that free supplies might not be of the best quality.*
- There was very limited comment that some older women might equate promotion of FP with the promotion of abortion.
- Women were very unclear about the LAM approach to FP. They were particularly unclear about the three criteria essential to method effectiveness.
- A small minority of women had not yet heard about the SDM approach to FP. However, several women stated that they were not inclined to trust the method's effectiveness. One woman stated that she found attending to the method every day to be burdensome.
- One group participant actually produced a set of cycle beads and gave a demonstration of their use. She was accurate in each step of the demonstration.
- Another woman suggested using the beads to indicate fertile days should one desire to become pregnant.
- VHT members noted that there are other sources of information about FP. They also noted that women had commented that they did not necessarily trust the information that came via public media to the same degree that they trusted the information given them through personal communication methods, such as the ACSP focus group activities.

Findings for the Mat District

Training and supervision of health providers: The ACSP initiated activities in the Mat District in the second year of the project. The first VNM two-day FP training for village level VNMs occurred in June 2005. An additional one-day SDM training for VNMs at the health center level was conducted in December 2005. One half of the health center VNMs had not previously received any training in FP, so the two-day FP training curriculum was offered to these individuals before the SDM training. A total of 87 VNMs (both health center and village levels) received the FP training, and a total of 18 VNMs (from the pool of 87) received the SDM training. The 16 VNMs and 30 VHEs who participated in C-IMCI+ training (including SDM and LAM) in 2006 received additional FP training through this strategy. Health center nurses have also received numerous visits and on-the-job trainings from the project staff.

Planning for the extension of FP services to the village level has been undertaken. Fifteen of 76 villages were selected in July 2006 to serve as pilot villages in this extension program.

Progress toward learning objectives: The following findings provide qualitative evidence of progress toward additional project indicators. These data were obtained during focus group discussions conducted among women of reproductive age, and among the VNMs and VHEs serving the project in Bulqize District. Additional information was derived from site visits made to FP service delivery points and from discussions with male members of the community.

- VHEs and VNMs mentioned all the approved MoH methods.
- The degree to which beneficiaries trusted the various methods was mixed (both men and women).
- There were differing opinions about the effectiveness of different methods (both men and women).
- Some mentioned the benefits of child spacing.
- Both women and men were aware that they can obtain free FP methods and also know where to purchase the commodities.

- VNMs suggested that they use FP as an entry point for their support group meetings. VNMs noted that they feel that interest in FP services is increasing. (One noted that during her first meeting she was able to recruit four new users.)
- Women and men had heard about LAM, but were not able to fully describe the three conditions/criteria for its use.
- The use of cycle beads makes it more interesting for women to learn about the SDM. There were a few women in both focus groups who were able to explain correctly the use of SDM (one in particular used the method for pregnancy); however, there was mixed opinion about SDM effectiveness.
- Women who had knowledge about SDM realize the importance of having an open relationship with their spouse.
- Men who had knowledge about FP methods mentioned the importance of a good relationship with their partners and realized that all methods have pros and cons. Men mentioned that they feel that their wives are more interested in FP in the past 5 years, given that there is now a greater method choice.

Constraints, concerns and limitations: Current MoH reproductive health guidelines authorize VNMs to provide the following methods: LAM, SDM, condoms, pills and injectable contraception. IUD insertion and tubal ligations can only be performed by physician providers (Ob/Gyn specialists). Current guidelines do not presently allow the distribution of FP commodities by community-based, non-professional, personnel (including VHEs).

The interest in use of FP methods was limited to some degree by the fact that many of the men in this community are employed in settings outside of the community, including work abroad (e.g, Greece, Italy) for many months at a time. This did not, however, limit women's interest in learning about the methods that were available, should they wish and/or need to obtain them.

Discussion of family planning is culturally constrained. It is considered by some to be embarrassing not an appropriate topic for discussion in public. It was noted that men might try to curtail conversation when the subject of family planning is introduced into the focus group discussions taking place in their presence. Mothers-in-law were also noted to limit discussion of such content. It was also noted during focus group discussions conducted for this MTE that there was a noticeable decrease in participation/response when the topic of family planning was introduced.

Overall summary of progress toward target for family planning interventions.

Twelve indicators were established for the family planning intervention. Six of these indicators will be measured at end of project through the KPC survey. Qualitative and anecdotal information suggests that satisfactory progress is being made to transmit the messages related to family planning. Women were consistently aware of the various methods available but consistently preferred oral and injectable contraceptive methods, for ease of use. Women were not overly concerned about the side effects. However, supplies are not sufficient and sometimes not even present at health centers, requiring that women change methods frequently.

Women were the primary audience for family planning messages. It was more difficult to engage men in these discussions, and, in some instances, men discouraged continued discussion of the topic. Women expressed some degree of inclination to select a family planning method without involving their male partners in the decision.

The SDM and LAM methods are generally viewed as less reliable by community members. On the other hand, health providers are more willing to elect the SDM method for personal use. The

criteria for selecting or using the LAM are not completely clear.

The ACSP has also made satisfactory progress toward objectives related to training of family planning providers, and expansion of access to and quality of services provided. Quantitative data, and suggestions for amendments to four project indicators are presented in Section 3 of this report, and Annex A.

Recommendations related to family planning

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of the VNM drug boxes, specifically, the availability of FP commodities at service delivery points.
- The FP message must be augmented clearly to indicate that the free contraceptive supplies distributed by MoH are of good quality (i.e., comparable to supplies that can be obtained from private suppliers).
- Specific strategies and messages should be developed to target men; a more progressive influential male could be selected to help with FP service promotion.
- The project should work with other NGOs engaged in FP promotion to develop negotiation tools for women, to help them openly to discuss the use of various FP methods with their husbands.
- The LAM message needs to be clarified and stressed; in particular, the criteria for election of the method need to be amplified.

Overall summary of cross-cutting findings related to project interventions

The communities are generally receptive to the education and counseling interventions and welcome the VNMs and VHEs into their homes for this purpose. There is compelling qualitative evidence to suggest that satisfactory progress is being made toward meeting quantitative end-of-project targets for the majority of indicators set for each of the four project interventions. However, there is presently no method or strategy to confirm that all families in the target communities are receiving the messages. Many meetings occur by serendipity, in locations where opportunity arises. Community members are identified through the recommendation of others (the "snowball sampling" method). This results in repeat visits to certain families, while other families may not be included in project interventions.

Recommendations related to cross-cutting findings

- Develop and distribute more information/leaflets to support the four high impact activities, secure or develop additional take home materials addressing different topics in order to

stimulate the interest of project families in learning about broader health interests.

- Try different learning approaches (role play or drama) during support group activities to ensure that women are more engaged in learning and are not passive listeners. Mix practice and theory (e.g., cooking demonstration, preparation of ORS, hand washing). Develop competitions between communes/villages.

- Use the periodic meetings (already occurring) to hold a special session on a health topic that has been identified by the VHTs. This is to serve as an additional educational opportunity and incentive.

- The project should target more remote families that are not accessing health services due to distance barriers.

- Develop a simple tool or form that can be used to identify families in each neighborhood (registry system to confirm full participation.

c. New tools and approaches

ACSP developed cue cards to assist VHT members to recall, and effectively to convey, the C-IMCI messages about the health of children 0-5 years of age, and family planning topics. These cue cards (appended to the Year 2 annual report) are based on the most recent health information available from WHO, and have been approved by the Albania MoH.

ACSP staff used personal digital assistants (PDA) during the FP population baseline study. Project staff believe that this was unique (if not the first) use of PDAs for this purpose in USAID Child Survival and Health Grant Projects. (This impression could not be verified by the evaluator). The project perceived the advantage of time saved in data collection and data entry.

The ACSP has conducted or is presently engaged in a number of operations research studies to inform the project interventions. The Grandmother Study, performed in project year 1, was conducted to determine the decision-making patterns within community families. The identification of the most influential family members would enable the project appropriately to target their outreach and their messages about family and community behaviors. The study report can be found in the Year 1 annual report.

A doer/nondoer study was recently conducted. The study methodology was based on the BEHAVE behavioral change communication theory. The study investigated factors related to adoption or non-adoption of recommendations related to the project interventions. Results of the study led to some modification in emphasis on project activities. One example of this is the modification of the intention to establish oral rehydration corners at health posts, instead, redirecting these messages to families at the household level. The results of this study will be included in the Project Year 4 annual report.

A special study on the Standard Days Method is presently in progress. It is more fully described in Section 3 of this report. It will also be included in the Project Year 4 annual report.

A pilot program to expand family planning services to the village health post level will be implemented in the near future. This pilot program will represent an innovation in family planning service provision for

the prefecture. It enhances the already unique innovation of including family planning into the C-IMCI protocol (C-IMCI +).

2. Cross-cutting approaches

The ACSP proposed to integrate three-cross-cutting implementation strategies into the activities that were designed for each of the four project intervention areas. These three strategies are:

- community mobilization,
- tailored behavior change communication to improve key household behaviors and care-seeking practices,
- capacity building to improve access, availability, and quality of services.

a. Community mobilization

The ACSP translated the overall project goal (to improve the health status of WRA and children 0-5 years) into a set of internal project objectives that would promote sustainability of the project:

- to complement and strengthen the existing health care system,
- to mobilize communities to take responsibility for their health, and particularly for their children's health, and
- to bridge the critical gap between community needs and health

Community mobilization was identified as a priority strategy if the project were to achieve its objectives. It was recognized that community mobilization was essential to the Community IMCI+ component of the program. It was also recognized that such mobilization was essential to both the shorter- and longer-term impact of the program's activities.

The recruitment of project's volunteers is one of the most important steps of the project because it realizes the community mobilization process. The quality of community mobilization is a sensitive process which could be better addressed through the two following moments: (a) appropriateness of developing criteria and job description terms for volunteers; and (b) accuracy of the recruitment process.

Statement by ASCP Project Staff, Fall 2004
(citation drawn from internal project documents)

The process for recruitment of volunteers is depicted in Table 1. The process was designed with the intention of selecting the most appropriate approach to raising awareness and interest in volunteering and also to promote commitment to volunteering over the longer term. The *target* number of volunteers was two to three VHEs for each VHT. (The VNM member of the VHT is an MoH employee). One VHT was established for each village (health post level). There are a varying number of villages (and therefore health posts) within communes and, accordingly, the number of VHTs per commune also varies. Actual numbers of VHT members recruited are provided in Section B.1. in the introduction to district-level activities. At the time of the MTE, the ACSP had completed its expansion in two out of the three districts in the project area (Diber and Bulqize). Coverage had been established for 93 and 40 villages respectively, which represents 64 percent and 60 percent of the total number of villages of these districts. The expansion process has only recently begun in the Mat District, but is expected to be completed by the end of the fiscal year. *Please refer to Appendix F for an expanded discussion and additional documentation of VHE recruitment and coverage.*

Table 1: Volunteer Recruitment Process

FIRST Step: Health Center level *(Participatory approach)*	SECOND Step: Village level *(Participatory approach)*
PARTICIPANTS *(from all villages of the health center)* - Village elders - Village nurse/midwife, family doctor - Other key persons(teachers, village school headmaster, head of commune etc)	**PARTICIPANTS** - Village Elders - Village nurse/midwife - Other key persons in the village - Possible candidates (at least 6-10 people)
DISCUSSION - ACSP Description - Role and responsibilities of the Health Volunteer - Date of recruitment	**DISCUSSION** - ACSP Description - Role and responsibilities of the Health Volunteer - Performance of recruitment

The communities in Diber prefecture are rather similar in social, demographic, and geographic characteristics. However, the lack of infrastructure (roads, telephone land lines, health post facilities) has a more adverse impact in the more remote areas, and only very limited numbers of health personnel serve these communities. Residents of these more remote communities tend to perceive their health needs differently (i.e., lack of access affects the perception of how critical a health concern might be). In addition, the community members demonstrate more isolation, and less social cohesion. Therefore the community mobilization process implemented in the more remote communities has had to be modified, relying more heavily on individual outreach and less on the use of influential members of the community or community leaders.

The community mobilization process used key findings from the baseline studies (KPC and grandmother study) to increase awareness regarding community problems. These findings were used as key messages when advocating with the community about the activities that the project planned to implement in the community. The baseline findings provided the link between community needs and the rationale and strategies that would be used to address them.

The project's acute awareness of community differences prompted the adaptation of project approaches to implementation of the four high-impact activities. For example:

- The target number of volunteers recruited through the community mobilization process was increased to overcome the barriers related to accessing households scattered over the remote and physically challenging geographic area. (Access by foot is often the only feasible means of reaching a particular household). The larger number of volunteers makes it more likely that the *community-based growth monitoring and promotion* activity will be conducted for all families and that *proactive home visiting* can and will occur, when the need is identified.
- Supervision of field activities that are focused on health education has been emphasized in the interest of providing support to the larger number of volunteers. Therefore, it is more likely that the *young child, and family planning focus groups* will, in fact, occur.
- Health promotion materials, (leaflets, brochures) that present information about conditions that are seasonal in characteristic (e.g., diarrhea is more prevalent in summer), have been scheduled to be distributed as frequently as possible in these remote communities, so that they are available at the time of need.

Several relevant community characteristics had to be considered when devising the strategy for community mobilization. It was recognized that recruiting volunteers was only a first step. A next important step was for volunteers to take action to engage other members of the community to act in their own best interest. Therefore volunteer recruitment and design of the process for community engagement took the following factors into account:

- *Religious barriers*

  Albania is a predominantly Moslem country. Religious beliefs concerning certain health care practices (particularly family planning) were carefully considered when crafting program health education message.

- *Lack of infrastructure and equipment for carrying out the project's activities*

The government-sponsored health care facilities (hospitals, health centers, health posts) are, in the majority, sub-standard (confirmed by findings from the Health Facility Assessment conducted at baseline). Several of the villages do not even have a government health facility. Health personnel in those villages provide essential health services from in homes (their own, or a village household).

VHT members were encouraged to identify feasible and suitable alternative venues for conducting community meetings, and were provided essential equipment (such as weight scales) that could be transported between venues.

- *Cultural barriers regarding hierarchy within the family*

The Grandmother Study confirmed that there is a certain decision-making hierarchy within the family, especially with regard to the project's interventions focused on children 0-59 months old. Most decisions about issues regarding the feeding and health care of infants and young children are made by individuals other than the primary caretaker (who is, in most cases, the mother). The mother-in-law has a very influential role. The project has made a specific effort to engage these influential family members as recipients of health care messages (e.g., as focus group participants), to increase the effectiveness of field activities. (Note that the number of mothers-in-law and grandmothers who serve as VHEs was not documented during the MTE. The project could be encouraged to affirm this number and if it is disproportionately small, perhaps make the concerted effort to recruit more of these women to serve in that role.)

- *Cultural barriers regarding discussion of FP topics*

The project staff selected female VHEs to deliver the FP messages and distributed heath educational materials that women could choose to share with their husbands in the privacy of the home, and took steps to promote a high attendance rate of VNMs in FP training sessions so that that every women could find her VNM qualified to provide FP services. The training itself has been focused, in addition to technical information related to each FP modern methods, on other skills regarding FP counseling and how to promote the confidentiality and ease of access to FP education.

- *Economic barriers*

Most families in the project area have only a modest economic income. Therefore the project has developed its health promotion materials regarding infant and child feeding with a focus on the use of locally produced foods that are readily available and rich with essential nutritional elements. These foods are particularly included in discussions about complementary feeding.

b. Communication for behavior change

The program is addressing behavior change communication through the use of trained VHTs conducting high impact activities using IEC materials. All VHT members have received five days of training on C-IMCI to give them the skills, knowledge, and tools to conduct health education sessions. ACSP's four high-impact activities are implemented in group settings to increase awareness and knowledge and to reinforce key practices at the household level. A variety of educational materials and tools have been distributed by ACSP to VHT members to use and to distribute during the health education sessions. ACSP cue cards guide VHT members in delivering the project's 11 main messages (in addition to supportive messages) to improve MCH practices, in addition to FP (as described in the DIP). VHT members interviewed stated that they find the C-IMCI and FP cue cards useful. During site visits the cards were very often found prominently displayed in nurses' consultation room.

Leaflets on diarrhea management, ARI, and FP have been distributed by VHTs to the target audience. Nearly all VHTs interviewed showed an interest in receiving leaflets, as they had already distributed the supply given to them by the project. Furthermore, VHT members stated that there was a close relationship between the nurse midwife and volunteer health educator, which has helped facilitate the care-seeking practice of mothers with sick children.

The ACSP has become aware of two concerns relative to BCC and has made initial plans to address them. It is known that the project is reaching the same women on several occasions. It is very likely that mothers who receive the same message on repeated occasions will become bored of hearing it and may disengage from participatory learning. Additionally, certain mothers may not be well reached via the current outreach methodology (as has been previously noted). ACSP hired a health program officer (HPO) in August 2005 in part to strengthen the BCC component.

The HPO has good experience conducting behavior change activities using health volunteers to improve nutrition-related practices of mothers with children under 5. In addition the ACSP program manager and M&E officer were trained on the BEHAVE Framework in January 2006. They in turn trained all ACSP program-related staff (including AlbRC staff) on this methodology. Staff members are now well-equipped to strengthen and implement behavior change activities. Another result of this training has been the implementation of the Doer/Non-doer survey in all three districts. Five behaviors were assessed in this study: exclusive breastfeeding, diarrhea home management, complementary feeding, management of ARI, and FP. The survey serves as a monitoring tool to assess changes in behaviors and for program planning purposes, especially in relation to BCC. Program staff has made plans to develop new activities or expand existing ones to improve the BCC component, based on findings from the Doer/Non Doer survey, MTE, and ACSP M&E reports.

- Through regular trainings/workshops ACSP will capacitate community mobilizers to provide support and supervision to VHTs in the implementation of existing and BCC activities. The program budget as revised for the 04 project year allocates more funds for CM training than in any prior year. Currently, training/workshops for CM are planned quarterly. Furthermore, the revised budget includes support for regular meetings at the commune level with all VHTs.

- Monitoring tools have been developed to assess and help improve the performance of VHTs in delivering each of the high-impact activities. It is completed by the DHC during her supervisory visit to identify and strengthen weaknesses in the performance of the VHT (Appendix G, H).

- ACSP will produce and distribute to VHTs more of the same leaflets originally given to them. During the Doer/NonDoer interviews, which were completed at each participant's house, interviewees noted many mothers had ACSP leaflets on hand and mothers stated that they found them useful. ACSP staff members are also collecting other possible materials that can be distributed to the target population, which can be easily adapted or reproduced as they are, with little effort. For example, UNICEF produced a flip chart for Albanian-speaking Kosovoins that depicts simple graphic images and messages on MCH. If the electronic version is available and not copyrighted, then adapting it for Albania could be relatively easy. The flip chart may be effective in reaching mothers who are not participating in the program or stimulate VHT members who are becoming weary of delivering the same messages. (*Note that* there is a small Romani community who migrate through the area. They may be best reached through this more indirect strategy.)

- Focus groups conducted with men as part of this MTE revealed that they had little knowledge on modern family planning methods. Many of these men were in their 40s and were adults during the communist period when talking about sex was taboo. There is a need to strengthen the FP component to target men better, especially younger ones. When addressing men, the project should take into consideration certain issues. For example, a majority of the men migrate to other countries (e.g., Greece, Italy) for economic reasons, but return in August and December to be with their families. It is during this time they will need some type of FP. It is also assumed that their migration to other areas

has impacted their knowledge and behavior on FP. In addition, some men may not feel comfortable meeting in a formal setting (like a clinic or school) to discuss FP. However, they may be reached through informal settings, such as coffee shops, and other spots where they congregate.

Recommendations related to behavior change communication

- A FP education program and materials should be developed, specifically targeted toward and focused on men, which incorporate the understandings gleaned from project experiences.
- Project staff should assertively pursue the acquisition or development of additional educational materials, specifically seeking to secure materials developed by other organizations that address project-related messages and also materials that focus on other health topics.
- Project staff should interact as much as possible with JSI to learn from and expand upon the BCC component of the family planning expansion project on which JSI and ACSP are partnering in Diber District to evaluate the potential for expansion of these BCC activities in the other ACSP districts.

c. Capacity building approach

i. Strengthening the PVO organization

AmRC did not include specific objectives for the Private Voluntary Organization (PVO) capacity building activities into the ACSP. However, professional development is an overall key strategy for the AmRC as an organization to ensure effective program impact vis-à-vis strengthened staff capacities. Capacity strengthening activities for AmRC staff working on the ACSP have been integrated into work plans since the start of the project in October 2003.

AmRC headquarters uses the Performance Development Plan (PDP) process to assess staff performance, capacity strengthening needs, and skill level. The AmRC headquarters staff who contribute to the ACSP project and participate in the PDP process include the program officer for Europe/Eurasia, the MCH advisor, the financial analyst and the M&E advisor. The AmRC health delegate posted in Albania also participates. The AmRC health delegate reviews deliverables of the ACSP program manager to provide feedback and technical support for planning activities and, in turn, local project staff members in Albania are supervised by the ACSP program manager. The PDP cycle is July 1 through June 30 consistent with the AmRC fiscal year. The Albania project staff is also assessed on a yearly basis (the calendar year). The performance report is an outcome of staff assessments. This report informs project planning and professional development plans for each staff person.

The PDP measures the percentage of annually planned work activities that are actually achieved. Adjustments are made to these activities during the annual review process to keep the project and staff member on target. The PDP is, therefore, viewed and used as a tool for measuring changes in capacity

Headquarters staff assigned to the ACSP have relevant medical, health, and program management experience that is in line with project objectives and activities. Staff have also received program-relevant

continuing education, such as training in the BEHAVE model for behavior change, over the life of the project. Staff members have participated in pre-award assessments, KPC surveys, and the mid-term evaluation. These participatory experiences have been strategically planned as efforts to enhance staff skills and knowledge. AmRC staff members responsible for ACSP administration have also all been trained on USAID rules and regulations and have taken regular refresher training on AmRC financial and human resource policies and procedures.

Table 2: Staff involvement in training activities

Staff member (by title)	Training topic	Date of training
Washington DC-based project staff		
Maternal Child Health Advisor (Technical Backstop)	CORE Group and Flex Fund grantee meetings (including mini-universities and OR Workshop) and other relevant technical workshops	Project year 2 and 3
	Assessment experience gained through participation in MTE	Project year 3
Program Officer for Europe/Eurasia	Assessment experience gained through participation in MTE	Project year 3
	CORE Group and Flex Fund grantee meetings (mini-universities, OR Workshop)	Project year 2 and 3
	AmRC headquarters Integrated Planning Workshop (included environmental assessments, project design/proposal writing, M&E strategies, strategic planning)	Project year 3 (January 2006)
	USAID rules and regulations	July 2004; July 2005
Albania country-based project staff (Tirana)		
ACSP Program Manager	BEHAVE behavior change training	January 2006
	Informal training through initial KPC and other assessments (HFA, FP), MTE	Project years 1,2,3
	Assessment experience gained through Doer/Non-doer studies and operations research study on SDM	Project year 3
	Experience gained through participation in DIP writing and mini-university	Project year 1
	USAID rules and regulations	October 2005

AmRC Health Program Officer	USAID rules and regulations	October 2005
AmRC Health Program Officer	USAID rules and regulations	August 2003
	Assessment experience gained through Doer/Non-doer and SDM operations research studies, and participation in MTE	Project year 3
	AmRC finance training	May 2004; November 2005
ACSP M&E Officer	BEHAVE behavior change training	January 2006
	Assessment experience gained through Doer/Non-doer and SDM operations research studies, and participation in MTE	Project year 3
Albania country-based project staff (Diber prefecture)		
ACSP Training Officer and AlbRC Branch Secretary – Diber	Project internal training on BEHAVE model	Project year 3
	Assessment experience gained through participation in Grandmother Study, Doer/Non-doer and SDM operations research studies, and participation in MTE	Project years 2,3
	Training as C-IMCI trainer	Project years 2,3
	Additional training provided by Albania Red Cross	Project years 2,3
ACSP Office Manager – Diber	Training on financial management for non-finance professionals (by NGO Co-Plan)	Project year 2
	Project internal training on BEHAVE model	Project year 3
	Assessment experience grained through participation in MTE	Project year 3
ACSP District Health Coordinator – Bulqize	Project orientation	Hired at time of MTE Project year 3
ACSP District Health Coordinator – Mat	Project internal training on BEHAVE model	Project year 3
	Assessment experience grained through participation in Doer/Non-doer and SDM operations research studies, and participation in MTE	Project year 3
	Training as C-IMCI trainer	Project years 2,3
	Project internal training on BEHAVE model	Project year 3
	Assessment experience gained through participation in Doer/Non-doer and SDM operations research studies, and participation in MTE	Project year 3

These trainings have had a very positive effect on the capacity of project staff to implement ACSP program activities. This effect can be demonstrated by the following activities in which ACSP staff members have engaged, subsequent to these training events.

- Participation of AmRC headquarters staff in all activities related to ACSP project design and baseline studies informed the design of the Cambodia Child Survival Project that was awarded to AmRC by USAID during the ACSP second project year.
- ACSP experience also enhanced capacity of AmRC staff involved in the preparation of CSHGP/USAID proposals for child survival programs in Ethiopia and Tajikistan.
- ACSP staff has shared lessons learned in volunteer management, project interventions, etc. with the Cambodia Child Survival staff. Particular lessons learned relate to the cost share requirements of Child Survival grants:
- The ACSP finance and administrative staff person (Tirana) has been involved in training other AmRC staff and partners in the region (Turkey).
- ACSP program staff have disseminated new skills gained from participation in a BEHAVE workshop to other ACSP staff, Albanian Red Cross Staff, and other USAID grantees (e.g., JSI).
- There were no negative audit findings in 2004, likely attributable to the high degree of financial and personnel management capacity, some of which was gained through on-the-job and other training opportunities.

At the same time, interviews conducted with project staff revealed an intense interest in additional training and, in some cases, staff members expressed the need for this assistance to increase effectiveness in their performance of assigned duties. The following training needs were specifically mentioned:

- There is a need for capacity building for conduct of the final KPC/FP survey. The baseline KPC was conducted under the leadership of an external consultant. The ACSP project manager participated in that study, and played an important role on the FP baseline survey (applying a very similar methodology), but does not feel fully confident to conduct the final study, without, at minimum, supportive consultation.
- There is an expressed desire on the part of Albania country-based staff (project manager and coordinators) for training in project design, management, and the planning of training events.
- Leadership training in supervision, volunteer, and staff management, including human resource and finance policies and procedures, would be welcomed, specifically for Albanian Red Cross personnel, who will be assuming the lead for sustainability of project activities.
- There is a specific need for training in information technology (trouble shooting internet and hardware problems), particularly among the Diber prefecture-based staff, where the availability of immediate (or at least timely) technical support is very limited in the community.
- Training in fundraising would be important, particularly for the AlbRC/ACSP staff.

Recommendations related to PVO capacity building

- AlbRC/ACSP should receive on-the-job or external training in project management responsibilities (including but not limited to human resources and financial management), and fundraising.

- Sources of external support/consultation for IT should be identified for the Diber field office.

- The AmRC program manager should begin planning for a mechanism to provide on-site or

at-a-distance support to the country-based staff, for conduct of the end-of-project KPC study.

ii. Strengthening local partner organizations

The Albanian Red Cross is the American Red Cross's major local partner in the ACSP. The AlbRC had completed a self-assessment for governance in 2001 as well as nationwide surveys to gauge public perception of its services in 2001 and 2003, both with the assistance of AmRC. The generally favorable results of these surveys provided evidence to support the decision of AmRC to engage with AlbRC in seeking to develop this child survival project. The availability of these recent assessments also supported the decision of ACSP project personnel not to conduct an additional organizational capacity assessment of the AlbRC.

The CSP project did review the findings from these assessments to design its initial capacity building activities with the AlbRC. For example, the project designed its volunteer management systems on the structures created by the AlbRC in its Volunteer Manual: Summary of Volunteer Policy and Guidelines, written in 2002.

A new project agreement was signed between AmRC and the AlbRC in January 2006 and took effect in May 2006. This provided the opportunity to restructure and reorganize the responsibilities of the two organizations, with significant move toward transferring more responsibility to the AlbRC for conduct of ACSP activities. For example, the AlbRC assumed a greater responsibility for the financial management of project funds as well as reporting both financial and project performance. The specifics of the AlbRC financial management responsibilities were structured according to USAID rules and regulations.

The Albania Red Cross operates through various sub-branches. The ACSP operates in the governance district of the Diber branch. Therefore, the project agreement took concrete steps to combine the management of the ACSP project with the operations of the AlbRC Diber Branch. For example, in May 2005, the responsibilities of the open ACSP project position of training officer were combined with the responsibilities the AlbRCs' Diber branch secretary. Shkendie Kaba was hired through a joint recruitment effort by the two Societies, and her salary is shared by the two Societies.

The merging of the position of ACSP training officer with the position of AlbRCs' branch secretary has greatly extended the AlbRCs' contacts and networks throughout the prefecture and its communities. The extensive travel of project staff throughout the three districts and the conduct of complementary project activities with government health authorities at all levels has resulted in the development of new alliances throughout the prefecture.

The position of AlbRC Diber branch administrator was expanded from a part-time to a full-time position, supported by ACSP, through a time-sharing arrangement between the two Societies. Anjeza Ismaili was recruited to support ACSP project activities in the prefecture as well as to direct AlbRC activities, such as first aid instruction for new drivers, fundraising campaigns, food drives for vulnerable community members, selling of membership cards and art exhibitions to display the art projects of school children that promote key Red Cross messages.

The project provided funding to recruit and hire three AlbRC District health coordinators. The DHCs were carefully trained by the project to provide and to supervise ACSP field activities. They were, in

addition, trained in volunteer management issues that support other Red Cross programs. The addition of full-time DHCs served to revitalize the AlbRC Diber Branch activities in each of the three districts – Mat, Bulqize and Diber – as dedicated, motivated staff served to bring Red Cross programs to each district and its communities. The salary expenses for these three positions are reflected as a shared cost in the budgets of the two organizations, although, at present, all funds are obtained from the ASCP. These positions were new to both the ACSP and the AlbRC Diber branch, and are critical for stimulating both project and Red Cross activities at the district level.

The position of technical officer and deputy program manager based in Tirana was closed. A new project position was created in Burrel (Mat District) to support project activities. Position responsibilities were re-conceptualized and the position was re-titled community health specialist. This position will also provide additional support for Red Cross programs in the Mat district. (This position was described in Section I.B.b. The job description is included as Appendix I.)

The project's addition of 283 volunteer village health educators (VHEs) served to dramatically revitalize the Diber branch's network of volunteers throughout the prefecture. The focus of the VHEs on providing outreach to difficult-to-reach villages extended the AlbRC presence beyond the district centers into 149 communities. The project's future plans call for the addition of another 25 communities (an additional 80 VHEs) in Mat district. The project has begun to extend the scope of these volunteer VHEs, initially dedicated to project activities, through the integration of parallel AlbRC health programs into their job descriptions.

An outcome of these ACSP capacity building initiatives for the AlbRC is the positive impact that has been noted on Albanian Red Cross membership, in Diber District. Since the inception of the project in Diber, Red Cross membership has continually increased as community members participate in project activities and increase their awareness of Red Cross activities. For example, each project training activity includes an invitation to become a Red Cross member. Project activities provide opportunities to share Red Cross informational materials with communities that do not typically have access to this information.

The mass production and distribution of the IEC materials (family planning methods, diarrhea treatment procedures, nutrition and complementary feeding, growth monitoring charts, safe pregnancy/motherhood recommendations, identification of respiratory infection symptoms) has been very well received by project volunteers and beneficiaries. These materials, which carry both the ACSP and AlbRC logos on their covers, have greatly increased the awareness and public image of the AlbRC throughout the many communities of the prefecture.

Invitations to the project's Behavior Change Communication Methodology three-day training workshop, held in Durres, were extended to two staff members of the AlbRCs' Durres Branch and three members from USAID grantee JSI. Project plans call for project staff to partner with these two Durres staff members to conduct similar workshops in other AlbRC branches.

The very evident benefits of capacity building for the AlbRC are, nevertheless, balanced by increasing workload demands and challenges. The simultaneous demands of an increasingly active AlbRC branch with the project implementation responsibilities of a growing USAID project are particularly challenging for the AlbRC Diber branch secretary. One unfortunate event has already occurred in 2005. Mutually compelling priorities for the ACSP and the AlbRC made it necessary that the branch secretary revise plans for personal leave to meet deadlines.

A second major challenge for the AlbRC at the end of the ACSP will be the assumption of financial responsibility for both ACSP and AlbRC programming, in addition to providing 100 percent funding of

the positions. (Several individuals interviewed acknowledged that the AlbRC fund-raising, proposal, and report-writing capacities are not well developed.) The project's finance and administrative officer is actively working with her AlbRC counterpart to familiarize her with USAID rules and regulations. Initial progress has been reported by participants to be satisfactory. However, this very important process should be completed within the next project year, to ensure a smooth transition to the AlbRC Diber Branch, as well as continued transparency of project finances.

The variance in the salary and entitlement structures of the project and the AlbRC may produce friction as the two entities continue to merge activities and personnel. Currently, for example, project personnel earn approximately10-20 percent more than their AlbRC counterparts

Finally, it is noted that the AlbRC Diber branch carries a debt, acquired prior to engaging in partnership with the AmRC for ACSP activities. The AlbRC Diber branch secretary, who is responsible for both the branch activities and, as ACSP training officer, also responsible for project activities, is in continual dialogue with the AlbRC headquarters finance department to ensure proper management of project funds, i.e., to ensure that these funds are used only for project purposes.

Recommendations related to building capacity of the Albania Red Cross project partner

- The AmRC and ACSP project staff should assist the AlbRC Diber Branch to develop a strategic plan, in the interest of promoting sustainability following the conclusion of the project. The plan should address features such as (but not limited to) the following:
    - a fundraising plan that addresses the reduction/elimination of the inherited Diber branch debt;
    - a common organization chart that integrates responsibilities for both ACSP project and AlbRC activities;
    - a practical budget that can be sustained without external funds;
    - specific activities to increase the membership; and,
    - support and engagement with the MoH and similar governance structures.
- Develop strategies to integrate the ACSP project team (based in Tirana) into the activities of the AlbRC headquarters offices and the Diber branch. This could include increasing the time and presence of each Tirana project staff in the Diber office, and integrating ACSP project and AlbRC headquarters finance and reporting systems.
- ACSP staff should look for training and other professional development opportunities (both regional and at-a-distance), in which project staff (as a priority) and volunteers (if possible) could engage. These trainings should focus particularly on health issues of women and young children, and financial and human resource management.
- ACSP staff should conduct quarterly VHT training sessions. Periodic training sessions on health topics that have been identified by the VHTs as important complements to their C-IMCI+ training (e.g., injection procedures, HIV/AIDS, drug use, and treating children with high fever) will serve as an additional educational opportunity and motivation to continue with the project. It will also address a consistent request from the VHTs for further health education on different health issues.
- Facilitate exchange visits for VHEs and VNMs to visit other VHTs within Diber

prefecture as a motivational and learning opportunity. These visits should be facilitated by project personnel with structured agendas to allow strong performing VHTs to work with and mentor weaker VHTs by sharing best practices and lessons learned.

- Organize activities to bring district- and prefecture-level VHTs together to demonstrate their competence in key project messages through friendly competitions. These events, similar to the AlbRCs' first aid competitions, could be extended to the branch level. Friendly competitions serve to share best practices among VHTs, recognize high performing volunteers, and build teamwork between VHTs from different communities.

- Review the incentives, recognition, and job aids for volunteers. Project staff should interview experienced VHEs and VNMs to assess the most valued combination of incentives, recognition activities, and job aids to be implemented. A carefully designed package of incentives (e.g., lunch money, transportation money, training opportunities); recognition events (inclusion in newsletters, public ceremonies, special awards for top volunteer performers, a piece of clothing [e.g., hat, shirt]) and job aids (paper, pens, informational leaflets, Red Cross identification) will keep retention levels high and volunteers motivated.

- Develop strategies further to integrate the project VHTs and the Red Cross volunteer network. Although the different volunteers have different activities, all identify themselves as Red Cross volunteers. Recruit more than two volunteers in each village.

- Budget additional project funds to provide modest expense reimbursement to VHEs when they host project-related meetings in their own homes.

iii. Health facilities strengthening

A total of 10 data collection instruments were adapted for the baseline health facility assessment that collected information from health centers and health care providers at different levels. Table 3 details the instruments and specific areas by facility type.

Table 3: Health Facility Assessment Tools

Instrument	Instrument Name	Areas of Assessment
I. Rural Ambulancas		
1A	Health Worker (HW) Interview	• Activities and services • FP services (service provision, service utilization, community outreach) • Child health / maternal and newborn clinical management knowledge • HW perceptions
2C	Equipment and Supply Questions	• Space and equipment • Drug and supply management • Record keeping
II. CHCs / Urban Pediatric Ambulancas		
1D	Observation of HW treating children 0-59 mo.	• Observation checklist

2B	Information for Child Health 0-59 mo.	• General questions for director • Clinical knowledge of HW • HW perceptions
3	Exit Interview – Treatment of Sick Child	• Information about illness episode • Medications given • Immunization • Family planning • Satisfaction
4	Facility, Equipment, and Supply Questions	• Space and equipment • Management of drugs and supplies • ORT corner • Record keeping • General information
III. Women's Consultancy Centers / Maternities		
1B	Services, Facility, Equipment, Supplies Questions	• Antenatal care • Delivery facilities • Postpartum activities
1C	Health Facility Information and Health Worker Interview	• Service utilization • Record keeping • Availability of methods and information
2A	Client Exit Interview	• Sources of information • Availability of methods • Decision making process
2D	Health Worker Knowledge	• Training • Knowledge of antenatal, delivery, and postpartum conditions

Information was collected regarding the availability and quality of services in the project target districts. These tools were adapted by the Health Facility Assessment (HFA) team from standard HFA tools to reflect the realities of the Albanian health system. The assessment team included personnel from the AlbRC, the AmRC, and health supervisors representing the Albania MoH. The inclusion of MoH supervisors served to strengthen the tie between the project staff and MoH personnel. The team also included an external consultant from John Hopkins University.

Information from the HFA was shared with the public health authorities from the three districts. Some key findings detailed in the project's updated DIP were useful in developing project implementation plans and activities. The assessment team felt that the HFA results had qualitative value and were used to illuminate KPC findings, guide discussion during the DIP workshop, formulate additional questions, and guide priorities for future actions. Overall, however, the HFA instruments collected a vast quantity of information that was not used, as health facility strengthening was not a priority project intervention.

The following key HFA findings were selected by the project, as health facility strengthening activities that would need to be addressed to foster the success of project interventions and to strengthen health facility service provision:

- Most primary health care providers at commune health centers and health posts (VNMs) had no training in the past five years and no specific training in management of childhood illnesses, nutrition, antenatal care or family planning. The IMCI and C-IMCI+ training activities conducted for VNMs throughout Diber prefecture addressed this gap.

- There were no standard case management protocols in most of the health centers and health posts. The endorsement of C-ICMI as the national health care strategy, and the training activities conducted by the project, addressed this gap.
- Regular and frequent growth monitoring and promotion did not take place at the village level. This gap was addressed through implementation of ACSP high impact interventions related to infant and child nutrition and growth promotion.
- Most rural health centers or posts lacked weight scales. The ACSP project provided these scales in all project activity areas.
- Few providers were able to cite known danger signs for young infants and children and they lacked counseling skills. The training strategies developed for the ACSP were targeted to increase provider skills in each of these competency areas.
- Many essential medications such as ORS and antibiotics were not available in emergency drug boxes. The ACSP has been in continued dialogue with MoH personnel to remediate this gap, which, at least in one part, also represents a gap between two extant MoH policies (as discussed in section B.1.b.3).
- Few family planning service delivery points and health facilities had printed health education materials. The ACSP has engaged in a proactive campaign to produce these materials, and also collaborates with other NGOs engaged in similar health projects, to disseminate relevant materials produced by any project partner or collaborator.

The ACSP focuses project activities primarily at the community level (health centers and health posts). There are very strong linkages between the community-level health care personnel and the community members whom they serve, as, in most cases, the provider is also a resident of the community that s/he serves. The linkages between health center/health post staff and the providers in health facilities is less well-developed. HFA strengthening activities that would be appropriate for ACSP project personnel to address and actions that have already been taken to resolve them have been noted above. Additional recommendations that relate to an interface between health facilities and the community (both health providers and beneficiaries) have been made in previous sections of this report (see sections b1 through b4).

The MTE generated information about certain gaps in the interface between ACSP project beneficiaries and the activities or behaviors of health facility personnel. These include:

- ACSP beneficiaries are gaining knowledge about the importance of iron and folate supplementation; however, there is a supply gap (an MoH responsibility) that makes it difficult for beneficiaries to act on this information.

- Community-members have gained new knowledge about the importance of immediate and exclusive breastfeeding; however, it is reported that labor and birth personnel are not necessarily supportive of this behavior, and do not facilitate it.

  The majority of births to residents of Diber prefecture (and to Albanian women in general) occur in hospitals (there is one hospital in each district). Comments made by women who participated in the focus groups indicated that the hospital-based personnel were not, in general, supporting the exiting MoH policy that the newborn be placed in skin-to-skin contact and immediately breastfed (MoH Reproductive Health Policy, 2003). Project beneficiaries who knew the value of these activities through their participation in health education events, reported that they were told not to ask birth attendant personnel for such services (*"Shut up. You are too noisy.")*

Additionally, there is a gap in the feedback loop between the hospital and the community. (Feedback is a specific component of the IMCI protocol). For example:

- Little is known about how hospital-based physicians perceive the management of children referred for hospital care of severe diarrhea and acute respiratory infections. Community-based caretakers (both family caretakers and health center/health post VNMs) report that they rarely receive any information about the effectiveness with which C-IMCI protocols have been implemented.

- There also seems to be very little in the way of feedback from hospital facility to health center/health post, concerning hospital discharge instructions and/or aftercare of children discharged for treatment of diarrhea or ARI. Project VNMs were not aware of any specific feedback transmittal form that was in use for this purpose.

Recommendations related to health facilities strengthening.

- ACSP staff should engage hospital birth attendants and newborn and child health providers (both doctors and nurses) in dialogue about the mandates of MoH Reproductive Health Guidelines, IMCI and C-ICMI recommendations, related to maternal health in the antenatal, postnatal and postpartum periods, and the recommendations related to newborn, infant, and child nutrition, to promote appropriate and more effective integration of health beliefs and practices.

- ACSP staff should identify the appropriate representative/office within the MoH, and transfer the information gleaned from the HFA and from this MTE so that the data are available for uses beyond the purposes and life of the ACSP project.

iv. Strengthening health worker performance

The ACSP has addressed the improvement of health care worker performance in compliance with the project's interventions. The project has supported existing national strategies and policies of the MoH in terms of expansion/rolling out of IMCI and FP training for VNMs and the establishment, field testing, and finalization of the C-ICMI+ protocol in Diber prefecture. The project has even proposed solutions that go beyond these policies which might be piloted in the Diber prefecture and then expanded nation-wide (e.g., the FP activities that the project integrated into the C-IMCI training – the "+" in C-IMCI+). The majority of project activities have been realized with the project's resources. However, coordination with other donors has made it possible for the ACSP to be successful in covering additional activities (e.g., providing training to selected health workers cadres who were not targets of ACSP). Specific examples include the following:

- During the expansion of clinical IMCI expansion through the Diber prefecture, UNICEF provided funds for training of family doctors in the Mat and Diber districts, while ACSP sponsored training for the remaining village nurse midwives (VNMs); ACSP provided the actual training for all participants.
- ACSP collaborated with the USAID-sponsored JSI FP project to create a mutually supportive calendar of training activities. JSI first provided FP training for family doctors and midwives in health center level. ACSP then followed on, to complete the same training for all village nurse midwives, at the community level. This collaboration yielded the intentional effect of creating "in place," a cohort of supervisors, and a referral network.

- The project has created, or adapted, then distributed numerous job aids for VNMs and VHEs for use during health education sessions.
- The supervision system established by the ACSP and for the SDM study can serve as a model that might be adopted by the MoH for non-project health provider personnel.

v. Training

The major components of the ACSP training strategy are the following:

a) training component

The 10-day course of clinical ICMI training in Diber district (134 VNMs) and Mat district (89 VNMs) represent an enhanced capacity for more then 90 percent of village health workers. Family Planning training activities conducted in all three districts of Diber prefecture enhanced the skills of 226 VNMs who provide health service in more then 90 percent of villages of project area. The two-day FP training was accompanied by a pre/post test which was administered to all VNMs and showed a significant improvement of their knowledge in this matter. Community IMCI+ to date has been expanded in Diber and Buqlize district and has recently started in Mat district. This innovative curriculum contributed to the strengthening of health worker performance by two means:

- strengthening the teaching and counseling skills regarding health promotion and health education in the community for VNMs, as previous trainings sessions has been more focused on technical/clinical components of their daily routine, and
- providing an effective approach for implementing health promotion activities through involvement of two through village health educators (VHEs) for each community.

The methods and strategy for preparing trainers and supervisors to conduct IMCI, C-IMCI, and FP training for others followed the WHO recommended teaching strategies, and used the WHO and UNICEF curriculum materials and guidelines that have been endorsed by the MoH. ACSP staff (all medical doctors) trained the trainers (some nurses), who then trained others in IMCI. These same ACSP staff also trained trainers of C-IMCI+, some of whom did not have formal medical or nursing backgrounds (which is appropriate for the C-IMCI content). Some of *these* trainers are also ACSP staff members.

b) Health education materials (leaflets, booklets, manuals etc)

Health care providers were provided during their training events with written materials that could be used later, either for health promotion activities or as a ready reference to the updated/new information that they received during these trainings. ACSP also distributed health materials produced from other organizations when covering interesting topics related to ACSP activities, such as the UNICEF booklet about “safe motherhood,” an antenatal care manual for pregnant mothers, URC leaflets that address modern FP methods, and a UNICEF leaflet concerning acute respiratory infection (prevention measures, danger signs, and health care seeking), and control of diarrheal disease (preventive measures, danger signs, home treatment, and health care seeking).

c) Supervision component

The ACSP had implemented a very rigorous program of supervision for VHT members (more fully described in section B.1.b). However, in the interest of sustainability, the major responsibility for supervision of MoH-sponsored health providers (including all VNMs) should ultimately be vested in the public health directorates in each district to ensure the continuation of quality health service delivery and

also to enable the provision of any support required by field health workers. Examples of the ways in which supportive supervision improved the performance of health workers include the following:

- ACSP staff is providing supervision for providers involved in the Standard Days Method Case Study. Project staff used the "SDM knowledge improvement tool" (Appendix J) and two supervision guides for health workers and health facilities in the selected health centers for this case study. The high "performance to standard" outcomes documented with these forms, provides some assurance that supportive supervision (which includes immediate performance feedback) has contributed to high quality service delivery.

- ACSP staff presently support the public health directorate's efforts to assume responsibility for the supervision of NMs in health centers, including those VNMs involved in the pilot expansion of FP services to the village level. This process is presently evolving. The process involves coordination with the MoH Institute of Public Health and JSI (USAID grantee) in the effort to develop a simpler reporting form to be used at the village level, and to ensure that there is an ample supply of these report forms available at point of use. The governmental supervisory team will also be supported logistically to adapt and use appropriate tools during supervision for ensuring quality service at all service delivery points (hospital to health post) in the community.

  The pilot project to expand FP services to selected villages was developed after review of results of data gathered during supervision activities of providers engaged in the SDM case study. It was observed that some VNMs who had received FP training would use their own initiative to obtain FP commodities in order to supply their remote communities, while, in other health centers, the stock of contraceptive commodities was irregular and/or inadequate (e.g., stock-outs of selected methods). The common gap identified in both of these instances was the aspect of supervision. Therefore this information helped the project staff and public health directorate to discuss and negotiate on how to improve this component.

- Growth monitoring and health promotion is a field activity that clearly demonstrates the value of C-IMCI+ in the improvement of the performance of health workers. The distribution of weight scales to all village health teams, the provision of refresher training on growth monitoring (how to use the scale and how to record the information properly), and health promotion (how to provide nutritional counseling specific to the needs of each individual child that is monitored) were considered necessary steps to ensure quality service. Each has been initiated and included in the project work plan.

- The "community outreach" strategic intervention that will soon be implemented in the Diber district by JSI will be focused on the technical and health promotion skills of health workers with respect to FP activities. Previous trainings given to the health workers have provided upgrades to their technical (2-days training on FP curriculum) and health promotion skills ("+" component of C-IMCI+ training). This new component will offer an added value, trying to combine both of these components, shaped within a specific methodology developed by JSI, which aims to improve the performance of health workers in regard to FP indicators.

d. Sustainability strategy

The three main components of the ACSP sustainability plan are:

- creating strong community health activities that are valued by the community and actually improve MCH and FP practices,
- incorporating VHTs into other AlbRC activities, and
- strengthening the AlbRC Diber branch capacity to provide long-term support to the VHTs.

Activities in which the ACSP engages tend to be implemented in close collaboration with local and national stakeholders, donors, and other key players. This coordination is intended to strengthen the network that must be in place to support sustainable transition of program activities at the project end.

The ACSP has developed four databases to monitor community health education and program training activities. These databases maintain records on a) the number of volunteers (VNMs and VHEs) trained and currently active (e.g., reporting monthly), b) background information on each community, c) the number of government health staff trained on SDM, FP, IMCI, and C-IMCI, and d) training outcomes (e.g., pre-post knowledge scores). Data collection (e.g., VHT monthly activity reports) and maintenance of the registry of persons trained is done in partnership with AlbRC program staff as part of the sustainability plan. ACSP staff review these data at least quarterly to prepare reports to AmRC headquarters that contain updated information from these data bases reflecting progress toward targets indicated in the PMP.

The volunteer data base is a key component of the sustainability plan that the ACSP is developing. These volunteers are AlbRC members; therefore, it is key to be able to track them and their performance to manage them effectively. The database also allows the AlbRC to monitor their involvement in community-based volunteerism, in the interest of offering them opportunities to become engaged in a broader variety of activities. A recommendation has been made that the ACSP work with AlbRC to craft a method for tracking “cost share equivalent” time. Sustainability of this project will depend on the ability to retain current volunteers over longer periods of time, and continually to attract new volunteers.

The volunteer database also serves to assist other groups (government or NGOs) seeking to incorporate AlbRC volunteers into other community activities. The database was used recently to help URC identify community volunteers for their community-based TB project in the Diber prefecture.

The selection and role of the CMs was delayed until the third quarter of Project Year 3. The CMs, who were only recently selected, will receive training in August 2006 and begin field support to each VHT at least once a month. The supervision gap was filled by DHC and senior program staff. They have conducted site visits three times each week in Diber and Bulqize districts to ensure adequate support. ACSP staff believes that adequate support and supervision is essential for project success and sustainability. ACSP administrative staff recently revised the budget to strengthen supervision and support at the village level. Supervisory visits by program staff will be enhanced in all sites with the addition of another DHC and vehicle (arrival date August 10, 2006). Furthermore, the previous deputy program manager position was altered to become the community health specialist position. This new position is anticipated to be filled by mid-August, although recruitment has been more difficult than expected. The person who fills the position will be located in the Mat district AlbRC office, in the interest of assisting project sustainability by strengthening activities and bringing more recognition to that sub-branch office. However, many potential candidates were not interested in taking up residence in that location.

The Doer/NonDoer Survey conducted in 2006 has provided ACSP with useful data to assess progress towards KPC indicators and information concerning how to modify C-IMCI activities to have a greater impact in changing behaviors. Furthermore, if participating mothers see a significant change in the health

of their children, this might create a demand and support for VHTs that will help sustain activities once funding has ceased.

Partnership with other NGOs has been a mutually supportive strategy in many ways. URC has adopted parts of the ACSP community health education outreach methodology, and ACSP has used URC FP leaflets. Recently some VHTs were trained by URC on how to conduct TB awareness in their communities. JSI and ACSP regularly meet to discuss and collaborate on various activities. The projects are working synergistically to expand FP down to the village health post level in Diber district, which is beyond the level currently in place by the MoH. This partnership includes the MoH and Diber district health department at all stages of planning and implementation, in the interest of sustainability. The counseling and education outreach methodology in Diber will be slightly different than C-IMCI+ activities implemented in other districts. JSI plans to use an innovative counseling method, which is designed to counsel clients based on their stage in the behavior change process of adopting a modern FP method. Furthermore, JSI will do FP counseling at the household level (such as a CBD--community-based distributor) with support from VHTs. Currently CBD is not done in Albania. JSI selected the Diber district because of the capacity of the ACSP VHTs and the good working relationship that ACSP had developed with the district health department.

A variety of activities are occurring between the AlbRC and AmRC to ensure that the project is sustainable. ACSP holds regular meetings with the AlbRC focusing specifically on program integration and phase-out. These activities include the following:

- A new program agreement (PA) has been negotiated between the AmRC and AlbRC. The AlbRC has greater responsibility than in any previous project year, particularly with respect to the handling of program-related funds (e.g., training, field staff salaries, supervision), reporting of project progress, and decision making). The PA also sets a strategy for the ACSP phase-out, including transfer to the AlbRC of salary responsibility for the three DHCs, the AlbRC branch secretary and the AlbRC national health coordinator (ACSP/AmRC counterpart). The ACSP finance officer/administrator and finance assistant/office manager provide technical support and review at the national and local level to ensure compliance of AmRC and USAID financial requirements, Moreover, AmRC has in place a sub-recipient checklist to monitor monthly AlbRC compliance to donor rules and regulations.

- ACSP and AlbRC management staff are considering offering additional trainings for VHT members as incentives, and to maintain their active role as an AlbRC volunteer. Training in first aid is one example of the types of training that they could receive.

- The management capacity of senior-level AlbRC staff to conduct C-IMCI in other districts is being strengthened: The ACSP supported the AlbRC, in partnership with UNICEF, in the implementation of C-IMCI activities in three communities in the Kukes prefecture. ACSP provided technical support and helped to create the partnership between UNICEF and AlbRC. AlbRC and UNICEF are planning to conduct another short-term replication of the C-IMCI protocol in another community area in need. ACSP is providing technical support to AlbRC to expand C-IMIC activities in other regions of the country in hopes that UNICEF will recognize them as leaders in this area.

- The Diber branch program related staff are being assisted to implement structured trainings, supervision and behavior change activities. ACSP has included AlbRC program staff in nearly all trainings, and when possible has made them trainers of trainers. C-IMCI activities are now conducted under their supervision. Furthermore, all program staff have been trained on the BEHAVE framework and have been involved in implementation of the Doer/NonDoer Survey. As a result, they have a very

good background on behavior change and will be involved in the development and revision of community activities.

- Lastly, VNMs interviewed during the MTE expressed great satisfaction working with their VHEs. The ACSP hopes that by strengthening the community activities in changing practices, it will strengthen the performance of VHTs to the point where the district health department will decide to invest in the VHEs.

The Program Manager made the point that there are many government and NGO structures that could readily take over many of the IMCI activities, although it would take time fully to develop those mechanisms. However, the C-IMCI strategy is a unique matter, not well served by current MoH service configuration. He made the point that the project's purpose would be well served if the project could create the C-IMCI model, and leave it in place for replication throughout the country, where appropriate (see further discussion in section 10).

3. Family planning

The Albania MoH Reproductive Health guidelines affirm the right to informed choice in family planning. The *mix of methods* addressed in the MoH approved family planning training curriculum includes information about all the MoH approved methods (pills, injectables, IUD, condom, SDM and LAM.) The curriculum addresses technical issues (such as product safety) and proper use (dosage, timing).

However, sustaining an adequate supply of contraceptives at the health center and health post levels is a problem that was identified at baseline, and that has continued to be of concern through the project lifetime. Various methods such as injectables and oral contraceptives are not regularly available. This results in gaps in method utilization and/or requires that women change methods frequently, thus decreasing (current) method reliability, and increasing the potential of side effects.

Furthermore, MoH guidelines state that only a trained Ob/Gyn specialist can provide intrauterine devices, which means that this method is only available in urban areas. In addition, VNMs do not currently have access to any contraceptives at the village level. The methods, when available, are offered at the health centers, at women's consultative centers and at urban and rural maternity centers.

This occurs at a time when focus group discussions with family planning providers, family planning users (both men and women), and other key informants revealed that *interest in family planning services* is increasing. The LMIS captures the number of methods that are currently being distributed at the health center level including the urban women's consultative center, maternities and hospitals in the three districts. Data from the LMIS also confirms that there is an increase in the number of family planning users for the Diber prefecture.

The project promotes all of the MoH approved methods. The project is also documenting the introduction of the Standards Days Method and promoting LAM. Both of these methods are considered modern methods of family planning. An SDM study currently in progress will document the introduction and assess feasibility of including this method within the MoH approved method mix. Cycle beads are currently not in the LMIS commodity inventory. (A JSI representative noted *"Lack of cycle beads is a recognized gap."*) ACSP personnel stated that they were waiting for the results of the SDM case study, prior to implementing any discussions (or advocacy) concerning inclusion of cycle beads into the LMIS-managed information and distribution system. The study results should be available early in Project Year 4.

Given that the ASCP activities do not impact contraceptive supply it would be appropriate to consider downward adjustment of the EOP targets for indicators related to new acceptors and current users of family planning, and also for the couple years of protection distributed. (See section B.1.b.4.)

The following FP counseling materials were developed, modified and/or re-produced by the ACSP for use at the community level.

- counseling card for all family planning methods offered in FP services (adapted from JSI/MoH materials),
- cue cards with all necessary information to use for family planning activities in the community,
- leaflets describing all modern FP methods (a product designed by URC),
- job aids for SDM counseling (counseling cards and handouts),
- SDM poster (pre-tested and ready for distribution in health centers and posts),
- SDM inserts and leaflets for other methods. (These were developed by JSI.)

The ACSP continues to work very closely with the USAID funded JSI program in the Diber prefecture with respect to family planning *service provision*. After family planning training was completed for VNMs, the project had several key meetings with the MoH, UNFPA, and USAID to discuss the issue of ensuring contraceptive supplies in the Diber prefecture. These meetings occurred during the pilot program's beginning planning stages to extend supplies to the village level. Discussions included the importance of strengthening the supervisory system for the provision of family planning services.

Project staff participated in a family planning round table discussion June 7-8, 2006. This round table was organized by the MoH with the support from JSI and included the participation of other important family planning stakeholders in Albania. These included URC, USAID, UNFPA, IPH and Nesmark (a FP social marketing NGO funded by the German government). (NESMARK receives funding from the German government to conduct social marketing of FP in pharmacies.)

The round table had the following objectives: 1) to review the family planning role of all key stakeholders; 2) to update the process of transferring responsibilities among key players regarding the LMIS that was developed for the MoH; and 3) to discuss future challenges and potential solutions for improving and expanding high-quality family planning services on behalf of community.

During the round table meeting, the project staff formally presented the project's plan to pilot FP services at the village level. The extension plan will include the following activities:

- Selection of pilot villages where family planning contraceptives will be available at the health post levels,
- Advocacy for the regular supply of methods at the pilot village health posts,
- Provision of logistical support for the MoH's family planning focal person to conduct supervisory visits to all pilot health posts.

The ACSP has completed the selection of 35 village health posts in the Diber and Mat districts to participate in the pilot project. (An expansion to another 10 to 15 villages in Bulqize district is being planned.) The ACSP asked for assistance in the process from public health authorities and family doctors of each district. These individuals were asked to select the pilot villages based upon criteria below. Each village selected should have:

- a health building (to ensure opportunity for confidential service provision),
- a VNM living in the village in which s/he works (preferably female),
- a motivated VNM,
- a health post with staff trained on FP and equipped with appropriate materials (job aids, counseling cards, etc),
- a VNM who was actively engaged in distributing contraceptive methods to current FP users.

There is evidence that *access to FP* methods is also increasing, due, in part, to ACSP activities. The project has an indicator that measures the number of people who live within a 5-kilometer distance of a service delivery point. A directive that ASCP recently received from the Flex Fund indicates that this indicator should include measurement of both a trained provider *and* the availability of supplies. ACSP has reached *more than 80 percent of the target* for trained providers at the time of the MTE, which is one of the two measures of access to family planning services. However, progress toward achievement of this indicator is far less favorable, when the availability of supplies is factored into the equation – a matter largely outside the control of the ACSP. The current pilot expansion program will address the supply of contraceptives at the village level and will extend the service delivery points.

ASCP project personnel should reconsider the EOP target for this indicator. See section B.1.b.4.

Anecdotal evidence supplies additional support for the *effectiveness of ACSP project interventions in FP*. A family planning trainer interviewed for the MTE noted that he had seen a decrease in the number of deliveries occurring in the maternity center in the Diber district in which he trained as a medical resident, and in which he currently provides ob/gyn services. He attributes this, in great part, to the ACSP and JSI FP activities that have been implemented. He cited a figure of 35 deliveries per day in 2002 (prior to ACSP programming), now reduced to 15 to 20 per day (fourth quarter of Year 3 of the child survival project).

His personal experience was echoed by comments made by other health providers and also by district MoH personnel. The district health director in Bulquize stated that since 1992 the district birthrate had fallen from 1,400 births a year to 600. Much of this change was likely due to changes in the population (out-migration); however he stated that *"this may be partially due to the project."*

The project has developed a supervisory tool that collects information regarding the C-IMCI+ activities that are conducted at the community level by VHTs, as part of a *quality improvement* protocol. Job aids such as the counseling cards and brochures have been distributed to all VHTs to help improve the quality of service provision including counseling and education. The ACSP, in its expansion of the FP service pilot project, will develop a simple reporting form or tool that will capture the number of methods distributed at the village or health post levels. The ACSP will confer and consult with JSI (and other NGOs engaged in FP activities) to design forms that are not duplicative and do not unnecessarily increase the recording and reporting burden for FP providers. The intent of the new form is that the village nurse midwives can share this information with the health center staff so that the information can be put into the LMIS.

The American Red Cross has a full-time compliance officer based in Washington who offers project support to ensure compliance with all USAID rules and regulations. Overview of compliance with federal guidelines and regulations with respect to FP counseling are the responsibility of the technical backstop. AmRC also requires that the project must submit a monthly sub-recipient checklist that serves to monitor the compliance of project partners on this issue.

The project identified barriers for family planning use during the Doer/Non-doer study conducted among project beneficiaries who were current contraceptive users and non-users. This analysis showed that the availability of free contraceptives, ease of use, and partner support or involvement were important reasons why individuals used family planning methods. The principal barrier among non-users was the non-availability of methods. Other barriers perceived were cost, stigma, distrust, lack of information, and fears of harmful effects, but these were not as significant. Information derived from focus group discussions conducted during the MTE suggested that open communication with partners and accurate information regarding side effects was of importance. Respondents also noted their reluctance to speak about FP with male health personnel. Project staff stated that family doctors, especially male physicians, were noted to be reluctant to offer family planning services in their everyday practice. They see this service as an optional activity that increases their workload.

Standard Days Method case study: ACSP has begun an introduction of the SDM in the Diber prefecture through a one-year pilot project and case study to determine whether nationwide distribution is feasible and acceptable to users. The study activities began in January 2006 in all districts and involve VNMs in 17 health centers (7 in Diber, 6 in Mat, 4 in Buiquize). Health centers were selected for the study based upon the following criteria:

- Motivated VNMs who are interested in and have good knowledge of SDM;
- Location of the health center,
- Health centers that offered all approved MoH methods so that users have full, informed, choices.

New SDM users will be recruited in the selected health centers until August 31, 2006. The following tools were developed for data collection: Admission form, knowledge improvement assessment tool, supervision form for FP providers, follow-up form, exit form, and pregnancy module. Follow-up visits will be conducted after the first 6 weeks after enrollment and again after 3 months. An exit interview will be conducted after another 3 months. The study will conclude after the final exit interviews of the last group of users have been completed. This is projected to occur in March 2007. Pregnancy rates and method discontinuation rates are among the primary outcome variables that are addressed in the study.

Data will be analyzed by the project staff with support from AmRC headquarters. A study report will be written that will document the results and pilot experience. This report will be widely disseminated among the key family planning partners including the MoH, Institute of Public Health, USAID, UNFPA, URC, and JSI. Study results will also be shared with USAID Washington, the Flex Fund, Institute of Reproductive Health – Georgetown University, and the greater child survival community.

A preliminary review of findings from the case study indicate that current SDM users chose the method based upon the fact that it is a natural method with no side effects. Users are well aware of the two eligibility criteria for use of the method: length of cycle (between 26 and 32 days) and agreement and involvement of partner. It is too soon in the study to draw conclusions about the relationship between study variables (e.g., quality of counseling sessions) and successful use of the SDM. Project staff members are monitoring the quality of counseling by the use of the provider knowledge improvement tool.

Preliminary study data also suggest that there is a high level of satisfaction among all current SDM users and their partners. Anecdotal evidence from focus group discussions with SDM users conducted during the MTE showed that users had a good level of understanding of correct method use and knew how to use cycle beads to count days. They also mentioned the use of calendars as a second method to count cycle

days. Clients were able identify their fertile days correctly. A few women noted that they used this method to get pregnant as they were better able to understand their bodies and their fertility cycles.

C. Program management

1. Planning

The ACSP was the first child survival grant application that had been prepared by the American Red Cross, International Services Division. The original proposal was written by senior staff members of the AmRC/Washington, with contributions from AmRC delegates in the Eastern European region and staff from the AmRC/Albania delegation. Other AmRC headquarters principals, including the M&E and finance officers were involved in the development of program strategies. The proposal team engaged external consultant services (Dr. Gilbert Burnham, Johns Hopkins University) to assist with conceptualization and programmatic planning.

The DIP was written by a larger program team that included some, but not all, of the members of the proposal writing team (several had moved to other agencies or assignments). The DIP team members included the full complement of ACSP program staff hired in the first year of the project. Team members represented technical, M&E, and financial experts. Dr. Gilbert Burnham continued in his role as consultant.

The technical interventions were planned with a keen eye to the results of numerous baseline studies conducted not only by the ACSP team (the KPC, an additional FP indicator study required for Flex Fund purposes, and HFA), but also to the results of studies conducted by project partners or collaborators. These included several self-assessment studies conducted by the Albania Red Cross in the years just prior to the ACSP proposal (to assess capacity building and sustainability needs and strategies) and a UNICEF study on MCH indicators conducted in 2000. The Albania MoH had conducted a reproductive health survey in 2002, and these results also informed the planning strategy.

The planning process continually evolves. Information gained through key informant interviews at the time of the MTE indicate that ACSP staff engage in ongoing dialogue with relevant Albania government ministry representatives and with other NGOs that operate in the country, and specifically in the Diber prefecture. ACSP has been very willing to revisit the planning process, and revise annual work plans to be responsive to the constraints, challenges, and opportunities that have been presented. A specific example of very effective inter-organizational planning is the amendment that ACSP made to its calendar of FP training events to accommodate the training events planned by JSI in the district(s). ACSP allowed JSI to precede its own activities. The health promotion officer at URC said "*This is a plus for us, because we found data, like the HFA, that was useful."* The end result of this collaboration was the creation of a cadre of FP supervisors (trained by JSI) who could serve the purposes of the ACSP quality improvement strategy.

The project's goals and objectives are clearly known at the technical services level of the American Red Cross, International Services Division. Some degree of concern was expressed by technical officers that the Child Survival *program of work* (e.g., the mission and objectives of the Child Survival Health Grants program), which underpins the ACSP may be less well-known by their superiors. There has been a turnover of staff at that level. This has generated a need to revisit the fundamental issues related to child survival grant programming. There have been a few instances in which technical staff had to question whether the ACSP had the full support of upper-tier administrative personnel.

At the same time, the project's goals and objectives are very well-known to stakeholders at the USAID/Albania mission, the Albania MoH, and other NGOs engaged in health and family planning work in the country. The project is particularly well-known, and greatly respected, by community beneficiaries. ACSP administration, and staff are very transparent about program activities and freely share information about their plan of work and their monitoring and evaluation activities.

The M&E strategy for the ACSP is particularly well-developed, and very well-supported at AmRC/headquarters and ACSP field levels. The current ACSP M&E officer was hired during the project's second year, but, with the support of key ACSP staff, quickly came "up to speed" on monitoring requirements, and crafted several innovative approaches to documentation (more fully discussed in section 7 below).

The program manager expressed the concern that the FP activities cited for the Flex Fund might have been subsumed under the Child Survival FP targeted activities. This would have reduced the burden of dual reporting and eliminated certain conflicts that have generated a good deal of additional work for project staff (such as the additional baseline survey that had to be conducted because of differences in definitions of indicators and denominators). He indicated that the project had a significantly lengthy set of activities/interventions, and that any one of the ACSP interventions *alone* could consume a large proportion of actual workload, i.e., *"30% is a full-time job."*

2. Staff Training

Program staff is defined for this discussion (Section C2 and following sections) as personnel who have direct authority or responsibility for administrative or technical tasks related to the ACSP, or who receive some or all of their salary from ACSP funds. Therefore the discussion explicitly *excludes* the trainers and supervisors who conduct IMCI, C-IMCI, and FP training for others and the VHTs who provide the community-based services.

Specific detail of staff training events in which AmRC/headquarters and ACSP program staff have engaged is provided in Table 2 of this report. These trainings have been specifically targeted to ensure the readiness of staff for job-related responsibilities and to ensure compliance with USAID and other federal regulations (and specifically, those related to family planning). The majority of this training has been informal and "on-the-job". There is a specific line item in the ACSP budget designated as "staff development," but the April 28, 2006 budget amendment sets that figure at $6,000 over the life of the project.

The project's health program officer noted that he had not had sufficient orientation to the project indicators, or any training in how to measure them. He stated that he had asked for advice and assistance in this matter, but it was "*very slow in coming*."

ACSP staff stated that they have never been formally surveyed by ACSP administration regarding any additional training that might be of need or interest to them. These staff members said that, on occasion, they had expressed a need for training (specifically, finance and information technology), and were told that they should/could search for opportunities, and then bring that information to the attention of the program manager. Staff members expressed the opinion that ACSP administration should have been proactive on behalf of staff, doing the work of finding training opportunities that matched training requests.

Two ACSP staff received formal training in the BEHAVE framework, and then trained all other ACSP staff in turn. A number of recommendations were set forth in Section B.2.c.i. of this report, that are applicable in this context.

Recommendation related to staff training

- ACSP administrators should regularly query all staff about their perceptions of need for additional training related to their project responsibilities. Administrators should be proactive in assisting staff to identify sources for this training and should assist staff to identify resources, including ACSP budget resources, to pay for this.

3. Supervision of program staff

There has been a substantial turnover of staff during the project's three years at both the AmRC/headquarters, the ACSP country office in Tirana, and at the field level (see section 4 below). ACSP staff at each of these levels expressed the concern that their orientation to the project and their specific project responsibilities had been rather limited. The AmRC/headquarters program officer noted that she was oriented to the program and its objectives primarily through the reading of documents. The country-based program manager noted that he has had to work with three program officers and three technical backstops (all AmRC/headquarters positions) over the life of the project to date. The current program officer and technical backstop, both of whom assumed their positions at approximately the beginning of Project year 3, have each traveled to Albania to immerse themselves into project activities and concerns in order to be well-prepared to offer practical supervision and assistance to country-based staff.

A technical consultant (job title: health program officer) was hired in the project's second year to offer country site-based technical support to the program manager (a specific and strategic capacity building intervention). There is some element of supervision that is inherent in this role, although that is not the primary purpose of this position. The program manager expressed a mixture of confidence and of concern about supervision of and technical support for his position in Project year 5, when the two-year contract of the technical consultant will expire.

The field staff in the Diber branch office is supervised by program staff based in Tirana through the following mechanisms:

- Weekly conference calls to discuss activities, resolve problems, and craft the next week's plan of work,
- Internet e-mail and/or telephone calls on a daily basis, as the need arises,
- periodic site visits to the Diber branch, during which Tirana-based personnel work jointly with Diber-based personnel to review procedures, or provide supportive supervision, and
- Periodic meetings held in the Tirana offices, where Diber branch personnel engage in needs-based discussions, and receive information or supervision as required.

Staff evaluated these supervisory mechanisms as very helpful and very supportive. They supported the project's new initiative to shift supervisory duties to Community Mobilizers (volunteer staff), and acknowledged that the completion of the mid-term evaluation and the SDM case study would also ease their workload burden. The AmRC and ACSP staff pattern is depicted in an organogram presented as Appendix K.

The finance and administration staff member in the Tirana office has the additional task of supervising the work of the AlbRC finance personnel as it relates to ACSP project funds. This workload will increase under the terms of the new PA, when a larger proportion of project funds will be expended under AlbRC authority.

4. Human resources and staff management

The rather high degree of staff turnover at the Tirana and Diber branch offices has created both challenges and opportunities for the ACSP. ACSP personnel applied critical thinking and evidence-based decision-making as they carefully considered the most immediate and future needs of the project, whenever position vacancies allowed them to reconsider best use of project staff funds.

Project Year 1:

- All ACSP positions were advertised and filled.
- The project was initially administered with support at the country level by the AmRC regional health delegate. That regional office (originally sited in Macedonia, then relocated to Bulgaria) closed, and administrative responsibilities were shifted to the Tirana country office.

Project Year 2:

- The deputy manager and training officer resigned in order to accept a similar position with the JSI FP project. Deputy managerial responsibilities were assumed by the technical officer, and the AlbRC Diber district health coordinator was promoted to the position of training officer, while retaining her duties with the Albania Red Cross.
- The AmRC liaison officer/ MTE officer resigned for personal reasons. The decision was made to refashion this position into that of a full-time M&E officer, as the responsibilities for M&E were increasing in intensity and proportion to project activities. The program manager assumed liaison responsibilities.
- The cashier at the Diber branch resigned. Her position was also closed, and responsibilities were transferred to the Diber branch administrator.
- A district health coordinator was hired as a replacement for the individual who had been promoted to training officer.
- A second DHC position was created for the Diber district, where the largest amount of program activity takes place, and, therefore, the supervision needs are greatest.

Project Year 3:

- The DHC in Bulqize resigned for personal reasons. The position was refilled in June 06.
- The technical officer and deputy manager resigned, in order to accept a government placement. This position was closed, and the position of community health specialist for the Mat District was created, as project activities were gearing up in that area. That position is presently advertised.

ACSP personnel policies and procedures are governed by overarching AmRC policies, amended, wherever necessary, to conform to Albanian laws and regulations. There are explicit job descriptions for each position. The terms of service are clearly specified. Staff members receive annual performance

evaluations that are participatory in nature. The performance evaluations are linked to a merit-based compensation scheme. All staff spoke very positively about their experiences with the job interview, hiring, orientation, and contracting systems and about the performance review process.

Recruitment of open positions at project headquarters (Tirana) are advertised in the local newspaper. E-mail notices are sent to other NGOs. Positions available in the districts are advertised on local television and through posting of notices on community bulletin boards.

Staff members specifically noted that there was a strong spirit of collaborative and cooperative teamwork. All team members helped one another when there were competing priorities or when individual workloads were temporarily unbalanced. Staff members felt that there were sufficient personnel to manage project tasks, but that the gearing up of activities in Mat would increase that workload.

The DHC in Diber district provided details about an amendment that had been made to her days and hours of work at a time when she was faced with challenging family responsibilities. The flexibility that she was afforded allowed her to keep her job and also to meet these competing and compelling personal obligations.

Staff members were also clearly aware that the ACSP was a time-limited project, and that there will likely be no effort to extend the project at the end of its 5-year term. Staff members sign 1-year contracts. The 2006 contacts included an additional one-month "bridging contract" to cover the period when the new PA was being negotiated.

Staff members are aware of the new program agreement recently negotiated with the AlbRC. Some staff members have already assumed dual appointments (e.g., the DHCs and the training officer), as a first step in the transition to the sustainability phase of the ACSP close-out. Most staff stated very overtly that they were not certain that AlbRC would be able to retain every position. In the words of one ACSP staff member "*The capacity that has been built has given this project life…but others will have to find the funds.*"

The ACSP project partner, the Albanian Red Cross, and specifically the Diber branch (which will assume the major responsibility for sustaining activities in the post-project year) are more challenged in terms of personnel, workload and supervision. Capacity building activities for the AlbRC are fully explored in section 2.c.2. Several recommendations for building staff management capacity of the AlbRC are presented in section 2.c.2. and are not repeated here.

5. Financial management

The financial management *policies and procedures* implemented by ACSP reflect the overarching financial management strategy and systems of the AmRC. Financial management policies and procedures are commendable. Financial controls are of such high quality that there were no negative audit findings in Project Year 2.

The American Red Cross maintains an off-site (not outsourced) "corporate transactional support" office located in Charlotte, North Carolina for the management of raw financial data files. This off-site source also does record management. Original data are kept at this site for two years, and then sent to secure storage.

Project financial data are entered at the Diber branch and at the Tirana office into a proprietary database (Quicken). Data are exported as Excel files and transmitted to Tirana, and then to the national office(s)

where they are entered into an Oracle financial database. Program Activity Reports are prepared monthly that depict the flow and rate of the spend-down of project funds. These are shared with the Tirana office.

The AmRC finance officer (and/or his predecessors) has/have made field visits to Tirana to train project staff in financial policies and procedures. He is available on a day-to-day basis by e-mail and by phone for technical support and supervision.

The Tirana-based finance officer supervises the work of the branch administrator (Finance Assistant) at the AlbRC Diber Branch. They use all of the supervision strategies that were described in section C.3. Electronic banking is used to transfer funds between the two offices.

The ACSP *budget* is sufficient to sustain the project according to plan. That said, there were some difficult periods in the earlier project years, and there are other considerations and arrangements that amplify that finding.

- All administrative costs related to the ACSP, which were to be shared among several regionally administered projects, had to be assumed by the ACSP budget when the regional office closed.
- The addition of an ex-patriate technical advisor in project year 2, for a 2-year contract period, was an additional strain on finances.
- However, the USAID donor funds are augmented with an AmRC match that exceeds the donor contribution and has greater flexibility for expenditure (see expanded discussion that follows).
- The new project agreement with AlbRC shifts a large amount of money to their control. There are some critical concerns about the capacity of the AlbRC, and the Diber Branch personnel, to manage these funds. ACSP administration has chosen to make this shift at the mid-point of the project, so that the effectiveness of capacity building interventions (in this case, the capacity to plan and manage a budget in compliance with existing policies and procedures) can be closely monitored.

Table 4 depicts the project budget, reflecting donor contribution, AmRC cost share, and expenditures to date of the MTE. The cost share obligation cited in the original proposal was $570, 837 (34 percent of the total budget). This amount was adjusted upward when the DIP was submitted, resulting in an AmRC cost share total of $1,412,054, an amount that exceeded the total donor contribution, and equal to 56 percent of the total amended budget. The AmRC program implementation officer conducted an extensive review of the ACSP operations and related budget (overall and by line). Many recommendations emerged that were intended to bring the ACSP budget back into better proportional balance. Subsequent discussions with USAID Child Survival and Technical Service Group (CSTSG) personnel confirmed that AmRC was held to the cost share that is stated in the cooperative agreement, and not to the figure cited in the DIP, as the cooperative agreement was never amended to reflect that higher contribution.

The information presented in Section B.1 of this report, and Table 4 (below) indicate that the AmRC is spending donor funds at a rate proportional to the pace of training activities (see timeline). ACSP is making incremental, satisfactory, progress toward meeting end of project targets. Activities were suspended for several months in Project Year 2, as severe winter weather made it impossible to travel on the mountain roads. These delayed trainings have been recently conducted or scheduled. Activities are just now beginning to gear up in the Mat District. Therefore, a higher “burn rate” for donor funds is expected in Year 3, Quarters 3 and 4.

Table 4: Project Budget

Budget Line Item	Total in budget	Expenditures to Date (2 years, 7 months)	Progress toward target
• USAID donor contribution	1,099,679	471,651	43%
• AmRC cost share (as stated in cooperative agreement)	570,837	641.029	112%

The cost share obligation has already been met, and exceeded. Nevertheless, the recently amended budget indicates the intention of AmRC to make additional contributions of its unrestricted funds to support ACSP activities. The AmRC cost share contribution was projected *and has already been allocated* as an all-cash contribution. The ACSP was the first Child Survival grant proposal submitted by the AmRC. The organization had no experience with strategies or methods to track volunteer services and configure them as cost share equivalents. The AmRC has put such a system in place for second CS grant awarded to the AmRC for a project in Cambodia.

Recommendation related to budget:

- Work with AmRC-HQ Finance staff to develop a volunteer tracking system to capture cost-share information. Train Albanian Red Cross finance personnel on this process, as a capacity-building exercise, to demonstrate an alternative cost-sharing methodology.

6. Logistics

The AmRC gained legal status in Albania during the second year of the project. Prior to gaining this status, AmRC was supported by the International Federation of Red Cross and Red Crescent Societies (Federation) and operated under their legal status in Albania. However, the Federation closed its office and operations in Albania early in the project's lifetime. Therefore, for a period of several months, AmRC funneled major project purchases through the AlbRC partner. This slowed down the funds transfer process at times, and particularly so when there was a discrepancy between financial statements that were shared between the organizations. The ACSP financial officer stated that there were no instances in which these discrepancies could not be resolved; however, time was wasted. There have been very few instances in which these delays had even any minor, and certainly no major effect on implementation of project activities.

The recent amendment to the project agreement transfers much larger sums of money to the Albania Red Cross, which will assume primary responsibility for logistical management. ACSP staff members are prepared to work very closely with AlbRC finance and administrative personnel to offer support, in the interest of building the AlbRC organizational capacity to perform these services. The outcome and impact of this new PA on the logistical support of ACSP activities will have to be closely monitored.

The recent budget revisions[1] (submitted to USAID on July 26, 2006) accommodate the purchase of a third project vehicle. The vehicle will be placed in the Mat district, where the pace of project activities will greatly increase in project year 4.

The substantial logistical challenges to procurement and distribution of FP supplies is outside of project control, but it does affect program operations. ACSP personnel are working with URC (health reform), UNFPA (FP procurement) and JSI (FP activities, including community outreach) to raise consciousness of the MoH about this issue, and to seek ways to increase the effectiveness of the implementation of the LMIS.

7. Information management

The project's performance monitoring plan was developed with the very able assistance of AmRC HQ M&E personnel. The baseline KPC, Facility Assessment, and Flex Fund surveys were conducted with assistance from external consultants.

Monitoring forms were developed by project staff in the project's first years. They were designed in consultation with the village midwives, and designed to augment existing recording and reporting systems. The community-level reporting forms were not then (or now) linked to the MoH HMIS, which does not extend past health center level.

The current M&E officer joined the project in March 2005. She inherited an M&E system that she describes as "less than adequate." Field monitoring and reporting forms contained inherent flaws that made them cumbersome to use and prone to error. She redesigned those forms, tested the amended versions in the field, and implemented a revised monitoring system by the beginning of the third project year.

The documentation of community-based data occurs through the following process:

- The data collection form (Appendix L) is completed by the VHT member
- VHEs give these forms to the VNM member of the VHT.
- The VNM gives the forms to another volunteer, who gathers forms from all VNMs who serve the various villages in the commune. (Note: This person is not a member of the VHT. ACSP personnel have recruited *additional* volunteers for this specific task--one per commune. Project staff remarked that there had been very little turnover in these volunteer positions.)
- The volunteer gives all forms to the DHC.
- The DHC enters these data into an ACCESS database that was designed by the M&E technical officer for the specific purpose.
- The data are periodically and regularly sent by e-mail to the M&E officer, located in the Tirana office.
- The M&E officer scans these data for quality (e.g., range errors, missing data), and cleans all data, when possible.
- The M&E Officer conducts an aggregate data analysis each month, and also by district. She uses Excel for the "frequencies" data.
- Reports are generated from the data. This information is shared during the next weekly staff meeting and used as a basis for creating the quarterly work plan.

The M&E officer works in close collaboration with the MoH and with JSI, as there are several areas of overlapping interest and responsibility. The FP expansion plan in the Diber district represents a novel

[1] Approval for budget revisions was received from USAID on October 10, 2006.

attempt to bring FP to the community level. A simple reporting form is being developed that VNMs can use for reporting their community-based data to the health center, where it can be added to the LMIS, which is presently linked only to that level of health service delivery. She intends to work with JSI as well, as they expand their own FP interventions in Diber district. JSI has already agreed to explore with ACSP the development and use of a single form – or at least a "common element" version –to reduce the paperwork burden on VNM team members.

URC's health reform initiative is another area of interface. URC has assisted the MoH to improve the health management information system (HMIS). This reform has already reduced the paperwork previously required for providers at the hospital and commune-level health facilities. The ACSP often needs data from the HMIS to augment its own reporting requirements. The MoH has always accommodated those requests. It is now the intent of the ACSP M&E officer to raise the interest of the MoH to receive community-based data, which is presently not tracked in the HMIS.

The M&E officer was not a member of the ACSP project staff at the time of the baseline KPC, HFA, Grandmother study, or the hand-held calculator pilot project. She did participate in the Doer/Non-doer study, and selected elements of the design and implementation of the SDM case study. She expects to play some role in the SDM analysis.

8. Technical and administrative support

Project staff requested and received external consultant technical support for the conduct of the KPC baseline survey from Dr. Gilbert Burnham, Professor, Johns Hopkins University Bloomberg School of Public Health. Dr. Burnham provided technical assistance for the design and implementation of the study (including training of survey workers), and the analysis and interpretation of results. The project survey team included representatives of the MoH, IPH, Tirana University Hospital and JSI. The AlbRC Diber Branch Secretary also assisted with logistical support. Dr. Burnham also provided technical assistance with aspects of the Health Facility Assessment. The ACSP project manager was a member of that team. He confirms that these studies could not have been conducted without this external technical consultation, as the AmRC headquarters did not have any staff member who was experienced with this process.

The project conducted a second population-based survey for the family planning project components, to meet Flex Fund requirements. They included selected questions from the KPC in order to validate certain results. The project did not require direct field support for this subject, but had technical back-stop from AmRC/headquarters from Dr.Jim Ricca. Staff continued to communicate with Dr. Burnham about their progress. The pilot study of use of hand-held calculators was an added feature of this baseline study, and was facilitated by CSTS (David Cantor) and Flex Fund (Virginia Lampreht).

Dr. Judi Aubel of the Grandmother Project (an NGO that focuses on the role of older women as influential decision makers) provided leadership for a qualitative inquiry into key household practices for child health. This study was conducted as an operational research study. Study results helped the ACSP staff to shape effective field interventions, by identifying the best audience for the topics to be discussed.

The current SDM case study is being conducted with the internal organizational support of the AmRC headquarters maternal child health advisor. ACSP staff acknowledged that they were not skilled in research study design and required assistance to frame and to implement this study.

AmRC Headquarters technical and management staff have changed frequently over the three year life of the project. The current program officer and the maternal child health advisor, both of whom assumed their responsibilities for the ACSP project in the recent project year, have each traveled to Albania to

immerse themselves in project activities in order to gain understanding of project needs for further technical support. They are available by e-mail and telephone; however, heavy travel schedules, and lack of internet access in some field setting, do render them inaccessible to ACSP country staff for brief periods, from time to time.

Project staff anticipates the need to have some degree of technical support for the conduct of the end of project KPC. The program manager expressed some degree of competence in procedural matters related to the study design and implementation and some degree of confidence in his ability to lead the process. However, he would wish to receive, at minimum, off-site consultation during the study process, and also during the data analysis and interpretation phases.

Other technical support that AmRC headquarters staff intend to provide include data analysis, writeup, and dissemination of the SDM study, the editing and finalization of the BEHAVE study results, and publishing other technical articles on C-IMCI+ and the use of PDAs. The ACSP has set a EOP target of four professional papers or peer-review publications, but none have been published to date of the MTE.

There will also likely be the need to offer capacity building technical support to the Albanian Red Cross staff members as they assume the larger role in project management under the new project agreement. This may include technical assistance in general program administration skills, in all aspects of field-based implementation of project activities, and in all aspects of financial management and compliance. The Diber branch will be assuming responsibility for management and monitoring a larger number of volunteers than ever before.

Recommendations related to technical assistance.

- AmRC headquarters program officer should explore ways and means to provide support to ACSP staff for planning and implementation of the end of project KPC survey. This could be addressed through involving staff in KPC training courses or facilitating on-line study opportunities.

- Am RC headquarters staff and ACSP country-based staff should regularly consult with AlbRC staff at the national office and Diber branch levels to discuss all issues related to the transition and assumption of program responsibilities and to offer technical assistance and support for any need that is identified.

9. Mission collaboration

The ACSP is funded through USAID/DC. The USAID Albania mission in Tirana does not have direct responsibility for monitoring this project. Nevertheless ACSP personnel have taken great care to keep Mission personnel in touch with project activities and invested in project support. ACSP promotes mission collaboration through

- sharing the project's annual reports in the interest of information dissemination,
- ensuring that all AmRC staff and consultants who visit the ACSP are introduced to and have the opportunity to discuss the ACSP project with USAID/Albania representatives,.
- keeping mission representatives up-to-date with progress and results related to the Operational Research studies planned and implemented by the project (such as a pilot study of the use of hand-held calculators for collecting field data, and the SDM case study).

The ACSP goals and objectives link to the CSHGP/USAID intermediate results for its health grants program (2002):

- IR1: Increased quality of child and maternal health and nutrition and infectious disease programs implemented by PVOs and their local partners.
- IR2: Increased sustainability of child and maternal health and nutrition and infectious disease programs and interventions initiated by PVOs and their partners.
- IR3: Child and maternal health and nutrition and infectious disease program strategies, tools and approaches adapted, tested, and applied.

The ACSP works in close collaboration with URC and JSI, who are administering USAID/Albania mission-granted projects. URC operates a national project (ProShendeti) focused on the process of health reform for the primary health care sector in Albania. The ProShendeti activities overlap with ACSP activities in the Diber prefecture. ACSP has shared with URC the approach applied in the field for community mobilization and awareness. URC has relied on the experience gained from the ACSP to design its own community mobilization strategy. The ACSP facilitated the development of URC's network of VNM and community health workers in the Diber prefecture through sharing information about effective strategies for the selection of committed volunteers who would engage in URC's field activities. URC has, in turn, shared FP health education leaflets, which were distributed through the ACSP project volunteer's network.

The ACSP also closely collaborates with JSI, as it implements the mission-funded national Albania Family Planning Project (AFPP). The AFPP focuses on supervision of FP service provided at the health center level. The ACSP conducts complementary activities in the Diber prefecture, specifically with respect to training of health workers; AFPP trainers completed the training of designated health staff (one health center and two VNM in each health center), while ACSP has completed the same training activity for all VNMs in the Diber prefecture. The AFPP decision to pilot its recently developed community outreach strategy in the Diber prefecture was prompted by AFPP's knowledge of the ACSP commitment to VNMs to provide them additional training in family planning - the "+" component of C-IMCI+.

This collaboration has ensured better use of resources, especially human and financial resources, and has avoided duplication of each organization's effort on common health issues. The collaboration has created synergy between output in the field and program impact.

10. Contributions to scale/scaling up

ACSP's intentions with respect to scaling up were to demonstrate the impact of C-IMCI+ as an effective strategy for improving access and quality to health care services. The Albania MoH has already endorsed the IMCI strategy. The community-IMCI approach represents the missing component in the MoH national strategy. One small demonstration project has already been conducted in Kukes district that explored the feasibility of the Albanian Red Cross to serve as a key partner with the MoH and UNICEF in expanding C-IMCI throughout the country. This replication had multiple positive effects:

- to test successfully the C-IMCI model outside of Diber prefecture;
- to test the premise that the AlbRC could assume responsibilities for major activities of the ACSP, after the project end, and

- to give better evidence to the MoH about the C-IMCI+ approach being demonstrated by the ACSP. UNICEF's Albania mission has expressed positive comments regarding this replication and interest in funding a replication in another neighboring area.

The MoH also fully supports the expansion of family planning services to the community level (the "+" in C-IMCI+). Coordination with other mission-funded projects has ensured better coverage of the population with new/higher quality health services provided from newly trained health workers. The family planning community outreach pilot project in Diber district is an example of this expansion.

The overarching question about scaling up of C-IMCI in Albania is whether the effort is worth the expense that would be required to reach communities in the manner that is being modeled by the ACSP. The ACSP project manager was of the opinion that there are three or four prefectures in the country that have health indicators that are in priority need of such an intervention. There are also some prefectures that have so few children in residence (the men have migrated, reducing the birth rate, or, alternatively, whole families have migrated) that C-IMCI might not be a cost-effective strategy.

11. Civil Society Development

ACSP has provided IMCI, C-IMCI, FP and SDM training to most of the nurses (and some doctors) in the Diber prefecture. Through partnership with UNICEF, ACSP has arranged for four district health staff to be trained on IMCI supervision. Soon, ACSP will conduct training on maternal nutrition to nurses in MCH facilities. The expansion of FP down to the village level in 15 sites in each district is being done in partnership with the MoH IPH and district health directors and their staffs. The ACSP staff hopes to develop the capacity of MoH district-level staff to conduct FP outreach education at the village level and to monitor the quality of FP services. JSI will partner with ACSP in these efforts conducted in the Diber district.

ACSP has fully engaged local community leaders (e.g., commune heads) in discussions of the project's benefits to the community. The project could do more to involve these influential leaders in deliberation of ways and means to understand the information that has been and is being generated by the project (e.g., HFA, findings about community sanitation), to build a stronger base for "institutionalization" (sustainability) of project activities. Commune councils do have health commissions, with responsibility for hygiene and environment. One commune head noted that she wished to "*take an active role in analysis of data, sharing experiences, and joint-decision making for health activities in the community.*"

12. Widespread development or adoption of innovative approaches

Currently ACSP in conducting a case study on SDM in pilot sites in the Diber prefecture. ACSP is documenting successes and challenges of implementing and incorporating SDM within the method mix to determine if SDM should be widespread in Albania. This study was in progress at the time of the MTE, but results are expected to be available in the following project year. The findings will be widely disseminated.

ACSP has added family planning education to C-IMCI, to make it C-IMCI+. The project will report on the appropriateness of this innovation and provide recommendations for future C-IMCI programs considering this approach.

An innovation that has received little comment in this MTE, but that is discussed in some detail in the Year 1 project report is the innovative data collection approach used by ACSP when it conducted an "expanded KPC" to generate additional baseline information to meet Flex Fund data requirements. Data

collectors used hand-held computers (personal digital devices) to input the information directly into these portable computers, from which field data could be exported to the aggregate study database. This study has not yet been presented or published, but ACSP personnel have been urged to do so.

13. Equity

The country of Albania ranks 72nd out of 177 countries on the Human Development Index (United Nations Development Program-UNDP, 2005), and is characterized by that Index to be a country at "medium human development." The Diber prefecture, in which the ACSP activities are sited, is an impoverished, rural, mountainous area in northeastern Albania. Over 26 percent of the population lives in poverty (less than $2 US per person per day). An additional 44 percent live in extreme poverty --less than $1 US per person per day (Data cited in DIP.)

ACSP to date has completed its expansion in two out of three districts of the project area (Diber and Bulqize districts). The project has implemented activities in 93 (Diber) and 40 (Bulqize) villages that represent 64 percent and 60 percent, respectively, of the total number of villages of these districts. Activities begin in the Mat district in June 2006. The project anticipates reaching 45 out of 76 district villages, which is a total of 59 percent of the villages in this district.

14. Visibility and recognition of the project and PVO grantees:

The ACSP gave a presentation on family planning in 2005 to a regional audience that included key stakeholders at the national level. However, there are other reports and studies that could be formally presented. The "Grandmother Study", conducted in Project year 1, identified key household influentials/decision-makers. ACSP staff members are not aware of any presentation or publication that has emerged from this study that was led by an external consultant.

The innovative approach of using hand-held computers to foster high-quality improvement in the collection of field data and to facilitate rapid data entry is another study that should be disseminated and shared with other PVOs. ACSP contracted consultant services for that study. The lead consultant gave a regional presentation on the topic. The MTE consultant has urged ACSP staff to urge its consultant to disseminate these findings more broadly.

D. Other issues identified by the team

There are no further issues to be identified here.

E. Conclusions and Recommendations

Findings of this mid-term evaluation offer evidence that the Albanian Child Survival Project has established the necessary and sufficient structures and processes that will enable it to make continued, sustained, progress toward meeting its end-of-project targets, established in accord with the projects' strategic objective, desired intermediate results, and project objectives. The project has the full support of the Albania Red Cross (the project's country partner), and the Albania Ministry of Health, at both the national and prefecture levels. The ASCP is working in excellent collaboration with other NGOs to leverage the strength and effectiveness of its interventions.

The ACSP has made satisfactory progress toward achieving its training objectives. Village health teams have been established in each of the three districts of the prefecture. Two of the three districts now have a VHT functioning in the majority of villages. Training has been recently initiated in the third district. The

number of family planning providers has been markedly increased. A pilot project is currently being implemented that will extend the number of service delivery points to the community level.

Project beneficiaries offer compelling testimony to support the finding that health messages are being transmitted effectively. End-of-project targets for improvements in health indicators are likely to be attained for most focus areas. There is less evidence of progress toward attainment of project targets related to control of diarrheal disease and prevention and treatment of acute respiratory infection. The ACSP needs to find ways (including the engagement of appropriate government ministries and community leaders) to address community behaviors related to disposal of waste products (including disposable diapers) and similar environmental water and sanitation practices. The ACSP also needs to engage proactively with MoH personnel and other NGOs involved in health sector reform and family planning to correct the current conflicts that make it difficult (if not illegal) for VHNs to act according to IMCI and reproductive health guidelines (specifically, the stocking of drug boxes and the administration of antibiotics). Results of the Health Facility Assessment and these MTE findings should be shared more broadly with other agencies and personnel who could act upon them to address certain constraints that limit the project beneficiaries' ability to put into practice their new information and knowledge (e.g., facility health provider attitudes about immediate breastfeeding, stock-outs of iron and vitamin supplements, uninterrupted availability of FP commodities).

The capacity-building activities and strategies in which the ACSP has engaged have two primary objectives:

- creation of a *model* of community-based action for health (the VHT, engaged at the household and community level) that can be replicated throughout the country, and
- strengthening the management abilities (administrative, finance, volunteer recruitment and coordination) of the local partner, the AlbRC, to provide a nexus for dissemination of that model.

The ACSP has initiated several supportive supervision strategies that are designed to strengthen the capacity of VHTs to evaluate their work and to use both qualitative and quantitative feedback to identify the need for change. The intention is that both community and VHT members will be their own best advocates for quality improvement. The project has also initiated the transfer of administrative responsibility for various aspects of the ACSP work plan to the AlbRC, so that there is the benefit of time, over the remaining life of the project, to provide the necessary and appropriate supervision and support.

The AlbRC administration (national and district branches) are presently challenged in their capacity to sustain the current level of ACSP activities. However, there are other MoH and NGO offices/agencies that could appropriately share (or accept) selected tasks (e.g., IMCI and FP). This would allow the AlbRC to focus on C-IMCI, building from its strengths in community-based volunteerism. This coalition of interested stakeholders will serve to enhance the potential for long-term sustainability of the scope of ACSP interests. ACSP personnel have already initiated discussions and actions to promote consideration of such a plan.

A list of conclusions and recommendations resulting from this mid-term evaluation follows.

Recommendations related to nutrition findings

- Increase the educational activities conducted with facility birth providers (particularly nurses and nurse-midwives) to promote their support of immediate breastfeeding

Enhance the message about the importance of iron and folate for pregnant and postpartum mothers.

Recommendations related to control of diarrheal disease finding

- The project needs to take a leadership role in educating the communities about the water and sanitation impact of community practices related to the disposal of feces, and disposable diapers. This role can include engagement of other NGOs (e.g., URC's health reform project) in directing attention of public health authorities about this environmental issue.

- The educational message about distinction between simple and severe cases of diarrhea, and when to seek a higher level of care needs to be strengthened.

- The educational message about proper timing and method of hand washing needs to be enhanced.

- The educational message about distinction between simple and severe cases of diarrhea, and when to seek a higher level of care needs to be strengthened.

Recommendation related to acute respiratory infection findings

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of the VNM drug boxes; specifically, ensuring the availability of antibiotics for the first dose in treatment of ARI.

Recommendations related to family planning

- The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of the VNM drug boxes; specifically, ensuring the availability of FP commodities at service delivery points.

- The FP message must be augmented clearly to indicate that the free contraceptive supplies distributed by MoH are of good quality (i.e., comparable to supplies that can be obtained from private suppliers).

- Specific strategies and messages should be developed to target men; a more progressive influential male could be selected to help with FP service promotion.

- The project should work with other NGOs engaged in FP promotion to develop negotiation tools for women and to help them openly to discuss the use of various FP methods with their husbands.

- The LAM message needs to be clarified and stressed; in particular, the criteria for election of the method need to be amplified.

Recommendations related to cross-cutting findings

- Develop and distribute more information/leaflets to support the four high-impact activities and secure or develop additional take home materials addressing different topics to stimulate the interest of project families in learning about broader health interests.

- Try different learning approaches (role play or drama) during support group activities to ensure that women are more engaged in learning and are not passive listeners. Mix practice and theory (e.g., cooking demonstration, preparation of ORS, hand washing). Develop competitions between communes/villages.

- Use the periodic meetings (already occurring) to hold a special session on a health topic that has been identified by the VHTs. This is to serve as an additional educational opportunity and incentive.

- The project should target more remote families that are not accessing health services due to distance barriers.

- Develop a simple tool or form that can be used to identify families in each neighborhood (registry system) to be used to confirm full participation.

Recommendations related to behavior change communication

- A FP education program and materials should be developed, specifically targeted toward and focused on men, which incorporate the understandings gleaned from project experiences.

- Project staff should assertively pursue the acquisition or development of additional educational materials, specifically seeking to secure materials developed by other organizations that address project-related messages and also materials that focus on other health topics.

- Project staff should interact as much as possible with JSI to learn from and expand upon the BCC component of the family planning expansion project on which JSI and ACSP are partnering in Diber District to evaluate the potential for expansion of these BCC activities in the other ACSP districts.

Recommendations related to PVO capacity building

- AlbRC/ACSP should receive on-the-job, or external training in project management responsibilities (including but not limited to human resources and financial management), and fundraising.

- Sources of external support/consultation for IT should be identified for the Diber field office.

- AmRC program manager should begin planning for a mechanism to provide on-site or at-a-distance support to the country-based staff for conduct of the end of project KPC study.

Recommendations related to building capacity of the Albania Red Cross project partner

- The AmRC and ACSP project staff should assist the AlbRC Diber Branch to develop a strategic plan, in the interest of promoting sustainability following the conclusion of the project. The plan should address features such as (but not limited to) the following:

    - a fundraising plan that addresses the reduction/elimination of the inherited Diber branch debt;
    - a common organization chart that integrates responsibilities for both ACSP project and AlbRC activities'
    - a practical budget that can be sustained without external funds;

    - specific activities to increase the membership; and,
    - support and engagement with the MoH and similar governance structures.

- Develop strategies to integrate the ACSP project team (based in Tirana) into the activities of the AlbRC HQ offices and the Diber branch. This could include increasing the time and presence of each Tirana project staff in the Diber office, and integrating ACSP project and AlbRC HQ finance and reporting systems.

- ACSP staff should look for training and other professional development opportunities (both regional and at-a-distance), in which project staff (as a priority) and volunteers (if possible) could engage. These trainings should focus particularly on health issues of women and young children, and financial and human resource management.

- ACSP staff should conduct quarterly VHT training sessions. Periodic training sessions on health topics that have been identified by the VHTs as important complements to their C-IMCI+ training (e.g., injection procedures, HIV/AIDS, drug use, and treating children with high fever) will serve as an additional educational opportunity and motivation to continue with the project. It will also address a consistent request from the VHTs for further health education on different health issues.

- Facilitate exchange visits for VHEs and VNMs to visit other VHTs within the Diber prefecture as a motivational and learning opportunity. These visits should be facilitated by project personnel with structured agendas to allow strong performing VHTs to work with and mentor weaker VHTs by sharing best practices and lessons learned.

- Organize activities to bring district- and prefecture-level VHTs together to demonstrate their competence in key project messages through friendly competitions. These events, similar to the AlbRCs' first aid competitions, could be extended to the branch level. Friendly competitions serve to share best practices among VHTs, recognize high performing volunteers, and build teamwork between VHTs from different communities.

- Review the incentives, recognition, and job aids for volunteers. Project staff should interview experienced VHEs and VNMs to assess the most valued combination of incentives, recognition activities, and job aids to be implemented. A carefully designed package of incentives (e.g., lunch money, transportation money, training opportunities); recognition events (inclusion in newsletters, public ceremonies, special awards for top volunteer performers, a piece of clothing [e.g., hat, shirt]) and job aids (paper, pens, informational leaflets, Red Cross identification) will keep retention levels high and volunteers motivated.

- Develop strategies further to integrate the project VHTs and the Red Cross volunteer network. Although the different volunteers have different activities, all identify themselves as Red Cross volunteers. Recruit more than two volunteers in each village.

- Budget additional project funds to provide modest expense reimbursement to VHEs when they host project-related meetings in their own homes.

Recommendation related to health facilities strengthening.

- ACSP staff should engage hospital birth attendants, and newborn and child health providers (both doctors and nurses) in dialogue about the mandates of MoH Reproductive Health Guidelines, IMCI, and C-ICMI recommendations. Emphasis should be on those guidelines related to maternal health in the antenatal, postnatal and postpartum periods and the recommendations related to newborn, infant and child nutrition to promote appropriate and more effective integration of health beliefs and practices.

- ACSP staff should identify the appropriate representative/office within the MoH and transfer the information gleaned from the HFA and from this MTE, so that the data are available for uses beyond the purposes and life of the ACSP project.

Recommendation related to staff training

- ACSP administrators should regularly query all staff about their perceptions of need for additional training related to their project responsibilities. Administrators should be proactive in assisting staff to identify sources for this training, and should assist staff to identify resources, including ACSP budget resources, to pay for this.

Recommendation related to budget:

- Work with AmRC headquarters finance staff to develop a volunteer tracking system to capture cost-share information. Train AlbRC finance personnel on this process, as a capacity-building exercise, to demonstrate an alternative cost-sharing methodology.

Recommendations related to technical assistance.

- AmRC headquarters program officer should explore ways and means to provide support to ACSP staff for planning and implementation of the end of project KPC survey. This could be addressed through involving staff in KPC training courses or facilitating online study opportunities.

AmRC headquarters staff and ACSP country-based staff should regularly consult with AlbRC staff at the national office and Diber branch levels to discuss all issues related to the transition and assumption of program responsibilities and to offer technical assistance and support for any identified need.

II. The Action Plan

A. Response to Recommendations

The following action plan is a response to the recommendations and findings of the American Red Cross-Albanian Child Survival Project mid-term evaluation (MTE). It has been developed with input from numerous partners and stakeholders (e.g. Albanian Red Cross and American Red Cross, Albanian MoH, IPH, UNICEF, JSI, and URC). A round table discussion was held with the above partners to discuss the MTE findings, gather suggestions, and develop activities to improve program impact. Many partners stated that the meeting was also a good learning experience for them and provided useful information that is relevant to their activities. Following the round table, informal meetings with certain partners were held to further develop the action plan. Also, key findings from the ACSP Doer/Non-Doer analysis (based upon the Academy for Educational Development BEHAVE Framework) conducted this year were used when developing the activities for this action plan to ensure that barriers are being addressed and to improve the effectiveness of proposed activities in changing behaviors.

For each recommendation ACSP has provided a response. Responses either include specific activities addressing the recommendation or a rationale why the stated recommendation is difficult to implement. In some cases, recommendations were grouped due to their similarity and the activities addressing them were combined.

Nutrition Related

Increase the educational activities conducted with facility birth providers (particularly nurses and nurse-midwives) to promote their support of immediate breastfeeding and enhance the message about the importance of iron and folate for pregnant and postpartum mothers.

- The project will improve the counseling and referral system through training for health workers of urban and rural maternities and Women Consultancy Centers (WCC) focusing on nutrition and micronutrients for pregnant women as planned in the DIP . Training will be done using a specific curriculum, which is (1) complementary to the real needs of health personnel that counsel pregnant women and the target population (i.e. addressing concerns of mothers regarding immediate breastfeeding, supplementation, bottle feeding, etc.); and (2) contains Public Health Directorate (PHD) input and recommendations.
- ACSP will coordinate with PHD for effective supervision ensuring the implementation of the relevant official MoH guidelines.
- Proactive home visits –VHTs will visit the households of pregnant women to promote correct practices and behaviors relative to iron and folate intake, immediate breastfeeding (within the first hour after delivery), and regular prenatal check-ups. ACSP will develop a leaflet, "Mother's Guide to a Safe and Healthy Pregnancy," containing messages about the needs of pregnant women . The leaflet will contain a reminder table to record health data, as recommended in the prenatal protocol, which has to be collected by the health worker over the course of a woman's pregnancy.
- Advocacy with PHD: key health personnel in charge of following pregnancies to re-enforce their legal obligations in regard to complying with the law of "reproductive health" approved on April 4, 2002.

Control of Diarrheal Disease

The project needs to take a leadership role in educating the communities about the water and sanitation impact of community practices related to the disposal of feces, and disposable diapers. This

role can include engagement of other NGOs (e.g., URC's health reform project) in directing the attention of public health authorities to this environmental issue.

- Although addressing this recommendation could possibly help control diarrhea disease (CDD), there are some complex issues which would need to be negotiated with multiple local partners, but the lack of infrastructure does not support a feasible solution for ACSP. However, during C-IMCI+ activities, ACSP will promote proper disposal of diapers and feces. We will also discuss with URC the need to address this issue.

The educational message about distinction between simple and severe cases of diarrhea and when to seek a higher level of care needs to be strengthened.

The project will continue to re-enforce information about diarrhea signs and symptoms:

- ACSP is already promoting the early diagnoses of diarrhea and the identification of signs of severe diarrhea. ACSP will also continue to stress the importance of this during focus group discussions and proactive home visits.
- ACSP messages promote the use of ORS solution as an effective home treatment, and appropriate health care-seeking practices.

The educational message about proper timing and method of hand washing needs to be enhanced.

- The proper timing and method of hand washing are promoted during our ongoing Control of Diarrhoea Disease education sessions. In addition, correct hand washing and hygiene promotion will be also addressed during the growth monitoring and education sessions on complementary feeding.

Acute Respiratory Infection

The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of VNM drug boxes; specifically, ensuring the availability of antibiotics for the first dose in treatment of ARI.

- ACSP will link advocacy efforts with UNICEF (the main national partner on increasing MoH commitment in regards to the IMCI national strategy) to address the lack of drug box supplies and availability of the first antibiotic dose.

Family Planning

The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to the stocking of VNM drug boxes; specifically, ensuring the availability of FP commodities at service delivery points.

- ACSP has begun working with the MoH, IPH, PHDs (in three districts), and JSI to pilot the expansion of FP service delivery points to 47 villages in the Diber prefecture. As part of this piloting system, the current agreement with the PHD is to effectively implement the following list of activities:
    - Develop relevant criteria for site selection and define expansion areas (this has already occurred);
    - Train VNMs who will be included in the expansion process of the FP service package;

- Advocate with IPH and UNFP to ensure that the increased quantities of contraceptives are available as a result of the increased number of FP Service Delivery Points;
- Support the PHD in planning and implementing an effective supervision system; and
- Summarize the expansion process through appropriate documentation to advocate with MoH and IPH to expand this experience to other parts of the country.

The FP message must be augmented clearly to indicate that the free contraceptive supplies distributed by MoH are of good quality (i.e., comparable to supplies that can be obtained from private suppliers).

ACSP expansion of FP SDP will increase access and availability of modern methods, which will help to improve perception in the communities about the quality of contraceptives supplied by MoH in the following ways:

- The expansion will include intensive supervision to providers and FP promotion by volunteers at the village level;
- Messages about the good quality of MoH FP commodities will be reinforced by developing and distributing new IEC materials;
- Messages about the quality of FP commodities by health providers will be transmitted during VHT focus group discussions promoting FP modern methods.

Specific strategies and messages should be developed to target men; a more progressive influential male could be selected to help with FP service promotion.

Behavior Change Communication

A FP education program and materials should be developed, specifically targeted toward and focused on men, which incorporate the understandings gleaned from project experiences.

- The project will identify respected male individuals in the communities who will be trained to organize FP educational sessions. This activity will be implemented in villages with a large population and where it is more likely to find the target audience. The training curriculum will focus on the specific needs of males with regard to FP services (i.e. increasing knowledge about available contraceptives, side effects, and proper use, etc.) Also, the current MoH official curriculum will be used as a reference in developing our curriculum.
- The FP education outreach approach will take into consideration cultural barriers related to men. Male volunteers will distribute existing FP leaflets in places where males might gather (billiard halls, cafés, shops, etc.) As Diber prefecture has a high proportion of males who emigrate abroad (more then 40 percent), leaflet distribution will be done mainly during the months of the year when men are back home for holidays, such as December or July to August.
- VNMs in Diber district will use appropriate forms designed for the "Negotiation Counselling" method by JSI to identify the barriers relative to couples, especially males, analyse the problem and consequences and define ways to address them. AmRC will expand FP services in 20 villages in Diber District. If this methodology is effective, AmRC will consider expanding this approach in the remaining 2 districts.

The project should work with other NGOs engaged in FP promotion to develop negotiation tools for women to help them openly discuss the use of various FP methods with their husbands.

Project staff should increase their interactions with JSI to learn from and expand on the BCC component of the family planning expansion project on which JSI and ACSP are partnering in the

Diber District. This will allowACSP to evlauate the potential for expansion of these BCC activities in the other ACSP districts.

- ACSP is partnering with JSI to expand family planning services in Diber district and is working with the DHC to ensure that commodities are available in at least 20 villages in that district. On the demand side, JSI will train VNMs in all villages in Diber district to conduct home visits using the "Negotiation Counselling" methodology which is designed to change couple's behaviors regarding contraceptive use. The following steps will maximize ACSP interaction with JSI to identify how the "Negotiation Counselling" component can best fit into ACSP C-IMCI+ activities:
  - ACSP staff will be trained on "Negotiation Counselling" methodology designed for village nurse midwives.
  - ACSP with support from JSI will consider the best scenario to expand the "Negotiation Counselling" component into other villages where C-IMCI+ activities are currently being implemented.

The LAM message needs to be clarified and stressed; in particular, the criteria for election of the method need to be amplified.

- ACSP will reinforce the LAM method, in particular the criteria for effective use of the method through the following activities:
  a. Proactive home visits for pregnant mothers that will include clear explanation of the LAM criteria.
  b. Reinforcement of LAM criteria information as part of the FP focus group discussions with VNMs and VHEs.

<u>Cross-Cutting Areas</u>

Develop and distribute more information/leaflets to support the four high-impact activities, secure or develop additional take home materials that address different topics to stimulate the interest of project families in learning about broader health interests.

Project staff should assertively pursue the acquisition or development of additional educational materials, specifically seeking to secure materials developed by other organizations that address project-related messages and also materials that focus on other health topics.

- The need for BCC material supporting our four high-impact activities will be addressed through the reproduction of existing material or the development of new materials. These materials, most likely leaflets, will contain messages focused on prevention, home diagnosis, health care seeking, treatment, and referral for children with ARI, in compliance with IMCI and C-IMCI+ materials. ACSP will try to use existing materials (e.g. from UNICEF in Kosovo) that can be easily adapted to our target audience due to time and cost constraints. These materials will be distributed during outreach activities.
- Based on VHT recommendations, ACSP will distribute existing materials on other health- related topics of interest to the community to stimulate their interest which might come from ACSP or other projects that we overlap regarding the interventions.

Try different learning approaches (role play or drama) during support group activities to ensure that women are more engaged in learning and are not passive listeners. Mix practice and theory (e.g.,

cooking demonstration, preparation of ORS, hand washing). Develop competitions between communes/villages.

- Develop a new IEC tool called "mother's knowledge check-up form" on each ACSP topic will be used in conjunction with a new cue card to be used for assessing knowledge and increase active participation of mothers in topics of interest. This tool will contain some visual images relative to the topic for the target audience on the front side (such as a mother feeding her child enriched porridge) and questions /responses on the back side that will be the VHE will use to assess how much and how well the information was received during the educational session to better structure future educational sessions.
- Develop "Mother's Guide to a Safe and Healthy Pregnancy" containing messages relevant to the needs of pregnant women. The leaflet will contain a reminder table to record health data, as recommended in the prenatal protocol, which has to be collected by the health worker over the course of a woman's pregnancy. Pregnant mothers will be engaged to actively follow healthy pregnancy-related practices.
- ASCP will introduce food demonstrations based on examples given by mothers who are DOERs and will organize practical preparation sessions where mothers bring food items available in their households so that they prepare a nutritious meal/snack for their children . During food demonstrations, proper hand washing messages will be reinforced.
- VHTs along with 'leader mothers' will conduct proactive home visits to households with growth faltering children due to frequent diseases, poor nutrition practices, and inappropriate care. As stated earlier, these leader mothers have healthy children due to their practices and are respected in the community; they thus will not only be able to demonstrate appropriate health practices but they are accepted and respected by other mothers.
- Demonstration sessions regarding the effects of home rehydration therapy (with the intention of teaching the preparation and administration of ORS and possibly the use of supplements depending upon availability and cost. The project will work closely with the MoH and UNICEF to advocate for the inclusion of zinc supplements in the essential drug list and the development of national MoH guidelines.
- "Leader mothers" and VHTs will be trained using the simple "Ask, Look, and Feel" approach to diagnose dehydration. Children with signs of severe dehydration will be referred immediately to the clinic. For home care treatment, mothers will be given ORS packets plus zinc supplements, if available, and trained on how to administer it using appropriate guidelines for community health workers.

Use the periodic meetings (already occurring) to hold a special session on a health topic that has been identified by the VHTs. This is to serve as an additional educational opportunity and incentive (see response below).

Building Capacity of the Albanian Red Cross Project Partner

ACSP staff should conduct quarterly VHT training sessions. Periodic training sessions on health topics that have been identified by the VHTs as important will complement their C-IMCI+ training (e.g., injection procedures, HIV/AIDS, drug use, and treating children with high fever) and will serve as an additional educational opportunity and motivation to continue with the project. It will also address a consistent request from the VHTs for further health education on different health issues.

- The DHCs will include in their monthly reports suggestions from the VHTs for health topics to include in meetings and training sessions. Based on these suggestions, ACSP staff will develop agendas for these quarterly meetings with the VHTs.
- Refresher training activities for functioning VHTs will be developed based on feedback coming from support visits that ACSP staff perform periodically in the field. Training curriculum to be defined based on perceived VHE specific needs and community interest.
- ACSP will discuss with URC the possibility of involving VHTs in their field activities (e.g., trainings) on URC specific health topics (e.g., TB, antenatal care, etc.), which correspond to community needs and also VHT interest.

The project should target more remote families that are not accessing health services due to distance barriers.

Develop a simple tool or form that can be used to identify families in each neighborhood (registry system) to confirm full participation.

- In the larger communities where VHTs have expressed concerns about covering the target population, a registry will be developed that will be used to assess the coverage of ACSP high-impact activities. The use of a registry for all families in each VHE coverage area will help: (1) to define the coverage area for each VHT member, and (2) to better document the coverage of the target population in their area. In hard-to-reach areas ACSP will use "leader mothers" (as described below) to identify families.
- VHTs will identify and train new volunteers or leader mothers. During implementation of their high-impact activities they have gained excellent knowledge about the practices of mothers in their community. Mothers that show active participation and are doers of correct practices as promoted by ACSP will be recruited as leader mothers in order to assist VHEs in the mobilization of hard-to-access families in particularly scattered villages. These mothers should come from those areas identified as hard-to-reach.
- The leader mother, from those hard-to-reach areas, will assist the volunteer in conducting special activities in these areas. These activities may include:
    - Conducting special weighing sessions (held once in three months). The mobilization of the target group and facilitation of the weighing session can be done by the VHEs (that in hard-to-access areas can be replaced by leader mothers). The overall process will be subject of supervision and monitoring by CM and DHC.
    - Leading educational sessions on health topics which represent clear interests of the community itself
    - Conducting food demonstration sessions using existing community recipes. ACSP will identify three simple and quick recipes using locally available produce. Food demonstrations will use food from the participant's home. Education sessions given during food demonstrations will address frequency of feeding and the nutritional value of local versus store bought foods (the latter typically being more expensive and containing empty calories).
    - Ensuring effective use of "vaccination day" on which various activities can be organized in order to promote interesting topics as perceived from the community; and
    - Ensuring the involvement of reluctant families through proactive home visits.

- ACSP will adapt the current monthly reporting form to evaluate coverage of the target population, and the numbers of those who attend project activities.

<u>PVO capacity building</u>

AmRC/ACSP should receive on-the-job, or external training in project management responsibilities (including, but not limited to, human resources and financial management, and fundraising).

ACSP staff should look for training and other professional development opportunities (both regional and at-a-distance), in which project staff (as a priority) and volunteers (if possible) could engage. These trainings should focus particularly on health issues of women and young children, and financial and human resource management.

Recommendation related to staff training
ACSP administrators should regularly query all staff about their perceptions of need for additional training related to their project responsibilities. Administrators should be proactive in assisting staff to identify sources for this training, and should assist staff to identify resources, including ACSP budget resources, to pay for this.

- The ACSP Program Manager and AmRC headquarters program officer have already registered for the CSHGP Backstop Institute in December 2006. They are registered for the KPC Training of Survey Trainers and the Program Design, Monitoring, and Evaluation tracks respectively.
- The project management staff will conduct regular evaluations of the project staff needs, assessments of the available resources and identify relevant training opportunities. They will develop an appropriate questionnaire to evaluate the training needs, as perceived by the project staff and from further discussion with the project management staff to rank priorities (headquarters management staff might be involved in this process).
- Training opportunities will be focused on development, preparation, and testing of health educational materials. The analysis of different opportunities for training might include the following options: AmRC headquarters brings an external consultant to Albania to train the entire staff; a technical ACSP staff receives this training abroad and trains other project staff; or ACSP identifies an opportunity to get this training in country in order that more staff members will be able to attend it.

Sources of external support/consultation for IT should be identified for the Diber field office.

- There is currently in place a part time IT professional to ensure that the required services are available when needed.

Capacity Building
AmRC program manager should begin planning for a mechanism to provide on-site or at-a-distance support to the country-based staff, for conduct of the end-of-project KPC study.

Technical Assistance
AmRC headquarters program officer should explore ways and means to provide support to ACSP staff for planning and implementation of the end-of-project KPC survey. This could be addressed through involving staff in KPC training courses, or facilitating on-line study opportunities.

- See response above re: attendance in CSHGP Backstop Institute in December 2006. Lessons learned from this training will be shared with ACSP staff and volunteers.
- The AmRC headquarters program officer will also be active in identifying further training opportunities and resources for the ACSP staff.
- The program manager will organize a staff a training activity to review the baseline survey methodology.

- AmRC MCH Advisor will review the various survey instruments, which are in compliance with USAID guidelines for the project's end-line surveys. This review will include logistical implications of doing both a KPC and FP population end line survey (the KPC and FP surveys were done separately at baseline).
- In coordination with AmRC headquarters, identify an effective way to provide technical expertise on site for end-line surveys. Different options to be considered include PM getting training (e.g., KPC TOST – Training of Survey Trainers) and the selection of an external consultant.

Building capacity of the Albania Red Cross project partner

The AmRC and ACSP project staff should assist the AlbRC Diber Branch to develop a strategic plan, in the interest of promoting sustainability following the conclusion of the project. The plan should address features such as (but not limited to) the following:

- ACSP HPO will lead key players in developing a strategy that include pertinent issues related to sustaining project activities.
- Identify a team led by AlbRC that develops the strategic plan.

a) a fundraising plan to address the longterm sustainability of the Diber branch beyond the ACSP project:

- AmRC will consider supporting a portion of the salaries of the Diber branch secretary/ACSP training officer. Under the current agreement, ACSP funds for this position terminate at the end of year 4. The Diber branch's current financial situation does not allow it to support this very important position.
- As part of the strategic plan, ACSP will work with the AlbRC OD officer to identify fundraising activities that can be incorporated into ACSP activities.

b) a common organization chart that integrates responsibilities for both ACSP project and AlbRC activities:

- ACSP has developed an organization chart that clearly highlights the roles and responsibilities for AlbRC headquarters and branch and AmRC/ACSP staff.

c) practical budget that can be sustained without external funds:

- Hold a training for AlbRC Diber branch senior management in: finance, administration and management in compliance with approved AlbRC policies
- Operationalize AlbRC's Diber branch's strategic plan by including a practical budget to sustain the branch beyond the ACSP project. ACSP will provide recommendations and facilitation support to the AlbRC in the development of this budget and strategic plan.

d) specific activities to increase membership and support, and encourage engagement of the AlbRC with the MoH and similar governance structures.

- ACSP will facilitate a roundtable with AlbRC headquarters and the Diber branch to identify ways to strengthen the Diber branch.

- ACSP will work with AlbRC hadquarters and the Diber branch to develop outreach strategies to further engage the MoH.
- ACSP will strengthen the Diber branch's capacity in proposal writing and reporting to potential donors.
- ACSP will assist the Diber branch in the assessment and identification of possible donors.
- ACSP will support the Diber branch's initiatives to further develop the activities of the three sub-branches.

Develop strategies to integrate the ACSP Project Team (based in Tirana) into the activities of the AlbRC headquarters offices and the Diber branch. This could include increasing the time and presence of each Tirana project staff in the Diber office, and integrating ACSP project and AlbRC headquarters finance and reporting systems.

- Provide support to AlbRC initiatives that build on ACSP experiences and expertise, for example, the C-IMCI replication in Kukes or partnering with AlbRC district health projects that adopt ACSP activities.
- The sustainability plan will also address this issue.

Organize activities to bring district- and prefecture-level VHTs together to demonstrate their competence in key project messages through friendly competitions. These events, similar to the AlbRCs' First Aid Competitions, could be extended to the branch level. Friendly competitions serve to share best practices among VHTs, recognize high-performing volunteers, and build teamwork between VHTs from different communities.

The recommendation for "friendly competitions" will be slightly altered to allow VHTs to share "lessons learned" and "best practices" without the element of competition. Willing and interested VHTs will be invited to organize and make short presentations for their peers at the branch and sub-branch level. These activities will allow ACSP to remove the element of "winning and losing" in competitions while retaining the opportunity for VHTs to learn from peers.

Facilitate exchange visits for VHEs and VNMs to visit other VHTs within the Diber prefecture as a motivational and learning opportunity. These visits should be facilitated by project personnel with structured agendas to allow strong performing VHTs to work with and mentor weaker VHTs by sharing best practices and lessons learned.

Review the incentives, recognition, and job aids for volunteers. Project staff should interview experienced VHEs and VNMs to assess the most valued combination of incentives, recognition activities, and job aids to be implemented. A carefully designed package of incentives (e.g., lunch money, transportation money, training opportunities); recognition events (inclusion in newsletters, public ceremonies, special awards for top volunteer performers, a piece of clothing [e.g., hat, shirt]) and job aids (paper, pens, informational leaflets, Red Cross identification) will keep retention levels high and volunteers motivated.

- Identify incentives for VHEs through suggestions in the DHCs' monthly report.
- Provide VHT exchange visits to facilitate experience sharing.
- Produce and distribute AlbRC t-shirts, hats, bags, pens, badges, etc. as a way to increase motivation and build team morale.

- Conduct recognition activities for strong performing VHEs, make"thank you" phone calls on important dates, give modest awards for highest performers, have project activities organized around popular fests, etc.
- Provide refresher C-IMCI training sessions for VHEs and VNMs.
- Plan and organize training sessions on health topics outside of ACSP requested by VHEs.
- Identify training opportunities with other NGOs working in the same sector and geographic area for VHTs.

Develop strategies further to integrate the project VHTs into the Red Cross volunteer network. Although the different volunteers have different activities, all identify themselves as Red Cross volunteers. Recruit more than two volunteers in each village.

To further link VHT volunteers with the Red Cross volunteer network, ACSP will:

- Include VHTs into mainstream AlbRC volunteer activities such as fundraising and membership recruitment.
- Provide standard AlbRC identification materials to all AlbRC Diber branch volunteers, both VHTs and others.
- Invite other AlbRC volunteers to attend ACSP-sponsored activities.
- Provide simple orientation on ACSP activities to AlbRC volunteers not involved in ACSP activities.

Budget additional project funds to provide modest expense reimbursement to VHEs when they host project-related meetings in their own homes.

- It is noted that project-related meetings represent a social event within the village and there have been no findings that people are reluctant to host other community members for ACSP field activities.

<u>Health Facilities Strengthening</u>

ACSP staff should engage hospital birth attendants, and newborn and child health providers (both doctors and nurses) in dialogue about the mandates of MoH Reproductive Health Guidelines, IMCI and C-ICMI recommendations related to maternal health in the antenatal, postnatal and postpartum periods. They should also discuss the recommendations related to newborn, infant, and child nutrition to promote appropriate and more effective integration of health beliefs and practices.

The rationales for not implementing this specific recommendation are:

- As a community-oriented project, ACSP is focused on the primary health care sector and is not in a strong enough position to dialogue with health facility structures that provide secondary health care service.
- Some of the health topics included in this recommendation are related to reproductive health (antenatal, postnatal, and port-partum periods) which is not a component of Albania Child Survival Project.

ACSP staff should identify the appropriate representative/office within the MoH, and transfer the information gleaned from the HFA and from this MTE, so that the data are available for uses beyond the purposes and life of the ACSP project.

- The HFA report has been shared on a variety of occasions with the MoH. The MTE preliminary results have also been shared with the MoH. and the final MTE report will be shared with MoH and other relevant stakeholders.

Budget

Work with AmRC headquarters finance staff to develop a volunteer tracking system to capture cost-share information. Train AlbRC finance personnel on this process, as a capacity-building exercise, to demonstrate an alternative cost-sharing methodology.

The recommendation is not relevant because:

- As defined in the project cooperative agreement, ACSP cost share has already been covered by actual funds from AmRC and the agreement does not mention volunteer time as cost share.

Technical Assistance

AmRC HQ staff and ACSP country-based staff should regularly consult with AlbRC staff at the national office and Diber branch levels to discuss all issues related to the transition and assumption of program responsibilities and to offer technical assistance and support for any need that is identified.

- ACSP will maintain regular meetings with key AlbRC staffto encourage and support the transition of project responsibilities to AlbRC.
- Currently ACSP is developing a tool that facilitates AlbRC to develop a sustainability strategy that will define the level C-IMCI+ activities they would like to sustain in Diber after donor funding has ceased. This process will involve key partners and stakeholders in conducting an appropriate financial and strategic assessment with respect to the level of activities they want to sustain.
- ACSP will train VHTs, who are AlbRC volunteers, on other topics of interest to them to strengthen and maintain a volunteer base in the Diber prefecture, thus increasing the likelihood of sustaining C-IMCI+ activities.

II. B ACTION PLAN – TABLE FORMAT

#	ACTIVITIES	TIME FRAME								BENCHMARK / *TARGET*	COMMENT / STATUS
		Quarters of 4th yr				Quarters of 5th yr					
		I	II	III	IV	I	II	III	IV		
Nutrition Related ***Increase the educational activities conducted with facility birth providers (particularly nurses and nurse-midwives) to promote their support of immediate breastfeeding and enhance the message about the importance of iron and folate for pregnant and postpartum mothers.***											
1	The project will improve the counseling and referral system through training for health workers of urban and rural maternities and Women Consultancy Centers (WCC) focusing on nutrition and micronutrients for pregnant women.									81 VNMs	Training will be done using a specific curriculum, which is (1) complementary to the real needs of health personnel that counsel pregnant women and the target population (i.e. addressing concerns of mothers regarding immediate breastfeeding, supplementation, bottle feeding, etc.); and (2) contains Public Health Directorate (PHD) input and recommendations.
2	Proactive home visits –VHTs will visit the households of pregnant women to promote correct practices and behaviors relative to iron and folate intake, immediate breastfeeding (within the first hour after delivery), and regular prenatal check-ups.									NA	ACSP will develop a leaflet, *"Mother's Guide to a Safe and Healthy Pregnancy"*, containing messages relative to the needs of pregnant women and with a reminder table to record health data as recommended in the prenatal protocol which has to be collected by the HW over the course of a woman's pregnancy.
3	Advocacy with PHD staff: key health personnel in charge of following pregnancies to re-enforce their legal obligations in regard to complying with the law of "reproductive health" approved on April 4,2002.									3 districts	
4	ACSP will coordinate with PHD for effective supervision ensuring the implementation of the relevant official MoH guidelines.									3 districts	
Control of Diarrhea Diseases ***The project needs to take a leadership role in educating the communities about the water and sanitation impact of community practices related to the disposal of feces and disposable diapers. This role can include engagement of other NGOs (e.g., URC's health reform project) in directing the attention of public health authorities to this environmental issue.***											
1	Although addressing this recommendation could possibly help control diarrhoea disease (CDD), there are some complex issues that would need to be negotiated with multiple local partners, and the									N.A.	Various round tables focused on "diarrhea prevention" topic will be used to raise the issue of risk factors linked with inappropriate disposal of feces in rural

#	ACTIVITIES	TIME FRAME								BENCHMARK / *TARGET*	COMMENT / STATUS
		Quarters of 4th yr				Quarters of 5th yr					
		I	II	III	IV	I	II	III	IV		
	lack of infrastructure does not support a feasible solution for ACSP. However, during C-IMCI+ activities, ACSP will promote proper disposal of diapers and feces. We will also coordinate with URC to address this issue.										communities
The educational message about distinction between simple and severe cases of diarrhea, and when to seek a higher level of care needs to be strengthened.											
1	ACSP is already promoting the early diagnoses of diarrhea and the identification of signs of severe diarrhea. ACSP will also continue to stress the importance of this during focus group discussions and proactive home visits.									180 VHTs	
2	ACSP messages promote the use of ORS solution as an effective home treatment and appropriate health care seeking practices.										
The educational message about proper timing and method of hand washing needs to be enhanced.											
1	The proper timing and method of hand washing are promoted during our ongoing CDD education sessions. In addition, correct hand washing and hygiene promotion will be also addressed during the growth monitoring and education sessions on complementary feeding.									180 VHTs	
<u>Acute Respiratory Infections</u> ***The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to stocking of VNM drug boxes; specifically, ensure the availability of antibiotics for the first dose in treatment of ARI.***											
1	ACSP will join advocacy efforts with UNICEF to address the lack of drug box supplies and availability of the first antibiotic dose.									N.A.	UNICEF is the lead national partner on the IMCI national strategy. ACSP participation in the IMCI national committee will provide good opportunities for advocacy.
<u>Family Planning</u> ***The project needs to advocate with the MoH and other local stakeholders to improve logistics and supply issues related to the stocking of VNM drug boxes; specifically, ensure the availability of FP commodities at service delivery points.***											
1	ACSP has begun working with the MoH, IPH, PHDs (in three districts), and JSI to pilot the expansion of FP service delivery points to 47 villages in the Diber prefecture. As part of this piloting system, the current agreement with the PHD is to effectively implement the following list										

#	ACTIVITIES	TIME FRAME								BENCHMARK / *TARGET*	COMMENT / STATUS
		Quarters of 4th yr				Quarters of 5th yr					
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	of activities:										
.1	• Develop relevant criteria for site selection and define expansion areas (this has already occurred)									Criteria have been identified	Already occurred
.2	• Train VNMs who will be included in the expansion process of the FP service package;									50 VNMs	Certified trainers to conduct a one-day refreshment training for already trained VNMs.
.3	• Advocate with IPH and UNFP to ensure that the increased quantities of contraceptives are available as a result of the increased number of FP service delivery points;									Advocacy to be carried out	Selected villages will be provided with supplies during the first quarter.. Subsequent reports coming from those villages will document the need for contraceptives.
.4	• Support the PHD in planning and implementing an effective supervision system;									N.A.	Project documents will describe support given to PHD to strengthen and maintain an effective district based supervisory system.
.5	• Summarize the expansion process through appropriate documentation to advocate with MoH and IPH to expand this experience to other parts of the country.									Periodic reports shared with MoH	Periodic national reports prepared by national FP program located in the IPH will be used to document the expansion by examining various FP indicators.
The FP message must be augmented clearly to indicate that the free contraceptive supplies distributed by MoH are of good quality (i.e., comparable to supplies that can be obtained from private suppliers).											
1	ACSP expansion of FP SDP will increase access and availability of modern methods, which will help to improve perception in the communities about the quality of contraceptives supplied by MoH in the following ways:										
.1	• The expansion will include intensive supervision to providers and FP promotion by volunteers at the village level;									Monthly supervisory schedule shared with PHDs	
.2	• Messages about the good quality of MoH FP commodities will be reinforced by developing and distributing new IEC materials;									IEC materials disseminated	Various IEC materials to be produced either from ACSP resources or from other FP projects.
.3	• Messages about the quality of FP commodities by health providers will be transmitted during VHT focus group discussions promoting FP modern methods.									180 VHTs	Issue regarding quality of FP methods distributed from public health sector to be included in community health education sessions and in IEC materials.
Specific strategies and messages should be developed to target men; a more progressive influential male could be selected to help with FP service promotion											

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Behavior Change Communication ***A FP education program and materials should be developed, specifically targeted toward and focused on men, which incorporate the understandings gleaned from project experiences***											
1	The project will identify respected male individuals in the communities who will be trained to organize FP educational sessions. This activity will be implemented in villages with a large population and where it is more likely to find the target audience.									Around 40 males to be recruited from 20 large communities and trained	The training curriculum will focus on the specific needs of males with regard to FP services (i.e. increasing knowledge about available contraceptives, side effects, and proper use, etc.) Also, the current MoH official curriculum will be used as a reference in developing that curriculum.
2	The FP education outreach approach will take into consideration cultural barriers related to men. Male volunteers will distribute existing FP leaflets in places where males might gather (billiard halls, cafés, shops, etc.)									Leaflets to be disseminated	As Diber prefecture has a high proportion of males who emigrate abroad (more then 40%), leaflet distribution will be done mainly during the months of the year when men are back home for holidays, such as December or July to August.
3	VNMs in the Diber district will use appropriate forms designed for the "Negotiation Counselling" method by JSI to identify the barriers relative to couples, especially males, analyze the problem and consequences and define ways to address them. AmRC will expand FP services in 20 villages in the Diber district. If this methodology is effective, AmRC will consider expanding this approach in the remaining 2 districts.									20 VNMs	If effective, this experience will be expanded in other 25 villages, piloted from ACSP and MoH to be regularly supplied with FP modern methods in the other two districts of Diber prefecture (Mat and Bulqize districts).
The project should work with other NGOs engaged in FP promotion to develop negotiation tools for women, to help them openly discuss the use of various FP methods with their husbands ***Project staff should increase their interactions with JSI to learn from and expand upon the BCC component of the family planning expansion project on which JSI and ACSP are partnering in the Diber district. This will allowACSP to evlauate the potential for expansion of these BCC activities in the other ACSP districts.***											
1	ACSP is partnering with JSI to expand family planning services in the Diber district and is working with the DHC to ensure that commodities are available in at least 20 villages in that district. On the demand side, JSI will train VNMs in all villages in Diber district to conduct										

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	home visits using the "Negotiation Counseling" methodology which is designed to change couple's behaviors regarding contraceptive use. The following steps will maximize ACSP interaction with JSI to identify how the "Negotiation Counselling" component can best fit into ACSP C-IMCI+ activities:										
.1	• ACSP staff will be trained on "Negotiation Counselling" methodology designed for village nurse midwives.									3 ACSP staff	
.2	• ACSP with support from JSI will consider the best scenario to expand the "Negotiation Counselling" component into other villages where C-IMCI+ activities are currently being implemented.									Detailed work plan finalized for ACSP area	If effective, this experience will be expanded to another 25 pilot villages in Mat and Bulqize districts.
The LAM message needs to be clarified and stressed; in particular, the criteria for election of the method need to be amplified.											
1	ACSP will reinforce the LAM method, in particular the criteria for effective use of the method through the following activities:										
.1	▪ Proactive home visits for pregnant mothers that will include clear explanation of the LAM criteria.									180 VHTs	
.2	▪ Reinforcement of LAM criteria information as part of FP focus group discussions with VNMs and VHEs.									180 VHTs	
<u>Cross-Cutting Areas</u> ***Develop and distribute more information/leaflets to support the four high impact activities, secure or develop additional take home materials addressing different topics in order to stimulate the interest of project families in learning about broader health interests.*** ***Project staff should assertively pursue the acquisition or development of additional educational materials, specifically seeking to secure materials developed by other organizations that address project-related messages, and also materials that focus on other health topics.***											
1	The need for BCC material supporting our four high-impact activities will be addressed through the reproduction of existing material, or the development of new materials. These materials, most likely leaflets, will contain messages focused on prevention, home diagnosis, health care seeking, treatment and referral for children with ARI, in compliance with IMCI and C-IMCI+									N.A.	In order to effectively use project's own resources, good coordination with other projects will give additional opportunities for using their IEC materials.

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		Quarters of 4th yr				Quarters of 5th yr					
		I	II	III	IV	I	II	III	IV		
	materials. ACSP will try to use existing materials (e.g. from UNICEF in Kosovo) that can be easily adapted to our target audience due to time and cost constraints. These materials will be distributed during outreach activities.										
2	Based on VHT recommendations, ACSP will distribute existing materials on other health-related topics of interest to the community to stimulate their interest which might come from ACSP or other projects that we overlap regarding the interventions..									IEC materials to be disseminated to the community	Guest lectures will be a separate activity used to address particular interests of community on separate health topics.
Try different learning approaches (role play or drama) during support group activities to ensure that women are more engaged in learning and are not passive listeners. Mix practice and theory (e.g., cooking demonstration, preparation of ORS, hand washing). Develop competitions between communes/villages.											
1	Development of a new IEC tool called "mother's knowledge check-up form" on each ACSP topic will be used in conjunction with a new cue card to be used for assessing knowledge and increase active participation of mothers in topics of interest. This tool will contain some visual images relative to the topic for the target audience on the front side (such as a mother feeding her child enriched porridge) and questions /responses on the back side that will be used by the VHE to assess how much and how well the information was received during the educational session, in order to better structure future educational sessions.									New forms developed and produced for all VHTs	New form development is to be carried out during the first quarter of project's 4th year and final production will occur during the second quarter.
2	Develop "Mother's Guide to a Safe and Healthy Pregnancy," which contains messages relevant to the needs of pregnant women. The leaflet includes a reminder table to record health data, as recommended in the prenatal protocol, which has to be collected by the HW over the course of a woman's pregnancy. Pregnant mothers will be engaged to actively follow healthy pregnancy-related practices.									New forms developed and produced for all VHTs	Before this other "new form" is developed, a close discussion with MoH and PHDs needs to take place in order to ensure full compliance with current guidelines in the Reproductive Health sector in Albania.
3	ASCP will introduce food demonstrations based on examples given by mothers who are DOERs and will organize practical preparation sessions where									Select areas with higher risks for	Other project opportunities (like periodic meetings) will allow for testing of new approaches to disseminating information

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	mothers bring food items available in their households so that they prepare a nutritious meal/snack for their children. During food demonstrations, proper hand washing messages will be reinforced.									malnutrition	such as, "food demonstration" activities which will be implemented in selected areas where there is still high risk for malnutrition.
4	VHTs along with 'leader mothers' will conduct proactive home visits to households with growth faltering children due to frequent diseases, poor nutrition practices, and inappropriate care. As stated earlier, these mothers have healthy children due to their health practices and are respected in the community; they thus will not only be able to demonstrate appropriate health practices, but also are accepted and respected by other mothers.									"leader mothers" to be selected	Additional IEC materials need to be provided to "leader mothers" selected in hard-to-reach areas in order to enable high quality activities.
5	Demonstration sessions regarding the effects of home rehydration therapy (with the intention of teaching the preparation and administration of ORS and possibly the use of supplements depending upon availability and cost). The project will work closely with the MoH and UNICEF to advocate for the inclusion of zinc supplements in the essential drug list and the development of national MoH guidelines.									180 VHTs	These activities will be implemented through out the whole year but will be more intense before the hot months when there is a higher prevalence of diarrhea especially in young children in rural areas.
6	"Leader mothers" and VHTs will be trained using the simple "Ask, Look, and Feel" approach to diagnose dehydration. Children with signs of severe dehydration will be referred immediately to the clinic. For home care treatment, mothers will be given ORS packets plus zinc supplements, if available, and trained on how to administer it using appropriate guidelines for community health workers.									N.A.	MoH guidelines regarding diarrhea treatment needs to be reviewed and discussed together with UNICEF's policy on this matter.

Use the periodic meetings (already occurring) to hold a special session on a health topic that has been identified by the VHTs. This is to serve as an additional educational opportunity and incentive (see response below)

<u>Building Capacity of the Albanian Red Cross Partner</u>

ACSP staff should conduct quarterly VHT training sessions. Periodic training sessions on health topics that have been identified by the VHTs as important will complement their C-IMCI+ training (e.g., injection procedures, HIV/AIDS, drug use and treating children with high fever) and will serve as an additional educational opportunity and motivation to continue with the project. It will also address a

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consistent request from the VHTs for further health education on different health issues.											
1	The DHCs will include in their monthly reports suggestions from the VHTs for health topics to include in meetings and training sessions. Based on these suggestions, ACSP staff will develop agendas for these quarterly meetings with the VHTs.									4 DHCs	
2	Refresher training activities for functioning VHTs will be developed based on feedback coming from support visits that ACSP staff perform periodically in the field. Training curriculum to be defined based on perceived VHE specific needs and community interest.									180 VHTs	At least one refresher training will be carried out for the remaining project time, which will be accompanied by other similar training activities.
3	ACSP will discuss with URC the possibility of involving VHTs in their field activities (i.e. trainings) on URC specific health topics (i.e. TB, antenatal care, etc.), which correspond to community needs and also VHT interest.									3 districts	This opportunity will be explored and after that planned to occur in joint ACSP and URC project areas in the Diber prefecture.
The project should target more remote families that are not accessing health services due to distance barriers. ***Develop a simple tool or form that can be used to identify families in each neighborhood (registry system), in order to confirm full participation.***											
1	In the larger communities where VHTs have expressed concerns in covering the target population, a registry will be developed which will be used to assess coverage of ACSP high impact activities. The use of a registry for all families in each VHE coverage area will help: (1) to define the coverage area for each VHT member, and (2) to better document the coverage of the target population in their area. In hard-to-reach areas ACSP will use "leader mothers" (as described below) to identify families.									N.A.	
2	Identification and training of new volunteers or leader mothers will be done by VHTs. During implementation of their high impact activities they have gained excellent knowledge about the practices of mothers in their community. Mothers that show active participation and are doers of									N.A.	New volunteers will be identified and trained to replace drop-outs.

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	correct practices as promoted by ACSP will be recruited as leader mothers in order to assist VHEs in the mobilization of hard-to-access families in particularly scattered villages. These mothers should come from those areas identified as hard-to-reach.										
3	ACSP will adapt the current monthly reporting form to evaluate coverage of the target population, and the numbers of those who attend project activities.									Monthly reporting year to be adapted	
4	The leader mother, from those hard-to-reach areas, will assist the volunteer in conducting special activities in these areas. These activities may include: ▪ Special weighing sessions (held once in three months). The mobilization of the target group and facilitation of the weighing session can be done by the VHEs (that in hard-to-access areas can be replaced by leader mothers). The overall process will be subject of supervision and monitoring by CM and DHC. ▪ Leading educational sessions on health topics which represent clear interests of the community itself ▪ Conducting food demonstration sessions using existing community recipes. ACSP will identify three simple and quick recipes using locally available produce. Food demonstrations will use food from the participant's home. Education sessions given during food demonstrations will address frequency of feeding, nutritional value of local versus store bought foods (the latter typically being more expensive and containing empty calories.) ▪ Ensuring effective use of "vaccination day" on which various activities can be organized in order to promote interesting topics as perceived from the community; and ▪ Ensuring the involvement of reluctant families through proactive home visits.									Project periodic report to document the occurrence of those activities.	

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PVO capacity building ***AmRC/ACSP should receive on-the-job or external training in project management responsibilities (including, but not limited to, human resources and financial management, and fundraising).*** ***ACSP staff should look for training and other professional development opportunities (both regional and at-a-distance), in which project staff (as a priority) and volunteers (if possible) could engage. These trainings should focus particularly on health issues of women and young children, and financial and human resource management.*** ***Recommendation related to staff training*** ***ACSP administrators should regularly query all staff about their perceptions of need for additional training related to their project responsibilities. Administrators should be proactive in assisting staff to identify sources for this training, and should assist staff to identify resources, including ACSP budget resources, to pay for this.***										
1	The ACSP Program Manager and AmRC headquarters program officer have already registered for the CSHGP Backstop Institute in December 2006. They are registered for the KPC Training of Survey Trainers and the Program Design, Monitoring and Evaluation tracks respectively.									2 project staff	The current training courses, scheduled for December 2006, will provide project staff technical knowledge and skills in relevant areas of project implementation.
2	The project management staff will conduct regular evaluations of the project staff needs, assessments of the available resources and identify relevant training opportunities. They will develop an appropriate questionnaire to evaluate the training needs, as perceived from the project staff and further discussion with the project management staff in order to prioritize (headquarters management staff might be involved in this process).									N.A.	An Annual Performance Evaluation for project staff will give a good opportunity for supervisors to assess the need and various opportunities for supplemental training activities for various staff members.
3	Training opportunities will be focused on development, preparation, and testing of health educational materials. The analysis of different opportunities for training might include the following options: AmRC headquarters brings an external consultant to Albania to train the entire staff; a technical ACSP staff receives this training abroad and trains other project staff; or ACSP identifies an opportunity to get this training in									Training opportunities materialized regarding BCC related skills	Given the project's large need for IEC materials it is necessary that staff members have training opportunities that review the development, testing and production of materials.

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	country in order that more staff members will be able to attend it.										
Sources of external support/consultation for IT should be identified for the Diber field office.											
1	There is currently in place a part-time IT professional to ensure that the required services are available when needed.									Dropped.	
Capacity Building ***AmRC Program Manager should begin planning for a mechanism to provide on-site or at-a-distance support to the country-based staff, for conduct of the end of project KPC study.*** **Technical Assistance** ***AmRC headquarters program officer should explore ways and means to provide support to ACSP staff for planning and implementation of the end of project KPC survey. This could be addressed through involving staff in KPC training courses, or facilitating on-line study opportunities.***											
1	The ACSP program manager and AmRC headquarters program officer have already registered for the CSHGP Backstop Institute in December 2006. They are registered for the KPC Training of Survey Trainers and the Program Design, Monitoring, and Evaluation tracks respectively.									2 project staff	The current training courses, scheduled for December 2006, will provide project staff technical knowledge and skills in relevant areas of project implementation.
2	The AmRC headquarters program officer will also be active in identifying further training opportunities and resources for the ACSP staff.									Training opportunities identified.	
3	The Program Manager will organize a staff a training activity to review the baseline survey methodology.									Staff training to be done	
4	AmRC MCH advisor will review the various survey instruments, which are in compliance with USAID guidelines for the project's end line surveys. This review will include logistical implications of doing both a KPC and FP population end line survey (the KPC and FP surveys were done separately at baseline).									N.A.	
5	In coordination with AmRC headquarters, identify an effective way to provide technical expertise on site for end-line surveys. Different options to be considered include PM getting training (e.g., KPC									N.A.	

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	TOST – Training of Survey Trainers) and the selection of an external consultant.										
Building capacity of the Albania Red Cross project partner ***The AmRC and ACSP project staff should assist the AlbRC Diber Branch to develop a strategic plan, in the interest of promoting sustainability following the conclusion of the project. The plan should address features such as (but not limited to) the following:***											
1	ACSP HPO will lead key players in developing a strategy that include pertinent issues related to sustaining project activities.									Strategy for Sustainability to be issued	
2	Identify a team lead by AlbRC that develops the strategic plan.									A team establishment to be completed.	
a) a fundraising plan that addresses the reduction/elimination of the inherited Diber branch debt:											
1	AmRC will consider supporting a portion of the salaries of the Diber branch Secretary/ACSP Training Officer. Under the current agreement, ACSP funds for this position terminate at the end of year 4. The Diber branch's current financial situation does not allow it to support this very important position.									1 person	
2	As part of the strategic plan, ACSP will work with the AlbRC OD officer to identify fundraising activities that can be incorporated into ACSP activities.									N.A.	ACSP staff will explore opportunities in the area to help AlbRC Diber branch get additional funds from other donors, and to be prepared to manage them.
b) a common organization chart that integrates responsibilities for both ACSP project and AlbRC activities':											
1	ACSP has developed an organizational chart that clearly highlights the roles and responsibilities for AlbRC HQ and branch and the AmRC/ACSP staff.									Organizational chart to be done	Already carried out
c) practical budget that can be sustained without external funds											
1	Hold a training for AlbRC Diber branch senior management in the following topic areas: finance, administration, and management in compliance with official policies and other core documents approved by AlbRC									1 person (Diber branch Administrator)	Note: Activities in other bullets of this recommendation will strengthen the financial situation and human resources which will contribute to project sustainability.
2	Operationalize AlbRC's Diber branch's strategic plan by including a practical budget to sustain the branch beyond the ACSP project. ACSP will provide recommendations and facilitation support to the AlbRC in the development of this budget and strategic plan.									Sustainability Plan finalized	

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		I	II	III	IV	I	II	III	IV		
d) specific activities to increase membership and support, and encourage engagement of the AlbRC with the MoH and similar governance structures.											
1	ACSP will facilitate a round table with the participation of senior management from AlbRC HQ and Diber branch to identify ways to strengthen the Diber branch.									Round table organized	ACSP will directly assist Diber branch in the assessment and identification of the list of possible donors. Note: The ACSP logistics will facilitate and support the Diber branch in its initiatives to enliven the activities of AlbRC in the 3 sub-branches. The increased number of activities will lead to the improvement of the image of the AlbRC thus contributing to the increase of membership itself. In addition, every single project implementation will require AlbRC HQ and branch level leadershipto coordinate with the relevant government agencybe it a health, social, or disaster management/response type project etc.
2	ACSP will work with the AlbRC HQ and Diber branch to develop outreach strategies to further engage the MoH.									N.A.	
3	ACSP will strengthen the Diber branch's capacity in proposal writing and reporting to potential donors.										
4	ACSP will assist Diber branch in the assessment and identification of possible donors.										
5	ACSP will support the Diber branch's initiatives to further develop the activities of the 3 sub-branches.										
Develop strategies to integrate the ACSP Project Team (based in Tirana) into the activities of the AlbRC HQ offices and the Diber Branch. This could include increasing the time and presence of each Tirana project staff in the Diber office, and integrating ACSP project and AlbRC HQ finance and reporting systems.											
1	Provide support to AlbRC initiatives that build on ACSP experiences and expertise for example, the C-IMCI replication in Kukes or partnering with the AlbRC district health projects that adopt ACSP activities. The sustainability plan will also address this issue.									N.A.	The sustainability plan will also address this issue through looking for other opportunities to support other health initiatives of AlbRC.
Organize activities to bring district- and prefecture-level VHTs together to demonstrate their competence in key project messages through friendly competitions. These events, similar to the AlbRCs' First Aid Competitions, could be extended to the branch level. Friendly competitions serve to share best practices among VHTs, recognize high performing volunteers, and build teamwork between VHTs from											

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different communities.											
1	The recommendation for "friendly competitions" will be slightly altered to allow VHTs to share "lessons learned" and "best practices" without the element of competition. Willing and interested VHTs will be invited to organize and make short presentations for their peers at the branch and sub-branch level. These activities will allow ACSP to remove the element of "winning and losing" in competitions while retaining the opportunity for VHTs to learn from peers.									N.A.	
Facilitate exchange visits for VHEs and VNMs to visit other VHTs within Diber prefecture as a motivational and learning opportunity. These visits should be facilitated by project personnel with structured agendas to allow strong performing VHTs to work with and mentor weaker VHTs by sharing best practices and lessons learned.											
Review the incentives, recognition and job aids for volunteers. Project staff should interview experienced VHEs and VNMs to assess the most valued combination of incentives, recognition activities and job aids to be implemented. A carefully designed package of incentives (e.g., lunch money, transportation money, training opportunities); recognition events (inclusion in newsletters, public ceremonies, special awards for top volunteer performers, a piece of clothing [e.g., hat, shirt]) and job aids (paper, pens, informational leaflets, Red Cross identification) will keep retention levels high and volunteers motivated.											
1	Identify incentives for VHEs through suggestions collected and reported from DHCs (as part of their monthly report).									180 VHTs	
2	Provide exchange VHT visit opportunities for motivation and to facilitate experience sharing.									180 VHTs	
3	Produce and distribute Red Cross project shirts, hats, bags, pens, badges, etc as a way to increase motivation and build team morale.									180 VHTs	
4	Conduct recognition activities that serve as special individualized rewards for strong performing VHEs. (e.g., "thank-you" phone calls on important dates, project activities organized around popular fests such as 7th and 8th of March, etc.)									180 VHTs	
5	Provide refresher C-IMCI training sessions and periodic meetings with VHEs and VNMs.									180 VHTs	At least one refresher training to be done that will be accompanied by other training / updating opportunities for VHT members
6	Plan and organize meetings focusing on health topics outside of ACSP focus. These topics will									N.A.	

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		I	II	III	IV	I	II	III	IV		
	represent community concerns as requested through the VHEs. A specialized doctor can be invited and educational materials can be produced and distributed to the target audience of that community.										
7	In certain areas where other NGOs (such as URC or JSI) are conducting community activities, ACSP will look for possible partnerships allowing VHTs to benefit from other NGO activities.									N.A.	
Develop strategies further to integrate the project VHTs into the Red Cross volunteer network. While the different volunteers have different activities, all identify themselves as Red Cross volunteers. Recruit more than two volunteers in each village.											
1	Include VHTs into mainstream AlbRC volunteer activities such as fundraising and membership									N.A.	Through providing simple orientation on ACSP activities to AlbRC volunteers not involved in ACSP activities.
2	Provide standard AlbRC indentification materials to all AlbRC Diber branch volunteers, both VHTs and others.										
3	Invite other AlbRC volunteers to attend ACSP-sponsored activities.										
4	Provide simple orientation on ACSP activities to AlbRC volunteers not involved in ACSP activities.										
Budget additional project funds to provide modest expense reimbursement to VHEs when they host project-related meetings in their own homes.											
1	It is noted that project-related meetings represent a social event within the village, and there have been no findings that people are reluctant to host other community members for ACSP activities.									Dropped	
<u>Health Facilities Strengthening</u> ***ACSP staff should engage hospital birth attendants, and newborn and child health providers (both doctors and nurses) in dialogue about the mandates of MoH Reproductive Health Guidelines, IMCI and C-ICMI recommendations, related to maternal health in the antenatal, postnatal, and postpartum periods and the recommendations related to newborn, infan,t and child nutrition, in order to promote appropriate and more effective integration of health beliefs and practices.***											
1	The rationales for not implementing this specific recommendation are:										
.1	As a community oriented project, ACSP is focused on the primary health care sector and is not in a strong enough position to dialogue with health facility structures that provide secondary										

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	health care service.										
.2	Some of the health topics included in this recommendation are related to reproductive health (antenatal, postnatal and port-partum periods) which is not a component of Albania Child Survival Project.										
ACSP staff should identify the appropriate representative/office within the MoH, and transfer the information gleaned from the HFA and from this MTE, so that the data are available for uses beyond the purposes and life of the ACSP project.											
1	The HFA report has been shared on a variety of occasions with the MoH. The MTE preliminary results have also been shared with the MoH and the final MTE report will be shared with MoH and other relevant stakeholders.										
Budget ***Work with AmRC-HQ finance staff to develop a volunteer tracking system to capture cost-share information. Train Alb Red Cross finance personnel on this process, as a capacity-building exercise, to demonstrate an alternative cost-sharing methodology.***											
1	The recommendation is not relevant because, as defined in the project cooperative agreement, ACSP cost share has already been covered by actual funds from AmRC and the agreement does not mention volunteer time as cost share.										
Technical Assistance ***AmRC HQ staff and ACSP country-based staff should regularly consult with AlbRC staff at the national office and Diber branch levels to discuss all issues related to the transition and assumption of program responsibilities, and to offer technical assistance and support for any need that is identified.***											
1	ACSP will maintain regular meetings with key AlbRC staff to encourage and support the transition of project responsibilities to AlbRC.									N.A.	
2	Currently ACSP is developing a tool that facilitates AlbRC to develop a sustainability strategy that will define the level of C-IMCI+ activities they would like to sustain in Diber after donor funding has ceased. This process will involve key partners and stakeholders in conducting an appropriate financial and strategic assessment with respect to the level of activities they want to sustain.									N.A.	
3	ACSP will train VHTs, who are AlbRC volunteers, on other topics of interest to them to strengthen									N.A.	

#	ACTIVITIES	TIME FRAME								BENCHMARK / *TARGET*	COMMENT / STATUS
		Quarters of 4th yr				Quarters of 5th yr					
		I	II	III	IV	I	II	III	IV		
	and maintain the volunteer base in Diber. prefecture, thus increasing the likelihood of sustaining C-IMCI+ activities.										

Appendix A. Changes to DIP

The original proposal included the plan to promote Vitamin A supplementation (VAS). However, this was modified at the time of the preparation of the Detailed Implementation Plan (DIP). The Albanian IMCI protocol recommends that Vitamin A supplementation occur in only severe case management of malnutrition. The project decided not to promote Vitamin A to conform to national policy and norms. The revised plan was to review Vitamin A policies and protocols with the MoH and UNICEF, because UNICEF is the MoH's main collaborative partner for the clinical IMCI national strategy. Two years after DIP nothing has changed in the Albanian MoH policy regarding Vitamin A supplementation: Vitamin A deficiency is not considered a public health concern in pediatric age-groups in Albania.

As has been previously stated the results framework of the DIP does not include baseline values from the ACSP population-based family planning survey, which was done in August 2004, following submission of the DIP. Thus it is incorrect. Some of the footnotes in the results framework of the DIP make reference to this point. The ACSP Year One Annual Report includes the most recent results framework in which family planning indicators were finalized based on our family planning baseline survey findings.

The following recommended changes to the DIP are in reference to the results framework in the year one annual report, and to the narrative sections of the DIP.

A) Revisions

The original project proposal indicated that a larger number of villages (N= 279) would be covered by the C-IMCI+ strategy. However, after discussion with the ARC Program and Technical Officers and with concurrence of officials from CSHGP/USAID, this number was reduced to 190 villages in order to enhance the quality of supervision in villages where VHTs were already implementing the intervention. However, it should be noted that the percent of the target population reached in the entire target area is more than 80%, achieving the WHO criteria for C-IMCI+ coverage. To ensure strong field supervision, ACSP has revised the DIP budget to increase resources and staffing in the field community support. This includes an additional vehicle and more capacity building of Commune Mobilizers/supervisors.

The indicator # 12: *"% of population that lives within 5 km of a FP service delivery point (SDP)"* Based on recent information ACSP suggests modifying the values for this indicator**.** The family planning baseline survey results showed that 69% of the population in Diber prefecture lives within 5 km of a FP SDP. Based on ACSP experience in the field, this proportion is too high in comparison to the low number of FP SDP (n= 21out of 279 health posts) in the area at that time. The reasons postulated why the proportion is so high are related to errors in sampling and the limitations of the survey questions for this indicator. The sample sites may have over represented the few FP SDP sites that existed at baseline, which serve the largest populations. Also, the 69% value represents all WRA who:

1. said they "knew of a FP service delivery point" (*This criteria excluded those women who didn't "know" of a service delivery point. This lack of knowledge may have been due to a distance of more then 5 km from FP SDP.*) AND those who
2. perceived the distance from FP SDP as within 5 km of their home *(The accuracy of the distance calculation is questionable).*

To establish a more accurate baseline value ACSP has added the total target population in all sites where FP services were being offered at baseline to determine the proportion based on the

total target population in the prefecture. Based on this calculation the new baseline value is 35%. In the scenario of this new baseline value and the fact that ACSP is not addressing the contraceptive supply issue directly, the end line target should be revised to 60%.

The indicator #18: *"% of village nurse midwives using supervision checklists for VHEs."* C-IMCI+ teams have been trained to work as a team through combined attendance of VHEs and VNMs at the same training sessions. In this way, the VNM does not have supervisory capacity, but is an equal member of a team. Currently, ACSP supervisory staff, primarily the DHC, conducts supervision at minimum on a bi-monthly basis for each VHT. This involves using tools to monitor VHT status and activity level, and to assess and improve health education sessions. Also, reports of each visit are produced and put in a file or data base on each VHT. This information is pertinent for monitoring VHT performance in relation to the quantity and quality of activities, and also for addressing their needs. Based on these needs, periodic meetings and trainings are being conducted. As stated above, the DIP budget was revised to increase supervisory activities and strengthen the performance of VHTs. In addition to the bi-monthly visits by ACSP staff, ACSP has begun selecting Commune Mobilizers from existing VHT members that show exceptional dedication and capacity for supervising other VHTs. At the moment, it has been planned and budgeted for each CM to conduct monthly visits of each of their VHTs. Thus, we suggest the following revised indicator to be used at EOP: "*bi-monthly supervision of every functioning VHT will be done by supervisory personnel (i.e. ACSP staff, and CMs) using a structured method and tools designed to support and improve VHT performance."* Accomplishment towards this indicator can be verified through reports and records maintain on each VHT.

The indicator #3: *"Number of CYP distributed within the program area to the target population per annum,"*
The indicator #4: *"% of women married or in union for 15-49 years who are not pregnant or are unsure who are using a modern Family Planning method,"* AND
The indicator #5: *"Number of WRAs who report being a 'new user' of a modern method of FP per annum."*
According to the Flex Fund these are critical indicators and cannot be omitted. Another option may be to revise them, in terms of reducing their EOP target values. The rationale is that the achievement of current EOP target values cannot be reached unless ACSP activities directly impacted contraceptive supply, which they do not.

Supervisory visits by ACSP and Public Health Directorate of health workers at maternity facilities are scheduled based on different topics the project is focused on (i.e. family planning, breastfeeding practices, etc) and are not done quarterly, as suggested in the DIP. However, visits are done in accordance with the public health directorates needs on the relative health topics.

B) Omit

The indicator #9: *"% of village ambulancas with ORT corners installed and functioning"*. The importance of promoting ORT corners decreased as the project's focus shifted to education in the preparation of ORT. The intention of the ORT corners was to create a central location in which caretakers could be instructed in the proper technique for preparation and administration of the ORS. The ACSP project reconsidered the establishment of ORT corners primarily because a majority of the villages did not have a functioning health post, where this ORT corner was to have been established. Secondly, ORS sachets were readily available from a variety of vendors in the community, at an affordable price (Tresol is the brand name of the product available in Albania.) Third, Young Child Support Group sessions conducted by VHTs educate mothers on how to prepare and administer ORS. A recently completed doer/non-doer study of mothers of children under age 5 was conducted to investigate six behaviors related to all of the ACSP project objectives. One of these behaviors addressed ORT usage during an episode of diarrhea. Results of this study confirmed that "lack of knowledge" of how to prepare the ORT solution was *not* associated with the status of non-doer, and therefore did not represent a barrier to effective use of the solution in time of need. For these three reasons, the ACSP elected to remove the indicator concerning establishment of ORT corners from its Project Monitoring Plan.

The indicator #7: *"percent of mothers who received iron or iron/foliate supplements during last few months of pregnancy"* has been partly addressed through YCSG (Young Child Support Group) educational sessions and will partially be addressed through ACSP promotion of prescription of supplements during our one-day nutrition training to maternity ward nurses. This training will include key VHEs or CMs to strengthen the link between community and maternity nurses and to address barriers perceived by both partners relative to this issue which impact the demand. However, it is not ACSP role, as described in the DIP, to address the supply side of iron foliate supplements. Therefore, it is suggested this indicator be omitted.

The indicator # 30: *"% of mothers that cite fast/difficult breathing as a danger sign for neonates"*

The indicator # 32: *"% of mothers who can cite at least 3 neonatal danger signs"*

The two above indicators relating to household knowledge of mothers on dangers signs of neonates should be omitted. Referring to technical materials from WHO&UNICEF, the age-group covered by IMCI is 1 week till 5 years old. C-IMCI protocol covers the same age-group. Albanian IMCI protocol adapted and officially approved by MoH, together with C-IMCI protocol (developed by ACSP in compliance with clinical IMCI) does not cover the first week of infancy. Health promotion materials produced and job aids developed, in the context of C-IMCI community educational activities, reflect this requirement. As a result, the field educational sessions do not cover health topics related to the above mentioned indicators.

Appendix B. Evaluation team members and their titles

External Consultant/Evaluation Team Leader:
Judith T. Fullerton, Ph.D., CNM, FACNM
International Consultant: Maternal/Child Health, Evaluation and Research
Professor (retired): University of California San Diego School of Medicine
Professor (tenured, retired): University of Texas Health Science Center San Antonio
Professor (tenured, retired): University of Texas El Paso, College of Health Sciences

District Evaluation Teams:

Diber:
Judith Fullerton,
External Consultant
Bethany Weaver, M.A.
AmRC/DC Program Officer for Europe/Eurasia
Fabian Cenko, M.D., M.P.H.
ACSP Project Manager
Ermira Elezi, CSP
ACSP District Health Coordinator

Bulqize:
Collin Elias, M.P.H.
ACSP Health Advisor
Thomas Carmody, M.B.A.
AmRC/DC, Sr. Advisor, Organizational Development
Shkendie Kaba,
ACSP Training Officer, **and**
Branch Secretary, Albanian Red Cross
Anduela Cami, B.S., Nurse Midwife
ACSP District Health Coordinator

Mat
Sujata Ram, M.P.H.
AmRC/DC Maternal Child Health Advisor
Ditila Doracaj, M.D., M.H.S.M
ACSP M&E Advisor
Sanije Meta,
CSP District Health Coordinator

Support provided by: Albanian Red Cross, Zamir Muca, Secretary General

Appendix C. Evaluation assessment methodology

The mid-term evaluation of the American Red Cross/Albania Red Cross Albania Child Survival Project was conducted in accord with the principles set forth in the *Participatory Program Evaluation Manual* (Aubel J, USAID, CSTS, 1999). The MTE occurred in five phases.

Phase I: Preplanning meetings

The evaluation goals and objectives were established by the American Red Cross Program Officer, in consultation with ARC administration, and the ACSP country-based project team. An evaluation scope of work was prepared (*step 1).* An external consultant was selected from among a number of individual recommended to ARC. The external consultant was approved by the CSHGP. Additional members of the evaluation team were identified (*step 2).* Preliminary plans were made for scheduling and logistical support (*step 3).* Project documents were provided for review by the consultant, who, in turn, prepared draft materials for use in the evaluation activities. These included a framework for the evaluation process, a sampling strategy and interview guides (*step 4).* These materials were shared with evaluation team members (*step 5).*

Phase II: Evaluation planning workshop

Evaluation team members assembled in Tirana on July 8 to discuss, amend and augment the draft materials (*step 6).* The evaluation team refined the evaluation questions and methodologies, with the primary objective of arriving at a common understanding of the purpose of each question, and a common definition of terminology. Particular attention was paid to the issue of words and phrases that might present a problem in translation to the Albanian language (*step 7).* Evaluation target groups (key informants, stakeholders, beneficiaries) were elaborated. Data gathering methodologies (key informant interviews, focus groups, review of quantitative data) most likely to be appropriate and effective among the target groups were identified (*step 8).* The draft forms of data collection instruments were then revised to reflect the agreed-upon definitions, methods, and strategies (*step 9).* Team members were organized into District evaluation teams. Each team was led by one individual relatively external to the ASCP country-level program (the external consultant, an ARC/DC Headquarters representative or the resident Health Advisor). Team members included at least one ACSP project staff member. The District Health Coordinators served as logistical coordinators. A calendar of field activities (data collection sites, interviewees) was prepared (*step 10).* Forms were duplicated prior to departure.

Phase III: Fieldwork: preparation, data collection & analysis

Appointments and arrangements for meetings were made in advance, with assistance provided by the field office staff in Peshkopi. Teams dispersed to the three districts. Each team had a driver and vehicle for logistical support (*step 11).* Activities are cited in the calendar that accompanies this narrative. A very few amendments to the original plan were made, as circumstances dictated (*step 12).* The External Evaluator changed teams on day 3, in order to gather first-hand information of the circumstances in 2 of the 3 districts. Team members in each district met at the end of each day to compare field notes, to discuss their observations, and to prepare summary notes about their findings (*step 13).* A summary field note was prepared that

documented the aggregate findings and conclusions of team members (*step 14*). The teams that worked in Diber and Bulquize districts were accommodated at the same hotel in Peshkopi, and therefore had the opportunity to discuss findings among the two teams. However, the team located in Mat was too far distant for that purpose.

Phase IV: Workshop to formulate lessons learned

Evaluation team members gathered in Tirana to discuss and compare the findings by District. Common threads were identified. Discrepancies among findings were queried and dissected to determine whether the finding might have been influenced by any error in methodology (e.g. a translation error), or whether it represented a true lesson learned. An overarching "finding" for each of the four high impact interventions was drawn. Recommendations were developed for consideration by the Evaluation Consultant for (*step 15).* Evaluation team members also provided feedback to the External Evaluator about the effectiveness and limitations of the methods, and of the impact of her leadership style on the implementation of the evaluation process (*step 16).*

Phase VI: Development of an action plan

A summary of the process and of the findings and lessons learned about the project's four high impact activities was prepared and presented first to the USAID/Albania Health Officer and then to a meeting of key program stakeholders. The organizations represented at that meeting are presented in the table that accompanies this narrative (*step 17).* Stakeholders assisted the evaluation team to strategize about actions that could be taken to address the constraints and/or recommendations that had emerged from the assessment of the four project focus areas (nutrition, diarrheal disease, acute respiratory infection and family planning) (*step 18).* That draft plan was left in the hands of the ASCP project personnel, to be amended and /or incorporated into the action plan that would accompany the MTE report.

Phase VII: Finalization, dissemination and discussion of evaluation report.

The evaluation report was authored and edited by the External Consultant. She included information gleaned from preliminary and informal drafts of selected sections of the report (e.g., descriptions of training activities) that were authored by project and evaluation team members. The first draft was circulated among all Evaluation team members for correction of errors. The Evaluation Consultant made all final decisions about content (*Step 19).* ARC and the ACSP staff have made plans to disseminate the MTE findings, and the action plan, to a wide audience of interested stakeholders (*step 20).*

Appendix C.a. Documents Reviewed

Albania Red Cross reports and documents
ARC monthly project reports
Budget and financial reports
C-IMCI protocols as adapted for Albania
DIP: including project workplan, M&E matrix
Grandmother study report
Health facility assessment
Project training curricula and materials
MOH reports on child survival and family planning
Organograms
a) – depicting relationship between ARC and Albania RC
b) – depicting ACSP project
Paper written about use of handheld computers for data collection (author citation not provided)
Project agreements
Project proposal
Standard Days Method study protocol/data collection forms
Year 1 annual report/supporting documents
Year 2 annual report/supporting documents

Appendix C.b. Interview Guides

DISTRICT **FORM A**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Beneficiaries – Women and Children

Group Members	**N of participants**
Mothers of children under age 2	
Women of reproductive age (15-49)	
Grandmothers	
Others (list)	
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Ensure that responses will be aggregated, and that no single individual will be identified***	
1. Please talk about the things that are happening in this community which you heard about through the VHE and/or VNM.	***Probe for*** • Growth monitoring • Nutrition advice and counseling • Establishment of young child supports groups • Talks about family planning
2. When the VHE or VNM gives you advice, is it nearly the same as, or very different from what you already knew about how to feed your baby?	***Probe for*** • What things are different? • How is it different? • Do you feel comfortable doing things in new or different way? • **Grandmothers,** are these ways of doing things better than the old way?
3. When the VHE or VNM gives you advice, is it nearly the same as, or very different from what you already knew about how to feed your young children?	***Probe for*** • What things are different? • How is it different? • Do you feel comfortable doing things in new or different way? • Grandmothers, are these ways of doing things better than the old way?
4. What (if any) changes have you made in the way you feed your infant and young children, because of the advice you have been given?	***Probe for*** • Breastfeeding practices (immediate post-birth; exclusive for six months • Complementary feeding for infants and young children • Types of *different* foods introduced as a result of new learning

OPTIONAL QUESTION 5. What sorts of foods are the most nutritious types that are available in this community? **Please keep count of responses.**	• Meat	• Cereal/Grain	• Fruit	• Vegetables
6. Do you use iodized salt in your household? **Please keep count of responses.**	Yes		No	

7. Please name some signs that would tell you that your child has a lung infection. **Please note any signs that are NOT mentioned even one time by the respondents.**	***Probe for:*** • Fast or difficult breathing • High fever • Vomits everything • Not eating or drinking • Looks unwell • Lethargic or difficult to wake cough
8. What would you do to take care of your child if you think the child has a lung infection? **Please note any signs that are NOT mentioned even one time by the respondents.**	***Probe for:*** • Care seeking • Following treatment recommendations (e.g., taking full course of antibiotic)
9. Please name some signs that would tell you that your child was having severe diarrhea. **Please note any signs that are NOT mentioned even one time by the respondents.**	***Probe for:*** • Lethargy • Agitation • Sunken eyes • Dry skin • Not drinking as before or "drinks thirsty" • Blood and/or mucus in stool • Diarrhea persists more than 14 days • Dry tongue
10. What would you do to prevent diarrhea or to take care of your child if the child was having diarrhea? **Please note any signs that are NOT mentioned even one time by the respondents.**	***Probe for:*** • Hand washing • Disposal of feces • Use of ORT • Continued fluids and feeding during diarrheal episodes • Seeking care for the child if the diarrhea persists or if there are bloody stools • Do NOT use antibiotics unless prescribed
11. What do you do about food and fluid when your infant or child is sick?	***Probe for:*** • Offer the same amount or more food or fluid than when the child is well
12. What do you do about food and fluid when your child has been sick but is getting better?	***Probe for:*** • Offer the same amount or more food or fluid than when the child is well
13, What information have you received from VHEs or VNMs about family planning?	***Probe for:*** • Types of methods

				• Effectiveness of various methods • Benefits of child spacing • Where to obtain contraception methods	
14. Have you heard about the LAM method of family planning?				***Probe for:*** • Effectiveness of the method • When it is appropriate to use the method • How do you know when it is time to change to another method?	
15. Have you heard the name "Standard Days Method?"			***Ask:*** • What do you know about this method of family planning? • How does it work? • Who told you about how it worked? • Where did this teaching happen?	***Probe for:*** • Can you trust this method to Prevent pregnancy? • Is it a good approach? (as opposed to 'messy", "inconvenient", "expensive", "difficult to understand")	
16. Has a VHE or VNM ever come to your home? **Please keep count of responses.**			Yes	No	
If answer to Question #16 is YES…ask: For what purpose did she come to your home?"					
Additional questions for women with children under age 2					
17. What month of pregnancy did you begin prenatal care? **Please keep count of responses.**	< 4 months	5th or 6th	7th or 8th	9th	No prenatal care
18. Did you enroll for prenatal care earlier than you did in another pregnancy? **Please keep count of responses.**		Yes		No	
19. If yes…was this because of advice you received from **Please keep count of responses.**	VNM	Neighbors	Grandmother	Sister or friend	Anyone who you know was part of ACSP
20. When you were at prenatal care, did anyone talk to you about nutrition? **Please keep count of responses.**		Yes		No	
21. When you were at prenatal care, did anyone talk to you about taking vitamins? **Please keep count of responses.**		Yes		No	
22. When you were at prenatal care, did anyone talk to you about iron? **Please keep count of responses.**		Yes		No	
23. Is there anything else you would wish us to know about this project?					
Thank you for your participation……					

DISTRICT **FORM B**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Beneficiaries – Men

Group Members:	**N of Participants**
Male youth (age 12 – 18)	
Young men of reproductive age (18 – 59)	
Others (list)	

Introduce the project and the interviewers…..
Indicate the purpose of this interview
Ensure that responses will be aggregated, and that no single individual will be identified

1. Have you – or have your wife – or have your mother/sisters participated in group learning sessions outside of your home? **Please keep count of responses**	**Yes**	**No**
2. What topics did your family member say were discussed at these sessions?	***Probe for:*** • Nutrition for the child and the family • Breastfeeding • Tips on how to take care of children at home when they are sick • Tips about when to take a child to see health care services at a facility • Family planning	
3. Has a VHE or VNM ever come to your home?	**Yes**	**No**
4. **If answer to Question #16 is YES…ask:** For what purpose did she come to your home?"		
4. What information have you or your wife received from VHEs or VNMs about family planning?	***Probe for:*** • Types of methods • Effective ness of various methods • Benefits of child spacing • Where to obtain contraceptive supplies	
5. Have you heard about the LAM method of family planning?	***Ask:*** • What do you know about this method of family planning? • How does it work? • Who told you about how it works? • Where did this teaching happen?	***Probe for:*** • Can you trust this method to prevent pregnancy? • Is it a good approach? (as opposed to "messy", "inconvenient', "expensive", "difficult to understand.")
6. Have you heard the name "Standard Days Method?	***Ask:*** • What do you know about this method of family planning? • How does it work? • Who told you about how it worked? • Where did this teaching happen?	***Probe for:*** • Can you trust this method to Prevent pregnancy? • Is it a good approach? (as opposed to 'messy", "inconvenient", "expensive", "difficult to understand")

7. Is there anything else you would wish us to know about this project?
Thank you for your participation.

DISTRICT **FORM C**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Beneficiaries - Community Leaders

Group Members:	**N of participants**
Village elders	
Village leaders (e.g., community council leaders)	
Others: (List)	
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Ensure that responses will be aggregated, and that no single individual will be identified***	
1. What changes have you seen in the health of the community over the last two years (or since the project began here)?	
2. Please describe the things that are being done by the ACSP that you think have affected the changes that you see in your community.	
3. What things about the project are very satisfactory to you?	
4. What things about the project cause some concern?	
5. Is there anything else you would wish us to know about this project?	
Thank you for your participation.	

DISTRICT **FORM D**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Village Health Educators and Village Nurse Midwives

Group members	**N of participants**
VHE	
VNM	

Introduce the project and the interviewers…..
Indicate the purpose of this interview
Ensure that responses will be aggregated, and that no single individual will be identified
NOTE TO THE FACILITATOR: Please ask the groups to respond separately – so they hear and understand that each member has a specific role…

1. Were you a Red Cross volunteer before working for the CSP?
Interviewer: please keep count of "yes" answers, according to participant type _____ VHE _____VNM

2. **If answer to Q#1 is yes, ask:** Please describe the types of volunteer activities in which you participated.

3. **If an answer to Q#2 is given, ask:** Please describe the types of training(s) that you received from the AlbRC.

4 **(VHE) or (VNM)** Please describe the ways in which you conduct or participate in child growth monitoring and promotion activities in the community.

5 **(VHE) or (VNM)** Please describe the ways in which you conduct or participate in maternal and child health promotion activities in the community.		***Probe:*** • Assessment of ARI • Assessment of diarrheal disease • Nutrition – mother, infant, child
6 (**VHE) or (VNM)** Please talk about your program of home visiting.	***Ask:*** • How often? • Most recent? • How many per week/per month	***Probe:*** • Are you welcomed into the home more often than not?
7 Please describe the ways in which you advocate for family planning.		***Probe:*** • Types of methods discussion • SDM in particular
8 Please describe the type and amount of supervision and guidance you have received for your work.	***Ask:*** • Do you feel comfortable that you know what you are supposed to be doing? • Was the C-IMCI training of good quality?	***Probe:*** • Sufficient • Timely • Feedback received

9. What kinds of data do you collect for your work with the project?

10. Please describe the ways that you gather data, and how you handle that data. (to whom, how, how often?)

11. Please tell us the types of things that would motivate you to continue your service as a volunteer.	***Probe:*** • Need for more or different incentives • More or different types of training • Job aids • Project newsletters • Recognition (award, special attention) • Anything else?

12. Please tell us about any challenges or barriers that you have encountered when trying to do your work.

13. Are there some things that would help you to do your work better?

14. Please tell us anything else that it would be helpful for us to know about the ACSP and/or your role as a volunteer?	***Ask:***

	• Recognition of self as a volunteer • Respect for role
Thank you for your participation.	

DISTRICT **FORM E**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Collaborative Partners and Other NGOs

Individuals Interviewed		
Participants:	**Titles**	**Organization**
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Note that organizational titles, rather than names, will be used in the report.***		
1. Please describe the ways in which the activities in which your organization engages complement the activities of the ACSP.		
2. Please describe the communication styles and patterns that characterize the relationship between your organization and the ACSP.		
3. Please describe any sources of conflict/disagreement/dissonance that might have occurred, or are a current problem in the working relationship between your organization and the ACSP.		
4. **UNICEF only** – has there been any change from the MOU regarding UNICEF sponsorship of IMCI (curriculum, protocols, materials, actual teaching)?		
5. Is there anything else you would wish us to know about this project?		
Thank you for your participation.		

DISTRICT **FORM F**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Prefecture and District level Ministry of Health personnel

Individuals Interviewed		
Name	**Title**	**Prefecture/District**

Introduce the project and the interviewers…..
Indicate the purpose of this interview
Note that organizational titles, rather than names, will be used in the report.

1, Please discuss the added value that the ACSP has brought to the Prefecture, and to the Districts.

2.Please name the activities in which the ACSP is engaged in (the Prefecture, or the specific district).

3 Please describe the nature of the relationship between the ACSP and the MOH personnel.

4. Please describe the nature of the relationship between the ACSP and the facility based health care personnel.	***Probe for:*** • Are they well received? • Is there competition for attention? • Are there conflicts between what is recommended by MoH guidelines for health care service delivery, and what is recommended by ACSP?

5. Please describe the nature of the relationship between the ACSP and the community based health care personnel

6. Please describe the nature of the relationship between the ACSP and the community members/residents.

7. What aspects of the ACSP program are currently being "scaled up" by MOH?
a) How?
b) By what date will these programs be district wide? Prefecture wide? Country-wide?

8. What things have improved in the time the ACSP has been in the Prefecture/District?	***Probe for:***
	• Refresher training for VNM
	• New supplies in PHC facilities
	  • ORT corners
	  • ORT salts and antibiotics now available in village emergency drug boxes.
	  • Weight scales
	  • Health education materials for pregnancy and/or family planning
	  • Case management protocols developed and/or distributed

9. Please comment about the quality of record keeping and information sharing that occurs between the MoH/District and the ACSP.

10. Please discuss family planning commodity supply and the logistics management information system.

11. Please discuss plans/feasibility for MOH assumption of IMCI roll out throughout country.

12. Is there anything else you would wish us to know about this project?

Thank you for your participation.

DISTRICT **FORM G**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

INTERVIEW/OBSERVATION GUIDE
Monitoring & Evaluation Personnel

Individuals Interviewed		
Name	**Title**	**District**
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Note that organizational titles, rather than names, will be used in the report.***		
1. Please discuss what changes have been made to the HMIS and/or the LMIS since you started working with the ACSP.		
2. Please name any new forms that have been developed for transmittal of data since the ACSP began. **Please attach a copy of each form mentioned.**		
3. Was there sufficient orientation for everything who would use these forms, so that they can be used effectively?		
4. Did the changes that were made (if any) improve the system, or make it more confusing? Please explain….		
5. Is there anything else you would like to tell us about the project?		
Thank you for your participation.		

DISTRICT- **FORM H**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Hospital and health facility personnel

Individuals Interviewed			
Name	**Title**	**Facility**	**District**
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Note that organizational titles, rather than names, will be used in the report.***			
1. Were you a part of the health facility assessment that was conducted by the ACSP? **Please keep count of responses.**	**Yes**	**No**	
2. Did you ever receive any feedback from the health facility feedback about things that were good, or things that could be improved? **Please keep count of responses.**	**Yes**	**No**	
3. What changes have you seen in this facility over the last two years?			
4. Please describe the things that are being done by the ACSP that you think have affected the changes that you see in your facility and in the ways the facility responds to the needs of the community.			
5. How have you benefited professionally from participating in this project?			
6. What things about the project are very satisfactory to you?			
7. What things about the project cause some concern?			
Supervisory Personnel only:			
8. Please describe the things that you do to provide supervision to VNM and/or VHEs.			
9. Have you changed the ways that you provide this supervision because of your involvement in ACSP?		***Probe*** • A new checklist • A regular schedule for visits • A system of feedback, used regularly	
10. Do you have any suggestions about ways that the supervisory system could be improved?			
11. What do you think will happen to this supervision system when the ACSP ends? Who will fund it? Who will monitor it?			
MTE Team Member: Please specifically look for and note presence or absence of the following:			
Item	**Present**	**Absent**	
Oral rehydration corner			
Cycle beads in FP clinic supply closet			
Cycle bead brochures			
FP counseling cards			
Cue cards (job aids)			
Any other materials with ACSP/UARC/AlbRC/UAID logo List specifically:			
Thank you for your participation.			

DISTRICT **FORM I**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
CSP Administration – DC and Country Level

Individuals Interviewed		
Name	**Title**	**Prefecture/District**

1. Please discuss the added value that the ACSP has brought to the organization.	
2. Please speak about the challenges that were encountered trying to get the project implemented.	
3. Please describe the successes of the project as you see them, to date.	
4. Please describe the nature of the relationship between the ACSP and the MOH personnel (e.g., supportive?, trustful?, helpful? conflictual?)	
5. Please talk about sustainability of the project activities after the ACSP ends.	***Ask:*** • What plans have already been made to transition the project to the field? • How likely do you think it will be that VHEs will continue with their activities? • Have staff been prepared for new jobs? • What are plans for financial sustainability?
6. Please describe the nature of the relationship between the ACSP and the facility based health care personnel	***Probe for:*** • Are they well received? • Is there competition for attention? • Are there conflicts between what is recommended by MoH guidelines for health care service delivery, and what is recommended by ACSP?
7. Please describe the nature of the relationship between the ACSP and the community based health care personnel.	
8. Please describe the nature of the relationship between the ACSP and the community members/residents.	
9. What aspects of the ACSP program are currently being "scaled up" by MOH?	***Ask:*** • How? • By what date will these programs be district wide? Prefecture wide? Country-wide?

10. What things have improved in the time the ACSP has been in the Prefecture/District?	***Probe for:***
	• Refresher training for VNM
	• New supplies in PHC facilities
	  • ORT corners
	  • ORT salts and antibiotics now available in village emergency drug boxes.
	  • Weight scales
	  • Health education materials for pregnancy and/or family planning
	  • Case management protocols developed and/or distributed

11. Please describe the relationship between ACSP, USAID TO (DC), USAID (Albania). Be specific about means of collaboration, interaction, agreements/disagreements, ways forward.	
12. Please describe any present activities or future plans that represent "scaling up" of ACSP.	
13. Please describe any accomplishments of the ACSP related to building the capacity of civil society institutions or government institutions in Albania.	
14. **External Evaluator will use questions from USAID CSHGP MTE Guidelines Re:** a) program management (planning, staff training, supervision of program staff, human resources/staff management) b) financial management c) logistics	

d) information management e) technical and administrative support
Thank you for your participation.

DISTRICT **FORM J**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Family Planning Providers (Counselors) and Supervisors

Individuals Interviewed		
Name	**Title**	**Prefecture/District**
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Note that organizational titles, rather than names, will be used in the report.***		

1. Please discuss the added value that the ACSP has brought to your program or to your practice with respect to family planning.						
2. Please speak about the challenges that were encountered trying to get the family planning project activities implemented.						
3. Please describe the successes of the project as you see them, to date.						
4. What changes have you noted in availability of family planning supplies in this facility, since ACSP began?						
5. What steps have been taken by ACSP to affect availability of supplies?						
6. Are adequate supplies being maintained?						
7. What types of FP are offered through this SDP? **List all**	At service delivery points		At community level		At facility level	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
8. What NEW types of FP are offered through the SDP since the ACSP began? **List all NEW types.**						
9. What is your sense about the increase/decrease in FP from the community?						

10. Have FP providers received continued professional development?	***Ask: Increase or decrease in*** • use of any method • use of any modern method • use of SDM
11. **IF SDM is offered through this SDP** Please describe how you feel this method is being received by community members.	***Ask:*** • recent • of good quality • with supervision system
MTE Team Member: Please specifically look for and note presence or absence of the following:	***Ask:*** • How satisfied are community members with the method? • How many people out of every 100 select this method? • Why do you think people do not accept the method, or quit using the method? • Do you have any sense, or any information, about people who got pregnant while using the method (wanting NOT to get pregnant)?

Item		
Oral rehydration corner	**Present**	**Absent**
Cycle beads in FP clinic supply closet		
Cycle bead brochures		

FP counseling cards		
Cue cards (job aids)		
Any other materials with ACSP/UARC/AlbRC/UAID logo List specifically:		

DISTRICT `

FORM K

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE

Minimum of 5 Users of FP (SDM users to be included if they can be identified)

Individuals Interviewed					
Introduce the project and the interviewers….. ***Indicate the purpose of this interview*** ***Ensure that responses will be aggregated, and that no single individual will be identified***					
User #	**Years Married**	**Number of Children**	**Months/Years using SDM (if applicable)**	**Currently satisfied with the method**	
				Yes	**No**
1					
2					
3					
4					
5					
1. Is this the first time that you used a method of family planning that you needed to obtain from a clinic?					
2. Where did you obtain the information about the methods that were available to you?				***Probe for:*** • Family planning support groups • VHE or VNM • Facility information posters/brochures	
3. Did you receive enough information/counseling to make you feel comfortable about using the method?			**Yes**	**No**	
4. Would you share with us the type of method that you selected? ***Note to Interviewers: If method is SDM, please fill in the information at top of form, and proceed with the following questions. Otherwise, thank the individual for participation***					
5. What were your reasons for choosing SDM as a method compared to other methods?					
6. Did you receive enough information/counseling to make you feel comfortable that you know how to use the method?			**Yes**	**No**	
7. Do you use the Cycle Beads?			**Yes**	**No**	
8. **For clients who answer Yes to Question #6**					
8.a) How often do you move the band?					
8.b) Do you use another method to count the days of your cycle?			**Yes**	**No**	
8.c) On what days of your cycles should you abstain from sex or use another method?					
Thank you for your participation.					

DISTRICT **FORM L**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Albania Red Cross

Individuals Interviewed	
Name	**Title**
1. Please tell us what you know about the ARC CSP (or – "Please describe the nature of the relationship between the ACSP and the AlbRC personnel.").	
2. Please describe your role (if any) in the ARC CSP.	
3. Please describe the way that the AlbRC headquarters and the branch offices provide assistance to one another.	
4, Please discuss the added value that the ACSP has brought to the Albania Red Cross.	
5. Please speak about any challenges that you have encountered in maintaining a relationship between the ARC and the AlbRC.	
6. Please describe the successes of the CS project as you see them, to date.	
7. Have you received training in any skill as a direct result of participation with the ARC in the CSP (e.g. – probe for - financial management or organizational leadership, volunteer management system)? ***Please describe the training…***	
8. Please talk about sustainability of the project activities after the ACSP ends. What role will the AlbRC assume in keeping project activities in place? (Who? How? What?)	
9 Please describe any accomplishments of the ACSP related to building the capacity of civil society institutions or government institutions in Albania..	
Thank you for your participation.	

DISTRICT **FORM M**

ALBANIA CHILD SURVIVAL PROGRAM
MID-TERM EVALUATION

FOCUS GROUP INTERVIEW GUIDE
Family Planning Trainers (Tirana)
IMCI and C-IMCI Trainers (Field – note that IMCI was not done in Bulchize)

<table>
<tr><th colspan="7">Individuals Interviewed</th></tr>
<tr><th colspan="2">Name</th><th colspan="2">Title</th><th colspan="3">Prefecture/District</th></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="3"></td></tr>
<tr><td colspan="7">Introduce the project and the interviewers…..
Indicate the purpose of this interview
Note that organizational titles, rather than names, will be used in the report.</td></tr>
<tr><td colspan="7">1. Please describe the type of training that you received from the CSP.</td></tr>
<tr><td colspan="7">2. Please describe the successes of the project as you see them, to date.</td></tr>
<tr><td colspan="7">3. Please speak about the challenges that were encountered trying to get the family planning or IMCI project activities implemented, following your training.</td></tr>
<tr><td colspan="7">4. What changes have you noted in availability of family planning supplies in the district facilities, since ACSP began?</td></tr>
<tr><td colspan="7">5. What steps have been taken by ACSP to affect availability of supplies?</td></tr>
<tr><td rowspan="2">6. Are adequate supplies being maintained?</td><td colspan="2">At service delivery points</td><td colspan="2">At community level</td><td colspan="2">At facility level</td></tr>
<tr><td>Yes</td><td>No</td><td>Yes</td><td>No</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="7">7. What plans are being made by MOH to expand the training of trainers for FP or IMCI or C-IMCI, after the CSP ends?</td></tr>
<tr><td colspan="7">NOTE TO INTERVIEWERS: Ask about the district coverage. Is it clustered or distributed throughout? Are the individuals that are being recruited for training being drawn from the whole district or from a limited number of communities?</td></tr>
<tr><td colspan="7">Thank you for your participation.</td></tr>
</table>

Appendix D.a. Calendar of Field Activities

ACSP MTE

Day by day schedule of team activities in Diber Prefecture

#	Date	Diber		Bulqize		Mat	
		Location	Audience Form used	Location	Audience Form used	Location	Audience Form used
1	Jul-12	Arras	VHEs + VNMs (HC) - **D**	Shupeze	C-IMCI trainer - **M**	Burrel	Family Doctors –**H**
2		Kastriot	VHEs + VNMs (HC) - **D**	Gjorice	HC staff + FD - **H**	Burrel	FP providers (WCC+HC)*–**J**
3		Kastriot	FP service providers – **J**	Gjorice	Head of Commune – **C**	Komsi	Man beneficiaries - **B**
1	Jul-13	Peshkopi	Primary Health Care Dir.- **F**	Shupenze	VHE + VNMs (HC) - **D**	German	Project beneficiaries - **A**
2		Tomin	FP + SDM users – **K**	Dushaj	Project beneficiaries - **A**	Komsi	VHEs + VNMs (HC) - **D**
3		Tomin	Comm. leaders (HC[1] + VEs)– **C**	Bulqize	Public Health Care Dir.-**F**	Muzhake	Project beneficiaries - **A**
4		Tomin	IMCI trainer – **M**	Bulqize	FP service providers - **J**	Burrel	Primay Health Care Chief - **F**
5		Trepce	Man beneficiaries – **B**			Burrel	AlbRC representatives - **L**
1	Jul-14	Herbel	Women beneficiaries **– A**	Homesh	Women beneficiaries **– A**	Derjan	SDM users - **K**
2		Peshkopi	C-IMCI+ trainers (2 pers) – **M**	WCC	FP + SDM users – **K**	Ulez	FP users- **K**
3				Shup+Gjor	FP service providers - **J**	Baz	Head of commune – **C**
4				WCC	Health Providers - **H**	Baz+Ulez	VNMs (2 pers – individ.) – **H**
1	Jul – 15	Erebare	Women beneficiaries **– A**	Sopot	Women beneficiaries **– A**	Burrel	C-IMCI+ trainers (2 pers) – **M**
2		Maqellare	VHEs + VNMs (HC) **– D**	Zerqan	VHEs + VNMs (HC) - **D**	Burrel	IMCI+ trainers (2 pers) – **M**
3				Shupenze	Man beneficiaries – **B**	Burrel	Public Health Care Chief – **F**
4						Burrel	AlbRC representatives – **L**

* audience was composed from staff coming from WCC, 2 HC focal points, district based focal point.

Acronyms:

AlbRC: Albanian Red Cross **HC**: Health Centre **HC[1]**: Head of Commune

C-IMCI+: Community Integrated Management of Childhood Illness and Family Planning

FD: Family Doctors **FP**: Family Planning

VHE: Village Health Educators **VNM:** Village Nurse Midwives

WCC: Women's Counseling Center

Appendix D.b. Individuals Interviewed

Individual or Group Member	Title	Method of Interview		
		Individual	Group	Telephone
Washington DC-based project staff				
Bethany Weaver	Program Office for Europe/Eurasia	X		
Sujata Ram	Maternal Child Health Advisor (Technical Backstop)	X		
Alice Willard, Ph.D.	Sr. Technical Advisor, Monitoring & Evaluation	X		
Svafa H Ásgeirdóttir	Branch Director (Compliance Officer)	X		
Kevin D. Mitchell	Sr. International finance Analyst Finance/International Services	X		
Thomas Carmody	Sr. Advisor Organizational Development International Services	X		
Albania country-based project staff (Tirana)				
Fabien Cenko, MD, MPH	ACSP Program Manager	X		
Collin Elias	ARC Health Program Officer	X		
Amila Gjoni	ACSP Finance Office	X		
Ditila Doracaj	ACSP Monitoring & Evaluation Officer	X		
Albania country-based project staff (Diber Prefecture)				
Shkendie Kaba	ACSP Training Officer and AlbRC Branch Secretary – Diber	X		
Tueta	ACSP Office and Finance Manager – Diber	X		
Emira Elezi	ACSP District Health Coordinator – Diber	X		
Sanije Meta	ACSP District Health Coordinator – Bulqize	X		
Anduela Cama	ACSP District Health Coordinator – Diber	X		
ACSP Project Partner – Albanian Red Cross				
Zamir Muça	Secretary General	X		
Professor Shyqyri Subashi	President	X		
Ariana Deliana	Blood Coordinator Health Program	X		
Project consultant/others				
Gilbert Burnham, Ph.D.	Professor, Johns Hopkins University Bloomberg school of Public Health			X
Brenda Wolsey	Peace Corp volunteer	X		
USAID Albania				
Zhaneta Shatri	Health Specialist	X		
Ministry of Health (Country, Prefecture or District)				
Dr. Gani Korsita	Director of Primary Health Services	X		

	– Mat District			
Mustafa Shehu	District Health Director – Bulquize		X	
Bihone Sallaku	FP and Health Education Nurse – Bulquize District		X	
Arap Shehu	Secretary to District Health Director – Bulquize District		X	
Sabri Toska	Obstetrician – Bulquize		X	
Dritan Hajdari	Primary Health Care Director – Diber District	X		
NGO Representatives: Albania				
Manuela Murthi	Project Director Albania Family Planning Project JSI	X		
Gasmend Koduzi, MD	Training Officer Albania Family Planning Project JSI	X		
Dorina Tocaj	Health Promotion Officer URC	X		
Robert Carr	Program Coordinator UNICEF	X		
Project volunteers (VHT members, trainers)				
Title	**N of participants**	**Method of Interview**		
		Individual	**Group**	**Telephone**
Family planning trainer	1	X		
Community IMCI trainer	4		X	
Clinical IMCI trainers	2	X	X	
IMCI and C-IMCI national trainer	1		X	
Village Nurse Midwives	29		X	
Village Educators	35		X	
Hospital and Health Personnel – Diber, Bulquize, Mat Districts				
Family doctors – Mat District	2		X	
General practice physicians – Mat District	2		X	
Pediatrician – Mat District	1		X	
OB/GYN physician – Mat District	1		X	
Nurse Midwives – Bulquize District	8		X	
Nurses - Women's and Childrens Center – Bulquize District	5		X	
Epidemiologist: Primary Health Services – Mat District	1		X	
Family planning providers (counsellors) and supervisors				

FP focal point nurse – Mat District	1		X	
Nurse – Women's Consultancy Center – Mat District	3		X	
Nurse Midwives (FP providers at health center) – Mat District	3		X	
FP nurse providers – Diber District	10		X	
FP nurse supervisor – Diber District	1		X	
FP nurse providers – Bulquize District	4		X	
Family doctor – Diber District	1		X	
FP Provider (uncategorized) – Diber District	1		X	
Project community beneficiaries				
Mothers of children under age 2	14		X	
Women of reproductive age (15-49)	55		X	
Grandmothers	3		X	
Others (uncategorized)	2		X	
Male youth (12-18)	2		X	
Young men of reproductive age (18-59)	26		X	
Men age 60 +	3		X	
Standard Days Method Users	13		X	
FP users (methods other than SDM)	6		X	
Community Leaders				
Commune Head	3	X		
Commune Secretary	1	X		
Village elders	3			
Organizations represented at stakeholders presentation				
Albania Red Cross	3		X	
JSI/Albania Family Planning Program	2		X	
MoH Institute of Public Health	2		X	
MoH	2		X	
UNICEF	1		X	
URC	2		X	

Appendix E: Progress to target – indicators independent of KPC survey – Data from DIP
VNM=Village Nurse Midwife **VHE**= Village Health Educator
Yearly targets indicate the denominator used in calculation of annual or EOP target.

Indicator	**Year 1 target (#)**	**N (#)**	**% of Year 1 target**	**Year 2 target (#)**	**Accomplished**		**Year 3 target (#)**	**Accomplished**		**Baseline N or %**	**EOP target**		**% of EOP target**
					N (#)	**% of Year2 target**		**N (#)**	**% of Year 3 target**		**N (#)**	**%**	
Goal: Improved health status of women of reproductive age and children 0-59 months in Diber Prefecture													
% of **villages** with functioning C-IMCI+ teams that report data to project M&E system													
	0	0		76	73	96	124	118	95	0%		80	**95 %**
% of **village nurse midwives** in Diber Prefecture trained in IMCI													
	0	0		217	213	98	0	0		18%		75	**98%**
% of **VHEs** using job aids													
										0%		75	**Evidence of progress**
% of **village nurse midwives** using supervision checklists for VHEs													
	n/a	n/a		n/a	n/a		n/a	n/a		0%		75	**Removed from DIP**[1]
Number of **VNMs** trained in **FP**[2]													
	0	0		86	75	87	163	170	> 100	0%	245	100	**98%**
Number of **Providers in maternities**, commune health centers and antenatal clinics trained in selected essential actions for nutrition and micronutrients													
	0	0		60	0	0%	21	0	0	0%	81	100	**0%**[3]
Number of **VHEs** trained in C-IMCI+ to be teamed with facility-based providers to promote and support the nutrition and micronutrient intervention													
	n/a	n/a		n/a	n/a		n/a	n/a			30female 30 male		**0%**[3]
Monthly **growth monitoring and health promotion** sessions – focus on children 0-23 months													
	0	0		343 sessions	199	58[4]	1860 sessions	1,499	81	n/a	n/a	n/a	**on track**
Monthly **proactive home visiting** (no target established – as indicated)													
	0	0		n/a	220	n/a	n/a	1384	n/a	n/a	n/a	n/a	
Monthly **young child support groups**													
	0	0		343 sessions	450	>100	1,860 sessions	2,527	>100	n/a	n/a	n/a	**on track**
% of **village ambulances** with ORT corners installed and functioning													
	n/a	n/a		n/a	n/a		n/a	n/a	0	0%		50	**Removed from DIP**[1]
Number of **CYP** distributed by the program to the target population per annum[5]													

Indicator	Year 1 target (#)	N (#)	% of Year 1 target	Year 2 target (#)	Accomplished		Year 3 target (#)	Accomplished		Baseline N or %	EOP target		% of EOP target
					N (#)	% of Year2 target		N (#)	% of Year 3 target		N (#)	%	
	n/a			n/a	1,354		n/a	1,012[6]		N=287	1,500		**on track**
Number of **WRAs** who report being a "new user" of a modern method of FP per annum[5]													
	n/a			n/a	1,043		n/a	1,142[6]		N =1,099	3,500		**on track**
% of the **population** that lives within 5 km of a family planning SDP[7]													
	n/a	n/a		n/a	n/a		n/a	n/a		35%[8]		60[8]	**on task**
% of **MCH SDPs** in the target area offering FP services[7]													
	n/a			n/a	34	n/a		34		7.8%		20	**on track**
Monthly Family planning focus groups													
				343 sessions	324	94	1860 sessions	1932	103	n/a	n/a	n/a	**on track**
AlbRC has computerized volunteer database in place and operational at branch level										No	Yes		**In progress**
N of professional papers or peer-reviewed publications generated and disseminated by ACSP by EOP											4		**Not on target**
% of VNM that received at least 3 issues of (quarterly) project newsletter over the past 12 months										0%		80	**Activity deferred**

[1] Regarding the changes to the DIP section, please refer to relative rationales that have been incorporated in the MTE report.
[2] The target number of VNMs to be trained in FP has been reduced due to the training contribution given by JSI in the project area.
[3] This training activity has been postponed until year 4. VHEs will attend the same training with facility based health staff.
[4] The low performance in the year 2 is linked with a lack of baby weighing scales which are essential for growth monitoring and health promotion sessions.
[5] This indicator is not calculated based on project data, rather on data collected from the Logistic Management Information System (LMIS).
[6] The year 3 accomplished value represents only the first three quarters.
[7] ACSP is on track with the training of more then 80% of the VNMs in FP. ACSP is also partnering with MoH and its stakeholders to impact the regular supply of contraceptives in project area (the second essential requirement that defines the FP SDP).
[8] The baseline value of this indicator was overestimated during the DIP writing process. The current assessment suggests 35% as a baseline value. As a result, the EOP target was reduced to 60%. Please refer to the MTE report and Annex A for more rationale on this issue.

Appendix F Supervision system in place for Albania Child Survival Project

This document explains the supervisory outreach system for support of the Village Health Teams (VHTs) under the Albanian Child Survival Project (ACSP). It addresses the following questions:

1 What is the role of the CM (job description)?

2 How should the CM be selected and where from?

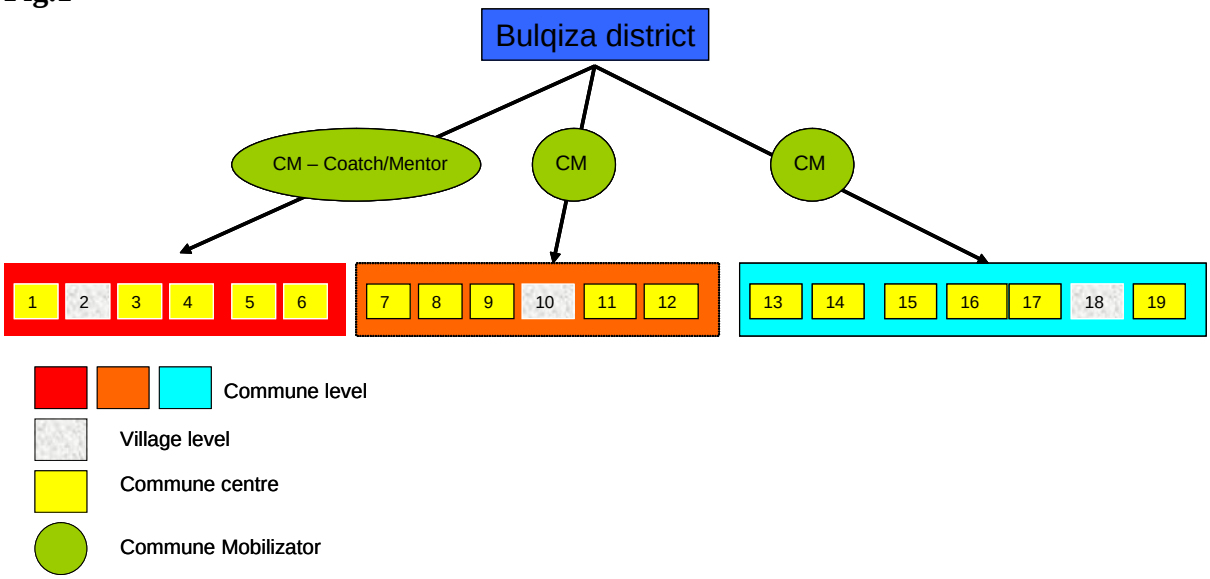
3 How much time will the CM have to dedicate?

4 What will be the incentives for the CM?

5 Logistic barriers for supervision system (CM, ACSP staff)?

The diagram (fig.1) below is taken as an example:

Fig.1



Background: The network of ACSP volunteers was established, and in order to achieve the community related outcome indicators the ACSP will have to complete following steps using a community participatory approach as mush as possible.

a. Information and advocacy of the project in the community and involvement of local stakeholders in this process.

b. Volunteer recruitment through a participatory approach in the community establishing a clear process of requirements, rights and responsibilities for each volunteer.

c. Volunteer training process to enable them to conduct future field activities through an easy and practical approach.

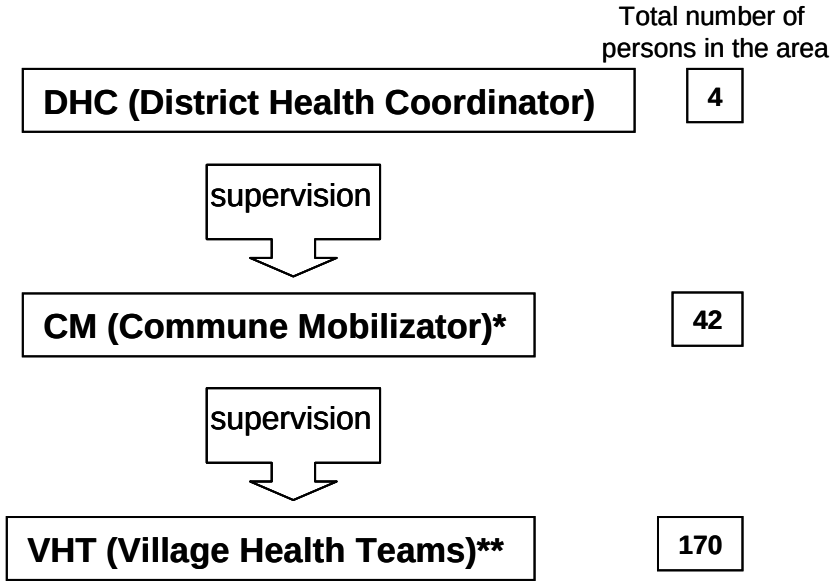
d. Volunteer network supervision which ensure their good performance in the field considering and addressing in time relative barriers especially those who relate to community attitudes.

e. Clear incentive system relying on AlbRC volunteer experience and other local organizations using volunteers.

f. Setting up a clear system to monitor the volunteer performance ensuring their management through defining clear responsibilities and positions (fig.2). The monitoring process from top to bottom considers the CM (commune mobilizators) as key components. However, this task should be addressed through simple a clearer tools for measuring the quality of the field activities organized from volunteers and barriers encountered to realize the positive impact in the community. The quality methodology used need "to feed" with data the adaptation process of the C-IMCI.

Fig. 2

Supervisory network in ACS Project area (Diber prefecture)



* # of CM is bigger then number of communes in project area (i.e communes with many villages might have more then one CM)

** VHTs are composed in average of 2 VHE and 1 VNM in every village the project is rolled out

1 What is the role of the CM (job description)?

Commune Mobilizor is a key person that has to ensure the *effective supervision/capacitation/evaluating impact* of VHT (village health teams) in the implementation of field activities proposed in the DIP (four high impact activities).
The information collected in regard to these activities, as part of the Monitoring and Evaluation system, might be split in *quantitative* and *qualitative* data as below:
The next two boxes show some simple questions that guide the staff on the development of the relative tools.

Quantitative data required through answering the following questions:

1. how many VHT members (VHE and VNM) are still involved in the field activities?
2. How often VHT members and community are met during the field activities?
3. # of participants in these field activities (from the community)?

The current Monthly Reporting Form can provide information in regard to the above questions 1 and 2.

Qualitative data required through answering the following questions:

1. How well VHT members are performing during the field activity
2. How much these field activities has succeeded in changing the BEHAVIOR of the community members (outcome indicator)

Question 1 should be addressed through a supervisory checklist use to describe the qualitative issues addressed during each field activity (like inviting the right people based on the topic to be discussed, ensuring real participatory approach during the discussions, addressing the technically correct messages to the community etc).
The question 2 might be addressed through small scale qualitative approaches like Doer/Non-Doer analyses to understand the barriers, identify and monitor specific activities.

2. How should the CM be selected and where from? (background, specifications)

It is recommended to have the CM selected from the VHT members; therefore CM can be either health personnel (VNM) or a volunteer community member (VHE). The table below shows specific positive aspects relative to the background of the CM being either a VNM or VHE.

Tab.1

#	CM as a VHE	CM as a VNM
1	When appropriately selected more efficient supervision	More sustainable (since that is part of their job)
2	Provide more community tailored information	Support the health structure supervisory system
3		More technical skills

General requirements for CM:

- Coming from the community
- Good replication
- Good practices
- Good communication skills
- Commitment & adequate free time

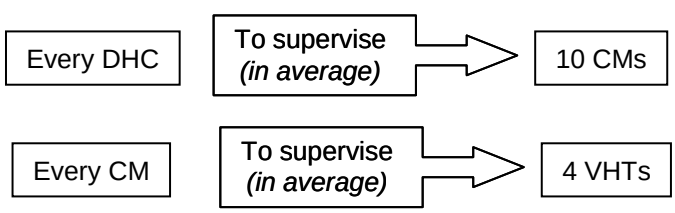
3. How much time will the CM and DHC have to dedicate?

The workload distribution will be approximately 4 VHTs to be supervised from each CM. This will ensure that time effort required will be feasible for the designed CM. In the same time the supervision frequency to each subsequent level will allow an appropriate and effective monitoring of field activities and collecting data to be able to keep on track with process indicators.

In other words the CM has to dedicate around 4 full days effort every month as shown in the diagram below (fig.3):

Fig.3

# of persons (workload) for every level in the supervisory system



4. What will be the incentives for the CM?

Incentives, as an important aspect of volunteer, will be addressed taking into consideration the experience gathered from the project implementation so far and relying on AlbRC practices.

The table below shows the incentives, target for each of them and the mechanism that might increaser retention and motivation/commitment of the VHT's members.

The incentive system for CM through trainings, update meetings, involvement in our supervisory schedule, will constitute in the same way the project's effort to ensure their capacitating for fitting in their responsibilities.

Tab.2

#	Activity	Frequency	Target audience	Incentives/benefits perceived from participants
1	5-days training on C-IMCI+	Once	VHT members (VHE&VNM&CM)	Knowledge , skills, per-diem,
2	2-days Refreshment on C-IMCI+	Once	VHT members (VHE&VNM&CM)	Knowledge , skills, per-diem,
3	2-days CM technical training	Every 3 months	CM	Per-diem, recognition' -
4	Periodic meetings	Every 4 months	VHT members (VHE&VNM&CM)	- per-diem, recognition; - Kits of FP methods, ORS packets; - IEC materials (cue cards) - Tee-shirt / cap
5	Other incentives (?)	Periodically	CM	- One phone card/mo; - 10 USD travel reimbursement/ mo; - bag with hand-outs

5. Logistic barriers for supervision system (CM, ACSP staff)?

The current map of VHTs (one er each village) has been rolled out in 90 villages split almost equally amongst Diber and Bulqiza district (respectively 50 and 40) and taking into consideration the average number of 3.5 members for each VHT mean around 300 volunteer out in the field. During the next 5 months the recruitment phase will end and there will be functioning around 170 VHTs in all three districts of the project area with a total number of around 600 VHE. This number has been reduced from the DIP mentioned reference as a result of an analyses with the project staff which can be summarized below:

a. Small villages in the remote areas will require more resources to get them involved in the C-IMCI+ approach. This would have been a barrier for the project staff to dedicate enough time to all areas in terms of supervision and monitoring.
b. The C-IMCI+ approach implies the recruitment of volunteers which fit in some simple but essential requirements for succeeding in the impact indicators in the community. If all villages would have been involved, then probably the project would not have been successful and not just due to the inappropriate approach used rather then quality of volunteer in some villages of the project area.
c. The number of volunteers recruited should allow their effective management; if more volunteers are enrolled, resources will not be enough for providing supervision and monitoring for all f them. Appropriate supervision is considered a key element for the succeeding of the positive behavior change aimed to realize in the community.

The Fig.2 shows how the workload has been determined amongst different levels in order to ensure effective and timely supervision is in place for the volunteer network. In addition, the logistic component, due to the low accessibility during cold months of the year and bad infrastructure, has been elaborated and as a result raising the need for an extra car in order to make feasible the monthly supervision schedule (see tab 3 for the summary of the logistic information)

Tab.3

#	District	Diber	Mat	Bulqize
1	# of communes (total)	**14**	**7**	**11**
2	# of communes (to be reached by ACSP)	**12**	**6**	**10**
3	# CM	**22**	**10**	**10**
4	# functioning VHTs (so far)	**50**	**0**	**40**
5	# functioning VHTs (till the end)	**90**	**40**	**40**
6	# DHC	**2**	**1**	**1**
7	# commune centers reached by private transportation*	**5**	**3**	**3**
8	# commune centers reached with ACS project vehicle*	**5**	**3**	**3**
9	Vehicle location	**Yes**	**No**	**Yes**
10	# of field visit with ACS project vehicle**	**15**	**9**	**9**
11	# field visit with private/own transportation/DHC	**10**	**3**	**3**

* The closest communes can be reached by private transportation while the most remote ones need the project vehicle

** Almost in all communes there are villages that cannot reached by DHC if not supported from the project's vehicle.

Appendix G VHE Performance Checklist

Supervision of the High Impact Activity

District _____ Comm. _____ Village _____
Date __/__/__ Name,Surname _____

Note: Use √ or **X** in the apposite box, according to your findings and the number of visit. Give additional explanations in the Comments.

GROWTH MONITORING AND PROMOTION SESSION

Use of Scale		**1**	**2**	**3**	**4**
1	Scale is set-up in a safe place				
2	Scale is set at volunteer's eye level				
3	Scale is set to zero				
Weighing of Child					
4	Weight of the child is read properly				
5	Age of child is calculated correctly				
6	Child weight and age is marked correctly on the growth chart				
7	Other information on card is completed properly				
8	Weight and nutrition status of child is clearly explained to mother				
9	Malnourished child is referred to the health provider				
Health Education Presentation					
10	Job aides (cue card, IEC materials) are used correctly				
11	Nutritional practices & counseling is done correctly				
12	Main messages are presented clearly to the target audience (simple words and language)				
13	Participatory techniques are used properly				
14	Does she demonstrate compassion for the participant ideas:				
a.	Listen attentively				
b.	Express appropriate feelings				
c.	Answer correctly questions/concerns of participants				
15	M&E form is complete at the end of the session				

How do you rate the overall performance of the VHE during this activity?

□ Bad □ Insufficient □ Satisfactory □ Good

YOUNG CHILD SUPPORT GROUP and FAMILY PLANNING SESSION

Health Education Presentation		**1**	**2**	**3**	**4**
1	Community participation is satisfactory (4-5 mothers, care-takers or WRA)				
2	Target group is chosen properly according to the type of activity				
3	Job aides (cue card, IEC materials, cycle beads, etc) are used correctly				
4	Topics discussed are chosen properly				

Appendix G VHE Performance Checklist

5	Main messages are presented clearly to the target audience (simple words and language)				
6	Participatory techniques are used properly				
7	Does she demonstrate compassion for the participant ideas:				
a.	Listen attentively				
b.	Express appropriate feelings				
c.	Answer correctly questions/concerns of participants				
8	M&E form is complete at the end of the session				

How do you rate the overall performance of the VHE during this activity?

□ Bad □ Insufficient □ Satisfactory □ Good

COMMENTS/ Suggestion for Improvements:

Appendix H Monitoring Visit Checklist

NOTE: T*o be completed by DHC in postraining period (for the first three months)*

1. District _____ Commune_____ Village _____ Date ____ /____ / _____

2. Place of meeting _____

3. Participants:

1. ____VNM _____
2. ____VHE _____
3. ____VHE _____
4. ____VHE _____
5. ____Other community members: ___ Mothers ___ Grandmothers ___ Husbands

4. Drop outs: □ Yes □ No Name/Surname _____

5. Monitoring forms are completed: □ Correctly □ Not correctly

(Note: See carefully how monitoring form is completed and explain it if neccessary)

6. Monitoring form collection system is working? □ Yes □ No

7. VHT is equipped with job aids for performing the high impact activities in the community:

□ Cue Card
□ Scale
□ Leaflets, brochures
□ Health book
□ Newletter
□ CycleBeads
□ Other _____

8. During visit, DHC followed one of high impact activities: □ Yes □ No

□ GM □ YCSG □ FPSG □ PHV

QUESTIONS FOR VHTs:

9. In your opinion, information received during C-IMCI training is sufficient to perform your activities in the community?

□ Yes □ No □ Do not know

10. In your opinion, the interest and participation of the community in your activities is:

□ Not good □ Good □ Very good

Reason(s) why: _____

11. Do you think the support from ACSP staff is:

□ Not sufficient □ Satisfied □ Need to be improved

Comment: _____

12.Which are problems/difficulties encountered during post-training period?

_____

_____

_____

13. How do you feel when you work with the community?

□ Not satisfied □ Satisfied □ Very satisfied

14. Successful story (if any):

Appendix I – Role description of the Community Health Specialist

Position Title:	Community Health Specialist (CHS), Albanian Child Survival Project
Reports To:	ACSP Manager / HPO
Location:	Burrel, Albania
Employment period:	1 year position with chance of renewal

Overview: The Albanian Child Survival Project is a community based project with the objective to increase the practice of key MCH and FP household behaviors. The project is being implemented in the Diber Prefecture by the American Red Cross and Albanian Red Cross.

Position Summary: Community Health Specialist Officer position is located in Burrel and work on the entire Diber prefecture. Provides backstopping support to the ACSP Manager in the areas of supervision, administration, reporting and work plan management. Works with the M&E Officer in the design and implementation of behaviour change community based activities to improve maternal and child health through increasing key safe household practices and increasing family planning practices. This position entails overall coordination & management of the community outreach system (Village Health Teams (VHT) and Commune Mobilizer's (CM) in collaboration with the AlbRC/ACSP staff located in Diber. CSH will play an important role on leading the implementation and management of all field related CM and VHT activities: trainings, supervision and monitoring of their progress. S\he will work together with District Health Coordinators in conducting ACSP community activities. S/he plays a key role in developing and implementing quantitative and qualitative assessments for monitoring program progress and identifying areas of improvement.

Major Responsibilities:

1. Work in partnership with the AlbRC staff in the Diber Prefecture in implementation of all ACSP activities.
2. Makes regular field visits (3 days/week) within Diber Prefecture to supervise project field activities (staff, VHTs and CMs).
3. Provides backstopping support in the field to ACSP Manager.
4. Supports District Health Supervisors and Communities in the selection of Community Mobilizers and Volunteer Heath Educators.
5. Train and support CM and VHTs to implement community health activities designed to improve MCH related behaviours.
6. Assesses program progress in increasing household behaviours and identifies appropriate solutions/activities to barriers encountered of activities.
7. Produce community newsletter designed to educate and motivate VHTs, and inform partners of program of activities.
8. Produces monthly reports detailing achievements towards planned activities and project objectives.
9. Work with key persons at the district health departments to ensure FP and C-IMCI+ activities are supported by and follow government health guidelines.
10. Identifies areas within the community outreach system needing improvement and develops strategies to strengthen them.

Appendix I – Role description of the Community Health Specialist

Scope: Collaborate with Training Officer, District Supervisor (3) exercising supervisory role on community oriented activities involving 170 Village Health Teams, including 44 Community Mobilizers and health provides. Assists ACSP Manager and M&E Officer in the development, implementation and monitoring of all behaviour change activities.

Key Qualifications:

- Academic degree in health-related field, Nurse with MPH preferred.
- At least 3 years of community health or social work experience with health education-related activities.
- Education related to maternal and child health, nutrition, and health prevention.
- Demonstrated experience in training, planning, management and supervisory skills
- Familiar with the health sector and ideally, have worked with Village Nurse Midwives
- Understand behaviour change approach to improving health.
- Willingness to live in Mat district and travel 2 days/week to the districts in Diber Prefecture.
- 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

Appendix J STANDARD DAYS METHOD KNOWLEDGE IMPROVEMENT TOOL (KIT)

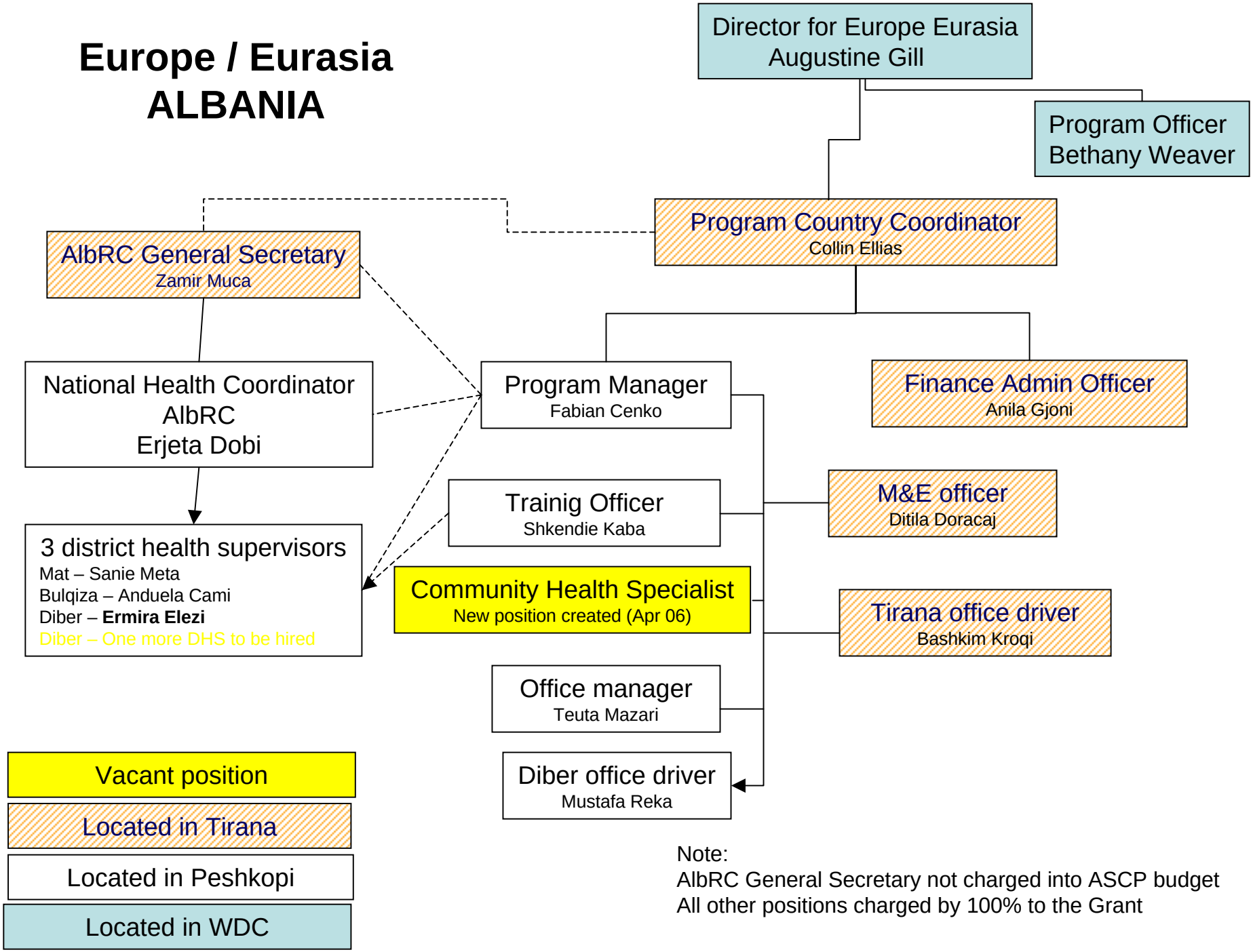
Instructions: Ask the provider the following questions. If s/he responds correctly, mark "1". If s/he does not respond correctly, mark "0" and explain the concept. For questions that were answered incorrectly, please reinforce the knowledge and ask these questions again during your next visit.

CycleBeads		VISIT No.			
		1	2	3	4
1.	What do CycleBeads represent?				
1.a.	• The menstrual cycle. Each bead is a day of the cycle.				
2.	What do the colors of the beads in the necklace represent?				
2.a.	• The red bead represents the first day of menstruation.				
2.b.	• The brown beads represent the infertile (safe) days.				
2.c.	• The white beads represent the fertile days.				
2.d.	• The dark brown bead helps the woman know if her cycle is too short to use the method.				
3.	When does the menstrual cycle begin and end?				
3a.	• The menstrual cycle begins on the first day of a woman's period and ends on the day before her next period begins.				
4.	Are all women's menstrual cycles the same length?				
4a.	• No, they may be different. Some cycles may last more days than others.				
User Instructions					
5.	Pretend that I would like to use the method. Explain to me how to use CycleBeads (Give the provider a set of CycleBeads to use in the demonstration).				
5.a.	• Move the ring to the red bead the first day of menstruation.				
5.b.	• Mark this day on your calendar.				
5.c.	• Move the ring every day to the next bead in the direction of the arrow.				
5.d.	• Move the ring at the same time every day.				
5.e.	• Avoid unprotected sex during the white bead (fertile) days.				
5.f.	• May have unprotected sex on brown bead (non-fertile) days.				
5.g.	• If period comes before dark brown bead, see provider.				
5.h.	• If period does not come the day after she reaches the last bead, see provider.				
6.	Should the user move the ring on the days she has her period?				
6.a.	• Yes, she should move the ring everyday.				
7.	What should the user do when her next period starts?				
7.a.	• Move the ring to the red bead, skipping over any remaining beads.				
7.b.	• Mark this day on her calendar.				
8.	What should the user do if her period comes after she has gone to sleep at night?				
8.a.	She should move the ring to the red bead when she gets up in the morning.				
9.	Should the user move the ring to the red bead when full flow of menstruation starts?				
9.a.	She should move the ring to the red bead as soon as she notices initial drops of blood, regardless of the flow.				
Eligibility Criteria					
10.	Who can use CycleBeads? (What are the criteria to use the Method?)				
10a.	• Women with cycles between 26 and 32 days.				
10b.	• Couples who think they can avoid unprotected sex on the days when the woman can get pregnant.				

11.	Can a woman begin to use CycleBeads if she does not know her cycle length?				
11a.	• Yes, if her period comes about once a month.				
11b.	• Yes, if her period comes when she expects it.				
Special Circumstances That May Affect Cycle Length					
12.	Can a woman who is postpartum or breastfeeding use the method? If so, under what circumstances?				
12a.	• If she has had at least four periods since her baby was born.				
12b	• If her last cycle was between 26 and 32 days long.				
13.	Can a woman who has discontinued use of the 3 month injection (Depo Provera) use CycleBeads? If so, under what circumstance?				
13a.	• Yes, if three months have passed since her last injection.				
13b.	• If her periods have returned.				
13c.	• If her last cycle was between 26 and 32 days long.				
14.	Can a woman who has recently used other hormonal contraceptives use CycleBeads?				
14a.	• Yes, if her cycles were between 26 and 32 days before using the hormonal method (pill, implant, one-month injection).				
15.	Can a woman who has discontinued use of the IUD use CycleBeads?				
15a.	• Yes, if her cycles were between 26 and 32 days while using the method.				
16.	Can a woman who has recently had a miscarriage or abortion use CycleBeads?				
16a.	• Yes, if her cycles were between 26 and 32 days long before becoming pregnant.				
16b.	• Once she has stopped any bleeding associated with the miscarriage or abortion and her period has returned to normal.				
16c.	• She can begin using CycleBeads at the start of her next period, and use another method in the meantime.				
17.	Can a woman who has recently used emergency contraception use CycleBeads?				
17a.	• Yes, if her cycles were between 26 and 32 days before using emergency contraception.				
17b.	• She can begin using CycleBeads at the start of her next period, and use another method in the meantime.				
Starting the Method					
18.	When can a woman who meets the eligibility criteria begin using the Method?				
18a.	• If she remembers the date of her last period she can begin using the method immediately.				
18b.	• If she does not remember the date of her last period she can begin using the method when her next period starts, but advise her she should avoid unprotected sex in the meantime.				
19.	Can a provider give a woman CycleBeads who meets the eligibility criteria but does not remember the first day of her last period?				
19a.	• Yes, immediately. She will begin using them the first day of her next period.				
20.	When should the user visit his/her provider for help?				
20a.	• If her period does not start by the day after moving the ring through the last brown bead, which means that her cycle is longer than 32 days long.				
20b.	• If her period comes before she is able to move the ring on the dark brown bead, which means that her cycle is shorter than 26 days long.				
20c.	• If the couple has any problems managing the white bead days or identifying her fertile days.				
20d.	• If the couple has unprotected sex on a white bead day.				

Follow-up Visit					
21.	What should the woman do if she can't remember whether or not she has moved the ring to the next bead?				
21a.	• Check her calendar and count how many days have gone by since the first day of her last period. Then count the same number of beads and place the ring on the correct day.				
22.	When should a follow-up visit be scheduled?				
22a.	• A follow-up visit should be scheduled based upon the instructions outlined in your program or institution. In cases where programs typically schedule a follow-up visit, it is usually after one month.				
23.	What should you check during the follow-up visit?				
23a.	• Her cycles are still between 26 and 32 days. (Check her calendar or ask the user if she has ever had her period before reaching the dark brown bead. Or if she has not had her period the day after completing the last bead.)				
23b.	• The couple knows how to use the CycleBeads correctly (the ring is on the correct bead and they know the meaning of the white and brown beads and what to do on those days).				
23c	• The couple wants to continue to use the CycleBeads.				
23d.	• The couple is able to avoid unprotected sex during the fertile (white bead) days.				
24.	When should the user switch to another method?				
24a.	• If she has more than one cycle out of the 26 to 32-day range more than once in a twelve month period.				
24b.	• If the couple cannot avoid unprotected sex during the fertile days.				
Couple Aspects					
25.	Should a couple with an STI or HIV/AIDS risk use CycleBeads?				
25a.	• No, they should use a condom every time they have sex.				
26.	What should a couple do to prevent pregnancy while using the Standard Days Method?				
26a.	• They should avoid unprotected sex during the white bead (fertile) days.				
27.	What should a couple do when the ring is on a white bead?				
27a.	• Avoid unprotected sex.				
28.	What should a couple do when the ring is on a brown bead?				
28a.	• They can have unprotected sex.				

Europe / Eurasia
ALBANIA



Note:
AlbRC General Secretary not charged into ASCP budget
All other positions charged by 100% to the Grant

Supervision of the High Impact Activity

District _____ Comm. _____ Village _____
Date __/__/__ Name,Surname _____

Note: Use √ or **X** in the apposite box, according to your findings and the number of visit. Give additional explanations in the Comments.

GROWTH MONITORING AND PROMOTION SESSION

Use of Scale		**1**	**2**	**3**	**4**
1	Scale is set-up in a safe place				
2	Scale is set at volunteer's eye level				
3	Scale is set to zero				
Weighing of Child					
4	Weight of the child is read properly				
5	Age of child is calculated correctly				
6	Child weight and age is marked correctly on the growth chart				
7	Other information on card is completed properly				
8	Weight and nutrition status of child is clearly explained to mother				
9	Malnourished child is referred to the health provider				
Health Education Presentation					
10	Job aides (cue card, IEC materials) are used correctly				
11	Nutritional practices & counseling is done correctly				
12	Main messages are presented clearly to the target audience (simple words and language)				
13	Participatory techniques are used properly				
14	Does she demonstrate compassion for the participant ideas:				
a.	Listen attentively				
b.	Express appropriate feelings				
c.	Answer correctly questions/concerns of participants				
15	M&E form is complete at the end of the session				

How do you rate the overall performance of the VHE during this activity?

□ Bad □ Insufficient □ Satisfactory □ Good

YOUNG CHILD SUPPORT GROUP and FAMILY PLANNING SESSION

Health Education Presentation		**1**	**2**	**3**	**4**
1	Community participation is satisfactory (4-5 mothers, care-takers or WRA)				
2	Target group is chosen properly according to the type of activity				
3	Job aides (cue card, IEC materials, cycle beads, etc) are used correctly				
4	Topics discussed are chosen properly				

5	Main messages are presented clearly to the target audience (simple words and language)				
6	Participatory techniques are used properly				
7	Does she demonstrate compassion for the participant ideas:				
a.	Listen attentively				
b.	Express appropriate feelings				
c.	Answer correctly questions/concerns of participants				
8	M&E form is complete at the end of the session				

How do you rate the overall performance of the VHE during this activity?

□ Bad □ Insufficient □ Satisfactory □ Good

COMMENTS/ Suggestion for Improvements:

Appendix M.a.

IMPROVING BEHAVIOR CHANGE COMMUNICATION:

RESULTS OF DOER/NON-DOER STUDY

Albania Child Survival Project
May 2006
- DRAFT-

Table of Contents

Acronyms

ACSP - Albanian Child Survival Project
AlbRC – Albanian Red Cross
AmRC – American Red Cross
ARI – Acute Respiratory Infections
BC – Behavior Change
BCC – Behavior Change Communication
CDD – Control of Diarrheal Diseases
EBF – Exclusive Breastfeeding
FP – Family Planning
IEC – Information, Education, Communication
IMCI – Integrated Management of Childhood Illness
KPC – Knowledge, Practices and Coverage
MTE – Mid Term Evaluation
ORS – Oral Rehydration Solution
VHE – Village Health Educator
VNM – Village Nurse Midwife
WRA – Women of Reproductive Age

Summary

The Albanian Child Survival Project (ACSP), a USAID funded project implemented by the American Red Cross (AmRC) in partnership with the Albanian Red Cross (AlbRC), is mobilizing communities to take responsibility for their own health, while improving access and quality of key services in the formal health system. The project goal is to improve the health status of women of reproductive age and children of 0-59 months.

In May, 2006, ACSP conducted a Doer/Non-Doer study in the target area to identify factors and characteristics of the target population relating to 5 behaviors the project is trying to improve to achieve its' goal. The behaviors are: (1) exclusive breastfeeding, 2) complementary feeding, 3) appropriate home treatment of diarrhea, 4) care seeking pattern for acute respiratory infection and 5) use of modern family planning method.

The five behaviors were selected based on recommendations from project village health team (VHT) members who work directly with the target population. Using a pre-determined list of behaviors, VHT members were asked to select the most important behaviors needing to be addressed for each program area (Nutrition, Control of Diarrheal Disease, Acute Respiratory Infection (ARI), and Family Planning). For each behavior, a questionnaire was developed by adapting previously existing questions designed to collect information on the following behavioral determinants: perceived consequences, self-efficacy, and social norms. For each behavior 30 Doers and 30 Non-Doers were targeted. During the data collection process the availability of Doers and Non-Doers ultimately determined how many were surveyed for each group. In some cases, the number is slightly above or below 30. Sites were selected based on the high number of women with children less than 2 years of age. For this study 33% of the sites were urban, and 67% of the sites were rural. For each behavior question(s) were developed and tested to identify Doers and Non-Doers.

Responses were tabulated using a coding sheet based on common responses. Results were analyzed comparing differences greater than 20-30% between Doers and Non-Doers. Key findings are:

Exclusive Breastfeeding. Differences between doers and non-doers for this behavior were found to be minimal. The most important determinant for non-doers to exclusively breastfeed their children was related to "insufficient" and "poor quality" breast milk. This may explain why a higher percentage of non-doer mothers stated "the child may not gain weight" as a disadvantage of exclusive breastfeeding. Another interesting finding is that approval of mother-in-laws of exclusive breastfeeding is more important for Non-Doers.

Complementary Feeding. A high percentage of both Doer and Non-Doer mothers knew that giving complementary foods to their children at 6 months helps them to develop better (54.8% and 51.4%, respectively). Doer mothers (23.3%) were more concerned with problems related to consumption of unsafe food compared with non-doer mothers (2.9%). This could indicate that they are more familiar with the behavior. The differences between Doers and Non-Doers in regards to approval by mother-in-laws (70% Doers vs. 43% Non-Doers) and husbands (43% Doers vs. 6% Non-Doers) for this practice were significant.

Appropriate Home Treatment of Diarrhea. Doers and Non-Doers (73% vs. 50% respectively) stated that ORS treatment "stops" and/or "improves diarrhea." However, only a third of

Doers and a fifth Non-Doers stated the value of ORS to replace lost fluids and salts. About half of Non-Doers (53%), in comparison with 17% of Doers, believed that ORS works to "improve vomit" and therefore have a misconception about the indication of ORS treatment. Two key determinants for mothers who stated giving ORS to their children every time they have diarrhea were "availability of ORS/Tresol" and "knowledge about preparation of ORS/Tresol." In addition, compared to Doers (0%), Non-Doers (27%) were likely to identify "lack of information" as a determinant for appropriate home treatment of diarrhea.

Care Seeking For Acute Respiratory Infection. Eighty two percent of interviewees (55 doers and non-doers vs. 67 of total interviewees) were well informed about the importance of healthcare seeking for purpose of "child would get better faster." However, 65% of Non-Doers, compared to 25% of Doers, believed that "health workers would not give appropriate care," suggesting lack of trust in health personnel by Non-Doers. More than half of doers (59%) and Non-Doers (52%) admitted that "support from husbands or other male family members" would make the behavior easier. Lack of knowledge and skills in recognizing danger signs were likely determinants for 31% of Non-Doers, compared to 5% of Doers.

Use of Modern Family Planning Methods. More than half of Doers and Non-Doers surveyed believed that contraceptives can prevent unwanted pregnancies. However, "side effects" from using contraceptives appears to be an issue. Also, 9% of Non-Doers stated that contraceptives are "safe" or "effective and easy to use" in comparison with 47% of Doers. A high number of Non-Doers compared to Doers stated women "can't get pregnant, once they stop contraceptives" (27.9% vs. 3.1% respectively). "Free of charge" and "easy to use" were stated as facilitating factors more often by Doers than Non-doers (59% vs. 17% and 38% vs. 12%, respectively). "Partner support or involvement" was found to be a facilitating factor for 29% of Non-Doers vs. 6% of Doers. More Doers appear to have other family members who are users of a family planning method than Non-Doers (44% vs. 19%, respectively.) Health personnel support was also more important for Doers than for Non-Doers (63% vs. 40%).

Based on the above findings there are many implications for strengthening project activities. The six most important ones are:

- Improve knowledge and reduce misconceptions regarding side effects of contraceptive use.
- Improve knowledge about benefits and appropriate use of ORS and improve mothers' skills in preparing it.
- Increase access and availability to modern contraceptives and ORS.
- Improve education activities to reduce mothers' belief that breast milk is not adequate for healthy weight gain, and that only in rare instances is the mother unable to breastfeed her child.
- When promoting complementary feeding practices target husbands and mother-in-laws to increase their approval for and support to mothers.
- During community outreach activities increase mother's trust in village health nurses by promoting the nurses' trainings and capacity in treating ARI and other illnesses.

I. Introduction

A. Child survival project in Diber Prefecture

The American Red Cross (AmRC) and Albanian Red Cross (AlbRC) are partnering to implement the Albania Child Survival Project (ACSP) in the three districts of Diber Prefecture: Diber, Bulqize, and Mat. Diber prefecture is an impoverished rural, mountainous area, located in northeastern Albania. The Districts are administratively organized into communes, which are aggregates of village communities. Diber District is the largest, with 14 communes; Bulqize has 7 communes, and Mat has 11. Since October 2003, the ACSP has been mobilizing communities to take responsibility for their own health, while improving access to and quality of key services in the formal health system. The project intervention areas are:

- Nutrition;
- Control of Diarrheal Disease (CDD);
- Acute Respiratory Infection (ARI); and
- Family Planning (FP)

The project applies three cross-cutting implementation strategies in the activities that are designed for each of the four project intervention areas:

- Capacity building to improve access, availability and quality of service
- Community mobilization to increase demand for, and use of, key services
- Tailored behavior change communication to improve key household behaviors and care-seeking practices

At the community level, health teams of trained AlbRC volunteers and village nurse/midwives (VMN) are carrying out the project interventions through implementation of four high-impact activities: community based growth monitoring and promotion, proactive home visiting, young child support groups, and family planning focus groups.

B. Rationale for conducting the "Doer/Non-Doer Study"

This study is an opportunity to measure the impact of current project activities, to identify obstructing factors to behavior change, decide on changes needed for project interventions, and to develop strategies to improve outcomes. The doer/non-doer tool is useful for improving behavior change strategies by identifying behavior determinants. A carefully crafted behavior change (BC) strategy is essential in aiding program beneficiaries to understand, appreciate, and apply new behaviors promoted by a health program. This qualitative study was conducted prior to the midterm evaluation (MTE) in order to serve as a monitoring tool to assess changes in behaviors to date and for program planning purposes. This study serves as an additional source of data to be used in the process following MTE. Five behaviors were assessed in this study: 1) exclusive breastfeeding, 2) complementary feeding, 3) appropriate home treatment of diarrhea, 4) care seeking pattern for acute respiratory infections and 5) family planning acceptance.

II. Study Methodology

A. Goal and Objectives

Goal:
To reinforce the behavior change strategies and activities in Diber prefecture communities regarding the ACPS interventions.

General Objective:
To increase the participation of the communities in ACSP activities by identifying behavioral determinants of the behaviors studied.

Specific Objectives:
1) Identify the advantages, disadvantages, facilitating factors and barriers, which support or bar groups from adopting a behavior.
2) Increase the capacity of the project staff to analyze and implement behavior change strategies.
3) Improve communication strategies through the identification of new communication channels.

B. Qualitative methods: Doer/Non-doer analysis tool

Doer/Non-doer analysis is a rapid assessment tool, which compares the responses of people who do the behavior (the doers) with those who do not (the non-doers) in order to identify the most important determinants. The seven steps in conducting Doer/Non-Doer analysis are:

1. Define behavior being promoted
2. Define "Doers" and "Non-Doers"
3. Adapt the following six questions:

> First, identify the doers and non-doers.
>
> 1. What are the advantages or good things, which happen if…[you adopt this behavior]?
> 2. What are the disadvantages or bad things, which happen if…?
>
> 3. What makes easier for you to…?
> 4. What makes more difficult for you to…?
>
> 5. Who would approve or support you if you…?
> 6. Who would disapprove or oppose if you...?

4. Collect responses in order to create a coding guide
5. Implement the study (include at least 20 doers and 20 non-doers)
6. Study the answers and
7. Investigate the differences

C. The choice of the behaviors studied

Five behaviors selected were identified by the community as particularly important and also difficult to encourage and instill in the community. In Appendix I you can find the form used to collect information.
The behaviors selected were the following:

1) Mothers of children 6-12 months exclusively breastfeed their child up to 6th month of age.
2) Mothers of children 6-12 months introduce complementary feeding (a variety of nutritious foods) to their children at the age of 6 months, along with breast milk.
3) Mothers of children 0-5 years old give their child oral rehydration solution (ORS) every time he/she has diarrhea.
4) Mothers of children 0-5 years old immediately seek health care for their child when the child has a fever/high temperature and/or fast/difficult breathing.
5) Women of reproductive age (18-49 years old), married or in a union, who are not pregnant AND wish to have another child after 2 years (or are unsure of when), OR don't want anymore children, use a modern contraceptive method to prevent unwanted pregnancies.

D. Data collection instrument

The data collection process was carried out through individual interviews. Each interview was conducted using a questionnaire focused on the five behaviours selected for this study. Each questionnaire contained six open-ended questions, which examine key, influencing factors that are advantages, disadvantages, facilitating, barriers, supporting and discouraging. There is also an initial screening question to identify doers from non-doers. After the questionnaires were developed for each behavior, study team members pre-tested the instruments. The purpose of the pre-test was to verify the adequacy and clarity of the questions for the interviewers as well as the interviewees, to become familiar with the tool, to verify the usefulness of the instructions prepared for each question and to explore the range of responses. Interviewing requires considerable skills on the part of interviewers. Immediately prior to the data collection a one-day refresher training on interviewing techniques was organized aiming to standardise questioning, record keeping, and probing in order to prevent the interviewers' bias from influencing the interviewees. Some of our study team members have completed previous training sessions and possess good knowledge and skills to competently do in-depth interviewing, note-taking and basic qualitative and quantitative data analysis.

E. Data collection sites and interviewees

The study sample included women of reproductive age (14-49 years old) in the three districts of Diber prefecture, from both urban and rural areas. The number of villages visited (10 in Diber, 8 in Bulqize and 5 in Mat district) was proportional to the number of births in the past five years, and also took into consideration the actual phase of when project implementation started in each of the districts. The villages selected were homogeneously distributed in each district. During data collection phase, each interviewing team visited one to two villages per day.
A total number of 60 people were interviewed for each behavior in order to get 30 Doers and 30 Non-Doers.
The distribution of doers and non-doers for each behavior and district is shown in the table below.

District	***Numbers of Doers/Non-Doers***	***Urban %*** (# of Doers/Non-doers)	***Rural %*** (# of Doers/Non-doers)
Diber	15 / 15 interviews	33% (5/5)	67% (10/10)
Bulqize	10 / 10 interviews	33% (3/3)	67% (7/7)
Mat	5 / 5 interviews	33% (1/1)	67% (4/4)
Total of Doers/Non-doers for 5 BEHAVIORS	150 / 150 interviews	45 / 45 interviews	105 / 105 interviews

At each site, the sample of interviewees, as recommended in this qualitative methodology, was selected using a *convenience sample*. Local contact persons, usually the VNMs, were informed of the criteria to use in choosing the interviewees. See Appendix II for the eligibility criteria of each behavior. The individual interviews were conducted in people's homes or gardens, in kindergartens or in health centers. Each interview was conducted in isolated spaces in order to avoid the interference of other family members and therefore, increase the accuracy of the responses.

F. Data collection and analysis

Data collection was carried out during a 4 –day period from May 23 to 27, 2006. The interviewers consisted of eight persons (5 of them were ACSP staff), divided into 4 teams. Two teams were assigned for Diber district, one for Bulqize and one for Mat. During each interview, one person had the role of facilitator/interviewer and the other of note taker. Two other persons were assigned to serve as supervisors for the four teams, observing the

interviews and assuring that each step of the study protocol was appropriately followed. See Appendix III for the checklist of supervision used.
Interviewers briefly explained the study objectives and obtained oral consent from each participant prior to the interview. Later the same day, the study teams met to discuss and verify the quality of the questionnaires completed. Data analysis was done after the data collection phase was carried out, followed by: finalising the coding guide; grouping the responses by categories; and tabulating the proportions of doers and non-doers answering each question in each category.

III. RESULTS

The most important differences between doers and non-doers are shown in the tables below (separated by behavior). Since the number of interviews done were approximately 30 for each group, “big” differences are considered differences of more than 30 percentage points where the confidence intervals do not overlap. However we still considered other differences if they corresponded to similar responses given from the mother relative to two or more different determinants.
See Appendix IV for the complete table of results.

Behavior 1: Mothers of children 6-12 months exclusively breastfeed their child up to 6 months of age.

Study Findings	No=37 % Doers	No=29 % Non-Doers
Disadvantages		
Child may not gain weight	**13.5**	**41.4**
More Difficult		
If mother hasn't enough and "good" milk	**27.0**	**62.1**
If mother has health problems (breast infection, other diseases) or is pregnant	**45.9**	**10.3**
Approves		
Mother-in-law	**35.1**	**62.1**
Disapproves		
No one	**62.2**	**34.5**

Behavior 2: Mothers of children 6-12 months introduce complementary feeding (variety of nutritious foods) to their child at the age of 6 months, along with breast milk.

Study Findings	No=31 % Doers	No=35 % Non-Doers
More Difficult		
Child experiences health problems from unsafe food	**23.3**	**2.9**
Approves		
Husband	**43.3**	**5.7**
Mother-in-law	**70.0**	**42.9**

Behavior 3: Mothers of children 0-5 years old give their child ORS every time he/she has diarrhea.

Study Findings	No=30 % Doers	No=30 % Non-Doers
Advantages		
Stops and improves diarrhea	**73.3**	**50.0**
Improves vomits	**16.7**	**53.3**
Easier		
If mother know how to prepare it	**56.7**	**13.3**
Information	**23.3**	**46.7**
More Difficult		
It is not easy to find ORS when you need it	**36.7**	**6.7**
Lack of information	**0.0**	**26.7**

Behavior 4: Mothers of children 0-5 years old immediately seek health care for their child when the child has fever/high temperature and/or fast/difficult breathing.

Study Findings	No=41 % Doers	No=26 % Non-Doers
Disadvantages		
Health workers would not give appropriate care (wrong treatment, overmedication, wrong diagnosis)	**25.0**	**65.4**
More Difficult		
Lack of knowledge of child danger signs	**4.9**	**30.8**
Disapproves		
No one	**78.0**	**46.2**

Behavior 5: Women of reproductive age (18-49 years old), married or in union, who are not pregnant AND wish to have another child after 2 years (or are unsure when), OR don't want anymore children, use a modern contraceptive method to prevent unwanted pregnancies.

Study Findings	No=32 % Doers	No=43 % Non-Doers
Advantages		
Safe, effective and easy to use	**46.9**	**9.3**
Disadvantages		
Can't get pregnant when you stop using contraceptives	**3.1**	**27.9**
Easier		
Available for free	**59.4**	**16.7**
Easy to use	**37.5**	**11.9**
Partner's support or involvement	**6.3**	**28.6**
More Difficult		
Inaccessibility (incl. unavailability)	**25.0**	**4.7**
Approves		
Health workers (doctors, VNMs, VHEs)	**62.5**	**39.5**
Relatives who are users of FP methods	**43.8**	**18.6**

Husband	**81.3**	**67.4**

IV. DISCUSSION

Knowledge and practice related to feeding and care of a sick child

1) Exclusive breastfeeding

According to the KPC survey results, 64% of women exclusively breastfeed their babies for 1 month, 45% for the first three months and 34% for the first 5 months. According to the information collected during Doer/Non-doer study, almost all of respondents (98%) breastfeed their babies in the first months of life. One important finding during the data collection process was the fact that in villages where ACSP community activities had started and village health teams (VHTs) are functioning well, like in Diber and Bulqize districts, it was easier to find Doers and more difficult to find Non-doers for this behavior. The opposite scenario was presented in other villages where project activities were not initiated (like in Mat district). However, almost half of doers (43.2%) said that breast milk is "the best milk for babies" but were not able to list some of the advantages of exclusive breastfeeding up to 6 months.
More than 60% of doers and non-doers know that breast milk "helps in better development of their children" and "protects them from illness".
Differences between doers and non-doers for this behavior were found to be minimal. The most common determinant for the non-doers to exclusively breastfeed their children was related to a perception of having "insufficient" and/or "poor quality" breast milk. This explains why a higher percentage of non-doer mothers stated that "the child may not gain weight" as a disadvantage to exclusive breastfeeding. The same percentages of doers and non-doers ((54.1% and 55.2% respectively) considered "having enough breast milk" a facilitating factor. In addition, compared to non-doers, doers were more likely to believe that any mothers' health problem, especially breast ones and a new pregnancy, may make it difficult to feed their babies only with breast milk during the first six months. The results show that approval of mothers-in-law of exclusive breastfeeding is more important for non-doer daughters-in-law than doer ones.

2) Introduction of complementary feeding

Results of the KPC survey have shown that 82% of all children aged 6 to 9 months receive semi-solid foods in addition to breast milk and 18% of all children begin receiving complementary food after 9 months of age. The grandmother approach study data are similar to the KPC results in that most mothers reported first introducing semi-solid foods at 6 months of age, though some began giving these foods earlier (at 3 months) and some introduce them later (up to 9 months). In our study, a good percentage of both doer and non-doer mothers knew that giving complementary foods to their children at 6 months helps them to develop better (54.8% and 51.4%, respectively) and the food is a good source of necessary vitamins (35.5% and 37.1%, respectively). The foods given to children complemented the breast milk; therefore "children feel satiated", "comfortable and sleep well". More than four-fifths of all mothers interviewed were aware of "side effects" of different foods when introducing them for the first time to their children. All mothers stated that factors which make it easier to adopt this new behavior mentioned information about the types of food to give, the appropriate amount and the acceptance rate of the children. Doer mothers (23.3%)

were more concerned of problems related to consumption of unsafe food compared with non-doer mothers (2.9%) and this could indicate that they are more familiar with the behavior. An important difference between doers and non-doers is which ones approve beginning with complementary food at 6 months. Mothers-in-law and husbands are great supporters of this practice for doer mothers. These findings are supported by the data collected during the grandmother study where mothers-in-law played an important role in advising the young mothers on when and what types of complementary foods should be introduced, especially when a woman has her first child.

3) Home treatment of diarrhea

Data collected during the KPC survey showed that in almost half of the cases, diarrhea was managed exclusively at home, without any referral to trained health workers, and only 16% of children 0-23 months of age were given some type of fluids or ORS. During the grandmother study, only a few women interviewees reported that ORS/Tresol is given. Results from the Doer-Non-doer study suggest that mothers' knowledge about the principles of ORS treatment consisted of "it stops and improves diarrhea". Less importance was given to the fact that "it replaces lost fluids" and salts (one in three doers and one in five non-doers reported that effect). Half of non-doers (53.3%), in comparison with 16.7% of doers, believed that ORS works to "improve vomit" and therefore have a misconception about ORS treatment, only in cases of diarrhea with vomiting. It appeared that mothers who used to give ORS to their children every time they had diarrhea could identify easily that "availability of ORS/Tresol" at the village level and "knowledge about preparation of ORS/Tresol" were the key pieces of knowledge for this behavior. In addition, compared to doers (0.0%), non-doers (26.7%) were likely to identify "lack of information" as a determinant for appropriate home treatment of diarrhea. Likewise, both doers and non-doers believe that children do not like the taste of rehydration salts (66.7% and 76.7%, respectively). The majority of interviewees (86.7% of doers and 73.3% of non-doers) recognize the role of health worker as an important supporter and adviser for home treatment of sick children.

4) Healthcare seeking for children with ARI

In Albania, where there is a long tradition of accessible health service, it is often assumed that all sick children are taken to health facilities. However, KPC results showed, only about half of child illness episodes are referred to health centers. The grandmother study found out that in almost all cases, childhood illnesses were initially diagnosed and treated at home and if the illness got worse or continued for more than 24 hours, the sick children were taken to a modern doctor. Our Doer/ Non-doer study showed that 82% of our interviewees (55 doers and non-doers vs. 67 of total interviewees) were well informed about the importance of seeking professional healthcare for the reason "child would get better faster". However, 65.4% of non-doers, compared to 25% of doers, believed that "health workers would not give appropriate care". This could suggest lack of trust in healthcare personnel by the non-doers. More than half of doers (58.5%) and non-doers (52.0%) admitted that "support from husbands or other male family members" would make the behavior easier, especially "when husbands were at home" (68.3% of doers and 65.4% of non-doers, respectively). Lack of knowledge and skills in recognizing danger signs was a likely determinant for 30.8% of non-doers, compared to 4.9% of doers. Since it appeared that "informed mother" (34.1% of doers) in the moment of a severe health crises directly seeks health care for her child without consent from others, it is hoped that once the mother is able to identify high risk signs she will respond in a timely

manner. The findings from the “who approve” section of this study confirmed the key role of mother-in-law (or grandmother) in illness management activities like diagnosing children’s health problems, advising referral to health care providers and accompanying sick children and mother to the doctor when husbands aren’t present. This was similar to what was found in the grandmother study.

5) Use of modern contraceptive methods

Results from the Flexible Fund Family Planning baseline survey showed that contraceptive prevalence for all modern methods in Diber prefecture is only 9% even though the contraceptive awareness level was high. The abortion rate was found to be high (over 300 per 1,000 live births in this survey). Most couples depended on non-modern traditional methods (periodic abstinence and especially withdrawal). In the Doer/Non-doer study more than half of the doer and non-doer women of reproductive age (WRA) believed that contraceptives can prevent unwanted pregnancies. “Side effects” when using contraceptive methods seemed to be one of the big issues. So, only 9% of non-doers believe contraceptives are “safe, effective and easy to use” in comparison with 46.9% of doers. The misconception that women “can’t get pregnant, while they stop them (contraceptives)” was found to be more prevalent among non-doers than doers (27.9% vs. 3.1%). Free of charge commodities and “easy to use” were stated as facilitating factors, and were recognized more by doers than non-doers (59.4% vs. 16.7% and 37.5% vs. 11.9%, respectively). Instead, “partner support or involvement” was found to be more important for 28.6% of non-doer women vs. 6.3% of doer women. Inaccessibility to commodities was a likely determinant of the use of modern contraceptive methods for the non-doers. Looking at differences between doers and non-doers regarding those who approve the behavior, it seemed that doer women have more family support, especially from husbands. Health personnel support was also more important for them than for non-doers (62.5% vs. 39.55%).

V. RECOMMENDATIONS / PROJECT IMPLICATIONS

Results from this study suggest the following project implications:

- Continue to promote the benefits of exclusive breastfeeding (EBF).
- Reinforce growth monitoring as a way of showing mothers that EBF produces healthy children and that mother's milk is of good quality and adequate, even during most illnesses.
- Reinforce starting complementary feeding at 6 months of age.
- Promote nutrient rich foods, especially those available in the home.
- Recognize the influential role of the mother–in-law and target her in the educational activities on EBF and complementary feeding
- Promote the proper effects of ORS/Tresol during diarrhea episodes.
- Promote demonstration sessions on how to prepare and administer ORS.
- Reinforce these promotions in the community of health workers trained recently in Integrated Management of Childhood Illness (IMCI).
- Reinforce knowledge and skills of mothers in recognizing child illness danger signs through training refreshers, development of leaflets, brochures or other IEC materials.
- Clarify potential key persons who discourage mothers in appropriate healthcare seeking behavior and target them during ACSP activities.
- Promote family planning services expansion in the project area in order to improve the access/availability of FP commodities.
- Develop precise key messages to address misconception about negative side-effects of contraceptive use.
- Develop specific FP activities targeting men. More emphasis should be put on improving dialogue between spouses and building negotiation skills of WRA.

APPENDIX I

Identifying Key Behaviors to Be Addressed

Questions

1. Based on your experiences which of the following behaviors are MOST people not doing? (read behaviors below and check off all that apply in column 1.)
2. Which behaviors do you think are the most important ones? (Ask her to rank 4 of them in order of most importance from 1-4.)

For physical growth and mental development

€ € Breastfeed children exclusively up to six months.
€ € Starting at about six months of age, feed children freshly prepared energy and nutrient rich complementary foods, while continuing to breastfeed up to two years or longer.
€ € Ensure that children receive adequate amounts of micronutrients (vitamin A and iron) through their diets.
€ € Use iodized salt for household consumption.

For disease prevention

€ € Dispose of feces, including children's feces, safely.
€ € Wash hands with soap after defecation, before preparing meals, and before feeding children

For appropriate home care

€ € Continue to feed and offer more fluids, including breast milk to children when they are sick.
€ € Give sick children appropriate home treatment for infections.

For seeking care

€ € Recognize when sick children need treatment outside the home and seek care from appropriate providers.
€ € Follow the health worker's advice about treatment, follow-up and referral.

APPENDIX II

CRITERIA for selecting the interviewees

Behavior 1: Exclusive breastfeeding

- Mothers with young children 6-12 months, AND
- Mothers who have regularly breastfed their child at least for the first week of his/her life.

Behavior 2: Complementary feeding

- Mothers with children 6 months up to 2 years old, AND
- Mothers who have regularly breastfed their child at least for the first week of his/her life.

Behavior 3: Appropriate home care

- Mothers with children 0-5 years old, AND
- Mothers whose children have experienced at least one episode of diarrhea (three or more watery stools on the same day) in the last 6 months.

Behavior 4: Health care seeking

- Mothers with children 0-5 years old, AND
- Mothers whose children have experience at least one episode of cold with fever and/or difficult, fast breathing, in the last 6 months.

Behavior 5: Family planning

- Women of reproductive age (18-49 years), married or in union, not currently pregnant, AND
- Women who wish to have another child after 2 years or more, or unsure when, AND
- Women who don’t want to have another child

APPENDIX III

AMERICAN AND ALBANIAN RED CROSS / ALBANIA
Direct Observation Interview Evaluation Form
For *Mothers with children 0-5 years old and WRA (women of reproductive age)*

BEHAVE Doer NonDoer Quality Study
May, 2006 Version
To be completed by Field Supervisors

Name of Supervisor:_____ Name of Interviewer: _____

District: _____ Village: _____

Date of Interview: _____/_May_/ 2006
Day Month Year

Instructions to Supervisors:

- The purpose of this form is two-fold: (1) to document the quality of the interviews, and (2) improve the Interviewer's performance in conducting the interview.
- Each day while you are out in the field, observe at least one interview for each Interviewer on your team.
- When the interview is complete, meet with the Interviewer in private. Discuss together the parts of the interview that went well, as well as what areas might be improved.

General Questions

		Yes	**No**
1.	Was the VNM[1] meet in the morning and appropriately explained the purpose of the study?.....	”	”
2.	Was the VNM asked to bring the team to the mothers who appropriately fit with the eligibility criteria?....		
3.	Was the requirement to interview the women separately, explained to the VNM?	”	”
4.	Was the person who answered the door of the residence greeted in a friendly manner?.....	”	”
5.	Was the Respondent selected according to the sampling protocol correctly?	”	”
6.	Was the Introduction and Informed Consent stated accurately?.....	”	”
7.	Did the Respondent consent to continue with the interview?.....	”	”
8.	Was the interview done separately with the woman, out of earshot of family members?….....	”	”
9.	Was the environment where the interview took place, calm and quiet?.....	”	”
10.	Did the Interviewer speak clearly and could the Interviewer be easily heard?.....	”	”
11.	Did the Interviewer address each question appropriately (referring to the recommendations given during the training)?	”	”
12.	Did the Interviewer probe in a neutral manner—not leading the Respondent to answer in one way or the other?	”	”
13.	Did the Interviewer explain questions when required (referring to the recommendations given during the training)?	”	”

[1] VNM – Village Nurse Midwife; health personnel serving in the sampled village

14. Was the Interviewer polite to the Respondent when asking for clarification? ..... ” ”
15. At the end of the interview, did the Interviewer thank the woman for her participation?..... ” ”
16. Use the space below for additional comments:

DESIRED BEHAVIOR: Mothers of children under two years old exclusively breastfeed their children up to 6 months of age.

Study Findings	No=37 Doers		No=29 Non-Doers	
Advantages	**No**	**%**	**No**	**%**
Child develops better (physical, mental, emotional, etc)	25	67.6%	18	62.1%
Child gains weight	3	8.1%	1	3.4%
Child feels satiated	3	8.1%	3	10.3%
Protects child from illnesses	26	70.3%	19	65.5%
Child likes it and seems happier	1	2.7%	2	6.9%
Breast milk is ready-to-use and doesn't need preparation; it's sterile and doesn't cost anything	11	29.7%	10	34.5%
Breast milk has all the necessary elements (vitamins, proteins, carbohydrates, ect) for the child	14	37.8%	9	31.0%
Breastfeeding protects mother's health	8	21.6%	5	17.2%
Mother feels comfortable and pleased	18	48.6%	11	37.9%
Mother says breast milk is the best for her child, it's mother's milk	16	43.2%	9	31.0%
Mother uses it as a family planning method	7	18.9%	3	10.3%
Creats a tight (emotional) relationship between mother and child	6	16.2%	7	24.1%
Do not know	0	0.0%	1	3.4%
Disadvantages	**No**	**%**	**No**	**%**
Child may not gain weight	5	13.5%	12	41.4%
Harmful for baby if mother is sick or pregnant	5	13.5%	1	3.4%
Mother feels tired	7	18.9%	8	27.6%
Takes time from work	2	5.4%	2	6.9%
Child may not eat other food after	1	2.7%	2	6.9%
Child feels uncomfortable	2	5.4%	5	17.2%
Aesthetic problems for mother (breast)	3	8.1%	1	3.4%
Nothing	22	59.5%	14	48.3%
Do not know	1	2.7%	0	0.0%
Easier	**No**	**%**	**No**	**%**
If mother has enough breast milk to satiate child	20	54.1%	16	55.2%
If mother has more time to breastfeed child on demand	13	35.1%	8	27.6%
If mother would be healthy and relaxed (not stressed)	10	27.0%	5	17.2%
If mother eat variety of good foods	6	16.2%	3	10.3%
If child likes breast milk	12	32.4%	5	17.2%
It's ready-to-use and doesn't cost anything	15	40.5%	7	24.1%
Information about breastfeeding	4	10.8%	0	0.0%
If family members help or support me	6	16.2%	6	20.7%
More Difficult	**No**	**%**	**No**	**%**
If mother hasn't enough" and "good" milk	10	27.0%	18	62.1%
If mother has health problems (breast infection, diseases, is pregnant)	17	45.9%	3	10.3%
If mother has work to do (in house or outside)	13	35.1%	8	27.6%
If child doesn't like it (and doesn't drink it)	3	8.1%	1	3.4%

APPENDIX M.b.

Research Findings

DESIRED BEHAVIOR: Mothers of children 6-12 months begin complementary feeding to their child, at 6 months, along with breast milk.

Study Findings	No=31		No=35	
	Doers		Non-Doers	
Advantages	**No**	**%**	**No**	**%**
Child gains weight	**9**	**29.0%**	**8**	**22.9%**
Child feels satiated	**12**	**38.7%**	**19**	**54.3%**
Child develops better (physically, mentally, emotionally, ect)	**17**	**54.8%**	**18**	**51.4%**
Takes all vitamins child needs	**11**	**35.5%**	**13**	**37.1%**
Improves child's digestive system	**3**	**9.7%**	**3**	**8.6%**
Child feels comfortable and sleeps well	**12**	**38.7%**	**18**	**51.4%**
Mother feels comfortable	**9**	**29.0%**	**6**	**17.1%**
It complements breast milk	**10**	**32.3%**	**6**	**17.1%**
Child doesn't get sick	**3**	**9.7%**	**5**	**14.3%**
Child gets used to eating all types of food	**1**	**3.2%**	**4**	**11.4%**
Mother knows complementary feeding is a good thing but can't explain them	**3**	**9.7%**	**0**	**0.0%**
Nothing	**0**	**0.0%**	**1**	**2.9%**
Disadvantages	**No**	**%**	**No**	**%**
Child might have side effects (abdominal pain, diarrhea, vomits, chokes, etc)	**28**	**90.3%**	**28**	**80.0%**
Child doesn't like it	**4**	**12.9%**	**4**	**11.4%**
Child may develop allergy to some foods	**6**	**19.4%**	**5**	**14.3%**
Child may have weight problems	**4**	**12.9%**	**2**	**5.7%**
Child doesn't feel comfortable	**3**	**9.7%**	**1**	**2.9%**
Consequences from food dose mistakes	**4**	**12.9%**	**6**	**17.1%**
Constipation	**3**	**9.7%**	**1**	**2.9%**
Child needs more care	**2**	**6.5%**	**3**	**8.6%**
Fear of weaning	**1**	**3.2%**	**6**	**17.1%**
Child might get sick frequently	**3**	**9.7%**	**6**	**17.1%**
Child's health problems from unsafe foods	**8**	**25.8%**	**9**	**25.7%**
Nothing	**5**	**16.1%**	**3**	**8.6%**

Do not know	1	3.2%	0	0.0%
Easier	**No**	**%**	**No**	**%**
If mother knows what foods and how much to give	8	25.8%	8	24.2%
If somebody helps her	13	41.9%	10	30.3%
Accessibility to fresh and a variety of foods	5	16.1%	4	12.1%
Child likes it (accepts it)	16	51.6%	17	51.5%
If mother has time to take care of child	10	32.3%	15	45.5%
If mother has more money to buy food	11	35.5%	18	54.5%
Education sessions by health workers	0	0.0%	3	9.1%
If mother recognizes child is growing healthy	5	16.1%	2	6.1%
Experience gained from other children	1	3.2%	1	3.0%
Nothing	0	0.0%	1	3.0%
More Difficult	**No**	**%**	**No**	**%**
If child doesn't accept the "new" food	17	56.7%	16	47.1%
Child health problems from unsafe food	7	23.3%	1	2.9%
Lack of money	6	20.0%	5	14.7%
Lack of time to prepare it	7	23.3%	8	23.5%
Work	4	13.3%	2	5.9%
Inaccessibility to a variety of foods	7	23.3%	4	11.8%
Laziness/neglect of mother	3	10.0%	4	11.8%
Lack of knowledge of appropriate foods for young child	3	10.0%	11	32.4%
Nothing	2	6.7%	3	8.8%
If mother is sick	1	3.3%	1	2.9%
Approves	**No**	**%**	**No**	**%**
Mother herself	11	36.7%	12	34.3%
Health workers	13	43.3%	16	45.7%
Husband	13	43.3%	2	5.7%
Mother-in-law	21	70.0%	15	42.9%
Parents	18	60.0%	21	60.0%
Mothers with experience	3	10.0%	4	11.4%
No one	0	0.0%	2	5.7%
Disapproves	**No**	**%**	**No**	**%**

Mother herself	1	3.3%	2	6.1%
Health workers	0	0.0%	2	6.1%
Husband	0	0.0%	3	9.1%
Mother-in-law	3	10.0%	4	12.1%
Mothers with experience	3	10.0%	4	12.1%
No one	21	70.0%	19	57.6%
Everyone	0	0.0%	1	3.0%

DESIRED BEHAVIOR: Mothers of children 0-5 years old give their children ORS every time they have diarrhea.

Study Findings	No=30 Doers		No=30 Non-Doers	
Advantages	**No**	**%**	**No**	**%**
Stops and improves diarrhea	**23**	**70.3%**	**15**	**50.0%**
Improves diarrhea	**7**	**23.3%**	**1**	**3.3%**
Improves vomiting	**5**	**16.7%**	**16**	**53.3%**
Improves general health status of the child	**23**	**76.7%**	**19**	**63.3%**
Replaces fluids and salts	**10**	**33.3%**	**6**	**20.0%**
Purges the body	**3**	**10.0%**	**4**	**13.3%**
Mother feels comfort	**3**	**10.0%**	**0**	**0.0%**
Child doesn't need medicines	**1**	**3.3%**	**2**	**6.7%**
Nothing	**1**	**3.3%**	**1**	**3.3%**
Do not know	**0**	**0.0%**	**2**	**6.7%**
Disadvantages	**No**	**%**	**No**	**%**
Child might vomit	**7**	**23.3%**	**5**	**16.7%**
Child doesn't get better	**2**	**6.7%**	**2**	**6.7%**
Harmful only in special circumstances (package expired, not stored in a safe place, dose is exceeded)	**5**	**16.7%**	**2**	**6.7%**
Child doesn't like ORS	**1**	**3.3%**	**3**	**10.0%**
Increases diarrhea	**0**	**0.0%**	**2**	**6.7%**
Nothing	**18**	**60.0%**	**12**	**40.0%**
Do not know	**0**	**0.0%**	**8**	**26.7%**
Easier	**No**	**%**	**No**	**%**
If it's easy to find it	**14**	**46.7%**	**10**	**33.3%**
If mother know how to prepare it	**17**	**56.7%**	**4**	**13.3%**
If child likes and drinks it	**15**	**50.0%**	**14**	**46.7%**
If mother has ORS package at home	**9**	**30.0%**	**8**	**26.7%**
If a pharmacy is nearby	**3**	**10.0%**	**2**	**6.7%**
Information	**7**	**23.3%**	**14**	**46.7%**
If a family member helps me	**3**	**10.0%**	**4**	**13.3%**

If mother knows that diarrhea will be improved	4	13.3%	6	20.0%
If mother has more time to dedicate to child	0	0.0%	3	10.0%
More Difficult	**No**	**%**	**No**	**%**
If child doesn’t like it (bad taste)	20	66.7%	23	76.7%
It is not easy to find ORS when you need it	11	36.7%	2	6.7%
If mother doesn't know how to prepare and give it	2	6.7%	7	23.3%
Lack of information	0	0.0%	8	26.7%
Mothers has too much work to do	1	3.3%	2	6.7%
Nothing	2	6.7%	1	3.3%
No person would help me (in finding or preparing and giving)	1	3.3%	2	6.7%
Mother doesn't believe ORS will stop diarrhea	0	0.0%	4	13.3%
No water at home	1	3.3%	0	0.0%
Approves	**No**	**%**	**No**	**%**
Health workers	26	86.7%	22	73.3%
Husband	8	26.7%	7	23.3%
Mothers with experience in using ORS	7	23.3%	7	23.3%
Mother herself	9	30.0%	7	23.3%
Informed persons (VHEs, teachers)	1	3.3%	1	3.3%
No one	0	0.0%	4	13.3%
Family members (mother and sister-in-law)	13	43.3%	13	43.3%
Disapproves	**No**	**%**	**No**	**%**
My mother	1	3.3%	1	3.3%
No one	21	70.0%	17	56.7%
Old people	3	10.0%	1	3.3%
Mother-in-law says to give the same things as she gave to her children	2	6.7%	4	13.3%
Mother herself, doesn't give ORS without the prescription by HW	0	0.0%	3	10.0%
Husband	1	3.3%	1	3.3%
Other family members	4	13.3%	4	13.3%

DESIRED BEHAVIOR: Mothers of children 0-5 years old immediately seek health care for their child when the child has fever/high temperature and/or fast/difficult breathing.

Study Findings	No=41		No=26	
	Doers		Non-Doers	
Advantages	**No**	**%**	**No**	**%**
Child would get better faster	**34**	**82.9%**	**21**	**80.8%**
Child can have appropriate care and treatment by health staff	**16**	**39.0%**	**12**	**46.2%**
No complications	**14**	**34.1%**	**11**	**42.3%**
Mother feels better (calms down)	**16**	**39.0%**	**6**	**23.1%**
Disadvantages	**No**	**%**	**No**	**%**
Health workers would not give appropriate care (wrong treatment, overmedication, wrong diagnosis)	**10**	**25.0%**	**17**	**65.4%**
Child might get worse (during the trip to health centre)	**6**	**15.0%**	**1**	**3.8%**
Takes time and money (for transportation and visit)	**3**	**7.5%**	**0**	**0.0%**
Nothing	**27**	**67.5%**	**12**	**46.2%**
Easier	**No**	**%**	**No**	**%**
If mother knows when to seek health care	**8**	**19.5%**	**5**	**20.0%**
If a health worker is always present in the health centre	**18**	**43.9%**	**10**	**40.0%**
If a health worker would come to my house	**6**	**14.6%**	**2**	**8.0%**
Husband (or other male family members) supports me (accompany mother to health centre)	**24**	**58.5%**	**13**	**52.0%**
If an equipped health centre is closer	**19**	**46.3%**	**12**	**48.0%**
If there are means of transportation and good road condition	**14**	**34.1%**	**7**	**28.0%**
A certain economic level	**3**	**7.3%**	**4**	**16.0%**
If child is visited by a specialized health worker that mother trusts	**3**	**7.3%**	**4**	**16.0%**
If mother doesn't need to pay for the visit and drugs	**1**	**2.4%**	**0**	**0.0%**
More Difficult	**No**	**%**	**No**	**%**
Lack of means of transportation and communication	**14**	**34.1%**	**5**	**19.2%**
Insufficient well trained health workers near home	**18**	**43.9%**	**8**	**30.8%**
Lack of knowledge of child danger signs	**2**	**4.9%**	**8**	**30.8%**

If no family member is available to accompany mother to health centre	7	17.1%	2	7.7%
Lack of time	3	7.3%	1	3.8%
Long distance to health centre	6	14.6%	4	15.4%
Lack of money for the taxi and/or to pay the doctor	9	22.0%	8	30.8%
Old family members say the child will get better at home	2	4.9%	3	11.5%
If no one can take care of my other children	1	2.4%	2	7.7%
Nothing	9	22.0%	1	3.8%
Approves	**No**	**%**	**No**	**%**
My husband, when he is at home	28	68.3%	17	65.4%
My mother-in-law	24	58.5%	12	46.2%
Mothers with young children	10	24.4%	11	42.3%
Male family members	25	61.0%	11	42.3%
Mother herself	14	34.1%	3	11.5%
Health workers (doctors, VNMs, CHW)	8	19.5%	2	7.7%
		0.0%		0.0%
Disapproves	**No**	**%**	**No**	**%**
Mother-in-law, who care more of home garden that my children	2	4.9%	2	7.7%
Mother herself	2	4.9%	4	15.4%
No one	32	78.0%	12	46.2%
Uninformed family members	1	2.4%	3	11.5%
Old family members	4	9.8%	3	11.5%
Husband says we have no money	1	2.4%	1	3.8%

DESIRED BEHAVIOR: Women of reproductive age (18-49 years old), married or in a union, who are not pregnant and wish to have another child after 2 years (or are unsure when), or don't want another child use a modern contraceptive method to avoid unwanted pregnancies.

Study Findings	No=32		No=43	
	Doers		Non-Doers	
Advantages	**No**	**%**	**No**	**%**
Prevents unwanted pregnancies	**24**	**75.0%**	**23**	**53.5%**
Protects against STIs	**8**	**25.0%**	**4**	**9.3%**
Protects woman's health	**12**	**37.5%**	**15**	**34.9%**
Safe, effective and easy to use	**15**	**46.9%**	**4**	**9.3%**
Helps to plan my births (when, how many)	**6**	**18.8%**	**14**	**32.6%**
Protects my child's health	**9**	**28.1%**	**9**	**20.9%**
Improves the relationship with husband (partner)	**2**	**6.3%**	**0**	**0.0%**
Woman feels safe and comfortable	**12**	**37.5%**	**11**	**25.6%**
Helps having free and satisfying sex with husband	**4**	**12.5%**	**5**	**11.6%**
My partner feels satisfied	**2**	**6.3%**	**4**	**9.3%**
Nothing	**0**	**0.0%**	**4**	**9.3%**
Disadvantages	**No**	**%**	**No**	**%**
Physical and mental side effects	**22**	**68.8%**	**37**	**86.0%**
Causes infection	**2**	**6.3%**	**6**	**14.0%**
Harmful for woman's health	**4**	**12.5%**	**12**	**27.9%**
Causes diseases (breast disease, cancer)	**5**	**15.6%**	**8**	**18.6%**
No safe for preventing pregnancies	**5**	**15.6%**	**2**	**4.7%**
Hard to use them correctly	**0**	**0.0%**	**2**	**4.7%**
Can't get pregnant when you stop them	**1**	**3.1%**	**12**	**27.9%**
Against religion	**0**	**0.0%**	**1**	**2.3%**
Harmful for my breastfeeding child	**0**	**0.0%**	**2**	**4.7%**
Do not know	**3**	**9.4%**	**1**	**2.3%**
Nothing	**8**	**25.0%**	**4**	**9.3%**
Easier	**No**	**%**	**No**	**%**
Available for free	**19**	**59.4%**	**7**	**16.7%**

Easy to use	12	37.5%	5	11.9%
Good understanding between partners	9	28.1%	4	9.5%
Information (from different sources: HW, mass media, ect)	16	50.0%	19	45.2%
If it's a safe and sure method	5	15.6%	12	28.6%
Confidentiality	2	6.3%	0	0.0%
Confidence in the method	4	12.5%	5	11.9%
Partner's support or involvement	2	6.3%	12	28.6%
Religion approval	0	0.0%	1	2.4%
If woman needs it	0	0.0%	6	14.3%
More Difficult	**No**	**%**	**No**	**%**
Inaccessibility (incl. unavailability)	8	25.0%	2	4.7%
Cost	6	18.8%	3	7.0%
Stigma (feels ashamed)	3	9.4%	1	2.3%
My partner says no	7	21.9%	13	30.2%
Distrust (unsure to any method)	3	9.4%	12	27.9%
Not easy to use	7	21.9%	7	16.3%
No factor	4	12.5%	0	0.0%
Lack of information	2	6.3%	6	14.0%
Fears of harmful effects	7	21.9%	16	37.2%
Against my religious belief	1	3.1%	1	2.3%
Desires a baby boy	0	0.0%	1	2.3%
		0.0%		0.0%
Approves	**No**	**%**	**No**	**%**
Health workers (doctors, VNMs, VHEs)	20	62.5%	17	39.5%
Relatives who are users of FP methods	14	43.8%	8	18.6%
Mothers and mothers-in-law	1	3.1%	3	7.0%
Friends	4	12.5%	7	16.3%
Woman herself	10	31.3%	8	18.6%
Husband	26	81.3%	29	67.4%
No one	0	0.0%	3	7.0%
Do not know	0	0.0%	1	2.3%
Disapproves	**No**	**%**	**No**	**%**

Health workers (doctors, VNMs, VHEs)	**2**	**6.3%**	**1**	**2.3%**
Parents	**12**	**37.5%**	**13**	**30.2%**
Friends, ex users of FP method	**9**	**28.1%**	**4**	**9.3%**
Woman herself	**0**	**0.0%**	**7**	**16.3%**
Husband	**4**	**12.5%**	**15**	**34.9%**
No one	**10**	**31.3%**	**12**	**27.9%**

Child Survival and Health Grants Program Project Summary

Oct-30-2006

American Red Cross, International Services (Albania)

General Project Information:

Cooperative Agreement Number: GHS-A-00-03-00007-00
Project Grant Cycle: 19
Project Dates: (9/30/2003 - 9/29/2008)
Project Type: Entry/New Partner

ARC Headquarters Technical Backstop: Patricia David
Field Program Manager: Fabian Cenko
Midterm Evaluator: Judith Fullerton
Final Evaluator:
USAID Mission Contact:

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Funding Information:

USAID Funding:(US $): $1,099,679 **PVO match:(US $)** $1,391,638

Project Information:

Description:

The Albania Child Survival Project – implemented jointly from American and Albanian Red Cross and in cooperation with Ministry of Health – is mobilizing the communities to take responsibilities fir their own health, while increasing access and quality of key services in the formal health system. The community mobilization, through volunteer recruitments and field activities which aim to increase the knowledge and practices of key household behaviors, will bridge the critical gap between community needs and health system services. There are three cross-cutting implementation strategies that will be applied to all technical interventions: 1) capacity building to improve access, availability, and quality of services; 2) community mobilization to increase demand for, and use of, key services; and 3) tailored behavior change communication to improve key household behaviors and care-seeking practices. These strategies are combined with four high impact community activities: 1) community based growth monitoring and promotion; 2) pro-active home visiting; 3) young child support groups; and 4) family planning focus groups.

Location:

Diber Prefecture, northeast Albania, comprising all three districts of Diber, Bulqiza and Mat, and covering all three towns and 279 villages.

Project Partners	Partner Type	Subgrant Amount
Albanian Red Cross	Subgrantee	$248,623.00
Subgrant Total		$248,623.00

General Strategies Planned:

Advocacy on Health Policy

M&E Assessment Strategies:

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

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

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

Interventions/Program Components:

Nutrition (15 %)

(IMCI Integration)
(CHW Training)
(HF Training)

- Comp. Feed. from 6 mos.
- Cont. BF up to 24 mos.
- Growth Monitoring
- Maternal Nutrition

Micronutrients (5 %)

(CHW Training)
(HF Training)

- Iodized Salt
- Iron Folate in Pregnancy

Pneumonia Case Management (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)

- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling

Control of Diarrheal Diseases (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)

- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

Breastfeeding (10 %)

(IMCI Integration)
(CHW Training)
(HF Training)

- Promote Excl. BF to 6 Months
- Intro. or promotion of LAM
- Support baby friendly hospital

Family Planning (30 %)

(IMCI Integration)
(CHW Training)
(HF Training)

- Knowledge/Interest
- FP Logistics
- Male Reproductive Health
- Youth FP Promotion
- Maternal/Neonatal Integration
- Community Involvment
- Access to Methods
- Policy

Target Beneficiaries:

Infants < 12 months:	**3,760**
Children 12-23 months:	**3,714**
Children 24-59 months:	**12,476**
Children 0-59 Months	**19,950**
Women 15-49 years:	**55,417**
Population of Target Area:	**221,669**

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months whose births were attended by skilled health personnel	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**0**	**0**	**0.0%**	**0.0**
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	**0**	**0**	**0.0%**	**0.0**
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 12-23 months who received a measles vaccine	**0**	**0**	**0.0%**	**0.0**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**0**	**0**	**0.0%**	**0.0**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**0**	**0**	**0.0%**	**0.0**
Percentage of mothers of				

children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**0**	**0**	**0.0%**	**0.0**

Comments for Rapid Catch Indicators

The percents for each indicator in the above table are based upon unweighted population figures. The percents in the DIP were weighted according to population size across the three districts. The difference between weighted and unweighted percents is not significant (less then 1.8% difference).

Sub Form 1: Project Identification

Grantee Project List
Flex Fund Home

American Red Cross

ARC (Albania)

General Information

Funding Mechanism:	CSHGP / USAID
USAID Washington Funding:	$329,903
USAID Mission Funding:	
ARC Match Funding:	
Cooperative Agreement No:	GHS-A-00-03-00007-00"
Project Start/End Dates:	(Oct 1, 2003 - Sep 30, 2008)
Project Name:	Diber Prefecture Child Survival Project

Project Description:

The Albania Child Survival Project (ACSP) is a five year USAID-funded project to improve the health status of women of reproductive age (WRA) and children 0-59 months old in Diber Prefecture in the north of the country. Diber Prefecture has a population of over 220,000 and is composed of three districts - Mat, Bulqize, and Diber. Seventy five percent of the population is rural and 31% are WRA.

Contraceptive prevalence is known to be low and the abortion rate high. One recent nationwide estimate put the abortion rate at 1 per 2.5 live births. ACSP is being implemented by Albania Red Cross (AlbRC) with financial and technical assistance from the American

Region:	Diber
District:	Diber, Mat, Bulqize Districts

Geographic Subareas <Help>

(Does this project collect, monitor and report on Flex Fund indicators for different *geographic* project subareas ?)

If this is true, click *Yes* and enter each distinct subarea name: If this is false, click *No*.	◉ Yes ○ No
Subarea Name Listing:	***Click Box Next to Name to Remove Subarea***
Diber	☐
Mat	☐
Bulqize	☐
Click Plus Icon to add New Subarea -->	+

Save and Continue

American Red Cross International Services (Alban

Diber Prefecture Child Survival Project

Sub Form 2: Project Contacts

Key Stakeholder Contacts

Grantee HQ Technical Backstop:	Sujata Ram
Grantee HQ Financial Backstop:	Grantee Contact List
Grantee Regional Contact:	Grantee Regional Contact List
Funding Mechanism Contact:	Susan Youll
USAID Mission Contact:	Zhaneta Shatri (SO 3.2 Health Team Leader)
USAID Washington Representative:	Virginia Lamprecht

Primary Field Contact

First name:	Collin
Last name:	Elias
Title:	ARC Field Representative/Health Delegate
Telephone:	355 4 379 025
Fax:	355 4 379 026
Email:	arcelias@albmail.com

Alternate Field Contact

First name:	Fabian
Last name:	Cenko
Title:	ACSP Program Manager
Telephone:	355 4 379 025
Fax:	355 4 379 026
Email:	arccenko@albmail.com

Partner Information:

Name	Type	$ Allocated	Remove
Albania Red Cross	Subgrantee	$73705	☐
JSI	Collaborating	$0.00	☐
URC	Collaborating	$0.00	☐

Click Plus Icon to add additional Partner --» +

Save and Continue

American Red Cross International Services (Albania)

Diber Prefecture Child Survival Project

Sub Form 3: Project Beneficiaries

Grantee
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Programmatic Area A: Adults

Type	Age Range	Diber	Mat	Bulqize
WRA	15-49	24,193	18,222	13,001
Married WRA	15-49			
Men	15-59	30,000	22,596	16,121

Programmatic Area B: Youth

Type	Age Range	Diber	Mat	Bulqize
Female Youth	10-14			
Female Youth	15-19			
Female Youth	20-24			
Male Youth	10-14			
Male Youth	15-19			
Male Youth	20-24			

Population of Target Area

	Diber	Mat	Bulqize
Population of Target Area:	96,774	72,890	52,005

Comments

American Red Cross International Services (Albania)

Diber Prefecture Child Survival Project

Grantee Project List

Flex Fund Home

Sub Form 4: Project Focus Areas

Key Technical Focus Areas	Contraceptive Methods Distributed
☐ Youth	☐ Female Sterilization
☑ Behavior Change Communication (BCC)	☐ Male Sterilization
☐ Community-based distribution (CBD)	☑ Pills
☐ Health Facilities	☑ IUD
☑ Integration	☑ Injectables
☐ Integration HIV/AIDS	☐ Implants
☐ Contraceptive logistics	☑ Male Condom
☐ Cost Recovery	☐ Female Condom
☐ Social Marketing	☐ Diaphragm
☐ Female Genital Cutting	☐ Foam/Jelly
☐ Post Abortion Care	☑ Lactational Amenorrhea
☐ Gender	☑ Standard Days Method
	☐ Fertility Awareness Methods (Non SDM)

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American Red Cross International Services (Albania)

Diber Prefecture Child Survival Project

Sub Form 5: Data Entry of Core Indicators

Project Data Phase: *Annual Report 3 Core Indicators (2006)* *More Information*

Core Indicator	Geographic Sub Area	Number	Numerator	Denominator	Percent (Auto-Calc)	Confidence Interval (Auto-Calc)	Yes/No
KR1. Couple Years of Protection (CYPs)	Bulqize						
	Diber						
	Mat						
KR2. Number of Acceptors New to Contraception	Bulqize						
	Diber						
	Mat						
R2.1. Percent of Clients who Receive Adequate Counseling	Bulqize						
	Diber						
	Mat						
R2.2. Percent of Facilities Offering 3 or More Modern FP	Bulqize						
	Diber						
	Mat						

Methods							
R3.1. Percent of Population Living Within 5 km of a FP Service Delivery Point	Bulqize						
	Diber						
	Mat						
R3.2. Percent of Facilities Reporting No Stockouts in the last quarter	Bulqize						
	Diber						
	Mat						
R4.1. Program Sustainability Plan in Place	Bulqize						☐
	Diber						☐
	Mat						☐

Comments

N/A for Midterm Evaluation

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