HELEN KELLER

ASSESSMENT OF THE VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)

May 28, 1993

Helen Keller International
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EXECUTIVE SUMMARY

The Vitamin A Technical Assistance Program (VITAP) was initiated by Helen Keller International in 1988, through a Cooperative Agreement from the United States Agency for International Development. The overall purpose of VITAP is to motivate and engage other organizations in joining Helen Keller International and host governments to reduce preventable blindness, morbidity and mortality associated with vitamin A deficiency. An external assessment of VITAP was conducted in the fall of 1992. The assessment team was comprised of Ms. Carol Valentine (Team Leader), Dr. Mary Ruth Horner, Mrs. Margaret Ferris-Morris and Ms. Alice Willard.

The objective of the assessment was to identify, quantify and describe the results of VITAP's collaboration with PVOs and NGOs at the field level. Five countries and two workshops were chosen for in-depth study, based on the nature and magnitude of VITAP's inputs into these countries and evidence of outputs achieved by the time the assessment began. The assessment described in this document was a special activity which took place between VITAP's mid-term evaluation (March 1991) and the final evaluation, scheduled for late 1993.

The team reviewed documents and conducted interviews with various PVOs in the United States. Questionnaires were sent to all Africa-based persons who had participated in a vitamin A regional workshop for East and Central Africa held in Zambia (June 1990) and a national workshop held in Nigeria (October 1990). Field visits were conducted by Ms. Valentine and Ms. Willard in Burkina Faso, Niger and Mali from November 4 to December 9, 1992. Mrs. Ferris-Morris and Dr. Horner visited the Philippines and Indonesia from November 9 to December 10, 1992. In each country, the team conducted interviews with PVO and NGO collaborators of VITAP and also with representatives of USAID missions and other development organizations. Field visits to project sites of VITAP collaborators were possible in all countries except Niger.

The outcomes of working with VITAP were described at two levels: as they affected the activities of a collaborating PVO, NGO or MOH and as they affected any community activities where these collaborators were working (i.e., at the level of the individuals who are vulnerable for vitamin A deficiency). Although VITAP was not originally designed to evaluate impact in terms of changes of behavior of mothers and children, the assessment team was charged with following the 'trail' of technical assistance from VITAP to the collaborator and from there, through activities of the PVO (or NGO or MOH) all the way to the households of the vulnerable groups.

The team concluded that VITAP has had an impressive effect in motivating and enabling PVOs, NGOs and Ministries of Health to undertake and sustain activities to address vitamin A deficiency. VITAP has produced a myriad of results, identifiable and quantifiable at the PVO (or NGO) level and in incipient, yet also identifiable, stages at the community level. In the course of its first four years, VITAP has undertaken a

number of different strategies in different contexts in pursuit of achieving its objectives. As a result of the analysis of, reflection on, and subsequent modification of its activities, VITAP has developed into an effective and flexible model for PVO-to-PVO (or NGO) technical assistance.

While VITAP has already stimulated and assisted many of its collaborators to develop and implement their own activities to address vitamin A deficiency, others are just beginning to become involved and still others, though not yet involved, have much potential for contributing to the joint effort. Therefore, VITAP's services are still a crucial factor in maintaining and expanding the fight to reduce morbidity, blindness and mortality due to vitamin A deficiency.

Specific highlights of the assessment findings include:

- **Incorporation of vitamin A activities into collaborators' on-going programs:**

VITAP's direct collaborators have made the organizational commitment to address vitamin A deficiency in their programming and can demonstrate through new policies, guidelines, action plans, budgets, materials, training plans and skilled staff, that they have incorporated this component into their organizational objectives.

- **Changes in behavior of at-risk groups:**

VITAP's collaborators have assisted members of their target communities to become more aware of and knowledgeable about vitamin A deficiency and how to address it. Specific activities undertaken by mothers in at-risk groups include increased production and consumption of vitamin A-rich foods and increased acceptance of vitamin A capsules for themselves and/or their preschool children.

- **Development of national health policies**

VITAP has been influential in the development of national health policies to recognize and address vitamin A deficiency in Indonesia, Mali, Niger, the Philippines and Zambia.

- **Expansion to include local non-governmental organizations**

Although VITAP was originally designed to work exclusively with U.S.-based PVOs, it has effectively responded to the need to expand this clientele to include local non-governmental organizations, especially in Asia.

- **Development of local expertise**

Many of VITAP's positive results have been accomplished through the careful selection, training and support of in-country consultants, thus minimizing the dependence upon and cost of expatriates.

- **Durability of collaboration with VITAP**

In the five countries visited, plus workshop participants surveyed, people who had collaborated with VITAP were able to remember clearly the specific activity -- even

though it had occurred two years earlier -- and attributed some of their subsequent actions to having participated.

- **An overall model for PVO-to-PVO technical assistance**

VITAP was able to take its original design and apply it, monitor it, adapt it and develop it into functional and effective alternatives in different countries. The resulting design as it currently exists and the underlying strategy represent valuable products for the development community.

- **Specific country highlights:**

  Burkina Faso: The text of a nutrition education story about vitamin A, which was developed by VITAP in Burkina Faso and originally produced as flipcharts in Burkina Faso and Mali, has been transformed into several different art forms and also spread to Niger.

  Indonesia: VITAP contributed to the Government of Indonesia's unprecedented decision to allow NGOs to participate in the Ministry of Health's efforts to reduce vitamin A deficiency. In just two years, VITAP assisted three NGOs to raise $710,000 to expand their vitamin A activities.

  Mali: Assisted by VITAP, World Vision has trained 615 village health workers to be able to recognize and address vitamin A deficiency in their communities.

  Niger: As a result of VITAP, Peace Corps Volunteers working on health projects are routinely trained in methods to identify and address vitamin A deficiency.

  Philippines: Through its excellent training model, VITAP has created a virtual cascade of activities to combat vitamin A deficiency. The numbers of people trained by VITAP's five key collaborators and their subsequent activities were too numerous to calculate accurately during the assessment. VITAP led to the development of Project MATA, a spinoff project which targets local NGOs.

In the course of becoming familiar with and understanding VITAP's accomplishments, the team identified factors which either supported or constrained VITAP in its implementation. Among the many components which worked in a positive manner to facilitate success were VITAP's ability to create demand and its ability to respond in a flexible fashion to this demand. Seven factors were identified as exerting a limiting influence on VITAP, including the chronic shortage of vitamin A capsules, the pervasive antiquated approach towards nutrition education and the inability to meet the demand for VITAP's services in West Africa.

The overall recommendation was that VITAP should continue, with some modifications. More specific recommendations include:

- **Final VITAP evaluation:** VITAP should consider including two components which follow-up on the VITAP assessment: an analysis of selected country-level topics, such as changes in behavior at the community level, and an analysis of the cost-effectiveness of selected VITAP inputs.

- **Initial country design:** For initiating activities in any new country, VITAP should use its past experience to choose among the most cost-effective management models and establish clear understanding with VITAP-related personnel vis-a-vis project objectives, strategy and reporting.

- **Client selection:** VITAP should continue to base its selection of clients on their past track record of effective use of VITAP inputs or potential for same.

- **Transferable skills:** VITAP should continue to focus technical assistance in training on transferable skills, especially in the areas of non-formal education, materials development, community assessment, monitoring and evaluation, and advocacy.

- **Communications for behavior change:** VITAP should explore opportunities: to use the Awa flipcharts for training in West Africa; to continue to develop materials with potential for regional replication; and to develop alternative funding mechanisms for materials.

- **VITAP expansion:** VITAP's training model from the Philippines should be replicated in other countries, other organizations and other sectors; VITAP's overall model of PVO-to-PVO technical assistance should be expanded to other programming sectors (e.g., Ministries of Agriculture and Education), other clients (especially local NGOs), other micronutrients (iron and iodine) and other geographical sectors (especially urban populations).

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ANNEXES

* Available from HKI upon request

ACRONYMS

ADRA	Adventist Development and Relief Agency
AED	Academy for Educational Development
BHW	barangay health worker (Philippines)
CCF	Christian Children's Fund
CRS	Catholic Relief Services
DMSF	Davao Medical School Foundation (Philippines)
HKI	Helen Keller International
MAP	Medical Ambassadors of the Philippines
MOH	Ministry of Health
NGO	non-governmental organization
PVO	private voluntary organization
SCF	Save the Children Federation
TA	technical assistance
USAID	United States Agency for International Development
VAC	vitamin A capsule
VAD	vitamin A deficiency
VITAP	Vitamin A Technical Assistance Program

I. BACKGROUND AND METHODS

The Vitamin A Technical Assistance Program (VITAP) was designed as a mechanism to encourage and engage other organizations in joining Helen Keller International in the battle against vitamin A deficiency. VITAP was funded through a Cooperative Agreement awarded to Helen Keller International in 1988 from the Office of Private and Voluntary Cooperation, Bureau for Food and Humanitarian Assistance of the United States Agency for International Development (USAID).

The purpose of VITAP is to motivate and help PVOs integrate vitamin A activities into their on-going child survival projects. VITAP itself does not work directly at the community level. Initially, VITAP focused its collaboration on U.S.-based Private Voluntary Organizations (PVOs)[1], particularly those with USAID Child Survival-funded projects. Gradually, VITAP's primary target group expanded to include local non-governmental organizations (NGOs), then governmental ministries in the host countries were added as an indirect, secondary target group. This two-pronged design in presented in Figure 1 on the next page.

The technical assistance provided by VITAP to its collaborators consists of four types: direct PVO capacity building; enhancement of PVO-government relations; dissemination of technical information; and human resource development. Specific examples from these categories are shown in Figure 1.

Through all of these activities, VITAP seeks to convince other organizations of the need to address vitamin A deficiency in their vulnerable target populations and to enable them to develop, implement and sustain appropriate activities as a response.

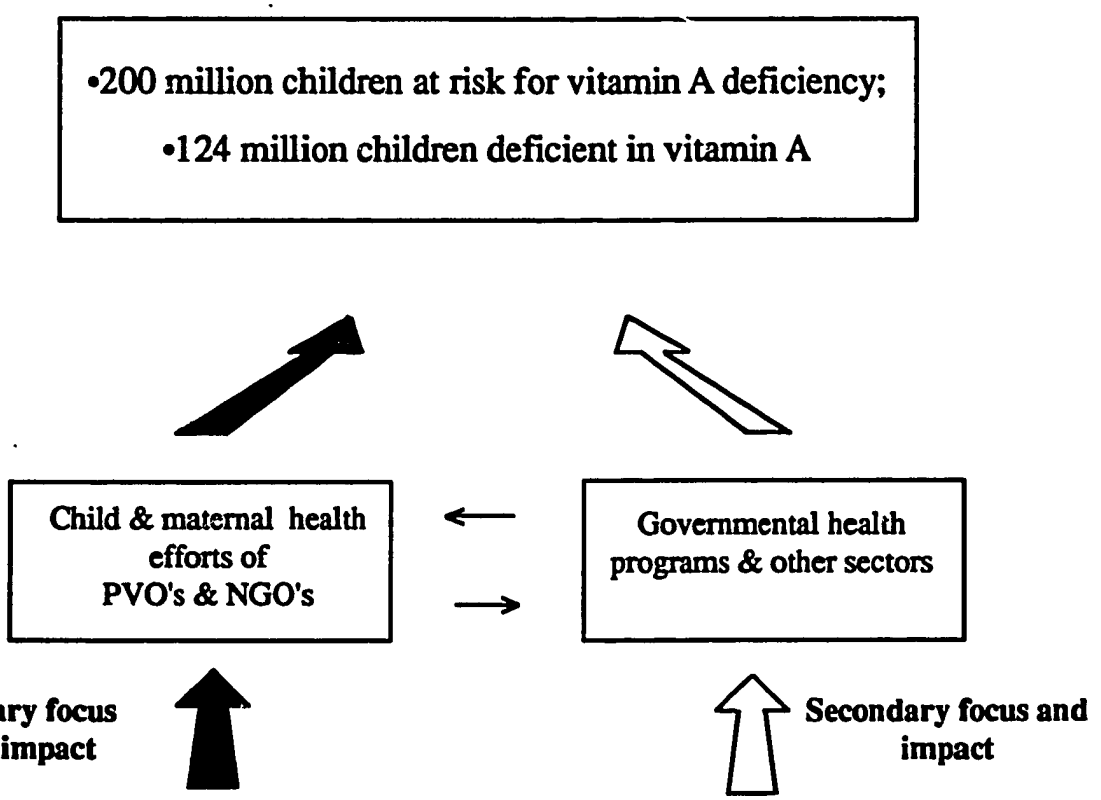
The midterm evaluation of VITAP was conducted in March 1991, but no overseas visits were made to the field sites of VITAP's collaborators due to travel restrictions during the Gulf War. As a result of recommendations from the midterm, VITAP modified its approach and began to focus and concentrate its resources on a smaller group of organizations in fewer countries.

In the fall of 1992, Helen Keller International (HKI), USAID and collaborating PVOs reviewed the worldwide scope of VITAP's activities in order to choose specific countries and activities for more in-depth study. The sample chosen was to reflect differences in VITAP interventions, intensity of assistance, administrative models (with and without HKI office or VITAP Coordinator in-country), amount of follow-up and PVO involvement in programming. Of the 22 countries reviewed, five were chosen (Burkina Faso, Indonesia, Mali, Niger and the Philippines) for the sample. In addition, two major workshops were chosen (a regional workshop for East and Central Africa and a national

[1]For the purposes of this document, "PVO" generally refers to a U.S.-based private voluntary organization and "NGO" refers to a local non-governmental organization.

Figure 1

VITAP Project Design



VITAP TECHNICAL ASSISTANCE

Direct PVO capacity building		PVO-Government enhancement	Dissemination of Technical Information			Human Resource Development
PVO/VITAP Collaborative Projects	Technical Staff Seminars	National, Regional Level Meetings	Technical Advice, Materials & Information	Newsletter, Country Profiles	HKI/VITAP Manuals & Guides	Consultant Referrals

workshop in Nigeria) for follow-up. More information about VITAP's inputs into the countries and workshops reviewed for choosing the sample is presented in Annex 1.

The subsequent activity described in this document is known as an "assessment" in order to distinguish it from a more formal evaluation. The assessment was designed to address specific questions of interest about the process and outcomes of VITAP. Adequate baseline data at the community level are not available from collaborating PVOs; therefore VITAP cannot be rigorously evaluated in terms of 'impact' - i.e., actual changes in behavior and health status of the PVOs' target populations.

Therefore, the assessment was undertaken in order to follow-up in depth with some of VITAP's collaborators in the field. The intention was to learn to what extent and how they used technical assistance from VITAP. And, if possible, the assessment team was to also identify and quantify the effects of the PVOs' own vitamin A activities on the behavior of individuals who are vulnerable for vitamin A deficiency. See Annex 2 for the Scope of Work of the assessment. The final comprehensive evaluation of VITAP is scheduled for the latter part of 1993 and will address a broad range of management and programmatic issues.

The VITAP assessment was conducted in the fall of 1993 by a team of consultants consisting of: Ms. Carol Valentine (Team Leader), Mrs. Margaret Ferris-Morris, Dr. Mary Ruth Horner and Ms. Alice Willard. See Annex 3 for biographical information about the team. A Team Planning Meeting was held so that representatives of USAID, VITAP and selected collaborating PVOs could share their perspectives on the objectives, scope and logistics of the assessment with the team.

The consultants reviewed documents and conducted interviews with selected staff members of Helen Keller International and various other PVOs in the United States. A questionnaire (see Annex 4) was sent to all Africa-based persons who participated in the regional workshop in Zambia (June 1990) and the national workshop in Nigeria (October 1990).

Field visits were conducted by Ms. Valentine and Ms. Willard in Burkina Faso, Niger and Mali from November 4 to December 9, 1992. Mrs. Ferris-Morris and Dr. Horner visited the Philippines and Indonesia from November 9 to December 10, 1992. The team conducted a total of 195 interviews with PVO, NGO and MOH collaborators of VITAP and also with representatives of USAID missions and other development organizations. Field visits to project sites of VITAP collaborators were possible in all countries except Niger.

II. FINDINGS

Part I - Specific Accomplishments of VITAP

Question 1 - What has VITAP achieved with respect to its project purpose, i.e., institutionalization of vitamin A into PVO programs?

The data collected by the assessment team show that VITAP's impact on PVOs and NGOs has been direct, substantial, enduring and far-reaching. VITAP's direct collaborators have made the organizational commitment to address vitamin A deficiency in their programming and can demonstrate - through policies, guidelines, action plans, budgets, materials, training plans and skilled staff - that they have incorporated this component into their organizational objectives.

Table 1 shows a summary of the types of inputs which VITAP developed with each of the PVOs and NGOs in each of the countries visited by the assessment team. For the most part, these activities were implemented by VITAP staff (from NY or in-country coordinators) or consultants (local or expatriate) working directly with staff members of the collaborating PVO or NGO. In the initial orientations and workshops, VITAP usually worked with a group of PVO collaborators; in contrast, follow-up technical assistance was generally provided to each PVO independently, based on that group's request. Where feasible, VITAP worked with one or more groups together when their requests were similar.

Table 2 shows a summary of the outputs which PVOs and NGOs produced as a result of their collaboration with VITAP. Some of the outputs, such as the initial training of PVO staff, took place with VITAP assistance; however, the majority of outputs listed were accomplished by the PVO or NGO with minimal or no input from VITAP. As a result of having worked with VITAP, the 2,168 trained staff were able to implement a myriad of community-level vitamin A activities on their own, usually in conjunction with their affiliates and/or volunteer health workers. Those PVOs and NGOs which have achieved some degree of incorporation of vitamin A activities into their program are indicated in the last column in Table 2. Types of activities which were considered in this category are: funding allocated for vitamin A activities; established agency guidelines and/or linkages related to vitamin A; and designated staff responsible for vitamin A activities.

The best example of how VITAP's overall strategy has been effective in motivating PVOs to join the battle against vitamin A deficiency in the populations they serve is illustrated by the case of the Philippines, shown in Figure 2. In that country, VITAP undertook a well-thought-out strategy for identifying five key PVOs as its core group, helped them develop skills and materials for incorporating vitamin A into their on-going programs, and then provided follow-up support as they carried out their vitamin A activities at the community level. The numbers of PVO and community staff trained and the breadth and depth of the activities they have undertaken were too extensive for the

Table 1. VITAP INPUTS

	Orientation # Participants	Follow-up Training of Trainers # Participants	Materials Developed	Proposals Developed with PVO & Funded	Other TA: Design, Assessment, Workshops
Burkina Faso (1,2)					
Africare	5		X		X
[illegible]S	11		X		
SCF	1	38	X		X
World Relief	10		X		X
Other (4)	11				
MALI (3)					
Africare	11		X		X
CARE	17				
Plan International	1				X
SCF	4		X		X
World Vision	4				X
Other	20				X
NIGER (1)					
Africare	32		X		X
CARE	3	85	X		
Other	3				
INDONESIA (1,2)					
ADRA	2	44	X		X
Fatayat			X		
IPPA/PKBI			X	X	
Lembaga B Potensia				X	
PATH			X		
Project CONCERN	1				
Sintesa				X	
World Vision	2				
Other	20		X		
PHILIPPINES (1,2)					
ADRA	1	79	X		X
CARE	1	86	X		X
CCF	3	31	X		X
CRS	2	3			X
SCF	1	44	X		X
Other	25	23			X
Project MATA				X	X
TOTAL	191	433			

1. HKI OFFICE in Country; 2. VITAP Coordinator; 3. Collaborative Project with VITAP; 4. MOH, UNICEF, local NGO, etc.

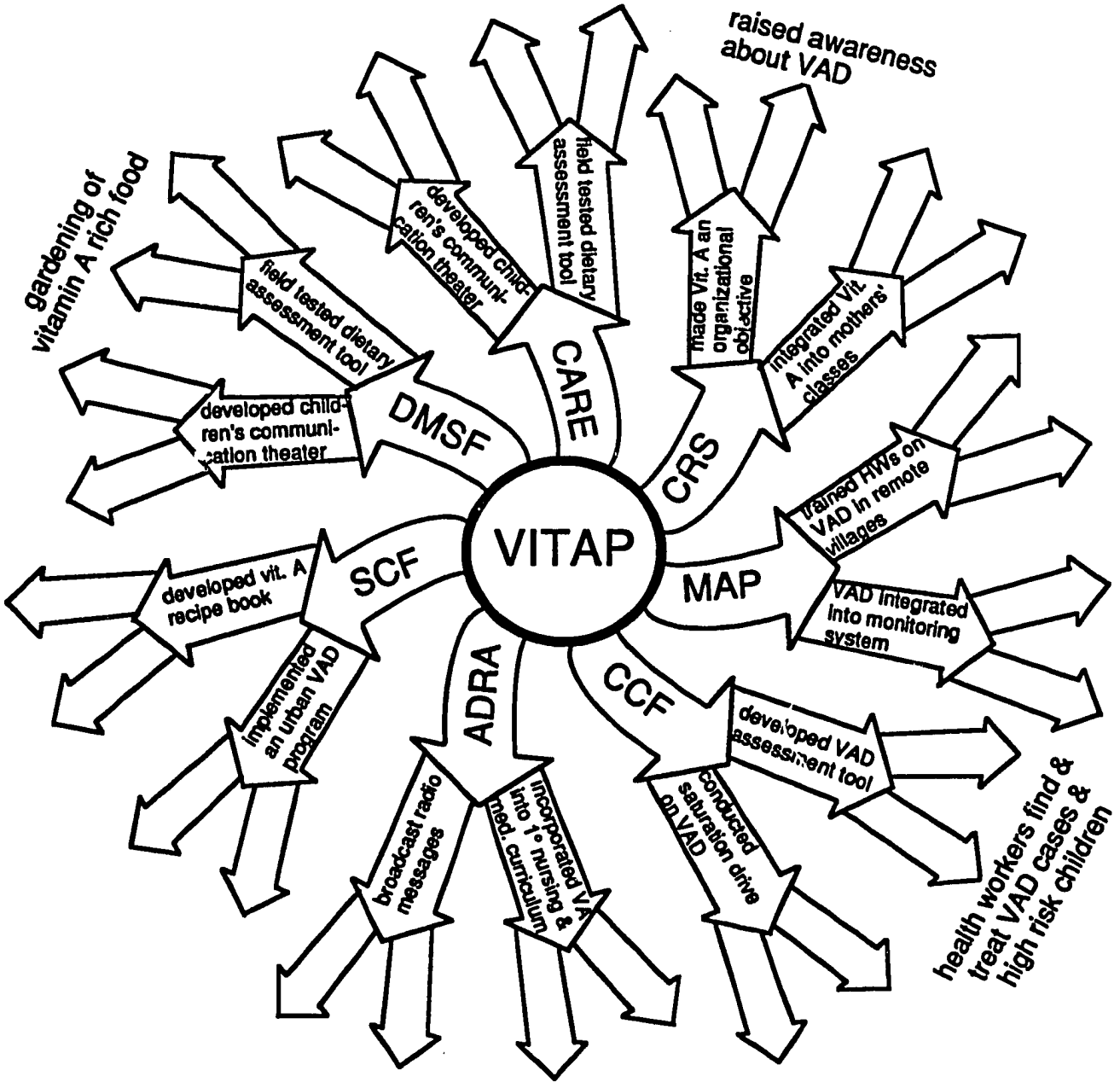
Table 2. PVO & NGO OUTPUTS

	PVO Health Workers Trained	Provide VAC	Increased Coverage of VAC Program	Production of Vitamin A- rich Foods	Nutrition Education to Mothers	Agency Incorporated Vitamin A into Program
Burkina Faso						
Africare	28		X		X	X
CRS	10		X		X	X
SCF	66		X	X	X	X
World Relief			X		X	X
Other						X
MALI						
Africare	30		X		X	
CARE	90		X		X	
Plan International					X	
SCF	45				X	
World Vision	615		X		X	
Other						X
NIGER						
Africare			X		X	X
CARE	335		X		X	X
Other						
INDONESIA						
ADRA	100		X	X	X	X
Fatayat			X		X	X
IPPA/PKBI			X		X	X
Lembaga B Potensia			X	X	X	X
PATH		X	X		X	X
Project CONCERN						X
Sintesa		X				
World Vision			X		X	X
Other						X
PHILIPPINES						
ADRA	550	X	X	X	X	X
CARE	86	X	X	X	X	X
CCF	87	X	X	X	X	X
CRS	55	X	X	X	X	X
SCF	71	X	X	X	X	X
Other		X	X	X	X	X
Project MATA		X	X	X	X	X
TOTAL	2168					

Figure 2

VITAP Collaboration in the Philippines
Selected Multiplier Effects...

To date, Vitamin A activities have reached 7 million children and mothers at risk for vitamin A deficiency (VAD)



Community Level

assessment team to quantify accurately. However, the underestimates are impressive: in just two years, approximately 980 health workers from five U.S.- based PVOs and 47 local NGOs have been trained in the detection, prevention and control of vitamin A deficiency and their organizations mobilized to apply this training at the community level.

In Indonesia, VITAP has developed a core group of eight PVOs and NGOs and, for the most part, activities are still concentrated at the level of working with the staff and volunteers of these organizations to enable them to carry out their own vitamin A activities.

In Africa, the results of VITAP's efforts are manifested in different forms, reflecting the flexible models which VITAP used in providing technical assistance to different countries. In the initial phase of VITAP, many consulting days of assistance were given to PVO clients in Burkina Faso, Mali and Niger. When this level of contact was abruptly reduced after the mid-term evaluation, VITAP was still able to maintain communications with its clients and PVOs that worked with VITAP were able to continue their efforts.

A fascinating example of unintended benefits from VITAP is provided by the work initially undertaken with two PVOs in Burkina Faso and Mali. The product of this activity consisted of a storyline about a family with a child suffering from vitamin A deficiency. This story was first disseminated in flipchart form and had limited success as a tool to engage rural women in discussions about the problem presented. However, the flipcharts found a viable niche when used with more literate audiences, e.g., in training health workers and in educating primary school children.

The story told by the flipcharts was further developed into dramatic pieces presented in schools and local communities and was introduced to Niger. Although VITAP lacked the field support of an HKI office in Burkina Faso and Mali, its collaboration with the Academy of Educational Development proved successful for supporting and sustaining the interest of PVO clients in implementing new activities in vitamin A.

Although VITAP was initially restricted to U.S.- based PVOs, this approach eventually was extended to local NGOs and, to some extent and when appropriate, collaborating government officials. The activities undertaken by these other collaborators, such as the gardening efforts of Peace Corps Volunteers in Mali and the NGOs supported by the Project MATA spinoff in the Philippines, have spread the message of VITAP to reach additional vulnerable groups. In Asia, there is concrete evidence that limited input - in the form of one to three well-defined consultancies - from VITAP to a very motivated PVO or NGO can result in new vitamin A programming. ADRA and World Vision in Indonesia and the Medical Ambassadors of the Philippines are examples of such groups that needed only a little assistance to successfully incorporate vitamin A into their on-going health programs.

This summary report only touches on the highlights of these findings; more complete information is presented in the five country reports found in Annexes 5-9.

Question 2 - What has VITAP achieved in pursuit of its ultimate goal, i.e., of changing behavior at the community level to reduce mortality and morbidity due to vitamin A deficiency?

The lack of baseline and follow-up data within each collaborating PVO or NGO made the objective evaluation of this question impossible at the time of the assessment. However, the team found qualitative evidence in every country where field visits were possible that VITAP is indeed making an impact at the community level through the work of its collaborating PVOs, NGOs and government ministries. The effect of these activities on the community is reflected in Table 3 under "Community Impact".

Data gathered by the assessment team, though qualitative and limited in scope, show that VITAP has been successful in addressing vitamin A deficiency among vulnerable groups. In Indonesia, PVOs and NGOs have recently been acknowledged as powerful partners to help the MOH distribute vitamin A capsules to all preschool children. In Mali, Africare, Save the Children and World Vision have successfully encouraged and assisted community families with growing vitamin-A rich foods. In the Philippines alone, the assessment team estimated that VITAP has already reached several million people through its efforts working with others to address vitamin A deficiency at the community level.

One major constraint facing VITAP's collaborators in four of the five countries visited is the chronic shortage of vitamin A capsules. Once convinced of the presence and seriousness of vitamin A deficiency in their target populations, PVO and NGO staff trained by VITAP quickly become frustrated if unable to obtain and distribute vitamin A capsules to those persons identified at risk.

In Indonesia, the one country with an adequate supply of capsules, distribution has been restricted by the reluctance of the MOH to allow NGOs to handle this supplement. However, VITAP made a major contribution to the recent and successful efforts to formally recognize and authorize the role which NGOs have in the semi-annual national campaigns to distribute vitamin A capsules to all pre-school children. As a result, the effects of VITAP at the community level in Indonesia can be expected to increase substantially in the future.

More information about the specific vitamin A activities which VITAP's collaborators have implemented at the community level is provided in the reports from the five countries visited (see Annexes 5 - 9).

Table 3. COMMUNITY IMPACT (1)

	Increased Community Awareness	Increased Vitamin A-Rich Gardens	Increased Coverage of VAC	Notes
Burkina Faso				
Africare	X			
CRS	X		X	Gardening activities planned
SCF	X			
World Relief	X	X		
Other			X	AED collaborative project
MALI				
Africare	X	X		
CARE	X			
Plan International				
SCF	X	X		
World Vision	X	X	X	
Other				AED collaborative project
NIGER				
Africare	X			Gardening activities planned
CARE	X			
Other			X	PCVs trained routinely
INDONESIA				
ADRA		X		
Fatayat				
IPPA/PKBI				
Lembaga B Potensia		X		
PATH				
Project CONCERN				
Sintesa				
World Vision				
Other				
PHILIPPINES				
ADRA	X	X	X	
CARE	X		X	
CCF	X	X	X	
CRS	X		X	
SCF	X	X	X	
Other	X	X		
Project MATA	X	X		Spinoff project from VITAP

(1) Reported or observed, not measured

Question 3 - How did VITAP's work with secondary clients enhance its ability to meet the goals pursued with primary clients?

VITAP recognized that PVOs and NGOs generally do not implement their health programs in a vacuum. The overall climate for development activities in a country, plus general and specific governmental health policies and guidelines, have a great effect on what PVOs and NGOs do and how they do it in the health arena.

Therefore, in seeking to motivate and enable PVOs to undertake activities to address vitamin A deficiency, VITAP assessed the general climate for vitamin A programming in each country. Factors which had a limiting effect on vitamin A activities were identified and addressed if possible. For example, if key multilateral health agencies were not well informed about the findings regarding the role of vitamin A in child survival, VITAP invested time and effort to improve this situation.

In addition, VITAP found ways to inform, educate and promote the MOH officials whose responsibilities included nutrition and vitamin A. If the Ministry of Health did not have a vitamin A policy, or if it was not specific or broad enough, VITAP focused on collaborating with the MOH to improve the policy. For example, in some countries VITAP worked toward changing the health policy so that vitamin A capsules were included on the essential drug list. Then and only then could PVOs and NGOs be comfortable and effective in developing and implementing their own vitamin A activities, in conjunction with an MOH which also shared the same goals vis-a-vis vitamin A deficiency.

As already mentioned, VITAP has helped encourage the government of Indonesia to relax its strict controls on the distribution of VAC by non-MOH personnel. In Burkina Faso, the National Health Card was modified with VITAP assistance to include information and recommendations about vitamin A. In the Philippines, VITAP has facilitated the development of crucial linkages and communication between the MOH and PVOs.

The results of this work with multilateral and governmental agencies provided new key components for the development and implementation of national vitamin A policy in a number of countries. Particularly impressive are the findings that over one half of the government workers who attended major vitamin A workshops in Africa indicated that their governments had established (or were in the process of establishing) a national vitamin A policy after the workshop.

Question 4 - What are some of the factors which have supported and constrained VITAP's success?

Factors which have supported and constrained VITAP's success fall into two categories: those which are under VITAP's control and those which are not.

Factors Facilitating Success

Not under VITAP's control, but especially contributory to VITAP's success, was the growing recognition -- worldwide -- of the scientific finding that vitamin A is crucial for child survival, far beyond its well-known physiological role in vision. VITAP's efforts in promoting this message were reinforced by those of other organizations saying the same thing. In addition, VITAP's status as a major activity of Helen Keller International helped it to gain the attention of its governmental, non-governmental, bilateral and multilateral clients. AID's concern about promoting vitamin A and its experience in working with HKI created a respectful working relationship with VITAP, in which AID was especially flexible in supporting the evolution of this new mechanism for PVO-to-PVO technical assistance.

Under VITAP's control are a number of elements of its design and strategy which seem to have played a special role in VITAP's success. These factors are:

- a clear focus on one problem, i.e., vitamin A deficiency;

- a logical and well-thought-out global strategy for identifying potential clients -- both primary and secondary -- and working with them to develop and implement tailor-made action plans;

- the ability to create demand for initial and follow-up services by, e.g.,

  1) cost-sharing -- for the initial orientations and for major international and national workshops, VITAP supported the costs for PVOs and NGOs and also the travel and per diem expenses of resource persons; for most subsequent workshops, PVOs and NGOs paid their own expenses, VITAP and multilateral agencies shared the costs for consultants and resource persons and also helped leverage UNICEF's support for MOH participation; VITAP and its clients shared costs for developing educational materials and for printing; in general, VITAP contributed relatively more in the beginning for workshops and other activities when PVO budgets could not expand and convinced the PVOs to increase their cost-share subsequently when they were able;

  2) providing technical assistance which allowed for transferring the skills developed in vitamin A, e.g., in assessment and training, to other interventions being implemented by the client (see Questions 5B and 5C for more details);

  3) paying special attention to the need to tailor technical assistance to the unique differences among clients; and

4) giving high priority to choosing qualified local consultants and also to having follow-up TA provided by the same or another consultant already familiar with VITAP;

- the flexibility in implementing its global plan, especially in adjusting to different situations as they arose in different countries - e.g., creating the coordinator position and addressing the need to respond to local NGOs;

- a variety of complementary forms of technical assistance to initially stimulate and subsequently train PVO and NGO clients to develop their own vitamin A interventions;

- the creation and support of networks of clients, scientific experts, donors and government officials (in-country, regionally and internationally);

- sustained, on-going communication with clients, from the office of VITAP/NY or those of the in-country coordinators, by phone, mail, informal visits, etc.; and

- controlling costs, which was complemented by the priorities for local consultants and cost-sharing with clients.

Factors Constraining Success

Some of the factors outside of VITAP's control which acted to limit its success are:

- the high turnover and transfer rates among MOH and PVO staff in West Africa;

- the relatively poorly developed health infrastructure -- governmental and non-governmental -- in West Africa;

- the chronic shortage of vitamin A capsules, witnessed by the assessment team in four of the five countries visited; and

- the antiquated approach of most development agencies and their workers to "nutrition education". The state-of-the-art in nutrition education, as observed by the assessment team, is particularly distressing in all countries visited. Minor exceptions were one PVO's mini-project in weaning foods education in the Philippines and several PVOs' efforts in reaching their non-literate clients in West Africa through drama. However, for the most part, health workers' understanding of the process of behavior change and their strategies for reaching mothers are still lodged in the paradigm of 'the provider of the correct information gives the relevant facts to those who need it and thus behavior will be changed'. Ironically, many health workers were frustrated as they know that this approach is not effective, yet they are not equipped with any alternatives.

Two limiting factors which were under VITAP's control are:

- the inability to meet demand in West Africa. VITAP's ability to create demand among its clients is listed above as a factor supportive of its success. However, the levels of demand which were created in the initial phase of VITAP also became a limiting factor. In Africa, VITAP's efforts to respond to all requests resulted in a dilution of its focus and impact. As a consequence, VITAP curtailed a number of its activities in Africa after the mid-term (March 1991), choosing to focus on selected collaborative projects. In Mali, Niger and Burkina Faso, the assessment team noted that this management decision produced gaps in VITAP's physical presence, sometimes up to six months or longer. Even though VITAP maintained contact with its collaborators in these countries, the assessment team concluded that the hiatus in major activities in which many people participated, e.g., a workshop, was partially responsible for the relatively small number of PVOs involved in vitamin A and their respective level of activities, as compared to Asia; and

- the reluctance to address PVOs' inadequacies in nutrition education (described above) because PVOs did not request this assistance and because it could not be provided effectively over a short period of time. However, VITAP has begun to work with two PVOs on this issue.

Part II - Models of Technical Assistance

Question 5 - How did VITAP's overall model of providing technical assistance contribute to the findings described in Part I?

Information gathered by the assessment team showed that VITAP was implemented differently in each country, for different reasons, yet has produced generally positive results towards achieving its overall project purpose. VITAP's singular focus, i.e., empowering PVOs and NGOs to undertake activities to reduce vitamin A deficiency, and its flexibility in doing so, are two of the key elements of success in VITAP's model of PVO-to-PVO assistance.

From the beginning, one of the operating principles of VITAP was that it would have to be flexible in order to capture the attention of other PVOs, convince them to engage in and commit resources to vitamin A programming and sustain their interest for more than the initial contact. VITAP's overall approach to working in any given country was the same, but the specific outcomes varied greatly, depending upon the requests of the PVOs and NGOs for VITAP's services.

VITAP's overall approach typically involved the following minimum core steps:

1. VITAP first reviewed the overall situation of vitamin A deficiency in the country under study to prepare it for receiving requests from specific clients.

2. With this information in hand, VITAP called together all the major players involved in vitamin A programming: the Ministry of Health, PVOs (especially those with AID-funded Child Survival grants), NGOs, universities, research institutions, etc. These groups were given an orientation to the overall vitamin A situation in their country and the services which VITAP had to offer.

3. Then, PVOs (and in some cases, NGOs) were invited to submit requests to VITAP for technical assistance in any number of programming areas: project design, assessment of vitamin A deficiency, training in vitamin A prevention and control and materials development.

VITAP offered its services on an increasing cost-share basis: in general, VITAP covered the fees for consultants (expatriate and local) and the client covered other costs when possible (e.g., transportation and per diem for participants in a training course). Frequently, VITAP worked together with two or more PVOs, which provided the opportunity for direct sharing among clients. At other times, VITAP worked with an individual PVO and shared outcomes of the consultancy with others afterwards. Examples in this latter category include developing an assessment tool for vitamin A deficiency, nutrition education materials and training designs.

Such an approach, i.e., responding to individual requests with tailor-made technical assistance and then applying the results as widely as possible with others, seems deceptively simple. However, some of the requests were very narrowly defined - e.g., for a French-speaking trainer with experience in nonformal educational techniques for Burkina Faso or for an Indonesian-speaking medical doctor with experience working with local NGOs in remote underserved areas. VITAP's offer of technical assistance generated numerous requests and in the majority of the cases reviewed by the assessment team, VITAP responded in a timely manner with good results. Several PVOs remarked that VITAP was unusual in that its representatives sought out clients - before, during and after the consultancy - to ask if there was anything more which VITAP could be doing to help them.

VITAP placed special emphasis on identifying the most appropriate consultants for the job. This required extra effort in recruiting consultants in-country, especially where HKI did not have a country presence. VITAP worked hard to develop and train consultants who could then be even more effective when called upon a second time.

In Indonesia and the Philippines, the volume of requests received after the initial orientations was so great that VITAP petitioned AID/PVC for a program revision in

order to hire part-time in-country consultants as coordinators. As a result, VITAP has been able to provide on-going, tailor-made assistance to its clients in these two countries. In just two years, the results obtained in the Philippines have been particularly impressive.

While it is not surprising that a well-chosen and supported in-country coordinator can generate significant positive results, VITAP has shown that it is possible to develop and support satisfied clients and produce enduring results without such on-going backup. The results from one-shot conferences and training workshops in Africa, especially those in Zambia, Nigeria, Mali and Burkina Faso, are testimony to VITAP's ability to make a lasting impression on participants.

Question 5A: How did regional and country workshops contribute to the achievement of VITAP's purpose (i.e. outcomes at the PVO level) and goal (i.e., outcomes at the community level)?

Sub-questions: Are these workshops valuable? Is there considerable spin off effect? Have field programs been implemented or strengthened as a result of the new information? Should workshops be continued as a service? What are the beneficial effects of networking? Has a network developed in the field? Is the network used by the workshop participants?

VITAP-initiated conferences and workshops have been key events in the varied constellation of activities which VITAP has undertaken in the countries reviewed by the assessment team. Many interviewees from different organizations mentioned the VITAP-sponsored conference or workshop as an introduction to and turning point for their organization's commitment to combat vitamin A deficiency. For some groups, i.e., ADRA and World Vision in Indonesia and the Medical Ambassadors of the Philippines, from one to three collaborative events with VITAP was all that was necessary for them to proceed on their own with vitamin A programming.

As mentioned earlier, VITAP's initial orientations in the Philippines and Indonesia generated such response that eventually in-country VITAP coordinators were hired to manage the demand for services. In Burkina Faso and Niger, the initial orientations, though smaller scale than those in Asia, created the crucial opportunities for PVOs to focus on the problem of vitamin A deficiency and to become familiar with VITAP's availability to help them better serve their target populations. In Mali, a national vitamin A conference, which was organized by HKI, preceded VITAP, so VITAP was able to proceed to working directly with individual PVOs.

The assessment team also reviewed results obtained by questionnaires sent to participants in two other VITAP-sponsored workshops. These workshops were implemented in 1990 -- over two full years before the assessment -- with the objectives of providing an orientation to and resources about vitamin A to development workers from

various governmental and non-governmental organizations. Representatives from 17 countries attended the East, Central and Southern African Workshop on Vitamin A Interventions and Child Survival, held in Lusaka, Zambia, from June 21 - 24, 1990. Over 100 representatives from non-governmental organizations and ministries attended the Nigerian National Workshop on Vitamin A Interventions and Child Survival from October 30 - November 2, 1990 in Otta, Nigeria. The Nigeria-based participants for the latter workshop included 24 representatives from the Federal Ministry of Health, 49 from various State Ministries of Health and 28 from various PVOs and NGOs.

Selected results from the questionnaires, which were pooled for the analysis by EPI Info, are presented in Table 4 on the following two pages. A total of 28 of 168 participants responded (17% response rate); 46% of the respondees were from government ministries.

One of the most notable outcomes from the two workshops was that half of the government workers responded that a national policy for the control of vitamin A deficiency had been developed after the workshop or that a policy was being planned. On the other hand, almost the same number of government workers were unsure of the vitamin A activities implemented by their agency.

Over half of the government workers reported that they had initiated activities to increase the consumption of vitamin A-rich foods as a result of the workshop. Responses from PVO and NGO representatives showed that they took VITAP's message seriously: 50% reported that their agency had allocated funds for vitamin A activities and 56% reported that vitamin A-related topics had been incorporated into their on-going training curricula after the workshops.

The greatest obstacles to implementation of vitamin A-related activities and policies reported by the respondents were: 1) funding (53%); 2) the need for additional technical assistance from HKI (35%), and 3) the fact that vitamin A deficiency was not a current priority (26%). Supervisory follow-up was noted as a problem by government workers but not by PVOs.

In conclusion, a surprising number of vitamin A-related activities were reported to have been initiated by PVOs, local NGOs and Ministries of Health as a result of two VITAP-sponsored workshops. These workshops were cost-effective mechanisms for establishing linkages, orienting health workers and governments and stimulating action to help eradicate vitamin A deficiency.

Table 4

SUMMARY OF RESPONSES TO 1990 REGIONAL AND NATIONAL AFRICAN WORKSHOPS

(Percent Response, n=28)

	Ongoing before Workshop			Initiated after Workshop			Being Planned			Not Sure		
	* PVO	GM	ALL	PVO	GM	ALL	PVO	GM	ALL	PVO	GM	ALL
National policy established regarding the control of vitamin A deficiency, e.g. including in national health plan	58	8	24	12	33	24	0	25	20	38	33	32
Working group established to coordinate national vit A deficiency control effort	0	17	8	17	25	29	0	17	17	83	42	46
Vitamin A capsules included in national Essential Drug Program?	50	15	26	13	31	26	13	0	11	25	54	37
Has your agency implemented activities to:												
Increase the local production of vitamin A-rich foods.	57	15	32	14	31	28	0	23	12	29	31	28
Increase the consumption of vitamin A-rich foods.	38	8	31	42	54	42	0	23	11	25	15	15
Provide vitamin A supplements (capsules) to:												
All pre-school children every 3 or 6 months.	33	8	18	33	25	23	17	8	14	17	58	45
Pre-school children with high risk factors.	29	18	27	43	18	27	14	9	14	14	55	32
Children with measles.	29	42	43	57	17	30	14	8	9	0	33	17
Post-partum mothers.	33	18	24	33	18	19	17	9	19	17	55	38
Train health workers in the prevention, recognition, and treatment of vitamin A deficiency.	33	42	42	56	33	39	11	17	15	0	8	4
Other activities.	100	20	33	0	10	20	0	50	33	0	20	13
Has your agency:												
Discussed the importance of vitamin A for child survival.	56	8	36	44	46	43	0	23	11	0	23	11
Submitted proposals which include vitamin A interventions.	50	0	24	38	42	40	13	42	28	0	17	8
Allocated funds for vitamin A-related activities.	33	0	17	50	0	13	0	42	30	17	58	39
Designated staff responsible for VA-related activities	50	17	40	38	17	20	0	8	4	13	58	36
Incorporated vit A-related topics into on-going training curricula	33	33	41	56	33	41	11	8	7	0	25	11
Adapted or developed educational or training materials on vitamin A for use in programs.	12	9	24	53	4	24	0	27	18	25	55	36
Established guidelines related to vitamin A.	11	33	26	44	17	22	0	17	15	44	33	57
Established linkages to other agencies working in vitamin A deficiency control.	22	9	25	44	18	29	11	27	17	22	45	29
Sent staff for training on vitamin A-related issues	22	8	16	22	0	12	33	42	32	22	50	40

terms of helping your agency to undertake the above activities, the workshop was (check one):

	PVO	GM	ALL
ery helpful	78%	54%	57%
ostly helpful	11%	31%	29%
lightly helpful	11%	0%	7%
id not help at all	0%	15%	7%

you have not been able to implement the plans you made as a result of the workshop, what have been the obstacles (please check all that apply):

	PVO	GM	ALL
ot enough funding	43%	50%	53%
itamin A not a current priority	14%	40%	26%
upervisor has not followed up on implementation plans	0%	10%	5%
upervisor has not followed up with me	0%	20%	11%
ot enough staff	0%	30%	16%
ly agency is unsure whether vitamin A deficiency is a problem	14%	20%	16%
eed assistance from Helen Keller International	14%	40%	35%

* (PVO = Local and US-based PV (GM = Government Ministry, ALL = Total response)

N = 28

Government = 13

US PVOs = 6

local NGOs = 3

Other = 6

28

Question 5B: How did technical assistance in assessment of vitamin A deficiency and project design contribute to the achievement of VITAP's purpose and goal?

At the beginning of VITAP, most of its potential PVO and NGO clients had had no programming experience with vitamin A. VITAP faced the double challenge of first convincing them that vitamin A deficiency was a worthy cause to take on and second, that they would be ideal partners for HKI in this endeavor.

VITAP's strategy for engaging PVOs and NGOs consisted of the overall orientations first, described above in 5A, coupled with follow-up with individual organizations, based on their requests for technical assistance. Often, the first joint venture between VITAP and a new client was assessing the magnitude and severity of vitamin A deficiency in the PVO's target population. When vitamin A deficiency was found, as it often was, the information provided indisputable proof that there was a problem and typically motivated the PVO to want to take steps to correct it.

At this point, VITAP became part of the solution to help the client with a problem, instead of just another special interest group trying to exploit a PVO's resources for pursuing its (i.e., VITAP's) narrowly-focused cause. For its part, VITAP not only wanted to convince others that vitamin A deficiency is a problem, it wanted to teach them how to find and address this problem on their own in the future.

In training PVOs and NGOs to conduct simple and rapid community-level assessments of vitamin A deficiency, VITAP took care to modify the assessment protocol to suit the users. For this, VITAP had to develop a simplified dietary method which was practical and inexpensive for PVOs to use in their own projects. Results of implementing the assessments and treating cases of vitamin A deficiency when detected were:

1) an increase in the knowledge and skill of the health staff to detect vitamin A deficiency,
2) an elevation of the status of community health workers,
3) an introduction to or reinforcement of skills in monitoring and evaluation, and
4) additional concrete evidence that the PVO (or NGO) was committed to assisting the target population.

The value of conducting assessments in communities at risk of vitamin A deficiency was exemplified in a hill-tribe village in the Philippines where Project Maluso, an affiliate of CCF, was working. While conducting a simple assessment, two cases of xerophthalmia were detected and treated. When the children's sight returned shortly afterwards, the whole community was convinced of the importance of vitamin A in their diet. The health worker's credibility was also elevated, and that worker became more enthusiastic about further developing the vitamin A aspects of the project.

Conducting assessments and then modifying project plans accordingly to address cases of vitamin A deficiency, if found, are two initial and very key elements in monitoring and evaluating a comprehensive vitamin A program. Some agencies interviewed during the assessment were either unaware of or did not know where to obtain an appropriate tool for community assessment. They assumed that in order to identify the nature and extent of vitamin A deficiency in their target groups, they would have to mount large-scale rigorous surveys. These same PVOs also expressed their interest in having hands-on training in implementing a community assessment. It appears that even though VITAP has been involved in numerous assessment activities with certain PVOs and in selected countries, it needs to market this service and the tools already developed on a wider basis.

Similarly, VITAP has not been able to provide in-depth assistance in on-going monitoring and evaluation. This particular situation is not surprising, since many PVOs typically worry about these latter two components at a separate and later date in the project cycle. Monitoring and evaluation are specific areas which PVO and NGO clients mentioned as a chronic need, not only for vitamin A programming, but in general.

Question 5C: How did technical assistance in training contribute to the achievement of VITAP's purpose and goal?

Sub-questions: Has training been institutionalized? Are there a curriculum and training strategy in use? Is the training plan dependent on an individual or are adequate technical materials available? Is staffing stable enough in a PVO to make training pay off?

One of the most common modes through which VITAP provided technical assistance to its clients was via training, for one or more organizations at a time. VITAP's strategy was not only to assist clients to undertake vitamin A programming, but to enable them to continue the work without VITAP at some point in the future. Therefore, regardless of the type of assistance requested by a client, VITAP was concerned that the staff members with whom it worked on any given assignment be chosen for their interest in and responsibility for transferring their new knowledge and skills to others in the organization. Although the training which VITAP provided naturally used information about vitamin A as the context, the programming skills which clients developed in the process, e.g., in assessment, non-formal education, and design, were easily transferable to other activities undertaken by their organization.

Of all the countries visited by the assessment team, the Philippines manifested the clearest, most comprehensive and effective VITAP training plan. VITAP's approach consisted of first creating a core group of trainers in each of five collaborating PVOs. These trainers were then responsible for developing vitamin A-related activities for their own staff, their affiliates' staff and/or for volunteer health workers associated with their

programs. The VITAP Coordinator was often called upon to participate as a co-trainer in these follow-up workshops for the PVO or NGO "implementers".

The next step in the Philippines was for the implementers to apply their new knowledge and skills to identify persons at risk for vitamin A deficiency in their target groups and to assist them in various ways to increase their intake of vitamin A. In just two years in one country, using this three-tiered training strategy -- i.e., training the trainers, who then train the implementers, who then work with community members -- VITAP has contributed to mobilizing a cadre of 980 professional and volunteer health workers who are capable of detecting vitamin A deficiency and taking steps to address it.

In most countries, VITAP typically expected to work with a client through the course of several activities in the programming cycle. In two cases, the assessment team discovered clients who were able to take their initial training and apply it to their own programs, with no additional direct VITAP input. The first example is from the Medical Ambassadors of the Philippines (MAP). Three of their staff members attended the initial VITAP orientation in 1990 and then proceeded to train all 45 staff how to incorporate procedures for the assessment, prevention and control of vitamin A deficiency into their clinic activities in remote villages. Even though only one of the three original trainees was still employed by MAP at the time of the assessment, the organization had succeeded in incorporating vitamin A into its program.

The second example is from Indonesia, where ADRA requested and received training in gardening which was complemented by adaptation of a manual on gardening in sandy soil. Then the trainees proceeded to help community residents create 55 gardens with vitamin A-rich vegetables. These two examples suggest that there may be other similar spin-off activities from VITAP's initial inputs which have evolved into positive results -- as yet unquantified -- at the community level.

Question 5D: How did the development of nutrition education materials contribute to the achievement of VITAP's purpose and goal?

Sub-questions: Have materials been adapted and/or translated into local languages? Are other materials that are being used in the field based on VITAP training materials?

Although VITAP developed and produced many different types of materials for a variety of audiences, this question focuses on those which were developed with clients with the intention of being used in educational sessions with community groups. In the Philippines, the VITAP Coordinator has worked with its core group of PVOs to develop several different materials for communicating messages about the prevention and control of vitamin A deficiency. The Coordinator had a series of meetings with Save the Children to discuss the creation, drafting and pilot testing of a recipe book which highlighted vitamin A. Similarly, the VITAP Coordinator assisted CARE in its efforts to develop a special vitamin A supplement for the FLANE (Fun Learning Activities for

Nutrition Education) kit. This kit, which includes board games, playing cards, posters and charts, is used by midwives to encourage mothers to engage in participatory learning activities.

The VITAP Coordinator in Indonesia has also assisted client PVOs and NGOs to develop appropriate materials in support of their vitamin A programming efforts. Specific materials under development or already in use are a flip chart and toy food models for use in preschools and a module for training religious groups about vitamin A. Indonesia has also benefitted from the translation and/or adaptation of VITAP materials from other countries.

The most extensive spinoff activities related to the development of nutrition education materials for VITAP has occurred in West Africa. Initially, VITAP responded to a joint request from the local staff of CRS and World Relief in Burkina Faso to develop visual aids to help their community-based health workers in their efforts to educate mothers about the importance of vitamin A-rich foods.

With the assistance of a VITAP consultant, a storyline was developed into two sub-themes and presented via flipcharts. The first storyline focuses on a pregnant woman named Awa who suffers from nightblindness and the second story describes her child who develops the classic signs and symptoms of vitamin A deficiency. In collaboration with the Nutrition Communications Project of the Academy for Educational Development, the PVOs field tested the prototype flipcharts in both Burkina Faso and Mali. Printing was arranged and supervised by VITAP in New York. The flipcharts are produced in French, but can be translated into local languages directly by health workers as the story is presented because the script is printed on the back of each page.

However, back in Burkina Faso, CRS, World Relief and later Save the Children subsequently found that the flipcharts were not effective in the hands of their volunteer health educators in the village setting. A key factor contributing to this situation is that the flipcharts were not integrated into a comprehensive training plan and therefore their potential users were ill-equipped for handling this new educational tool.

Nevertheless, these PVOs found that the value of these flipcharts lies primarily in the hands of teachers and instructors with already literate students, or where they can be used continually over some period of time with non-literate adults, as World Relief does in its community development training. AED has continued the original storyline and created three additional flipcharts, which they call 'storybooks'. The flip charts are now in their second edition and are being produced locally in Burkina Faso. UNICEF plans to have several thousand copies reproduced in Ouagadougou for distribution in schools and other training centers.

From Burkina Faso and Mali, the storyline about Awa has also spread to Niger. This dramatic tale has been transformed from print media into theater pieces presented in schools and local communities.

In sum, the dramatic tale and flipcharts which were the products of VITAP collaboration have stimulated a variety of spinoffs:

- To other audiences - originally designed for use with mothers, the flipcharts are now used for school children and to train health workers;
- To a more comprehensive plan - originally designed as stand-alone materials, AED in Mali has now developed a guide for the use of the flipchart.;
- To other forms - originally produced as flipcharts, the storyline has been transformed into radio spots and theater pieces for different audiences;
- To other countries - originally produced in Burkina Faso and Mali, the story spread to Niger; and
- To other content - the two original stories have now evolved into five.

Question 6: In the countries covered by the assessment, are there any combinations of technical assistance and/or other factors which seemed particularly effective?

In each country visited, the assessment team found a variety of outcomes that had been produced by PVOs, NGOs and governments, in cooperation with VITAP. In comparing the results from Africa to those from Asia, there were no apparent regional themes which could account for differences noted in the findings.

The Philippines is the country which stands out in the assessment for the breadth and depth of activities which have evolved as a result of VITAP. Many factors have contributed to the success of VITAP there, including the presence of a part-time in-country Coordinator and support from a well-established HKI office, its vitamin A programs and materials.

Nevertheless, the team attributes a significant proportion of VITAP's accomplishments in the Philippines to a single factor -- its three-tiered training plan -- already mentioned in the response to Question 5C. This design, plus the cost-sharing strategy which VITAP used in its implementation, represents a valuable model of PVO-to-PVO technical assistance which VITAP has created. Based on data collected by the VITAP Coordinator and the assessment team, in just over two years, VITAP's activities in the Philippines have ultimately reached approximately seven million people. This model deserves serious study for its potential replication in other countries, other organizations and other sectors.

III. DISCUSSION

1. Countries and activities chosen for the sample

By the time of this assessment, VITAP had provided assistance to 25 countries and had undertaken a wide variety of activities with different groups based in the U.S. and overseas. The range of experience upon which the assessment could draw was indeed vast. The sample eventually chosen, i.e., five countries and two major workshops, provided an excellent opportunity to investigate VITAP's interventions in more depth in diverse settings: in Asia and Africa; with and without an HKI office in-country; and with and without an in-country VITAP Coordinator.

2. The process of undertaking the assessment

The assessment team was charged with the difficult task of following the chain of technical assistance from VITAP, through the intermediaries of PVOs and NGOs, to the community. The assessment process was complicated by the fact that the PVO and NGO clients of VITAP were expected to take TA from VITAP, add it to their own body of skills and experience, and then produce one or more new activities within their own programs. As the direct connection with VITAP became separated -- in time and space -- from the vitamin A activities which its clients subsequently created, the VITAP "label" became harder and harder to trace. In fact, this is exactly the result which VITAP sought, as encouraging PVOS to assume the responsibility for addressing vitamin A deficiency is a key step to institutionalization of this public health objective into their organization's on-going mandate.

Furthermore, the original design of VITAP did not include provision for monitoring and evaluating the community-level activities which VITAP's clients undertook with their own target populations. Nevertheless, the assessment team found indications that VITAP's message has reached the community level in the countries visited - as evidenced by awareness of and correct knowledge about vitamin A, and specific activities, e.g., gardening and distribution of VAC. Especially noteworthy is that VITAP's messages about the cause, consequences, prevention and control of vitamin A deficiency:

- have reached the community level fairly intact after "travelling through" other organizations (PVOs, NGOs and Ministries of Health), and

- can be traced back to specific VITAP inputs, even after a two-year gap in some African countries between those inputs and the assessment team's review (by visit or questionnaire).

Even with these constraints, the receptivity of PVOs, NGOs and host country governments to having visits by the team turned out to be a significant aid to the assessment process. In all of its contacts with VITAP's clients and their target

populations, the team was welcomed with hospitality and openness about project activities. This warm reception communicated to the team that project ownership had indeed been developed by VITAP's partners and that they were generally proud to present their accomplishments.

3. Comments about the overall findings

A. Breadth, depth, durability and spinoffs of the outcomes

The findings described in the previous section, and in more detail in the individual country reports, are impressive for their: a) breadth, e.g., in the Philippines, VITAP and its collaborators have reached seven million people; b) profound effect on individual clients, e.g., ADRA (Philippines) has trained 550 health workers and World Vision (Mali) has trained 615; c) durability, e.g., a number of governmental and non-governmental development workers in Africa reported that some of their current vitamin A activities are a result of having participated in a single VITAP-sponsored workshop over two years ago; and d) unexpected spinoffs, e.g., the flipcharts developed in Burkina Faso evolved into different educational forms in neighboring countries.

B. The art of collaboration

VITAP has a mission, that is, to reduce the mortality and morbidity associated with vitamin A deficiency, and it has been able to engage the interest and resources of many others even though vitamin A deficiency is not a priority for any one of these collaborators. When collaborators become involved with VITAP, they voluntarily take on more work and more expense. VITAP's ability to develop other organizations into effective partners is due to many factors, as presented in the response to Question 4 in the previous section. Underlying this willingness to collaborate with VITAP is the mutual understanding that the client is also receiving something in return:

- Sharing costs with VITAP prevents the client from having to finance the entire activity alone;
- PVO and NGO field workers desperately need to have something concrete to offer to mothers and children in their target groups. Therefore, providing useful information and even VACs to prevent and control vitamin A deficiency helps to sustain field workers' commitment to a difficult job; and
- Many PVO and NGO field workers and their managers found VITAP's technical assistance valuable because it helped to develop skills in a particular programming area (e.g., project design, training, assessment, materials development) which were transferable to another activity.

C. Impact at the community level

At the time of the assessment, VITAP was only four years old. The assessment team found that VITAP's message had reached the community level and was being acted upon in all four countries where field visits were possible. Although the data gathered at this level were mostly qualitative, they strongly suggest that some of the results can already be quantified, resources permitting. In four years, VITAP has worked with and through numerous layers of bureaucracy of governments (of the USA and foreign countries) and non-governmental organizations (U.S.-based PVOs and local NGOs) in order to produce changes in the behavior - and improvements in the lives - of vulnerable groups. For example, in the Philippines, where VITAP and its collaborators have reached an estimated seven million people, one can safely assume that these joint efforts have saved the vision and lives of at least several hundred children.

D. Micronutrient deficiencies

During interviews with the assessment team, many of VITAP's collaborators brought up the subject of the "other" micronutrients - i.e., iodine and iron. These collaborators are joining nutritionists and health programmers worldwide as they focus their nutritional concerns on the triad of micronutrient deficiencies, which includes iodine and iron deficiencies as well as that of vitamin A.

The roles of these three essential nutrients are different in the body, as well as the etiologies of their deficiencies. Nevertheless, decision-makers look to those persons and organizations that already have expertise in vitamin A programming to take a leadership role in addressing the other two deficiencies. In the Philippines, VITAP has already expanded the range of its technical assistance to include iron and iodine deficiencies. VITAP and HKI will need to determine how VITAP might modify its overall mandate and approach to address all three micronutrients.

IV. CONCLUSIONS

1. VITAP has had an impressive effect in motivating and enabling PVOs, NGOs and Ministries of Health to undertake and sustain vitamin A interventions.

VITAP has produced a myriad of results, identifiable and quantifiable at the PVO, NGO and MOH levels and in incipient, yet also identifiable, stages at the community level. VITAP's direct collaborators have made the organizational commitment to address vitamin A deficiency in their programming and can demonstrate through new policies, guidelines, action plans, budgets, materials, training plans and skilled staff, that they have incorporated this component into their organizational objectives. These latter results have been obtained despite the fact that vitamin A deficiency has not traditionally been a high priority area for any of them.

2. VITAP is an effective mechanism for PVO-to-PVO technical assistance.

Overall, VITAP has created an effective model of PVO-to-PVO technical assistance to expand efforts to control and prevent vitamin A deficiency in the countries assessed. While numerous factors contributed to this success, the major ones included VITAP's ability to generate demand for its services, its flexibility in responding to the needs of its clients and its concern for maintaining communication with them.

Within VITAP's overall model for providing technical assistance, variations emerged in different countries. The three-tiered training model in the Philippines is especially noteworthy for the results it has produced in two years, with a limited budget. A part-time VITAP Coordinator has overseen the training of a core group of staff from five PVOs who in turn, as co-trainers, have multiplied their efforts through working with a myriad of community organizations and volunteer groups. Changes in behavior at the community level were visible and quantifiable.

3. There is still a need for VITAP.

The assessment report and the individual country reports describe many of the accomplishments which VITAP has achieved to date. Given the worldwide scope of VITAP, it understandable that activities are in different stages in different countries. The most motivated collaborators have forged ahead, others are gaining momentum and still others are just beginning to become involved in vitamin A activities. In addition, there are those groups which have just been identified as potential collaborators. Furthermore, many of VITAP's current collaborators have requested additional assistance in improving and expanding their efforts. While VITAP has already documented considerable success, there is a vast need for its services.

V. RECOMMENDATIONS

Overall, the assessment team recommends that VITAP should continue as currently designed, with the following modifications:

1. For the final VITAP evaluation

A. As follow-up to the assessment, conduct in-depth evaluations of selected country-level topics, especially changes in behavior of vulnerable groups. For example, an NGO collaborating with VITAP in the Philippines might conduct a community-level impact evaluation.

B. As follow-up to the assessment, analyze the cost-effectiveness of selected VITAP inputs, particularly in Indonesia and the Philippines, where in-country VITAP Coordinators have been working for approximately two years.

2. Initial country design

A. Use the experience that VITAP now has with different in-country management models (with and without a coordinator; with and without an HKI office), and choose among the most cost-effective models when initiating activities in new countries. Continue strong preference for local hires, especially as in-country Coordinators.

B. Ensure that HKI Country Directors, VITAP Coordinators and any other VITAP-related personnel have a clear understanding of VITAP's overall global strategy and the specific country design, objectives, strategy and reporting requirements.

3. Client selection

Continue to implement the recommendation from the mid-term evaluation, i.e., review results of VITAP to date on a client-by-client basis, so that priority for future assistance can be given to those clients with good track records of effective use of VITAP resources and opportunities provided or, in the case of new clients, their potential for same.

4. Transferable skills

Continue to offer TA to clients which helps their staff develop transferable skills while they are learning about vitamin A programming, especially in the areas of:

A. State-of-the art nonformal education techniques for literate and non-literate populations
B. Materials development and effective use of different media
C. Community assessment, monitoring and evaluation
D. Advocacy - PVOs and NGOs need to become articulate advocates for their own work so they can promote these causes in a variety of arenas, e.g., with intended clientele, politicians and donors.

5. Communications for behavior change

A. Seek out opportunities to use the Awa flipcharts for training health personnel and primary school children in West Africa.
B. Continue to develop materials on a country-by-country or regional basis with the potential for replication by other agencies, government bodies and other countries.
C. Continue to explore alternative funding mechanisms for materials, including cost-sharing with VITAP collaborators.

6. Expansion of VITAP

A. Share current experience

Expand the Philippines training model by replicating it in other countries, other organizations and other sectors.

Continue to document and share experiences-to-date with specific models of community-level assessment of vitamin A deficiency and distribution of vitamin A capsules, e.g., use of traditional birth attendants to reach postpartum women; and, use of school children to reach siblings.

B. Expansion of collaboration to other programming sectors

Continue to seek opportunities to enlist collaborators in other sectors to extend VITAP's messages and training, especially in the PVO- and NGO-assisted programs of the Ministries of Agriculture and Education, and other selected country-specific ministries, such as the Ministry of Religion in Indonesia. Concentrate on these other sectors in countries where the health infrastructure is especially weak.

Continue to develop policies to address vitamin A deficiency in famine mitigation and disaster situations. Consider a collaborative PVO project to pilot test and evaluate vitamin A strategies (i.e., VAC delivery, production of vitamin A-rich foods) to vulnerable populations in such a situation.

C. Expansion to other clients

Include local NGOs as potential candidates at the beginning of any new VITAP initiative. Also include the government ministries (e.g., Health, Agriculture, Education) as potential clients in countries where other agencies do not provide this service.

D. Expansion to other micronutrients (iron and iodine)

Provide appropriate packages of technical assistance, linked with VITAP, to governmental and non-governmental clients to address deficiencies of iron and iodine.

E. Expansion into other geographical sectors

Develop more urban models for the detection, prevention and control of vitamin A deficiency, given the increasing migration of people from rural to urban areas in most countries.

More detailed recommendations for VITAP may be found in the five separate country reports.

ANNEX 1

COUNTRIES AND WORKSHOPS REVIEWED TO SELECT SAMPLE

	AFRICA						CARIBBEAN	ASIA		
	Burkina Faso	Mali	Malawi	Niger	Nigeria	Zambia	Haiti	Indonesia	Kiribati	Philippines
PVOs: # of receiving TA	CRS, Africare SCF World Relief	Africare ADRA* Plan* WVRD* SCF PVOs w/ NCP/AED *Proposal Review	IEF ADRA SCF	Africare CARE	Africare ADRA (minimal)	ADRA Africare (current)	Eyecare World Vision CDS (local NGO)	ADRA, Church World Service PCI (local NGO) SCF	FSP	ADRA CARE CCF SCF CRS
Amount of input from VITAP	159 pds + Phase II # of Materials request -9	47.1 pds Phase II Materials - 6	116.1 pds Phase II	27 pds Phase II Materials - 6	27 pds Materials - 65	20 pds Phase II Materials - 11	204-1 pds Materials - 9	35 pds (underreported) Phase II Materials - 30	33.3 pds Materials - 4	75 pds Phase II Materials -35
Mix of interventions	Material Development; Gardening; Training; Program Design;	Policy Development; Assessment of VAD; Training; Proposal Review; Program Design; Regional Workshop	Gardening; Training; Program Design; Evaluation	Nutrition Education/ Training; Program Design	Assessment of VAD; National Workshop	Training; Policy Development; International Workshop	Social Marketing; Survey Design (dietary assessment); Training; Project design; Research (NOVA); National Workshop	Gardening Training; Program design; Evaluation /baseline; PVO Orientation Workshop; Materials development	Assessment of VAD	Assessment of VAD Training/ Nutrition Education; Materials development; Project Development; PVO Orientation Workshop;
MOH participation in T.A.	Yes	Yes; plus Regional Workshop	Yes	Yes	Yes Orientation Workshop	Yes Workshop & Follow-up	Yes	Yes	Yes	Yes
Training	Yes	Yes & Regional Orientation Workshop	Yes	Yes	No (Orientation only)	Yes & International Orientation Workshop	Yes & National Orientation Workshop	Yes & PVO Orientation Workshop	No	Yes & PVO Orientation Workshop
Current HKI Country Office?	No (recently established - no activities undertaken yet)	No	No		No	No	via local PVO (CDS) - closed 1.5 years ago	Yes	No	Yes
VITAP regional representative?	No	No	No	Yes (First 2 years) part-time	No	No	No	Yes - last 1.5 yrs	No	Yes (part-time)
Recommendation	yes	Yes	No	Yes	via questionnaire	via questionnaire	possible	Yes	No	Yes

September 24, 1992 pd = person days Phase II = VITAP Collaborative Project with PVOs begun after Oct 1991 and currently on-going ML

ANNEX 2

TERMS OF REFERENCE

HELEN KELLER INTERNATIONAL (HKI)
VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)
COOPERATIVE AGREEMENT NO. OTR-0284-11-00-8253-00

TERMS OF REFERENCE FOR VITAP IMPACT ASSESSMENT

Introduction:

In August 1988, Helen Keller International was awarded a five year grant from USAID's FVA/PVC Office to develop a vitamin A center of excellence in order to strengthen and enhance the efforts of Private Voluntary Organizations (PVOs) to reduce preventable blindness, morbidity and mortality associated with vitamin A deficiency in developing countries.

VITAP offered a range of services to the PVO community in order to accomplish the above. These services include, country or regional orientations on vitamin A, short terms technical assistance in training, assessments, strategic planning, evaluations and other areas, development of generic assessment and training tools, information dissemination and consultant referrals. VITAP, in general, undertook a brief situational analysis in each country before providing assistance in order to assess need and identify areas that needed strengthening at the country and PVO level.

VITAP's external mid-term evaluation (conducted March - April 1991) recommended that USAID continue to fund VITAP, but that VITAP revise the original Detailed Implementation Plan to incorporate recommendations from the mid-term including a more proactive approach to working with selected PVOs on well defined projects. VITAP's goal and range of services provided to the PVO community remains the same, however, emphasis has switched to providing tools that will facilitate the institutionalization of vitamin A deficiency control programs within the PVOs.

Due to travel restrictions, the mid-term evaluation did not look closely at VITAP's impact on vitamin A programming at the PVO field office and/or community level. Subsequently, USAID requested that VITAP free up funds to undertake an impact assessment. Therefore, an impact assessment of selected technical assistance provided by VITAP to PVOs will be conducted as a joint USAID/HKI activity in order to assess how well VITAP technical assistance was translated by PVOs into effective vitamin A programming at the community level.

Purpose:

The purpose of the activity is to assess VITAP's impact on vitamin A programming at the PVO field office and community level (to document tangible outcomes) and to assess how well VITAP technical assistance was translated by PVOs into effective vitamin A programming. The emphasis will be on assessing the technical assistance transfer process in order to identify the elements and activities that lead to successful (and unsuccessful) translation of technical assistance into appropriate program implementation at the community level.

Participation:

The assessment planning team is composed of representatives of the following organizations: USAID FHA/PVC; HKI/VITAP; IEF; Project Hope; Africare and ADRA. This team will meet to refine the Terms of Reference (SOW/TOR), confirm the assessment team composition and discuss the assessment protocol.

The assessment team will be composed of four members. Ms. Carol Valentine, a VITAP/HKI consultant, has been identified to serve as team leader and activity manager. Ms. Rudi Horner will be another team member. John Mckigney has been recommended to join the team due to his participation on the mid-term evaluation and extensive field work with USAID and PVOs. A fourth consultant is to be identified. The VITAP Deputy Director will be available to the team as a resource throughout the impact assessment.

Timing:

The first impact assessment planning meeting was held on June 3, 1992. The second planning meeting will be held during early September at USAID PVC Office. The assessment team will also participate in a two-day team planning meeting shortly thereafter (October) and team coordination meetings as necessary.

It is anticipated that the impact assessment protocol development will be completed by end September/early October. Field work, including U.S.-based and overseas-based work, will begin in early October and proceed through end December. During January 1993, the data collected will be compiled and analyzed and the final report will be completed. (The budget includes 175 person-days consulting time dependent on the hiring of a HKI/VITAP Assessment Manager full-time).

Site Visits:

a) The assessment team will visit HKI headquarters to review data compiled to date concerning the selected technical assistance services to be assessed (including a careful review of all mid-term evaluation questionnaires from PVO headquarters and field offices) and to interview key VITAP/HKI staff regarding anecdotal information.

b) As necessary, the assessment team will visit and/or phone selected PVO headquarters technical staff in order to gain additional information on the extent to which VITAP technical assistance may have benefitted the PVO field projects.

c) The assessment team will visit countries where the selected services provided to the PVO(s) by VITAP transpired. The number of countries and specific countries visited depend on which of VITAP's services have been selected by the planning team to assess/follow as case studies (and on available funds for country visits). While in a country, the team will look for signs of transfer to the PVO field office and to the field project, ie. outcomes at the community project level possibly related to services provided by VITAP.

Scope of Work:

General approach -

The impact assessment will be conducted both in the U.S (HKI and other PVOs, as necessary) and in countries where selected technical assistance was provided by VITAP. The emphasis will be on assessing VITAP's impact at the community level, therefore, the majority of activity will take place in the field where the services were actually provided.

The general approach will be to review the different categories of services provided by VITAP and select services to be followed from start to finish in order to assess the process and the impact on field activities (services/countries were selected at the September planning meeting from a list of services provided by VITAP to PVOs). Signs of transfer (assessing the transfer of technical assistance process and resultant products) will be looked at as well as signs of institutionalization of vitamin A activities at the community level and the PVO field office level and possibly at the PVO headquarters level. We will try to identify both successful and unsuccessful projects to help understand elements for successful transfer of technical assistance.

The assessment will focus on certain services which are of greatest interest to PVOs (including HKI) and USAID including:

A) country of regional workshops -to look at the impact of at least one large meeting, such as the Zambia Regional workshop or the Nigeria National Workshop (Are these workshops valuable? Is there considerable spin off effect? Have field programs been implemented or strengthened as a result of the new information? Should workshops be continued as a service? What are the beneficial effects of networking? Has a network developed in the field? Is the network used by the workshop participants?)

B) materials development and training materials (look at the use of materials at the local level, Have materials been adapted/translated into local languages? Are other materials that are being used in the field, based on VITAP training materials?);

C) training (Has training been institutionalized? Is there a curriculum and training strategy is use? Is the training plan dependant on an individual or are adequate technical materials available?)

D) short term technical assistance vs. collaborative project approach (look at both - retrospectively and prospectively - for collaborative projects); may not have had time (for collaborative projects) to have had an effect at the community level;

E) assistance to one PVO vs. a group of PVOs (Is it better to provide assistance to a group of PVOs vs. tailor assistance to an individual PVO?).

Assessment protocol development -

The evaluation team will develop a strategy for the impact assessment which will be reviewed and approved by both USAID and HKI.

The assessment strategy will employ quantitative and qualitative methodology, but the emphasis will be primarily on qualitative methods in order to look at the process of

transferring technical assistance, what worked?, what didn't work?, why? what outcomes can be attributed to VITAP?. The methodology will need to be creative and verify anecdotal information.

The assessment team will develop an interview schedule(s) for use in interviewing HKI/VITAP staff, PVO HQ staff, field-based PVO, MOH, community members and others.

U.S. based activity -

The team will carefully review specific documents related to the selected services including; the VITAP mid-term evaluation; annual reports; consultancy/staff reports; VITAP file with follow-up information.

The team will interview key VITAP/HKI staff regarding the selected services in order to understand the technical assistance transfer process and to clarify services provided, follow-up activity and ascertain any anecdotal information regarding outcome of the technical assistance provided.

The team will interview key PVO technical staff in order to verify the above information and to garner additional information regarding any spin-off effects of technical assistance provided.

Field based activity -

The team will travel to the site where the selected technical assistance was provided. The countries selected for site visits are Burkina Faso, Mali, Niger, Indonesia and the Philippines. Key staff at the PVO(s) field office will be interviewed regarding the service provided by VITAP, the process by which the service was provided and the impact of it at the field office. Other agencies involved such as UNICEF, WHO, USAID mission, MOH will be interviewed as appropriate.

The team will travel to the community/communities where the PVO utilized the technical assistance provided by VITAP either directly or indirectly. Health/agriculture workers and/or beneficiaries of the services given by PVOs will be interviewed/observed to assess knowledge, practice, attitude (KAP). There will most likely <u>not be</u> a baseline KAP regarding vitamin A so change in KAP will not be measurable in most cases. Signs of transfer will be noted such as use of (and correct use of) training/educational materials at the community level; number of community gardens with vitamin A rich foods etc.

Reporting -

The data will be compiled and analyzed by the team.

A report will be written which presents the results of the impact assessment including a description of VITAP's impact, in general, case studies of each selected activity and recommendations for future provision of technical assistance by HKI.

revised 10/92

ANNEX 3

BIOGRAPHICAL INFORMATION ABOUT THE ASSESSMENT TEAM

ANNEX 3

BIOGRAPHICAL INFORMATION ABOUT THE ASSESSMENT TEAM

Margaret Ferris-Morris

Margaret Ferris-Morris has over ten years of international development and relief experience as a maternal/child health nutritionist. Her technical expertise is in relief health operations and logistics, health programming, survey design and analysis, and training. In addition to French and Khmer language skills, she has been contributing author to numerous publications.

Most recently, Ms. Ferris-Morris has conducted consultant assignments in Cambodia with UNICEF, FAO, and World Vision International; and for USAID Office of Foreign Disaster Assistance in Cape Verde. She has worked extensively for the US Peace Corps- OTAPS designing training modules and conducting a training in Niger. Consultant services were provided for the American Red Cross National Headquarters, and she served for them in Niger and Europe.
Ms. Ferris-Morris commenced international work with the World Food Programme in Thailand as Nutrition Coordinator for refugee camps along the Thai-Kamphucean border. Domestic assignments were undertaken with the International Nutrition Unit/LTS and domestic community-based nutrition surveillance with Cornell University. She received a B.S. from Cornell University, and a M.S. from the University of Connecticut. Both degrees specialized in nutritional sciences.

Mary Ruth Horner, Ph.D.

Dr. Horner served as Team Leader of the Asia Team for the VITAP Impact Assessment. Dr. Horner has had eighteen years of experience working with U.S. - based private voluntary organizations and non-governmental organizations in developing countries. Her training and experience include all areas of primary health care, community participation and institutional development.

As a consultant, she has undertaken short-term domestic and international assignments with the Manoff Group, the MotherCare Project of JSI, VITAL, Helen Keller International and the Wellstart Expanded Program on Breastfeeding. She also works with the Synergos Institute providing support in fundraising and grant management to its NGO affiliate partner, Roda Viva, in Brazil.

Dr. Horner worked with CARE from 1982-1990, first as a Nutrition Advisor and then as Director of the Primary Health Care Unit. In the latter position, she was responsible for overall Child Survival projects. Dr. Horner was responsible for overall developing CARE's first Child Survival proposal in 1985 and managing all subsequent annual submissions and grants.

Before joining CARE, Dr. Horner worked in Brazil with UNICEF and the University of Brasilia. She received her undergraduate degree from the University of Delaware and her M.S. and Ph.D. degrees in Nutritional Sciences from the University of Wisconsin.

Carol Hopkins Valentine

Carol Valentine served as the Team leader for the VITAP Impact Assessment. Ms. Valentine has over twenty five years experience in international development and education for both the United Nations and academic institutions. Her specialization is in women in development and family planning and population issues.

As a consultant, she has undertaken assignments planning, evaluating, and analyzing Family Planning projects with USAID, UNICEF, UNFPA, and PAHO.

Ms. Valentine worked for the United Nations Fund for Population Activities from 1979 - 1986. During this time, she was responsible for the design, implementation and monitoring of population projects for the Africa and Middle East Branches. Before joining UNFPA, Ms. Valentine was program coordinator with the Center for Population and Family Health, School of Health, Columbia University, New York, NY.

Ms. Valentine holds a M.P.H. specializing in population and family health. She received her undergraduate degree from Bryn Mawr College.

Alice Willard

Alice Willard has fifteen years experience in African development and evaluation. She began as a Peace Corps Volunteer in 1978 and has built upon these skills and experiences through two M.A. programs, a doctoral candidacy, and ten years of contracting with A.I.D.

As a Research Associate with the Triton Corporation, Ms. Willard managed a comprehensive study of AID's project evaluations. As a consultant with the Africa development policy division of USAID, she conducted review and analysis of AID programs in thirteen African countries. Most recently, as a Senior Systems Analyst, she has trained and provided on-site technical assistance to AID missions in Mali, Niger, Mauritania, Senegal, the Gambia, Cameroon, Liberia, and the African Development Bank.

Her regional specialty is francophone Africa and her technical competencies include qualitative and quantitative methodologies, systems design and analysis, evaluation research, research and program design, and analysis.

Ms. Willard is ABD status in a Ph.D. program in Comparative International Development at Johns Hopkins University in Baltimore, MD. She holds two Master of Arts degrees, one in Sociology from Johns Hopkins University and another in International Development from The American University, Washington, D.C. Ms. Willard received her B.A. degree in French and Latin from State University of New York at Albany.

ANNEX 4

QUESTIONNAIRE FOR THE AFRICA WORKSHOPS

Questionnaire for Workshop Participants

Today's date:_____

Please answer the questions on behalf of the agency which you represented at the workshop. However, if you changed positions, and now work somewhere else, you may wish to fill out the questionnaire from the perspective of your current agency.

1. I am answering the questionnaire from the perspective of (*please check one*):

   ☐ the agency which I represented at the workshop
   ☐ a new position

   The agency referred to above is best described as (*please check one*):

   ☐ Government ministry
   ☐ Local NGO
   ☐ US-based PVO
   ☐ Other (*please specify*) _____

2. To the best of your knowledge regarding each of the activities listed below, please check ✓ if it was on-going before the workshop, was initiated after the workshop, or is still planned for the future. If you are uncertain or do not know, please check the box in the Not sure column.

	Ongoing before workshop	Initiated after workshop	Being planned	Not sure
• National policy established regarding the control of vitamin A deficiency, *e.g.*, included in national health plan.	☐	☐	☐	☐
• Working group established to coordinate national vitamin A deficiency control effort.	☐	☐	☐	☐
• Vitamin A capsules included in national Essential Drug Program.	☐	☐	☐	☐
Has your agency implemented activities to:				
• Increase the local production of vitamin A-rich foods.	☐	☐	☐	☐
• Increase the consumption of vitamin A-rich foods.	☐	☐	☐	☐
• Provide vitamin A supplements (capsules) to:				
All pre-school children every 3 or 6 months.	☐	☐	☐	☐
Pre-school children with high risk factors.	☐	☐	☐	☐
Children with measles.	☐	☐	☐	☐
Post-partum mothers.	☐	☐	☐	☐
• Train health workers in the prevention, recognition, and treatment of vitamin A deficiency.	☐	☐	☐	☐
• Other activities _____	☐	☐	☐	☐
Has your agency:				
• Discussed the importance of vitamin A for child survival.	☐	☐	☐	☐
• Submitted proposals which include vitamin A interventions.	☐	☐	☐	☐
• Allocated funds for vitamin A-related activities.	☐	☐	☐	☐

	Ongoing before workshop	Initiated after workshop	Being planned	Not sure
• Designated staff to be responsible for vitamin A-related activities.	☐	☐	☐	☐
• Incorporated vitamin A-related topics into on-going training curricula.	☐	☐	☐	☐
• Adapted or developed educational or training materials on vitamin A for use in programs.	☐	☐	☐	☐
• Established guidelines related to vitamin A.	☐	☐	☐	☐
• Established linkages to other agencies working in vitamin A deficiency control.	☐	☐	☐	☐
• Sent staff for training on vitamin A-related issues.	☐	☐	☐	☐

3. In terms of helping your agency to undertake the above activities, the workshop was (*check one*):

   ☐ very helpful
   ☐ mostly helpful
   ☐ slightly helpful
   ☐ did not help at all

   Please tell us why:

4. If you have not yet been able to implement the plans you made as a result of the workshop, what have been the obstacles (*please check all that apply*):

   ☐ Not enough funding
   ☐ Vitamin A not a current priority
   ☐ Supervisor has not followed up on implementation plans
   ☐ Supervisor has not followed up with me
   ☐ Not enough staff
   ☐ My agency is unsure whether vitamin A deficiency is a problem
   ☐ Need assistance from Helen Keller International in (*please specify*):_____
   ☐ Other _____

5. We would appreciate if you would send us any documentation (*e.g.*, training materials, brochures, field reports, proceedings from meetings or seminars, *etc.*) which provide more information about the vitamin A activities your agency has begun since the workshop.

   ☐ copy(ies) enclosed
   ☐ sent copy(ies) under separate cover
   ☐ document available; please send postage for mailing it to you

Thank you very much for your time and contribution! Please mail or fax this questionnaire to:

Helen Keller International
Attn: Carol Valentine
15 W 16th Street
New York, NY 10011 USA

Fax number: 212 / 463-9341