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**HELEN KELLER INTERNATIONAL**

**ASSESSMENT OF  
THE VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)**

**ANNEX 9. PHILIPPINES COUNTRY REPORT**

**November 9-25, 1992**

**BEST AVAILABLE DOCUMENT**

**Mary Ruth Horner, Ph.D.  
Margaret Ferris-Morris, M.S.**

**Helen Keller International  
90 Washington Street  
New York, NY 10006**

**HELEN KELLER INTERNATIONAL  
Vitamin A Technical Assistance Program  
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## **EXECUTIVE SUMMARY**

Vitamin A deficiency is one of the leading causes of blindness, morbidity and mortality worldwide, especially among preschool children in developing countries. In 1988, Helen Keller International was awarded a five-year grant from USAID to develop a program which would provide technical assistance and resources to other private voluntary and non-governmental organizations. This program, called VITAP (Vitamin A Technical Assistance Program), is designed to motivate and engage other organizations in joining HKI and the host government in the fight against vitamin A deficiency.

In 1991, the mid-term evaluation of VITAP was conducted, but no visits were made overseas to the field sites of VITAP's collaborators due to travel restrictions during the war with Iraq. In 1992, Helen Keller International, its collaborating PVOs and AID reviewed its VITAP activities in 22 countries and chose a group of five countries (Burkina Faso, Indonesia, Mali, Niger and the Philippines) and two international workshops which would be the focus of an in-depth assessment. Objectives of this assessment were to identify, describe and quantify the impact which VITAP was having on its collaborators and subsequently on the communities where those collaborators were working.

The country which is the focus of this report is the Philippines. The team members chosen for the VITAP assessment activity were Margaret Ferris-Morris, M.S. and Mary Ruth Horner, Ph.D., both nutritionists with extensive experience working with U.S.-based private voluntary and non-governmental organizations in developing countries. Ms. Ferris-Morris and Dr. Horner visited the Philippines from November 9-25, 1992 for the assessment.

The team's approach to learning about VITAP's activities focused on the review of VITAP documents, discussions with HKI staff and the VITAP Coordinator, discussions with Department of Health (DOH) and staff of five private voluntary organizations (PVOs) in Manila and their field representatives in Iloilo, Cebu, Zamboanga, Maluso and Davao.

HKI began working in the Philippines in 1976 and has played a major role in the development of the national program for the prevention and treatment of vitamin A deficiency. With technical assistance from HKI, the Department of Health has developed different models for the integration of vitamin A supplementation into existing governmental health services in order to expand the national vitamin A program, especially in areas with high prevalence of deficiency.

In 1990, VITAP was introduced to the DOH and potential collaborators in the Philippines as a mechanism to expand the national vitamin A program by engaging the support of U.S.- based PVOs. The initial workshop held in February 1990 was followed

up by developing action plans with collaborators who wanted to initiate or expand vitamin A activities through involvement with VITAP.

VITAP activities began in earnest in the summer of 1990 with the conduct of intensive trainings for program managers of key PVOs, i.e., Adventist Development and Relief Agency, CARE, Christian Children's Fund, Catholic Relief Services and Save the Children. VITAP's approach was to create in each PVO a core group of trainers who could then proceed to develop vitamin-A related activities within each organization, with some further assistance from VITAP. The PVO trainers in turn shared their new knowledge about vitamin A with field-based program implementers within their organization or with those associated with their local affiliates. Finally, the field implementers developed programs to train volunteer members of local health committees who have direct contact with mothers and other key community members. At the household level, mothers were expected to be able to incorporate the new knowledge about vitamin A into their child care and food preparation activities.

In slightly more than two years, with a part-time Coordinator and budget of \$53,000, VITAP has created a cascade of activities, in breadth and depth, related to vitamin A. It was not possible for the assessment team to estimate the total number of people who have been trained and to identify all of the spin-off activities already undertaken by the PVO core group.

Some of the key specific accomplishments of VITAP to date include, *inter alia*,

**At the PVO Level:**

- Fostering the development of awareness, commitment and specific activities among five US-based PVOs and at least 47 local NGOs to incorporate vitamin A into their on-going programs, even though vitamin A deficiency is not traditionally a high priority for any of them;
- Creating a cadre of 980+ professional and volunteer health workers who have been trained to detect and treat or refer high-risk cases for vitamin A deficiency (ADRA alone has trained 550 persons);
- Developing Project MATA (3 years; \$250,000), which addresses the need to incorporate local NGOs into the network to combat vitamin A deficiency;
- Producing four different materials for training health workers and for disseminating vitamin A information to the community;
- Enabling one NGO, the Medical Ambassadors of the Philippines, to incorporate vitamin A activities into its programs without needing follow-up assistance from VITAP;

- Increasing linkages among collaborators assisted by VITAP; and, as a result of all of the above,
- Demonstrating a cost-effective technical assistance model which is worthy of more in-depth review and adaptation to other countries where VITAP is working and to other sectors.

**At the COMMUNITY Level:**

- Increasing awareness of vitamin A among health workers and mothers;
- Increasing the number of gardens which include vitamin A-rich foods; and
- Increasing the distribution and consumption of vitamin A capsules, and, as a result of all of the above,
- Reaching an estimated several million children and mothers at-risk for vitamin A deficiency.

The overall key factor contributing to VITAP's success is an environment conducive to this type of program, including some elements which are under VITAP's control and others which are not. The elements which produce especially favorable conditions include:

- NGOs work well with the DOH and USAID in the Philippines;
  - The NGO community is well developed and sophisticated. Staff have a good understanding of the programming cycle and are committed to child survival program goals.
  - NGOs are respected by the DOH and USAID for their contribution in joining forces with the government to address health problems.
  - USAID is supportive of HKI's overall program, and is a key donor for specific projects, including Project MATA.
- VITAP works well with the DOH;
  - HKI has developed an excellent reputation for the quality of its work and its collaboration with the DOH.
  - VITAP assists in modeling alternative approaches of service delivery within the existing DOH system, allowing for extensive replication with slight adaptations by the DOH.

- **VITAP works well with NGOs;**
  - **HKI's work with organizations operates on a professional, 'soft sell' basis, with NGOs viewing HKI as the source of information and other resources about vitamin A.**
  - **VITAP has built concerns for sustainability into the project design, where plans of action have been tailored to fit into each NGO's system of operations.**
  - **Most VITAP collaborators have experience with integrated development projects including the following components: nutrition education, agricultural inputs, income generation and family and social welfare activities, increasing the likelihood of success of integrated strategies to increase vitamin A consumption over efforts of vertical programs.**
  - **VITAP plays an important role in bridging institutional barriers to allow local expertise of one agency to be shared with another.**
  - **VITAP seeks out locally-available and talented artists and consultants.**
  - **Collaborating NGOs have benefitted from the extensive experience and programming skills of the VITAP Coordinator.**
  
- **VITAP works well within HKI;**
  - **All of HKI's experience in the Philippines is brought to bear on the development and implementation of VITAP.**
  - **In the Philippines, VITAP developed creative approaches for working within the restrictions of the global VITAP grant.**
  - **VITAP and other HKI programs engage in activities which may benefit each other, e.g., developing more appropriate approaches to nutrition education and behavior change through pilot projects about weaning foods and the social marketing of vitamin A.**
  - **VITAP has benefitted from the excellent experience, programming expertise and managerial skills of HKI's Country Director.**

**There were two major factors noted which have a limiting effect on VITAP's ability to achieve its goals. One is the chronic nationwide shortage of vitamin A capsules, which limits the impact of any program - governmental or non-governmental - to address vitamin A deficiency.**

**The second major limiting factor, in the area of nutrition education, affects almost all of the DOH's and NGOs' efforts to modify behavior change *vis-à-vis* the consumption of vitamin A. The current understanding of the process of behavior change and the techniques needed to support its promotion are out-dated. Health workers 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'. In order to address this weakness, HKI, VITAP and the Nutrition Center of the Philippines are engaged in activities which can help develop more relevant approaches to helping mothers improve their behaviors related to the foods prepared for and consumed by their preschool children.

Other areas in which VITAP will need to focus more attention in the future are in:

- assisting collaborators to learn how to create and manage coalitions which advocate for health programs at the provincial, district and local levels;
- facilitating the documentation and dissemination of effective methods for promoting vitamin A within PVO programs;
- helping others to obtain funding for the development and production of training and communications materials;
- assisting NGOs and the DOH to procure and distribute sufficient supplies of vitamin A capsules (200,000 IU) on a timely basis; and
- designing and implementing a follow-up activity whereby all of the core VITAP collaborators and other key organizations can review progress to date, address roadblocks and make plans for the future.

In conclusion, VITAP has created a cost-effective model of PVO-to-PVO technical assistance to expand efforts to address vitamin A deficiency, control and prevention in the Philippines. This model deserves serious study for its potential replication in other countries, other organizations and other sectors. VITAP's approach to providing technical assistance and its strategies for working with a variety of different groups have brought about a wealth of achievements, in breadth and depth, in a relatively short period of time with a low budget.

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## ACRONYMS

<b>ADRA</b>	<b>Adventist Development and Relief Agency</b>
<b>ASEC</b>	<b>Assumption Social and Education Center</b>
<b>BHW*</b>	<b><i>Barangay</i> Health Worker</b>
<b>BNS</b>	<b><i>Barangay</i> Nutrition Scholar</b>
<b>CCF</b>	<b>Christian Children's Fund</b>
<b>CFARD</b>	<b>Cross Foundation Association for Rehabilitation of the Disabled</b>
<b>CHW*</b>	<b>Community Health Worker</b>
<b>CRS</b>	<b>Catholic Relief Services</b>
<b>DMSF</b>	<b>Davao Medical School Foundation</b>
<b>DOH</b>	<b>Department of Health</b>
<b>ETMCHP</b>	<b>Enhanced Targeted Maternal and Child Health Program</b>
<b>FLANE</b>	<b>Fun Learning Activities in Nutrition Education</b>
<b>H&amp;T</b>	<b>Health and Temperance</b>
<b>HKI</b>	<b>Helen Keller International</b>
<b>IDA</b>	<b>iron deficiency anemia</b>
<b>IDD</b>	<b>iodine deficiency disorder</b>
<b>IEC</b>	<b>information, education and communications</b>
<b>IGP</b>	<b>income generation project</b>
<b>MAP</b>	<b>Medical Ambassadors of the Philippines</b>
<b>NCP</b>	<b>Nutrition Center of the Philippines</b>
<b>NGO</b>	<b>non-governmental organization</b>

<b>OPT</b>	<b>Operation Timbang</b>
<b>PHCW*</b>	<b>primary health care worker</b>
<b>PVO</b>	<b>private voluntary organization</b>
<b>RHU</b>	<b>Rural Health Unit</b>
<b>SCF</b>	<b>Save the Children Federation</b>
<b>SDA</b>	<b>Seventh Day Adventist</b>
<b>TA</b>	<b>Technical Assistance</b>
<b>TMCHP</b>	<b>Targeted Maternal and Child Health Program</b>
<b>TOT</b>	<b>training of trainers</b>
<b>TFAP</b>	<b>Targeted Food Assistance Program</b>
<b>VAC</b>	<b>vitamin A capsules</b>
<b>USA</b>	<b>University of San Augustine</b>
<b>VAD</b>	<b>vitamin A deficiency</b>
<b>VADPC</b>	<b>vitamin A deficiency, prevention and control</b>
<b>VITAP</b>	<b>Vitamin A Technical Assistance Program</b>

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**\* These terms are often used interchangeably in the Philippines. Most often these terms refer to a local volunteer who is chosen and trained to work in a health program sponsored by the DOH, a PVO or an NGO. In some cases in the Philippines, this health worker receives a small stipend from the parent organization.**

## I. COUNTRY INTRODUCTION

The Philippines is an archipelago of 7,100 islands, of which only 880 are inhabited. Three main island groups encompass the majority of the country: Luzon, the Visayas and Mindanao. The total land area of 115,831 square miles has abundant natural resources. The population was 61 million in 1991, of which approximately four million persons belong to cultural minorities. Filipinos are predominantly of Malay origin, their ancestors having migrated from Indonesia and Malaysia. Approximately 85% of the population is Roman Catholic, one of the legacies of domination by Spain.

An estimated 70 different dialects are spoken in the Philippines, not one of which is the mother tongue of more than a quarter of the population. To promote national unity, the Government is encouraging the use of Pilipino, a form of Tagalog, as the national language. Approximately 45% of the population speaks English and an estimated 83% of the population 10 years and older is able to read and write at least one language.

Before the arrival of the Spaniards in the mid-16th century, Filipinos lived in widely scattered and almost isolated communities called *barangays*. To this day, the *barangay* has persisted as the smallest unit of government. The basic political subdivisions in the Philippines are the 73 provinces, 60 major cities, municipalities and *barangays*.

The Department of Health follows the civil government's structure, with decision-making at the central, regional, provincial and district levels. Health facilities below the district level are the Rural Health Units (RHUs), typically staffed with a midwife (two years training after high school) and sometimes a nurse (four years training). Volunteers complement the paid staff and consist of two groups: *barangay* (village) health workers (BHWs) and *barangay* nutrition scholars (BNSs). Both groups are trained through in-service experience and sometimes through programs of PVOs or NGOs collaborating with that clinic. These volunteers are specifically called upon to do home visits, and the nutrition scholars are supposed to follow-up with malnourished children.

Indicators of the total national coverage of health services show that 96% of all one-year-olds are immunized against tuberculosis and 83% against measles. Compared to other countries evaluated by UNICEF, the Philippines's under-five mortality rate of 46 is classified in the middle range. Despite steady progress, health services in much of the countryside and depressed urban areas are still inadequate. The Government has established *barangay* level health units in rural areas to extend the benefits of national health programs.

The 1991 infant mortality rate for the Philippines was 34/1000 live births, down from 81 in 1960. The major causes of infant death are pneumonia, respiratory infections and diarrhea; the five leading causes of morbidity are bronchitis, diarrhea, influenza, pneumonia and tuberculosis. All of these causes of infant mortality and morbidity suggest that underlying vitamin A deficiency could be a confounding factor.

In 1987, the results of a National Nutrition Survey indicated that levels of xerophthalmia and biochemical indicators of vitamin A deficiency (VAD) were below the WHO cut-off points which indicate a problem of public health significance. However, at about the same time, vitamin A surveys in selected geographical areas revealed an alarmingly different picture. Results of these studies, based on clinical signs of xerophthalmia or serum vitamin A, indicated that the prevalence of vitamin A deficiency was several times greater than the WHO cut-off levels (Impact Assessment Briefing Kit, November 1992).

Over the past three years, the Department of Health has drafted and approved policy guidelines on the treatment and prevention of vitamin A deficiency. Major milestones include:

1989:

Approval of a Five-Year Directional Plan to Prevent and Control VAD (1989-1993) which describes a program framework for the reduction of VAD. It is anchored on a four-pronged program: supplementation, nutrition education, fortification and agricultural production.

Approval of treatment and prevention guidelines for xerophthalmia and VAD. This circular provides guidelines on the target groups, dose and schedule for distributing vitamin A supplements. The guideline calls for:

- treatment of all xerophthalmic children with the WHO-recommended dose and schedule;
- one dose of 200,000 IU vitamin A for high-risk cases (diarrhea, measles, second and third degree malnutrition and cases of acute respiratory infections) and a follow-up dose six months later if a high-risk condition exists; and
- one dose of 200,000 IU vitamin A to post-partum mothers within one month after delivery.

1991:

Revised treatment and prevention guidelines to include distribution of one dose of 200,000 IU vitamin A supplement to mildly (first degree) malnourished children.

1992:

Draft policy to include the distribution of 100,000 IU to all infants at the time of measles immunization between 9-12 months of age.

For the future, one of the key factors operating in the Philippines which will affect the operations of HKI and many other PVOs and NGOs<sup>1</sup> is the decentralization of the Department of Health. This process, called 'devolution', was initiated in 1992. Devolution is bringing about a shift in resources from the central level to the provincial level and from there to lower levels of civil government, such as municipalities.

As devolution proceeds, resources for the DOH infrastructure (e.g., facilities and personnel) and operations (e.g., programs such as child survival) will be raised, managed and dispersed locally, for the most part, with some contributions still originating from the central level. As a consequence, health officials at each level will have to compete with priorities from other sectors (e.g., transportation, commerce, agriculture, communications) for available resources. Therefore, even though a program, such as the vitamin A program, has been operating nationally for any number of years, it now must be presented and defended to win the attention and resources of local government decisionmakers. Unless the importance of vitamin A for child survival, growth and development is brought forth in a convincing way to these politicians, all of the progress which has been made in vitamin A deficiency, prevention and control will be jeopardized.

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<sup>1</sup> For the purpose of this report, the term 'NGO' includes 'PVO' except where there is a need to make an explicit distinction between the two.

## **II. HELEN KELLER INTERNATIONAL IN THE PHILIPPINES**

Since the beginning of its work in the Philippines in 1976, Helen Keller International has played a major role in the development of the national program for the prevention and treatment of vitamin A deficiency. Based on experience and evaluation from its various projects, HKI helps formulate and promote broad level policy recommendations regarding vitamin A. Highlights of this collaboration with the DOH include:

### **1987 - 1990:**

With technical assistance from HKI, the DOH pilot-tested several vitamin A interventions:

- Integration of vitamin A supplementation into existing DOH community health services;
- Use of social marketing strategies to promote the consumption of foods containing vitamin A; and
- Re-examination of food fortification as a strategy to prevent VAD.

In mid-1989, the DOH launched a national program to implement vitamin A services, focusing on capsule distribution and nutrition education. Since that time, the DOH has been trying to mobilize resources to train health workers and provide them with the needed capsules and educational materials.

In late 1990, HKI and the DOH planned the design of the VITEX (Vitamin A Expansion) Project as a means to:

- model a way to strengthen the management capability of provincial health departments to execute capsule distribution and nutrition education interventions;
- and help expand the national vitamin A program to priority areas.

Subsequently, with data from a pilot study in Antique province (on the island of Panay), HKI encouraged the DOH to expand its protocol for the distribution of VAC to include all children with first degree malnutrition. HKI was also involved in promoting the incorporation of VAC into 'Operation Timbang' - the annual event where all preschool children are weighed. If any are identified as high risk at this time, they are supposed to be given a VAC.

Other projects which HKI implements in the Philippines include VITAP, Project MATA and the Modified Residency Training Program. Information about VITAP and Project MATA will be provided in subsequent sections. The majority of the information in this section has been taken directly from the Impact Assessment Briefing Kit (HKI-Philippines, 1992).

### **III. VITAP PROGRAM**

The Philippines was chosen as one key country for VITAP due to the continuing high prevalence of vitamin A deficiency and the potential for VITAP to contribute to the national vitamin A program through collaboration with PVOs. VITAP was officially introduced to the Philippines through a workshop in February 1990 which was attended by representatives of the DOH and potential collaborators. The level of interest which was generated caused HKI-Philippines to request approval from HKI-NY for hiring an on-site coordinator to follow-up with the group of PVOs which became the core group for VITAP. The VITAP Coordinator, Ms. Josie Caguioa, was first contracted to work for VITAP in early 1991 and has worked part-time (60%) since then.

In conformance with the stipulations of the VITAP grant, HKI-Philippines chose its collaborators for VITAP from among US-based PVOs working in health. The five which have worked with VITAP since the initial workshop are: Adventist Development and Relief Agency (ADRA), CARE, Catholic Relief Services (CRS), Christian Children's Fund (CCF) and Save the Children Federation (SCF). A summary of the VITAP Program, as presented in the Briefing Kit, is given below:

#### **VITAP - HKI/PHILIPPINES**

##### **I. Background:**

VITAP in the Philippines started in February 1990 helping five private voluntary organizations, namely CARE, CRS, CCF, ADRA and SCF, in their efforts to control and prevent Vitamin A Deficiency problem. To date, VITAP has provided a range of services to these PVOs in the form of orientations, assessment, program design & nutrition education. A total of three hundred twenty (320) PVO representatives have also been trained on the management of Vitamin A Deficiency cases. One of the significant outputs of the first training was the signing of a memorandum of understanding between the DOH and HKI governing the working relationship pertaining to VITAP.

##### **II. Goal:**

To strengthen the capacity of the PVOs to integrate and expand Vitamin A activities in their child survival program.

##### **III. Objectives:**

- Increase in house capabilities of PVOs in Vitamin A programming and strengthen existing skills.
- Increase number of PVO managers and field workers in managing Vitamin A Deficiency cases.

- Develop training and educational materials appropriate for PVO communities.
- Improve PVO-DOH linkage with respect to Vitamin A services.

#### **IV. Project Inputs:**

- Planning and Orientation Workshops among key PVO/DOH representatives.
- Training of PVO managers and field workers on Prevention and Control of VAD.
- Problem assessment to justify integration of Vitamin A activities in existing programs.
- Development of materials to support nutrition education activities.
- Establishing linkages of Department of Health (DOH), Department of Agriculture (DA) with PVOs during trainings.
- Vitamin A capsules provided by Department of Health (DOH).
- Regular meetings with PVO coordinators.
- Field visits to PVO project sites.

#### **V. Project Outputs:**

- Memorandum of Understanding between DOH-HKI signed.
- Training curriculum for trainers and field implementors designed.
- Appropriate interventions integrated.
- Knowledge and awareness of Vitamin A among target audience increased.
- Support materials for nutrition education developed.
- VAC coverage among target groups of PVOs increased.
- Issues/problems affecting PVO Vitamin A programming identified.

VITAP's approach towards stimulating and assisting PVOs to undertake activities to address vitamin A deficiency has developed in accordance with several guiding principles:

- working with a small and well-defined group of collaborators;
- working intensively with them initially to develop viable action plans;
- developing means to include the DOH and to encourage PVOs to do the same, in subsequent activities without VITAP;
- designing VITAP's inputs to reflect the different structures, capabilities, constraints, interests and requests of each collaborator;

- **emphasizing the building of linkages between and among organizations and demonstrating how this is done;**
- **assisting and encouraging the PVO to provide information to help both the PVO and VITAP to monitor and evaluate their joint activities;**
- **operating on the principle that each collaborator will share in the costs of any joint activity and that eventually, each collaborator will take full responsibility for continuing to carry out the action plan developed with VITAP; and**
- **creating opportunities for Filipino NGOs to receive similar assistance.**

**Given these principles, VITAP's strategy was to create in each PVO a core group of trainers who could then proceed to develop vitamin-A related activities within each organization, with some further assistance from VITAP. The PVO trainers in turn shared their new knowledge about vitamin A with field-based program implementers within their organization or with those associated with their local affiliates. Finally, the field implementers developed programs to train volunteer members of local health committees who have direct contact with mothers and other key community members. At the household level, mothers are expected to be able to incorporate the new knowledge about vitamin A into their child care and food preparation activities.**

#### **IV. RESULTS OF COLLABORATION WITH VITAP**

##### **A. Overall Results**

In the course of addressing its original mandate of working only with US-based PVOs, VITAP has also involved the Department of Health and local NGOs in specific activities to address VAD. In slightly more than two years, with a part-time Coordinator and a budget of \$53,000, VITAP has created a cascade of activities, in breadth and depth, in VADPC. It was not possible for the assessment team to estimate the total number of people who have been trained by VITAP, nor the number of people reached through collaborating agencies, nor the number of spin-off activities already undertaken by the PVO core group and other VITAP collaborators.

Some of the key specific accomplishments of VITAP to date include, *inter alia*,

- Fostering the development of awareness, commitment and specific activities among five US-based PVOs and at least 47 local NGOs to incorporate vitamin A into their on-going programs, even though vitamin A deficiency is not traditionally a high priority for any of them;
- Creating a cadre of 980+ professional and volunteer health workers who have been trained to detect and treat or refer high-risk cases for vitamin A deficiency (ADRA alone has trained 550 persons);
- Developing Project MATA (3 years; \$250,000), which addresses the need to incorporate local NGOs into the network to combat vitamin A deficiency;
- Producing four different materials for training health workers and for disseminating vitamin A information to the community;
- Enabling one NGO, the Medical Ambassadors of the Philippines, to incorporate vitamin A activities into its programs without needing follow-up assistance from VITAP;
- Increasing linkages among collaborators assisted by VITAP; and, as a result of all of the above,
- Reaching an estimated several million needy persons through information about vitamin A, through the creation of gardens which include vitamin A-rich foods and/or through distribution of vitamin A capsules; and
- Demonstrating a cost-effective technical assistance model which is worthy of more in-depth review and adaptation to other countries where VITAP is working and to other sectors.

The accomplishments of VITAP listed above are not only numerous and far-reaching, they have been achieved through very cost-effective methods. Placement of a VITAP Coordinator within the HKI office is a major contributor to overall cost-effectiveness. First, costs of a 60% part-time local consultant, i.e., the Coordinator, are less than investing in international consultants and associated travel. Second, effectiveness is enhanced by more frequent and intensive assistance by the local Coordinator, a situation which cannot be created by even regular visits by external consultants. Finally, low costs for consultants and artists, pilot testing and duplication in the Philippines has facilitated the creation and production of printed materials and a Dietary Assessment Manual which will benefit VITAP's efforts worldwide. All of these factors have contributed to the wealth of positive results which VITAP and its collaborators have achieved in approximately two and one-half years, with a budget of \$53,000.

### **B. Private Voluntary Organizations**

Results of VITAP's collaboration with the core group of five US-based PVOs are described in detail for each PVO in Annexes 3 through 7. In this section, additional information is presented which reflects common experiences and/or characteristics of at least two of the five PVOs of the core group. These factors contributed to the overall results identified above in section A.

As a group, the PVOs were very quick to begin to apply the new skills learned from VITAP. The PVOs responded positively to the overall pyramid training design, i.e., first train the PVO trainers, then the PVO's field staff and affiliates, then the community leaders and mothers. There were no major lapses in time between these different phases for the PVOs, even though VITAP was working with most of them separately.

On the whole, PVO staff interviewed were very energetic, committed, and self-motivated. They were pleased to learn about VADPC because it gave them something very concrete to offer to mothers and when appropriate, they could also distribute vitamin A capsules. The field-based PVO staff and volunteers are in frequent contact with mothers of high-risk children. A common element of PVO project designs is mothers' classes for nutrition education. Although the assessment team did not evaluate the nature and effectiveness of these classes, the fact that they are being held on a fairly regular basis increases the potential that mothers are learning important information about nutrition, in general, and vitamin A, in particular.

PVOs tend to work with groups which are disenfranchised - due to income, geographical location, cultural identity, age and/or sex. These groups typically have high percentages of children and mothers who are at-risk for a variety of nutrition and health-related problems. VITAP's efforts to help extend the DOH's coverage through the PVOs is an effective targeting mechanism for reaching those most in need of vitamin A supplementation.

Cost-sharing for training and materials is a component that organizations are willing to shoulder with VITAP. PVOs drew up plans of action with VITAP where each agency's costs were delineated. In addition, USAID has a supportive role with local NGOs and assists some agencies' programs (e.g., Project MATA, which works with local NGOs). An example of cost-sharing for materials development is the joint VITAP/SCF design and testing of the vitamin A recipe book. VITAP will assist with printing costs and distribution to other NGOs. Total costs up to the printing stage were less than US \$200.

As a rule, PVOs are not extensively familiar with each others' programs. Through the provision of technical assistance to these groups, VITAP is able to share key programming strategies and experiences among them in a non-threatening way. In addition, VITAP is able to encourage one PVO to seek out the assistance of another, thus creating new linkages among them. The assessment team was warmly received by all PVOs, even though its assignment was to investigate the results of their working with VITAP. The team interpreted this reception as an indicator of the pride which the PVOs have in showing what they have learned and what they are doing to address vitamin A deficiency.

Many US-based PVOs, particularly the large ones, do not have much experience in working with and through local NGOs. Among the core group in VITAP, SCF and CCF have extensive experience in the Philippines and the remaining three are also seeking and developing similar opportunities. This approach of collaborating with local NGOs is a key design component to promote the sustainability of positive behavior changes regarding vitamin A.

Micronutrient deficiencies have been a part of the VITAP approach since early 1991. Numerous VITAP collaborating field staff pointed out to the assessment team the need to go beyond vitamin A deficiency, leading to the conclusion that the general awareness is high of role of these nutrients in child health and survival. The integration of VAD-IDA-IDD (vitamin A deficiency - iron deficiency anemia - iodine deficiency disease) interventions into health and agriculture program components was already being undertaken, although the direct distribution of iodine has not yet commenced.

For more information about VITAP's work with ADRA, CARE, Catholic Relief Services, Christian Children's Fund and Save the Children, refer to Annexes 3-7, respectively.

### **C. Project MATA**

When VITAP was introduced to the Philippines in February 1990, HKI recognized the need and potential for extending this same type of assistance to local NGOs. As a result, HKI-Philippines designed and sought support for a similar project, called Project MATA ('mata' means 'eye' in Tagalog). USAID agreed to fund Project MATA and it began in August 1991. The objective of the project is to mobilize NGO partners to assist in the battle against malnutrition and nutritional blindness. Five of these NGO collaborators are located in the National Capital Region (i.e., Metro Manila) and 12 are in Region VI (Central Visayas).

Due to their common goal, VITAP and Project MATA have great potential for collaboration and mutual sharing of resources and learning. For example, one of VITAP's strategies for building the commitment of its collaborators was develop joint action plans with them. At the beginning of Project MATA, this strategy was extended by having all of the key parties participate in signing the project agreement which outlined their roles and responsibilities. Project MATA is following the pyramidal training approach developed by VITAP, i.e., forming a core of NGO trainers, who then train their own staff and volunteers, who then train community leaders and mothers in VADPC.

VITAP contributed to the training of some of the future collaborators of Project MATA. This was a result of the on-going relationships which some of VITAP's five PVO partners already had with local NGOs. Some representatives of these local NGOs were invited to participate in VITAP-sponsored training before Project MATA began. In Iloilo, the regional office of Project MATA, these NGOs then became officially associated as collaborators of Project MATA.

The assessment team visited Project MATA and two of its collaborators in Iloilo. These two NGOs demonstrate some of the same characteristics which have made PVOs successful in VITAP: their interest in helping their target populations improve their health status; their positive approach towards receiving technical assistance; and their commitment to empowering local community groups to solve their own problems. In contrast, Project MATA's NGO collaborators are smaller than US-based PVOs and therefore require even more tailor-made assistance to enable them to effectively participate in VADPC. After only 18 months in operation, it is very clear that Project MATA will not be able to respond to the growing demand for technical assistance from additional NGOs.

The exchange of information between and among HKI programs, i.e., VITEX, Project MATA and VITAP, is both supportive and balanced. Each project has clear mandates and target populations, yet certain aspects are shared and experiences are built upon, enriching each program. Management of these three separate, but very related, projects has successfully avoided the common traps of bureaucratic overlap and competition.

For more information on Project MATA, see Annex 8.

#### **D. Department of Health (DOH)**

One of VITAP's stated objectives in the Philippines is to "improve PVO-DOH linkage with respect to vitamin A services" (Impact Assessment Briefing Kit, 1992). To that end, the DOH was signatory to the agreement which launched VITAP in 1990. Since HKI has been working with the DOH in the Philippines since 1976, there was already a well-defined and well-respected relationship between the two groups when VITAP was initiated. Although VITAP resources cannot be used directly and explicitly to train DOH staff, many of these persons have benefitted from involvement as co-trainers with VITAP, and therefore help to achieve VITAP's overall goals.

HKI has supported the training of many DOH personnel in VADPC through its other projects, and very intensively since 1989. Some of these DOH staff are then called upon to assist with VITAP as members of the training teams. This strategy has helped develop and/or reinforce positive relationships between the DOH and VITAP's collaborators.

Despite the DOH's extensive infrastructure, number of trained employees and fairly-well equipped facilities, there are certain factors which limit VITAP's contribution to the DOH's vitamin A program. There is a chronic shortage of VAC nationwide, which hampers all efforts to address VAD. VITAP finds that after health workers become trained in VADPC, some of them are unable to initiate or continue their efforts due to a lack of VAC. In addition, while many health workers are well motivated to help their constituents, they are ill-equipped in their communication skills. Thus, precious time spent with mothers does not lead to the desired behavioral changes.

Overall, the relationships between and among VITAP, its five PVO collaborators and the DOH are positive and mutually supportive. More information about the DOH is found in Annex 9.

#### **E. Other Organizations**

##### **1. Medical Ambassadors of the Philippines**

The Medical Ambassadors of the Philippines (MAP) is an NGO which has been working in preventive and curative PHC in isolated areas in the Philippines since 1975. This NGO works with cultural minorities, typically tribal groups, in areas unreached by the DOH. MAP identifies and trains local community members to be PHC providers and supports their efforts on-site for three years.

Three representatives of MAP attended the vitamin A workshop at NCP in August 1990. At that point, these staff members were given a supply of VAC. The only other contact which MAP had with VITAP was to request (and receive) copies of a vitamin A poster for each of their 45 health staff (nurses and physicians) working at field sites throughout the country.

The assessment team contacted MAP to learn what one organization did on its own, with no follow-up, as a result of its original training with VITAP. Although two of the three staff members who attended the 1990 workshop were no longer with MAP, the third person was available and the other three interviewees were well informed about MAP's incorporation of vitamin A into their programs. A summary of their vitamin A activities includes:

- A video about vitamin A was shown at their national conference, attended by all field-based staff;
- Vitamin A posters from VITAP were distributed to all field-based staff;

- A new manual on Mother's Health Education, for each field site, includes information on VADPC;
- When MAP's original supply of VAC ran out, they requested and received a large supply from the DOH; and
- Information about cases of VAD and subsequent treatment is collected monthly at all MAP field sites and reported to their donors and to the DOH.

The MAP staff interviewed stated that they had not expected any VITAP-initiated follow-up after the original training, and that if assistance were needed, they would make their needs known to VITAP, as in the example of the posters. MAP understood the relevance of the VADPC for its target populations and acted immediately to train its field staff.

These results from MAP are noteworthy on several levels. First, they reflect a "best-case", and very real, scenario of a motivated NGO which takes relevant information from a training event and uses it immediately and comprehensively throughout their programs, without needing any follow-up. Second, since VITAP was unaware of the full extent of MAP's application of the VADPC training, there may be other NGOs who have acted similarly in response to their VITAP training. And third, this example with MAP illustrates the limitations of the assessment team in trying to report the true breadth and depth of the VITAP experience beyond the information gathered directly during the two-week period of the visit to the Philippines.

## 2. Nutrition Center of the Philippines

The Nutrition Center of the Philippines (NCP) is an autonomous organization dedicated to improving the nutritional status of vulnerable groups in the Philippines. It is engaged in a variety of activities, such as development of policy with the DOH, curriculum reform for health professionals, development of nutrition training materials for health workers at several levels and for teachers of elementary school students, design and implementation of training courses for health workers and development and testing of weaning foods.

The NCP was contracted by HKI to jointly develop and implement the initial training events which were sponsored by VITAP in the first half of 1990. Currently, NCP has a major role in training activities for the DOH and in developing and testing communications materials for nutrition education. Educational and promotional materials developed by the NCP reflect the organization's understanding that "nutrition education" involves behavior change and that effecting positive changes in behavior requires an ability to understand the mother and to communicate effectively with her. The Director of the NCP, Dr. Florentino Solon, is one of the pre-eminent professionals working in the area of vitamin A. His interest in vitamin A and the creativity and productivity of the NCP *vis-à-vis* communications and training materials provide strong support for VITAP's efforts. In addition, the DOH's willingness to

work with the NCP, and VITAP's good relationships with both the NCP and DOH are strong positive forces in the fight to address VAD in the Philippines.

### **3. Davao Medical School Foundation**

The Davao Medical School Foundation (DMSF), through its Institute of Primary Health Care (IPHC), is another long-term collaborator with HKI in the Philippines. As the community extension arm of the DMSF, the IPHC implements projects in low socio-economic communities in Davao and the surrounding rural areas. Its strategy includes working with and training community volunteers, with the aim of developing critical partnerships with relevant governmental and non-governmental organizations.

The IPHC was sensitive to the importance of vitamin A before VITAP began and was training the DMSF's medical students and community health workers in VADPC. Representatives of the IPHC attended VITAP's initial orientation in February 1990 and a subsequent one-week training course at NCP in August 1990. As a follow-up to the training, VITAP provided visual aids to the IPHC for use in its training.

In addition, the IPHC was chosen by VITAP in 1991 to be the site of pilot testing HKI's Dietary Assessment Methodology, which involved VAD assessment through dietary information, blood analysis and conjunctival impression cytology. Results revealed a high prevalence of children at-risk for VAD, which stimulated the IPHC to share the information with the DOH so that these children could receive VAC as soon as possible.

The IPHC is involved in a number of innovative approaches for improving the health status of children with varying degrees of malnutrition, with a special concern on developing the organizational and problem-solving capabilities of local groups. HKI's relationship with IPHC is one of mutual learning and sharing of complementary resources.

## **V. DISCUSSION AND CONCLUSIONS**

There are obvious limitations to the conclusions which can be drawn from the document reviews, interviews and community-level qualitative surveys undertaken by the assessment team. In particular, it is difficult to differentiate results due to VITAP from those of previous efforts of HKI, e.g., radio spots, of NCP and the Ministry of Education in schools and of the vitamin A program within the Ministry of Health. Therefore, where possible, the assessment team has tried to provide specific examples of VITAP's activities and results to support any general conclusions presented.

The fact that VITAP has been able to develop in such breadth and depth in the Philippines is due to a variety of factors. The overall key factor contributing to VITAP's success is an environment conducive to this type of program, including some elements which are under VITAP's control and others which are not. The factors supporting VITAP's accomplishments focus on the relationships between and among key organizations with which VITAP is associated, as described below:

NGOs work well with the DOH and USAID in the Philippines:

- The NGO community is well developed and sophisticated. Staff have a good understanding of the programming cycle and are committed to child survival program goals.
- NGOs are respected by the DOH and USAID for their contribution in joining forces with the government to address health problems.
- USAID is supportive of HKI's overall program, and is a key donor for specific projects, including Project MATA.

VITAP works well with the DOH:

- HKI has developed an excellent reputation for the quality of its work and its collaboration with the DOH.
- VITAP assists in modeling alternative approaches of service delivery within the existing DOH system, allowing for extensive replication with slight adaptations by the DOH.

VITAP works well with NGOs:

- HKI's work with organizations operates on a professional, 'soft sell' basis, with NGOs viewing HKI as the source of information and other resources about vitamin A.
- VITAP has built concerns for sustainability into the project design, where plans of action have been tailored to fit into each NGO's system of operations.
- Most VITAP collaborators have experience with integrated development projects including the following components: nutrition education, agricultural

inputs, income generation and family and social welfare activities, increasing the likelihood of success of integrated strategies to increase vitamin A consumption over efforts of vertical programs.

- VITAP plays an important role in bridging institutional barriers to allow local expertise of one agency to be shared with another.
- VITAP seeks out locally-available and talented artists and consultants.
- Collaborating NGOs have benefitted from the extensive experience and programming skills of the VITAP Coordinator.

VITAP works well within HKI:

- All of HKI's experience in the Philippines is brought to bear on the development and implementation of VITAP.
- In the Philippines, VITAP developed creative approaches for working within the restrictions of the global VITAP grant.
- VITAP and other HKI programs engage in activities which may benefit each other, e.g., developing more appropriate approaches to nutrition education and behavior change through pilot projects about weaning foods and the social marketing of vitamin A.
- VITAP has benefitted from the excellent experience, programming expertise and managerial skills of HKI's Country Director.

While the supporting factors listed above are the overriding determinant in creating VITAP's working environment, there are also some negative factors in this same environment. The elements identified which limit the full impact of vitamin A programming on target groups are:

- The process of behavior change:

A common observation of the majority of development groups met is their inadequate understanding of behavior change and the role of nutrition education in promoting messages. In general, the efforts of both NGOs and DOH to modify behavior change *vis-à-vis* increased consumption of vitamin A-rich foods are based on the paradigm of 'the provider of the correct information gives relevant facts to those who need it (generally mothers) and thus the information will be applied and behavior will change'. Development workers admit that following this paradigm has not worked, but more relevant paradigms are not readily available;

- The role of vitamin A in child survival:

Almost without exception, development workers and their volunteer colleagues know that vitamin A is critical for vision and can identify good food sources. However, many of them were generally not aware of the newer information about vitamin A's more fundamental role in protecting against some of the common gastrointestinal and respiratory diseases of childhood and its implications for mortality;

- **Decentralization of DOH services:**

With the newly passed local government code placing much of the authority for health services under local district and municipal control, NGOs and the local DOH will need to work together in new political domains to secure commitment and budgetary support for vitamin A and other child survival programs;

- **Inadequate supplies of vitamin A capsules:**

Structural and capacity problems of vitamin A capsule supply continue to be problematic throughout the country. The assessment team did not pursue this topic as it was not appropriate for the Scope of Work. In sum, the VAC supply issue is complex, involving international and national agencies in the public and private sectors. About one half of the VACs needed for high-risk populations is available at any given time. With the advent of devolution of the health care system, wealthier provinces will be able to purchase needed supplies and provide transport. Some NGOs have considered purchasing capsules directly to avoid DOH shipping delays which typically range from six months to a year. At the time of the assessment, a major shipment of VACs was expected from UNICEF which would alleviate the shortfall to a certain degree; and

- **Fear of assuming responsibility:**

There is widespread trepidation among DOH and NGO health workers to distribute VAC. Many representatives of both groups express a great need for tight control of VAC, due to an incident in Bicol nearly seven years ago in which a child's death was attributed to consumption of a high dose vitamin A capsule.

Even though the environment in which VITAP has operated in the Philippines has been a very positive one, the VITAP Coordinator and VITAP collaborators deserve much credit for the results they have achieved together. The assessment team concludes that VITAP has significantly contributed to the integration of vitamin A concerns and activities into the programs of its collaborating agencies, even though vitamin A deficiency has not traditionally been a high priority for any of them.

In conclusion, VITAP has created a model of PVO-to-PVO technical assistance to expand efforts to address vitamin A deficiency, control and prevention in the Philippines. This model deserves serious study for its potential replication in other countries, other organizations and other sectors. VITAP's approach to providing technical assistance and its strategies for working with a variety of different groups have brought about a wealth of achievements, in breadth and depth, in a relatively short period of time with a low budget.

## **VI. RECOMMENDATIONS AND FUTURE STEPS**

The ideas mentioned below are not necessarily new issues for VITAP and the HKI staff. They are mentioned here to emphasize their importance for the VITAP program.

### **A. Devolution**

The process of devolution calls for new coalitions between governmental and non-governmental agencies concerned with public health issues such as vitamin A deficiency. These coalitions will have to be formed and strategies developed in order to gain the attention of local government officials and an appropriate share of their resources. VITAP is in an excellent position to encourage its governmental and NGO collaborators that an advocacy role is now vital to their continued ability to effectively address vitamin A deficiency. As these issues are of equal concern to the collaborators in Project MATA, they should also work with VITAP to help design and implement the type of training and materials which are necessary for developing health-oriented 'political lobbying skills' for NGOs.

### **B. Nutrition education**

Addressing the challenge to move theoretical concepts and practical applications of nutrition education to a more sophisticated level in the Philippines will definitely require multi-sectoral and multi-organizational resources. VITAP can make some key contributions, through:

- developing opportunities through which Save the Children's organizational approach to training volunteer health workers in combatting vitamin A deficiency can be promoted with and integrated into programs of other PVOs and NGOs;
- incorporating relevant aspects of HKI's prior experience in social marketing into VITAP's current activities;
- continuing its collaboration with the Nutrition Center of the Philippines in sharing ideas about developing and testing new materials for nutrition education;
- incorporating relevant aspects of HKI's current pilot experience in improving weaning foods into VITAP's work with other groups, e.g., teaching other groups the rationale and techniques for learning from mothers - on a one-by-one basis - which specific changes they are willing to make *vis-à-vis* increasing their childrer.'s consumption of vitamin A; and
- applying results from HKI's current intervention in training health workers in counseling skills into VITAP's work with non-HKI groups.

### **C. Promotion and dissemination of good ideas**

VITAP can help accelerate the efforts to combat vitamin A deficiency by encouraging and assisting PVOs and NGOs to document and share their experiences in integrating vitamin A concerns into their own programs. Since these groups rarely have a major focus on vitamin A, they do not apply resources in any systematic way for sharing information about a 'minor activity'. VITAP can help fill this void by seeking opportunities to help them document these experiences and to help them gain access to appropriate fora for sharing them as well.

### **D. Cost-sharing**

In the Philippines, Helen Keller International has long operated on a principle of cost-sharing with its collaborators, since HKI does not implement projects acting alone. One of the greatest recurrent costs which HKI and its collaborators face is for the development and reproduction of training and communications materials. As VITAP continues to stimulate more groups to become involved in addressing vitamin A deficiency, VITAP and its collaborators must look jointly for supplemental funds to support the cost of materials.

### **E. Follow-up**

In its first two years of operation in the Philippines, VITAP has generated a multitude of interest and activity. It is now timely to bring the key VITAP actors - ADRA, CARE, CRS, CCF and Save the Children - together with the Ministry of Health, VITEX and Project MATA to review progress to date, address roadblocks and make plans for the future.

## **PHILIPPINES - ANNEX 1**

### **List of Contacts**

#### **HELEN KELLER INTERNATIONAL**

1. **Mr. Rolf Klemm**, Country Director
2. **Ms. Josie Caguioa**, VITAP Coordinator
3. **Ms. Juvy Malato**, Project MATA Director

#### **USAID/MANILA**

1. **Mr. John Heard**, Chief, Office of Food for Peace and Voluntary Cooperation
2. **Mr. David Nelson**, Assistant Director, FFP/PVC

#### **DEPARTMENT OF HEALTH**

1. **Mrs. Adelisa C. Ramos**, Director, Nutrition Service
2. **Dr. Teresita Bonoan**, Director, Community Health Services
3. **Dr. Cabetingen**, Regional Representative, City Health Department, Cebu
4. **Dr. Lourdes Labiano**, Regional Health Officer, Zamboanga
5. **Mrs. Evelyn Capistrano**, Regional Nutritionist, Zamboanga
6. **Mrs. Evelyn Fernandez**, Nurse, Canelar RHU, Zamboanga City

#### **NUTRITION CENTER OF THE PHILIPPINES**

1. **Dr. Florentino Solon**, Executive Director

#### **PVOS AND NGOS**

##### **ADRA**

1. **Mr. Lamar Philipps**, Country Director
2. **Mr. Leomer Batulayan**, Assistant for Development Projects, North Philippine Union Mission
3. **Mr. Abraham Carpena**, Health & Temperance Director, Central Philippine Union Mission, Cebu
4. **Mrs. Norma Moralde**, Health Director, Central Visayas Mission, Cebu
5. **Mr. Jonathan Casio**, Health Educator, Miller Hospital, Cebu
6. **Mr. Cesar Colo**, Regional Director, Cebu
7. **Ms. Shirley Aguinaldo**, Health Director, Davao Mission

## **ASEC**

1. **Ms. Elmie Cajilig, Community Nutritionist, Iloilo City**
2. **Ms. Elnora Perez, Administrative Officer, Iloilo City**

## **CARE**

1. **Ms. Dawn Wadlow, Assistant Director, Manila**
2. **Mrs. Ophelia Reyes, Nutrition Specialist, Manila**
3. **Mr. Iver Alabanza, Program Officer, Iloilo**

## **CRS**

1. **Mr. Paul Cunningham, Country Representative**
2. **Ms. Fely Leño, Regional Manager, Luzon Regional Office**
3. **Ms. Jo Sembrano, Project In-charge, St. John Baptist, Tagaytay, Rizal**
4. **Ms. Bing Miguel, Diocesan Nutritionist, Antipolo**
5. **Ms. Carol Limbaga, Field Program Officer, Zamboanga**
6. **Ms. Grace Diong, Dietary Nutritionist, Diocese of Basilan**
7. **Ms. Eda Detros, Regional Manager, Davao City**
8. **Ms. Marilyn M. Matilac, Regional Nutritionist, Mindanao Regional Office**

## **CCF**

1. **Ms. Saturnina Hamili, Executive Director**
2. **Ms. Nellie Calimoso, Program Manager, Social Development Department**
3. **Ms. Christina Hangod, Project Area Coordinator**
4. **Ms. Edna Jaurigue, Project Manager, Himalaya Project, Lucena City**
5. **Ms. Emy Rodriguez, CFARD**
6. **Ms. Marlene Esperarte, CFARD**
7. **Ms. Ludy Bonja, Project Maluso, Basilan**
8. **Ms. Jean Feofilo, Project Maluso, Basilan**
9. **Ms. Josie Suyu, Project Manager, Project Pagasa, Los Banos, Laguna**
10. **Ms. Florencia Santa Maria Gloria, Parent's Association, Iloilo City**

## **DAVAO MEDICAL SCHOOL FOUNDATION**

1. **Dr. Josephine Quianson, Director, Institute of Primary Health Care**

## **MAP**

1. **Dr. Pete Bañas, Director**
2. **Dr. Orlie de Ocampo, Physician**
3. **Ms. Belle Villaneuva, Nutritionist**
4. **Ms. Alice Bañas, Supervisory Nurse**

## **SCF**

1. **Ms. Edna Tesora, Program Director**
2. **Ms. Letty Basilio, Health Coordinator**
3. **Mr. Yusah Baddong, Program Director, Iloilo**
4. **Ms. Teresita Chua, Health Coordinator, Iloilo**
5. **Emily - Midwife, St. Martin de Porres *Barangay* Health Center, Parañaque, Metro Manila**
6. **President, Homeowner's Association, *Barangay* Tanguig, Bicutan**
7. **Members, Parent's Group, *Barangay* Tanguig, Bicutan**

## **UNIVERSITY OF SAN AUGUSTINE**

1. **Ms. Lilia Tevis, Head, Nutrition Department**
2. **Ms. Eva Montano, Faculty, Nutrition Department**
3. **Ms. Erlina Colina, Faculty, Nutrition Department**

## PHILIPPINES - ANNEX 2

### Documents Reviewed

#### Christian Children's Fund

1. CCF Preliminary Assessment Report. CCF Project Managers, August 1991.
2. Trainer's Training on Vitamin A Prevention, Detection and Control. July 21-23, 1992. Sponsored by: Christian Children's Fund, Inc. and Helen Keller International - VITAP. No date.

#### Department of Health

3. Vitamin A FLANE Kit. No date.

#### Helen Keller International - New York

4. Training of CRS Field Implementors in Vitamin A Deficiency (VAD) Control and Prevention. May 27-30, 1992. DMSF Training Center, Davao City, Philippines. July 1992.

#### Helen Keller International - Philippines

5. VITAP Terminal Report 1990. VITAP in the Philippines. 1990 Annual Report for VITAP. November 30, 1990.
6. VITAP Consultative Workshop Report. VITAP progress report for October - December 1991.
7. VITAP Monthly Reports. VITAP Progress Report covering period March 16 - September 30, 1992.
8. PVO Profile and T.A. Request. Information on each PVO and their plans. December 1991.
9. VITAP Field Reports. Collection of reports coming to VITAP from collaborators. No dates.
10. Impact Assessment Briefing Kit. November 1992.

## **Nutrition Center of the Philippines**

11. Seminar Workshop Report 1990. Description of February 1990 Orientation to PVOs about Vitamin A.
12. Training on Vitamin A Deficiency (VAD) Prevention and Control. Summary Report and Project Plans. June to August 1990. Date: October 1990.
13. An Evaluation Report of The Training on Vitamin A Deficiency Control and Prevention. Covers the three NCP Trainings. The Philippines Nutrition Program Support Training Division.
14. An Update on the Activities of Some Graduates of the 1990 Training Courses on Vitamin A Deficiency Control and Prevention. Series of 1991-3.

## **PHILIPPINES - ANNEX 3**

### **Adventist Development and Relief Agency (ADRA)**

The information presented in Annexes 3-7 for PVOs follows the same format. First, a short summary of the PVO is provided. Then, the 'VITAP Inputs' section identifies those activities, mainly training, in which VITAP was transferring knowledge and skills to the PVO. The 'VITAP and PVO Inputs' section which follows describes those activities which VITAP and the PVO designed and implemented together, to further the knowledge and skills of the PVO staff. Activities which the PVO went on to design and implement itself, with varying degrees of continued input by VITAP, are described in the 'Results' sections. If the assessment team visited any communities where the PVO or one of its affiliates was implementing vitamin A activities, these results are presented in a separate section. Finally, the last section identifies 'Plans for the Future' for working with VITAP.

### **Adventist Development and Relief Agency (ADRA)**

Information in this section was obtained through discussions with VITAP and ADRA staff in Manila and through visits to ADRA's Central Philippines Union Mission in Cebu and ADRA's Davao Mission.

#### **A. Organizational Structure**

ADRA is the main non-sectarian, humanitarian, development and relief agency of the Seventh Day Adventists (SDA). In the church structure, the country is divided into three Unions (North-Luzon, Central-Visayas and South-Mindanao). Each Union is divided into missions (17 total), each mission is divided into districts and districts are comprised of congregations. There are an estimated 600,000 SDA church members in the Philippines. In the field, the sectarian (SDA) and nonsectarian (ADRA) branches join hands in their work.

There are seven SDA hospitals in the country and ADRA has a health educator in each. They also run an International School of Public Health and a network of 100 schools which are usually attached to an SDA hospital.

Some programs supported by ADRA are disseminated throughout the entire SDA system, usually through the efforts of the Health and Temperance (H&T) Directors and their staffs, including health educators and nurses, which are part of each mission. At least one person on this staff has an MPH degree. H&T Directors must 'sell the idea' of vitamin A training to Union and Mission leaders, as this topic competes with all the others - health and otherwise. Other programs are restricted to a specific geographical area, e.g., the Palawan Program (on the island of Palawan, the most western area of the country), where ADRA trains community health workers (CHWs) in 10-15 villages; disaster relief, especially from typhoons in the Central Visayas area; and a now-completed project with refugees in Bataan

(a province in southern Luzon). The weekly radio programs on health are intended for everyone in the listening area.

Each church has a community service organization, called 'Dorcas', run by a woman volunteer, with assistants. All women of the church are members of Dorcas. In-service church training on health issues is organized through the Health & Temperance program. Outreach activities in health, including vitamin A, can be implemented through the H&T, Dorcas, radio, SDA schools, hospitals and general contact of parishioners with other members of the community.

Each mission of the SDA has an annual Federation meeting where different topics are addressed during the week. Health topics are included on the agenda for these meetings. In addition, pastors receive information about different health topics during quarterly meetings of the Health & Temperance departments. Pastors share this information with church members during weekly family meetings or via regular weekly services.

ADRA concentrates its efforts in community-based development activities and disaster preparedness and response. The former includes a wide range of activities in health, agriculture, infrastructure, empowerment and income generation.

#### **B. VITAP Inputs**

After the initial orientation by VITAP in 1990, ADRA was one of the first groups to make a formal request for VITAP assistance. In August 1990, a major 10-day training on VADPC was organized and implemented by the Nutrition Center of the Philippines (NCP) in coordination with HKI/Philippines. The 33 trainees included Health & Temperance Directors, physicians, health educators and nurses from ADRA's three major regional offices, the Manila headquarters and other selected field staff.

#### **C. VITAP and PVO Inputs**

After the initial training in August 1990, some of ADRA's newly trained Health & Temperance Directors initiated their own workshops for ADRA and SDA staff in their own provinces. No comprehensive information or figures are available to describe all of these workshops throughout the country. Nevertheless, there is much information about activities in specific locations.

#### **D. Results**

ADRA has incorporated VA into the curriculum of their 100 schools in the Philippines. This was an objective which was included in their action plan at the initial August 1990 training. Materials were provided at that time. The ADRA staff worked with NCP and HKI trainers to design a generic curriculum for integration into their schools.

In addition to the nationwide results above, ADRA has been particularly active with VITAP in two locations. Information is presented below to describe the vitamin A activities of the Southern Philippines Union Mission, based in Davao, and the Central Philippines Union Mission, based in Cebu. The assessment team visited both of these offices, but did not have the opportunity to visit ADRA's field sites.

#### 1. Southern Philippines Union Mission (SPUM) (Mindanao Area)

Immediately following the June 1990 training, ADRA's Mission in Davao (a major city on the island of Mindanao) requested VITAP assistance in developing a simplified protocol for the assessment of vitamin A deficiency. The VITAP Coordinator and Vitamin A specialist from HKI worked with 40 ADRA staff on this assignment during a three-day workshop in November 1990.

The ADRA Davao Mission then implemented the assessment to determine the level of VAD in 41 communities. The incidence of VAD and high-risk VAD cases was found to be high. Subsequently, ADRA integrated vitamin A into the school and radio programs, conducted trainings of their health workers (e.g., one nurse has implemented approximately five trainings since 1990 with approximately 150 health promoters) and initiated case findings and referrals of children at risk for VAD.

ADRA reports the following vitamin A activities as having been undertaken in the SPUM:

- Training of district pastors on VAD preliminary assessment
- Radio broadcast integrating VAD basic information (weekly for two hours)
- School rounds integrating VAD assessment and nutrition education
- Free clinics integrating VAD interventions
- Nutrition seminars
- Nutrition counseling and mother's classes
- Integration of vitamin A into medical and nursing curricula

In addition, ADRA's mission in Davao revised its health monitoring form to include recording information about eye symptoms of VAD, distribution of VAC and health talks given by promoters.

In July and August of 1992, VITAP facilitated another workshop with ADRA staff in Davao for evaluation of their vitamin A activities and new planning.

#### 2. Central Philippines Union Mission (CPUM)

The H&T Director of the CPUM has initiated training in VAD for ADRA staff and SDA health promoters in its four unions. In the Central Visayan Union, for example, the ADRA nurse is involved in four training courses per year, 35 people each, in each of the four missions every year. Since she has been trained in vitamin A, she is now incorporating that

information into these health workshops. Of the 800 health promoters in the CPUM, approximately 400 have already received training in VAD.

The H&T Director of the CPUM has taken the cause of vitamin A very seriously. Ever since his participation in the initial ADRA training at NCP in 1990, he has requested and received an increase in his budget in order to implement vitamin A activities. For 1993, the major increase in his budget is for transportation subsidies for local church delegates to attend the scheduled vitamin A trainings.

In a similar fashion, the nurse and health educator working with the CPUM have line items in their budgets for vitamin A. They must decide exactly how much of their total budgets they will devote to this item. The CPUM is including vitamin A in their yearly budgets (see the 1993 action plan in Attachment 1 to this Annex) and they expect to include it for years. Currently these budgets for vitamin A are relatively small and the CPUM is not ready to finance the cost of one of the most expensive items, materials. They requested 1,000 copies of an HKI poster, but have no other options if VITAP does not provide them free. Nevertheless, they understand and accept that neither VITAP nor HKI will be able to cover these costs to any great degree in the future.

Another line of training occurs through the SDA church structure. Once provincial pastors are trained, they call together delegates to train them in vitamin A. The delegates then return to their home parishes and call together a group of fellow parishioners and neighbors to share the new information. Some of these pastors have placed VITAP materials on church bulletin boards and have translated them into local languages.

Vitamin A activities which ADRA reports as having taken place in the CPUM are:

- Free clinics integrating VAD interventions
- Day care centers integrating nutrition education
- Radio programs
- Linkage with the Departments of Social Welfare, Health and Education for technical assistance and materials
- Provision of VAC supplements to high risk cases in out-patient department services
- School visitation to assess VAD cases and provide appropriate interventions
- Camp meetings with father, mothers and children
- Training of health promoters on VADPC
- Referral of cases to health centers
- Articles about vitamin A published in the "MISPA" newsletter which is sent to all SDA members
- A discussion with the Regional DOH Representative about offering ADRA's services to training DOH staff in VADPC

One of the noteworthy aspects of ADRA's collaboration with VITAP is the speed with which it applies the training it has received. For example, an ADRA nurse and health educator

from Cebu were trained in vitamin A in Iloilo in late September 1992. By the time of the assessment, just one month later, they had:

- Given a health talk on vitamin A to participants in a church meeting in Boracal;
- Added health talks about vitamin A to the evening activities related to a health assessment of Lapu Lapu City, a poor area located 30 km from Cebu; and
- Made plans for conducting eye exams in children 1-6 years old in an SDA school in a poor area outside of Cebu.

Additional vitamin A activities undertaken by ADRA:

- Placed health education information in the lobbies of SDA hospitals. VITAP provided the materials.
- Included VAC in the latest disaster relief efforts in Central Visayas and information about VADPC in their typhoon fact sheets.
- On the island of Palawan (western Philippines), an ADRA nurse developed six radio messages and broadcast them during nutrition month.

The collaboration between VITAP and ADRA and the extensive results obtained illustrate the potential of the VITAP model when working with an organized and motivated PVO. ADRA was interested in collaborating with VITAP from the very beginning of VITAP's work in the Philippines. VITAP responded to ADRA's request for training staff stationed throughout the country; a plan of action was developed; VITAP assisted in the training sessions in various ways; results have been monitored at the provincial and central levels; and VITAP has been called back to the provincial level to provide further assistance in reviewing progress to date, formulating next steps and training new staff.

Results of VITAP's work with ADRA provide concrete evidence that a technical assistance model can be effective in significantly expanding PVOs' activities to address vitamin A deficiency. Worthy of note are the many positive factors which facilitate working with ADRA:

Supporting factors:

1. The SDA Church structure is extensive and organized and communications channels are well developed.
2. Concerns about diet are part of the SDA philosophy - i.e., "the health message is the right arm of the Gospel"; ADRA considers its health programs are its strength.

3. Annual Federation meetings reach a large number of members, are held regularly and include health issues.
4. ADRA staff are full of energy, committed and self-motivated.
5. Some health workers say that the distribution of VAC adds to their status.
6. HQ staff in Manila are well trained in health and do not need further convincing about the importance of VA. They believe that it is possible to incorporate vitamin A into any relevant health training on child survival, community development, etc.
7. ADRA understands and accepts that cost-sharing is a principle of VITAP's collaboration.

Even though the supporting factors listed above are numerous and very important, there are also limiting factors associated with VITAP's collaboration with ADRA.

**Confounding factors:**

1. ADRA does not have a strong outreach component to non-SDA members.
2. Many ADRA staff who were given VAC after their training did not seek further supplies when the initial supply run out.
3. Some health workers say that VAD identification, treatment and referral now gives them more work.
4. ADRA needs to develop stronger linkages with other NGOs to share lessons learned.
5. In the North Union, there is 50% turnover already among those who have had vitamin A training. There is a constant need for training of newcomers and continuation training of other staff.
6. The process of monitoring and following up the vitamin A activities of ADRA's local health promoters, SDA pastors and volunteers is difficult because these persons are not obligated to report on this particular aspect of their work.

**E. Results at the Community Level**

The assessment team was not able to visit any communities nor speak to anyone who might have been reached by any of the above activities undertaken so far by ADRA. Nevertheless, even without this confirmation, the information provided by VITAP and ADRA staff strongly suggests that ADRA has mobilized its network to increase the distribution of VAC to high

-risk groups. In addition, ADRA is disseminating a wealth of information about vitamin A to these same high-risk groups, through a variety of complementary channels.

#### **F. Plans for the Future**

The PVO-VITAP Action Plan developed with ADRA for the period 1992-1993 includes the following:

**General Objective:** By the end of 1993, ADRA intends to have formulated and implemented comprehensive and realistic plans for VAD activities throughout its operational areas of Luzon, Visayas and Mindanao.

**Specific objectives include:**

1. 90% of the local counterpart (institutions) will conduct intensive VAD information drives by the end of December 1993;
2. Evaluation and replanning sessions are conducted by January-April 1992.
3. VAD pilot project are implemented by the end of December 1993.

For more details about one mission, see the Action Plan for 1993 for the Central Visayas Mission which immediately follows this Annex as Attachment 1.

## Attachment 1

1993 Action Plan for the Central Visayan Mission

## ACTION PLAN

ADRA

CENTRAL VISAYAN MISSION

PROJECT TITLE: VAD PREVENTION &amp; CONTROL PROGRAM AMONG PRE SCHOOLERS

Project Objectives	Activities	Persons Responsible	Time Frame	Resources Available	Resources Needed	Source	Cost
1.a. To reduce 10% of the prevalent high risk pre-schoolers by the end of 1993	-Barangay ocular survey	A Carpena J Casio N Moralde Health promoters	Jan-Dec 93	Resource persons	Visual Aids Lecture materials	HMMSH CPUM CVM	P 500.00
b. To detect 100% high-risk cases of VAD	-Get data information from BHC of high risk pre-schoolers -Actual interview of mothers whose pre-schoolers are positively identified with VAD -Operation Timbang						
2. By the end of 1993 20 mothers motivated to feed GLV 5 days a week to their children	-Interview mothers frequency of feeding their children w/ GLV -Organize mothers' class/club -Lectures & demo. -Home gardening -Home visit -Mid/y-end evaluation/ graduation	-do-	-do-	-do-	-do-	-do-	P 500.00
3. 100% pre-schoolers w/ high-risk VAD administered VAC by the end of 1993	-Supplementation -Counselling -Other health services	A Carpena J Casio N Moralde Dr L Pepito	-do-	-do- Dr L Pepito	-do- 30 comics	DOH HKI MSH	P 1,000.00

## **PHILIPPINES - ANNEX 4**

### **CARE**

Information in this section was obtained through discussions with VITAP and CARE staff in Manila and through visits to CARE's sub-regional office in Iloilo and to CARE-assisted DOH facilities in peri-urban Manila and Zamboanga City.

#### **A. Organizational Structure**

Since 1977, CARE-Philippines has worked with the Department of Health in conjunction with the Targeted Food Assistance Program. Selected participants (363,000 preschool children and 237,000 mothers) receive 1.4 kg. bulgur wheat and 0.4 kg green peas per person per month. In addition to the commodity distribution, other activities supported by this program include growth monitoring, nutrition education, deworming and immunization. The program is implemented through DOH facilities, with DOH staff managing the commodities and providing the health services.

In 1986, a three-year Title II Enhancement grant allowed CARE-Philippines and the DOH to develop additional activities in three provinces (on the islands of Bohol, Iloilo and Mindanao). Mothers who receive commodities are organized into 190 mothers' groups and the commodities are prepared on-site daily.

The DOH provincial health officer and the CARE area manager work through rural health centers and midwives for training of local mothers groups. For the three provinces of the Enhancement project, CARE has developed new nutrition education materials for midwives. The educational package, called 'Fun Learning Activities for Nutrition Education', or FLANE, was designed to encourage mothers to engage in participatory learning activities. Specific items included in the kit are board games, playing cards, posters and charts. The FLANE kit has been translated into five local languages and distributed to 11,000 nutritionists and midwives.

#### **B. VITAP Inputs**

A CARE representative attended the initial VADPC orientation seminar in February 1990 and then five additional CARE staff were trained at the August 1990 workshop. After that workshop, CARE developed its plan of action for collaborating with VITAP.

#### **C. VITAP and PVO Inputs**

The plan of action involved two major areas: training of field-based CARE program staff on VADPC and development of a vitamin A supplement for the FLANE kit. In VITAP terminology, these field staff represent the 'field implementers' group in the training chain which is between the core group of trainers and non-PVO community members.

**Training of field implementers.** VITAP assisted CARE in designing and implementing three workshops on VAD-IDA-IDD. Participating were 86 trainees from CARE's staff (field officers), CARE's collaborators in the DOH (District and Municipal Dietary Nutritionists) and representatives of 12 local NGOs. The training staff included A CARE trainer, DOH technical staff and the VITAP Coordinator. These workshops were held in Cayayan de Oro City (Misamis Oriental province) from November 22-23, 1990, in Iloilo City (Iloilo province) from April 15-17, 1991, and in Tagbilaran City (Bohol province) from January 29-31, 1991. For an example of the diversity of organizations represented at one of these workshops, see Attachment 1 to this Annex for a complete listing of participants.

**Development of a vitamin A supplement for the FLANE kit.** In addition to vitamin A, this supplement includes information on two other micronutrients, iron and iodine. CARE and VITAP plan to collaborate on all phases of this activity: needs assessment; creation of 10 individual activity items for the kit; pre-test; revision; completion of the English version; translation; translation validation; reproduction; distribution; training of field implementers (midwives and BHWs) on the use; and then monitoring actual use with mothers.

As of November 1992, work on this supplement has progressed through development of the first draft of the English version. CARE and VITAP anticipate continued close collaboration on this project throughout 1993.

#### **D. Results**

CARE is pleased with its collaborative efforts with VITAP, reporting that the VITAP Coordinator generates enthusiasm, follows through and is a dependable resource.

CARE's strategy in the Philippines is similar to that of HKI in that neither group has its own staff who interact directly with members of the target population. In CARE's case, it works with the DOH in nutrition-and health-related activities. The three workshops which were held with VITAP assistance reflect the huge potential of working with CARE due to its collaboration with the DOH and other groups.

On the other hand, outreach efforts can be stymied when the DOH is not able to expand its network to continue an activity initiated by CARE. Such is the case of the 106 Municipal Dietary Nutritionists who were working with CARE and the DOH in the Enhancement Project and who were trained in VADPC. The DOH could not support them as planned after the initial two years and all but 15 in Iloilo lost their jobs.

Through the training activities with VITAP, CARE is able to provide specialized training to DOH staff who might not otherwise have the opportunity. CARE and VITAP help to reinforce the DOH's own policies - such as integrating the distribution of VAC during EPI contacts - and provide support to the DOH staff who are charged with implementing these policies.

CARE's emphasis on the development and promotion of the FLANE supplement demonstrates considerable commitment to addressing micronutrient deficiencies. CARE received requests from other organizations for the original FLANE kit and could well provide this service again once the supplement is available.

Factors which support VITAP's collaboration with CARE are that CARE:

- Has an extensive network and strong organizational structure;
- Has a history of working through the DOH and is recently working more closely with and through local NGOs; and
- Is developing expertise in incorporating income-generating activities in programs with mothers' groups.

Confounding factors are that CARE:

- Is dismissed by some as a "dole-out organization" because of dependency which can be caused by food aid programs; and
- Has a very wide geographic scope of activity which works against close follow-up of any specific item (such as the FLANE kit) in a national program, except on a very small scale. Large program size can keep CARE, the DOH and VITAP from being aware of the positive and negative results of their vitamin A efforts.

#### **E. Results at the Community Level**

The VITAP assessment team did not undertake any community- or household-level interviews in places where CARE had trained the DOH or any local PVOs in VADPC.

#### **F. Plans for the Future**

CARE plans to advocate the use of the FLANE supplement in all areas of the Targeted Food Assistance Program. This includes training CARE staff and collaborating DOH and NGO staff in its use. One impediment to proceeding with this plan is that the Municipal Dietary Nutritionists which were initially trained in VADPC are no longer employed by CARE. CARE and VITAP intend to review the situation and to revise their overall plans accordingly.

In addition, CARE has expressed its interest in having VITAP's assistance with the evaluation of the effectiveness of the FLANE supplement, once it is in use by field implementers. Included in VITAP's plans is a focus on monitoring the use of the supplement by midwives.

Specific activities which CARE intends to undertake with VITAP, as stated in CARE's PVO-VITAP 1992-93 Action Plan, are:

- **enhance the nutrition education component of TFAD through the development of the FLANE supplement on micronu<sup>r</sup>rients;**
- **distribute the FLANE supplement and train implementers on its use and advocate for its use;**
- **establish linkages with local NGOs in selected provinces and train their local workers; and**
- **monitor activities of these NGOs in coordination with the DOH.**

ANNEX 6 CARE - Attachment 1 - Participants at VAD-IDAIDD Training

VAD-IDA-IDD  
 Punta Villa, Iloilo City (pg. 1 of 2)  
 April 15-17, 1991

Name	Position	Organization	Contact Person	Address
Alvarez	President	Katilingban Sang Mga Mainuswagong Mangingisda Mangunguma kag Manunugon Sang Malabor (KASAMMA-MALABOR)	Fe Alvares President	KASAMMA-M Barangay Mal Tibiao, Antipi
Bals	Field Officer (F.O.)	CARE - Philippines	Mr. Carlos Baltazar	CARE-Western Visayas 3rd Floor Virgen Sq. Brgy. Bldg. 7th Lacson Street, Bacolod City tel # 2-42-04/2-37-42
Divinagracia	(F.O.)	-do-	-do-	-do-
Parrenas	(F.O.)	-do-	-do-	-do-
Cajilig	Community Nutritionist	Assumption Socio-Educational Center (ASEC)	Cynthia Baga Project Officer	Bo. Obrero, Iloilo City tel: # 7-54-58
Chua	Health Coordinator	Save the Children Federation	Atty. George Jover Project Director	San Jose St., Molo Iloilo City tel # 7-16-86
Carmelo	Medical Consultant	Kahublagan Sang Panimalay	Ms. Jessica Salas Project Director	25 Magsaysay Village La Paz, Iloilo City tel. # 7-71-41
Rebustes	OIC-Manager	Archbishop Gabriel M. Reyes Memorial Foundation	Atty. Jose Peralta, Jr. Project Director	Lacerna St., Kalibo, Aklan
Ituralde	Community Worker	-do-	-do-	-do-
Pabalan	Community Dev't. Assistant	North Negros Community Dev't. Foundation, Inc.	Mr. Nestor Bayona Project Director	Lopez Sugar Corporation Fabrica, Negros Occidental
Sionosa	President	Paghili-usa, Inc.	Ms. Evelyn Jover Project Officer	Iloilo People's habitat Foundation, M.H. del Pilar St., Iloilo City tel. # 7-88-77
Perez	Community Trainor	Saint Paul Parish	Mr. Armande Fuertes Manager	Saint Paul Parish Csuayan, Negros Occidental
Suela	Member	City Health Office Mother Volunteers Organization	Dr. Joretta Moreno City Health Officer	Bacolod City Health Office Bacolod City tel. # 2-56-11
Drus	President	-do-	-do-	-do-
Montano	Faculty	University of San Agustin	Mr. Francis Gentoral Research Director	University of San Agustin Gen. Luna St., Iloilo City tel. # 7-48-41

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ANNEX 4 - CARE

Attachment 1

Participants at VAD-IDA-IDD Training (pg. 2 Of 2)

Name	Position	Organization	Contact Person	Address
16. Dolores Calvo	Municipal Dietary Nutritionist (MDN)	University of San Agustin	Dr. Francisco Durnayas Provincial Health Officer	Iloilo Integrated Health Office San Isidro, Jaro, tel. # 7-09-43
17. Remedios Huesca	MDN	-do-	-do-	-do-
18. Rose Andrea Padilla	MDN	-do-	-do-	-do-
19. Ms. Lourdes Patanao	MDN	-do-	-do-	-do-
20. Lyndelly Soubiron	MDN	-do-	-do-	-do-

BEST AVAILABLE DOCUMENT

## **PHILIPPINES - ANNEX 5**

### **Catholic Relief Services**

The assessment team's methods for collecting information about CRS included report reviews, interviews and visits to the:

CRS Country Director and Northern Luzon Regional Director in Manila;  
Antipolo parish staff in Rizal;  
Regional Director and staff in Zamboanga and Basilan; and  
Regional Nutritionist and parish nutritionist in Davao City, Davao.

Although field visits were planned, they were not possible due to inclement weather, security concerns (in Basilan) and scheduling conflicts.

#### **A. Organizational Structure**

Catholic Relief Services (CRS) is a PVO administered by the Board of Bishops, with policies and programs which reflect the teachings of the Catholic Church. Nevertheless, it assists all persons in need, regardless of creed, race, or nationality. CRS responds to these needs by aiding victims of disaster, providing assistance to the poor to alleviate immediate needs, supporting self-help programs for community development and restoring dignity, and collaborating with other agencies with programs which contribute to a more equitable society. CRS works through the Catholic church system in dioceses which are administrative regions similar to the district and provincial divisions of the country.

CRS has been working with child survival projects and large scale food distribution of Corn Soya Blend and Nonfat Dried Milk (NFDM) for malnourished children identified in 'Operation Timbang' (an annual nationwide growth monitoring screening) and through their targeted maternal and child health program (TMCHP). One child per family is enrolled for two years in the food supplementation program. Afterwards, mothers can join income generation programs also implemented by CRS. Nutrition classes are given once monthly for mothers participating in take-home food distribution and more frequently for those participating in on-site food distribution. Home visits are made to the most severely malnourished children.

CRS is also involved in monetizing donated commodities, particularly NFDM and dried peas. They, like CARE, has selected enhancement areas (ETMCHP) where nutrition efforts are targeted. CRS program participants in Rizal number 5000 in 11 centers; in Zamboanga, 6370 participants, including tribal populations, and in Davao, 7000 participants in 17 parishes.

## **B. VITAP Inputs**

CRS staff attended the initial VITAP orientation session and subsequent NCP training in August 1990. VITAP provided technical assistance for developing CRS Action Plans in 1990, 1991 and 1992 and for training staff and purchasing vitamin A support materials.

## **C. VITAP and NGO Inputs**

After the initial NCP training, enthusiasm and momentum for VAD programming grew. Six months later, CRS and two other PVOs asked VITAP to conduct a follow-up training on VAD. Three CRS project managers and representatives from 23 local NGOs attended. One year project plans were drawn up for each agency. In April 1991, CRS staff in Antipolo requested a follow up training (training of trainers) for 26 parish health workers and in May 1992, CRS Davao requested a similar workshop for 26 participants.

## **D. Results**

Key results from this collaboration are:

- Vitamin A programming has been prioritized as a CRS objective and included in their written plans of action, e.g.,
  - 1) The Diocese of Antipolo, TMCHP Operating Plan for 1989-90 had no objectives for vitamin A. However, the January 1992-December 1993 Plan had this objective stated as: "All children enrolled in the program shall have been clinically diagnosed and treated of VAD" (*sic*).
  - 2) Vitamin A information has been added to the monthly mothers' classes and to livelihood projects containing gardening.
- Eleven communities have been assessed for VAD using the tool developed with CCF.
- Staff who attended vitamin A workshops were expected to implement 'echo trainings' to share their information with nutritionists, program managers and *barangay* health workers. In the Davao region, in less than six months, eight dioceses have incorporated VADPC in their programs and half of the Dioceses have conducted 'echo trainings' with their parish staff. At the time of the assessment, two more parishes planned to conduct TOT workshops on VADPC within the next month.
- 'Echo trainings' are implemented independently of VITAP financial assistance. Parishes, however, did request additional IEC materials and VAC.
- CRS and the parishes have made a financial commitment to vitamin A programming.

- Rapid transfer of vitamin A information is made within CRS, to the Catholic churches and to CRS program participants.
- Nutrition education is routinely carried out. During the annual nutrition month, the Antipolo parish conducted a nutri-quiz and cooking contest, both with vitamin A messages. Bingo cards are used to teach a balanced diet. Methods of teaching, however, are based on the old educational learning paradigm.
- The level of interaction between VITAP and CRS is high, e.g., the VITAP Coordinator is regularly invited to CRS monthly staff meetings in Antipolo; VITAP and CRS have held the most - at least 7 - consultative meetings of all the PVO collaborators; and the VITAP Coordinator has made two field visits for monitoring purposes.
- Micronutrients are already integrated into CRS' programming. VAD-IDA-IDD are included in the training given to CRS and to mothers. No iodine pills are distributed although iron supplements are given via rural health clinics.

#### **E. Discussion**

At each site visited, CRS stated that becoming involved with VITAP and vitamin A programming has created opportunities for facilitating linkages between CRS and DOH. The CRS staff involved are particularly pleased with this outcome, as they had been trying to develop such a relationship for a long time. The integration of vitamin A programming into CRS has also helped to link interested dioceses by giving staff VADPC skills to share in trainings. Other new skills noted by staff were: VAD knowledge and detection, increased confidence in delivering messages and new techniques for giving lectures.

HKI has a positive image within CRS. In his interview with the assessment team, the CRS Country Director pulled out a thick file of correspondence with HKI and said they always have responded promptly and professionally. He also mentioned that CRS' vitamin A program in Thailand has had a positive impact on national health policy. This same point had also been made in the pre-trip telephone interview with CRS' USA headquarters.

The CRS vitamin A program components looks good on paper, but unfortunately the assessment team was unable to see CRS in action. The prevailing feeling was that many nutritionists and local level staff are ill-equipped to successfully execute the multiple tasks of food preparation and distribution, education, and income generation activities. There was little transfer of CRS' knowledge of what works and what does not work among CRS programs internationally, resulting in institutional memory loss. The lack of a trained program officer based in Manila to conduct follow-up and supervisory visits to field sites is a drawback for such a large program. In addition, the CRS program needs to develop expertise in the area of health communications, especially in new project areas supported by

monetized food aid. CRS could benefit by additional linkages with NGOs and calling on other health and education professionals in country.

### **Supporting and Confounding Factors**

Supporting factors which have contributed to the success of VITAP working through CRS are:

- CRS is a large organization with an extensive network throughout the country parish system, and reaches a substantial percentage of the population.
- Linking of CRS programs with the DOH has strengthened inter-organizational ties and collaborative efforts.
- With the strategy of increasing monetized food aid, CRS could be more effective in combatting malnutrition as well as enhancing income. The impact of monetization will be monitored by CRS.
- A new 1992 inter-diocesan plan to share results via 'cross site visits' (i.e., visits from one field office to another) may strengthen lessons learned.
- The program priorities of CRS staff are training of local leaders and advocacy with local government.
- CRS Davao is incorporating non-formal education techniques in its training of trainers. CRS will test this new education paradigm for wider replication.
- VAC supply will likely not be a problem in at least one CRS project area - Davao - because of the general prosperity of the region.
- CRS and its parishes have made a financial commitment to vitamin A programming.

Confounding factors include:

- Supervision could be enhanced. CRS' staff in Manila includes no project personnel with the responsibility for project supervision.
- Some field staff are afraid to give VAC (from the Bicol incident) and VAC supply is sporadic. CRS does not purchase VAC directly and often the local DOH does not give VAC to CRS' trained community health workers.
- CRS workers in hill tribe areas have an additional set of problems. Long distances, security issues, language and custom barriers make programming, reporting and education very difficult.

- CRS will need to do its own 'in-house' advocacy with church officials and bishops to obtain priority and funding, especially for education, seeds, IGP and vitamin A programs.
- Shortages of food commodities exist, with a concomitant loss of program participants.

#### **F. Plans for the Future**

CRS program managers are very interested in continuing to collaborate with VITAP. Desired topics for future joint activities include: developing skills in counseling, supervision, management, follow-up and assessment; one-on-one case building; and elaborating more concrete indicators for program success. Given that these interests are more related to general project management skills, as opposed to specific vitamin A programming skills, VITAP will need to adapt its technical assistance accordingly to respond to CRS' requests, while still addressing its central concern of vitamin A deficiency, prevention and control.

## **PHILIPPINES - ANNEX 6**

### **Christian Children's Fund**

The methods the assessment team used to collect information from CCF included review of documents, interview with US headquarters, and visits to the:

CCF Executive Director and project staff in Manila,  
Staff of CCF's affiliates - Cross Foundation Association for Rehabilitation of the Disabled and Project Pagasa in Bay, Laguna Province,  
CCF affiliates which work with parents' associations and villagers in Iloilo, and  
CCF Project Maluso staff and Somal villagers in Basilan.

#### **A. Organizational Structure**

Christian Children's Fund serves 40,000 children in 83 'child focus' projects through child sponsorship in the Philippines. CCF operates by assisting local program affiliates to implement a range of programs for poor children, their families, and their communities, while also supporting the affiliate as well. Affiliates assume responsibility for operation of child focus programs after CCF withdrawal. Fifty percent of CCF projects are operated locally by parents who also manage 80% of the funding, with the aim of developing long-term sustainability. Assistance is typically planned for five years but can extend to 12 years. Groups of affiliates meet twice per year to share experiences.

#### **B. VITAP Inputs**

CCF staff attended the VITAP orientation (February 1990) and NCP workshop (August 1990). The initial training was followed by a five-day training of trainers (TOT) with CCF staff and six project affiliate members (August 1990).

#### **C. VITAP and NGO Inputs**

Based on these initial activities, the following collaborative efforts took place:

- Development of a VAD preliminary assessment tool, for use by field implementers;
- Development of a training design for the training of trainers and leaders;
- Development of a research design for conducting a baseline study;
- Training of trainers for 23 social workers working in Manila, Central & Northern Luzon (October 1990); and
- Training of trainers for 21 program participants (July 1992) on improved knowledge and skills for influencing mothers' knowledge, attitudes and behaviors related to vitamin A.

## **D. Results**

The VITAP Coordinator visits CCF field projects targeted for technical support and assistance. CCF and occasionally its affiliates send reports to VITAP. Follow-up and feedback mechanisms operate well between VITAP and CCF. The VITAP program has helped reinforce linkages with the DOH and CCF affiliates. CCF coordinates with the DOH by calling on them as a resource for provision of VAC, collaboration for VAD detection and referral, and sharing and provision of IEC materials. Additional results include:

- The preliminary VAD assessment tool was used in five communities where health workers found and treated VAD cases and high-risk children. In the case of one affiliate, CFARD, a 'saturation drive' was conducted for distributing VAC to all children under six. Later this assessment tool was adapted by CARE, CRS and SCF.
- Relationships between one affiliate (Project Pagasa) and its parent organization (Christofel Blindenmission) were strengthened due to shared interests in combating VAD.
- One CCF Project Manager's initiative to train staff about VADPC with her own project time and money has resulted in some additional training of parent's association members and other project affiliate staff.
- VACs were delivered to hill tribe populations typically unreached by the DOH system. CCF's efforts in reaching these populations has played a crucial role in health care delivery to them. Nutrition and gardening education are also conducted. In Project Maluso, a project for the hill tribes of Basilan, the vitamin A program component met with acceptance because a post-measles child with a Bitot's spot was treated and cured.
- Numerous affiliates have undertaken the integration of vitamin A into bio-intensive gardening activities.

## **E. Results at the Community Level**

The level of awareness and delivery of information about vitamin A deficiency and the role of vitamin A in child survival were increased, at the very least, with project staff, parent's association members (the parents in the communities where CCF affiliates had programs) and families supported by CCF sponsorship. In general, families not reached directly by CCF affiliates did not have accurate knowledge of the role of vitamin A for the body or for child survival. Even in families where the knowledge about vitamin A was high, and vitamin A-rich vegetables were served often in soup, children were allowed to leave the leafy greens at the bottom of their bowls.

Communities where CCF affiliates had projects received VAC and nutrition and gardening education. In one target group reached by Project Maluso, education about home gardening has been well integrated in their vitamin A activities. One project participant's home had a 'magic square' (a garden one square meter in size which includes vitamin A-rich vegetables) and was generating income from the sale of excess produce from it. Most affiliate projects have income generation components, which *may* play a role in increasing consumption of vitamin A.

### **Supporting and Confounding Factors**

Some factors add and others detract from the success which VITAP has in collaboration with CCF. The supporting factors which were identified are:

- Local NGOs (affiliates) such as parents' and homeowners' associations are developed with CCF assistance, aspiring for sustainable programs, and hence potential 'institutionalization' of vitamin A programming. These program staff originate from and reside in the villages where they work with CCF.
- CCF's widespread local affiliate network (approx. 100 groups) has potential for replication of successful VAD programs.
- CCF and affiliate staff are highly motivated and committed.
- CCF and its affiliates collaborate well in sharing resources.
- Many traditional midwives have become collaborators in the VAD program, assisted by VAD training from the DOH. Delivery of VAC to post-partum women is integrated into PVO activities.

Confounding factors include:

- The number of CCF project staff is limited for nearly 100 affiliates.
- The importance of and messages about vitamin A may become 'watered down' and/or distorted when passed through various channels, e.g., from VITAP to CCF to Project Affiliate Manager to affiliate staff to parents' association members to mothers. As an example, one parent's association member interviewed in Laguna gave VAC to children under 12 (wrong target group), and ran out before finding a child with nightblindness.
- Child sponsorship has its advantages and disadvantages. Families may clearly benefit from increased inputs (educational, health, VAC, financial), however disparities were seen among villagers where non-CCF families did not receive VAC.

- **Trained DOH and NGO staff must work hand-in-hand. CCF had trained its affiliates, however, in areas where DOH staff were not trained, cooperation for VAC delivery was difficult.**
- **Materials are lacking for non-literate populations. Ethnic hill tribe populations, exhibiting some of the highest rates of VAD and high-risk children, need appropriate vitamin A materials for non-literate and low-literate target groups.**

**In conclusion, the enthusiasm of CCF's project and affiliate staff in implementing vitamin A activities, coupled with the grass roots nature of CCF, constitute conditions for potentially augmenting CCF's current widespread impact on increasing the consumption of vitamin A by target groups.**

## PHILIPPINES - ANNEX 7

### Save the Children Federation (SCF)

The assessment team reviewed documents, conducted interviews and made visits to the:

SCF Project Director and a Technical Coordinator in Manila,  
A SCF-supported DOH urban clinic in Manila (San Martin de Porres),  
SCF parent's association members and President of the *Barangay*  
Homeowner's Association in *Barangay* Tanguig in urban Manila, and  
SCF Director and project staff for Guimaras, based in Iloilo.

#### A. Organizational Structure

Save the Children started its work in the Philippines in 1982 in rural Guimaras Island, located in the Central Visayas Region. SCF later expanded its programming to Northern Luzon in 1985 and to urban slum areas of Metro Manila in 1987. Their two-fold aim is to:

- 1) promote improvements in children and their families' social, economic and environmental quality of life and
- 2) strengthen community and local government participation in *barangay* development.

VAD program objectives are promoted by both of these aims - the first, via improvements in the health of children and mothers, and their family's food production and consumption, and the second via cooperation and training support with locally SCF-supported health units.

#### B. VITAP and NGO Inputs

One SCF staff member attended the initial collaborative meeting and then attended the VAD training (February 1990). Subsequent TA provided by VITAP was for two, two-day VADPC trainings of 44 primary health care workers each (BHWs and mother volunteers), with a focus on assessment and nutrition education. These workshops were coordinated with the DOH. One additional VADPC workshop was conducted with 12 SCF PHC workers in October 1992. A detailed outline of the joint SCF-VITAP Action Plan for 1992-1993 was drawn up at the PVO/VITAP consultative meeting in 1991 (See Attachment 1 to this Annex for a copy of this plan).

Developing a recipe book was a joint VITAP-SCF endeavor which included reviewing SCF reports, a field visit and at least four consultative meetings. VITAP assisted with overall technical assistance and in pilot testing. At the time of the assessment, plans were to use VITAP funds to print 2000 copies of the book for NGOs, reserving 100 copies for SCF.

### **C. Results**

SCF's vitamin A program reaches a population of approximately 900 families in four communities in Metro Manila and 12 communities (approximate population 16,000) on the island of Guimaras.

SCF collaborates with the DOH for improving health center services and staff skills including those of the BHW attached to the health units. These activities are essential steps in SCF's approach to 'institutional development', which also includes a training program based on felt needs of the people with whom they work - DOH staff, BHWs and the community. The DOH is called upon for consulting and advisory services.

The assessment team visited a DOH urban clinic in San Martin de Torres, a low-income community of 13,980 people in metro Manila. The clinic and its outreach programs are assisted by SCF. Through the DOH, the PHC staff workers received trainings in VAD. A CARE-developed FLANE kit was given out during these trainings and is being used by the BHWs and midwife at the center. CARE donated food is also distributed to eligible malnourished children. As a result of the VAD training, all of the staff know how to detect and refer high-risk cases of VAD to the nurse and midwife for treatment with VAC. SCF assists the staff through training in health communications and counseling techniques, including vitamin A messages.

BHWs encourage mothers to plant vitamin A rich foods by giving seeds. District health centers also sporadically give mothers seeds, however, this gardening component has had mixed results.

PHC workers used the CCF-developed preliminary assessment tool for VAD detection in four communities. On a family basis, the prevalence of high risk cases was 60%, as 30 of 50 families in one community had at least one member identified with vitamin A-related illness. Children with Bitot's spots and nightblindness were found in the new SCF project area.

As a result, in October 1992, SCF and VITAP developed a training program designed to improve the knowledge, attitudes and skills of 71 PHWs in 'old' and 'new' project areas. Priority topics included healthy foods, especially those rich in vitamin A, and VAC. Using experiential learning methods, SCF found that retraining staff with new techniques in the 'old' areas was more difficult than in 'new' project areas, where these techniques were used from the beginning of SCF's work in the community. The participatory techniques and counseling are designed to assist health staff help mothers to improve feeding behaviors and create home gardens. The trained PHWs are now integrating VAD assessment and non-formal nutrition education into their community activities. One PHC worker serves about 20 families with education and counseling.

The team observed a training session where volunteer health workers - mostly young mothers - were learning how to conduct four non-formal activities to undertake with mothers in their neighborhoods: song, game, drama, and Catchword. The SCF trainer processed the training sessions using the 'Four A' model, i.e., after each ACTIVITY, the trainer assisted the participants through ANALYSIS, ABSTRACTION and APPLICATION phases. Underlying this approach is the assumption that mothers who participate in similar problem identification and solving may be more successful in changing their vitamin A-related behaviors.

In the Guimaras project area, VAD-IDA-IDD are incorporated into the family health classes. After the VITAP training, SCF staff working in Guimaras became more aware of their specific target groups - the BHWs and mothers. Vitamin A-rich foods have been promoted in agriculture, as part of their income generation project (not attributed to VITAP). In Guimaras, SCF has worked closely with the DOH in inter-agency planning sessions and conducting a VAD survey.

#### **D. Discussion**

Vitamin A is incorporated into all SCF programs. Since SCF typically works in relatively small project areas, flexibility and targeting of more intensive programming are possible. SCF's strengths in vitamin A programming are pilot testing vitamin A activities, developing materials, and close monitoring of results. SCF is one of the first PVOs to conduct non-formal training for mothers in how to teach other mothers. Even more effective nutrition education techniques might be developed if SCF resource staff were teamed up with other VITAP collaborators.

#### **Supporting and Confounding Factors**

##### **Supporting Factors--**

- SCF is a small, flexible, well developed PVO.
- SCF's staff are committed and open to new initiatives.
- Operations research can be performed easily within SCF's programming design.
- Community participation is a key element in their programs.
- Monitoring and evaluation of programs is not viewed as cumbersome.
- SCF and HKI have offices in the same building, facilitating coordination of activities and technical assistance between the two organizations.

SCF trains its PHC staff and volunteers in order to increase their knowledge and skills in problem-solving, data analysis, financial management, facilitating and conducting family health classes. These skills are important for sustaining positive behavior changes brought about through their program. SCF also teaches and encourages tapping into other funding sources in preparation for SCF's eventual phase out from the community.

## **Confounding Factors--**

- **Socio-economic factors contributing to malnutrition are present in the communities SCF serves, therefore integrated approaches are needed to address VAD. Examples of problems encountered include: children don't like to eat green leafy vegetables; vitamin A-rich foods are expensive and/or subject to taboos; lack of skills in preparing foods; little space around individual homes for vegetable gardens; and mothers initiate bottlefeeding after 5-6 months in order to return to work.**
- **Acceptance of the strategy of mothers training mothers may be difficult initially. To obtain broader acceptance for the volunteer PHC workers in the community, they were presented at the General Assembly of the Homeowner's Association, and described their purpose and activities.**

## **E. Plans for the Future**

**VITAP and SCF will conduct a joint evaluation of the use of the recipe book which SCF developed with VITAP's assistance. Further discussions will be undertaken about having SCF staff assist with various aspects of VITAP trainings, such as experiential nutrition education techniques. SCF is also interested in refresher courses with VITAP input to assist with broadening knowledge and skills of trainers.**

Attachment 1 - SCF-VITAP Action Plan

**PVO - VITAP ACTION PLAN**

1992 - 1993  
PERIOD

**ORGANIZATION** . . . **SAVE THE CHILDREN (MANILA)**

**CONTACT PERSON** . . . **LETTY T. BASILIO**

**ADDRESS** . . . **US PEACE CORPS. COMPOUND  
2139 FIDEL A. REYES STREET  
MALATE, MANILA**

**GEN. OBJECTIVE** . . . **By the end of 1993, the old and new PHW will be able to identify, implement and monitor vitamin A program on their respective cluster/ community.**

**SPECIFIC OBJECTIVE** **To equip<sup>d</sup> the PHW with more knowledge and skills on the prevention/treatment of vitamin A deficiency to all at risk mothers and children below 6 years old.**

**To reduce malnutrition problem by incorporating nutritious food also rich in vitamin A in all our Karindaria.**

**To develop<sup>d</sup> monitoring information system that will ensure/facilitate vitamin A program impact.**

## **PHILIPPINES - ANNEX 8**

### **Project MATA**

Information in this section was obtained through discussions with the VITAP Coordinator in Manila, a visit to the Project MATA Coordinator in Iloilo and visits to two of Project MATA's affiliates, Assumption Social and Education Center and the University of San Augustine, in Iloilo.

#### **1. Organizational Structure**

In August 1991, HKI-Philippines initiated a new effort, called Project MATA ('mata' means 'eye' in Tagalog), in collaboration with local NGOs. The objective of the project is to mobilize NGO partners to assist in the battle against malnutrition and nutritional blindness. Five of these NGO collaborators are located in the National Capital Region (i.e., Metro Manila) and 12 are in Region VI (Central Visayas).

Project MATA was developed in response to the potential which NGOs offer in terms of collaborating in vitamin A programming and to the restrictions of the VITAP grant *vis-à-vis* working with local NGOs. The criteria for choosing the participating NGOs were: involvement in health, nutrition or agricultural services; provision of direct services to the community; full-time staff; and provision of 20% of staff salary for two staff members to work with Project MATA.

#### **2. VITAP Inputs**

Although Project MATA is an HKI project with a separate budget and staff from VITAP, it is a direct outcome of VITAP because VITAP had demonstrated the critical need to work with local NGOs as well as with US-based PVOs. Just as VITAP has benefitted from all the prior work which HKI has done in the Philippines, Project MATA has benefitted from the experience of VITAP which preceded it. The current institutional relationship is one whereby the VITAP Coordinator serves as a resource person for Project MATA.

#### **3. VITAP and PVO Inputs**

VITAP contributed to the training of some of the future collaborators of Project MATA. Some representatives of local NGOs were first trained in VADPC through VITAP, before Project MATA began. When CARE developed its second provincial-level training, held in Iloilo from April 15-17, 1991, the participant list included three staff from CARE, one from SCF and 16 other persons who represented nine local NGOs.

A cost sharing workshop in Iloilo was conducted under the auspices of Project MATA in April 1992. ADRA sent five of its new health educators who paid their own transportation

and the registration fee. These ADRA participants were those who could not attend the original VITAP training in August 1990.

#### 4. Results

Two of the groups which sent participants to the CARE training in Iloilo were Assumption Social and Education Center (ASEC) and USA (University of San Augustine).

##### Assumption Social and Education Center (ASEC)

ASEC is a private Catholic school which is partially supported by a Japanese donor. The school is located in Barrio Obrero, a large, poor, peri-urban *barangay* in Iloilo. The 513 students are primarily from Barrio Obrero and three other neighboring *barangays*. One of ASEC's principles is a commitment to reach out to the parents of ASEC students and that similarly, the parents have a responsibility towards the school. ASEC involves the community in income generation projects (IGP) and requires parents to pay nominal 'counterpart' contributions towards school costs.

ASEC has an outreach staff who are involved in community activities with parents of ASEC students. One of these outreach staff, Elmy Cajilig, the coordinator of Area 4, attended the VAD training in April 1991. As a biology graduate, she had already been exposed to general information about vitamin A. However, the emphasis on adding oil to vegetables to increase vitamin A absorption was new to her.

As a result of her training, Ms. Cajilig has shared the information with a group of five visiting international development students and produced a module for training parents in the community about vitamin A.

##### Nutrition Department of the University of San Augustine (USA)

One member of the Nutrition Department attended the training in Iloilo which was sponsored by CARE in April 1991. Afterwards, trainees were given VAC to be used in their respective operational areas. For USA, this area is *barangay* Bonifacio, a poor community which serves as the locale for the Public Health Nutrition practicum of seniors in the Nutrition Department.

Methods used by students to promote improved nutrition include: growth monitoring; deworming; cooking demonstrations and sampling of the dishes prepared; nutrition education talks; and inviting mothers to come to the University for cooking classes. These activities are supplemented by IGP efforts undertaken by business students.

In January 1992, the students weighed the 179 preschoolers and found 40% with mild malnutrition, 25% with moderate, 16% with severe and no visible cases of VAD. The students and parents set up a daily supplementary feeding program soon thereafter. During

the course of this six-month project, the VACs received at the training were distributed to 31 moderately and severely underweight preschoolers. When this VAC supply ran out, the

USA requested more from the DOH but was told there were none available. During the interview, the assessment team was asked if it could help them obtain more.

The overriding factor which supports VITAP's collaboration with Project MATA is their joint commitment to the same goal, which is reflected in their excellent communications and sharing of resources. The VITAP-CARE-ASEC-MATA connection (i.e., VITAP originally trained CARE; CARE trained ASEC and then ASEC became a collaborator in MATA) is a fascinating one of collaboration, sharing resources and extending the impact of training. Given this precedent in working together, VITAP and MATA can probably develop other examples whereby they can collaborate within the limitations of their donors, and still produce a result whose impact is greater than the sum of separate and distinct inputs from VITAP and MATA.

On the other hand, a confounding factors in this collaboration is that VITAP and MATA funds cannot be co-mingled. This can create a problem in the case where a local NGO becomes involved in VADPC through its association with a US-based PVO collaborating with VITAP. If that PVO cannot continue to be supportive of the NGO's efforts in VADPC, the NGO may not necessarily be able to develop a direct connection with HKI unless it is in Project MATA's geographical operational area.

## **5. Results at the Community Level**

The assessment team did not interview any health workers or mothers in the *barangays* where ASEC and USA are working.

## **6. Plans for the Future**

Information is given below for two of Project MATA's collaborators which were visited by the assessment team and for intra-agency plans between Project MATA and VITAP.

### **ASEC**

The ASEC outreach staff assist the communities in undertaking planning assessments and with the results, develop interventions to meet their objectives. These assessments have been recently completed and when the results are analyzed, ASEC will determine how the objectives and strategies of VADPC can fit into new plans for the four *barangays* where they work.

ASEC has been chosen as one of 12 NGO partners to work with Project MATA. Thus, in addition to the community vitamin A activities mentioned above, ASEC will also be closely involved with the other NGOs working with MATA. In early 1993, the ASEC science

teachers will meet with the national and regional representatives of Project MATA to develop ways in which VADPC can be incorporated into activities for ASEC students.

In addition to the outreach with parents and curriculum development with science teachers, ASEC has three other mechanisms for promoting messages about vitamin A: through articles in the Project MATA newsletter; through discussions with parents about the results of quarterly weighing of their children; and through the foods which parents prepare for students in the school canteen.

### University of San Augustine

Each group of nutrition majors takes the Public Health Nutrition course in their senior year and works for six months in a needy *barangay* selected by the DOH. The nutrition faculty expressed their interest in continuing a vitamin A outreach program with community residents. The students will most likely use methods which their predecessors have used, and if VAC are available, they will distribute them. When VITAP and Project MATA are able to expand their efforts in improving the techniques for health education, the faculty and students of the Nutrition Department of USA would seem like a receptive audience.

### Collaboration between VITAP and Project MATA

The ways in which VITAP and Project MATA will work together in the future include:

- joint consultation with on-going project activities, especially those which take place in areas where both projects are operating;
- development of strategies and materials to help collaborating PVOs and NGOs design and implement advocacy-related activities in conjunction with devolution;
- sharing project resources to meet joint goals, e.g., Project MATA will invite new ADRA staff from the North Union to participate in VADPC training;
- development of networking connections between collaborating PVOs in VITAP and NGOs in MATA;
- distribution of the Project MATA newsletter to VITAP's collaborators;
- consultation with the VITAP Coordinator regarding trainings for Project MATA; and
- consideration of a joint symposium in 1993 for VITAP's and MATA's collaborators to share their experiences.

## **PHILIPPINES - ANNEX 9**

### **Department of Health**

Comments made in this section are based on interviews with the VITAP Coordinator in Manila and DOH officials in Manila, Cebu (Rural Health Unit of Labangon), Zamboanga (Regional DOH office and the Rural Health Unit of Canelar in peri-urban Zamboanga) and Davao (Regional DOH office).

#### **1. HKI, the DOH and VITAP**

One of VITAP's stated objectives in the Philippines is to "improve PVO-DOH linkage with respect to vitamin A services" (Impact Assessment Briefing Kit, 1992). To that end, the DOH was signatory to the agreement which launched VITAP in 1990. Since HKI has been working with the DOH in the Philippines since 1976, there was already a well-defined and well-respected relationship between the two groups when VITAP was initiated. Although VITAP resources cannot be used directly and explicitly to train DOH staff, many of these persons have benefitted from involvement as co-trainers with VITAP, and therefore help to achieve VITAP's overall goals.

HKI has supported the training of many DOH personnel in VADPC through its other projects, and very intensively since 1989. Some of these DOH staff are then called upon to assist with VITAP. For example, the VITAP Coordinator strongly recommends that a member of the DOH be included on the training team for any PVO workshop related to VADPC. VITAP's collaborators have acted on this suggestion and have found that involvement of the DOH in this way serves many purposes:

- It provides an opportunity for the DOH to inform PVO staff about the DOH's policies and guidelines;
- The DOH trainer can practice training skills and up-date her/his knowledge about vitamin A and the PVO's programs;
- It reinforces the seriousness of the messages about vitamin A in that DOH personnel trained in one situation are then expected to pass on their knowledge to others; and
- It promotes an appreciation of the importance of collaboration among agencies to combat VAD.

#### **2. Supporting Factors**

The following factors related to the DOH provide favorable support for the implementation of VITAP:

- **Knowledge about VADPC**

Health personnel have a correct understanding of the role of and need for vitamin A, even if it is limited to the relationship of vitamin A and vision. Therefore, PVOs do not have to try to change any deep-seated inappropriate beliefs inherited from their culture or from earlier professional training, which is the case with trying to un-train health personnel about breastmilk supply and exclusive breastfeeding.

In general, DOH staff interviewed could easily cite the list of at-risk factors for giving VAC, with the caveat that none of them mentioned the fairly recent addition of first degree malnutrition. Interviewees could also identify specifically where and when they had had their training about VADPC.

- **Involvement of the DOH**

VITAP has been very deliberate in implementing its work as one element of support to the DOH's national vitamin A program: VITAP invites the DOH to provide facilitators for training teams and encourages PVOs to do the same when they do their own training; once PVO trainees ran out of initial supply of VAC, they were told to go to the DOH - not VITAP - for more.

- **Support of HKI's VITEX Project**

The efforts and activities of VITEX support those of VITAP in those provinces where both projects are operating. DOH staff who are trained via VITEX are expected to share their training with others. The assessment team interviewed one Regional DOH nutritionist who had been trained by VITEX in October 1991. In December, she was a co-trainer for a group of 480 DOH trainees, including municipal health officers. These officers then trained the nurses who are in charge of individual rural health units. The nurses were responsible for training their staff in the RHU, including midwives, BHWs and BNSs. During the visit to the Canelar RHU, the nurse reported that she had been trained through this network.

- **Role of volunteers**

There is widespread understanding among health professionals and decision makers that BHWs and BNSs are volunteers and need proper support. The BHWs and BNSs are absolutely crucial links in VADPC between the high risk child (and its family) and the health unit. In some areas, the DOH is helping these volunteers begin income generation projects, in recognition of their need to support their families financially.

### **3. Confounding factors**

The following factors impede the DOH's ability to work more effectively with VITAP:

- Shortage of vitamin A capsules

There is a chronic shortage of VAC nationwide. In only two interviews, i.e., with the Medical Ambassadors of the Philippines and the Canelar RHU, did the respondents state that they had enough VAC for their needs. This shortage is a long-standing problem and has hampered everyone involved in VADPC.

- Nutrition education

Even though there is a positive working relationship between VITAP and the DOH, the DOH is limited in its efforts to effectively promote vitamin A. In general, the DOH has been limited in going beyond very old-fashioned concepts and methods of 'nutrition education'. There are specific staff members, e.g., the BHWs and BNS, who have 'nutrition education' as a major responsibility and who say that they are actively engaged in this with mothers. However, the DOH is putting a lot of time into methods which do not work and with or without formal or informal evaluation of these methods, is not taking any major steps to try to improve them. However, the DOH's on-going collaboration with the Nutrition Center of the Philippines could provide a channel for more innovative nutrition education materials and methods to become available to the DOH.

- Local RHU staff

The midwives who are usually in charge of an RHU are overburdened with all of the concerns of providing health services and managing the RHU. If they do not understand the full impact of VAD, and its relationship with the other childhood diseases they must treat, they are unlikely to make VADPC a priority. Even if they do appreciate the importance of vitamin A, they may have other, more pressing, tasks to carry out.

- Trends - or fads - in global health priorities

Some health professionals mentioned an earlier program which operated in the Philippines called VADAG (Vitamin A Deficiency, Anemia and Goiter). This program came and went and now the interest in micronutrients has resurfaced with a new name: VAD-IDA-IDD. Some of these professionals wonder how long attention will be focused on this triad before another health priority takes over.

- Devolution

Although the devolution process was indeed a reality at the time of the assessment, it was not clear to most persons interviewed (in the DOH or elsewhere) just how the process would affect them or their program operations. It was even less clear to them if and how they were going to take steps to try to influence the process such that their programs would not suffer in the future, when programs in VADPC will be managed by local government authorities.

This situation complicates the picture for the DOH, HKI and other NGOs involved in health. Its advent requires local advocacy about health issues with all governors and mayors.

- Responsibility for VAC distribution

Even though the incident about a child allegedly dying from a VAC happened in Bicol seven years ago, there is a lingering and pervasive paranoia about VAC. One consequence is a reluctance on the part of the DOH to authorize NGOs to distribute VAC, except in remote geographical areas where the NGOs are providing health services directly. Another consequence is that health staff within RHUs delegate the distribution of VAC to the highest ranking person, e.g., the physician or the nurse, instead of training and involving all staff, especially the midwife, BHWs and BNS.

In addition, some health personnel have a negative attitude about the role which NGOs can play in extending and improving the DOH's health services. For some, this negative attitude stems from their experience participating in the time-consuming and - to them - distracting, tasks associated with the distribution of donated food aid.

- Expanded role of vitamin A in morbidity and mortality

When health workers discuss VAD, they refer to going to look for cases. While this was the strategy for identifying children with nightblindness or more serious signs of xerophthalmia, it is no longer the indicated strategy for VADPC. They need to understand that all children with risk factors are very likely to have sub-clinical cases of VAD and that indeed, many of these children are among the ones whom they see at the clinic every day, suffering from diarrhea, respiratory infections and other common diseases of childhood.

In addition, nightblindness does not attract the attention of mothers the way that a cough or fever might. Health workers need assistance in convincing mothers that nightblindness is serious and that it can be treated.

- Operation Timbang

Operation Timbang was designed as a method for screening the community for undernourished children and thus to serve as a rough surveillance system to gauge the nutritional status of the community and the country over time. Unfortunately, for the most part, its real purpose has deteriorated in the minds of the implementers and it has become solely associated with screening to target the distribution of PL 480 commodities.

Nevertheless, in those areas where Operation Timbang does take place, it is very likely that the children being weighed would have either first, second or third degree malnutrition and therefore be eligible for receiving a VAC on the spot.