Albania- Reducing malnutrition in children

Spanish MDG Achievement Fund for Children, Nutrition and Food Security
A Government of Albania programme implemented by the United Nations and financed by the Government of Spain

One UN Outcome:

Increased use of integrated quality basic services in health, education and protection delivered in an efficient, transparent, accountable and equitable manner

Programme Duration: 3 years Anticipated start/end dates: Jan 2010 – Dec 2012 Fund Management Option(s): pass-through Managing or Administrative Agent: UNDP(administrative agent)	Total estimated budget: **$4,000,000** Sources of budget: • UNDP/Spain MDG-F

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List of Acronyms

AFSS	Agriculture and Food Sector Strategy
AWP	Annual Work Plans
C-IMCI	Community-Integrated Management of Childhood Illnesses
CMR	Child Mortality Ratio
CSO	Civil Society Organization
CPU	Child Protection units
CRU	Child Rights units
DHS	Demographic Health Survey
EU	European Union
FAO	Food and Agriculture Organization
FNAP	Food and Nutrition Action Plan
GDP	Gross Domestic Production
GoA	Government of Albania
HFA	Height for Age
HH	Household
HQ	Head Quarters
IBFAN	Infant breast feeding
INSTAT	National Institute of Statistics
IDA	Iodine/Iron deficiency
IEC/BCC	Information Education Communication/Behavioral change communication
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Ratio
IPH	Institute of Public Health
IYCF	Infant and young child feeding
JP	Joint Programme
LBW	Low Birth Weight
LSMS	Living Standards Measurement Survey
M&E	Monitoring and Evaluation
MDG	Millenium Development Goals
MICS	Multiple Indicator Cluster Survey
MAFCP	Ministry of Agriculture, Food and Consumer Protection
MoH	Ministry of Health
NGO	Non-governmental Organization
NSDI	National Strategy for Development and Integration
PHC	Primary Health Care
PSC	Project Steering Committee
PRSP	Poverty reduction strategy paper
SD	Standard Deviation
UN	United Nations
UNDAF	United Nations Development Framework
UNICEF	United Nations Children Fund
UNRCO	United Nations Resident Coordinator Office
USAID	United Stated Agency for International Aid
WFA	Weight for Age
WFH	Weight for Height
WHO	World Health Organization

2. Executive Summary

The goal of the Joint Programme on Nutrition is to prevent and address malnutrition and food insecurity in Albania among high risk child population groups, through strengthening national policy development and enhancing technical capacity at national and local levels.

Poverty is a root cause, but not the only cause of hunger, malnutrition and food insecurity. Social inequity, lack of education inadequate health services, and inadequate knowledge and skills in basic food and nutrition practices are important factors directly affecting nutritional status. Investments in each of these areas are critical to breaking the cycle of poverty and malnutrition. The strategies and interventions of this programme recognize that poverty, hunger, poor health, lack of education, and social and economic discrimination are closely interconnected. They must be addressed in concert if sustainable improvements in the health and wellbeing of the poor are to be achieved.

The programme brings a nutrition focus to the ongoing results-based support by WHO, UNICEF and FAO for the achievement of the MDGs. It adds a food and gender perspective to the work on health sector policy, improvement of basic health services and protection of the most marginalized and vulnerable groups, The Joint Programme is aligned with the One UN programme in Albania as it contributes to more transparent and accountable governance, more effective national policies, and quality public services. It promotes progress particularly towards MDG1 (eradication of poverty and halving malnutrition), MDG4 (reducing child mortality) and MDG5 (improving maternal health).

The Joint Programme links to several strategies and goals of the National Strategy for Development and Integration (NSDI). It directly supports Strategic Priority 3 of the NSDI which is rapid, balanced and sustainable economic, social and human development, which also aims to reduce the infant mortality rate to 5 per 100,000 live births by 2013.

Three main outcomes of the Joint Programme address mother and child malnutrition at national and local levels: a) Strengthened national capacities to incorporate nutritional objectives into sectoral polices and programmes; b) Cross sectoral interventions addressing malnutrition are developed, tested and implemented in target areas; c) National capacities strengthened to provide nutrition services to the public.

The Joint Programme will be implemented by the Ministry of Health, Ministry of Agriculture, INSTAT, specialized institutions, regional authorities, and civil society organizations, with support from UNICEF, WHO, and FAO. The Ministry of Health will be responsible for overall achievement of the programme objectives and coordination of its implementation with the Ministry of Agriculture and other key stakeholders.

Participating institutions and organizations aim to ameliorate malnutrition in high–risk rural and peri-urban communities through successful multi-sectoral interventions. This will include the development of national policies and building of partnerships. The programme will systematically strengthen capacities mainly of health personnel, frontline health workers, and food and agriculture experts working on household food security. Rigorous monitoring of processes, outcomes and results will inform policy development and action.

The interventions will take place in five districts of Northern Albania (in Kukes and Shkodra Prefectures) and in 2 peri-urban municipalities of Tirana. These areas are severely affected by child malnutrition (especially stunting), have large numbers of Roma population, and are either poor (rural) or have high rates of unemployment (urban). The selected areas in Northern Albania are already receiving support from the One UN programme, are featured in the thematic window on Youth Employment and Migration of the UNDP-Spain MDG Achievement Fund, and are the target of the WHO programme on Maternal and Child Health supported by Spanish government. This offers opportunities for linkages and synergies, including the work conducted by UNIFEM on gender.

3. Situation Analysis

The Government of Albania (GoA) and its prefecture, district and municipal administrations need assistance to ameliorate malnutrition in infants, children and women[1]. Under nutrition[2] in infants and young children is a key underlying determinant not only of infant and child mortality, but also of permanent physical and mental disability at very young age. When children are undernourished before their 2nd birthday, they can suffer irreversible cognitive and physical damage, thus affecting their prospects for future health, welfare and economic wellbeing. The consequences continue into adulthood, they accumulate to lower economic productivity and poor social development, and are passed on by the affected communities to the next generation as undernourished girls and women have children of their own. Undernourished pregnant women are at higher risk of miscarriage or delivering a newborn with low birth weight (LBW).

Albania has enjoyed a high economic growth rate during the recent decade. Gross domestic product (GDP) growth averaged almost 7% per year during 1992-2006; 46 percent of GDP was derived from services, 21 percent from agriculture and 23 percent from industry and construction[3]. Likewise, since 2000, the reduction of poverty measured by household expenditure has been impressive (Albania Poverty Assessment 2007). Despite the significant overall reduction in the number of poor or extremely poor households, the prevalence of infant and young child malnutrition, especially stunting, in Albania remains alarmingly high (Table 1).

But Albania remains among the poorer countries in Europe. In 2005, by World Bank estimates, 18.5 percent of the people in Albania were poor and 3.5 percent were extremely poor. The robust aggregate economic growth also masks sizable contrasts in income and consumption between urban and rural areas, and between resource-rich and poor sections in society[4]. Poverty and extreme poverty affects predominantly the rural areas, and larger, less educated families, as well as peri-urban communities with high unemployment rates. An analysis in 2004

[1] In January-February 2008, The Lancet published a series of extensive reviews by international experts on the prevalence and impact of maternal and child malnutrition in the world as well as the evidence-based interventions that, if adopted at scale, could significantly reduce the problem. The interventions in this proposal incorporate the recommendations of this series, available at http://www.thelancet.com/collections/series/undernutrition (Accessed 16 October 2008)

[2] Malnutrition in children may take different forms, one of which is over-nutrition leading to obesity. This proposal is focused on the more life-threatening form in resource-poor families, namely under nutrition, which encompasses stunting, wasting and deficiencies of essential vitamins and minerals, collectively referred to as micronutrients. Stunting and wasting are measurable by child anthropometry, as was done in the MICS. Children who are too short are classified as *stunted* and those who have too low weight as *wasted.* Stunting reflects usually a failure of adequate feeding over a long time period, often combined with recurrent or chronic illness. Wasting usually results from recent nutritional deficiency.

[3] Ministry of Agriculture, Food and Consumer Protection. Albanian Agriculture in Figures 2007

[4] World Bank. Albania: Urban growth, migration and poverty reduction. A poverty assessment. June 19, 2007.

of poverty and income inequality measures in Albania[5] notes that the districts in the mountainous north and northeast fare worst.

Further in-depth analysis by UNICEF[6] and the World Bank (Albania Poverty Assessment 2007) gives strong evidence of the multiple dimensions and the disproportionate impact of household poverty on children. The overall gains in poverty reduction for children do not always match those experienced by adults and elderly people and are not spread evenly between younger and older children, or between households of different sizes. The very presence of children can push a household into income poverty. Household poverty has further influence on the enrollment rate in secondary schools: in urban areas 60 percent of children in the poorest fifth of the households were enrolled, while this was 40 percent of the poorest fifth in rural areas, and this affects especially girls. The analysis of child poverty suggests that a "pro-poor" policy response should be accompanied by improvements in safety nets and public transfers for households with children.

Albania has one of the highest infant mortality rates (IMR) in Europe. Infant deaths are more than three times higher than the target set by the European Union, with an IMR of 18 deaths per 1,000 compared to a target of 5.4. Both the IMR and the child mortality rate (CMR) (i.e. the probability of dying before the 5th birthday) are strongly related to the mother's education level and household wealth. The CMR in the lower 20% poorest Albanian households (26 per 1,000) is four times as high as in the richest quintile (6 per 1,000) according to the Multiple Indicator Cluster Survey (MICS) carried out by the National Institute of Statistics with UNICEF support in 2005. A nutrition study conducted by an intersectoral working group (Ministry of Health, Ministry of Agriculture, private sector) and a UNICEF consultant during January – March 2009, using standard epidemiological procedures suggests that one-fifth to one-quarter of the mortality of infants and young children in Albania is attributable to their suboptimal nutritional status. Poor nutrition can lead to reduced immunity, impaired physical and mental development and reduced productivity.

The maternal mortality rate in Albania is difficult to estimate in view of the small population size, the low crude birth rate and the incomplete demographic registration. Nevertheless, given the state of obstetrical services in Albania, a Health Sector Note by the World Bank in 2006 has concluded that the survival of expectant mothers in Albania compares relatively unfavorably with many other countries in the region[7]. The mother's nutritional status has an impact both on the delivery (anemia as a predisposing factor for poor obstetric outcome) as well as on the growth of her child.

Similar as in other countries in Europe, Albania experiences a combination of rising over-nutrition, especially among urban privileged groups whose increasing consumption of refined foods is paired with lower physical activity, and residual under-nutrition among pregnant women, infants and children especially in remote areas with significant food and livelihood insecurity. The double burden of malnutrition is clearly indicated by the presence of stunting at 22.3% and overweight among 20% of children under five, as measured by the 2005 MICS. Stunting among under-five year-old children is second highest of all the countries in the WHO European region.

[5] INSTAT & UNICEF. The situation of children and young people at the regional level in Albania. UNICEF Innocenti Research Center, November 2004
[6] UNICEF Innocenti Social Monitor 2006. Understanding Child Poverty in South-Eastern Europe and the Commonwealth of Independent States. UNICEF Innocenti Research Center, 2006
[7] World Bank. Albania Health Sector Note. February 2006. http://go.worldbank.org/8H4RQ2DPM0 (Accessed 27 October 2008)

Moreover, the growth failure of infants in Albania occurs exceptionally early in life. More than one in five newborn babies is already growth-stunted before reaching six months of age.

Table 1: Malnutrition in children aged 0 - 59 months, Albania 2005 (MICS data)

	Underweight (%) (WFA<-2SD)	**Stunting (%)** (HFA<-2SD)	**Wasting (%)** (WFH<-2SD)	**Obesity (%)** (WFH>+2SD)
Residence				
Urban areas	4.9	22.6	4.8	24.1
Rural areas	9.0	22.1	7.5	18.1
Age				
Below 6 months	7.7	22.7	7.3	20.8
6 – 11 months	9.0	22.7	5.8	19.6
12 - 23 months	7.4	19.5	6.5	16.3
24 - 35 months	8.5	21.6	5.3	17.4
36 - 47 months	5.9	24.6	6.6	19.6
48 - 59 months	7.6	22.5	7.5	25.5
Household wealth				
20% poorest	12.9	30.1	5.3	18.7
Second	9.2	22.9	12.1	16.4
20% middle	8.0	24.1	2.4	20.9
Fourth	3.2	18.4	6.4	26.5
20% richest	3.0	13.9	5.9	18.5

Surveys suggest that stunting is being" passed on" by parents to their newborns for an inter-generational effect. This does not mean that stunting among infants and young children is inevitable and cannot be addressed. On the contrary, young children have the capacity to "catch up" with normal growth around their 2nd birthday.

Table 2: Risk ratios of malnutrition by household wealth index, Albania 2005 (MICS data)*

	Underweight (%) (WFA<-2SD)	**Stunting (%)** (HFA<-2SD)	**Wasting (%)** (WFH<-2SD)	**Obesity (%)** (WFH>+2SD)
Household wealth				
10% most poor	1.81	1.33	1.71	0.80
20% poorest	1.74	1.32	2.46	0.81
20% middle	1.00	1.00	1.00	1.00
20% wealthiest	0.37	0.61	2.21	0.94
10% most wealthiest	0.38	0.66	2.62	0.88

* The risk of malnutrition is set 1.00 for children in the 20% mid wealthiest households

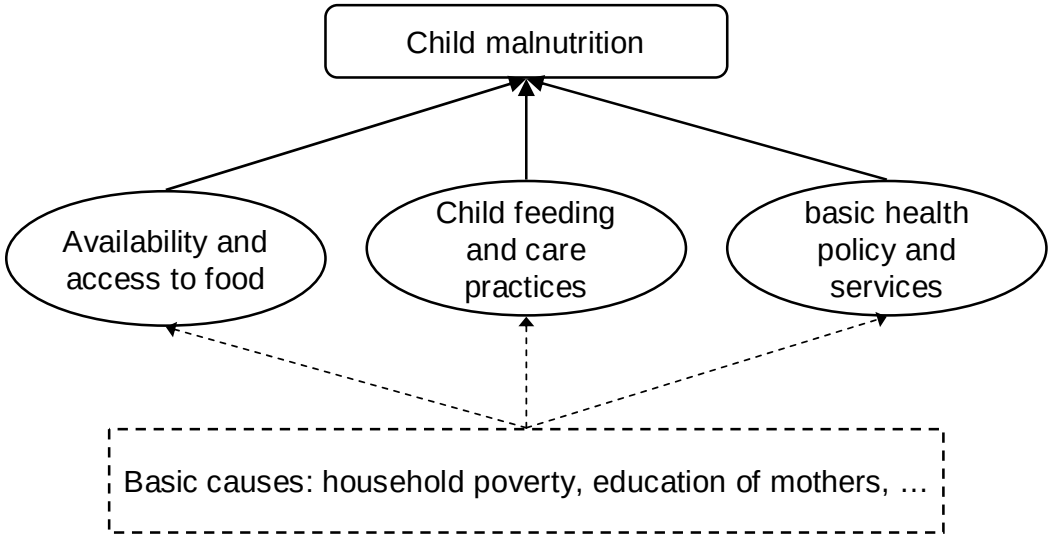
Like for underweight, the relationship of stunting with poverty is striking. MICS data show that the under-fives in the poorest 10% of households run twice the risk of stunting than those in the 10% wealthiest households (Table 2). Also the high wasting prevalence among under-five-year olds, at 6.6% overall, is a concern. Wasting affects rural more than urban children and, as is the case with stunting, wasting already occurs very early in life. Finally, also obesity (overweight) is elevated. Almost one quarter of the under-fives in the urban centers of Albania is overweight. Contrary to underweight and stunting, however, obesity does not show a clear relationship with household poverty or wealth. Stunting and wasting among children in Albania, therefore, are

predominant in the poor, resource constrained rural families and the unemployed urban families, while the problem of obesity is more sizable in urban areas.

A population-representative iodine deficiency survey in the fall of 2006 (Assessment of Iodine Deficiency Status among Albanian Children and Pregnant Women 2006) showed that notwithstanding the sizable progress in Albania toward success of the universal salt iodization strategy, the median urinary iodine concentrations in school-age children and pregnant women remain below required standards. Enforcement of a law approved by Parliament was stepped up in 2008 to ensure that all salt for human nutrition (consumer salt, food industry salt and salt used in livestock feeding) is iodized.

A study conducted in 2000 among a small sample of preschool children in Lezha district showed high prevalence of iron deficiency anemia. To assess the prevalence of anemia disaggregated at prefecture level, the Demographic Health Survey (which commenced in November 2008) has conducted hemoglobin measurements of children and women and findings from this survey will inform the joint programme. The prevalence of deficiencies of other micronutrients is unknown but xerophthalmia (consequence of Vitamin A deficiency) or rickets (consequence of Vitamin D deficiency) are not considered to be frequent.

As confirmed by the inter-sectoral nutrition study (January-March 2009, mentioned above), food availability, health status and child care and feeding practices are the three contributing causal factors for infant and young child malnutrition. Underlying to the lack of food access and low utilization of health care services are household poverty and poor educational status of mothers.



Food production: Agriculture is the main occupation of Albania's rural population and its most important source of income. The agricultural production and agro-processing sector contributes approx one-fifth to the national economy and employs more than half of the active labor force. Recently, the average growth of agricultural production has been 3 to 3.5 percent per year, thus lagging behind the overall national economic growth. This is due to small and fragmented land holdings, poor irrigation and drainage systems, low levels of technology, limited market access, and poor business connections with agribusinesses at the end of the supply chain.

Because of Albania's efforts to accede to the European Community, the first National Food and Nutrition Action Plan 2003 – 2008 (FNAP) was oriented mainly on the policy, strategy and actions to improve food safety, thus contributing in the growing trend[8] in food export to nearby EU countries. The share of the crop and livestock production that enters the domestic and foreign markets remains low at 28-30%. It however illustrates the potential of increased farm family earnings by the stimulation of agricultural production. Of the approximately 2,100 current food processing enterprises, 46% are in the bread and flour sector, followed by the dairy industry at 18%. The food processing industry employs more than 10,000 workers, largely in small and very small enterprises. In addition to the production of fruits, olives and grapes (viniculture) and livestock products, the Agriculture and Food Strategy 2007 – 2013 prioritizes industrial processing of fruit and vegetables, grapes, milk and meat. The agriculture and food sector is of key importance not only for raising rural incomes but also for urban employment and earning potential.

Albania's food balance sheet[9] shows that the dietary energy supply per person in 2000-2002 was 2,880kcal, or approx. 25 percent above the projected requirements of 2,275kcal needed for maintaining energy balance. Although a trend analysis up to 2000-02 indicated that the undernourishment target implied in the Millennium Development Goals was on track, food access in consumer markets has since been under pressure due to the soaring world energy prices, associated with a growing inequity in resource distribution and utilization. The remaining poverty (Albania Poverty Assessment, 2007), combined with the high price-elasticity of foods that are relatively rich in absorbable iron such as meat and meat products, suggest that the poorer sections of society may be at risk. Pregnant women and young children among the poor will be most vulnerable to anaemia due to iron deficiency[10].

Feeding practices: Studies[5] conducted in Albania indicate that the high infant malnutrition rate is also related to inadequate infant and young child feeding (IYCF) practices, including poor exclusive breastfeeding practices and early introduction of additional foods. Fortunately, Government health policies and programmes have led to almost all deliveries taking place in maternities with skilled medical attention. Not all the maternities in Albania have yet earned a "Baby Friendly" certificate, however. Although more than 10% of the newborns are being fed so-called pre-lacteal foods during their stay in the maternity, introduction of breastfeeding during the first 3 days is nearly universal[11]. However, only one-third of the newborns are being exclusively breastfed[12] until they are 6 months old. By that time, one quarter of infants are fed artificial milk[5].

Against modern IYCF standards, the frequency and composition of feedings complementary to breastfeeding after age 6 months are not optimal. Only 75% of the 6-8 month-old infants are given additional feeds twice a day and 80% of the 9-23 month-olds three times a day. On a more positive note half of the mothers in Albania continue breastfeeding their children to age 12-17 months and that almost one quarter continue breastfeeding until the 2nd birthday of the child[5,6]. Also, a MoH/UNICEF/IBFAN study confirmed that the variety of complementary feedings after

[8] Important export products include fruits, vegetables, wine, olive oil and livestock products, all of which can be stimulated in rural disadvantaged communities.
[9] Food and Nutrition Division. Nutrition Country Profile, Republic of Albania 2005. Rome, Food and Agriculture Organization of the United Nations.
[10] Buonuomo E et al. Iron deficiency anemia and feeding practices in Albanian children. *Anali di Igiene* **17**: 27-33, 2005
[11] E.g Ministry of Health, UNICEF and IBFAN: Monitoring of breastfeeding practices in infants and young children in Albania. Tirana, 2007
[12] MICS data, including the high percentage of infants who are offered water

age 6 months are adequate, with cereals and vegetables predominant (85% of children), followed by meat, potatoes, pumpkin and carrots, and fats and oils and milk products (approx. 50%). The amount of foods offered to breastfed children is unknown, however. The same variety of foods is given to non-breastfed children, although they are being offered more meat, fats and milk products. About 25% of infants are not breastfed at 6-11 months, one half at 12-17 months and three quarter of children at 18-23 months of age. These data are exemplary for a growing international recognition that effective counseling of mothers of young infants on proper feeding practices requires special skills.

Health and nutrition policy: The dramatic political and socio-economic changes of the past ten years have increased the vulnerability of Albanian children to malnutrition and health care. Many Albanian children, especially those from poor families face a great risk of exclusion. Social policies that adequately address the needs of children and ensure a protective environment are virtually absent. The existing social assistance mechanism, while providing benefits, fails to ensure health care and nutrition of children. The current Food and Nutrition Action Plan (FNAP) 2003-2008, has mostly bypassed the need to immediately address the food insecurity and malnutrition situation of the population, especially of the most disadvantaged sections of society and the most vulnerable groups of children and women. There is as yet no mechanism at high GoA level to oversee, discuss and decide on priorities for investments in food security and nutrition[13] through health sector and partner channels. Cognizant of the alarmingly high and persistent under nutrition levels, the failure of economic growth alone to address the malnutrition situation, and the limitations in the current FNAP, the highest-level MoH officials are fully committed to change in the health and nutrition policy development and management processes and to support the strengthening and innovation of services, products and information deliveries proposed in this Joint Programme. The Ministry of Health has indicated strong commitment to stimulate a policy dialogue with high level GoA, the Agriculture sector and MoH partners in civil society who are instrumental in creating an improved food, health and nutrition situation for the population.

4. Strategies, including lessons learned and the proposed joint programme

4.1 Background /context

The Joint Programme will bring a nutrition focus to the ongoing results-based UNCT work to support GoA on the achievement of the MDGs, in particular the work on the most marginalized and vulnerable groups (UNICEF) and basic health services and health sector policy (WHO). It also adds a food and gender perspective (FAO). The programme is aligned with the One UN programme in Albania as it contributes to more transparent and accountable governance, more effective national policies, and quality public services. It promotes progress particularly towards MDG1 (eradication of poverty and halving malnutrition), MDG4 (reducing child mortality) and MDG5 (improving maternal health).

The programme aims to integrate several strands of Government health and agriculture goals and priorities, through:

[13] World Bank. Repositioning Nutrition as Central to Development. Directions in Development. Washington, DC, 2006. This publication offers a solid rationale and summarizes proven mechanisms for managing national policy priority and programmatic action for the health, food and nutrition issues addressed in this Joint Programme

- supporting development of national policy,
- a coordinated set of actions (direct implementation of interventions as well as training of key next-generation service providers) to prevent and address under nutrition in children and women in highly affected rural and peri-urban areas, and
- Involving several sectors under the leadership of MoH.

The programme links to a number of strategies and goals in the National Strategy for Development and Integration (NSDI). It directly supports Strategic Priority 3 of the NSDI which is rapid, balanced and sustainable economic, social and human development which has as its strategic goal to reduce the infant mortality rate to 5 per 100,000 live births by 2013.

The JP supports the following priorities of the Government of Albania:

1. Agriculture priorities
   - Increase financial support to farms, agricultural and agro-industrial businesses with special emphasis on fruit trees, vineyards, vegetables and animal farming, as well as on the industrial processing of fruit, grapes, vegetables, milk and meat, on the basis of the advantages in different areas of the country and
   - Increase the quality and safety of agricultural and agro-processing products
2. Health priorities:
   - Increase the capacity to efficiently manage services and facilities
   - Increase access to effective health services. The low utilization of health services in Albania calls for specific measures to improve access by people who are poor or live in rural areas.
3. Social protection:
   - Reduce absolute poverty to 10% by 2013 according to the results of household surveys.
4. Social inclusion
   - Assist vulnerable groups – in particular, the national child strategy covers all aspects of child poverty.

The One UN Programme/UNDAF addresses these issues in the Governance (Social Inclusion) and Basic Services pillars.

The Ministry of Agriculture, Food and Consumer Protection (MAFCP) leads the execution of the Agriculture and Food Sector Strategy 2007-2013 (AFSS). The strategy aims to increase the competitiveness of the Albanian agriculture, benefit farmers' incomes and the overall economy, increase employment opportunities in rural areas, and establish higher food standards. AFSS does not include any interventions focused on improvement of the nutritional status of the population. It does not address food insecurity and the special needs of the most vulnerable segments of the population.

Strategic priorities to reach such goals include:

i. improving access to financing for farms, agricultural and agro-processing businesses;
ii. improving management of agricultural land, including consolidation, irrigation, and drainage;
iii. improving marketing of agricultural and agro-processing products;
iv. increasing the level and quality of technologies, information, and knowledge of farmers and agro-processors;
v. Improving the food safety system, to increase support, controls and certification of agri-food standards.

The strategic sectors to focus UN assistance and advocacy include fruit-growing (including olives) and viticulture; horticulture; livestock; industrial processing of fruits and vegetables, grapes and milk and meat. The MAFCP uses a results-based management matrix with indicators and targets from 2007 to 2013.
The National Food and Nutrition Action Plan will be developed during implementation of the Joint Nutrition Programme, and will complement the AFSS focusing on food security and safety to reduce malnutrition within the most vulnerable groups adopting an approach suitable for each category of beneficiaries.

In 2007, the “Inter-Sectoral Rural Development Strategy of Albania (2007-2013)” was prepared by an inter-ministerial working group with the MAFCP as secretariat, main convener and coordinator. The document is consistent with the EU Rural Development principles and approaches. However, the roles and responsibilities of MAFCP as the institution in charge of coordination, implementation and monitoring of the rural development strategy as well as the participation of other Ministries, including the MEWWA and METE, need to be better specified.

Legislation prepared by MAFCP aims to approximate the EU directives and regulations in the area of food supply and safety. The MAFCP focuses on the food industry’s role, promoting technology development and import substitution. MAFCP is working with MOH to develop regulations for the quality and wholesomeness of a range of foods for sale, including imported foods for special dietary use by pregnant women, infants and young children. The regulations specify detailed criteria and requirements on proper composition, illegal pesticides and maximum allowable levels of pesticide residues, as well as proper labeling, and they are used for food inspections at the points of import and public sales. MAFCP has set specific standards for vitamin and mineral ingredients in food supplements, and the Ministry is collaborating with MOH to develop guidance for promoting informed choices by the public of food products.

The Ministries of Health and Agriculture have focused their interventions mainly on food safety and have mostly overlooked the issues related to nutrition and food security. Lack of data for policy development and action, inadequate capacities in public health nutrition and insufficient warning systems to help identify food security problems and plan interventions to improve the nutrition situation are contributing to malnutrition among women and children clearly among the highest in the region.

In order to improve household food security, all the impediments that constrain a household’s ability to acquire and utilize the food necessary to meet the nutritional needs of all family members must be addressed. This includes factors such as : the amount and variety of foods available within households and in local markets, food prices and household incomes. Less obviously, but of no less importance, are other non-monetary factors such as: the nutritional knowledge and attitudes of caregivers about foods, social and dietary customs, family and child care and feeding practices, and the competing demands on women’s time that may constrain their ability to secure, prepare, serve and adequately store food.

Among families with few resources, it is especially important to increase their understanding of the food needs of each family member and their knowledge and skills in how best to distribute scarce food resources among the family. Effective nutrition education and

imparting of practical skills in food, health and nutrition can often make a significant contribution to reducing hunger and malnutrition even without improvements in food supplies and incomes.

Better nutrition among women, coupled with improved food and nutrition-related knowledge, attitudes and practices by women, girls and other community members, can contribute to women's empowerment and gender equality, significantly reduce child mortality and morbidity, improve maternal health and play a crucial role in the prevention of both communicable and non-communicable diseases.

The Joint Programme helps assure the pro-poor aspects of the interventions by using a participatory, community-based approach, involving people who are poor and marginalized. Engagement of beneficiaries will be ensured through mother support groups, community health boards, local action groups, national rural network and other community groups that would participate in the needs assessment process and monitor delivery of services. This is reinforced by strengthened capacities of local institutions and providers so that they can sustainably continue to engage with their local populations.

4.2. Lessons learned

- In recent decades in Europe, nutrition energy intake has exceeded expenditure, leading to a dramatic increase in obesity and its consequences, such as diabetes, cardiovascular diseases and cancer. Obesity has reached epidemic proportions, accounting for 7–8% of the total disease burden. More than two thirds of the population does not engage in sufficient physical activity, accounting for a further 3.3% of the burden. (Reference: European Food and Nutrition Action Plan 2007-2012) At the same time, food insecurity and under nutrition remain important issues, especially among low-income and vulnerable populations, including children, pregnant women and elderly people. Deficiencies in micronutrients (especially iron, iodine, Vitamin A and foliate) are a concern, as is the rate of exclusive breastfeeding.
- Importance of modeling social safety nets for children - the Albanian government has undertaken a broad social policy reform, which deals with the economic and social needs of children. The government is working to draft a Child Rights Code, which will pave the way to shift from needs based to rights based approach. In this context, the introduction of Child Allowances Policy within the social assistance policy is of critical concern Reference: Social Policy Reform document

- Important causes of malnutrition in Albania are related to inadequate food access at household (HH) level, inadequate child care and feeding practices and insufficient utilization of Primary Health Care services, these in turn are rooted in the human, economic and organizational arrangements that determine how the available resources are used. Reference: Nutrition situation analysis February 2009

- Nutrition counseling with special emphasis on exclusive breastfeeding and increased frequency of complementary feeds should be connected to better monitoring of child growth to detect stunting. The counseling of mothers on nutrition of their children requires special skills training of the PHC staff. Reference: reports from implementation of C-IMCI in Albania.

- In the poorest northern districts, a multi-sector comprehensive strategy with community mobilization as the central element can address the special concern for the poor nutrition of women and children. The overwhelming disparities that families face in these districts must be countered by rural development programs that have broader objectives, including agricultural development. It is in rural areas that the existing directives and protocols for community IMCI, with joint collaboration among the health center staff, municipalities and child protection units should be exploited more fully to generate community based actions with leadership by the health sector. Reference: nutrition situation analysis February 2009

- **Good practices from global health strategies indicate:**

1. Supporting a healthy start
Ensuring good nutrition and safe food during the first few years of life pays dividends throughout life. Key actions should promote proper nutrition and safe food for pregnant women, exclusive breastfeeding for the first six months of life, improved complementary feeding, and safe and balanced meals provided by schools and kindergartens.

2. Providing comprehensive information and education to consumers
Good communication and information are essential to achieve healthy lifestyles, food safety and a sustainable food supply in the population. For example, public campaigns should inform consumers about healthy nutrition and the importance of proper hygiene.

3. Strengthening nutrition and food safety in the health sector
The health sector has a critical responsibility in reducing the burden of nutrition-related and food borne diseases. Consistent and professional diet and lifestyle counseling by primary care professionals can influence individuals' choices. Key actions include engaging care providers in monitoring infant and child growth using the new WHO standards, measuring weight and assessing diets in adults, and promoting breastfeeding, a balanced diet, safe food-handling practices and physical activity. In addition, improving the safety and quality of food in hospitals is essential to ensure faster recovery.

4. Monitoring, evaluation and research
Surveillance systems for nutritional status, food availability and consumption, physical-activity patterns and food borne diseases should be simple and sustainable, tailored to countries' needs. The impact of programmes and policies to reduce the burden of food- and nutrition related diseases should be evaluated.

4. 3 The proposed joint programme

The Joint Programme aims to address mother and child malnutrition at national and local levels through three main outcomes: a) National capacities strengthened to incorporate nutritional objectives into sectoral polices and programmes; b) Cross sectoral interventions addressing malnutrition are developed, tested and implemented in target areas; c) National capacities are strengthened to deliver nutrition services to the public.

The Joint Programme will be implemented by the Ministry of Health, Ministry of Agriculture, INSTAT, specialized institutions, regional authorities, and civil society organizations with support

from UNICEF, WHO, FAO. The Ministry of Health will be responsible for overall coordination, implementation, achievement of JP objectives and coordination with Ministry of Agriculture and other key stakeholders.

The programme aims to implement successful multi sectoral interventions in high –risk rural and peri-urban communities, in combination with strengthening of national policy development, building of partnerships, systematic capacity building mainly of health sectors staff and frontline health workers but also food and agriculture experts in issues related to household food security issues. Rigorous monitoring of processes, outcomes and results will inform policy development and action.

The interventions will take place in five districts of Northern Albania (in Kukes and Shkodra Prefectures) and in 2 peri-urban Municipalities of Tirana. These areas are highly affected (especially by stunting) have large numbers of Roma population, and are either poor (rural) or highly affected by unemployment (urban).
Communities in the selected target areas will be proposed by technical staff of the Ministries and local government based on socio economic indicators, geographical access, remoteness, engagement of local authorities and receptiveness for intervention. The baseline survey in target intervention areas, in addition to the existing information, will provide a useful basis for selection. Final selection will be agreed by the government programme manager, UN coordinator and the Programme Management Committee
Frontline workers including nurse/midwives, teachers, agriculture extension workers, Red Cross volunteers, and collaborators of Albanian Agribusiness Council will be engaged during the implementation and will help mobilize the communities.
Resource-poor communities will be provided with a comprehensive package of interventions including: cash transfers, nutrition education, and improved quality of health services and establishing a surveillance system that will flag problems related to nutrition and food security. The selected areas in Northern Albania are already receiving support from the One UN programme (Gender) , are featured in the thematic window on Youth Employment and Migration of the UNDP-Spain MDG Achievement Fund, and are the target of the WHO programme on Maternal and Child Health supported by Spanish government. Capacity building for improved use of gender disaggregated data and planned research to assess gender roles and household food and nutrition will link with results of previous work supported by UNIFEM in Kukes and Shkodra. Synergies will be created between conditional cash transfers planned under this Joint Programme with ongoing work on social assistance, gender dimensions and impact at family level supported by UNIFEM

Expected results of joint programme are summarized as follows:

1. A National Coordination mechanism, based on multi-disciplinary and multi-sector participation, established/strengthened under high-level Government leadership and serviced by a small Secretariat in MoH
2. Four specialized studies completed. These studies will build on and complement data collected under LSMS and DHS. Results used in improving the formulation of the second National Food and Nutrition Policy and Action Plan, to be adopted by GoA. Engagement of local government staff in these surveys also builds their capacity to better collect, analyze and use data in the future.

3. A community-based food, nutrition and infant/young child growth performance surveillance system is devised, pilot-tested and institutionalized in the Ministry of Health.
4. At least 50% of the 75,000 at-risk under-three-year-old children in selected Programme areas will receive proven nutrition interventions (GMP, IMCI, micronutrients) through frontline health care, aimed at promoting their healthy growth and development, followed by evidence of improved performance and effectiveness of delivery.
5. IEC/BCC campaigns to increase the awareness, skills and behaviors for reducing chronic malnutrition in children and women conducted at national level with special focus in targets areas (5 Districts and 2 Municipalities of Tirana.) The general population will benefit from media events with wide coverage while interventions using specific communication channels such as interpersonal communication will focused only on target areas. The package of IEC materials may be used in other areas, once they are tested, provided that funding from other sources will become available.
6. A new PHN training curriculum, tested in the regular training of PHC workers, submitted for acceptance by the Medical University.
7. Performance of regional directorates of public health will be analyzed, and their capacity in supportive supervision of frontline health workers improved, with special reference to efforts to address malnutrition in disadvantaged communities.

UN agencies and government institutions will have the following roles by outcome and output of the JP. Implementation of the JP will be lead by the Ministry of Health in close collaboration with Ministry of Agriculture, local health and food and agriculture authorities, INSTAT, and civil society organizations.

Outcome 1: National capacities strengthened to incorporate nutritional objectives into sectoral polices and programmes

Output 1.1. – Advocacy and awareness raising programme to address malnutrition and food security developed and implemented, targeting policy and decision makers- **WHO** will support this output in close coordination with FAO and UNICEF to ensure integrated approach and high level advocacy and awareness raising interventions. Key government actors are the Ministry of Health and Ministry of Agriculture, which will coordinate with other interested line ministries and provide direct support to the high level coordination structure.

Outputs 1.2.& 1.3. Development of 3rd National Food and Nutrition Action Plan- The MOH and Ministry of Agriculture will be leading the policy formulation process. **WHO and FAO** will support the process in this component supported by UNICEF ensuring that the knowledge base established for policy development process and national food and nutrition action plan is realistic, and implementable (specific studies conducted as agreed by participating UN agencies with one agency leading and other agencies providing inputs according to their areas of expertise). Specialized institutions such as INSTAT, IPH (institute of Public Health) ISUV (Institute of food safety and veterinary research) consumer associations and civil society representatives including AAC (Albanian Agribusiness Council) and other umbrella organizations will participate.

Output 1.4: A strengthened national food and nutrition surveillance system – **UNICEF** will closely coordinate with FAO and WHO in areas of food security and planning and implementation of GM process. MOH, Ministry of Agriculture and local authorities in target areas will be responsible for design and implementation of the system that will provide data on

nutritional status and food security of population and especially deprived population groups for policy formulation and for prompting quick actions to address malnutrition. MOH and IPH will have a significant role in preparing the training package and conduct the actual capacity development with service providers and other identified community structures. Regional health, food and agriculture authorities will implement the system in target areas.

Outcome 2 - Cross sectoral interventions addressing malnutrition are developed, tested and implemented in target areas

Output 2.1. Develop, test and implement community based intervention models to address malnutrition and household food insecurity- Local authorities and communities in target areas, with the support of **UNICEF** will coordinate interventions in this component. UNICEF will help to fine tune existing models and design new ones in close cooperation with FAO for promoting household food security and WHO for technical expertise and best practices related to reduction of malnutrition. Procurement of drugs for supplementation will be managed by UNICEF. Local health, food and agriculture authorities, and existing Child Rights Units/Child Protection Units (social work) will be partners, together with any civil society organizations working in this area.

Output 2.2. Capacity building of service providers at national and in target areas to conduct Growth Monitoring and Promotion (GMP) and deliver nutrition counseling- **UNICEF** will support capacity building activities in target areas with technical and normative guidance from WHO on new growth monitoring charts and the design of integrated nutrition training modules. FAO will provide technical inputs in assessing knowledge gaps and design components of the training package related to food security and consumer education. MOH and IPH will take active part in finalizing the training modules and conducting training programmes. They will institutionalize future trainings through continuous medical education and other sustainable mechanisms using existing government structures.

Output 2.3. Development of communication materials for improved care and feeding practices targeting mothers, families and communities. **UNICEF** will lead the communication for behavior change component of the communication strategy for this Joint Programme. Messages will be tailored by target audience identifying best communication channels and dissemination. WHO and FAO will provide inputs in designing the communication materials. The health promotion units of the MOH and IPH will lead the communication initiative in close cooperation with Ministry of Agriculture and civil society.

Outcome 3 - National capacities strengthened to deliver nutrition service to the public

Output 3.1. Curriculum for public health nutrition training developed, tested and promoted in pre-service training. The Ministry of Health will lead the development of public health nutrition curricula together with the national center for continuous medical education, the medical faculty, and the nursing academy. **WHO** will support this process, FAO will provide technical assistance and UNICEF will assist with capacity building and procurement of supplies.

Output 3.2. Improved supervision mechanisms for nutrition interventions - **WHO** will lead the revision and preparation of guidelines for the supervision system, and will work closely with UNICEF to support the integration of the revised supervision system into exiting PHC structures. This includes the strengthening of the role of MCH inspectors. The MOH will work closely with

IPH, Health Insurance Institute (HII) and local health authorities to ensure adequate service delivery.

During the design of the Joint Programme, UNICEF and WHO (the resident agencies of this proposal) engaged with a broad array of partners. These included official health, agriculture and local administrations, the scientific community, the food and nutrition enterprise sector (e.g. Albanian Agribusiness Council, milling, salt and other processors of common foods), NGOs working on food, health and nutrition, and consumer-interest groups. The Joint Programme builds on an assessment and analysis, supporting the formulation by government of a multi-sector policy and strategy for investments aimed at improving the nutrition status of disadvantaged populations. The assessment was strongly dependent on the engagement of national and local actors, and this will be so for the execution of the proposed programme. In the selected rural communities, UNICEF is already collaborating with local NGOs on community based interventions such as C-IMCI (community IMCI), or the establishment of gardens as alternative pre school interventions. The programme also provides opportunities to leverage resources from the agro-industry, NGOs, educators, and the media – many of which are encouraged by the prospect of collaborating with the UN and the government of Albania in giving children in Albania a better start in life.

Based on its recent experience of managing the universal salt iodization strategy, the MoH is well placed to assume leadership of this multi-sector coalition. The encouraging progress toward iodizing the salt for human consumption offers demonstrates how public health programs can be managed when other actors, including the private sector, have essential roles to fulfill.

The Institute of Public Health (IPH) in Tirana supports the Government in the assessment, design and evaluation of public health programs. The need for more specialized and in-depth research on food and nutrition programming can be addressed in collaboration with various departments in the Medical or Agricultural University.

5. Results Framework

Results of the Joint Programme contribute to the results of the One UN programme – improved quality of basic services delivered to population - and is in line with government priorities as stated in NSDI and policy directions of the Ministry of Health and the Ministry of Agriculture.

Outcome 1- National capacities strengthened to incorporate nutritional objectives into sectoral polices and programmes

Outcome 1 will enhance national capacities for developing, implementing and monitoring inter-sectoral actions to address problems of malnutrition and food insecurity. This will be achieved through the establishment of a national coordination structure for food and nutrition at high government level, which will facilitate inter-sectoral collaboration and raise the profile of nutrition in the political and public arena. A carefully designed advocacy strategy will contribute to raising awareness on food insecurity and malnutrition among key stakeholders. Support to formulation of the 3rd FNAP will help address the lack of emphasis in the current policy document (2nd FNAP) on issues of food insecurity and malnutrition among vulnerable and at risk population groups. Specific data collection activities will provide information related to gender-specific determinants of the nutritional status of the family. Additional data on the impact of high food

prices on food security of vulnerable population groups and on the causes of and potential solutions to major micronutrient deficiencies will also contribute to this. The development of National Food and Nutrition Surveillance system will help to ensure ongoing monitoring and early warning of food insecurity and malnutrition. By initiating a food and nutrition surveillance system, the programme enables GoA and its partners to track trends and make evidence-based decisions on nutrition related policies and resource allocations

Outcome 2 Cross Sectoral interventions addressing malnutrition are developed, tested and implemented in target areas

Outcome two will be achieved through activities aimed to strengthen the capacity of local government (Health and Agriculture) and civil society organizations to design, implement and monitor nutrition and food security interventions. Practical Intervention Models will be developed based on previous experiences and community needs assessment conducted in the early stages of the programme. Community Based interventions will include community IMCI; gardens of mother and children, and breastfeeding support groups for improved infant and young child feeding practices. Improved access to and consumption of micronutrient rich foods will be achieved through establishment of school and community gardens. These will link small-scale food production with learning about nutrition and health. The intervention will help establish a nutrition-friendly school and community environment, with an emphasis on clean water and sanitation, and will provide increased access to nutritionally adequate and safe food. The gardens will add nutritional value (micronutrients) and variety to local diets; they will help promote healthy eating habits, and will improve the basic agricultural skills and nutrition knowledge of the local community. Depending on the local conditions, support will be provided to establish vegetable gardens, fruit trees and small animal production.

Prevention of malnutrition and micronutrient deficiencies in high risk areas will be addressed by providing sprinkles with MOH approved supplements as an immediate relief action. This will be supported and sustained in the long term by food and nutrition education for improved dietary habits and dietary diversification. Modeling of conditional cash transfers for children linked to improved food and nutrition status will be initiated, contributing to the development of social safety nets. Implementation of these models in Albania and integration into the social insurance scheme will require international expertise of successful models from other countries.

The programme will develop the capacity of health providers in target areas to conduct growth monitoring and nutrition counseling. Capacity building of health providers in growth monitoring and training of multisectoral teams in design implementation and monitoring of food and nutrition interventions will be in line with recommendations envisaged by the food and nutrition action plan. A communication strategy for behavior change targeting family and communities for improved care and feeding practices for mother and children will also be designed in accordance with food and nutrition action plan. A KAP survey in the early stages of the programme will help identify current dietary and feeding practices, household level food distribution and other factors influencing maternal and child nutrition. The results of this survey will feed into the development of a comprehensive communication strategy with clear messages, identified target audiences and effective communication channels. A variety of food and nutrition education materials will be developed and delivered to identify target audience. Implementation in target areas will provide models for scaling up in other regions of the country. Lessons learned from interventions in

target areas will feed into policy development and action at national level to improve nutrition outcomes.

Outcome 3 National Capacities strengthened to deliver nutrition services to the public.

Outcome 3 will be achieved through the development of a public health nutrition curriculum for inclusion in the health-related pre-service education and an advanced post graduate certificate programme. This will contribute to the sustainability of the overall programmes objectives and activities while simultaneously raising the profile of a PHN among healthcare professionals. The participation of public health professionals in specialized nutrition courses will also be encouraged and will help to sustain the outcomes. Other activities will seek to identify and address obstacles in the delivery and supervision of nutrition interventions through PHC services. The performance of supervisors will be analyzed, leading to recommendations to the MoH to improve the supervision system. Important outcomes of this component are nutrition education programmes for families and institutions in the capital and rural areas.

The project will systematically and critically capture the experiences and results, examine evidence of successes, and evaluate the outcomes to inform the food, health and nutrition policy of GoA.

Table 1: Results Framework

MDG-F joint program: Reducing malnutrition in children - Albania

Joint Programme outcome 1: National capacities strengthened to incorporate nutritional objectives into sectoral polices and programmes - Indicator: Nutritional objectives clearly stated into government policy documents and resources allocated to address malnutrition and food insecurity

JP Outputs **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
					Y1	Y2	Y3	Total
Output 1.1. – Advocacy and awareness raising programme to address malnutrition and food security developed and implemented, targeting policy, decision makers and the general public **Indicator:** **- National coordination mechanism for food and nutrition strengthened** **Baseline:** **No coordination mechanism at high level exist** **Indicator:** **- Number of National and regional staff trained in intersectoral actions to address malnutrition and food insecurity** **Baseline:** **No recent capacity development exercises for government officials for intersectoral food**	Coordinating mechanism for food and nutrition strengthened	WHO	***MOH***	1.1.1. Support National coordinating mechanism for food and nutrition	***10,000***	***10,000***	***10,000***	***30,000***
	Enhanced national capacity for inter-sectoral actions to address malnutrition and food insecurity	WHO	***MOH***	1.1.2. a National and regional consensus building workshops on intersectoral actions to address malnutrition and food insecurity (including launching)	***20,000***	***2,500***	***2,500***	***25,000***
		FAO	***MOA***	1.1.2 b. Technical support to and participation in consensus building workshops on intersectoral actions to address malnutrition and food insecurity	***7,000***			***7,000***

and nutrition actions **Indicator:** **- National massmedia campaign developed and implemented** **Baseline:** **No advocacy plan for food and nutrition exist**	National mass-media communication campaign developed and implemented to increase commitment and investment of policy and decision makers	UNICEF	***IPH***	1.1.3.a Advocacy events, key stakeholders meetings, materials and information package developed and disseminated, media communications and periodic information updates to the public	43,000	5,000	5,000	***53,000***
		FAO	***MOA***	1.1.3.b Support development of communication materials and advocacy activities focusing on food security issues	***7,000***	***7,000***	***7,000***	***21,000***
		WHO	***MOH***	1.1.3.c. Support elaboration of key communication messages on consequences of malnutrition	***4,000***	***4,000***	***4,000***	***12,000***
JP Outputs	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
(Give corresponding indicators and baselines)					Y1	Y2	Y3	Total
Output 1.2. Technical support for strengthening data collection and utilisation of data on food, health and nutrition	Review of existing data sources and nutrition indicators and framework for collection of food and nutrition data developed	WHO	MOH	1.2.1.a Review existing data sources and information systems on food and nutrition security and identify information needs of data users	8,000	4,000	4,000	16,000

Indicator : Number of national and regional staff trained in intersectoral actions to address malnutrition and food insecurity **Baseline: No recent capacity development exercises for government officials for intersectoral food and nutrition actions** **Indicator: National data collectors, producers and users trained and surveys conducted** **Baseline: Sufficiently disaggregated data on gender and household food security do not exist**		FAO	INSTAT	1.2.1.b Organize meetings and workshops to review existing information and new DHS and LSMS data on food prices, household food security, nutrition and status of women and carry out secondary analyses	16000	9,000		25,000
	Capacity strengthened for the collection, analysis and use of gender-disaggregated data relating to food, health and nutrition	FAO	INSTAT	1.2.2.a. Training of national data producers and users in relevant statistical tools for the collection analysis and use of gender disaggregated data		46,000	22,000	68,000
		UNICEF	IPH	1.2.2.b Inputs to design training module for data collection on nutrition and gender with focus on children		10,000		10,000
		WHO	IPH	1.2.2.c Technical assistance to prepare training module on health and nutrition indicators		6,000		6,000

	Improved information available on the effects of high food prices and gender on the food security of vulnerable groups and at-risk households	FAO	INSTAT	1.2.3.a. Provide technical and financial assistance for developing, carrying out and analyzing rapid data collection activities at community/household level in project target areas, including gender roles and household food and nutrition (baseline for target areas)	87,500	32,500		120,000
		UNICEF	IPH	1.2.3.b Input to prepare baseline survey tool sections for impact of food prices in children	10,000	5,000		15,000
		WHO	IPH	1.2.3.c Input to prepare baseline survey tool using a health systems perspective	3,000			3,000
	Situation analysis and mapping of milling industry completed. Feasibility of flour fortification shared with key stakeholders	UNICEF	KASH	1.2.4.a. Technical and financial support for conducting a situation analysis and feasibility study for flour fortification and assist in disseminating information	46,500	25,000		71,500
		WHO	KASH	1.2.4.b. Technical support to analyze the link between fortification and micronutrient deficiencies in the survey tool and preparation of the final report	10,000	5,000		15,000

	Statistically significant survey conducted in year 1 identifying main causes of anaemia in high prevalence areas of the country as identified in DHS	WHO	IPH	1.2.5.a. Technical and financial support for conducting a survey to identify the main causes of anaemia in high prevalence areas and analysing and disseminating results	200,000			200,000
		UNICEF	***IPH***	1.2.5.b Technical support for conducting secondary analysis based on DHS data for mapping of IDA and providing inputs for further research on causes of anaemia	***20,500***			20,500
JP Outputs	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Y1	Y2	Y3	Total
Output 1.3. Development of 3rd National Food and Nutrition Action Plan **Indicators:** **3rd NFNAP developed** **Baseline:** **Current FNAP has insufficient focus on nutrition and food security issues**	Capacity strengthened for analysing impact of policy choices and decisions on food, health and nutrition	FAO	***MOA***	1.3.1.a. National and regional inter-sectoral policy workshops held to strengthen capacity to analyse impact of policy choices and decisions on food security		10000		10,000
		WHO	***MOH***	1.3.1.b National and regional inter-sectoral policy workshops held to strengthen capacity to analyse impact of policy choices and decisions on health and nutrition		20,000		20,000

Capacity strengthened for developing and implementing National Food and Nutrition Action Plans (NFNAP)	WHO	***MOH***	1.3.2. Support to the technical inter-sectoral working group for NFNAP development and implementation		13,000	13,000	26,000
Development of 3rd NFNAP	WHO	***MOH***	1.3.3.a. Review and analyze 2nd NFNAP and other relevant sectoral policies and evaluate lessons learned		40,000		40,000
	FAO	***MOA***	1.3.3.b Technical input to the review and analyze of 2nd NFNAP and other relevant sectoral policies from a food security and gender perspective		$13,000		13,000
	UNICEF	***MOH***	1.3.3.c Review and analyze 2nd FNAP and other relevant policies and evaluate lessons learned with regard to child nutrition including most at risk		$11,500		11,500
	WHO	***MOH***	1.3.4.a. Technical and financial support to organize the Policy Formulation workshop			***13,000***	13,000
	FAO	***MOA***	1.3.4.b Technical assistance to prepare agenda and materials addressing food and security issues and link of nutrition and agriculture			***7,000***	7,000
	WHO	***MOH***	1.3.5.a Consultation and review process including workshop on draft NFNAP involving line ministries, private sector, CSOs			***18,000***	18,000

		FAO	***MOA***	1.3.5.b Technical input to prepare the consultation and review process and development of the draft plan			***10,000***	10,000
		UNICEF	***KASH***	1.3.5.c Technical input to consultation review process focusing on target areas and consumers			***8,000***	8,000
		WHO	***MOH***	1.3.6. Preparation, presentation and dissemination of the final NFNAP			***15,000***	15,000
JP Outputs **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
					Y1	Y2	Y3	Total
Output 1.4: Strengthening of National food and nutrition surveillance system **Indicator:** **National FNS system developed** **Baseline:** **Growth monitoring data are collected at individual level but not analysed and used to flag out problems, no surveillance in**	Enhanced capacity for forecasting and early warning of food insecurity or food emergencies	FAO	***MOA***	1.4.1. Workshops in each of the target areas on improving crop production survey methods, sampling frames, food balance sheet estimates and for monitoring climate change and market change prices and regular reports on food availability		***38,000***		38,000

place	Central Government and project target areas staff trained in rapid nutrition and food security assessment	FAO	***MOA***	1.4.2.a Training workshops for selected local community service providers and national government in rapid food security and nutrition assessment techniques		***38,000***		38,000
		UNICEF	***IPH***	1.4.2.b Support preparation of training modules for health workers in rapid child nutrition assessment techniques		***12,000***		12,000
		WHO	***IPH***	1.4.2.c Technical assistance to develop training modules for rapid health and nutrition assessments		***10,000***		10,000
	Tracking system developed on impact of high food prices and food shortages on food and nutrition security	FAO	***MOA***	1.4.3. Technical assistance to develop a tracking system in target areas on the impact of high food prices and food shortages on food and nutrition security		***26,000***	***25,000***	51,000
	Intersectoral coordination structure for FNS established	UNICEF	***IPH***	1.4.4.a Establishment of intersectoral technical working group to develop indicator framework for food and nutrition surveillance (FNS)		***6,000***	***5,000***	11,000
		FAO	***MOA***	1.4.4.b Technical support to define food security component of surveillance system		***5,000***	***5,000***	10,000
		WHO	***IPH***	1.4.4.c Technical support to define nutrition component of surveillance system		***6,000***	***6,000***	12,000

	FNS framework developed	UNICEF	***IPH***	1.4.5.a Development of methodology and framework for FNS, including indicators, data collection systems, software development and training		***23,000***	***25,786***	48,786
		FAO	***MOA***	1.4.5.b Assist in development of methodology and framework for food security component of surveillance system		***10,000***	***8,000***	18,000
		WHO	***IPH***	1.4.5.c Assist in development of methodology and framework for nutrition component of surveillance system		***8,000***	***6,000***	14,000
	Framework for sentinel sites in project areas developed	UNICEF	***IPH***	1.4.6.a Development of framework for sentinel sites in project areas			***25,000***	25,000
		FAO	***MOA***	1.4.6.b.Support development of surveillance framework for sentinel sites in project areas			***10,000***	10,000
		WHO	***IPH***	1.4.6.c Technical assistance to define structure and distribution of sentinel sites in project areas			***5,000***	5,000
		UNICEF	***IPH***	1.4.7 Pilot testing of sentinel site system in selected areas			***20,000***	20,000

Joint Programme outcome 2 :Cross sectoral interventions addressing malnutrition are developed, tested and implemented in target areas Indicator: Community based intervention models to address malnutrition and food insecurity implemented in target areas.								
	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
					Y1	Y2	Y3	Total
Output 2.1. Develop, test and implement community based intervention models to address malnutrition and household food in security **Indicator:** **- percentage of children in target areas receiving interventions addressing malnutrition and household food insecurity**	***Capacity of local personnel and CSOs in nutrition and food security interventions assessed***	UNICEF	***IPH***	2.1.1. Conduct assessment of capacities of local health and agriculture personnel and CSOs working in nutrition , to design, implement and monitor nutrition and food security interventions in target areas		$15,000		15,000
	Community needs assessment conducted	UNICEF	***CSOs***	2.1.2. a Conduct participatory needs assessment using community based planning approaches to define community based interventions in target areas		$20,000		20,000
		FAO	***MOA***	2.1.2.b Technical inputs to develop food security component of participatory needs assessment		$10,000		10,000
		WHO	***MoH***	2.1.2.c Technical inputs to develop GMP component of participatory needs assessment		$5,000		5,000

100 persons from local government and CSOs trained in design, implementation and monitoring of nutrition interventions	UNICEF	***CSOs***	2.1.3.a. Training of health and agriculture personnel in local government structures and CSOs working in nutrition related activities in the design, implementation and monitoring of nutrition and food security interventions		$45,317		45,317
	FAO	***MOA***	2.1.3.b. Technical support to develop training modules on design, implementation and monitoring of food security interventions for agriculture personnel and CSOs		$18,000		18,000
	WHO	***MOH***	2.1.3.c. Technical support to develop training modules on design, implementation and monitoring of nutrition interventions for health personnel		$9,000		9,000
Community based models designed and implemented in target areas	UNICEF	***SCOs***	2.1.4.a Based on community needs assessment, design and implement models (community IMCI, gardens of mothers, BF mother support groups, distribution of MOH approved sprinkles) to address problems related to malnutrition and food insecurity at hh level including models of conditional cash transfers within the social assistance system, linked to child nutrition		$110,000	$275,662	385,662

		FAO	***KASH***	2.1.4.b. Technical support to design implementation of community based intervention models (garden-based learning and nutrition education)		$22,000		22,000
		WHO	***MOH***	2.1.4.c. Contribute experience from other countries and best practices into design of Albania specific models		15,000	10,000	25,000
	Models aiming to improve access to and consumption of micronutrient rich foods implemented in target areas	UNICEF	***KASH***	2.1.5.a Support implementation of interventions to improve access to and consumption of micronutrient rich foods (community & school gardens etc)		$71,000	$160,000	231,000
		FAO	***MOA***	2.1.5.b Support development of models to improve access to micronutrient-rich foods		$14,000	$25,000	39,000
		WHO	***MOH***	2.1.5.c Technical support to develop behavioral models to improve consumption of micronutrient-rich foods		10,000	10,000	20,000
JP Outputs **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
					Y1	Y2	Y3	Total
Output 2.2. Capacity building of health providers at national and in target areas to conduct Growth Monitoring and Promotion (GMP) and deliver nutrition counseling **Indicator:** **Integrated training module on feeding practices developed**	***Assessment on knowledge gaps in nutrition among health providers conducted***	UNICEF	***IPH***	2.2.1.a Assessment on knowledge gaps in nutrition among service providers	***20,000***			20,000
		FAO		2.2.1.b. Inputs to prepare methodology of assessment from a food security perspective	***7,000***			7,000

Baseline: **No nutrition training module exist**		WHO	***MOH***	2.2.1.c. Support to develop needs assessment tool on nutrition knowledge gaps among service providers	***10,000***			10,000
	Integrated training modules on nutrition developed	UNICEF	***Professionals associations***	2.2.2. a Develop integrated training modules based on existing modules on GM, BF counseling, complementary feeding, young child feeding and nutrition during pregnancy	***40,000***			40,000
		FAO	***MOA***	2.2.2.b. Technical guidance to develop food security and consumer education component of integrated training modules	***25,000***			25,000
		WHO	***MOH***	2.2.2c Technical and normative guidance to introduce the new growth monitoring charts as part of integrated training module	***15,000***			15,000
	Around 300 health service providers in target areas trained in nutrition	UNICEF	***MOH***	2.2.3.a Workshop with trainers to review and revise training materials		***10,000***		10,000
		WHO	***MOH***	2.2.3.b. Technical support to trainers workshop		***10,000***		10,000
		UNICEF	***MOH***	2.2.4.a Training of service providers in target areas in growth monitoring and promotion , BF, complementary feeding, nutrition during pregnancy		***75,000***	***100,000***	175,000
		WHO	***MOH***	2.2.4.b Support to develop training methodology		***10,000***		10,000
	Supervision and follow up methodology	UNICEF	***MOH***	2.2.5.a Design and implement supervisory follow up methodology			***43,000***	43,000

	developed	WHO	***Local health authorities***	2.2.5.b. Technical support to development of supervisory methodology			***15,000***	15,000
	Training modules revised and finalized for national implementation	UNICEF	***MOH***	2.2.6.a Revise training modules following training workshops in target areas, preparation of final materials and plan for national scale up			***12,000***	12,000
		WHO	***MOH***	2.2.6.b Support finalization of integrated training modules using lessons learned from global nutrition interventions			***10,000***	10,000
JP Outputs **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Y1	Y2	Y3	Total
Output 2.3. Development of communication for behavior change targeting families and communities for improved care and feeding practices for mothers and children **Indicator:** **Varied and comprehensive BCC package by target audience developed** **Exclusive breatfeeding rates** **Intra household food distribution** **Mimimum dietary diversity** **Infant and young child feeding frequency**	***Kap survey conducted in target areas***	UNICEF	***CSOs***	2.3.1a Conduct a baseline KAP survey in target areas, on nutrition and feeding practices, hh food security and food distribution within the family including research on community and hh level factors that constrain and/or facilitate mothers in good IYCF	***57,000***			57,000
		FAO	***MOA***	2.3.1.b.Inputs to develop food security and food distribution within family sections of the KAP survey tool	***25,000***			25,000
		WHO	***MOH***	2.3.1.c. Inputs to develop nutrition and feeding practices sections of the KAP survey tool	***10,000***			10,000

	Communication strategy for behavior change designed	UNICEF	***IPH***	2.3.2 aDesign communication for behaviour change strategy to address issues of malnutrition and food insecurity		***30,000***		30,000
		FAO	***MOA***	2.3.2.b. Technical assistance to develop behaviour models for addressing HH food insecurity		***26,000***		26,000
		WHO	***IPH***	2.3.2.c. Technical inputs to develop behaviour models for improved nutrition practices		***10,000***		10,000
	Food and nutrition education materials developed according to identified target groups	UNICEF	***IPH***	2.3.3.a. Develop and deliver appropriate food and nutrition education materials focused on adequate feeding and nutrition of infants, young children and mothers, combining various communication channels to reach target population groups		***125,000***	***311,653***	436,653
		FAO	***IPH***	2.3.3.b. Support the development of educational materials focusing on consumer education and food security		***50,000***		50,000
		WHO	***MOH***	2.3.3.c. Support the development of educational materials focusing on maternal and child feeding		***10,000***		10,000
		UNICEF	***IPH***	2.3.4. Prepare and introduce nutrition module into core curricula for compulsory education	***70,000***	***30,000***		100,000
Joint Programme outcome 3 : National capacities strengthened to deliver nutrition services to the public nutrition developed and structure of nutrition service delivery elaborated							Indicator: Capacities in public Health	

JP Outputs (Give corresponding indicators and baselines)	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Resource allocation and indicative time frame*			
					Y1	Y2	Y3	Total
Output 3.1. Curriculum for public health nutrition developed, tested and introduced in pre-service training **Indicator:** **Public Health Nutrition curricula for pre-service training developed** **Baseline:** **Currently module is not existing**	**Public Health Nutrition Curricula for pre-service core nutrition curriculum and advanced certificate course developed**	WHO	MOH	3.1.1.a. Establish and support technical working group to develop public health nutrition curricula	$8,000	$8,000	$8,000	24000.00
		FAO	MOA	3.1.1.b. Technical input to working group to develop public health nutrition curricula for pre-service training	$5,000	$8,000	$5,000	18000.00
		WHO	MOH	3.1.2. Review and adapt internationally available materials to national settings	30,000	30,000		60000.00
		UNICEF	MOH	3.1.3. Participation of 2-3 public health professionals in short or medium term specialized nutrition courses	15,000	10,000		25000.00
		WHO	IPH	3.1.4. Endorse pre-service module on public health nutrition training		10,000		10000.00
		WHO	IPH	3.1.5. Introduce modules into curricula		30,000	30,000	60000.00
	Curriculum materials prepared	UNICEF	Printing house	3.1.6. Design, layout and printing of curriculum materials			$54,400	54400.00
JP Outputs **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Y1	Y2	Y3	Total

Output 3.2. Improved supportive supervision health sector mechanisms to strengthen delivery of interventions aiming at reducing malnutrition **Indicator:** **Supervision on nutrition included within health reforms in Primary Health Care**	**Existing supervision mechanisms reviewed and supervision tool developed in year 1**	WHO	MOH	3.2.1. Establish multi-stakeholder technical working group to review supervision modalities	10,000			10000.00
	Supervision tool integrated into PHC in year 2	WHO	MOH	3.2.3. Include nutrition monitoring and BCC in supervision list of Regional Directorates for Public Health and HII		13,000		13000.00
		UNICEF	***Local health authorities***	3.2.4. Support integration of supportive supervision in target areas			***3,000***	3000.00
M&E **(Give corresponding indicators and baselines)**	Participating UN organization-specific Outputs	Participating UN organization corporate priority	Implementing Partner	Indicative activities for each Output	Y1	Y2	Y3	Total
	Support for M&E	WHO			10,000	10,000	25,000	45000.00
	Support for M&E	FAO			***6000***	***9000***	***13,000***	28000.00
	Support for M&E	***UNICEF***			***75,000***	***30,000***	***49,000***	154000.00
FAO	Indirect Support Cost**							49980
	Programme Cost							714000

UNICEF	Indirect Support Cost				151432
	Programme Cost				***2163318***
WHO	Indirect Support Cost				***60270***
	Programme Cost				861000
Total					**4000000**

6. Management and Coordination Arrangements

6.1 Management and Coordination Principles

This programme will be implemented by the Ministry of Health and the Ministry of Agriculture and combines the technical and financial inputs of WHO, FAO and UNICEF. The three key programme outcomes are aligned with the goals of Albania's NSDI. The three UN organizations have a history of collaboration with the Albanian government. More recently, the UN organizations jointly supported the Ministries of Agriculture and Health on Avian Influenza preparedness, in salt iodization and the design and implementation of the Demographic Health Survey.

The government will designate a national programme manager from MOH (or a government institution). The programme manager will be responsible for coordinating between the participating government ministries and institutions, to ensure that planned activities are carried out by the assigned institutions, at national, regional or local level as appropriate. The national programme manager will report back to the Steering Committee, as required, on the progress and constraints that can be resolved through intervention at the level of the steering Committee.

On their part, each of the participating UN organization will appoint a technical advisor to the Joint Nutrition Programme. UNICEF as the lead agency will ensure overall programme coordination of the Joint Nutrition Programme. The UNICEF Representative, assisted by the Technical Advisor to be appointed by UNICEF, will, over and above her/his role, have additional responsibilities for bringing together the inputs of the UN organizations. In particular, she/he will ensure that the inputs are sequenced and delivered on time, and that periodic narrative and progress reports both for the Resident Coordinator and the National Steering Committee are prepared. The technical advisor will also provide the UNICEF technical inputs and management of UNICEF financial resources. Respective terms of reference have been prepared; these have been agreed by the participating UN organizations so as to ensure that adequate authority has been vested to UNICEF to intervene as appropriate. The Joint Programme and the management structured described above will ensure that existing management capacities and structures are used and adapted as necessary to ensure cost effective and sustainable coordination. The transfer of these coordination capacities to government structures will be encouraged to ensure long term sustainability. Innovative information technologies will be used to better share information among UN organizations and government departments regardless of location.

Next to the management responsibilities of the Programme Coordinator, table 3 reflects the division of labor among UN organizations participating in the Joint Nutrition Programme

Component	Sub-components and activities		Agencies technical-operational roles		
			UNICEF	WHO	FAO
A. Reduce malnutrition	A1. Proven nutrition interventions		**lead**	*support*	support
	A2. Parallel IEC/BCC campaign		**lead**	inputs	inputs
	A3. Complementary approaches		**lead**	inputs	inputs
B. F&N Policy and Planning	B1. Develop 2nd Food and Nutrition Policy		*support*	**lead**	inputs
	B2. Establish HFN surveillance		**lead**	Support	inputs
	B3. Research knowledge gaps	1. Causes of anemia in children and women	*support*	**lead**	support
		2. Impact of soaring food and energy prices	inputs	inputs	**lead**
		3. Flour fortification situation analysis	**lead**	inputs	inputs
		4. Gender roles in household food and nutrition problems	inputs	inputs	**lead**
C. Capacity development	C1. PHN curriculum development		*support*	**lead**	inputs
	C2. Strengthen MCH inspector capacity		*support*	**lead**	support
D. M&E, scaling-up and sustainability	Capture experiences, share results, execute exit strategy		**lead**	*support*	*support*

Each organization will provide its support as detailed below:

UNICEF will closely support the lead line ministry, MOH, to ensure that all inputs and outputs of UN agencies and partners are coherent, measurable, sustainable and in accordance with the timeframe and budget of the work plan. UNICEF will host FAO staff and experts on mission, providing office space and other support to ensure these missions are productive and well linked to the agreed workplans. Next to the programme coordinator, UNICEF will provide a programme assistant with appropriate experience and profile for this Joint Nutrition Programme, who should have a previous experience in coordination and knowledge of GOA public health policies and systems Strategic use of teleconferencing, web conferencing and other conferencing technologies will also be applied to keep partners, resident UN agency staff and non-resident staff (FAO) attuned to workplan progress and latest developments.

WHO has hosted FAO staff in the past and also accommodates WHO's international experts on mission in Albania. This hosting function will be closely coordinated with UNICEF and FAO. WHO will provide an internet SharePoint? This is an interactive tool that will house all documents, workplans, and activity monitoring sheets, travel details, calendars and information from the project management group. This innovative way of working will maintain ownership with the line ministries who will have access and use this for sharing of information with UN agencies as well as between government departments and civil society organizations.

The **FAO** component will be implemented under the lead of the Sub regional Coordinator (SRC) for Central and Eastern Europe in Budapest in absence of FAO Representation in Albania. Management of the component will be done by the SRC, who will be responsible for the overall

supervision as well as budget and reporting. The SRC will supervise the inputs provided by technical experts both from the Regional Office for Europe (REU) and Central Asia in Budapest and Headquarters. REU will provide inputs regarding gender as well as partly on nutrition. Important inputs will be provided by technical officers at FAO HQ. The SRC and her office will closely liaise with the other partners of the component including the appointed national focal points in the relevant Ministries on the basis of the prepared workplan to either provide FAO's inputs to the other components or to request the other partners' inputs under the FAO lead components. Regular meetings will take place during expert missions or via telephone or video conference link as well as through the internet based share point. The SRC or a designated officer will regularly participate in the Programme Management Committee.

The **UNRCO** will provide support to the coordination of this joint programme through expertise in monitoring and evaluation and through promotion of spirit and practices of joint programming Additional budget for this is indicated in the results matrix and will serve to strengthen support to all MDGF joint programmes in Albania.

6.2 Coordination Structures

Based on the past and ongoing experiences in collaboration, the programme will rely on the existing **National Steering Committee** set up for all MDGF joint projects in Albania for strategic guidance including approval of annual work plans and budgets.

In addition, specific to this programme is the **Programme Management Committee** (PMC) comprised of representatives of UNRCO, UNICEF, FAO, WHO, MOH, MoAg, and the Spanish Embassy in Tirana. The PMC will meet quarterly to review and discuss:

- Development of Annual Work Plans (AWPs) toward the outcomes of the MDG proposal.
- Review of major progress against AWPs
- Review partnership development and performance
- Discuss and guide prioritization and synchronization of activities
- Review implications for policy making and decisions

Each ministry will allocate a focal point at implementation level for daily interaction with the implementing UN partners forming a project management group. UNICEF takes the lead role in coordinating the efforts of the participating UN organizations and will liaise closely with all national, regional and local government partners at the strategic level. At the technical level each UN agency will interact with partners related to their activities, linking closely with other agencies and partners to ensure coordination of those activities that are joint.

Ministries and specialized institutions at national level will ensure local authorities under their supervision are involved in the process. A series of capacity building interventions for data collection and management, priority setting and planning nutrition interventions will build mulitsectoral teams at district level (Health, Agriculture, Education, Civil Society) that will participate throughout the duration of the programme.

The Albanian Agribusiness Council (a private sector institution) will participate in planning and implementing interventions – both at national and local level – based on their established institutional relationships with the Ministry of Agriculture, extended network of members all over the country, and successful past collaboration experiences.

7. Fund Management Arrangements

The contributions of the MDG-F will be transferred to the participating UN Organizations through UNDP as the Administrative Agent in line with provisions of Annex 4 of the Guidance Note. Each participating Agency assumes complete programmatic and financial responsibility for the funds disbursed to it by the Administrative Agent and decides on the execution process with its partners and counterparts following the Agency's own applicable regulations.

Each Agency will establish a separate ledger account for the receipt and administration of the funds disbursed by the Administrative Agent. The participating Agencies will provide certified financial reports according to the budget template provided in the MDG-F Operational Guidance Note issued by the MDTF Office. They will deduct their indirect costs on contributions received not exceeding 7 percent of the Joint Programme budget in accordance with the provisions of the MDG-F and the Memorandum of Understanding signed between the Administrative Agent and participating Agencies.

Installments will be released in accordance with the annual work plans approved by the NSC. The release of funds is subject to meeting the minimum commitment threshold of 70% of the previous funds released to the participating Agencies combined. If the 70% threshold is not met for the Programme as a whole, funds cannot be released to any Agency, regardless of the individual agency's performance.

The following year an advance can be requested at any point after the combined Commitment against the current advance has exceeded 70% and the workplan requirements have been met. If the overall commitment of the Programme reaches 70% before the end of the twelve-month period, the participating Agencies may – after endorsement by the NSC – request the MDTF Office through the Resident Coordinator to release the next installment ahead of schedule.

8. Monitoring, evaluation and reporting

The preparation of detailed information related to the timing and delivery of products, services and activities will mainly be the responsibility of the programme management team. The programme management team's work schedules will include regular supportive supervision visits in the areas targeted for programme support. Joint monitoring visits of the project team, UN agencies and the government officials will be periodically scheduled. Key performance indicators will be included in the regular implementation reports and in reports of specific components.

Scheduled periodic visits by Agency specialists will add to the relevance, accuracy and reliability of capturing the programme's results and contribute to lessons learned to inform future policy and strategy, and to advocacy and publicity.

Monitoring and evaluation will take place in accordance with the One UN Programme monitoring and evaluation plan. The MDTF Office is responsible for producing the annual Consolidated Joint Programme Progress Report, which will consist of three parts:

- *Management Brief*: The Management brief consists of analysis of the certified financial report and the narrative report. The management brief will identify key management and administrative issues, if any, to be considered by the NSC.

- *Narrative Joint Programme Progress Report*: This report is produced according to the integrated Joint Programme reporting arrangement. It will be reviewed and endorsed by the PMC before it is submitted to the MDTF Office.

- *Financial Progress Report*: Each Participating UN Organization will submit to the MDTF Office a financial report stating expenditures incurred during the reporting period.

The participating Agencies have primary responsibility to develop tools and methodologies to better monitor and evaluate the work of the Programme. Bi annual status reports will be prepared by each Agency together with their government counterparts. The Programme Coordinator will consolidate the report based on inputs of each agency and submit to AA and MDG-F secretariat. The Programme Coordinator will provide to the AA quarterly financial updates.

The Joint Programme will be subject to a mid-term review and to a final evaluation to assess the relevance and effectiveness of the intervention and to measure the results, on the basis of the indicators of achievement. The mid-term review will be organized by the MDG-F Secretariat.

Table 2: Joint Programme Monitoring Framework (JPMF)

Expected Results (Outcomes & outputs)	Indicators (with baselines & indicative timeframe)	Means of verification	Collection methods (with indicative time frame & frequency)	Responsibilities	Risks & assumptions
Outcome 1: National capacities strengthened to incorporate nutritional objectives into sectoral polices and programmes **Output 1.1.** – Advocacy and awareness raising programme to address malnutrition and food security developed and implemented, targeting policy and decision makers **Output 1.2.** Technical support for strengthening data collection and utilisation of data on food, health and nutrition **Output 1.3.** Development of 3rd National Food and Nutrition Action Plan **Output 1.4:** Strengthening of National food and nutrition surveillance system	Indicator: - A high level coordination mechanism established for integrated nutrition and food security policies and programmes. Baseline: No intersectoral coordination mechanism for integrated nutrition and food security policies and programmes at high level exist Indicator: - Number of National and regional staff trained in intersectoral actions to address malnutrition and food insecurity Baseline: No recent capacity development exercises for government officials for intersectoral food and nutrition actions Indicator: - National mass media campaign developed and implemented Baseline: No advocacy plan for food and nutrition exist Indicator: National data collectors, producers, and users trained and surveys conducted Baseline: Sufficiently disaggregated	Ministerial order for establishment of National Coordination structure for Food and Nutrition Minutes of meetings of coordination structures Media coverage reports Training and workshop reports Survey reports Awareness raising communication materials produced and disseminated	Official reports from government of Albania Official workshop reports Training reports Examples of mass communication materials	Participating agencies and government partners	Assumptions: Improvement of food and nutrition status of women and children remains a priority of the government of Albania All major ministries and institutions will commit to implementation of activities No major institutional changes occur during the implementation of the project Risks: Competing priorities of government institutions may shift focus from implementation of JP Mitigation strategies: High level coordination mechanism will help raise the nutrition and household food security issues high in the government agenda and make investments for nutrition priority not only of one ministry (MOH) but the whole government. Risks: Release of DHS and LMS data is delayed Mitigation strategy Close follow up of the process and the fact that UNICEF and WHO are supporting DHS process and ensuring that deadlines are met

	data on gender and household food security do not exist Indicator 3rd National Food and Nutrition Action Plan (FNAP)developed Baseline: Current (FNAP) has insufficient focus on nutrition and food security issues. Indicator: Food and Nutrition Surveillance system developed Baseline: Growth monitoring data are collected at individual level but not analysed and used to flag out problems; no surveillance system in place Indicator Number of steering committee meetings attended by all key members Number of working group meetings attended by all key members Number of joint decisions of government institutions taken and implemented				

Outcome 2 :Cross sectoral interventions addressing malnutrition are developed, tested and implemented in target areas Output 2.1. Develop, test and implement community based intervention models to address malnutrition and household food in security Output 2.2. Capacity building of health providers at national and in target areas to conduct Growth Monitoring and Promotion (GMP) and deliver nutrition counselling Output 2.3. Development of communication for behaviour change targeting families and communities for improved care and feeding practices for mothers and children	Indicator: - Community based intervention models to address malnutrition and household food security implemented in target areas - Integrated training module on nutrition developed - Number of health workers participating in integrated nutrition training - Percentage of children in target areas receiving interventions addressing malnutrition and household food insecurity. - Exclusive breastfeeding rates - Intra household food distribution - Infant and young child feeding frequency - Minimum dietary diversity - Varied and comprehensive BCC package by target audience developed	Training and workshop reports Survey reports (KAP)	Baseline and end line surveys Official training reports Pre and post training evaluations Official reports from regional authorities (health & food and nutrition) Annual and quarterly progress reports	Participating agencies and government partners	Assumptions: All major ministries, institutions and local government authorities will commit to implementation of activities Risks Competing priorities of government institutions may shift focus from implementation of JP
outcome 3 : National capacities strengthened to deliver nutrition services to the public Output 3.1. Curriculum for public health nutrition developed, tested and introduced in pre-service training	Indicator: Public Health Nutrition curricula for pre-service training developed Baseline: Currently module is not existing Indicator:	Finalized and approved core curricula on nutrition and official approval Guidelines by MOH on implementation of nutrition supervision	Official reports of MOH Annual and quarterly progress reports		Assumptions: All major ministries and institutions will commit to implementation of activities Risks: Turnover of trained personnel and change in position

Output 3.2. Improved supportive supervision health sector mechanisms to strengthen delivery of interventions aiming at reducing malnutrition	Supervision on nutrition included within health reforms in Primary Health Care	package			Mitigation strategy: Agreement with the government to ensure trained people are retaining their position for e certain period of time

9. Legal Context or Basis of Relationship

Albania is a pilot country of the One UN initiative. The One UN Programme in Albania includes resident and non-resident UN agencies, funds and programmes which strategically contribute to Albania's development priorities as outlined in the National Strategy for Development and Integration (NSDI). The following UN agencies and funds are participating in the One UN programme in Albania: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Volunteers (UNV), the United Nations Development Fund for Women (UNIFEM), the World Health Organization (WHO), the UN High Commissioner for Refugees (UNHCR), the International Labor Organization (ILO) and non-resident agencies such as the UN Environment Programme (UNEP), the UN Educational, Scientific and Cultural Organization (UNESCO) and the Food and Agriculture Organization (FAO).

UNICEF, WHO, and FAO have signed, as participating Agencies, the Memorandum of Understanding regarding the Operational Aspects of the UNDP Spain Millennium Development Goals Achievement Fund (MDG-F) and, therefore, have agreed that the United Nations Development Programme (UNDP) serves as the Administrative Agent responsible for the administration of the MDG-F. Each Agency will carry out the Joint Programme activities in accordance with the regulations, rules, directives and procedures applicable to it. Accordingly, personnel shall be engaged and administered, equipment, supplies and services purchased, and contracts undertaken, in accordance with the provisions of such regulations, rules, directives and procedures. On the termination or expiration of this Agreement, the matter of ownership shall be determined in accordance with the regulations, rules, and directives and procedures applicable to the participating Agencies, including, where applicable, its basic agreement with the Government concerned.

Table 3: Basis of Relationship

Participating UN organization	Agreement
UNICEF	The assistance envisaged in the JPD is regulated by the Basic Cooperation Agreement (BCA) concluded between the Government and UNICEF on July 23rd, 1993, which provides the basis of the relationship between the government and UNICEF.
WHO	The Regional office for Europe of the Word Health Organization and the Ministry of Health of Albania have signed a Biennial Collaborative Agreement on September 17, 2007.
FAO	*The Republic of Albania is a member of FAO and accepts the basic text of FAO (including rules and regulations in finances etc.) since becoming a member of FAO on 12 November 1973. Due to the fact that FAO is a non-resident agency in Albania, FAO is usually represented through UNDP and its legal framework in the country. FAO currently prepares a National Medium Term Priority Framework, which will be signed in 2009.*

10. Year One Work plans and budgets

JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 1.1. – Advocacy and awareness raising programme to address malnutrition and food security developed and implemented, targeting policy and decision makers **Indicator:** **- Coordination mechanism for food and nutrition strengthened** **Baseline:** **1. No coordination mechanism at high level exist** **Indicator:** **- Number of National and regional staff trained in intersectoral actions to address malnutrition and food insecurity** **Baseline:** **1. No recent capacity development exercises for government offcials for intersectoral food and nutrition actions** **Indicator** **- National massmedia campaign developed and implemented** **Baseline:** **No advocay plan for food and nutrition exist**	Coordinating mechanism for food and nutrition strengthened	WHO	1.1.1. Support National coordinating mechanism for food and nutrition	x	x	x	x	MOH	MDG-F	Contract Personnel Travel	2,000 6,000 2,000
	Enhanced national capacity for inter-sectoral actions to address malnutrition and food insecurity	WHO	1.1.2 a. National and regional consensus building workshops on intersectoral actions to address malnutrition and food insecurity (including launching)		x	x	x	MOH	MDG-F	Contract Personnel Travel Transport Supplies	9,000 8,000 1,000 1,000 1,000
		FAO	1.1.2 b. Technical support to and participation in consensus building workshops on intersectoral actions to address malnutrition and food insecurity		x	x	x	MOA	MDG-F	Personnel (a) Travel	5,800 1,200
	National mass-media communication campaign developed and implemented to increase commitment and investment of policy and decision makers	UNICEF	1.1.3 a. Advocacy events, key stakeholders meetings, materials and information package developed and disseminated, media communications and periodic information updates to the public		x	x	x	IPH	MDG-F	Personnel Contracts Supplies	23000 15000 5000
		FAO	1.1.3.b Support development of communication materials and advocacy activities focusing on food security issues	x	x	x	x	MOA	MDG-F	Personnel (a) Travel	5,800 1,200

		WHO	1.1.3.c. Support elaboration of key communication messages on consequences of malnutrition		x	x	x	MOH	MDG-F	Personnel	4,000
JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 1.2. Technical support for strengthening data collection and utilisation of data on food, health and nutrition **Indicator : Number of national and reginal staff trained in intersectoral actions to address malnutrition and food insecurity** **Beaseline: No recent capacoty develppment exercises for government officals for intersectoral food and nutrition actions** **Indicator: National data collecotrs, producers and users trained and surveys conducted** **Baseline: Sufficiently dissagregated data on gender and household food security do not exist**	Review of existing data sources and nutrition indicators and framework for collection of food and nutrition data developed	WHO	1.2.1. a. Review existing data sources and information systems on food and nutrition security and identify information needs of data users	x	x	x	x	MOH	MDG-F	Personnel	8,000
		FAO	1.2.1.b Organize meetings and workshops to review existing information and new DHS and LSMS data on food prices, household food security, nutrition and status of women and carry out secondary analyses	x	x	x	x	INSTAT	MDG-F	Personnle (a) Personnle (b) Travel	4,000 9,000 3,000
	Improved information available on the effects of high food prices and gender on the food security of vulnerable groups and at-risk households	FAO	1.2.3.a. Provide technical and financial assistance for developing, carrying out and analysing rapid data collection activities at community/household level in project target areas, including gender roles and household food and nutrition (baseline for target areas)	x	x	x	x	INSTAT	MDG-F	Contracts Personnel (a) Personnle (b) Training Travel Transport Supplies	15,000 15,000 35,000 7,000 8,000 2,000 5,500

	UNICEF	1.2.3 b Input to prepare baseline survey tool sections for impact of food prices in children	x	x	x	x	IPH	MDG-F	Contracts personnel (a)	5000 5000
	WHO	1.2.3.c Input to prepare baseline survey tool using a health systems' perspective	x	x	x	x	IPH	MDG-F	Personnel	3,000
Situation analysis and mapping of milling industry completed. Feasibility of flour fortification shared with key stakeholdres	UNICEF	1.2.4.a. Technical and financial support for conducting a situation analysis and feasability study for flour fortification and assist in disseminating information		x	x	x	KASH	MDG-F	Personnel contracts	21,500 25,000
	WHO	1.2.4.b. Technical support to analyze the link between fortification and micronutrient deficiencies in the survey tool and praparation of the final report		x	x	x	KASH	MDG-F	Contract Personnel Travel	1,000 7,000 2,000
Statistically significant survey conducted in year 1 identifying main causes of anaemia in high prevalence areas of the coutnry as identified in DHS	WHO	1.2.5.a. Technical and financial support for conducting a survey to identify the main causes of anaemia in high prevalence areas and analysing and disseminating results	x	x	x	x	IPH	MDG-F	Contract Personnel Travel Training Transport Supplies Equipment Miscellaneous	135,000 25,000 4,000 10,000 1,000 20,000 3,000 2,000
	UNICEF	1.2.5.b Technical support for conducting secondary analysis based on DHS data for mapping of IDA and providing inputs for further research on causes of anaemia	x	x	x		IPH	MDG-F	Personnel	20,500

JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 2.2. Capacity building of health providers at national and in target areas to conduct Growth Monitoring and Promotion (GMP) and deliver nutrition counseling **Indicator:** **Integrated training module on nutrition developed** **Number of health workers participating in integrated nutrition training**	***Assessment on konwledge gaps in nutrition among health providers conducted***	UNICEF	2.2.1.a. Assessment on knowledge gaps in nutrition among service providers		x	x	x	IPH	MDG-F	Personnel Contracts	13,000 7,000
		FAO	2.2.1.b. Inputs to prepare methodology of assessment from a food security perspective		x	x	x	MOA	MDG-F	Personnle (a) Travel	5,800 1,200
		WHO	2.2.1.c. Support to develop needs assessment tool on nutrition knowledge gaps amonh service providers		x	x	x	MOH	MDG-F	Personnel Contracts Travel	7,000 1,000 2,000
	Integrated training moduels on nutrition developed	UNICEF	2.2.2.a. Develop integrated training modules based on existing modules on GM, BF counseling, complementary feeding, young child feeding and nutrition during pregnancy	x	x	x	x	MOH	MDG-F	Personnel Contratcs	25,000 15,000
		FAO	2.2.2.b Technical guidance to develop food security and consumer education component of integrated training modules	x	x	x	x	MOA	MDG-F	Personnel (a) Travel	21500 3,500
		WHO	2.2.2.c. Technical and normative guidance to introduce the new growth monitoring charts as part of integrated training modules	x	x	x	x	MOH	MDG-F	Contract Personnel Travel	2,000 11,000 2,000

JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 2.3. Development of communication for behavior change targeting families and communities for improved care and feeding practices for mothers and children **Indicator:** **Varied and comprehensive BCC package by target audience developed** **Exclusive breastfeeding rates** **Intra household food distribution** **MInimum dietary diversity** **Infant and young child feeding frequency**	***Kap survey conducted in target areas***	UNICEF	2.3.1. a Conduct a baseline KAP survey in target areas, on nutrition and feeding practices, hh food security and food distribution within the family including research on community and hh level factors that constrain and/or facilitate mothers in good IYCF	x	x	x		CSOs	MDG-F	Personnel contracts	35,000 22,000
		FAO	2.3.1.b. Inputs to develop food security and food distribution within family sections of the KAP survey tool	x	x	x	x	MOA	MDG-F	Personnel (a) Travel	21500 3,500
		WHO	2.3.1.c. Inputs to develop nutrition and feeding practices sections of the KAP survey tool	x	x	x		MOH	MDG-F	Contract Personnel Travel	2,000 7,000 1,000
		UNICEF	2.3.4. Prepare and introduce nutrition module into core curricula for compulsory education		x	x	x	IPH	MDG-F	Personnel Contracts	32,582 37,418
JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 3.1. Curriculum for public health nutrition developed, tested and introduced in pre-service training	**Public Health Nutrition Curricula for pre-service training**	WHO	3.1.1 a. Establish and support technical working groups to develop public health nutrition curricula	x	x	x	x	MOH	MDG-F	Contract Personnel Travel	2,000 5,000 1,000

Indicator: **Public Health Nutrtion curricula for pre-service training developed** **Baseline:** **Currently module is not existing**	**developed in year 2**	FAO	3.1.1. bTechnical input to working group to develop public health nutrition curricula	x	x	x	x	MOA	MDG-F	Personnel (a)	5,000
		WHO	3.1.2.a. Review and adapt internationally available materials to national settings	x	x	x	x	MOH	MDG-F	Contract Personnel Travel	6,000 20,000 4,000
		UNICEF	3.1.3. Participation of 2-3 public health professionals in short or medium term specialized nutrition courses	x	x	x	x	IPH	MDG-F	Personnel Training	10,000 5,000
JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Output 3.2. Improved supportive supervision health sector mechanisms to strengthen delivery of interventions aiming at reducing malnutrition **Indicator:** **Supervision on nutrition included within health reforms in Primary Health Care**	Exisiting supervision mechanisms reviewed and supervision tool developed in year 1	WHO	3.2.1. Establish multi-stakeholder technical working group to review supervision modalities		x	x	x	MoH	MDG-F	Contract Personnel Travel	2,000 7,000 1,000
JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		

				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
Monitoring and Evaluation	Support for M&E	WHO				x	x	MOH	MDG-F	Personnel	10000
	Support for M&E	FAO			x	x	x	MOA	MDG-F	Personnel (a) Travel	4,500 1,500
	Support for M&E	UNICEF			x	x	x	MOH	MDG-F	Personnel Contracts	57,000 18,000
JP Output	UN organization-specific Annual targets	UN organization	Activities	TIME FRAME				Implementing Partner	PLANNED BUDGET		
				Q1	Q2	Q3	Q4		Source of Funds	Budget Description	Amount
FAO	Programme Cost **										185,500
	Indirect Support Cost**										12,985
UNICEF	Programme Cost										397,000
	Indirect Support Cost**										29,735
WHO	Programme Cost										348,000
	Indirect Support Cost										25,065
***Total**	**Programme Cost**										**930,500**
	Indirect Support Cost										**67,785**

*Note: UNRCO is seeking 15,582 toward overall M&E management support for year one.

Personnel costs per
agency
WHO: National programme officer 50,000 USD, advisor for technical backstopping : 17,000 USD, Assistant : 27,000 USD, Intl expert: 34,000 USD

FAO: Assistance for technical backstopping: 30,000 USD, Project assistant: 43,200 USD, International expert: 54,800 USD

UNICEF: Manager : 200,000 USD, National Programme assistant: 27,000 USD, contribution to UNRC : 15,582 USD

Annex 1 -Capacity for Nutrition Intervention for Women and Children

This annex offers some initial information about the capacity in the Albanian set-up for programming and delivering actions aimed to improve the nutrition situation for women and children.

The table below summarizes some strengths, weaknesses, opportunities and threats that are considered relevant for the policy and institutional set-up of Albania, with emphasis on the needs for planning, execution and monitoring of actions through the health service and the agriculture-agribusiness industry.

a. SWOT matrix

Strengths • National development policy strategy based on MDG achievement targets • Health & Agriculture strategies emphasize PHC priority and rural production/agro-processing potential • Aggregate food supply well balanced • A dynamic agribusiness industry • Medically qualified PHC personnel, especially in urban areas • WHO protocols in place, incl. IMCI • Universal delivery in maternities • High breastfeeding initiation • Legislation on breast milk substitutes	Weaknesses • Nutrition targets not measured in national strategy for development (NSDI) • Optimum nutrition not explicitly stated in Health or Agriculture strategies • No nutrition profession or career perspective • Limited evidence-based planning, design and implementation of nutrition strategies/actions • PHC staff not skilled in effective mother and child nutrition counseling • Low public perception of value of prevention • Limited public promotion of healthy diet, physical activity and nutrition • Low incentives for working in rural areas
Opportunities • Inter-sector linkages: Partnerships for nutrition at national and local levels • Creating an optimum mixture of supplementation and fortification • Community-IMCI guidance for actions in rural, remote districts • Inserting nutrition in the School of Public Health and Nursing	Threats • Water safety and environmental pollution • Limited hygiene, sanitation and drainage • Delays in economic, health, agricultural and social progress in rural areas • Ongoing urban-rural and external migration • Reliance on economic development

• Rural agriculture potential for a sustainable wholesome food supply • High agro-industry interest in nutrition-value added food supply • Nutrition counseling, connected to weight gain and child feeding history	alone to address problems of suboptimal nutrition • Expectance that the health sector by itself can solve the suboptimal nutrition situation • Limited research and experimentation on practical steps to improve nutrition for women and children (e.g., counseling) • Global financial turmoil may jeopardize domestic decisions to improve nutrition

b. Kukes and Shkodra Prefectures: PHC capacity

The northernmost Prefectures Kukes and Shkodra, located on the border with Kosovo and Montenegro, are two remote, rural areas of Albania of high concern for health and development of their population. Kukes Prefecture, with a population of ±100,000 people and measuring 2,373km^2, is situated in the northeast of Albania and encompasses 3 districts: Kukes, Has and Tropoje. The Shkodra Prefecture measures 3,562km^2, has 225-250,000 people, is located in the far northwest, and has also 3 districts: Shkoder, Malesia e Madhe and Puke.

Working with the resident UNDP team, each Prefecture has articulated a regional development plan to improve social and economic status in the region through accelerating economic growth, increasing the access and quality for schooling, promoting gender equity and ensuring better access to health care. The regional MDG plans of 2005[14] defined a baseline against which to measure improvements in the selected priority areas of each Prefecture. The number of health care facilities for delivering PHC services for women and children may be taken as a proxy indicator for the capacity in the Prefectures for programming actions to improve the nutrition situation.

The Kukes regional development plan of 2005 states: “Kukes is considered one of the poorest regions in Albania with respect to the access and quality of health care services. The health of the citizens in the region has been hampered by a multitude of factors including insufficient and/or inadequately trained health care staff and shortages of necessary supplies and safe medicine. Of particular concern is the lack of supporting maternal and infant health care services in the region. In short, the general conditions of the hospitals and health centers are not sufficient to meet the needs of the population.”

In Shkodra Prefecture, 72% of the population lives in Shkoder district, and the districts Malesia e Madhe, and Puke are among the most rural of Albania. The Prefecture has 5 municipalities, 29 communes and 269 villages. The Shkodra regional plan summarized the situation for women and children in 2005 as follows: “*Mother and child health care* is based on the analysis of maternal and child mortality incidence and on the access level to basic health care. In this analysis it comes out that half of the communes of the district of Puka do not have a health center; approximately 2/3 of the villages of Shkodra Region, where approximately 50% of the

[14] http://www.undp.org.al/index.php?page=rds

rural population lives, do not have out-patient clinics; access to pharmaceutical services is very low; specialized doctors are very hard to find."

Kukes and Shkodra Prefectures: Capacity of maternal and child health services, 2007

	No of centers		No of MDs		No of nurses/midwives	
Prefecture	Urban	Rural	Urban	Rural	Urban	Rural
Child consulting centers:						
Kukes	1	21	1	20	10	25
Shkodra	8	17	8	43	38	222
Maternal consulting centers:						
Kukes	1	21	1	19	6	128
Shkodra	4	17	3	43	10	221

The numbers of urban and rural PHC consulting centers and staffing in 2007, according to MOH data, are shown in the table above, suggesting shortages in Kukes Prefecture of MDs overall and a low ratio of nurses in CCCs in rural PHC services. In Shkodra, staff shortage especially affects the prenatal clinics.

c. Agro-processing industry

The table below is a summary of characteristics of the agro-processing industry of Albania, taken from the 2007 Agricultural Statistical Yearbook. The bread & confectionary (connected with the flour milling), milk & dairy, and mineral water & soft drinks processing industries are exemplary strong agribusiness sectors. The MAFCP strategy seeks opportunities in the fruits and vegetables sector. The oil processing sector may provide future room for export market growth in olive oil.

Number of enterprises and employees, and reported production by agro-industry, Albania 2007

Agro-industry	Number of enterprises	Number of employees	Production
Bread and confectionary	967	3,433	260,400 ton bread
Milk and dairy products	344	1,181	59,027 hl milk, 630 ton butter, 12,924 ton cheese and 14,735 ton yoghourt
Flour milling	217	716	427,186 ton wheat flour
Refined oils	134	333	14,789 ton oil and 3,879 ton olive oil
Wine and beer production	112	816	365,889 hl beer and 15,279 hl wine

Butcheries, meat products	71	908	9,145 ton ham and sausage
Water and soft drinks	54	959	706,495 hl mineral water and 692,914 hl soft drinks
Alcohol distilleries	51	252	37,881 hl alcoholic beverages
Tinned fruits and vegetables	20	176	807 ton tinned vegetable, 96 ton tomato sauce, 306 ton jam/compote and 60,890 hl fruit juice
Other	70	1,519	Fish, sweets, ice cream etc
All enterprises	2,040	10,293	47,970Mln Leke (2006 value)

Annex 2 - Child Mortality attributable to the Suboptimal Nutrition Situation of Women and Children

This chapter reports on the projected consequences of malnutrition among women and children in Albania. The calculations are based on key prevalence data described in the chapters before, and brings them together with relative risks of disease and mortality due to the given conditions, as obtained from the international literature. The procedure in this chapter is similar to that used in the calculations by WHO for the global burden of disease, and to methods in the international literature describing the worldwide nature and seriousness of mother and child under nutrition (Black RE et al 2008, *op cit*).

Albania	**Number**	**Assumptions**
Total population (thousand)	3,172	SOWC, 2008
Crude Birth Rate (births/1,000 population)	12	UNICEF estimate
Newborns/year	38,064	
Infant Mortality (Infant Deaths/1,000)	**13**	2006, MDG report 2007
Infant deaths/year	495	
Child Mortality (Child Deaths/1,000)	**18**	2006, MDG report 2007
Child deaths/year	685	
Breakdown of infant and child mortality		
Early neonatal (1st week)	136	27.5% of IMR
Late neonatal (wk 2-4)	87	17.5% of IMR
1 - 5 months	148	remainder
6 - 11 months	124	25% of IMR
12 - 59 months	190	CMR minus IMR

The above table shows the basic assumptions for estimating the consequences of malnutrition for infant and child mortality. At a population size of 3.172million (State of the World's Children, 2008) and a crude birth rate of 12 per 1,000 population (UNICEF estimate), there are ±38,000 newborns per year in Albania. Using the reported infant and child mortalities[15] for 2006 of 13 and 18 per 1,000 live births respectively, 495 infants and 685 children under age 5 are dying each year. These early deaths are separated by age group in the bottom half of the table on basis of estimated proportions for each period. For example, IPH estimated that 40 percent of the infant deaths in Albania take place during the neonatal period (Situation Analysis for Child and Adolescent's Health and Development, 2007). We assume that another 25 percent of the infant deaths occur between 6 and 12 months of age. The mortality for children, aged 12-59 months, is obtained by the difference between the child and infant deaths.

The existing prevalence estimates for Albania for LBW, suboptimal infant and young child feeding practices, and weight for age are used for calculating the number of nutrition-attributable deaths. The table below shows the relative risks of these conditions for the age groups listed. For example, compared to newborns with birth weights above 2.5kg, the risk of

[15] http://intra.undp.org.al_ext_elib_download__id=1005&name=Millennium Development Goals Report 2007.pdf

death in newborns with LBW are 4 and 2 for the 1st week (early neonatal period) and weeks 2-4 after birth (late neonatal period), respectively[16]. Thus, although the factors underlying the occurrence of LBW operate during the pregnancy period *before* birth, the condition itself affects the likelihood of survival during the period *after* birth.

Relative risks of mortality and morbidity associated with suboptimal nutrition

Condition and consequence	Relative Risks	Age group affected by the stated consequence
Low birth weight (LBW), mortality	4	1st week
Low birth weight (LBW), mortality	2	weeks 2-4
No breastfeeding, respiratory disease	4.7	1-5 months
Early complementary feeding, respiratory disease	2.8	1-5 months
Inadequate complementary feeding, respiratory disease	2.8	6-11 months
Inadequate young child feeding, respiratory disease	1.75	12-59 months
Low weight for age, mortality	9.7, 2.5 and 1.8	6-59 months

The international evidence shows that infants who are not breastfed from birth (i.e. are fed artificially) have a 4.7-fold risk of contracting respiratory disease during their age 1-5 months relative to exclusively breastfed infants; introducing complementary feeding before age 5-6 months carries a risk of respiratory disease of 2.8 during the age of 1-5 months, and so on[17]. For calculating the mortality due to these improper infant feeding practices, we use 40 percent as the proportion of hospitalized children who die from respiratory disease (MOH estimate). For low weight-for-age, the immediate mortality risks depend on the severity of weight deficits, and were taken from the study by Black et al 2008, referenced before (See illustration on page 17).

Rather than relative risks, the population attributable fraction (PAF) is the bottom line when expressing the burden of malnutrition for mortality[18]. To arrive at age-group specific proportions of deaths attributable to their prior suboptimal nutrition, the relative risks for each condition are combined in the next table with the relevant prevalence data for Albania.

Population mortality attributable to suboptimal nutrition

Condition, group	Prevalence	Attributable mortality fraction
LBW, week 1	6.9%	17.1%
LBW, weeks 2-4	6.9%	6.5%
No breastfeeding, 1-5 months	15%	36% times 40% = 14.3%
Early comp feeding, 1-5 months	25%	31% times 40% = 12.4%

[16] Ashworth A. Effects of intrauterine growth retardation on mortality and morbidity in infants and young children. *European Journal of Clinical Nutrition* **52**: S34-S42, 1998

[17] Victora CG et al. Effect of breastfeeding on infant and child mortality in less developed countries: A pooled analysis. *The Lancet* **355**: 451-5, 2000

[18] Yip R & Scanlon K. The burden of malnutrition: A population perspective. *Journal of Nutrition* **124**; 2043S-2046S, 1994

Inadequate comp feeding, 6-11 m	40%	33% times 40% = 13.2%
Inadequate young child feeding, 12-23 m	25%	16% times 40% = 6.3%
Low weight for age, 6-59 months:		
Category with Z-score<-3	1.7%	13.1%
Category with -2<Z-score<-3	4.8%	6.7%
Category with -1<Z-score<-2	10.1%	7.5%

The population-attributable fractions[19] indicate that 17.1 percent of the early neonatal deaths and 6.5 percent of the late neonatal deaths in Albania are attributable to LBW. On basis of the data of MICS 2005 and the Breastfeeding Monitoring 2007, we assume that at least 15 percent of 0-6 month-old infants are fed with artificial milk and that 25 percent of each cohort of newborns is given complementary foods too early. Based on these assumptions, the suboptimal infant feeding practices would explain 14.3 percent and 12.4 percent, respectively, of the infant deaths between 1 and 6 months of age. On basis of the same data sources, we estimate that at least 40 percent of infants aged 6-11 months in Albania and 25 percent of children after their 1st birthday are not adequately fed with complementary feeds, leading to nutrition-attributable mortality fractions of 13.2 percent and 6.3 percent in their respective age groups. Finally, we used the original MICS 2005 dataset to calculate the percentage affected 6-59 month-old children by Z-score for weight for age. The table shows that 27.3 percent (13.1 plus 6.7 plus 7.5 percent, respectively) of the mortality in the 6-59 months age group is attributable to existing malnutrition, characterized by the respective weight deficits for the children's ages.

The projected number of deaths thus derived is given in the table below. The estimated number of deaths among the 12-59 month-old children has been corrected for the overlap in deaths attributed to suboptimal child feeding and those due to low weight for age among the same children.

Number of deaths attributed to suboptimal nutrition			**% of all deaths in the age-group**
Age group	**All deaths**	**Suboptimal nutrition-attributable number of deaths**	
0-1 months	223	29	13%
1-5 months	148	40	27%
6-11 months	124	39	32%
12-59 months	190	47	24%
TOTAL	685	154	22.5%

Our estimations would indicate that some 20 to 25 percent of the child mortality in Albania may be related to the suboptimal nutrition situation in women and children. The nutrition-attributable deaths constitute different percentages of the deaths across the various age-groups, with a lower proportion among infants during their 1st month of life and increasing proportions as the infants and children grow older. A sizable proportion of the projected deaths (27 and 32 percent

[19] Eide GH and Heuch I. Attributable factions: Fundamental concepts and their visualization. *Statistical Methods in Medical Research* **10**: 159-90, 2001

during the post-neonatal period) relates to artificial feeding and early introduction of complementary feeds during the period that exclusive breastfeeding is recommended.

Various estimates for the underlying IMR and CMR were tested in assessing the robustness of these calculations. Although the absolute number of deaths for different IMR and CMR were varying, the proportional distribution of nutrition-attributed deaths across the age groups did not change very appreciably and the overall percentage of deaths due to suboptimal nutrition in women and children remained at almost one quarter.

In conclusion, using standard epidemiological procedures and the most current prevalence data for LBW, inadequate infant and young child feeding and child underweight, this illustration suggests that one-fifth to one-quarter of the mortality of infants and young children in Albania is attributable to the suboptimal nutrition situation. Although the absolute numbers of child deaths are small, the proportional attribution appeared quite robust upon testing different IMR and CMR levels. The simulation also indicates that a major share of the nutrition-related deaths is attributed among the 6-11 month-old infants, and that this is related to the sizable proportion of infants who are not breastfed or are offered complementary feedings already before the age of 6 months. Our findings are in general accordance with international experience. The assumptions used in the simulation are somewhat uncertain, but the overall estimate nevertheless indicates the substantial reductions in infant and child mortality that can be obtained in Albania by improving the nutrition situation for women and children.

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