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HELEN KELLER INTERNATIONAL

**Vitamin A Expansion Project in 3 Provinces
in the Philippines
Cooperative Agreement No. DAN-5116-A-00-0074-00
Project No. 936-5116**

ANNUAL REPORT
OCTOBER 1990 - SEPTEMBER 1991

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<u>CONTENTS</u>	<u>PAGE NO.</u>
1.0 BACKGROUND	1
2.0 PURPOSE, GOALS AND OBJECTIVES	1
3.0 KEY INTERVENTIONS	3
4.0 MAJOR ACTIVITIES AND INPUTS	3
5.0 MAJOR OUTPUTS	8
6.0 ANALYSIS OF PROGRAM OUTPUTS <i>(Major Indicators of Program Effectiveness and Progress)</i>	9
7.0 PROBLEMS AND CONSTRAINTS	11
8.0 MONITORING AND EVALUATION	12
9.0 HUMAN RESOURCES <i>(Project Organizational Structure)</i>	21
10.0 REVISED ANNUAL IMPLEMENTATION PLAN TIMELINE	22
11.0 FINANCIAL REPORT	
12.0 PROJECT DOCUMENTS	

**"EXPANSION OF VITAMIN A SUPPLEMENTATION AND
NUTRITION EDUCATION INTERVENTIONS TO THREE
PROVINCES IN THE PHILIPPINES"
(VITEX PROJECT)**

**FIRST ANNUAL REPORT
OCTOBER 1990 - SEPTEMBER 1991**

Cooperative Agreement No. : DAN-5116-A-00-0074-00

• **BACKGROUND**

In the Philippines, AID support to HKI helped catalyze a Department of Health (DOH) policy on vitamin A Supplementation, the development and approval of a National 5-Year Directional Plan for the Prevention and Control of VAD, and the testing of a delivery system for VAC distribution and nutrition education. Based on lessons learned through joint DOH-HKI pilot projects, the DOH is intensifying and expanding vitamin A services to new provinces and regions. This is being done within the context of the DOH's major thrusts of integrating health services for mothers and children, decentralizing program planning and health service management and promoting child survival.

This 3 year (1990-1993) project provides technical assistance to 3 provinces (*Quezon, Northern Samar & Zamboanga Sur*). These provinces were selected to represent different ethnic and geographic settings. These are priority provinces based on child survival and DOH indicators. HKI will assist in the development of intervention models 1.) vit. A supplementation to xerophthalmic and high-risk children, and post-partum mothers 2.) nutrition education to promote dietary practices among mothers of weaning age infants. To measure the extent to which the models are effective, the project will measure pre-post levels of xerophthalmia prevalence, VAC coverage and consumption vitamin A rich foods.

• **PURPOSE, GOALS AND OBJECTIVES**

Purpose

The overall purpose of the project is to provide technical assistance to the Philippine Department of Health to expand its vitamin A program and to strengthen its capability to plan and execute services aimed at reducing VAD in the context of integrated health services for child survival.

- ❖ To develop, test, produce and distribute a package of communications materials for health workers, teachers and mothers to promote increased consumption of foods containing vitamin A among families of malnourished children and infants.
- ❖ To conduct 3 special monitoring studies (1 per province) to assess VAC coverage, VAC supply, distribution of nutrition education materials, and exposure to nutrition education messages.
- ❖ To conduct 3 post-intervention studies (1 per province) to determine changes in xerophthalmia prevalence, vitamin A supplementation coverage, key food behaviors and the capacity of the health service with respect to VAD prevention and control.
- ❖ To convene 6 technical advisory group meetings with senior level DOH personnel to review project progress and assess project results for national policy implications.

❖ **KEY INTERVENTIONS**

Vitamin A Supplementation

This intervention aims to provide vitamin A supplementation to xerophthalmic and high risk children, as well as post-partum mothers.

Nutrition Education

This intervention aims to promote increased consumption of foods containing vitamin A in the context of overall nutrition among risk groups for VAD. The primary targets will be mothers of infants and preschoolers, as well as pregnant and lactating mothers. The secondary targets will be community members such as village elders, health professionals and local teachers who help shape food behavior in the community.

❖ **MAJOR ACTIVITIES AND INPUTS** : Oct. 1990 - Sept. 1991

Activity 1

Developed and submitted to USAID the Detailed Implementation Plan and Project Design.

Inputs

- ☛ HKI conducted a series of consultative meetings with key DOH managers and nutrition experts in the development of project design to conform with DOH overall nutrition and child survival program.
- ☛ Identified 3 expansion provinces considered part of DOH's priority provinces. This represents a change from the 5 provinces originally proposed as project sites.
- ☛ HKI sponsored a consultative workshop to review the DOH supplementation strategy and policy. The workshop resulted in the following recommendations:
 - a. change the age group for VAC supplementation from 6-83 months to 6-59 months to facilitate integration of VAC supplementation with other DOH services targetting children under 5 years of age.
 - b. include mildly malnourished children (1st degree) as targets for VAC supplementation, with the existing target groups (2nd and 3rd degree malnourished, recent measles, lower respiratory tract infection and chronic diarrhea cases).
 - c. incorporating a nutrition education section in the Implementing Guidelines.

These recommendations were presented to the DOH Program Directors for discussion, and approved for policy implementation.

Activity 2

Formed the Vitamin A Technical Advisory Group (TAG)

Inputs

- ☛ The official members of the TAG are as follows:

Chairman	:	Dr. Manuel Roxas	-	Undersecretary for Public Health Services
DOH Members:		Mrs. Adelisa Ramos	-	Director, NS
		Dr. Linda Milan	-	Director, Foreign Assistance Coordination Services
		Mrs. Cresencia Cruz	-	Asst. Secretary for Financial Operations
Other Member:				
Agencies:		Dr. Florentino Solon	-	Exec. Director, NCP
		Dr. Ian Darnton-Hill	-	Regional Advisor in Nutrition, WHO
		Ms. Bituin Gonzales	-	Prog. & Planning Officer, UNICEF
		Mr. Rolf D.W. Klemm	-	Country Director, HKI

Activity 4

Formed Regional and Provincial Task Forces

Inputs

- ☛ HKI conducted field visits to each of the project areas to brief the provincial technical staff on the project, conduct preliminary assessment of the status of vitamin A activities and health personnel capabilities with respect to vitamin A skills. During the field visits, members of the Provincial Vitamin A Task Forces were identified.
- ☛ HKI participated in the DOH Area - Program Based Planning Workshops and conducted an orientation of vitamin A project among provincial health implementors in each province.
- ☛ HKI sponsored a 1-day consultative conference with Regional and Provincial Health Officers of the 3 expansion provinces, to review and finalize the Memo of Agreement between DOH-HKI. Memo of Agreement specifies the roles and responsibilities of each agency at different levels.

Activity 5

Developed Research Design and Provincial Operational Plan.

Inputs

- ☛ HKI sponsored a 3-day live-in planning workshop in April on the Development of Alternative Delivery Strategies for VAC Supplementation and Nutrition Education interventions. The research design, in which the project will investigate the effectiveness of these strategies was also formulated. Participants included members of the Vitamin A Provincial Task Forces from the three (3) expansion areas and key members of the DOH. Nutrition Service staff headed by Mrs. Adelisa C. Ramos.
- ☛ HKI hired Ophelia Mendoza, DrPH as project consultant to provide guidance and direction in the development of the research design protocol.

Activity 6

Conducted three pre-intervention studies in the form of rapid assessment (1 per province) to determine xerophthalmia prevalence, vitamin A supplementation coverage, key food behaviors and the capacity of the health service with respect to VAD prevention and control.

Inputs

- ☞ HKI with DOH developed the pre-assessment protocol (sampling design, data collection tools, etc.).
- ☞ Trained 15 physicians and 18 interviewers who composed the survey team in the three provinces.
- ☞ Provided VAC supplementation to identified xerophthalmia and high-risk preschoolers.
- ☞ Provided logistics in the conduct of the 3-month survey in the three provinces (*Quezon, N. Samar & Zamboanga Sur*).

Activity 7

Developed the Protocol for the Formative Research to assess food practices and beliefs regarding infant and child feeding, source of advice and other information from primary and secondary targets.

Inputs

- ☞ HKI hired Dr. Karen Castaneda, a nutritional anthropologist as a consultant for a study on weaning practices and beliefs. She provided principal guidance in the development of the research protocol and served as trainer in the conduct of in-depth interviews and focus group discussion.
- ☞ Trained DOH counterparts in the conduct of in-depth interviews and focus group discussion.

Activity 8

Revised the Trainer's Manual and Training Curriculum for the Provincial Training Team/Supervisors and for the Field Implementors.

Inputs

- ☛ HKI sponsored a Training of Trainers (TOT) for DOH and HKI staff involved with planning and implementing Vitamin A Deficiency. This workshop was facilitated by **Ms. Kirsten Laursen**, HKI/NY Deputy Director for Training. The technical inputs gained from the TOT refocused the design and approach of the training curriculum which is more experiential in approach and based on the principles of adult learning.

Activity 9

Developed the Project Monitoring and Evaluation System.

Inputs

- ☛ HKI developed a Manual of Instructions in the conduct of the Routine/Monthly Monitoring of the project to determine project accomplishment, problems with quantitative and qualitative data. (Details are discussed in the monitoring and Evaluation Chapter)

MAJOR OUTPUTS

1. Developed the Project Detailed Implementation Plan and Project Design.
2. Revised DOH Vitamin A Supplementation Policy.
3. Formed and organized the Vitamin A Technical Advisory Group (TAG).
4. Sponsored two (2) Quarterly Consultative Meetings of the TAG.
5. Hired five (fulltime) project staff to provide technical support to each provinces.
6. Hired and contracted project consultants.
7. Formed the Regional and Provincial Task Forces who will play a major role in the implementation of project activities in the provinces.
8. Signed Project Memorandum of Agreement between HKI and DOH.

9. Developed the Research Design and Protocol in the three expansion areas.
10. Completed three pre-intervention surveys (1 each per province). A total of 11,403 preschoolers were examined and 6,106 mothers were interviewed. (Details of the Baseline Survey report is discussed in Monitoring and Evaluation section)
11. Developed the Formative Research Protocol to assess weaning food behaviors and practices.
12. Completed data collection on formative research in one province (Quezon Province).
13. Developed the Monitoring and Evaluation System of the VITEX Project.

➤ **ANALYSIS OF PROGRAM OUTPUTS** (Major Indicators of Program Effectiveness and Progress)

Year 1 of the project represents the developmental phase. As a result of the groundwork initiated by HKI in the development of the DIP, the project has laid a strong foundation for the implementation phase.

Even with the slow start-up of the project the major activities set in year 1 have been attained. Moreover, in addition to developing the implementation capacity in the project province, HKI's efforts have impacted upon the National Vitamin A Program implementation in terms of supplementation policy revisions, a review of the national procurement scheme and the use of training methodologies.

- ↳ **Formation of Vitamin A Technical Advisory Group** (TAG): HKI formed a TAG composed of key DOH program directors to guide project implementation and promote utilization of project findings. The TAG includes the directors of the MCH, Health Education and Nutrition Services. The TAG will widen its representation to include UNICEF, an MSH Child Survival Team member, and the Nutrition Center of the Philippines (NCP). The purpose of such broad representation is to promote vitamin A's importance beyond the traditional nutrition sector, and promote wider donor support and coordination.

- Change in DOH Vitamin A Supplementation Policy due to lessons learned from the DOH-HKI vitamin A pilot projects and recent findings on vitamin A research studies worldwide. DOH Supplementation Policy was revised to include all under nourished children (based on weight for age) as targets for semi-annual VAC distribution. Hence, the project has incorporated this in the over-all project framework.
- Formation and Establishment of the Project Management Structure.

With the DOH current thrust of decentralization and integration, the project's strategy has focused its technical assistance at the provincial level to strengthen provincial capability in planning and implementing Vitamin A Program. HKI has developed a management structures which enables it to give appropriate and pro-active assistance through the following processes and mechanisms:

- ✎ Formation of vitamin A Task Forces in the Provinces.
- ✎ Designation of counterparts at the Nutrition Service Central Office to provide support to the Regional and Provincial Task Force.
- ✎ Definition of roles and responsibilities at each level.
- ✎ Hiring of HKI area coordinators based in each project area.
- ✎ Provision of HKI/Manila Financial and Administrative oversight through periodic on-site reviews.

- Selection of the three expansion provinces, namely: **Quezon, Northern Samar and Zamboanga Sur.**

These provinces were selected to represent different ethnic and geographic settings, which provide an opportunity to develop different provincial models for expanding and strengthening VAC supplementation and nutrition education.

Moreover, these provinces were selected based on child survival and DOH indicators, wherein other resources are tapped together with HKI input to result in greater impact.

- Completion of the Pre-Intervention Surveys in each province.

- Involvement of DOH counterparts in the conduct of the survey from Central Office.
- Involvement of DOH provincial level technical staff in the supervision and conduct of the survey. By involving local DOH staff, HKI has produced a cadre of local experts in VAD who serve as catalyst for program awareness and DOH program ownership.
- Preliminary results indicate a significant level of xerophthalmia in each of the 3 provinces (see results in appendix).
- A very low VAC coverage rate was revealed in the three provinces.

• PROBLEMS AND CONSTRAINTS

Problems were encountered during the first project year and resulted in changes in the implementation plan. A revised implementation plan is included in the appendix. The problems and their consequences on project implementation are as follows:

1. From September 1990 - October 1991, the DOH underwent a planning process to develop a comprehensive Nutrition Plan (CNP). In order to conform with the plan, HKI delayed finalizing the Detailed Implementation Plan (DIP) until the Nutrition Service developed a draft framework for its CNP.
2. DOH bureaucratic and budgetary constraints are posing substantial difficulties in obtaining VAC in a timely fashion for vitamin A program expansion provinces. HKI has helped facilitate coordination between UNICEF and the DOH's Nutrition Service to ensure a steady supply for HKI assisted provinces. HKI, however, is considering assisting the DOH to reassess its overall micronutrient procurement process to systematize what now appears to be an inconsistent and unpredictable procurement process.
3. Inability to recruit suitable candidate for Communications Program Manager position delayed the development of the nutrition education intervention.

4. Rains, insurgency and unpassable roads limited and/or slowed access to some of the baseline survey villages. Suitable alternatives were selected without affecting the reliability and representativeness of sampled villages.
5. Lack of available transport either promised by the local DOH or for hire has slowed the data collection during the baseline survey. HKI made provisions to hire private transport to overcome this problem.

➤ **MONITORING AND EVALUATION**

To monitor and evaluate the implementation, the project planned the conduct of Pre-Post Intervention Surveys, Formative Communications Research, a Health Service Provider Survey, Special Monitoring Studies and Routine Reporting. During year 1 of the grant the following monitoring and evaluation activities were undertaken and completed:

Preliminary Assessment Survey among Health Personnel in the three Project Provinces.

The survey assessed the levels of knowledge and skills of health personnel on Vitamin A Deficiency, Detection and Management. A total of 173 health personnel answered the self-administered questionnaire.

Preliminary findings indicated were as follows:

- In Zamboanga Sur, about 50% personnel had received previous training in VAD. On the whole, knowledge levels were high. Specific weak areas, however, included clinical signs of xerophthalmia and appropriate doses and supplementation schedule for xerophthalmic and high risk children.
- In Samar, a majority of the personnel have not been trained on VAD. In Quezon, 100% of the personnel have been trained. However, weak implementation of VAC supplementation was noted by provincial supervisors due to fears among health personnel in giving the high dose VAC because of its suspected toxicity.

- VAC (200,000 IU) available at the Provincial Health Office and in some Rural Health Units, however, the presence of other vitamin A supplement preparations of different dosages at the field units add to the confusion in appropriate dose and supplementation schedule of the targets.
- Anecdotal evidence suggesting a serious VAD problem in the three provinces was strong. A Local term for XN ("halap-halap") existed, RHP and PHNs reported having seen XN, XIB and X2/X3 in past six months. Low measles coverage and measles outbreak reported in interior districts hard to reach municipalities. The nutritionists report low consumption of foods containing vitamin A among children, late introduction of nutritious weaning foods and food shortages in certain areas.
- Very limited IECs for nutrition available.
- Many health personnel received a copy of the DOH vitamin A guidelines, however, there is still a fair number (mostly new personnel) who have not been provided with copies.

Three Pre-Intervention Surveys (1 in each province) were completed

I. Objectives of the Baseline Survey are:

To determine: xerophthalmia prevalence
 vitamin A supplementation coverage
 KAP of mothers key food behaviors
 capacity of the health service with respect to VAD prevention and control

II. Methods

- Kind of survey: Pre-Post intervention cross-sectional survey design

- Study Subjects and Form of Assessment

Preschoolers	-	Nutritional status/
(6 mos. - 83 mos.)	-	clinical assessment
Mothers of Preschoolers	-	Interview schedule
Rural Health Midwives	-	Interview schedule
Barangay Health Workers	-	Interview schedule

■ Survey Sample Size

Table 1. Summary of Survey Sample Size for the Three Province

Province	Total No. of Municipalities	Sampled Municipalities	Sampled Bgys.	No. of Target PS	No. of Target RHMs	No. of Target BHWs
Quezon	40	20	40	3220	40	80
N. Samar	24	15	36	3205	36	72
Zamboanga Sur	40	21	42	3215	42	80
TOTAL	104	56	118	9640	118	236

■ Treatment Groups - Each province was divided into four treatment groups

- Treatment 1** OPT with team approach and Nutrition Education classes
- Treatment 2** OPT with team approach and distribution of IEC materials
- Treatment 3** OPT with team approach and distribution of IEC materials and strengthened mother's classes
- Control** Existing OPT and Existing Nutrition Education classes

■ Data Variables

Preschooler

- ☛ Nutritional status
- ☛ Presence/absence of Xerophthalmia (i.e., nightblindness, Bitot's spot, Corneal Ulcer, Corneal Scar)

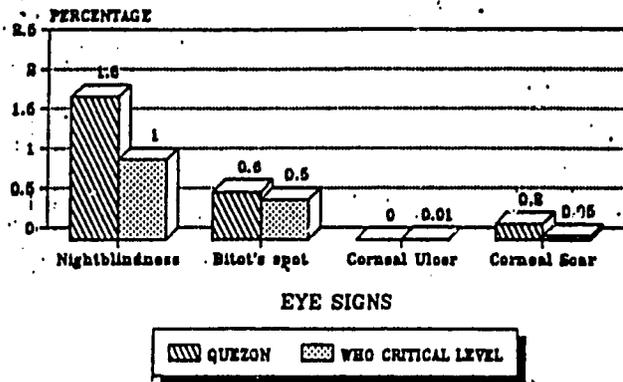
Mother of preschooler

- ☛ General characteristics
- ☛ Contact with health worker
- ☛ Knowledge on Vitamin A
- ☛ Mother's perception of Mother's class
- ☛ Mother's perception to OPT
- ☛ VAC coverage
- ☛ Breastfeeding practices
- ☛ Weaning practices
 - foods given to weaning children
 - frequency of giving them
 - foods added to lugaw

RHM/BHW

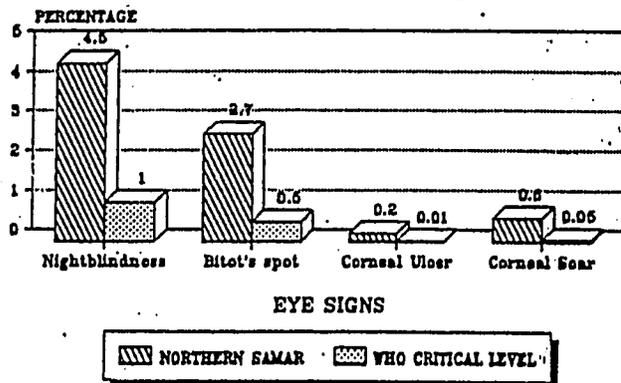
- ☛ General Information
 - ☛ Current activities of RHM
 - ☛ OPT activities
 - ☛ Nutrition education activities (conduct)
 - ☛ Health and Nutrition education (content)
 - ☛ RHM/BHW trainings
 - ☛ RHM-BHW interaction
 - ☛ VAC supplementation
- Composition of Survey Teams: 1 DOH Physician
3 Interviewers
Provincial Task Force Members
Area Coordinator
- Survey Work Flow
- Station 1 Registration of Mothers
 - Station 2 Weighing of children/determination of nutritional status
 - Station 3 Mother's Interview
 - Station 4 Clinical assessment of eye signs

**XEROPHTHALMIA PREVALENCE RATE
IN QUEZON PROVINCE COMPARED WITH
WHO CRITICAL LEVELS**



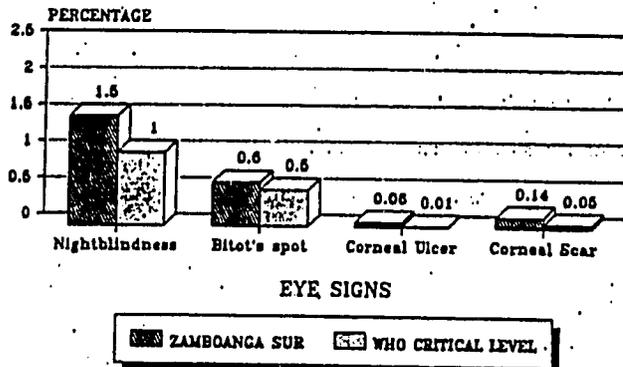
BASELINE SURVEY, 1991

**XEROPHTHALMIA PREVALENCE RATE
IN NORTHERN SAMAR PROVINCE COMPARED
WITH WHO CRITICAL LEVELS**



BASELINE SURVEY, 1991

**XEROPHTHALMIA PREVALENCE RATE
IN ZAMBOANGA SUR. PROVINCE COMPARED WITH
WHO CRITICAL LEVELS**



Baseline Survey, 1991 (Based on data submitted by Area Coordinator)

Formative Research on Weaning Practice
Highlights of the Study Design

WEANING PRACTICE STUDY

Purpose:

To develop appropriate nutrition education strategy (message and communications strategy) to promote improved weaning practices in the project area.

Objectives:

- ↳ To develop an in-depth understanding of current weaning practices and the factors which shape those practices (e.g. food availability, beliefs, food preferences, sources of advice).
- ↳ To determine what conditions need to exist in order for mothers to adopt recommended weaning practices.
- ↳ To determine factors affecting the participation of mothers in mothers classes.
- ↳ To determine the factors affecting the ability of midwives and BHWs to conduct mothers classes, distribute materials to mothers and follow up mothers practices in the home.

Respondent Groups

- ↳ Mothers or caretakers with children between 0-24 months (who are malnourished)
- ↳ Health Workers (Physicians, Nurses, Midwives, BHWs)
- ↳ Others (Hilots, Village elders, etc.)

Methods:

- ↳ In-depth interviews
- ↳ Focus group discussions
- ↳ Observation of actual infant feedings
- ↳ Simple market survey (list available foods and costs)

Survey Sites

A minimum of 3 villages per province purposefully selected in areas where malnutrition among young children is a problem.

Data Collection Tools Needed

- ✎ In-depth Interview Guide (Mothers, Barangay Health Workers and Hilots)
- ✎ Focus Group Discussion Guide
- ✎ Market Survey Checklist

Survey Team Composition

- ✎ Provincial Health Educator
- ✎ Area Coordinator

Variables

A. Mothers of children 0-24 months

- ✦ General Demographic Information
- ✦ Perception of Health
- ✦ Feeding Practices
- ✦ Weaning Practices
- ✦ Perceptions of Foods for Young Children
- ✦ Receptivity to Proposed Weaning Practices
- ✦ Functions of Food
- ✦ Sources of Vegetables and Fruits
- ✦ Vitamins: Awareness and Knowledge
- ✦ Mothers Decision Making Authority
- ✦ Sources of Advice and their Credibility
- ✦ BHW Contact and Credibility
- ✦ Participation in Nutrition Education Activities
- ✦ Leisure and Media Habits
- ✦ Psychographic Profile

B. Health Workers

- ✦ General Demographic Information
- ✦ Perceptions of Foods for Young Children
- ✦ Receptivity to Proposed Weaning Practices
- ✦ Conduct of Nutrition Education Activities
- ✦ Perception of Nutrition Education Activities

C. Hilots and Others

- ✦ General Demographic Information
- ✦ Perception of Health
- ✦ Perceptions of Foods for Young Children
- ✦ Receptivity to Proposed Weaning Practices
- ✦ Sources of Advice and their Credibility
- ✦ Mother Contact and Credibility
- ✦ Participation in DOH Health Services

D. Market Survey

- ◆ Food Availability
- ◆ Food Cost

Routine Monitoring

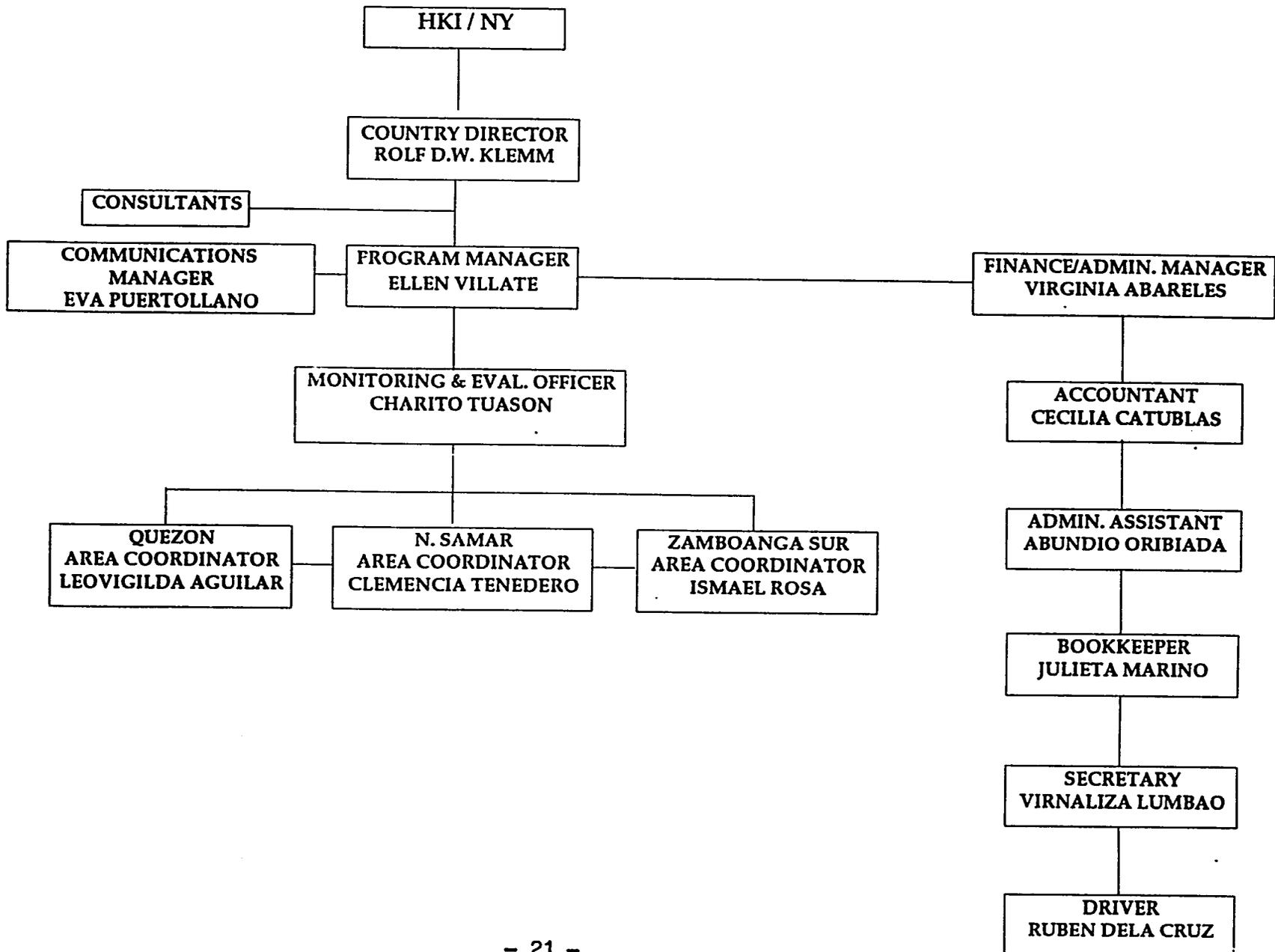
On-going monitoring and documentation of project activities has been integrated into the project management structure from the beginning of the project. This has been accomplished through regular submission of Project Monthly and Quarterly Accomplishment Reports from the field to HKI/Manila to HKI/New York.

A Project Monitoring and Evaluation Manual was developed to ensure that all activities of the project are done according to plan. The manual includes objectives, monitoring and evaluation indicators, project monitoring scheme, use of routine monitoring forms from DOH and HKI report forms.

To track the project progress in the field, the project uses the existing DOH Field Health Services Information System (FHSIS) forms. However, the project recommended to DOH a Quarterly Vitamin A Status Report. This form would include the consolidated monthly accomplishment or coverage of front-line health workers of those given Vitamin A Capsules and mothers who have heard the Nutrition Education messages. The format is being revised by the DOH and finalized for approval by the Nutrition Service, DOH.

9.0 HUMAN RESOURCES

**HKI / PHILIPPINES
ORGANIZATIONAL STRUCTURE**



10.0 Revised Annual Project Implementation Plan Timeline (Year 2)

ACTIVITIES	Y E A R 2												OUTPUT INDICATORS
	1	9	1			1	9	9	2				
	O	N	D	J	F	M	A	M	J	J	A	S	
PREPARATION OF OPRT'L. PLAN	✓	✓											Operational Plan developed
TRAININGS & REORIENTATION TRAININGS													Trainings at all level completed
* Preparation and production of training materials	✓	✓	✓										
* Trainor's training (Provincial level)		✓											
* Preparation for implementors training													
a. Social Preparation	✓	✓	✓										
b. Preparation of training materials	✓	✓	✓										
* District and Municipal Trainings (Supervisors, District RHPs & PHNs)		✓	✓	✓	✓								
* Barangay Trainings (Field Implementors, RHMs)			✓	✓	✓								
* Community (BHWs)				✓	✓	✓							
* Orientation/Workshops with other GOs and NGOs							✓	✓					
* Orientation Trainings on NE Campaign							✓	✓					
DISTRIBUTION OF VAC													VAC distributed
* Identification of target group				✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Requisition of VAC & IEC materials				✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Distribution of VAC & IEC materials				✓	✓	✓	✓	✓	✓	✓	✓	✓	
NUTRITION EDUCATION CAMPAIGN													Nutrition Education campaign launched
* Launching and airing of radio spots							✓	✓	✓	✓	✓	✓	
* Individual dietary counselling					✓	✓	✓	✓	✓	✓	✓	✓	
* Group counselling through mothers classes					✓	✓	✓	✓	✓	✓	✓	✓	
MONITORING & SUPERVISION ACTIVITIES													Monitoring activities on-going regularly
* Supervisory visits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Collection of monitoring data (accomplishments)				✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Data review / processing				✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Data analysis and interpretation				✓	✓	✓	✓	✓	✓	✓	✓	✓	
* Regular meetings and status reporting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

ACTIVITIES	YEAR 2												OUTPUT INDICATORS	
	1991			1992										
	O	N	D	J	F	M	A	M	J	J	A	S		
CONSULTATIVE CONFERENCES/ PROGRAM REVIEW				✓					✓				✓	Consultative conferences conducted
EVALUATION ACTIVITIES														
* Baseline Survey														
a. Data organization and encoding	✓	✓	✓	✓	✓	✓								
b. Statistical runs			✓	✓	✓	✓								
c. Data analysis and interpretation			✓	✓	✓	✓								
d. Partial/preliminary report						✓								
e. Write-up (Writesops)						✓								
f. Preparation of data for presentation						✓								
* Weaning Study														
a. Complete data collection in two provinces	✓													
b. Collation of findings		✓	✓											
c. Analysis and interpretation				✓	✓									
d. Dev't. of Communication Plan					✓	✓								
e. Prep. of Prototype Materials and Pretesting					✓	✓								
f. Production of materials						✓								
* Midterm Assessment														
a. Dev't. of tools and protocol for mid-term assessment									✓					
b. Data collection										✓	✓			
c. Data processing										✓	✓	✓		
d. Data analysis and interpretation										✓	✓	✓		
DOCUMENTATION	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Progress reports updated

LIST OF DOCUMENTS

1. **VITEX Detailed Implementation Plan**
2. **Revised DOH Policy on Vitamin A Supplementation**
3. **Dept. Order for Vitamin A Technical Advisory Group**
4. **Minutes of the TAG Meeting (2)**
5. **Signed Memorandum of Agreement (including Dept. Orders for Task Force Members)**
6. **Tools Used in Preliminary Assessment of Health Personnel**
7. **Baseline Survey Protocol (Research Design)**
8. **Formative Research Protocol (Manual of Instruction)**
9. **Monitoring and Evaluation Manual of Instruction**
10. **Quarterly Reports for Year 1 (3 Report)**
11. **Job Descriptions & Resumes of Project Staff & Consultant**
12. **Other Documents Available:**
 - ⇒ **Training of Trainers Reports by Ms. Kirsten Laursen**
 - ⇒ **HKI Staff Development Workshop Proceedings**

VITEX Detailed Implementation Plan

HELEN KELLER INTERNATIONAL, PHILIPPINES

DETAILED IMPLEMENTATION PLAN

EXPANSION OF VITAMIN A SUPPLEMENTATION AND
NUTRITION EDUCATION INTERVENTIONS
TO THREE PROVINCES IN THE PHILIPPINES

COOPERATIVE AGREEMENT NO. DAN-5116-A-00-0074-00

SUBMITTED TO: The Office of Nutrition
 Bureau of Science and Technology
 AID, Washington, D.C.
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JANUARY 31, 1991

26

DETAILED IMPLEMENTATION PLAN
HKI/PHILIPPINES

<u>TABLE OF CONTENTS</u>	<u>PAGE NO.</u>
I. BACKGROUND..... THE PROBLEM	1
II. LOCATION AND DURATION.....	2
III. PURPOSE, GOALS AND OBJECTIVES.....	3
IV. MAJOR OUTPUTS.....	5
V. TARGET POPULATION..... TOTAL TARGET NUMBER TARGET FOR VITAMIN A SUPPLEMENTATION TARGET FOR NUTRITION EDUCATION	6
VI. KEY INTERVENTIONS..... VITAMIN A SUPPLEMENTATION NUTRITION EDUCATION	7
VII. MONITORING AND EVALUATION..... EVALUATION DESIGN MONITORING DESIGN. OTHER STUDIES MONITORING AND EVALUATION INDICATORS	9
VIII. PROJECT FRAMEWORK..... INPUTS PROCESS OUTPUTS OUTCOME	13
IX. IMPLEMENTATION PLAN..... DESCRIPTION OF ACTIVITIES TIMELINE	15
X. HUMAN RESOURCES..... ORGANIZATIONAL STRUCTURE KEY POSITIONS CONSULTANTS	22
XI. BUDGET.....	26

APPENDICES

**MAP OF PROJECT AREAS
LIST OF DOH CHILD SURVIVAL PROVINCES**

ABBREVIATIONS

AID	Agency for International Development
BHWS	Barangay Health Workers
DOH	Department of Health
HKI	Helen Keller International
VAC	Vitamin A Capsule
VAD	Vitamin A Deficiency

28

I. BACKGROUND

Section 1.1 THE PROBLEM

Vitamin A deficiency (VAD) has long been known to be the primary cause of preventable blindness among children in the Philippines. Rates of xerophthalmia, a severe form of VAD, have exceeded WHO critical levels in nutritionally depressed provinces for more than a decade. Until recently, VAD generated little public health concern, except among blindness prevention agencies. Recent research findings, however, link VAD directly and dramatically to child survival. The general conclusion of the XIII International Vitamin A Consultative Group (IVACG) meeting in Nepal (5-19 November, 1989) suggested that repleting vitamin A stores in deficient populations effectively reduces mortality.

Increased vitamin A intake plays a crucial role in a child's capacity to resist respiratory, urinary and intestinal infections. In the Philippines, these infections are responsible for the greatest disease load in children and are major causes of infant and child death. These findings signal vitamin A's much broader relevance and urgency for public health and nutrition programs. The new findings clearly point the need for the Department of Health to become more aware of vitamin A deficiency and the linkage to child mortality, and, more importantly, to aggressively integrate vitamin A interventions into its on-going health services.

Globally, AID has been credited with recognizing and supporting the expansion and integration of vitamin A services into existing health programs. In the Philippines, AID support to HKI helped catalyze a DOH policy on vitamin A supplementation, the development and approval of a National VAD Prevention and Control Directional Plan, and the testing of a delivery system for VAC distribution and nutrition education. With these in place, the next step is to execute and intensify vitamin A interventions in a larger number of provinces and geographic settings.

This project provides an excellent opportunity to enhance DOH program momentum through expanding and strengthening vitamin A interventions in additional provinces.

The DOH is currently undergoing a process to integrate key health services for mothers and children aimed to promote survival of children beyond 5 years of age. The prevention and control of VAD through supplementation and nutrition education constitute key nutritional interventions towards this end.

The DOH is also engaging in a decentralized area-based planning process to strengthen provincial management of its health services. This is a significant departure from its former centralized planning and execution mode. As such, technical assistance at the provincial level is needed for the development of local planning, implementation and management models and skills. This project targets DOH priority provinces as its locus for developing and strengthening VAD assessment, planning and implementation skills and systems.

In summary, the project aims to develop provincial models for expanding and strengthening VAC supplementation and nutrition education within the context of integrated health services for mothers and children.

II. LOCATION AND DURATION

Section 2.1 LOCATION

The project will take place in three provinces spanning the major geographical divisions of the country. They are Zamboanga del Sur located in Mindanao, Northern Samar located in the Eastern Visayas, and Quezon Province located on the main island of Luzon. These provinces were selected in consultation with the DOH on the basis of the following criteria. They:

1. Constitute areas of greatest need based on child survival and DOH indicators.
2. Have high rates of malnutrition.
3. Have been targetted by the Nutrition Service of the DOH as priority provinces for vitamin A program expansion.
4. Have known or probable serious vitamin A deficiency.
5. Lack an intensive vitamin A supplementation and nutrition education program.
6. Provide an opportunity for models developed under HKI's previous CSII grant to be adapted to very different ethnic and geographic settings.

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Section 2.2 DURATION

The project duration will be three-years, beginning October 1, 1990 and ending September 30, 1993.

III. PURPOSE, GOALS AND OBJECTIVES

Section 3.1 PURPOSE

The overall purpose of the project is to provide technical assistance to the Philippine Department of Health to expand its vitamin A program and to strengthen its capability to plan and execute services aimed at reducing VAD in the context of integrated health services for child survival.

Section 3.2 GOALS

1. To reduce vitamin A deficiency and its associated ocular manifestations, morbidity and mortality in the three project provinces.
2. To increase the proportion of high risk groups receiving a VAC to 60% in the past six months.
3. To increase the mean frequency of consumption of foods containing vitamin A among pregnant and lactating mothers, and children 6-59 months of age.
4. To increase the effectiveness of DOH personnel to plan, implement and manage a VAC supplementation intervention within the 3 project provinces.
5. To increase the effectiveness of DOH personnel to plan, implement and manage nutrition education interventions aimed at promoting change in essential feeding practices related to VAD in the 3 project provinces.

Section 3.3 OBJECTIVES

1. To conduct 3 pre-intervention studies in the form of rapid assessments (1 per province) to determine xerophthalmia prevalence, vitamin A supplementation coverage, key food behaviors and the capacity of the health service with respect to VAD prevention and control.

2. To develop 3 area-based VAD prevention and control plans (1 per province) for the implementation of vitamin A supplementation and nutrition education interventions in each of the 3 project provinces.
3. To develop 4 vitamin A training programs, one each for DOH supervisory staff, DOH field implementers, community volunteers and school teachers.
4. To develop 3 provincial level vitamin A communications strategies (1 per province) to promote VAC coverage and increased consumption of foods containing vitamin A among target groups.
5. To develop, test, produce and distribute a package of communications materials package for health workers, teachers and mothers to promote increased consumption of foods containing vitamin A among families of malnourished children and infants.
6. To conduct 3 special monitoring studies (1 per province) to assess VAC coverage, VAC supply, distribution of nutrition education materials, and exposure to nutrition education messages.
7. To conduct 3 post-intervention studies (1 per province) to determine changes in xerophthalmia prevalence, vitamin A supplementation coverage, key food behaviors and the capacity of the health service with respect to VAD prevention and control.
8. To convene 6 technical advisory group meetings with senior level DOH personnel to review project progress and assess project results for national policy implications.

These objectives reflect HKI's role as a technical assistance agency. While not being a direct service provider, HKI's efforts aim to improve and expand the vitamin A services delivered through the DOH system. As such, HKI's ultimate aim is to develop a model to increase VAC coverage and consumption of vitamin A rich foods among the risk groups in the project provinces. To measure the extent to which the model is effective, the project will measure pre-post intervention xerophthalmia prevalence, VAC coverage and vitamin A-rich food consumption among risk groups.

IV. MAJOR OUTPUTS

YEAR ONE:

- | | |
|---|--------------------|
| 1. Formation of the following committees: | |
| Advisory Group | 1 |
| Provincial Task Forces | 3 |
| 2. Operational Planning Workshops | 3 |
| 3. Orientation Seminars | 3 |
| 4. Pre-intervention rapid assessments of xerophthalmia, VAC coverage, feeding practices and health service capability | 3 |
| 5. Development and Printing of Training Package | |
| 5.1 Training Team Organized | 1 |
| 5.2 Training curriculum for field supervisors | 1 |
| 5.3 Training curriculum for field implementers | 1 |
| 5.4 Training curriculum for school teachers | 1 |
| 6. Development and Printing of Nutrition Education Campaign Materials (eg. radio spots, comics and posters) | 1 set per province |

YEAR TWO

- | | |
|---|-------------|
| 1. Operational planning workshops | 3 |
| 2. Training of health personnel, field supervisors and field implementers. | 1,100 |
| 3. Training of selected school teachers, and other GO and NGO representatives | 1,000 |
| 4. Dissemination of communication materials | |
| Radio spots | 3 per prov. |
| Counseling card sets | 1,100 |
| Case detection cards | 1,100 |
| Comics | 300,000 |
| 5. Mid-year Assessment | 1 |
| 6. Special Monitoring Studies | 3 |
| 7. Reorientation Trainings of Health Personnel | 1,100 |

- 8. Consultative Workshops 2
- 9. Workshops with Gos/NGOs 3

YEAR THREE

- 1. Operational Planning Workshops 3
- 2. Consultative Workshops 3
- 3. Completion of Post-Intervention Surveys 3
- 4. Final Evaluation and Documentation 1
- 5. Project Results Presentations 3
- 6. Vitamin A National Conference 1

V. TARGET POPULATION

Section 5.1 TOTAL TARGET NUMBER

In terms of overall numbers, the project estimates to reach and serve approximately 60% of the following with respect to vitamin A supplementation and nutrition education: (Note, there is some overlap among targets with respect to each intervention)

<u>Province</u>	<u>Total Population</u>	<u>FOR SUPPLEMENTATION</u>		<u>FOR NUTRITION</u>
		<u>Underweight 6 mos to 59 mos</u>	<u>Post-Partum Mothers</u>	<u>EDUCATION Females of Reproductive Age</u>
Zamboanga Sur	1,184,000	88,800	35,520	318,000
Norther Samar	378,000	28,350	11,340	100,000
<u>Quezon</u>	<u>1,129,000</u>	<u>84,675</u>	<u>33,870</u>	<u>301,000</u>
Total	2,691,000	201,825	80,730	719,000

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282,555

SECTION 5.2 TARGET GROUPS FOR VITAMIN A SUPPLEMENTATION

Consistent with DOH policy regarding targets for VAC supplementation, the project will assist the provincial health offices to reach and provide vitamin A supplements to:

34

- * Children with Xerophthalmia
- * High risk children (6-59 months) defined as children who are underweight, recently had measles, severe respiratory tract infections or chronic diarrhea.
- * Post-partum mothers in VAD endemic areas.

SECTION 5.2 TARGET GROUPS FOR NUTRITION EDUCATION

The project will target the care takers of children (mostly mothers) and also those who influence the opinions and behavior of these care takers with respect to feeding practices. The project will assist the provincial health offices to develop, implement and evaluate a communication strategy aimed at promoting the increased consumption of foods rich in vitamin A among:

Primary Target:

- Pregnant Mothers
- Lactating Mothers
- Mothers of Infants 0-5 months
- Mothers of children 6-36 months

Secondary Targets:

- Health Workers
- Physicians
- Community Leaders
- Hilots

VI. KEY INTERVENTIONS

HKI will assist each provincial health office to develop, implement and evaluate a VAC distribution intervention and a nutrition education intervention. While complementary, each intervention has separate (although, overlapping) targets and services. As such, each intervention is discussed separately.

It is important to remember that in each of these, HKI will serve as a catalyst and technical advisor, not as a service provider. As such, HKI will assist the provincial DOH technical staff to develop intervention models aimed to promote effective VAC distribution and nutrition education.

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27

Section 6.1 VITAMIN A SUPPLEMENTATION

This intervention aims to provide vitamin A supplementation to xerophthalmic and high risk children, as well as post-partum mothers.

HKI will employ the strategy of "integration" in concert with the DOH's thrust to integrate key health services for mothers and children. This will involve helping the province to identify integration points on three fronts: program, client and health facility. Xerophthalmia detection and VAC distribution to underweight children will be integrated with the yearly child weighing known as Operation Timbang. For children missed by the annual weighing, VAD screening and VAC supplementation will occur as routine adjunct measures in the case management of severe respiratory infections, chronic diarrhea and measles. One-time dosing of post-partum mothers will occur with post-partum home or clinic visits by the midwife or traditional birth attendant.

Building upon previous experience, a social marketing and demand generation strategy will be developed to promote follow-up supplementation for high risk children. This strategy will be based on an assessment of the consumers' perceptions, needs and values related to nutritional supplementation. It is hoped that this strategy will promote greater initiative by the targets and users of supplementation. This strategy will also include approaches to actively engage participation of village health volunteers, school children and local leaders. Materials for village health workers (BHWs), traditional birth attendants (hilots), local teachers and leaders will be developed to raise awareness about vitamin A deficiency and the need for supplementation among underweight children. A scheme to involve school children in VAD detection, referral and sibling follow-up will be explored.

SECTION 6.2 NUTRITION EDUCATION

This intervention aims to promote increased consumption of foods containing vitamin A in the context of overall nutrition among risk groups for VAD. The primary targets will be mothers of infants and preschoolers, as well as pregnant and lactating mothers. The secondary targets will be community members such as village elders, health professionals and local teachers who help shape food behavior in the community.

In collaboration with the DOH, HKI will develop a comprehensive communications program based on a social marketing approach. The project will develop a communication and training package for mothers, health workers and local leaders based on an assessment of their perspectives, practices and needs regarding nutrition and health. Key messages will be developed for dissemination through interpersonal and mass media channels.

VII. MONITORING AND EVALUATION

Section 7.1 EVALUATION DESIGN

1. Pre-Post Intervention Design will be used to compare pre-intervention prevalence of nightblindness and bitot's spots as well as VAC distribution coverage with post-intervention prevalence and coverage.
2. Quasi-Experimental design will be used to assess the effectiveness of the nutrition education intervention. Assignment to intervention groups will be based on residence in the project provinces. The control group will be drawn from a population which is similar to that of persons in the intervention group in terms of socio-economic, educational, age and cultural backgrounds. Pre-Post cross-sectional surveys will be conducted two years apart in both intervention and control areas to determine frequency of consumption of foods containing vitamin A, message exposure and source.

Section 7.2 MONITORING DESIGN

1. Special Monitoring Studies conducted 6 months after the start VAC distribution and nutrition education. These will assess adequacy of intervention implementation. These studies will employ record reviews, clinic visits, and in-depth interviews to cross-check actual distribution of vitamin A doses, assess adequacy of VAC supply, assess health worker skills, determine health worker knowledge of key nutrition messages, check mothers' access and exposure to messages and materials, investigate mothers' recall of messages and mothers' trial of behavior suggested by messages.
2. Routine Monitoring System which consists of the DOH's FSHIS (Field Service Health Information System) records, will be used to determine VAC distribution among 2nd and 3rd degree malnourished children and post-partum mothers.

Section 7.3 OTHER STUDIES

1. Focus group discussions with key informants and mothers of preschoolers will be conducted to determine common child feeding practices, beliefs and knowledge as well as sources to nutrition information. Information from these discussions will be used to refine questions for a cross-sectional survey on feeding practices as well as serve as inputs into the communication strategy.
2. Focus group discussions will also be conducted among school children (grades 1-6) to determine their food preferences, knowledge and attitudes. This information will be used as a basis for teaching materials to be used by the schools in motivating the school child to change his own feeding practices as well as to encourage his parents to alter their feeding practices with respect to preschool siblings in the household.

Section 7.4 MONITORING AND EVALUATION INDICATORS

To measure the degree to which project objectives have been met, performance indicators have been determined. These indicators have been grouped into three tiers. Tier one measures project inputs, tier two measures project outputs, and tier three measures project outcome.

VITAMIN A SUPPLEMENTATION

Tier One (Inputs):

1. 3 provincial planning workshops conducted (1 per province).
2. 3 provincial VAC distribution plans incorporated into all provincial area-based health plans (1 per province).
3. 3 rapid assessments of VAD prevalence, VAC coverage and health worker skills conducted (1 per province).
2. VAC supply procured and delivered in adequate amount and with adequate regularity.
3. VAD trainings conducted for provincial technical staff, hospital and rural health staff, school district nutrition coordinators, hilots and village health workers.

Tier Two (Outputs):

3. VAC supply adequate, available and adequately stored at 80% of health clinics and hospitals.
4. 80% of provincial technical staff, hospital and rural health personnel equipped with the skills needed for their respective functions in vitamin A supplementation.
5. 80% of underweight children participating in OPT given VAC supplements.
6. 60% of underweight children given follow-up VAC dose six months after OPT.
7. 80% of post-partum mothers whose birth was attended by a rural health midwife or trained hilot are given a one-time VAC dose.

Tier Three (Outcome):

1. Prevalence of nightblindness and Bitot's spots decreased by 50%.

NUTRITION EDUCATION

Performance indicators for nutrition education may need to be revised based on the data collected during rapid assessments. Key message formulation as well as access, exposure, knowledge and adoption indicators will be tailored to reflect the communication strategies adopted in each province.

Tier One (Inputs):

1. 3 provincial planning workshops conducted (1 per province).
2. 3 rapid assessments of dietary practices, attitudes and knowledge of mothers conducted (1 per province).
3. 3 provincial communications plan and strategy developed (1 per province).
2. Counselling cards developed and distributed to 100% of health workers in project provinces.

3. Radio spots developed and distributed to 100% of radio stations in project provinces.
4. Trainings conducted on key nutrition messages and messages delivery among 100% hospital and rural health staff.

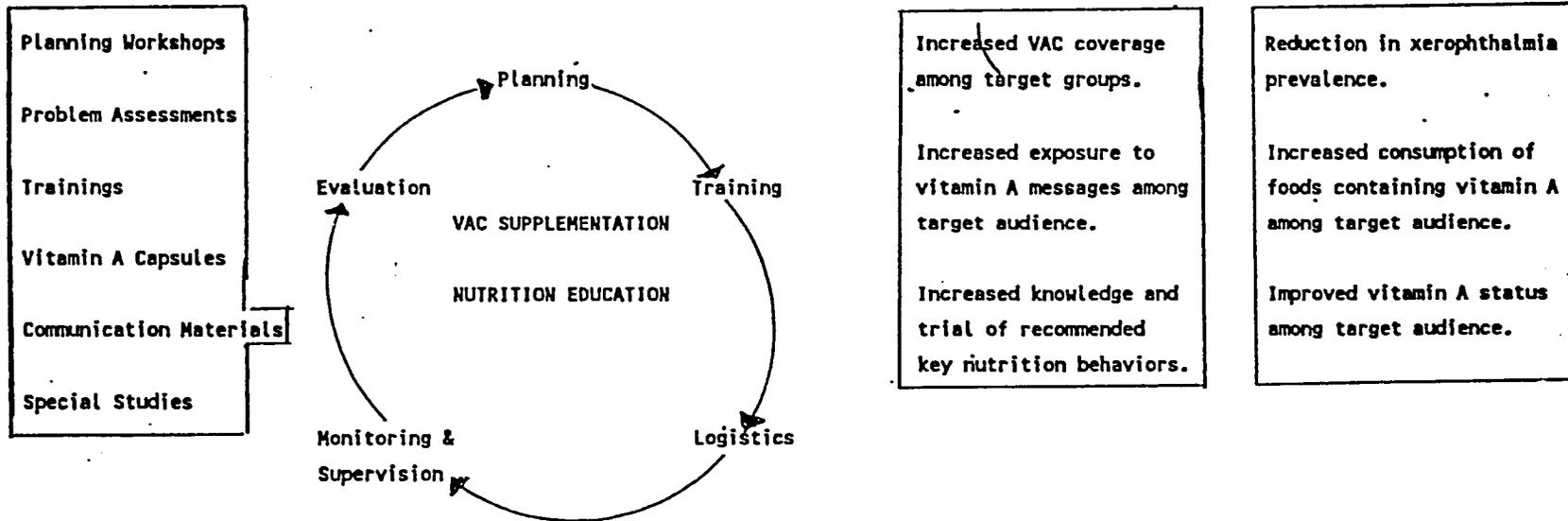
Tier Two (Outputs):

3. 75% of trainees know key nutrition education messages for each target group.
4. 50% of mothers of children 0-6 months have received advice on a vitamin A feeding message by the rural health midwife.
5. 50% of mothers 6-12 months have received advice on weaning food preparation by the rural health midwife.
6. 50% of mothers with underweight 1-3 year olds have received advised on a vitamin A feeding practice.
7. 50% of mothers attending pre-natal counselling have received advise on a vitamin A feeding practice.
8. The proportion of children aged 12-36 months of age eating foods containing vitamin A at least 3 times per week will be increased by 15%.
9. The proportion of infants 6-11 months of age eating lugao mixed with fish, oil and mashed yellow or green leafy vegetables at least 3 times per week will be increased by 20%.

VIII. PROJECT IMPLEMENTATION PLAN

Section 8.1 PROJECT FRAMEWORK

INPUTS----->PROCESS----->OUTPUT----->OUTCOME



PROJECT INPUTS

1. Planning and Orientation Workshops among key provincial DOH staff, DECS and select NGOs.
2. Problem assessments to determine VAD prevalence and feeding practices.
3. Vitamin A capsules (VAC) provided by the Nutrition Service and UNICEF.
4. Trainings of health workers, teachers, selected NGO leaders.
5. Communications materials to enhance interpersonnal contacts as well as radio spots.

PROJECT PROCESS

1. A cyclical process of planning, training, logistics, monitoring and evaluation will be used to implement vitamin A supplementation and nutrition education. Strategic processes which will be used during implementation include
 - * the integration of these services into DOH programs, facilities and patient contacts,
 - * strengthening of the DOH-DECS linkage to promote coordination with school teachers and children, and
 - * promotion of community awarenss and support through DOH-NGO linkages.

PROJECT OUTPUTS

1. Increased VAC distribution among high risk groups particularly underweight children and post-partum mothers.
2. Improved dietary practices and increased consumption of vitamin A rich foods among pregnant and lactating mothers, infants and children.
3. Improved vitamin A status of the risk groups.

IX. IMPLEMENTATION PLAN

Section 9.1 DESCRIPTION OF ACTIVITIES

The project will be implemented in three phases, the developmental phase, the implementation phase and the evaluation phase. The key program activities is outlined below.

DEVELOPMENTAL PHASE: This phase serves to organize project management, define roles and responsibilities, identify key activities and necessary technical resources, solicit local input, and prepare project areas for the implementation of proposed services. HKI will catalyze these activities by organizing planning sessions, providing technical input and following-up agreed upon activities. Major activities include:

1. Formation of an Advisory Group - This group will be composed of key DOH policy workers involved in the DOH Child Survival Program and Integration of Health Services for Mothers and Child. Representatives from key collaborating agencies like UNICEF will also be invited on a regular basis to provide technical guidance and develop sustainability strategies.
2. Formation of an External Consultants pool and hiring of Area Coordinators HKI will provide services of technical consultants and project coordinators in the selected provinces. This strategy is to decentralize project management to facilitate implementation of the workplans.
3. Conduct of Social Preparation Activities - Social preparation will be conducted at each phase of project implementation and at each level of the DOH structure. This will be done through involving DOH health personnel in the process of project of planning, implementation and evaluation.
4. Formation of Regional/Provincial Task Forces - HKI will assist in the formation of regional and provincial task forces to generate and facilitate input into project management in all project activities. The task force will work closely with the HKI area coordinator.

5. Preparation of Operational Plan - Each province will develop an operational plan to integrate vitamin A supplementation and nutrition education into on-going health services. Workshops will be conducted to detail plans for integrating vitamin A supplementation into on-going services and developing a social marketing/nutrition education plan.

Integration of Vitamin A Supplementation Plan - This plan will use the model developed in Antique province (developed under CSII Grant) as a starting point and develop an operational plan including the major project components: training, vitamin A supplementation, monitoring and supervision and community support.

Social Marketing/Nutrition Education Plan - This plan will use the model developed in Region VI as a starting point and will outline (in operational details) the nutrition education objectives, broad strategies to be employed, resources and major activities.

5. Orientation Seminars - HKI and DOH will conduct in each province one day orientation seminars for local health personnel, NGOs, community leaders. This is aimed to dispell "toxicity" rumors and generate community support.

7. Conduct of Rapid Assessments - As part of the developmental phase, data will be collected to establish baseline xerophthalmia prevalence, skill level of health providers and information needed to develop an effective nutrition education strategy. HKI will encourage health personnel to conduct these "in-house" surveys and will provide technical guidance to the provincial task forces in carrying these activities out.

Rapid Assessment of Xerophthalmia Prevalence - Experience has shown that involving DOH personnel in rapid assessments to determine xerophthalmia prevalence is an excellent way to generate concern about the problem and build provincial-based expertise in the detection and management of VAD. These individuals can later be tapped as resource persons in training health personnel in the province.

Health Service Provider Assessment - This exercise is designed to identify skill and program needs which can be used to modify the training curriculum and program implementation strategy. It obtains local input from the field implementers which can be used to tailor implementation to their specific needs.

Food Behavior Assessments - Indepth interviews and focus-group discussions will be conducted to assess food practices and beliefs regarding infant and child feeding, source of advice and other information from primary and secondary targets.

8. Preparation and Production of Training and Implementation Materials Prior to the implementation of capsule delivery and nutrition education, a supply of vitamin A capsules will be available, training materials will be developed, and communication messages and strategies will be finalized. HKI will assist the provincial task forces to finalize training curricula, identify and provide resource persons, and coordinate materials development. HKI will also provide technical support to the development and pretesting of prototype materials, media plan and final messages production.

IMPLEMENTATION PHASE: This phase constitutes the major program component and will start in year 2 of the grant. It consists of implementing each intervention component including training of all health workers, provision of services (vitamin A supplementation and nutrition education), monitoring and supervision activities, community support and evaluation activities. DOH and HKI has developed guidelines in the implementation of each component for vitamin A. (Final draft is with DOH as of this writing).

The objective of each component is to integrate the activities within the existing DOH organizational structure. Another aim of the project is to catalyze and strengthen DOH-NGO partnership by linking the program with appropriate community groups and local leaders to generate community awareness, mobilize community participation.

A brief description of the activities are as follows:

1. Trainings - NS-DOH in collaboration with HKI has organized a core group of trainers. This core group will be tapped as trainers for the provincial trainings. Training of field implementors (RHU staff, the RHP, PHN and midwives and the village health workers) will aim primarily at upgrading their competencies in case detection, treatment & prevention of VAD cases and risk groups. A vitamin A training curriculum has been designed and developed for the Rural Health Midwives.

2. Distribution of VAC - The program will target children (ages 6 mos. to 5⁴ years) with xerophthalmia or high-risk conditions. Xerophthalmic children will be given therapeutic treatment. High-risk children (malnourished, chronic diarrhea, recent measles and ARI) will be given a prophylactic regimen every 6 months in accordance with DOH policy. Vitamin A capsules will be distributed through the existing health services by health personnel. The delivery of vitamin A capsules will be done through the existing DOH structure at the Regional, Provincial, District and Municipal levels. The focal part of the delivery is the Municipal level (Rural Health Unit). The Municipal Health Officer (MHO) will receive the supplies and the Public Health Nurse (PHN) will be the distributing officer. Rural Health Midwives (RHMs) from the different barangays will get their monthly supply from the RHU, based on the number of children enrolled in the distribution program in her program barangay. The midwives will in turn distribute the VAC directly to the target children with the assistance of the Barangay Health Worker. Referrals from the schools and NGOs will be validated by the midwives.

3. Conduct of Nutrition Education - Messages will be "launched" via mass media (radio) as well as interpersonal channels to promote increased VAC coverage and increased consumption of available vitamin A rich foods. This activity will be undertaken by health personnel, barangay health workers and school teachers.

4. Monitoring and Supervision Activities - Continuous monitoring and supervision of project activities will be integrated from the beginning of project implementation. This component is aimed to ensure that all activities of the project are done according to plan. The monitoring tools recommended by DOH would include (1) a logbook, to record a listing of all xerophthalmic children identified. The format of the logbook has been likewise designed. (2) the Under Five Care Card, will be used to record the VAC receipt, to assure that no child will receive more than the recommended dose. (3) the FSHIS forms or the Field Service Health Information System.
5. Community Support Activities - The project will provide opportunities to conduct workshops to assist DOH in strengthening its partnership with NGOs and schools in conducting nutrition education and case detection. The project will assist the partnership by providing training materials and referral forms and educational curricula for VAD prevention and control.
6. Conduct of Consultative Conferences - HKI will organize consultative conferences on a regular basis from year 1 thru year 3 of the grant. These conferences will provide an opportunity to share field experience of implementors with the supervisors and policy makers. Project progress, needs and problems arising in the field will be discussed and appropriate actions will be identified.

EVALUATION PHASE

1. Evaluation Activities: This refers to a series of evaluation activities planned for the life of the project.
 - 1.1 Pre-post Intervention Surveys - In consultation with the DOH, HKI will conduct pre-post surveys. These surveys will objectively measure VAC coverage, nutrition education dissemination and behavior change associated with project interventions.
 - 1.2 Special Monitoring Studies - HKI will assist DOH to develop protocol in the conduct of small studies at various intervals during project implementation. These special studies will determine extent of project progress, i.e. health providers performance, community response to the project and effectivity of materials developed.

1.3 Mid-term Evaluation and Final Evaluation - HKI will arrange for both of these evaluations to assess project progress in relation to proposed project objectives.

2. Documentation - This will consist of documenting the process of project implementation and assessing project findings. Documentation will include routine reporting, including status and update report, as well as technical reports.

Routine Reporting - Routine reporting will be conducted periodically and include the following:

- * Monthly report by HKI area coordinator to project manager.
- * Quarterly meeting of vitamin A task forces with project management group (HKI and DOH).
- * Quarterly report to HKI-NY / USAID/W.
- * Annual report to HKI-NY and advisory group.
- * Terminal report at project completion.

Technical Reports - The following technical reports will be produced by the project:

- * VAD Community Profile based on data collected during the baseline survey.
- * Baseline Survey Operations Manual.
- * Training Curriculum for Case Detection and Management of VAD.
- * Report on Case Detection Capability by Service Provider Level (MD, PHN, RHM, BHW).

A C T I V I T I E S	Y E A R 1												O U T P U T I N D I C A T O R S	
	1990						1991							
	O	N	D	J	F	M	A	M	J	J	A	S		
Approval of Grant														
Development of Detailed Implementation Plan and Project Design														DIP submitted to USAID & Project Design Finalized
1.1 Consultation meetings with DOH and other Health & Nutrition Experts re: Project Design		x	x	x										
1.2 Finalization of selected expansion areas with DOH					x									
1.3 HKI internal planning meetings					x									
1.4 Write-Up of the DIP					x									
1.5 Presentation of DIP to DOH for comments and approval					x									
1.6 Submission of DIP to HKI-NY and USAID/Washington					x									
Formation of advisory group (DOH)														Project advisory group formed
2.1 Identify chairman and members of the advisory						x								
2.2 Identify grp. roles & responsibilities						x								
2.3 Develop system of coordination and reporting						x								
Hiring and contracting project consultants and HKI area coordinator							x							Project consultant hired
3.1 Interview & screening of applicants							x							
3.2 Orientation & training of HKI area coordinators								x						
Social preparation in selected provinces														Memo of Agreement w/ selected prov.
4.1 Meetings with reg'l. and prov'l. health staff in selected provinces							x							
4.2 Field visits for ocular surveys							x							
Formation of regional and provincial Task Forces														Reg'l. & Prov'l. Task Forces formed
5.1 Identify individuals to form Vitamin A working group/task forces							x							
5.2 Orientation of roles and responsibilities identified								x						

	O	N	D	J	F	M	A	M	J	J	A	S	
Preparation of operatn'l. plan by each prov.													Operational Plan developed
6.1 Develop protocols/working documents						x							
6.2 Consultative workshops with regional and provincial task forces						x	x						
6.3 Submission & approval of operational plan to the PHOs, RHOs, NS and HKI						x	x						
Conduct of orientation seminar to the selected provinces								x	x				Orientations seminars conducted
Conduct of community assessments (surveys)													Baseline surveys completed
8.1 Develop survey tools and protocol						x	x						
8.2 Social preparation							x	x	x	x			
8.3 Hiring of survey team							x						
8.4 Training of survey team								x					
8.5 Data collection								x	x	x			
8.6 Data editing								x	x	x			
8.7 Data organization and encoding								x	x	x			
8.8 Statistical runs											x	x	
8.9 Data analysis and interpretation											x	x	
8.10 Partial/preliminary report											x	x	
8.11 Write-up (Writesops)												x	
8.12 Preparation of data for presentation													x
Preparation of training and implementation materials						x	x	x	x	x	x	x	Trg. & Impl. mat'l ready for prod'n.
10. Production of training and implementation materials										x	x	x	Materials Produced
6. Consultative conference/Program review									x			x	Consultative Conference conducted
8. Documentation								x	x	x	x	x	Progress reports updated

A C T I V I T I E S	Y E A R 2												O U T P U T I N D I C A T O R S
	1991						1992						
	O	N	D	J	F	M	A	M	J	J	A	S	
Preparation of Operational Plan			x										Operational Plan developed
1. Trainings & Reorientation trainings													Trgs. at all level completed
11.1 Trainor's training (Provincial level)	x												
11.2 Preparation for implementors training													
11.2.1 Social Preparation	x												
11.2.2 Preparation of trg. materials	x												
11.3 District & Municipal trainings (Supervisors, District, RHPs & PHNs)		x	x										
11.4 Barangay Trainings (Field implementors, RHMs)		x	x										
11.5 Community (BHWs)		x	x										
11.6 Orientation/workshops with other GOs and NGOs			x	x									
11.7 Reorientation trainings						x						x	
2. Distribution of VAC													VAC distributed
12.1 Identification of target group				x	x	x	x	x	x	x	x	x	
12.2 Requisition of VAC & IEC materials				x	x	x	x	x	x	x	x	x	
12.3 Distribution of VAC & IEC materials				x	x	x	x	x	x	x	x	x	
3. Nutrition Education Campaign													Nut. Ed. campaign launched
13.1 Launching & airing of radio spots					x	x	x	x	x	x	x	x	
13.2 Individual dietary counselling				x	x	x	x	x	x	x	x	x	
13.3 Group counselling through mothers classes				x	x	x	x	x	x	x	x	x	
4. Monitoring & Supervision Activities													Monit. Activities on-going regularly
14.1 Supervisory visits	x	x	x	x	x	x	x	x	x	x	x	x	
14.2 Collection of monitoring data (accomplishments)				x	x	x	x	x	x	x	x	x	
14.3 Data review/processing				x	x	x	x	x	x	x	x	x	
14.4 Data analysis and interpretation				x	x	x	x	x	x	x	x	x	
14.5 Regular meetings and status reporting	x	x	x	x	x	x	x	x	x	x	x	x	
5. Community Support Activities													Action Plans with comm. developed
15.1 Dev't. of protocol agreements with GOs and NGOs					x	x	x	x	x	x	x	x	
15.2 Workshops with GOs & NGOs & community groups & develop action plans					x	x	x	x	x	x	x	x	
15.3 Organization of the communities to implement the action plans					x	x	x	x	x	x	x	x	



Nutrition
Date 9-23-91
N. 136-6
SAN LAZARO COMPOUND
157 ALABAN AVENUE, STA. CRUZ
MANILA, PHILIPPINES
TEL. NO. 711-60-80

Republic of the Philippines
Department of Health

OFFICE OF THE SECRETARY

copy for:

The Director, National Nutrition Service

CERTIFIED TRUE COPY

Department Order
No. 168-F, s. 1991

HELEN B. MAG-IBA
CHIEF, RECORDS SECTION
DOH - MANILA

SUBJECT : Designation of Department of Health personnel to compose the Provincial Vitamin A Task Force for "Strengthening the Integration of Vitamin A in the Health Services for Mothers and Children Project" in the provinces of Quezon, Northern Samar and Zamboanga del Sur.

In connection with the implementation of "Strengthening the Integration of vitamin A in the Health Services for Mothers and Children Project" of the Nutrition Service of the Department of Health and the Helen Keller International, the following DOH personnel are hereby designated members to compose the Provincial Vitamin A Task Force (PVATF) for the provinces of:

1. Quezon (Regional Health Office No. 4)

Name and Position.

- 1.1 Dr. Wilfredo P. Frondoza
Medical Specialist III
- 1.2 Ms. Nellie Diaz
Supervising Public Health Nurse
- 1.3 Ms. Aster Veloso
Ms. Emma Coronado
Dietary Nutritionist II
- 1.4 Ms. Ritchie Villasanta
Provincial Health Educator

2. Northern Samar (Regional Health Office No. 8)

- 2.1 Dr. Nympha Caparoso
District Medical Officer
- 2.2 Mrs. Josefina Tan
Supervising Public Health Nurse/
MCH Coordinator

52

**Tools used
in Preliminary
Assessment of Health
Personnel**

**VAD PRE-ASSESSMENT QUESTIONNAIRE
DEPARTMENT OF HEALTH**

Note:

February 14, 1991

The Vitamin A Program in your province will receive support from Helen Keller International. In this regard, may we request a few minutes of your time to provide us a feedback on the implementation of your vitamin A activities. This is an effort to identify the need for a reorientation/ re-training among the VAD program implementors. Please help us to do so. Complete this exercise as best as you can.

Thank you very much.

Background Information:

<p>1. Name: _____</p>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>												
<p>2. Designation: RHP/PHN/RHM/BHW/T/DAYCARE WORKER</p>	<input style="width: 20px; height: 15px;" type="text"/>												
<p>3. Municipality: _____</p>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>												
<p>4. Area of Assignment: R H U _____ B H S _____ Barangay _____</p>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>												
<p>5. Date: _____</p>	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 15px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mo.</td> <td style="text-align: center; font-size: 8px;">day</td> <td colspan="2" style="text-align: center; font-size: 8px;">yr.</td> <td colspan="2"></td> </tr> </table>							mo.	day	yr.			
mo.	day	yr.											
<p>6. Age: _____</p>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>												
<p>7. Number of Years in Current Position: _____</p>	<input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>												
<p>8. Educational Attainment: 1 - Elementary Graduate 4 - Did not complete college 2 - High School Graduate 5 - College graduate: specify 3 - Vocational Graduate course _____</p>	<input style="width: 20px; height: 15px;" type="text"/>												
<p>I. <u>Status of VAD-IDA-IDD Program?</u></p>													
<p>1. Have you attended training on VAD-IDA-IDD?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO												
<p>2. If yes, duration (# of days): 1 2 3 4</p>	<input style="width: 20px; height: 15px;" type="text"/>												
<p>3. Have you received the DOH circular on the treatment and prevention of Vitamin A Deficiency?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO												
<p>4. Are vitamin A supplements available in your clinic?</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO												

5

5. If yes, what form?
6. Have you distributed any VAC (200,000 IU)?
7. If yes, to whom?
8. When did you distribute VAC?
9. Is there a local term for nightblindness?
10. Did you see actual case of xerophthalmia during the past 6 months?
If yes : what? Nightblindness
Bitot's spots
Corneal scars
11. What IEC materials have you received in the past year for nutrition education?
12. If you will undergo another training on Vit. A, what skills would you like to strengthen?

- VAC (200,000IU)
 Retinol drops
 White/Green Capsule (50,000IU)

YES NO

- xerophthalmic child
 pregnant mother
 post-partum mother
 measles case
 2nd/3rd malnourished
 school children
 child with chronic diarrhea
 child with ARI

- OPT Home visit clinic
 EPI Consultation
 UFC
 Others: specify

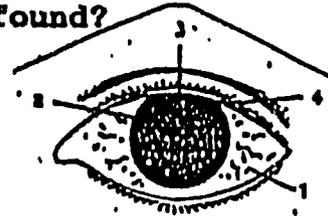
YES NO
If yes, what is it?

YES NO
 YES NO
 YES NO

- detect and treat of xerophthalmia cases
 detect and treat of high risk cases
 conduct of nut. educ. planning & assessment of VAD in the comm.
 recording & reporting of VAD cases
 involving the comm. in health & nut. program
 others - specify:

II. Training Needs Assessment Exercise (Please encircle the best answer)

1. The most common sign of vitamin A deficiency is:
 1. redness in the eye
 2. Bitot's spot
 3. nightblindness
 4. cataract
2. In what part of the eye are Bitot's spots found?
 1. conjunctiva
 2. cornea
 3. pupil
 4. eyelid
3. How is nightblindness determined?
 1. by examining the conjunctiva
 2. by examining the cornea
 3. by looking for an infection in the eye
 4. by asking the mother how the child acts in the dark
4. Which of the following conditions is not considered "high risk"?
 1. chronic diarrhea
 2. 1st degree malnutrition
 3. measles
 4. post-measles
5. A preschooler is at high risk for VAD if he:
 1. has red eyes
 2. drinks softdrinks
 3. has scabies
 4. is 2nd degree malnourished
6. How should you treat a child 1-6 years of age if he has nightblindness or Bitot's spots:
 1. give 3 capsules of 200,000 IU every week for one month.
 2. give 1 capsule of 200,000 IU everyday for one week.
 3. give 1/2 capsule of 200,000 IU today, tomorrow and after 2 weeks
 4. give 1 capsule of 200,000 IU today, tomorrow and after 2 weeks
7. Infants between 6 months and 1 year who have xerophthalmia should be treated:
 1. with the same dosage as preschoolers 1-6 years
 2. with half the dosage of preschoolers 1-6 years
 3. with only one capsule of 200,000 IU
 4. with 4 capsules because they are younger and need more Vitamin A.



V1

V2

V3

V4

V5

V6

V7

8. A 3 year old child who is 2nd degree malnourished should be given:
1. 1 capsule of 200,000 IU vitamin A
 2. 1 capsule of 200,000 IU vit. A today and one tomorrow
 3. 1 capsule of 200,000 IU vit. A everyday for one week
 4. 1/2 capsule of 200,000 IU vitamin A
 5. only food supplements since he is not a high risk child
9. A 5 year old child who has had diarrhea for more than 3 weeks should:
1. not be given any vitamin A since it might worsen his diarrhea
 2. be given 1 capsule
 3. be given 1 capsule today, tomorrow and in two weeks
 4. be given half capsule of 200,000 IU
10. A few children may have side-reactions to the high-dose vitamin A, such as:
1. measles and diarrhea
 2. headache and respiratory infection
 3. fever and parasites
 4. nausea and headache
11. Side reactions from high-dose vitamin A usually
1. last for more than a week and then disappear
 2. need to be treated with medicine
 3. are mild and go away by themselves within 24 hours
 4. require the child to go to the hospital
12. A Health Worker (HW) should examine the eyes of children if:
1. the child has measles
 2. the child is very malnourished
 3. the HW is conducting OPT
 4. the HW is assisting in TFAP
 5. only 3 and 4
 6. all of the above
13. After giving VAC to a child, you should:
1. advise the mother to give fish
 2. advise the mother to stop breastfeeding
 3. advise the mother to give her child small amount of green leafy vegetables cooked with oil everyday
 4. tell the mother that she does not need to give her child foods rich in vitamin A for a week because the capsule is enough
14. A child with diarrhea (more than 4 days) should be given
1. 200,000 IU VAC everyday for a week
 2. one 200,000 IU VAC and Oresol
 3. 200,000 IU VAC upon diagnosis and then two weeks later
 4. Oresol and antibiotic

V8

V9

V10

V11

V12

V13

V14

15. How much green leafy vegetables (GLV) should a child between 1-6 years old eat daily?
1. at least 1 cup
2. at least 2 cups
3. at least 1/2 cup
16. If a child was given a vitamin A capsule, you should:
1. write his name, age, date given in your logbook
2. mark the date, number of capsules and reason given in his USC card
3. both 1 and 2
4. no need to record
17. If you see a child who is very sick and malnourished, and you also notice that he has signs of vitamin A deficiency, you should:
1. treat the child for the sickness
2. treat the child with a vitamin A capsule.
3. advise the mother to go to the RHU and do nothing else
4. both 1 and 2
18. If you give VAC to a child with measles today,
1. you can be sure he will never have Vit. A deficiency
2. you should give VAC after a year
3. you should give VAC after 6 months
4. you should wait until he has nightblindness or Bitot's spots before giving another VAC
19. Which of the following foods contain the most vitamin A:
1. ampalaya leaves, saluyot, biscuits, softdrink
2. kamote tops, bread and pork
3. malunggay, gabi leaves, carrots, ripe papaya
4. rice, corn, biscuits, softdrink
20. If a child is night blind and not treated with vitamin A, he may:
1. get red and sore eyes
2. become blind
3. lose his teeth
4. get an enlarged throat
- V15
- V16
- V17
- V18
- V19
- V20

Thank you for your cooperation.

**Baseline Survey
Protocol
(Research Design)**

PROTOCOL FOR THE PRE-POST INTERVENTION ASSESSMENT

For The DOH-HKI Vitamin A Expansion Project

**DOH - HKI
MAY 1991**

PROTOCOL FOR THE PRE-POST INTERVENTION ASSESSMENT
For The DOH-HKI Vitamin A Expansion Project

I.	Vitamin A Project Executive Summary	
1.1.	Background	1
1.2.	Goal and Objectives	2
1.3.	Intervention	2
1.4.	Location and Duration	2
1.5.	Target Groups	3
1.6.	Project Framework	4 - 5
II.	Research Component	
2.1.	Rationale	6
2.2.	Research Objectives	7
2.3.	Research Design & Treatment Group	7 - 10
2.4.	Sampling Design & Sample Size	11 - 15
2.5.	Summary of Data Requirement & Targets	16 - 17
2.6.	Data Collection Methodology	18 - 21
2.7.	Guidelines in the Conduct of the Interview	22 - 25
2.8.	Preparation for the Field Works (Survey)	26 - 27
2.9.	Roles and Responsibilities of Survey Team	28 - 30
2.10.	Data Management	31 - 33
III.	Data Collection Tools and Interview Schedule	
IV.	Annexes:	
	A. Hand-out on Data Processing	
	B. How to get the weight of the P.S.	
	C. List of Sample Municipalities & Barangays	

I. Vitamin A Project Executive Summary

1.1 BACKGROUND

Why Vitamin A Deficiency?

- * Suspected high prevalence in country as evidenced by selected surveys on Xerophthalmia prevalence, serum vitamin A and vitamin A intake studies.
- * Linked to child survival. Recent studies have shown significant reductions in child mortality rates among supplemented groups compared with unsupplemented groups.

What are the DOH Vitamin A program thrusts?

- * Expansion of Vitamin A program to one province per region.
- * Integration of Vitamin A into existing services for mothers and children.
- * Decentralize planning and program management capabilities.

1.2 GOALS AND OBJECTIVES

Project Goal

- * Reduce Vitamin A Deficiency and its associated ocular manifestations, morbidity and mortality.

Project Objectives

- * To increase proportion of high risk groups receiving VAC within the past six months to at least 60%.
- * To increase the mean frequency of consumption of foods containing Vitamin A among risk groups.

1.3 Project Interventions

Vitamin A Supplementation

- * Detection and treatment of children with Xerophthalmia.
- * Detection and prophylactic treatment of children with high risk conditions (underweight, recent measles, chronic diarrhea, and lower respiratory infections).
- * Prophylactic treatment of post partum mothers within one month of child birth.

Nutrition Education

- * Development of a communications strategy (messages, media plan, and materials) to promote increased consumption of foods containing vitamin A.
- * Delivery message using interpersonal communications (eg. dietary counselling during consultation, mothercraft classes, teacher-child-parent contacts, BHWs, hilots, others, etc.) and mass media (eg. radio, print materials).

1.4 LOCATION AND DURATION

Location

- * The project will take place in three provinces. These are:
 - Zamboanga del Sur - Mindanao
 - Northern Samar - Visayas
 - Quezon Province - Luzon

The criteria for selection were based on the following:

- a. Constitute areas of greatest need based on child survival and DOH indicators.
- b. Have high rates of malnutrition.
- c. Have been targetted by the NS-DOH as priority provinces for Vitamin A expansion.
- d. Have known or probable service YAD problem.
- e. Have an intensive vitamin A supplementation & nutrition education program.

64

- f. Provide an opportunity for models to be adopted to very different ethnic and geographic settings.

Duration:

Project duration will be three-years, beginning October 1, 1990 and ending September 30, 1993.

1.5 TARGET GROUPS:

Target Group For Vitamin A Supplementation:

- * Children with Xerophthalmia.
- * High risk children (6-59 mos.) defined as children who are underweight, recently had measles, severe respiratory tract infections chronic diarrhea.
- * Post-partum mothers.

Target Group For Nutrition Education:

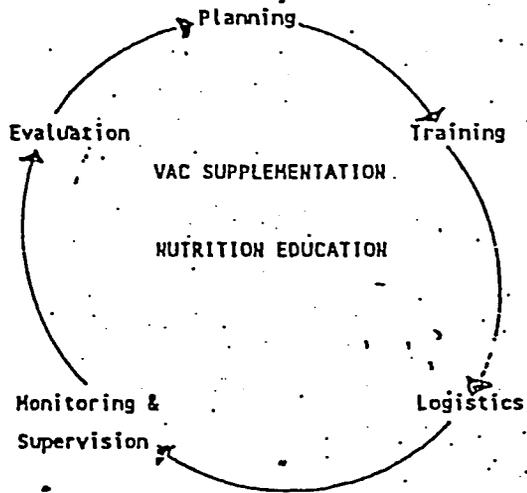
Primary Target : Pregnant Mothers
Mothers of infants 0-5 months
Mothers of children 6-36 months.

Secondary Target: Health Workers
Physicians
Community Leaders
Pilots

I.C. PROJECT FRAMEWORK

INPUTS-----PROCESS-----> OUTPUT-----> OUTCOME

- Planning Workshops
- Problem Assessments
- Trainings
- Vitamin A Capsules
- Communication Materials
- Special Studies



- Increased VAC coverage among target groups.
- Increased exposure to vitamin A messages among target audience.
- Increased knowledge and trial of recommended key nutrition behaviors.

- Reduction in xerophthalmia prevalence.
- Increased consumption of foods containing vitamin A among target audience.
- Improved vitamin A status among target audience.

PROJECT INPUTS

1. Planning and Orientation Workshops among key provincial DOH staff, DECS and select NGOs.
2. Problem assessments to determine VAD prevalence and feeding practices.
3. Vitamin A capsules (VAC) provided by the Nutrition Service and UNICEF.
4. Trainings of health workers, teachers, selected NGO leaders.
5. Communications materials to enhance interpersonnal contacts as well as radio spots.

PROJECT PROCESS

1. A cyclical process of planning, training, logistics, monitoring and evaluation will be used to implement vitamin A supplementation and nutrition education. Strategic processes which will be used during implementation include
 - * the integration of these services into DOH programs, facilities and patient contacts,
 - * strengthening of the DOH-DECS linkage to promote coordination with school teachers and children, and
 - * promotion of community awareness and support through DOH-NGO linkages.

PROJECT OUTPUTS

1. Increased VAC distribution among high risk groups particularly underweight children and post-partum mothers.
2. Improved dietary practices and increased consumption of vitamin A rich foods among pregnant and lactating mothers, infants and children.
3. Improved vitamin A status of the risk groups.

II. Research Component

2.1. Study Rationale

- 2.1.1. The study is part of the Vitamin A intervention program. To determine the impact of the intervention program, a baseline and endline survey will serve as an important basis for evaluation.
- 2.1.2. Prevalence surveys are needed to determine the nature, magnitude, severity and geographical distribution of Xerophthalmia.
- 2.1.3. The project will develop models for effective delivery of services for Vit. A Supplementation and Nutrition Education, hence, it is important to study the factors affecting the service delivery and the target group.

2.2. Research Objectives

2.2.1. For VAC Supplementation

- A. To determine and compare VAC coverage among 1st, 2nd, 3rd malnutrition and post-partum mothers between two strategies before and after intervention.
- b. To determine factors which affect the midwives and BHWs ability to integrate VAC supplementation into OPT thru team approach and follow-up visits.
- c. To determine factors which affect the hilot's ability to integrate VAC supplementation into post-partum visits.
- d. To determine the factors which affect mother's participation in OPT.
- e. To determine the problems met by the respective health workers with respect to:
 - * Integrating VAC supplementation into OPT.
 - * Conducting OPT by team approach
 - * Using hilots to distribute VAC to PP Women
- f. To determine and compare cost-effectiveness between two delivery strategies.

2.2.2. For Nutrition Education

- a. To determine the appropriate content and corresponding medium of the Nutrition Education messages to be disseminated.
- b. To determine the factors which affect the HW's ability to conduct MC and home follow-up.
- c. To determine the factors which affect the HW's ability to integrate the distribution of leaflets/comics into EPI and UFC contacts.
- d. To determine the factors affecting the participation of mothers in the "head start" class.
- e. To determine the effect of the above strategies in terms of:
 - * message exposure
 - * knowledge and recall of message
 - * trial of behavior promoted by message.
 - * improved nutritional status
- f. To determine problems met by the BHW and midwives in conducting "head start" class and integrating the distribution leaflets/comics into EPI and UFC contacts.
- g. To determine and compare the cost-effectiveness of the above strategies.

2.3. Research Design

2.3.1 Kind of Survey

1. Pre-Post intervention cross-sectional survey design will be used to compare pre-intervention prevalence of nightblindness and Bitot's spot as well as VAC distribution coverage with Post-intervention prevalence and coverage in the intervention and control areas. For Nutrition Education, frequency of consumption of foods containing Vit. A, message exposure, source will likewise be determined.

2. The same data collection instrument will be used for both pre-post intervention, and it will be conducted two years apart in both intervention and control area.

2.3.2. Study Subjects

Preschoolers : 6 mos. - 83 mos.

Mothers of Preschoolers

Rural Health Midwives

Barangay Health Workers

2.3.3. Treatment Groups

The province will be divided into four Treatment Groups as follows:

Treatment 1 - OPT with team approach and existing Nutrition Education Activities

Treatment 2 - OPT with team approach and distribution of IEC Materials

Treatment 3 - OPT with team approach and distribution of IEC Materials and strengthened mothers' classes.

Control Grp.- Existing OPT and Nutrition Education Activities

2.3.4. Definition (Features) of Treatment Groups / Delivery Strategies

A. Vitamin A Supplementation

Vitamin A Supplementation of Preschoolers (6 mos. - 59 mos.)

OPT with Team Approach - This means that the first dose of the VAC will be distributed/integrated during OPT. The features of the OPT are:

* OPT Team would compose of RHM, BHW, Mothers

* OPT Task Systematized

- Age & Weight Taking

- NS Determination

- Plotting on UFC Card

- Giving VAC, Interpret Results.

* OPT Participation Promoted

- Specify Month (Feb.)

- Poster /Bgy. Council /Etc.

For the follow-up Dose, the BHW will conduct the follow-up after six months.

Features are:

- * A designated week in July for follow-up dose
- * List of underweight will be given to the BHW with the VAC
- * Promotion of Follow-Up dose
- * Record Follow-Up dose receipt on UFC Card

Vitamin A Supplementation of Post-Partum Mothers

Post-Partum Women within one month of child birth will be given VAC during RHM Post Partum visit, RHM BCG Administration, thru Hilots and at the Hospitals. Special Training /Orientation for hilots will be conducted and VAC Receipt recorded on Mother's record.

B. Nutrition Education

Nutrition Education will focus to mothers' of weaning age children (6 - mos. - 24 mos.). The two delivery strategies adopted are:

1. Distribution of IEC Materials (eg. Leaflets / Comics) during EPI, USC or any patient contact of the RHM and BHW.
2. Mother's Class would feature the following:
 - * Weekly class for approximate two months.
 - * Use of Participatory Techniques such as Nutrigames, Demonstrations, Discussion
 - * Use of "Booklet" for mothers to apply and record adoption of Specific Practices

C. The Control Group means Municipalities or Districts under the control will be doing whatever is their existing or ongoing Vit. A Supplementation and Nutrition Education Activities.

12

2.4 Sampling Design:

The project used a Stratified Systematic Sampling with PPS (Probability Proportionate to Size). The Sampling Procedure is as follows:

1. Data Prepared

- List of Districts/Municipalities
- List of % OPT Coverages per District/Municipality
- Population per Barangay /Municipality

2. Allocation of Treatments

2.1 The total population of each province was divided into 4 (Let $M = \text{population}/4$) since there are 4 treatment groups:

Treatment 1 - OPT + Nutrition
Education

Treatment 2 - OPT + Distribution

Treatment 3 - OPT + Distribution +
Class

Control - No System + No
Nutri-Ed

2.2 The districts were then grouped together such that: (a) the sum of their populations would more or less approximate M and (b) the districts were more or less homogenous with respect to OPT coverage.

2.3 The different treatments were allocated to the 4 groups by drawing lots.

3. Choosing the Municipalities

3.1 For each of the treatment groups, the municipalities were stratified according to the following % OPT coverages:

< 50% - LOW

50% - 79% - MEDIUM

≥ 80% - HIGH

3.2. Two (2) municipalities were chosen from each of the stratum by using systematic sampling:

a) the municipalities and their populations were listed according to their stratum and their cumulative populations were determined.

b) the sampling interval, k , was computed

$$k = \text{cumulative population} / 2$$

c) a random number was selected between 1 and k . The first municipality in which the cumulative population was \geq random number was the first municipality to be included in the study.

d) the second municipality was determined by adding k to the first random number selected and comparing the resulting number to the cumulative population.

4. Allocation of Samples to the Municipalities

4.1 It was decided that 3,000 respondents would be included in the study per province. This means 750 respondents per treatment group. To give allowance for non-responses, 800 to 805 samples were allocated to the municipalities.

4.2 To determine the sample allocation for the municipalities, the principle of probability proportionate to size (PPS) was used.

4.3 Dummy Table:

Stratum	Municipality	Population	%	Sample Allocation
LOW				
MEDIUM				
HIGH				
TOTAL				

5. Allocation of Samples to the Barangays

5.1. For each of the municipalities, 2 barangays were chosen in the same manner using systematic sampling with PPS.

5.2. Dummy table:

Stratum	Municipality	Barangay	Population	%	Sample Alloc.
LOW					
MEDIUM					
HIGH					
TOTAL					

15

6. Selection of Rural Health Midwives for Interview

The midwife of the sample barangay will be targetted for the RHM interview. HKI-Area Coordinator or NS staff will be responsible to interview the midwife.

7. Selection of Barangay Health Workers

7.1. For each Sample Barangay, two Barangay Health Workers will be interviewed using a simple random sampling.

7.2. A list of Barangay Health Workers from the sample /selected barangay will be prepared by the midwife. The Area-Coordinator, will choose two BHWs and will be responsible to conduct the interview with the NS staff.

Summary of the Survey Sample Size

Province	Total No. of Mun.	No. of Sample Municipalities	No. of Sample Barangay	No. of target PS	No. of target RHMs	No. of target BHW
Zamboanga Sur	40	21	42	3215	42	84
N. Samar	24	18	36	3205	36	72
Quezon	40	20	40	3220	40	80
TOTAL	104	59	118	9640	118	236

DATA VARIABLES FOR BASELINE SURVEY

SOURCE OF DATA	TYPE OF INFORMATION		DATA COLLECTOR
	KEY VARIABLES	SPECIFIC INDICATORS	
1. Preschoolers	- Clinical Xerophthalmia	- XN, X1B, X2, X3, XS	Physician
	- Anthropometric Measurement	- 1st degree malnutrition - 2nd degree malnutrition - 3rd degree malnutrition	
	- High risk factors	- Measles in the past month, PEM, diarrhea, ARI, intestinal parasitism	
2. Mothers	- Household socio-economic status	- House ownership, maternal age and education, mother's employment status	Interview
	- Present Vitamin A Coverage	- Vitamin A receipt/Vitamin A supplementation in the past	
	- Utilization of health services	- Contact with BHW, RHM,	
	- KAP on Vitamin A	- Mother's recognition of the importance of Vitamin A, recognition of VAC, knowledge of Vitamin A rich foods	
	- Perception to OPT	- OPT participation	
	- Perception to Mother's Class	- Attendance to mother's classes	
	- KAP on food/feeding practices	- Breastfeeding/Weaning practice	

Continuation:
Data Variables

SOURCE OF DATA	TYPE OF INFORMATION		DATA COLLECTOR
	KEY VARIABLES	SPECIFIC INDICATORS	
3. RHM/BHW	VAD detection and management	- KAP on VAD	Task/Force
	Present Vitamin A coverage	- Vitamin A distribution	Area
	Vitamin A program adequacy of Systems	-	Coordinator

79

2.6. Data Collection Methodology:

The Baseline survey will be conducted by a survey team whose main task are:

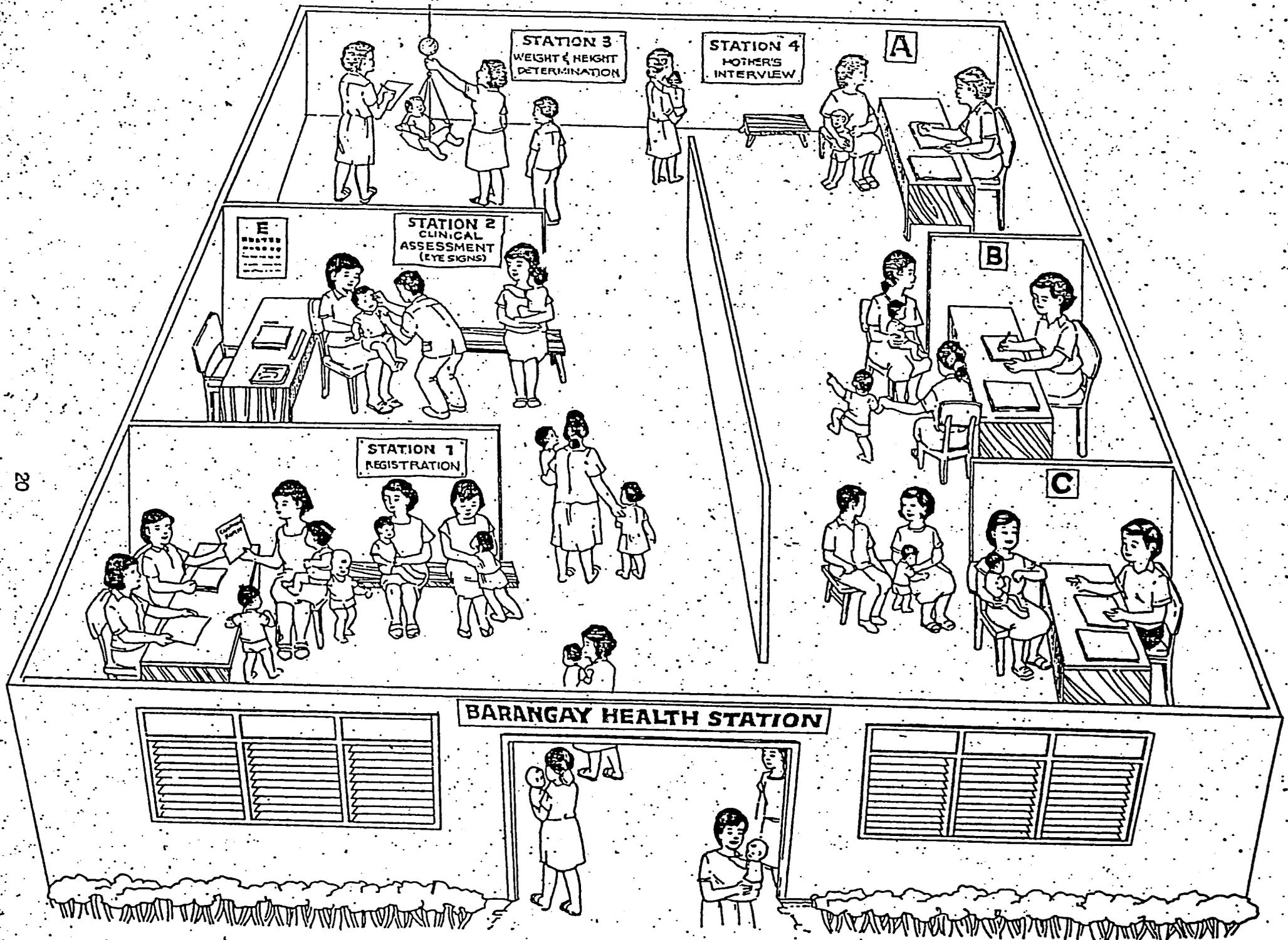
- 2.6.1. to gather (collect all information required within a specified period by means of standardized questions so that every individual surveyed responds to exactly the same questions.
- 2.6.2. to organize data for computerization, analysis and interpretation of results.

Data collections will be done by two(2) survey teams. Each teams will compose of:

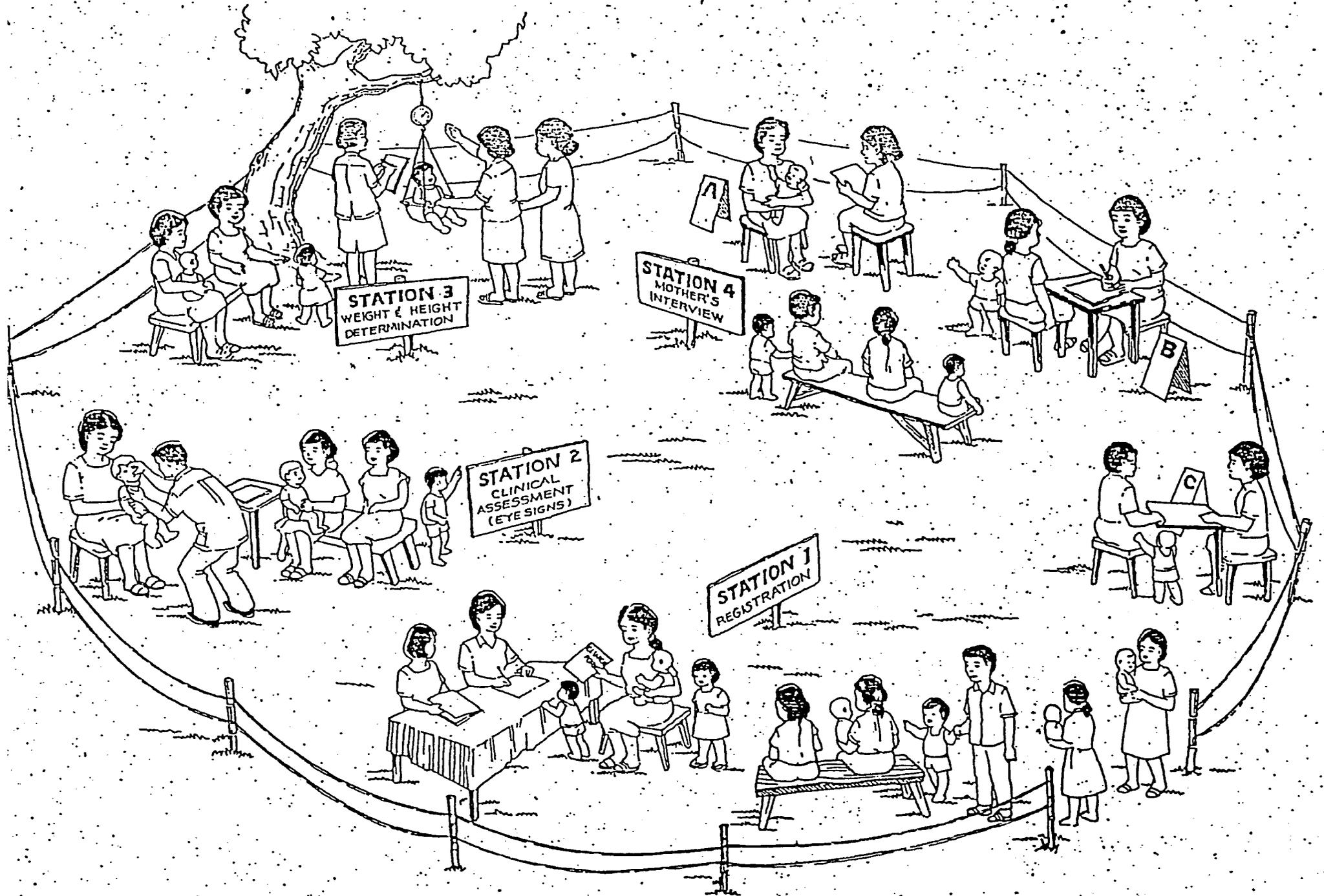
- 1 Medical Doctor - who will assess the presence or absence of Xerophthalmia among the target preschoolers.
- 3 Interviewers - who will conduct mother's interview on household information, feeding practices etc.
- 2-3 Facilitators- the RHM and who are residents of the area and will assist the team in the survey program.
- 1 Field Supervisor who is the member of the Prov'l Task Force who will oversee the survey work flow at the site and responsible for the quality control of the data required.
- 1 Area Coordinator together with the supervisor, he/she will conduct the social preparation and coordination in advance to the health personnel of sample barangay.

Except for the local facilitators, the survey teams will be thoroughly briefed about the project and trained to perform their specific function. Specific protocols for clinical examination, anthropometric measurements, household and dietary interviews will be followed for the standardization of the procedures. For quality control of data, the activities and performance of the teams will be monitored by a field supervisor and area coordinator.

All preschoolers in the sample barangay for the survey will be gathered as a group on a scheduled basis in a specified place agreed upon by the area coordinator and the RHM. The survey work-flow at the barangay is shown in Figure .



DATA COLLECTION WORK FLOW



DATA COLLECTION WORK FLOW

2.7. Guidelines In Conducting The Interview:

Pre-Interview Preparation

- 2.7.1. Make sure you have the necessary forms and questionnaires for the particular interviews you will be conducting, ie. household information, high-risk information, dietary questionnaire, health service provider questionnaire.
- 2.7.2. First seek the consent of the interviewee before conducting the interview.
 - a. State your name and the purpose of your visit. "I am (give your name) from the Department of Health. We are conducting a project for preschooler to reduce the prevalence of vitamin A deficiency and blindness among your children. I hope you can spare a few minutes to answer some questions about your family and yourself."
 - b. Be prepared to respond correctly to the following questions:
 - i. On questions if mothers' of all children in the municipality will be interviewed, please state that not all mothers' will be interviewed, but only a few.
 - i.i. On questions regarding what benefits the interviewees will get, please make it clear to the mothers that their participation will provide important information for the nutrition program.

On the Interview Set-Up/Atmosphere

1. As much as possible, choose a well-lighted, quiet and private place where you can conduct the interview.

2. Children and curious neighbors may be requested diplomatically to leave the interview area.
3. Check that you and the respondent are seated comfortably and facing each other.

On Specific Interview Guidelines and Techniques

Be familiar with the questionnaires of the survey. Ask questions conversationally. The following guidelines should be kept in mind when asking questions:

- a. Establish rapport with the respondent before starting the interview. A pleasant smile and asking how the respondent is will usually accomplish this.
- b. Be courteous in your manner of asking questions.
- c. Ask questions in the same manner, words and conditions for each respondent.
- d. Listen to response in entirety before recording the answer.
- e. Never ask leading questions.
- f. Use simple words which can be understood by the respondent.
- g. Ask only the questions in the questionnaires. Avoid any conversation with the respondent about the meaning or purpose of the questions.
- h. Make no display of authority. Be humble.
- i. Be patient and friendly. Never argue. Don't be easily discouraged by refusals.

- j. Show interest in the respondents' answers. Allow to talk freely and fully. Don't show reactions to statements or opinions the respondent makes. An occasional "uh-uh", "yes", "I see", or "that's interesting" will encourage the respondent to tell more. Smiling, nodding and remarks as "good, tell me more about that" are also encouraging.
- k. Repeat questions if necessary. Sometimes, the respondent wanders to some unrelated questions or she may not have understood the question. Respondents do not like to show their ignorance and often will not admit that they don't understand. Avoid embarrassing your respondent.
- l. Put yourself in the respondent's place. Recognize and understand the needs, feelings, and attitudes of your respondents.
- m. Take time with your respondent. Use tone of voice to make respondent feel she has time to think. Ask your questions slowly. Show a quiet, unhurried willingness to listen.
- n. Try not to force answers from your respondents. Make respondent feel comfortable and respected by periodically thanking her for the answer.

INSTRUCTIONS FOR FILLING-UP THE QUESTIONNAIRE FORMS

General Instructions:

1. Accomplishment and Coding

- a. The researcher/interviewer should use a lead pencil during interview in recording write-in information in all the forms.
- b. Enter write-in codes legibly with a pencil. Any wrong entry can simply be erased and replaced by the right one.
- c. For questions answerable by "others" always specify what those "others" are.
- d. Always fill-up the blocks for subject's I.D. and the spaces provided for Municipality, Barangay, Researcher/Interviewer and interview date.

2. Editing

- a. Make sure that there are no two subjects with the same I.D. number.
- b. Check whether all the I.D. numbers tally in every form.
- c. Check legibility and completeness of recorded entries in each form.

AGE DETERMINATION TABLE FOR THE MONTH OF JULY 1991

MONTH	YEAR							
	'91	'90	'89	'88	'87	'86	'85	'84
1 - JANUARY	6	18	30	42	54	66	78	
2 - FEBRUARY	5	17	29	41	53	65	77	
3 - MARCH	4	16	28	40	52	64	76	
4 - APRIL	3	15	27	39	51	63	75	
5 - MAY	2	14	26	38	50	62	74	
6 - JUNE	1	13	25	37	49	61	73	
7 - JULY	0	12	24	36	48	60	72	
8 - AUGUST		11	23	35	47	59	71	83
9 - SEPTEMBER		10	22	34	46	58	70	82
10 - OCTOBER		9	21	33	45	57	69	81
11 - NOVEMBER		8	20	32	44	56	68	80
12 - DECEMBER		7	19	31	43	55	67	79

Note: If Birthdate > Date of Weighing, deduct one (1) month from the answer.

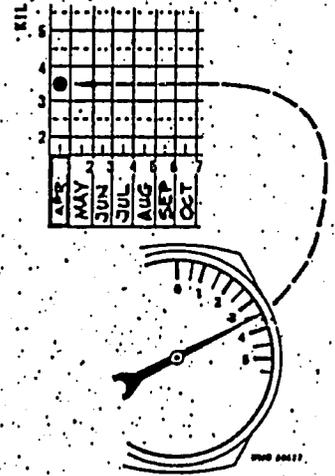
88

AGE DETERMINATION TABLE FOR THE MONTH OF JUNE 1991

MONTH	YEAR							
	'91	'90	'89	'88	'87	'86	'85	'84
1 - JANUARY	5	17	29	41	53	65	77	
2 - FEBRUARY	4	16	28	40	52	64	76	
3 - MARCH	3	15	27	39	51	63	75	
4 - APRIL	2	14	26	38	50	62	74	
5 - MAY	1	13	25	37	49	61	73	
6 - JUNE	0	12	24	36	48	60	72	
7 - JULY		11	23	35	47	59	71	83
8 - AUGUST		10	22	34	46	58	70	82
9 - SEPTEMBER		9	21	33	45	57	69	81
10 - OCTOBER		8	20	32	44	56	68	80
11 - NOVEMBER		7	19	31	43	55	67	79
12 - DECEMBER		6	18	30	42	54	66	78

Note: If Birthdate > Date of Weighing, deduct one (1) month from the answer

The most common spring scale (often called a Salter scale, although many other brand names exist) has a face or dial which looks like a clock. The weights are marked in kilograms around the dial. Some dials also show 100-gram divisions between kilograms, but the simplest scales only have kilograms marked by bold lines and 500 grams marked by thin lines. Such scales are convenient for workers with limited education because these lines are similar to those which are drawn on the most widely used growth charts (Fig. 4).



THE MARKINGS ON THE FACE OF THE SPRING SCALE CORRESPOND TO THOSE ON THE GROWTH-CHART. THIS HELPS THE HEALTH WORKERS IN COMPLETING THE CHART, PARTICULARLY IF THEY ARE NOT USED TO DECIMAL SYSTEMS.

ACCURATE WEIGHING IS IMPORTANT
Follow these steps

Accurate weighing is important. A community health worker can learn how to weigh a child quite easily by following the instructions given below.

1. Hang up the scale securely, keeping the dial at eye-level so that the weight can be read easily.
2. Adjust the pointer to zero before placing the child in the sling or basket. Most scales have a knob or screw to make this adjustment.
3. Undress the child with the help of the mother. It is better to weigh the child naked if it is not too cold and if local customs permit.
4. Place the child in the sling or basket with the help of the mother. Ask the mother to stand nearby and to talk to the child. The mother should not hold the child and the child's feet should not touch the ground when the weight is being read.
5. Read the weight on the scale. If the child is struggling try to calm him with the help of the mother and when he stops moving read the weight quickly.
6. Write down the weight in figures, for instance, 3.5 kg.

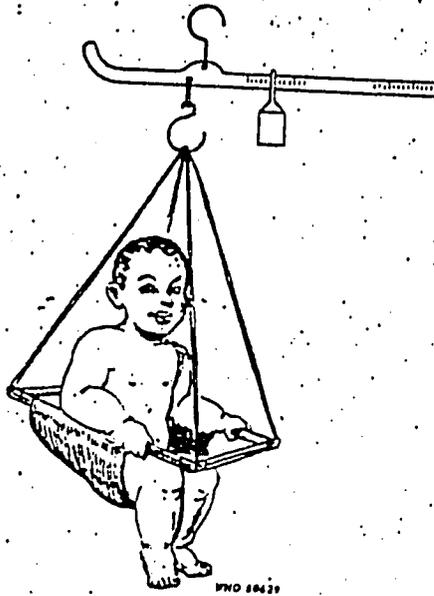
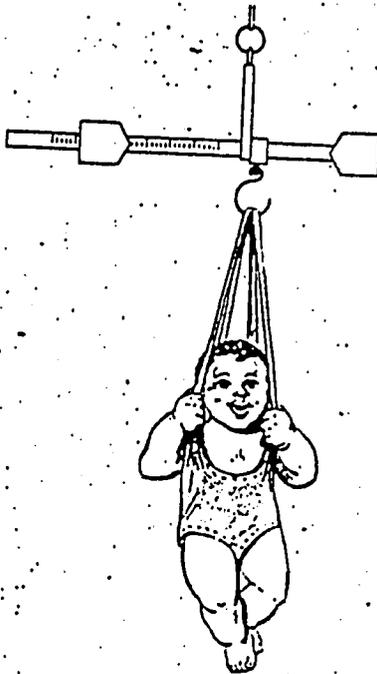
2.3 How to weigh a child accurately

A child's weight is a valuable measure of its health and nutrition. Weighing a child requires reliable equipment and a standard method to achieve accurate results.

There are two main types of weighing scale - beam balance scales and spring scales. A beam balance scale is usually accurate and reliable, but it is often heavy and expensive (Fig. 2). Scales of this kind are used in markets and shops in many countries and are therefore familiar. A spring scale on the other hand is quite cheap, fairly reliable, light, and easily carried. Such a scale has one hook above, to hang the scale from a beam or a branch of a tree, and one hook below from which hangs a sling or basket (for infants) a small chair, or pair of pants (for older children) (Fig. 3). The child is placed in the sling or basket, seated on the chair, or slipped into the pants as the case may be. It is important that the child feels secure and the mother does not mind her child being suspended in that way.

FIG. 2 TWO TYPES OF BEAM BALANCE

FIG. 3 A SPRING BALANCE



4. Coder should be exhaustive and mutually exclusive
 - code entry should cover all of possible answers for any given question
 - they should not overlap
5. It is good idea to adopt coding conventions for questions with similar answers.

4. Pattern Codes - a single code is allocated to each type of response, including multiple or combined responses. This is advisable when the types of multiple responses can be anticipated and are not many.

What birth control method are you currently using? (Check all that apply.)

- | | | | |
|--------------------------|------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | Pill | <input type="checkbox"/> | Male/Female Sterilization |
| <input type="checkbox"/> | IUD | <input type="checkbox"/> | Withdrawal |
| <input type="checkbox"/> | Condom | <input type="checkbox"/> | Others (Specify) |
| <input type="checkbox"/> | Rhythm/Ovulation | | |

Col. No.	Item	Coding Instruction
4	Birth control method used	1 - Pill 2 - IUD 3 - Condom 4 - Rhythm/Ovulation 5 - Male/Female 6 - Withdrawal 7 - Others 8 - Condom and Rhythm

Rules for Code Construction

- The objectives behind the question and the use of the question in the analysis should be considered in devising codes for the responses. 2. The code should not be any more detailed than necessary.
- Categories for free or open-ended questions might be determined from pre-test results or from a separate frequency tally of, say, the first 100 questionnaires to be processed.
 - if multiple reasons are given in an open-response format, codes might need to accommodate combination of answers.

93

2. Bracket Codes - each category refers to a range of numbers

Col. No.	Item	Coding Instruction
1 - 3	Respondent's Serial No.	Record as is
4	Monthly Income	1 - \$500 2 - \$500 - \$799 3 - \$800 - \$999 4 - > \$1000

3. Factual or Listing Code - type of coding used when the question is of the "multiple choice type." Here, a column is allocated for each possible answer with 0 and 1 as the usual codes used, representing "mentioned." This type of coding is advisable when several combinations of multiple responses are anticipated.

Whom did you consult to help you decide whether or not you should use a birth control method? (Check all that apply.)

- Husband
- Mother/Mother-in-law
- Friend
- Priest/Pastor
- Health Worker
- Others (Specify) _____

Col. No.	Item	Coding Instruction
4	Husband?	0 - No 1 - Yes
5	Mother-in-law?	0 - No 1 - Yes
6	Friend?	0 - No 1 - Yes
.	-	
.	-	
ETC.	ETC.	

94

SOME GENERAL EDITING RULES

1. Editors should be thoroughly familiar with the instructions to enumerators and to coders, as well as with their own instructions.
2. In NO CASE should the editor destroy, erase or make illegible the original entry filled in by the enumerator.
3. All marks on the schedule by the editor should be made in a distinctive color.
4. No answer should be changed without sufficient justification.
5. Schedules to be discarded or rejected should be submitted to the chief editor, who consults with the sampling director before placing them in an inactive file.
6. Editor's initials and date of editing each schedule should be entered on each schedule when it is edited.
7. The editors should be informed about sections of the schedule which may be cross-checked for consistency with other sections.
8. Errors which are apt to be most common and the means of detecting such errors should be pointed out.
9. It is utmost important to keep the number of changes in instructions and interpretation at a minimum.

CODING THE DATA

Purpose of Coding:

- to have the data represented with numerical or other symbols permitting rapid and flexible storage, retrieval and tabulation.

Types of Codes:

1. Field Codes - numbers are recorded as they are given by the respondent

Col. No.	Item	Coding Instruction
1 - 3	Respondent's Serial No.	Record as is
4 - 7	Monthly Income	Record as is
8 - 10	Height	Record inches in Cols. 9-10

Checking Procedure Usually Done by Three Persons:

1. Interviewer

- should review work after each completed interview, or at the latest by the end of the day
- particular attention should be given to
 - * legibility of the information
 - * missing answers
 - * inconsistencies
 - * lack of uniformity

2. Field Supervisor

- done upon receipt of the questionnaire
- purpose normally to detect obvious errors which can be corrected in the field

3. Editors at the Main Office

- purpose is to judge whether information is sufficiently complete to be coded
- alternative for very incomplete questionnaires
 - * consider as non-interview
 - * return to the field

PROCEDURES TO FACILITATE CODING

1. Precoding of difficult information

e.g. occupation cause of death

2. Preparation of complex computations or summaries to simplify subsequent coding process

- best carried out in research office by a few specialists

DATA PROCESSING

Ophelia M. Mendoza

Data Processing - generally to that survey component in which the data gathered in the survey are translated into a form suitable for statistical analysis.

Two Basic Subcomponents of Data Processing:

1. Editing - preliminary step in which the responses are inspected, corrected, and sometimes precoded according to a fixed set of rules.
2. Coding - technical procedure for converting verbal or written information into numbers or other symbols which can be more easily counted and tabulated.

Two main sets of activities in editing:

1. checking of the questionnaires
2. procedures to facilitate subsequent coding

THE CHECKING PROCEDURE

Specific Questions Considered During Checking Operations

1. Completeness
 - every questionnaire reviewed to determine if each question was answered
 - for items left blank, find reason for omission
2. Logical Inconsistencies
3. Comprehensibility
 - e.g. illegible handwriting

GENERAL EDITING INSTRUCTIONS

AT THE SURVEY SITE:

1. Review each Interview Form:

1.1 Check if all questions have been answered

1.2 If an item has been left blank, check if the omission occurred because a) the interviewer forgot to ask the question, b) he failed to record the answer or c) the respondent refused to answer the question.

2. Get the total number of Households/Preschoolers interviewed from the Masterlist at the registration site.

3. Check and compare the number of Households/Preschoolers with the accomplished Clinical Forms and Interview Forms.

4. Compute for the Survey Coverage

4.1 % Survey Coverage = $\frac{\text{Number of Children Surveyed}}{\text{No. of estimated Preschoolers [<7 yrs]}}$

4.2 Fill up the Daily Accomplishment Forms.

AT THE OFFICE:

1. Editing:

1.1 Make sure that there are no two subjects with the same Respondent Number.

1.2 Check whether all the Respondent Numbers tally in every form.

1.3 Check whether information is sufficiently complete to be coded.

2. Filing:

2.1 File each Daily Accomplishment Form in its designated folder.

2.2 Consolidate all accomplished Interview forms of each barangay in the designated folder.

3. Coding: Follow instructions in Coding Manual

DATA COLLECTION	SURVEY TEAM
FIELD EDITING	SURVEY TEAM
EDITING/ Check for completeness	FIELD SUPERVISOR
RE-EDITING/CODING (Staff House)	SURVEY TEAM
Batching of Data/ Hand carry to Manila 1x a month	FIELD SUPERVISOR
Incoming data recorded	HEAD OFFICE - HKI
DATA ENCODING	DATA ENCODER
EDITING/ DATA VALIDATION	HKI - TECHNICAL STAFF
STATISTICAL PROCESSING	HKI - TECHNICAL STAFF

DATA MANAGEMENT FLOW

12.10. DATA MANAGEMENT

The survey team will be trained on standard data collection procedures and data processing activities to ensure quality control of data. Data gathered into the survey will undergo two basic components of data processing: editing and coding.

Initial editing which includes checking for completeness, logical inconsistencies and comprehensibility will be done by the survey team in the field. The survey team will submit the accomplished forms to the field supervisor for second editing to detect errors which can be corrected in the field. These forms will then be returned to the survey team for re-editing and coding. Once the forms are edited and coded, they will be kept by the field supervisor and brought to Manila at least once a month.

The interview forms arriving in Manila will be encoded and data will be validated. If the data is found to be "clean" then statistical processing will follow.

DATA MANAGEMENT FLOW
FIELD LEVEL

DATA COLLECTION		FLOW OF FORMS	
PROCESS	SURVEY STAFF	FORMS TO BE ACCOMPLISHED	
Registration	Midwife/BHW	Masterlist	Clinical Form (carried by mother)
			↓
Clinical Exam	Medical Doctor		Clinical Form (w/ mother)
			↓
Anthropometry	Interviewer or Midwife/ BHW		Clinical Form (w/ mother)
			↓
Interview	Interviewer	Mother's Interview Schedule	Clinical Form (validated by field super- visor and left to the interviewer for safe- keeping)

100

5. Driver

*Take charge of fetching and transporting team members to and from one survey to another.

* to make himself available at all times to the team during the field survey, making sure that the schedule is followed at all times.

*to be responsible for the safety and maintenance of the vehicle.

*assist team members in carrying/doing manual work as necessary.

6. Field Facilitators/BHW

*assist in the activities of the survey team.

*facilitate location of mother's household as deemed necessary.

*assis in gethering mothers and pre-schoolers during the survey .

*assist survey team members in carrying/doing manual works as necessary.

106

2. HKI VAD Coordinator

- *over-all responsible for the efficient coordination of the survey of the two teams relevant to the following:
 - social preparation and systematic data collection flow.
- *assist and coordinate with the Task Force member /Field Supervisor on the above rules and regulations.
- *screen and recruit interviewees with task force in the conduct of the survey.
- *conduct social preparation activities with field supervisor.
- *responsible for the administrative and financial needs of the survey.
- *prepare status reports.

3. Physician.

- *Explain purpose of survey and survey process.
- *Perform clinical assessment for signs and symptoms of Xerophthalmia on all pre-schoolers (1-6 yrs.) in sample barangays.
- *assist the field supervisor in the social preparation activities as deemed necessary.
- *code and edit clinical exam form.
- *assist, consolidate / analyze and interpret results of clinical data.

Nutritionist

- *Interview mothers/companion of pre-schoolers on household information, feeding practices and KAP on Vit. A.

2.9 Roles and Responsibilities of the Survey Team

The project survey team is responsible for the data collection at baseline and endline survey. There are two survey teams, each team will consist of a Field Supervisor, a Medical Doctor, 3 interviewers and a driver. Each member of the survey team has the following functions:

Team Composition

Roles & Responsibilities

1. Vit. A Task Force Member
 - 1.1 Provincial VAD Task Force
 - *prepare the schedule of the sample barangays.
 - 1.2 NS-VAD Task Force (will be the Field Superv.)
 - *inform and coordinate with the appropriate health personnel at least one(1) week in advance the data and time of arrival of the survey team.
 - *request a convenient place of assembly, tables and chairs needed during the survey.
 - *assist in the efficient conduct of the survey team.
 - *assist in the orientation and training of the survey team.
 - *assist in data collection when necessary.
 - *coordinate with area coordinator logistical needs of the survey team.
 - *supervise the interview of mothers and edit the data collected.
 - *checks that survey forms are complete and correctly filled out.

3. During the survey the RHM & BHW should:

- * Gathers all preschoolers on the specified date, time and place of assembly.
- * Directs the BHW to distribute numbers to mothers as they come in for registration for the smooth conduct of the survey.
- * Together with the PHW and BHW, she helps in the registration by listing all the names of the mothers and children in the master list, assigning them their corresponding ID numbers upon registration.

2.8 Preparation for the Field Works (Survey)

Well in advance of the survey (at least one week before) the following activities should be completed:

1. Social Preparation:

- * Prepare the schedule (date & time) and venue of the survey of the sampled barangay.
- * Orient the appropriate health workers, barangay captain and the local community leader about the scheduled survey.
- * Request the midwife of the sample barangay to prepare the list of preschoolers ages 1-6 years.
- * The midwife with the help of the BHW prepares a place of the survey, the tables (6), chairs (8), benches needed during the survey.
- * Orient the health workers (MHO & Midwife) about the survey activity i.e., composition of the survey team, targets, date and time and venue.
- * Conducts ocular survey of the sample barangays as deemed necessary.

2. Before leaving for the Survey Barangay, the team should:

- * Review the supplies & equipment needed.
 - Do you have enough interview schedules for mothers?
 - Do you have enough clinical and masterlist forms?
 - Do you have your weighing scale, NS table etc.?
 - Does the physician have his supplies / equipment?
 - Vitamin A Capsules
 - Medicines?
 - Biscuits for Preschoolers?

PHILIPPINE NUTRITION PROGRAM
OPERATION TIMBANG
WEIGHT TABLE FOR PRESCHOOLERS (0-41 MONTHS)

Age at of Last Birth- date (Months)	UNDERWEIGHT						Normal Weight	Over Weight
	Severely Underweight (3rd Degree)	Moderately Underweight (2nd Degree)		Mildly Underweight (1st Degree)				
	Below & Up to	From	To	From	To	From	To	From & Above
0	2.0	2.1	2.6	2.7	3.1	3.2	3.7	3.8
1	2.5	2.6	3.2	3.3	3.8	3.9	4.6	4.7
2	3.0	3.1	3.6	3.7	4.5	4.6	5.5	5.6
3	3.4	3.5	4.3	4.4	5.1	5.2	6.3	6.4
4	3.8	3.9	4.7	4.8	5.7	5.8	6.9	7.0
5	4.1	4.2	5.2	5.3	6.2	6.3	7.6	7.7
6	4.4	4.5	5.6	5.7	6.7	6.8	8.1	8.2
7	4.7	4.8	5.9	6.0	7.1	7.2	8.7	8.8
8	5.0	5.1	6.3	6.4	7.6	7.7	9.2	9.3
9	5.3	5.4	6.7	6.8	8.0	8.1	9.8	9.9
10	5.5	5.6	6.9	7.0	8.3	8.4	10.1	10.2
11	5.8	5.9	7.2	7.3	8.6	8.7	10.6	10.7
12	5.9	6.0	7.4	7.5	8.9	9.0	10.9	11.0
13	6.1	6.2	7.6	7.7	9.1	9.2	11.1	11.2
14	6.2	6.3	7.7	7.8	9.3	9.4	11.3	11.4
15	6.4	6.5	8.0	8.1	9.5	9.6	11.7	11.8
16	6.5	6.6	8.1	8.2	9.7	9.8	11.9	12.0
17	6.6	6.7	8.2	8.3	9.9	10.0	12.1	12.2
18	6.7	6.8	8.4	8.5	10.1	10.2	12.3	12.4
19	6.8	6.9	8.5	8.6	10.2	10.3	12.4	12.5
20	6.9	7.0	8.6	8.7	10.4	10.5	12.7	12.8
21	7.0	7.1	8.8	8.9	10.5	10.6	12.9	13.0
22	7.1	7.2	8.9	9.0	10.7	10.8	13.1	13.2
23	7.2	7.3	9.0	9.1	10.8	10.9	13.2	13.3
24	7.3	7.4	9.2	9.3	11.0	11.1	13.4	13.5
25	7.4	7.5	9.3	9.4	11.2	11.3	13.6	13.7
26	7.5	7.6	9.4	9.5	11.2	11.3	13.8	13.9
27	7.6	7.7	9.4	9.5	11.3	11.4	13.9	14.0
28	7.7	7.8	9.6	9.7	11.5	11.6	14.1	14.2
29	7.7	7.8	9.7	9.8	11.6	11.7	14.2	14.3
30	7.9	8.0	9.8	9.9	11.8	11.9	14.4	14.5
31	7.9	8.0	9.9	10.0	11.9	12.0	14.5	14.6
32	8.0	8.1	10.0	10.1	12.0	12.1	14.6	14.7
33	8.1	8.2	10.1	10.2	12.2	12.3	14.9	15.0
34	8.2	8.3	10.2	10.3	12.2	12.3	15.0	15.1
35	8.3	8.4	10.4	10.5	12.4	12.5	15.2	15.3
36	8.3	8.4	10.4	10.5	12.5	12.6	15.3	15.4
37	8.4	8.5	10.5	10.6	12.6	12.7	15.4	15.5
38	8.5	8.6	10.6	10.7	12.8	12.9	15.6	15.7
39	8.6	8.7	10.7	10.8	12.9	13.0	15.7	15.8
40	8.6	8.7	10.8	10.9	13.0	13.1	15.8	15.9
41	8.7	8.8	10.9	11.0	13.1	13.2	16.0	16.1

INSTRUCTIONS FOR THE USE OF OPT WEIGHT TABLE:

Look for the child's age in months at the first column, then run your fingers horizontally until you find the column where the actual weight of the child falls. For example, a 5-month old child weighing 5.5 kg. is mildly underweight.

106

**PHILIPPINE NUTRITION PROGRAM
OPERATION TIMBANG
WEIGHT TABLE FOR PRESCHOOLERS (42-83 MONTHS)**

Age in of Last Birth date (Months)	UNDERWEIGHT						Normal Weight		Over- Weight
	Severely Underweight (3rd Degree)	Moderately Underweight (2nd Degree)		Mildly Underweight (1st Degree)		From	To		
	Below & Up to	From	To	From	To	From	To	From Above	
42	8.8	8.9	11.0	11.1	13.2	13.3	16.2	16.3	
43	8.9	9.0	11.1	11.2	13.3	13.4	16.3	16.4	
44	8.9	9.0	11.2	11.3	13.4	13.5	16.4	16.5	
45	9.0	9.1	11.2	11.3	13.5	13.6	16.5	16.6	
46	9.1	9.2	11.3	11.4	13.6	13.7	16.6	16.7	
47	9.1	9.2	11.4	11.5	13.7	13.8	16.7	16.8	
48	9.2	9.3	11.6	11.7	13.9	14.0	16.9	17.0	
49	9.3	9.4	11.6	11.7	14.0	14.1	17.1	17.2	
50	9.4	9.5	11.7	11.8	14.0	14.1	17.2	17.3	
51	9.4	9.5	11.8	11.9	14.1	14.2	17.3	17.4	
52	9.5	9.6	11.8	11.9	14.2	14.3	17.4	17.5	
53	9.5	9.6	12.0	12.1	14.4	14.5	17.6	17.7	
54	9.7	9.8	12.1	12.2	14.5	14.6	17.7	17.8	
55	9.7	9.8	12.2	12.3	14.6	14.7	17.8	17.9	
56	9.8	9.9	12.2	12.3	14.7	14.8	17.9	18.0	
57	9.8	9.9	12.3	12.4	14.8	14.9	18.0	18.1	
58	10.0	10.1	12.4	12.5	14.9	15.0	18.3	18.4	
59	10.1	10.2	12.6	12.7	15.1	15.2	18.5	18.6	
60	10.1	10.2	12.7	12.8	15.2	15.3	18.6	18.7	
61	10.3	10.4	12.8	12.9	15.4	15.5	18.8	18.9	
62	10.3	10.4	12.9	13.0	15.5	15.6	18.9	19.0	
63	10.4	10.5	13.1	13.2	15.7	15.8	19.1	19.2	
64	10.5	10.6	13.1	13.2	15.8	15.9	19.3	19.4	
65	10.6	10.7	13.2	13.3	15.8	15.9	19.4	19.5	
66	10.7	10.8	13.4	13.5	16.0	16.1	19.6	19.7	
67	10.8	10.9	13.5	13.6	16.2	16.3	19.8	19.9	
68	10.9	11.0	13.6	13.7	16.3	16.4	19.9	20.0	
69	11.0	11.1	13.7	13.8	16.5	16.6	20.1	20.2	
70	11.1	11.2	13.9	14.0	16.6	16.7	20.4	20.5	
71	11.2	11.3	14.0	14.1	16.7	16.8	20.5	20.6	
72	11.3	11.4	14.1	14.2	16.9	17.0	20.7	20.8	
73	11.4	11.5	14.2	14.3	17.0	17.1	20.8	20.9	
74	11.4	11.5	14.2	14.3	17.1	17.2	20.9	21.0	
75	11.5	11.6	14.3	14.4	17.2	17.3	21.0	21.1	
76	11.5	11.6	14.4	14.5	17.3	17.4	21.1	21.2	
77	11.6	11.7	14.5	14.6	17.4	17.5	21.2	21.3	
78	11.6	11.7	14.6	14.7	17.5	17.6	21.3	21.4	
79	11.7	11.8	14.7	14.8	17.6	17.7	21.6	21.7	
80	11.9	12.0	14.9	15.0	17.8	17.9	21.7	21.8	
81	12.0	12.1	15.0	15.1	17.9	18.0	21.9	22.0	
82	12.1	12.2	15.1	15.2	18.1	18.2	23.1	23.2	
83	12.2	12.3	15.2	15.3	18.2	18.3	24.3	24.4	

INSTRUCTION FOR THE USE OF OPT. WEIGHT TABLE:

Look for the child's age in months at the first column, then run your fingers horizontally until you find the column where the actual weight of the child falls. For example, a 60-month old child weighing 13.2 kg. is mildly underweight.

**Formative Research
Protocol
(Manual of Instruction)**

VITEX FORMATIVE RESEARCH
AUGUST 1991

MANUAL OF INSTRUCTIONS

DEPARTMENT OF HEALTH AND
HELEN KELLER INTERNATIONAL

FINANCIAL STATUS REPORT
 (Follow instructions on the back)

1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED
 U.S. AID/WASHINGTON

2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER
 DAN-5116-A-00-0074-00

OMB Approved No. 80-RO180

PAGE 1 OF 2 PAGES

3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code)
 HELEN KELLER INTERNATIONAL, INC.
 15 WEST 16th STREET
 NEW YORK, NEW YORK 10011

4. EMPLOYER IDENTIFICATION NUMBER
 13-5562162

5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER
 FRI.C-72-00-1481

6. FINAL REPORT
 YES NO

7. BASIS
 CASH ACCRUAL

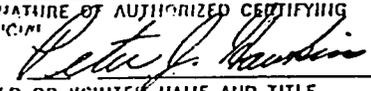
8. PROJECT/GRANT PERIOD (See instructions)
 FROM (Month, day, year) 9/30/90 TO (Month, day, year) 9/29/93

9. PERIOD COVERED BY THIS REPORT
 FROM (Month, day, year) 1/01/92 TO (Month, day, year) 3/31/92

PROGRAMS/FUNCTIONS/ACTIVITIES	STATUS OF FUNDS						TOTAL (g)
	(a) SALARIES	(b) FRINGE BENEFITS	(c) CONSULTANTS	(d) EVALUATION	(e) SUPPLIES	(f) EQUIPMENT	
Net outlays previously reported	\$ 142,484	\$ 20,234	\$ 9,357	\$ 31,933	\$ 13,022	\$ 165,640	\$ 531,949
Total outlays this report period	23,279	3,924	8,615	(2,371)	(1,926)	118	57,610
Less: Program income credits	0	0	0	0	0	0	0
Net outlays this report period (line b minus line c)	23,279	3,924	8,615	(2,371)	(1,926)	118	57,610
Net outlays to date (line a plus line d)	165,763	24,158	17,972	29,562	11,096	165,758	569,559
Less: Non-Federal share of outlays	17,159	2,291	7,049	423	1,147	159,512	238,001
Total Federal share of outlays (line e minus line f)	148,604	21,867	10,923	29,139	9,949	6,246	351,558
Total unliquidated obligations	0	0	0	0	0	0	0
Less: Non-Federal share of unliquidated obligations shown on line h	0	0	0	0	0	0	0
Federal share of unliquidated obligations	0	0	0	0	0	0	0
Total Federal share of outlays and unliquidated obligations	148,604	21,867	10,923	29,139	9,949	6,246	351,558
Total cumulative amount of Federal funds authorized	322,292	33,984	51,000	150,441	19,800	8,500	900,000
Unobligated balance of Federal funds	173,688	12,117	40,077	121,302	9,851	2,254	548,442

10. TYPE OF RATE (Place "X" in appropriate box) PROVISIONAL PREDETERMINED FINAL FIXED

11. CERTIFICATION
 I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.

12. SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL

 TYPED OR PRINTED NAME AND TITLE
 Peter J. Hawkins, Controller

13. DATE REPORT SUBMITTED
 4/21/92

14. TELEPHONE (Area code, number and extension)
 212-807-5851

REMARKS: Attach any explanations deemed necessary or information required by Federal sponsoring agency in compliance with governing legislation.

FINANCIAL STATUS REPORT <i>(Follow instructions on the back)</i>		1. FEDERAL AGENCY AND ORGANIZATIONAL ELEMENT TO WHICH REPORT IS SUBMITTED U.S. AID/WASHINGTON		2. FEDERAL GRANT OR OTHER IDENTIFYING NUMBER DAN-5116-A-00-0074-00		OMB Approved No. 80-RO180		PAGE OF 2 2 PAGES					
3. RECIPIENT ORGANIZATION (Name and complete address, including ZIP code) HELEN KELLER INTERNATIONAL, INC. 15 WEST 16th STREET NEW YORK, NEW YORK 10011		4. EMPLOYER IDENTIFICATION NUMBER 13-5562162		5. RECIPIENT ACCOUNT NUMBER OR IDENTIFYING NUMBER FRLC-72-00-1481		6. FINAL REPORT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		7. BASIS <input type="checkbox"/> CASH <input checked="" type="checkbox"/> ACCRUAL					
		8. PROJECT/GRANT PERIOD (See instructions)				9. PERIOD COVERED BY THIS REPORT							
		FROM (Month, day, year) 9/30/90		TO (Month, day, year) 9/29/93		FROM (Month, day, year) 1/01/92		TO (Month, day, year) 3/31/92					
STATUS OF FUNDS													
PROGRAMS/FUNCTIONS/ACTIVITIES >		(a) TRAINING	(b) TRAVEL	(c) ALLOWANCE	(d) OTHER DIRECT COST	(e) INDIRECT COST	(f)	TOTAL (g)					
a. Net outlays previously reported		\$ (2,148)	\$ 28,052	\$ 13,912	\$ 12,726	\$ 96,737		\$					
b. Total outlays this report period		21,395	(5,988)	(30)	361	10,233							
c. Less: Program income credits		0	0	0	0	0							
d. Net outlays this report period (Line b minus line c)		21,395	(5,988)	(30)	361	10,233							
e. Net outlays to date (Line d plus line d)		19,247	22,064	13,882	13,087	106,970							
f. Less: Non-Federal share of outlays		(2,278)	5,077	0	3,869	43,752							
g. Total Federal share of outlays (Line e minus line f)		21,525	16,987	13,882	9,218	63,218							
h. Total unliquidated obligations		0	0	0	0	0							
i. Less: Non-Federal share of unliquidated obligations shown on line h		0	0	0	0	0							
j. Federal share of unliquidated obligations		0	0	0	0	0							
k. Total Federal share of outlays and unliquidated obligations		21,525	16,987	13,882	9,218	63,218							
l. Total cumulative amount of Federal funds authorized		9,000	100,078	39,000	0	165,905							
m. Unobligated balance of Federal funds		(12,525)	83,091	25,118	(9,218)	102,687							
10. DIRECT EXPENSE		a. TYPE OF RATE (Place "X" in appropriate box) <input checked="" type="checkbox"/> PROVISIONAL <input type="checkbox"/> PREDETERMINED <input type="checkbox"/> FINAL <input type="checkbox"/> FIXED			b. RATE 21.6%			c. BASE		d. TOTAL AMOUNT		e. FEDERAL SHARE	
11. CERTIFICATION		I certify to the best of my knowledge and belief that this report is correct and complete and that all outlays and unliquidated obligations are for the purposes set forth in the award documents.			SIGNATURE OF AUTHORIZED CERTIFYING OFFICER: <i>Peter J. Hawkins</i>			DATE REPORT SUBMITTED 4/21/92		TELEPHONE (Area code, number and extension) 212-007-5851			
TYPED OR PRINTED NAME AND TITLE Peter J. Hawkins, Controller													

VITEX PROJECT

*MANUAL OF INSTRUCTIONS
FOR THE CONDUCT
OF VITEX FORMATIVE RESEARCH*

AUGUST 1991

PREPARED BY: VIGIL AGUILAR
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112

<i>TABLE OF CONTENTS</i>	<i>page</i>
1. BACKGROUND.....	1
2. VITEX RESERACH COMPONENTS.....	1
3. FORMATIVE RESEARCH.....	2
OBJECTIVES.....	2
METHODS.....	2
TOOLS.....	2
SAMPLING.....	3
STUDY RESPONDENTS.....	4
PLAN OF WORK.....	6
DATA ANALYSIS.....	9
4. INTERVIEW GUIDES	
MOTHERS	
IN-DEPTH INTEVIEW GUIDE	
FGD GUIDE: WEANING	
FGD GUIDE: NUTRITION EDUCATION	
BHW IN-DEPTH INTERVIEW GUIDE	
RHM IN-DEPTH INTERVIEW GUIDE	
HILOT IN-DEPTH INTERVIEW GUIDE	
FOOD AVAILABILITY CHECKLIST	
5. APPENDICES	
MODERATING FGDS	
SPECIAL PROBLEMS IN FGDS	
BACKGROUND ON WEANING	
BACKGROUND ON NUTRITION EDUCATION	

1. BACKGROUND

The goal of the VITEX project is to reduce VAD, and its associated ocular manifestations, morbidity and mortality. The project aims to attain this goal by:

1. increasing the proportion of high risk groups receiving a high dose (200,000 IU) vitamin supplement within the past six months to at least 60% in 2 years; and
2. increasing the mean frequency of consumption of foods containing vitamin A among risk groups.

The project will do this through introducing and intensifying the implementation of two interventions: vitamin A supplementation and nutrition education. These are described in detail in other documents (VITEX:DIP; VITEX: Briefing Kit, VITEX: Conceptual Framework).

2. RESEARCH COMPONENTS

The project will undertake several studies in connection with the design of specific interventions, monitoring of program implementation, and measuring project outputs and impact. These studies fall into three groups:

1. Pre-post Intervention Survey: designed to measure changes in xerophthalmia prevalence, VAC distribution, and feeding practices of mothers of 0-24 month old infants before and after the project interventions.
2. Formative Research: designed to provide insights into weaning practices and beliefs, the nature, conduct and perception of community nutrition education activities, and health workers needs with respect to VAC supplementation and nutrition education activities. This results of this study will be used shape the interventions, specifically, the nutrition education messages and media.
3. Monitoring Studies: designed to assess the progress and problems in project implementation.

The remainder of this manual will discuss the objectives, methods and operational details of the conduct of the formative research.

FORMATIVE RESEARCH

Objectives: The purpose of this study is to gain insights into mothers' and health workers' beliefs and perceptions with respect to project interventions. This will allow the program planners to conceptualize appropriate nutrition education messages, develop appropriate support strategies of health workers, and anticipate problems in implementing proposed interventions. Specifically, the study will:

1. Determine appropriate content and corresponding medium of nutrition education to be disseminated.
2. Determine factors affecting the participation of mothers in mothers classes.
3. Determine the factors affecting the ability of midwives and BHWs to conduct mothers classes, distribute materials to mothers and follow up mothers practices in the home.
4. Determine the factors which affect mothers participation in OPT.

Methods:

This study will use qualitative methods to obtain in-depth responses about what people think and how they feel with respect to the information areas listed above. It will primarily use two qualitative research techniques, in-depth interviews and focus-group discussions, and use an observation checklist to supplement interview findings.

Respondents Groups:

Respondents will consist of the following groups:

Mothers (of infants 0-24 months)
Hilots (and other community/family members who may play a significant role in shaping weaning practices and beliefs)
Health
Workers (midwives, barangay health workers)

Data Collection Tools:

In-depth interview, group discussion and observation guides for the respondent groups have been developed by the VITEX formative research team. Copies of these are provided in the appendix. Data collection tools are described below for each respondent group:

- A. Mothers:
1. INTERVIEW GUIDE which investigates mothers' SES, food practices, and media habits.
 2. GROUP DISCUSSION GUIDE on WEANING to be used by the FGD moderator in guiding a discussion about weaning beliefs and habits among mothers.
 3. GROUP DISCUSSION GUIDE on NUTRITION EDUCATION to be used by the FGD moderator in guiding a discussion on nutrition education activities and sources of advice in the community.
 4. FOOD AVAILABILITY OBSERVATION GUIDE (CHECKLIST) to be used by interviewer to determine food available in the household.
- B. Hilots
5. INTERVIEW GUIDE to be used when interviewing hilots (either in a group or individually).
- C. Health Workers
6. INTERVIEW GUIDE to be used when interviewing midwives and barangay health workers (either in a group or individually).

Sampling Design

Villages and respondents will be purposefully selected. As such, the sample will be non-random. (NOTE: Caution must be taken not to generalize study findings due to this fact).

1. Study Locations: Three villages will be sampled, one from each of the following types of municipalities: coastal, lowland farming, and upland. These geotypes have been selected because it is thought that geographic differences affect access and availability to food items and health services.

2. Criteria for Selecting Villages

- * Villages should represent the geotype well.
- * Barangays should be considered economically depressed.
- * Health services coverage should be average or poor.
- * Malnutrition among young children is known or probable.
- * Interviewer does not come from this barangay.
- * Peace and order situation is stable.

116

Study Respondents: In each barangay, 10-20 mothers of children between 0-24 months will be interviewed. BHWs, hilots, barangay captains (and, if necessary, others who play a significant role in shaping weaning practices and beliefs) will also be interviewed.

1. Selecting Mothers:

- * Interviews should be coordinated with the midwife in the barangay and the barangay captain. In selecting mothers, make sure she meets the criteria (i.e. has a living child who is between 0-24 months).
- * Go to different parts of the barangay (i.e. different puroks) and select every 8th household. If the household qualifies under the target group and the mother is home, interview her. Otherwise go to the next house until you find a mother who fits the target group. Do not just select mothers who are easy to get to or who are all related to each other or live near each other. This is very important to remember because we want the communication strategy to reach mothers who are not usually reached by other means of communication.

2. Number of Respondents/FGDs

In-depth Interviews:

- * Mothers: Each interviewer is expected to interview 3 mothers in the morning and to invite them to a focus group discussion planned for the afternoon. Two days will be spent in 1 village. On each day, in-depth interviews will take place with mothers in the morning, and one focus group discussion (FGD) will take place with a group of mothers in the afternoon or evening.
- * Hilots/BHW/RHM: Interviewers who are not part of the FGDs will interview the village hilots, rural health midwife, and others who are thought to significantly influence mothers' weaning practices and beliefs.

Focus Group Interviews (Mothers)

- * 8-10 mothers per group (those who were interviewed earlier in the day).
- * Conduct the Weaning FGD on one day, and the Nutrition Education FGD on the next day. Include the mothers who were interviewed in the morning of the same day for each group respectively.

3. Estimated Total Number of Respondents

	<u>In-depth Interviews</u>				<u>FGDs</u>	
	<u>Mothers</u>	<u>BHW</u>	<u>RHM</u>	<u>Hilot</u>	<u>Wean</u>	<u>Nut. Ed.</u>
Coastal	20	1	1	1	1	1
Lowland Farming	20	1	1	1	1	1
<u>Upland</u>	<u>20</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>1</u>
TOTAL	60	3	3	3	3	3

PLAN OF WORK / DAILY ACTIVITIES

1. PRE-INTERVIEW PREPARATION

- 1.1 Review materials on vitamin A rich foods, food preparation, weaning practices, radio programs, etc. so that you are very familiar with each of the information areas.
- 1.2 Carefully review all questions in question guide and make sure you understand each question.
- 1.3 Make sure you have needed supplies including batteries for your tape recorder, empty cassettes, pencils/pens and a notebook with a legend of major variables (eg. Demographic Information, Perception of Health, Perception of Food, etc.)
- 1.4 Make sure you know how to use the tape recorder well (ie. how to record, how to switch tapes once one is full, how to stop and start the tape recorder).
- 1.5 Know which barangays you will visit. This will be determined during the in-depth interview training. Contact the RHP and RHM to explain the nature of your research. Coordinate with them when you go to the selected barangays. Request from them a household index list and a map of the barangay for identifying respondents.
- 1.6 Make arrangements to bring a pack lunch so that your visit will not inconvenience the RHM or the community.

2. AT THE INTERVIEW SITE: BEFORE CONDUCTING THE INTERVIEWS

- 2.1 Coordinate with the health personnel in-charge. Brief them about the objectives, significance and methodology of your research.

- 2.2 Pay a courtesy call to the barangay captain and explain the nature of your research and ask for his cooperation. Present list of possible respondents for location, and schedule a time to interview him.
- 2.3 Select respondents according to the defined target groups (ie. mothers with children between the ages of 0 month to 24 months). In selecting respondents chose those who are:
 - * from poorer families
 - * distant from health services/barangay health station
 - * most likely to have children with vitamin A deficiency (as identified by RHM) or undernourished.
- 2.4 In selecting mothers from the same barangay, go to different parts of the barangay (ie. different puroks). Do not just select mothers who live next to each other and are easily reached. This is very important because we want the communications strategy to especially reach those who are not reached by other means of communication.

3. INTERVIEWING RESPONDENTS

- 3.1 Interview selected mother. Introduce yourself. Explain that you want to talk to her about her food practices and learn about her customs. Ask her permission to tape the interview.
- 3.2 Conduct the interview. Remember to practice what you learned about conducting interviews. See reference materials for review of the "dos and don'ts" of conducting interviews.
- 3.3 After the interview thank the mother for the information given.
- 3.4 Target 3 interviews per day.

4. AFTER THE INTERVIEW

- 4.1 Review your notes after each interview to make sure you can understand what you wrote, and to make sure you covered completely all areas of inquiry with the mother. You will use these notes and fill in anything you missed later in the day when you listen to the tape of the interview.

- 4.2 Listen to the tape of the interview and fill in the gaps in your notes.
- 4.3 Record the responses for each variable (ie. Weaning Practices, etc.) on a separate sheet where you will consolidate the findings of all of your interviews for each barangay.

5. ANALYSIS OF INTERVIEWS: REPORT WRITING

- 5.1 After completing the interviews of all respondents per barangay, a separate section for each target group should be written which consolidates the findings for each of the major variables. This means that a report for each barangay would include the following (see Analysis Plan, Steps in Consolidating the Interviews, Analyzing the Findings and Writing the Report for Each Barangay, and a Sample Report):

Mothers

Mothers of Preschoolers 0-24 months

Health Workers

Hilots

- 5.2 Submit consolidated reports for each village to the Area Coordinator by _____. Attach copies of your field notes and at least one of the taped interviews you conducted.

DATA ANALYSIS PLAN

1. WHO WILL ANALYZE THIS INFORMATION?

As the researchers, you will play an important part in consolidating the findings, analyzing the results and writing-up your findings. Since you have collected the information, it is best that you also take the responsibility for analyzing the information you collected.

2. WHAT IS THE PLAN FOR DATA ANALYSIS?

A separate report will be submitted for each barangay. Guidelines are provided to assist the researchers in consolidating the interviews, analyzing the findings and writing a report on the findings. the reports will be submitted to the _____ by no later than _____.

3. STEPS IN CONSOLIDATING THE INTERVIEWS, ANALYZING THE FINDINGS AND WRITING THE REPORT FOR EACH BARANGAY

3.1 General Comments about Analyzing Qualitative Research Findings

1. The intention of qualitative research is to obtain in-depth information from a few people more than quantitative data from a large sample of information. Therefore, in analyzing the findings it is important to try to draw out trends in practices and beliefs, identify patterns of responses made and identify key values and fears of respondents.
2. A critical aspect of qualitative research is to get a good understanding of why people do and believe what they do. It is not enough to find out simply what they practice or do. The reasons behind what people do is even more critical to a communications strategy, than simply what they currently do.

3.2 Steps in Consolidating the Interviews:

1. After each interview, carefully review the notes you took to make sure you have fully explored all areas of information in the question guide. You can do this by listening to the tape of the interview and see if all of the areas have been covered. It is important to note that after a respondent has told you what she does or how she behaves that you have asked why, and that you understand the respondent's explanation.
2. As much as possible, direct quotes of the respondents should be used, particularly when they are describing what they think or what they feel and believe in certain practices. Two examples of providing direct quotes are:

When asked "In what way a mother feels vegetables are good for her 1 year old son?", she answers "They are good because they make him alert and attentive".

When asked, "How do you feel about giving the first milk that goes out of your breast to your child?", and she response, "I would not give it because my grandmother says it is not good for the baby, and others say it is spoiled milk".

3. After each interview, it is useful to consolidate the responses for each variable on one sheet of paper. For example, one major variable is "Weaning Practices". After each interview is conducted, place the responses of each mother regarding weaning practices on one sheet of paper. This paper can be sub-divided into several subheadings such as "Initiation of Semi-solid Foods", "Misconceptions about Weaning", etc. It is best to consolidate the interviews after each day, so that by the time you have completed all of the interviews in one village, all of the responses are organized under a major variable heading, and ready to be analyzed.

3.3 Analyzing the Findings

1. If you have been consolidating the findings after each interview or two, at this stage you should have responses from each of the interviewees organized by major variables.
2. The first step in analyzing the responses by variable is to make sub-categories of the major variables and group the responses together. For example, if you have consolidated all the responses for leisure/media habits on one sheet, group those pertaining to kind of media together (eg. radio, print media, interpersonnel communication). Or, take the category on weaning, and subdivide this category into "First Foods Given", "Foods Good for 6-12 Month Child".
3. Then examine all of the responses for patterns and trends. For example, if mothers all said they fed their child green leafy vegetables daily, did they all mention green leafy vegetables during the food recall? Or, did a majority of mothers give certain responses that were similar? Were there noticeable differences in the responses/practices/beliefs that mothers gave on weaning practices, breastfeeding practices, etc.? Were there similar expressions or words that mothers used to describe their practices/beliefs?
4. Determine the highlights of your findings for each of the variables. For some of the variables, such as the 24-hour food recall, and food perceptions, you may actually want to count how many respondents had similar practices or beliefs. Listing the foods most commonly consumed is very valuable. Provide enough detail for each of the variables when you write up the report.

Steps in Writing the Report of Findings for Each Barangay

1. One report for each village should be made. The report will serve to consolidate the findings of the interview and highlight the major results.

2. The report should contain for each barangay:

PART I

1.1 Information to Identify Village

Name of Barangay, Geographical Type (ie. Urban slum/Coastal-Rural/Upland-Rural), Name of Municipality, Name of Province, Name of Interviewer.

1.2 Brief Description of the Village

Geographical setting.

Predominant Occupation of barangay residents.

Accessibility.

Presence of a Market.

Presence of a health center/health services available to village.

Economic status of village (presence of industries, resources, general economic classification).

1.3 Brief Description of Interview Conducted in Village

Highlights or significant occurrences.

Problems or difficulties encountered in conducting interviews.

Number of interviews conducted by target group.

Your assessment of how cooperative and honest the respondents were (ie. do you think they were telling you how things really are, or do you think they were telling you what they thought you wanted to hear).

PART II

2.0 Detailed Findings of Interviews

2.1 Mothers:

Preschoolers 0-24 months

Pregnant Mothers

Lactating Mothers

2.2 Health Workers

2.3 Hilots

For each target group, findings are to be organized by the major variables (see next page for suggested listing of major variables for each target group). Where possible, direct quotes from the respondents should be used to substantiate findings.

125

Interviewer _____
Barangay _____
Province _____

Municipality _____
Date _____

PAGE 1

GOOD MORNING. I AM _____. WE ARE CONDUCTING A STUDY IN THIS AREA TO UNDERSTAND THE FOOD HABITS OF THE COMMUNITY. WE ARE INTERVIEWING SOME PEOPLE LIKE YOU WHO HAVE YOUNG CHILDREN. I WILL BE GRATEFUL IF YOU COULD SPARE SOME TIME TO ANSWER A NUMBER-OF QUESTIONS. LATER IN THE AFTERNOON, WE WILL ALSO HAVE A DISCUSSION WITH A GROUP OF MOTHERS. WE WOULD LIKE YOU TO JOIN US (GIVE TIME AND PLACE).

I. GENERAL HOUSEHOLD INFORMATION

PAGE 2

Name of parent (person responding) _____

Mother's age? _____ yrs.

Educational Status of: Father _____

Mother _____

Pregnant _____ (months)

Lactating Yes No

Age of Youngest Child: _____ (months)

What is the occupation of the adults in the house:

Father _____

Mother _____

Others _____

What is the approximate income of the family per month? _____

Roughly what percent is spent on food? _____

Who takes care of the child during the day? _____

What is your religion? _____

What dialect do you speak in the house? _____

II. PERCEPTION OF HEALTH

Now, I'd like to talk to you about (name of infant/baby).

How would you say _____ health is?

What makes you say so?

Are you happy with _____ condition? Why? Why not?

What do you do to make sure _____ has good health?

(SPACE BELOW FOR WRITING RESPONSES)

III. BREAST FEEDING

Are you breastfeeding _____?

IF YES: How frequently?

Are you having any problems breastfeeding?

Are you giving any other kind of milk (powdered, canned)? What kind? Why?

How many times a day do you breastfeed _____?

IF NO: Why not?

IV. PREVIOUS DAY'S FOOD RECALL

Now I'd like to ask you about the food (name of child) eats. I would like you to tell me everything (name of child) ate or drank YESTERDAY. Include snacks, drinks including breastmilk, and everything else he ate YESTERDAY. What time did he wake up? Did you give him anything to eat or drink at that time? What was it? When did your child next have something to eat or drink? (Repeat for whole day)

3

TIME	FOOD OR DRINK GIVEN	REMARKS

Is this the usual food you feed _____?
 IF YES: Are there other foods you usually serve _____?
 What are these?
 IF NO: In what way was it different?
 What are the usual foods you feed _____?

V. FEEDING PRACTICES

Which of the following do you most commonly feed _____?

- RICE/ROOTCROPS/CEREALS FRUITS BEANS
 VEGETABLES MEAT/FISH/EGGS CONDIMENTS (SUGAR, OIL,

AFTER COMPLETING QUESTIONS BELOW FOR FOODS MENTIONED, ASK THE MOTHER "Do you feed _____ any (food)?" FOR CATEGORIES NOT MENTIONED. IF NOT-FF ASK, "Why not?"; IF FOOD IS GIVEN PROCEED WITH QUESTIONS BELOW.

MAKE SURE TO ASK ALL OF THE RELEVANT QUESTIONS BELOW FOR EACH CATEGORY. SOME QUESTIONS WILL NOT APPLY TO ALL CATEGORIES.

- What are all the kinds of (food) you feed to _____? PROBE. Any others?
At what age did you start giving (food) to _____? Why at this age?
How did you prepare them? Did you mix them with anything? What?
Which do you feed to _____ most often? Why?
Which of these does he like the most? Why?
Which of these do you feel is best for _____'s health? Why?
Do you feel there are any (food) bad for _____'s health? Which? Why?
Specifically do you feed _____ (specific food if not mentioned earlier such as DGLVs like malunggay, kangkong, or kamote tops)? Why/why not?
Do you feel these are good or bad for _____'s health? Why?
Are there any other (food) you want to give _____ but cannot? Which? Why?
Are there any (food) not well tolerated by _____? Which? Why?
Do you feel (food) perform any special function for infants? What?

VI. MEDIA HABITS

Do you listen to the radio? Yes No
 Which are your favorite programs?

During which time of the day do you listen most of the time? Why?

Is there any reading material in the house? Yes No
 What kind? (write specific names)

Do you read any ___ newspapers, ___ magazines or ___ comics?
 Which ones?

How often?

VII. MEDIA PERSONALITIES

Have you heard of any famous personalities? Who?
 Among the personalities you have heard of, who do you
 admire the most? Why?
 Among the personalities you have heard of, who would you like your
 child to grow up being like? Why?

THANK MOTHER FOR HER TIME. ASK HER TO ATTEND THE GROUP DISCUSSION
 LATER IN THE AFTERNOON (SPECIFY TIME AND PLACE) WHERE OTHER MOTHERS
 WILL BE GIVING THEIR OPINIONS ABOUT NUTRITION.

ASK MOTHER IF AND HOW OFTEN EACH FOOD ITEM IS CONSUMED BY THE FAMILY AND WHY?

FOOD ITEMS	CONSUMED		WHY?
	OFTEN	RARE	
DARK GREEN LEAFY VEG			
Alugbati, talbos			
Ampalaya, talbos			
Gabi, dahon			
Kamote, talbos			
Kangkong, talbos			
Kintsay			
Kulitis			
Espinaka			
Lato			
Letsugas			
Malunggay, talbos			
Mustasa			
Pako			
Petsay			
Saluyot			
Sampalok, talbos			
Sili, talbos			
Sitaw, talbos			
DARK YELLOW VEG			
Kalabasa, bulaklak			
Kalabasa, bunga			
Kamote, dilaw			
Karot			

131

MOTHERS (0-24 Months)

FGD GUIDE: WEANING
Mothers (of infants 0-24 months)

I. WARM-UP AND EXPLANATION (10 MINUTES)

A. INTRODUCTION

1. Thank you for coming.
2. Your presence is important.
3. (Describe what a focus group is--like an opinion survey, but very general, broad questions.)

B. PURPOSE

1. We will be discussing the way you feed very young children, the foods you give them, and why you feel they should be fed this way.
2. I'm interested in all your ideas, comments and suggestions.
3. There are no right or wrong answers.
4. All comments, both positive and negative are welcome.
5. Please feel free to disagree with one another. We would like to have many points of view.

C. PROCEDURE

1. I want this to be a group discussion, so you needn't wait for me to call on you. Please speak one at a time, though.
2. We have a lot to cover, so I may change the subject or move ahead. Please stop me if you want to add something.

D. SELF-INTRODUCTIONS

1. (Ask each participant to introduce herself) Tell us your name and something about yourself,--for example, what you do, how long you've lived in this area, how many children you have.

II. GENERAL PERCEPTION OF GOOD HEALTH AMONG INFANTS/YOUNG CHILDREN

A. Definition of Good Health

When can you say an infant/young child has good health?
What makes you say so? Anything else?

B. Ways to Ensure Good Health

What can you do to make sure an infant/young child has good health? Anything else?
Are there any things you want to do, but cannot not? What?
Why can't you do these things?

III. WEANING

A. Introduction of Semi-Solids

Other than milk, what other foods do you give to infants?
Why/why not?

Why do you give other foods? Probe.

When is the best time to start giving a young child food other than breastmilk? Why?

What was the first food that you started to give regularly to young children?

What were all the ingredients? How was it made?

How do you introduce foods to an infant? Why do you introduce foods in this way?

How often do you give semi-solid food to infants each day? each week?

And how much do you give every time?

B. Breastfeeding During Weaning

Do you continue giving breastmilk, even when you are introducing foods to your infant? Why/why not?

Do you breastfeed before or after you give infants food? Why?

C. Changes in Practices as Infant grows Older

At what age do you change the diet of infants? Why?

How do you change it? Why? (Probe about the quality of food, frequency of feedings, amount given at each feeding, etc.)

Do you give only one food at a time or a mix of foods to infants? If mixes, what mixes do you give? Why?

If single foods, why only one food at a time?

D. Benefits of Weaning Practices

What advantages or results have these foods given to your child? Do you see any changes in your child as a result of giving these foods? What changes have you noticed?

E. Willingness to try new or different foods

Would you be willing to try new foods for your baby? What kind of other foods would you be willing to try? Is there anything preventing you from giving these foods to your child now? What?

MOTHERS (0-24 MONTHS)

G. Mothers' Concerns about Infants During the Weaning Period

What worries you most about your 6-12 month old babies? Why? Probe.

Was there a particular time when you especially worried? What was this time? What made you worried?

What do you do to make sure that does not happen again? Why?

H. Weaning Food Preparation

How do you prepare foods for your baby?

Do you get foods for your baby from the food you prepare for the other family members, or do you prepare food specially for your baby?

Do you change the family food in anyway before you give it to your infant (add special ingredients? leave out certain ingredients? mash it?) How do you change the preparation? Why do you prepare it in this way?

Who usually prepares the food for young children?

How often do you cook these foods in a day?

I. Feeding Young Children

Who usually feeds young children?

How is the food given to young children? (spoon, cup, hand, pre-chewed by mother and given to child)

Do you feed them semi-solid foods as often as you breastfeed him during the day?

IV. FOOD PERCEPTIONS

A. Differences in the Way Infants of Different Ages are Fed

Is there any difference between the foods you feed a 4-6 month old baby and a baby who is 7-12 months? If yes, in what way do you feed them differently? Why do you feed them differently? (Repeat for 13-24 month old children)

B. Foods Good/Bad for 4-6 month old children

In your area, are there any foods which are considered particularly good for infants from 4 to 6 months of age?

What are these foods?

In what way are they considered good?

And are there any foods which are considered bad for young children from 4 to 6 months of age?

What are these foods?

In what way are they considered bad?

MOTHERS (0-24 Months)

C. Foods Good/Bad for 7-12 month old children

Repeat questions above for 7-12 month old infants.

D. Foods Good/Bad for 13-24 month old children

Repeat questions above for 12-24 month old infants.

V. FOOD FUNCTIONS

Food Functions: (draw on the foods mentioned by the mother earlier)

Of the foods you mentioned earlier...,, do you feel they have different functions?

What are these different functions?

Which foods perform which functions?

(Ask for the foods the respondent feels are necessary/good for the functions of

- * giving the body energy
- * protecting the body against diseases
- * helping the body to grow
- * helping intelligence to develop

VI. Vitamins: Awareness and Knowledge

Have you heard of vitamins? What are they?

Do foods contain vitamins? Which foods contain vitamins?

Do you feel (name of child) eats enough of these foods to be able to meet his/her requirement?

If not: Why does he/she not eat enough of these foods?

VII. Ways to Improve Weaning Foods

- * SHOW MOTHERS DIFFERENT PICTURES OF FOOD FROM FLANE KIT.
- * HAVE THEM SELECT WHICH THEY WOULD GIVE TO THEIR CHILD (6-12 MONTHS OLD).
- * HAVE THEM DEVELOP RECIPE IDEAS FOR COMBINING THE THREE FOOD CATEGORIES (MEAT/FISH/EGGS; VEGETABLES/FRUITS; AND DENSE CALORIES SUCH AS SUGAR OR OIL)
- * PROBÉ ON ALL THE INGREDIENTS THAT SHOULD BE INCLUDED AND THE MANNER OF PREPARATION.

- * AFTER RECIPES ARE DEVELOPED ASK THEM:

Have they tried feeding their child the recipe? Why, why not?
Would they be willing to try giving the recipe to their child? Why/why not?

MOTHERS (0-24 Months)

VIII. RECEPTIVITY TO PROPOSED BEHAVIORS

Now-a-days people say that in addition to breastfeeding a baby who is 4-5 months old, you should start giving him rice gruel mixed with oil plus one viand or vegetable. This mixture should be fed to the baby twice a day.

What do you think about this?

Do you feel you will be able to do this with your child? Why, why not?

How interested would you be in trying this?

What, if any, advantage/disadvantage do you think this would have for your infant? Why?

These days, people say that by 6 months of age, breastmilk is not enough for the baby. They say that in addition to breastfeeding a baby who is 6 months old, you should give him rice gruel mixed with oil plus viand and vegetables from the family pot. This mixture should be given to him at least 3 times a day.

What do you think about this?

Do you feel you will be able to do this with your child? Why, why not?

How interested would you be in trying this?

What, if any, advantage/disadvantage do you think this would have for your infant? Why?

IX. CLOSING

Before we end, I'd like to go around once more and ask each of you if there is anything else you'd like to say about how to feed infants. Anything that we haven't mentioned that would be important to you in how you feed your baby, or how you would recommend other mothers feed their baby?

Thank you so much for coming. You have been a good group and I have learned much from you.

FGD GUIDE: NUTRITION EDUCATION
Mothers (of infants 0-24 months)

I. WARM-UP AND EXPLANATION (10 MINUTES)

A. INTRODUCTION

1. Thank you for coming.
2. Your presence is important.
3. (Describe what a focus group is--like an opinion survey, but very general, broad questions.)

B. PURPOSE

1. We will be discussing about nutrition activities and how you learn about how to care for the nutrition and health of your children.
2. I'm interested in all your ideas, comments and suggestions.
3. There are no right or wrong answers.
4. All comments, both positive and negative are welcome.
5. Please feel free to disagree with one another. We would like to have many points of view.

C. PROCEDURE

1. I want this to be a group discussion, so you needn't wait for me to call on you. Please speak one at a time, though.
2. We have a lot to cover, so I may change the subject or move ahead. Please stop me if you want to add something.

D. SELF-INTRODUCTIONS

1. (Ask each participant to introduce herself) Tell us your name and something about yourself,--for example, what you do, how long you've lived in this area, how many children you have.

MOTHERS (0-24 months)

II. SOURCES OF ADVICE AND THEIR CREDIBILITY

I'd like to learn from you how you find out how to care for young infants and children, particularly, about what, how and when to feed them.

A. Advice From Within the House

Do you usually take any advice from anyone within the house about matters relating to child feeding and health?
Whose advice do you take?

B. Advice From Outside the House

Do you usually take any advice from anyone outside the house about matters relating to child feeding and health?
Whose advice do you take?

Whose advice would you really like to take?

Whose advice do you trust the most?

Who do you feel, in your village, knows the best about child feeding and health?

Is there anybody in your village who has been specially trained about child health and feeding?

Who is that?

III. BARANGAY HEALTH WORKER: CONTACT AND CREDIBILITY

Do you know the name of your barangay health worker? (to be checked)

Do you know her (but cannot mention name)?

Where do you meet her?

Does she come to your house? How often?

Do you ever take advice from her on child health/feeding?

Is the advice she gives you effective? Why/why not?

Would you trust her advice about child health and feeding?
Why/why not?

IV. RURAL HEALTH MIDWIFE: CONTACT AND CREDIBILITY

Do you know the name of your midwife? (to be checked)

Do you know her (but cannot mention name)?

Where do you meet her?

Does she come to your house? How often?

Do you ever take advice from her on child health/feeding?

Is the advice she gives you effective? Why/why not?

Would you trust her advice about child health and feeding?
Why/why not?

MOTHERS (0-24 months)

V. Nutrition Activities

Are there any nutrition activities which take place in your village? What are these?

Do you participate in them? Why or why not?

Which ones do you enjoy the most? Why?

Which do you enjoy the least? Why?

Which do you feel help you and your children the most? Why?

Participation in OPT

Are there occasions when children are weighed in this barangay?

Who organizes these?

Why do you feel these weighings are conducted?

Do you bring your child to be weighed? Why/why not?

Do you feel there are any advantages/disadvantages to having your child weighed? What are these?

Can these weighings help you or your child?

If yes, in what way? If no, why not?

Is there any way you feel OPT/weighing sessions should be changed? How? Why?

Significance of Nutritional Status

Have you ever been told that your child is underweight (1st, second or third degree malnourished)? Who told you?

What does it mean to you when your child is "underweight"/ 1st/2nd/3rd degree? (Probe)

IV. NUTRITION EDUCATION ACTIVITIES

Are there any activities which give information on child health and feeding that occur in your village?

What are these?

Have you ever participated in any? Why, why not?

Which activities do you like the most? Why?

Which activities do you like the least? Why?

Have you ever attended a class for mothers where information about child health and feeding is discussed? Why, why not?

IF YES:

Who organized the class?

How long was the class?

What did you like best about the class? Why?

What did you like least about the class? Why?

In what way, if any, would you want to change the class?

MOTHERS (0-24 months)

Would you attend a class about child health and nutrition taught by the midwife or BHW? Why/why not?

What topics on child health and feeding would you like to know more about?

If you were asked to give advice on how to improve nutrition education activities or classes, what advice would you give (where to hold, day/time to hold, activities to be included, etc.)

V. CLOSING

Before we end, I'd like to go around once more and ask each of you if there is anything else you'd like to say about how you learn about or would like to learn about infant health and nutrition. Anything that we haven't mentioned that would be important to you, or how you would recommend nutrition education activities are conducted?

Thank you so much for coming. You have been a good group and I have learned much from you.

RHM
IN-DEPTH INTERVIEW GUIDE

1. INTRODUCTION

Greetings. Introduce self. We are doing this study to understand the practices and food habits of the people in the area. We are interviewing people like you who regularly deal with them. I will be grateful if you could spare some time to answer a few questions.

2. PERSONAL INFORMATION

Let me start by asking you a few questions about yourself.

- What is your name?
- How old are you?
- How much have you studied?
- How many children do you have?
- What is your religion?

- For how long have you been working as a RHM?
- What made you decide to become a RHM?

3. JOB DESCRIPTION

I would like to try to understand what your work as a RHM involves.

- Can you tell me all the activities you undertake as a RHM?
- Which of these activities do you enjoy the most? Why?
- Which of these do you not like at all? Why?
- If you were asked to change your job description in any way, how would you do it?

4. NUTRITION AND HEALTH EDUCATION

- Do you talk to mothers about nutrition and health?
- Usually, on what topics do you talk to mothers about?
 - Any others?
 - On which topic do you spend most of your time? Why?
 - On which topic do you spend less time? Why?

RHM

- Where do you usually talk to the mothers? Do you go to their houses or do they come to your house or do you meet at some other place?
 - Which is the most usual?
- Do you feel you need any help to talk to mothers and advise them?
 - What kind of help would you like?
- Do you feel mothers follow your advice? What makes you say so?
 - Is there any thing else you feel will help mothers to follow your advice? What? Why?
- Have you conducted nutrition or health education activities (like mothers classes, mother craft, nutrition counseling, or others)?
 - Which did you enjoy doing the most? Why?
 - Which did you enjoy doing the least? Why?
 - Which activity do you feel benefitted the participants the most? What makes you say so?
 - Are you still doing these activities? (If not, why not?)

5. TEACHING AIDES/MATERIALS

- Do you use any teaching aides when conducting health or nutrition education classes?
 - Which kind of aides or materials make it easier for you to conduct health or nutrition education?
 - Which kind do you use most often? Why?
 - Which kind do you feel mothers enjoy the most? Why?
 - If you were asked to design a teaching material or aide which could be used for group teaching, what features would it have? (Why?)

6. HEALTH PROBLEMS OF INFANTS

- What do you feel is the state of health of young children and infants in the area?
- Why do you say so?
 - What are the common nutrition problems here?
 - What is being done here to control/prevent these problems? Anything else?
 - What more do you feel can be done?

RHM

7. FOOD HABITS IN THE AREA

What do you feel about the way mothers feed their infants and young children?

- Do you feel young children, say 6-12 months of age, get adequate quantities of all needed foods?
- Do you feel that there are some foods which are lacking in their diet? Which ones? Any others?
- Why do you feel they are lacking? Why do they not eat enough of them?

8. ADVICE ABOUT WEANING

Now I'd like to talk to you about advice you may give to mothers about ways to feed young infants, between 6-12 months old.

Do you ever talk to mothers about ways to feed infants who are between 6-12 months old?

What do you tell them? (Probe)

When do you recommend a mother start giving (name of child) food other than breastmilk?

Why at that age?

What is the first food that you recommend a mother start giving regularly to her infant?

How often do you recommend she give it to him each day? each week?

How do you recommend a mother prepare the food she gives to infants?

What do you feel is the best food a mother can give to her infant who is between 6-12 months of age? Why do you say so?

How often do you feel a mother should give this to her child each day?

Do you recommend a mother give her infant vegetables/fruit /fish/oil?

At what age should she start? Why?

Are there any vegetables/fruit/fish/oil which should not be given to a baby? Which ones? Why?

Are there any foods not well tolerated by young infants?
Which are these? In what way are they not well tolerated?

RHM

9. FOOD PERCEPTIONS

In your area, are there any foods which are considered particularly good for children from 4 to 6 months of age?

What are these foods?

In what way are they considered good?

And are there any foods which are considered bad for young children from 4 to 6 months of age?

What are these foods?

In what way are they considered bad?

Repeat for 6-12 month olds, and 13-24 month olds.

10. RECEPTIVITY TO PROPOSED BEHAVIORS

Now-a-days some people say that in addition to breastfeeding a baby who is 4-5 months old, you should start giving him rice gruel mixed with oil plus one viand or vegetable. This mixture should be fed to the baby twice a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

These days, people say that by 6 months of age, breastmilk is not enough for the baby. They say that in addition to breastfeeding a baby who is 6 months old, you should give him rice gruel mixed with oil plus viand and vegetables from the family pot. This mixture should be given to him at least 3 times a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

BHW
IN-DEPTH INTERVIEW GUIDE

1. INTRODUCTION

Greetings. Introduce self. . We are doing this study to understand the practices and food habits of the people in the area. We are interviewing people like you who regularly deal with them. I will be grateful if you could spare some time to answer a few questions.

2. PERSONAL INFORMATION

Let me start by asking you a few questions about yourself.

- What is your name?
- How old are you?
- How much have you studied?
- How many children do you have?
- What is your religion?

- For how long have you been working as a BHW?
- What made you decide to become a BWH?
- Totally, how much time would you be spending in a month as a BHW?

3. JOB DESCRIPTION

I would like to try to understand what your work as a BHW involves.

- Can you tell me all the activities you undertake as a BHW?
- Which of these activities do you enjoy the most? Why?
- Which of these do you not like at all? Why?
- If you were asked to change your job description in any way, how would you do it?

4. NUTRITION AND HEALTH EDUCATION

- Do you talk to mothers about nutrition and health?
- Usually, on what topics do you talk to mothers about?
 - Any others?
 - On which topic do you spend most of your time? Why?
 - On which topic do you spend less time? Why?

BHW

- Where do you usually talk to the mothers? Do you go to their houses or do they come to your house or do you meet at some other place?
 - Which is the most usual?
- Do you feel you need any help to talk to mothers and advise them?
 - What kind of help would you like?
- Do you feel mothers follow your advice? What makes you say so?
 - Is there any thing else you feel will help mothers to follow your advice? What? Why?

5. HEALTH PROBLEMS

- What do you feel is the state of health of young children and infants in the area?
 - Why do you say so?
 - What are the common nutrition problems here?
 - What is being done here to control/prevent these problems? Anything else?
 - What more do you feel can be done?

6. FOOD HABITS IN THE AREA

What do you feel about the way mothers feed their infants and young children?

- Do you feel young children, say 6-12 months of age, get adequate quantities of all needed foods?
- Do you feel that there are some foods which are lacking in their diet? Which ones? Any others?
- Why do you feel they are lacking? Why do they not eat enough of them?

7. ADVICE ABOUT WEANING

Now I'd like to talk to you about advice you may give to mothers about ways to feed young infants, between 6-12 months old.

Do you ever talk to mothers about ways to feed infants who are between 6-12 months old?

What do you tell them? (Probe)

When do you recommend a mother start giving (name of child) food other than breastmilk?

Why at that age?

147

What is the first food that you recommend a mother start giving regularly to her infant?

How often do you recommend she give it to him each day? each week?

How do you recommend a mother prepare the food she gives to infants?

What do you feel is the best food a mother can give to her infant who is between 6-12 months of age? Why do you say so?

How often do you feel a mother should give this to her child each day?

Do you recommend a mother give her infant vegetables/fruit /fish/oil?

At what age should she start? Why?

Are there any vegetables/fruit/fish/oil which should not be given to a baby? Which ones? Why?

Are there any foods not well tolerated by young infants?

Which are these? In what way are they not well tolerated?

8. FOOD PERCEPTIONS

In your area, are there any foods which are considered particularly good for children from 4 to 6 months of age?

What are these foods?

In what way are they considered good?

And are there any foods which are considered bad for young children from 4 to 6 months of age?

What are these foods?

In what way are they considered bad?

Repeat for 6-12 month olds, and 13-24 month olds.

9. RECEPTIVITY TO PROPOSED BEHAVIORS

Now-a-days some people say that in addition to breastfeeding a baby who is 4-5 months old, you should start giving him rice gruel mixed with oil plus one viand or vegetable. This mixture should be fed to the baby twice a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

These days, people say that by 6 months of age, breastmilk is not enough for the baby. They say that in addition to breastfeeding a baby who is 6 months old, you should give him rice gruel mixed with oil plus viand and vegetables from the family pot. This mixture should be given to him at least 3 times a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

HILLOT

HILLOT IN-DEPTH INTERVIEW GUIDE

1. INTRODUCTION

Greetings. Introduce self. We are doing this study to understand the practices and food habits of the people in the area. We are interviewing people like you who regularly deal with them. I will be grateful if you could spare some time to answer a few questions.

2. PERSONAL INFORMATION

Let me start by asking you a few questions about yourself.

- What is your name?
- How old are you?
- How much have you studied?
- How many children do you have?
- What is your religion?

- For how long have you been working as a hilot?
- What made you decide to become a hilot?
- Totally, how many deliveries would you be doing in a month?

3. PERCEPTIONS ABOUT PREGNANCY

Let me ask you a few questions about your profession.

- How many children do you deliver in a month's time?
- How do you like being a hilot?
- Do you face any problems in your profession? What are these?
- Are you the only hilot in the village?
- How many others are there?

How many pregnant women are here in this village now?

- At what stage of pregnancy do you come to know that there is a case?
- How do you come to know?
- Do mothers tell you?

HILOT

After you have delivered a mothers' baby, do you visit the mother?

- How often?
- For how long after the baby is born do you visit her?
- Do you ever visit her 4-6 months after delivering her baby? Why/why not?

Do you ever give advice to a mothers about how to feed their babies?

- Do they ask for advice or do you give advice on your own?
- What advice do you give them?

Do you ever talk to mothers about ways to feed infants who are between 6-12 months old?

- What do you tell them? (Probe)
- When do you recommend a mother start giving (name of child) food other than breastmilk?
- Why at that age?
- What is the first food that you recommend a mother start giving regularly to her infant?
- How often do you recommend she give it to him each day? each week?
- How do you recommend a mother prepare the food she gives to infants?
- What do you feel is the best food a mother can give to her infant who is between 6-12 months of age? Why do you say so?
- How often do you feel a mother should give this to her child each day?

Do you recommend a mother give her infant vegetables/fruit /fish/oil?

- At what age should she start? Why?
- Are there any vegetables/fruit/fish/oil which should not be given to a baby? Which ones? Why?

Are there any foods not well tolerated by young infants?

- Which are these? In what way are they not well tolerated?

8. FOOD PERCEPTIONS

Are there any foods which are considered particularly good for children from 4 to 6 months of age?

- What are these foods?
- In what way are they considered good?
- And are there any foods which are considered bad for young children from 4 to 6 months of age?
- What are these foods?
- In what way are they considered bad?

Repeat for 6-12 month olds.

HILOT

9. RECEPTIVITY TO PROPOSED BEHAVIORS

Now-a-days some people say that in addition to breastfeeding a baby who is 4-5 months old, you should start giving him rice gruel mixed with oil plus one viand or vegetable. This mixture should be fed to the baby twice a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

These days, people say that by 6 months of age, breastmilk is not enough for the baby. They say that in addition to breastfeeding a baby who is 6 months old, you should give him rice gruel mixed with oil plus viand and vegetables from the family pot. This mixture should be given to him at least 3 times a day.

What do you think about this?

Do you feel this is something you would recommend to mothers in this area? Why, why not?

SECTION 7

MODERATING A FOCUS GROUP

MAIN POINTS ADDRESSED

- Moderator's Opening
- Stage I: The Warm-Up
- Stage II: The Body of the Independent-Focused Discussion
- Stage III: Closure of the Group
- The Role of the Moderator
- After the Group

SECTION OBJECTIVES

1. To provide an in-depth understanding of the process of moderating a focus group.
2. To provide insight and concrete guidelines for evaluating the quality of a focus group, knowing what to look for and how to correct it.

Once participants are assembled in the focus group setting, the moderator will open the group by giving a brief introduction. Following the introduction, the moderator will proceed with the three major sections of the focus group: (1) the warm-up; (2) the body of the in-depth discussion; and (3) closure of the group. For each of these three major sections, the specific content, purpose and appropriate moderator behaviors will be discussed.

MODERATOR'S OPENING

Before a group actually begins, the moderator will provide a brief introduction. The objectives of this introduction are to relax respondents, to establish the "ground rules" for the group and to begin developing rapport with the group participants.

Respondents begin to relax when they observe that the moderator is relaxed and when the moderator speaks in a casual, friendly manner. Some informal banter as group members are being seated can be helpful.

The moderator introduces himself/herself. This is done by telling respondents his/her name and sometimes by providing information about himself/herself, which facilitates rapport with the group and establishes the group as a safe place for mutual self-disclosure.

The general purpose of the group is explained. Respondents are told why they have been brought together. This will facilitate their feelings of group purpose. They are also told what they have *not* been assembled for in order to reduce their anxiety and to eliminate any misconceptions.

Varying opinions are encouraged. Respondents are generally told that, in that group, there are no right or wrong answers and that it is okay to have feelings that are different from others. They are encouraged to feel free to give their frank and honest opinions.

The moderator's neutrality is established. The moderator generally assures respondents that he/she is in no way connected with the subject or product under discussion, and that their opinions will not make him/her feel good or bad or affect him/her in any way.

Group rules are given. Respondents are asked to speak one at a time and to interact but to avoid interrupting one another. If the group is being video- or audio-taped, other specific rules may be necessary.

STAGE I: THE WARM-UP

The *content* of this section generally consists of respondents giving their names and responses to a couple of nonthreatening questions about themselves, such as the number of children they have, the age and

sex of each child, how long they have been married and so forth. These questions should provide basic background facts relevant to the subject matter. If a specific product category is being discussed, some initial questions about product use, such as frequency of use or brand selection, may be appropriate during the warm-up stage. It is important to remember that:

1. Introductory questions that might place participants in stereotyped roles should not be used.
2. Introductory questions that will identify status differences among respondents should not be used.

The *purpose* of the warm-up is to transform the group, in approximately ten minutes, from several individuals to a participating and interacting group. In addition, the warm-up:

- Gives respondents the opportunity to speak very early in the group session. This will help to overcome speech anxiety—an anxiety that tends to mount if speech is delayed.
- Establishes the moderator and the group situation as "safe" and thereby initiates nonthreatening self-disclosure by respondents.
- Gives respondents some idea of what the group process is and permits them to "know" other group members.
- Provides the moderator and any group observers with a picture of the group that will (1) influence later questioning and (2) provide a frame of reference to evaluate what group members say during the remainder of the group.

The *moderator behavior* appropriate during the warm-up phase of the group is that of genuine interest in what participants have to say, of impartiality and of "unconditional positive regard." That is, the moderator makes no negative judgments about respondents regardless of what they say. The moderator also must do what is needed to obtain the initial background information for the group. This often will entail the following:

1. Probing respondents for *clarity* and *understanding* before proceeding with the next stage of the group. For example, if the average number of children among a group of young mothers is two and one group member reports having six children, probing may clarify that three of the children belong to a sister-in-law who is considered part of the family.
2. Maintaining the structure of the group and keeping group participants on a fairly narrow course so that the essential background information is obtained in a brief period of time with minimal digressions on the part of respondents.

STAGE II: THE BODY OF THE IN-DEPTH, FOCUSED DISCUSSION

The *content* of this portion of the group will involve a subtle transition from general topics to an increasingly specific discussion of issues to be covered. Typically this also will involve moving from concrete areas of discussion (such as the number of children in the household) to more abstract issues; from a factual discussion to a discussion of attitudes, feelings and deeply held beliefs, some of which may be relatively threatening to respondents. At some point in the group discussion, specific concepts or issues may be introduced by the moderator in order to focus respondents' reactions on key areas of interest.

The *purpose* of this stage of the group is to obtain an understanding of the true issues related to the topic area. The purpose also is to explore fully the nature of the attitudinal dynamics associated with respondent behavior and to observe, firsthand, the respondent language and emotions associated with the topic area. The purpose is not to quantify or to establish any estimates of degree associated with a particular area covered in the topic guide.

The *moderator behavior* appropriate for this section of the focus group is complex and requires a high order of skill. Some key moderator actions include:

In-depth probing to clarify and illuminate responses given by a group member. Some examples of probes include:

- Remaining silent—allow the respondent to amplify what he/she said.
- Using the mirror technique—restating what the respondent has just said.
- Repeating the respondent's words as a question—"It's good?"
- Confronting the respondent to clarify a position. "I'm a little confused. Earlier you said 'X', now you're saying 'Y'."
- Using "key word" probes such as the following:

Respondent Statement	Moderator Probe
"It's good."	"What about it is good?"
"I like the size."	"What is it about the size?"
"It would be convenient."	"In what way would it be convenient?"
"It works."	"How can you tell that it works?"

- Using the third-person technique. "You seem to feel strongly about this. How do you think others might feel about it?"
- "Can you tell me more about that?"
- "What about that?"
- "What do you mean by that?"
- "What makes you feel that way?"
- "Can you think of an example of that?"
- "I'd like to know more about your thinking on that issue."

- "I'm not sure I understand how you are using the word _____."
- "What are some of your reasons for feeling as you do?"
- "What does the message say for you?"
- "What does it say to you personally?"
- "What were you thinking as you were watching it?"
- "What stood out in your mind? What other things made an impression?"
- "You started to say something about. . . ."
- "You mentioned something about. . . ."
- "Did you get any new insights about. . . from the . . .?"
- "What words would you use to describe. . . .?"
- "Why?" or "Why not?"

2. **Sensitivity** to the receptivity level of participant disclosure at any given time during the group. A good group moderator will know when to move the group from a general discussion of child feeding habits to a more sensitive topic such as fears about infant mortality.
3. **Reweaving** information provided at an earlier stage of the group into the current discussion. Often a respondent will make a comment critical to the ultimate purpose of the group at a premature stage of the discussion. The moderator may let the comment drop until the appropriate point in the flow of the group and then ask the respondent to expand upon the comment that was made earlier. This not only shows the moderator's attention to what is being said but provides a smooth transition to new topic areas and helps to make the session a continuous discussion rather than a series of disjointed segments.
4. **Continuously linking** together comments made by different group members so that they present a cohesive group meaning.
5. **Flexibility** in discussing issues relevant to the topic, regardless of their presence in the topic guide. The moderator must know the subject matter and the objectives of the research well enough to know whether an unexpected direction in the group is useful information or an unnecessary digression.
6. **Handling special problems** that often occur in focus groups, such as conflicts between respondents or a general lack of enthusiasm on the part of the group as a whole.
7. **Using a variety of moderating tactics** and approaches intended to facilitate the group and make it productive. For example, an effective moderator will:
 - stimulate the group members to *talk to each other*, not necessarily to him/her;
 - know when to probe and when to keep quiet;
 - use in-depth probing without *leading* the respondents;

- be able to convey a lack of complete understanding about what a respondent says without appearing "phony";
- pay close attention to what is said in order to foster that behavior in the other group members;
- be sensitive to nonverbal cues given by respondents to understand better and facilitate respondents' *true feelings*;
- *not assume* that what a respondent says is what he/she really does or really means;
- encourage honest disagreement between respondents—not force a consensus;
- encourage unresponsive group members to speak;
- discourage dominant or disruptive group members;
- be kind but firm—combine a "disciplined detachment" with "understanding empathy";
- be permissive, but keep the group on track;
- expect the unexpected and know how to react to it;
- be prepared to improvise if something doesn't work or if no useful information is being gathered;
- use projective techniques or other "tricks" to gain more insight if respondents are unable to respond to direct questions.

STAGE III: CLOSURE OF THE GROUP

The *content* of this stage of the group consists largely of summarizing and recapping the identifying "themes" of the group. It may be appropriate at this time to open a discussion about the strength of attitudes expressed, or the degree to which some feeling that emerged is present among group members. It may also be appropriate to point out key differences that occurred between group members ("Some of you felt that, but others feel differently") and to clarify these distinctions. Additionally, closure may be a good time to point out any remaining inconsistencies in respondent statements and to seek clarification.

The *purpose* of this stage of the group is to assist the moderator, the observer and the respondents in understanding what has occurred during the group. It permits an opportunity for respondents to alter or clarify their positions or to add any remaining thoughts they may have on the subject matter. It also allows the moderator to test his/her conclusions and hypotheses for accuracy and appropriateness.

The appropriate *moderator behavior* for the closure stage is basically to summarize or nonjudgmentally identify differences of opinions among respondents and to synthesize the findings from the group.

THE ROLE OF OBSERVERS

The observation of the group discussion by those who ultimately will make use of the research can be one of the key benefits of focus groups. Observation provides first-hand experience with the target population, its attitudes, concerns, language and other responses. The respondents may be quite different from the observers in both social and professional background.

While viewing focus group discussions, observers can do several things to enrich their experiences. These points should be communicated to observers prior to the start of the focus groups.

- Observers should not expect every moment of the discussion to be meaningful, every question to work, or every response to be salient and quotable. Participants will be real people responding spontaneously.
- Observers should not expect to experience a consensus within a group or among groups. Qualitative research is designed to generate a range of responses, develop hypotheses and deepen understanding.
- It is important for observers to listen carefully to what is being said—that is, to avoid selective listening to support a preconceived point of view and to avoid projecting personal meaning and values into what is being said. In listening, it is important to be alert to shades of meaning and to word selection.
- Observers should try to watch as well as listen. Nonverbal cues can sometimes be more meaningful than verbal responses.
- During the discussion, observers should make notes of key impressions for discussion during the debriefing after the focus group.
- Observers may want to ask for additional probes or to insert new questions during the discussion or at the end of the session.

AFTER THE GROUP

Ideally, the moderator and observers should meet immediately following each session to discuss their impressions. This debriefing process is an opportunity to clarify and crystallize the meaning of what has transpired. It allows observers to check their impressions against the skilled listening and interpretation of the moderator, and it gives the moderator an opportunity to *discourage premature conclusions* before all the interviewing and analyses are completed. Also, it is the time to review priorities for subsequent interviews in the series. Some of the issues that may be addressed include:

Refinement of the topic guide. Should some unproductive areas of questioning be removed? Can some topic areas be approached differently to elicit richer, more meaningful responses? Are new topic areas needed? Should the flow of the discussion be altered?



155

Respondent qualifications. Is it necessary to alter or tighten respondent screening questions? For example, in listening to a group conducted among product users, it may become apparent that only those respondents who have been users for six months or more or who use the product frequently are really qualified for the discussion.

Cancellation or additional scheduling of groups. Is it necessary to cancel the remaining groups that have been set up in the series or to schedule new ones? For example, it sometimes becomes clear that the target population has been

incorrectly defined, that stimuli presented to the group are either off target completely (rejected) or are insufficiently formed (i.e., too abstract). In such cases, it is wise to cancel the remaining groups set up and return to the drawing board. On the other hand, additional groups may be warranted if it becomes apparent that added segments of the target population are relevant—new versus long-term product users, for example. It also may be of value to conduct additional groups with refined stimulus/concept materials or to explore unresolved issues and new hypotheses.

EXHIBIT 7-1 FOCUS GROUP EVALUATION FORM

Evaluation of the Focus Group

<i>Setup</i>	YES	NO
<ul style="list-style-type: none"> • Were respondents qualified? Did they meet the age, sex, family size, socioeconomic status, product usage or other requirements necessary to the research objectives? 	()	()
<ul style="list-style-type: none"> • Did the group composition make sense? Were respondents similar enough in terms of characteristics that matter for an effective group discussion to take place and for group findings to be unclouded by major respondent variables? 	()	()
<ul style="list-style-type: none"> • Was the size of the group right? Were all respondents able to participate and to talk for long enough to cover most of what they know on the subject? 	()	()
<ul style="list-style-type: none"> • Was the setting of the group appropriate? Was it natural and comfortable for group members— not so casual as to preclude control and not so formal as to inhibit spontaneity and an open expression of feelings? 	()	()
<ul style="list-style-type: none"> • Did the seating arrangement of the group work? Did it seem natural to respondents and did it facilitate group interaction? 	()	()
<ul style="list-style-type: none"> • Was the group free from outside interference such as observers, interruptions? 	()	()
<ul style="list-style-type: none"> • Was the length of the group appropriate? Was it long enough to obtain specific, actionable information and not so long that group members got bored or fatigued or began to over-intellectualize? 	()	()
<ul style="list-style-type: none"> • Was the content of the topic guide complete? Were all information needs and objectives met? 	()	()
<ul style="list-style-type: none"> • Was the content of the topic guide appropriate? Were the topic areas covered all relevant in terms of focusing the discussion on the study objectives, or did some questions throw the discussion off course? Were they questions that group members could answer? 	()	()

continue on page 44



II. Moderator Evaluation

Assign the moderator a rating for each item mentioned below (5 = excellent; 4 = very good; 3 = good; 2 = fair; 1 = poor.)

A. Moderator's preparation

- Understands the background and subject matter of the project
- Understands the research objectives
- Has collected all the sponsor's ideas
- Helped develop the topic guide
- Has the topic guide memorized
- Was ready before the group assembled

Rating

TOTAL

B. Moderator's manner

- Is relaxed and friendly
- Stimulates group interaction
- Generates enthusiasm and involvement
- Listens constructively
- Displays warmth and empathy
- Is nonjudgmental
- Probes without leading
- Conveys "incomplete understanding" effectively
- Is sensitive to the level of group disclosure
- Blends in, but controls
- Improvises when necessary
- Is flexible when pursuing new ideas
- Discusses, but does not question
- Displays neutral body language and facial expressions

Rating

TOTAL

C. Moderator's handling of group influences

- Discourages simultaneous talking
- Retains group spontaneity
- Discourages irrelevant conversation
- Discourages intellectualizing by respondents
- Permits individual differences of opinion
- Brings shy or unresponsive group members into the discussion
- Controls dominant or disruptive group members

Rating

TOTAL



157

III. Structure of the Group Discussion

Introduction: Moderator's Opening

	YES	NO
Put the respondents at ease	()	()
Explained the general purpose of the group	()	()
Encouraged conflicting opinions	()	()
Established moderator neutrality	()	()
Established openness: no right or wrong answers	()	()
Gave group "rules"	()	()
Began developing a rapport with the respondents	()	()
Provided a smooth transition to the next phase	()	()

Phase I: Warm-up

Established a good rapport with the respondents	()	()
Obtained necessary background information	()	()
Began stimulating group interaction	()	()
Give all respondents an opportunity to speak	()	()
Successfully diminished speech anxiety	()	()
Established the group as a "safe place"	()	()
Enabled group members to know each other	()	()
Stayed within the time limits	()	()
Provided a smooth transition to the next phase	()	()

Phase II: Body of the Group Discussion

Moved from the general to the specific	()	()
Did not disclose key issues prematurely	()	()
Obtained a depth of response to key issues	()	()
Obtained members' true feelings about topics	()	()
Linked information into a cohesive whole	()	()
Exhibited appropriate facilitating behavior	()	()
Exhibited appropriate controlling behavior	()	()
Provided a smooth transition to the next phase	()	()

Phase III: Closure

Identified key themes	()	()
Summarized key ideas	()	()
Revealed the strength of attitudes	()	()
Consolidated group feelings about issues	()	()
Identified individual differences of opinion	()	()
Gathered all respondent comments	()	()

IV. Post-Group Evaluation Issues

- | | YES | NO |
|--|-----|-----|
| • Is a substantial amount of post-group analysis necessary to separate true respondent feelings from those expressed due to moderator demands? | () | () |
| • Was this group conducted so that it can be evaluated across a series of groups, or will differences cloud the evaluation? | () | () |
| • Was the group outline sensitive to differences in group composition so that <i>differences</i> between groups in a series will be highlighted? | () | () |

V. Follow-Up Action

- Were all management information needs met? If not, how can these information gaps be filled?
- Were hypotheses developed that require follow-up? If so, how will these be pursued?
- Are more groups needed? If so, what are the purpose and objectives of these groups?
- Does the topic guide need revising? If so, in what way?
- Do certain findings need verification by quantitative research? If yes, what needs to be quantified?

SECTION 8

SPECIAL PROBLEMS THAT OCCUR IN FOCUS GROUPS

MAIN POINTS ADDRESSED

1. The opening Group Session
2. The Full Group Session
3. Special respondent problem
4. Loss of Control in the Focus Group
5. A Summary on Key Steps in Conducting Focus Group Research

SECTION OBJECTIVES

1. To provide guidelines for recognizing special problems that can occur in a focus group and to suggest strategies for handling these problems
2. To enable the observer/manager of a focus group research to identify problems that may interfere with focus group results

Conducting a truly effective and useful focus group requires a high order of skill in handling the problems that emerge within any group dynamic. In some cases, difficulties may relate to the group as a whole, while others occur as a result of the behavior of individual respondents. In either case, the results of the group may be seriously flawed if these problems are not skillfully dealt with. The following section identifies some of the most common problems that occur during a focus group and mentions strategies commonly used for handling them.

The conforming group session

In this group, members comply or agree with the "party line." Because focus groups generally deal with personal attitudes and beliefs that are not readily verifiable, there is a danger that group members will verbalize responses that simply go along with what other respondents have said and that do not express their true individual feelings. This is particularly problematic because it is difficult to determine whether respondents are conforming or whether a genuine consensus exists.

Strategy: Emphasize respondents' freedom to disagree during the opening section of the group and demonstrate respect for divergent opinions throughout the group. Another tactic is to have respondents report their opinions regarding a key issue secretly at first, followed by an open discussion. This may be accomplished by having each respondent note his or her opinion on a piece of paper as the issue is introduced to the group. Although the paper is never viewed, it forces the group member to take a position that is less easily swayed by others in the group. Less literate respondents can do this by using pictorial scales, such as the happy face scales.

The dull group session

The dull group is characterized by a general lack of enthusiasm and involvement on a group level. General apathy among group members may be due to factors outside the group situation. For example, respondents may have felt forced to attend the group or may be suspicious of the group process. Also, the subject matter may be intimidating or simply uninteresting to the group, or respondents may not be properly qualified for the discussion. Respondent apathy also may occur as a result of factors *within* the group. For example, the group may be too large, making interaction difficult. It may be over-organized and inflexible so that spontaneity is stifled, or it may be too loosely organized, leaving respondents dismayed. The moderator's tone may be too

formal, intimidating respondents, or too casual, appearing phony to the group. The group may proceed too quickly, preventing thoughtful respondents from participating, or too slowly, creating boredom on the part of group members.

Strategy: Set up the group realistically and thoughtfully in order to eliminate many outside factors that contribute to group apathy. A skillful and experienced moderator will circumvent many of the inside contributing factors. In addition, the following specific tactics may be useful in stimulating a dull group:

- If the subject matter does not seem to interest respondents, enthusiasm may be enhanced by asking the group to interact with the topic in a novel manner, such as creating personal stories around a key issue.
- If the subject matter seems too remote or abstract for respondents to relate to, it may be made more concrete by using stimulus materials such as concept boards or pictures of situations related to the topic area.
- If the subject matter seems too intimidating or personal, group members may be encouraged to talk by using projective techniques (see Section 5).
- Respondent involvement may occasionally be increased by somewhat confrontational behavior on the part of the moderator.
- Occasionally a short break will be required, permitting group members to move around and have side conversations that can be pursued later. This allows the moderator to "re-group," possibly consult with other members of the team and get a fresh start.

Special respondent problems

In addition to problems that concern the group as whole, there are a number of problems that frequently occur with individual respondents. These include:

The dominating respondent. This person attempts to take over the group—initiates the conversations, defends his/her position, seeks to influence others and must have the last word.

Strategy I: Avoid eye contact, or turn body away from the dominating respondent. Call on other members of the group by name. If necessary, politely tell the dominating respondent that although his/her thoughts are very interesting, you'd like to have the ideas of other group members as well.

Strategy II: On occasion it may be necessary to ask a dominating respondent to leave the group. This can be done by explaining to the respondent that "because you know so much about _____, we'd like you to complete a more detailed, in-depth questionnaire on the

subject." A "diversionary" questionnaire can then be administered to the dominant group member outside of the group room.

The timid respondent. This person is hesitant to speak at all, may be generally shy or anxious about the group situation, may or not feel his/her opinions are worthwhile.

Strategy: Use eye contact to pull the timid group member into the discussion and to communicate interest in what he/she has to say. Observe the timid member closely to see when he/she is ready to speak. If necessary, find an easy, nonthreatening question and encourage a direct response. If respondent becomes too ill at ease, continue the discussion with other respondents and come back to him/her later.

The expert respondent. This is a special variety of dominating respondent. Even if he/she is not attempting to lead the group, others will defer to him/her and their own opinions will be stifled.

Strategy: Determine if the respondent is a genuine expert or a pseudo-expert. If genuine, remind him/her that all comments are important and that others should be permitted to contribute, or ask the expert to respond only after others have been heard. It may also help to preface issues with "I know John is probably aware of. . . ."

If the respondent is a pseudo-expert, ask other group members to comment on his/her responses. It may even be necessary to be forceful and challenge him/her as much as the group will tolerate.

The verbose respondent. This person goes on and on, seemingly without end or purpose—may be a compulsive talker, or may be excessively nervous.

Strategy: Be more directive. Use probes to request specificity and concreteness. Direct the respondent back to the topic at hand. It may be necessary to politely interrupt him/her. Remind the respondent of the many topics you need to cover in a limited time frame. Do all of this carefully without alienating the respondent.

The irrelevant respondent. This person makes comments that don't relate to the topic area and can steer the group off the subject. He/she may be truly unknowledgeable, nervous or simply a poor listener.

Strategy: Try restating the question or paraphrasing. Consider coming back to the question later.

The incomplete respondent. This person gives partial answers or even *nonresponses*, such as "I don't know." These respondents are especially frustrating. Their behavior often comes from lack of confidence or unusually high anxiety.

Strategy: Work on strengthening rapport early in the discussion in order to prevent this from happening throughout the group. Try to get elaboration through restatement. Use other probing techniques.

The confused respondent. This person appears confused or overwhelmed during the group. He/she communicates this either verbally or nonverbally.

Strategy: Acknowledge the situation ("You seem confused. . . .") Try rephrasing the question, or perhaps provide an example. Attempt to ask the question again later in the interview.

The overly positive respondent. This person is glowingly positive in all responses. He/she may want to please you, to tell you what he/she thinks you want to hear.

Strategy: Remind the respondent of what he/she has been told during the warm-up: that you want to hear both positives and negatives. Try playing devil's advocate ("I've heard some people say just the opposite. . . ."). Try third-person wordings ("What about other people that you know? How do you think they would feel?").

The negative respondent. This person is negative in all responses. He/she may be using this interview to vent years of frustration and hostility. He/she may be determined not to tell you any favorable ideas or information.

Strategy: Be careful. Avoid reacting defensively. Try to defuse the respondent by acknowledging his/her hostility or negativism ("You seem to be angry about this. That's okay, because I want to find out how you really feel. . . ."). As above, try playing devil's advocate or probing in the third person.

The hostile respondent. This person "attacks" the moderator personally.

Strategy: Again, use care. Try to defuse the respondent by acknowledging the situation. Don't react defensively! Try a short period of silence. Put the onus on him/her to explain the reasons for the attack.

The disrupting respondent. This person disrupts the equilibrium of the conversation—he/she may state that another group member's ideas are wrong or that the moderator's questions are stupid.

Strategy: Attempt to stabilize the discussion quickly. Ask other participants to comment on the disrupting respondent's statement. (This may be dangerous if the disruptive statement embarrassed or angered someone.) Or present an alternative point of view: "That's interesting, but I've heard some people feel. . . ." This gives other respondents the opportunity to choose one side or the other and continue the discussion.

The questioning respondent. This person continues to ask the moderator for his/her opinions and feelings.

Strategy: Plead lack of experience or expertise on the subject. If that is inappropriate, acknowledge the situation ("Like anyone else, of course I have an opinion about this, but our purpose today is to find out how you feel. . . .").

If necessary, offer to give your opinions after the discussion is over. Another approach is to inquire about the thoughts and feelings that led to the respondent's questions. Try restating the question to the group.

Loss of control of the focus group

A skillful moderator will rarely lose control; however, a more inexperienced moderator may be quite anxious about losing control, and this anxiety may be manifested in many ways. Here are some signs to look for:

- Asking leading questions—those that imply the moderator already knows the answer.
- Asking double-barreled questions—asking two or more questions before giving the respondent a chance to answer the first question.
- Interrupting unnecessarily—cutting off a respondent in anticipation of his/her answer.
- Making assumptive statements—the moderator infers something not yet stated by the respondent.
- Giving advice to a respondent about what he/she should do.
- Changing topics too quickly—not allowing the respondent to complete his/her thoughts in one area before moving to another.

A SUMMARY OF KEY STEPS IN CONDUCTING FOCUS GROUP RESEARCH

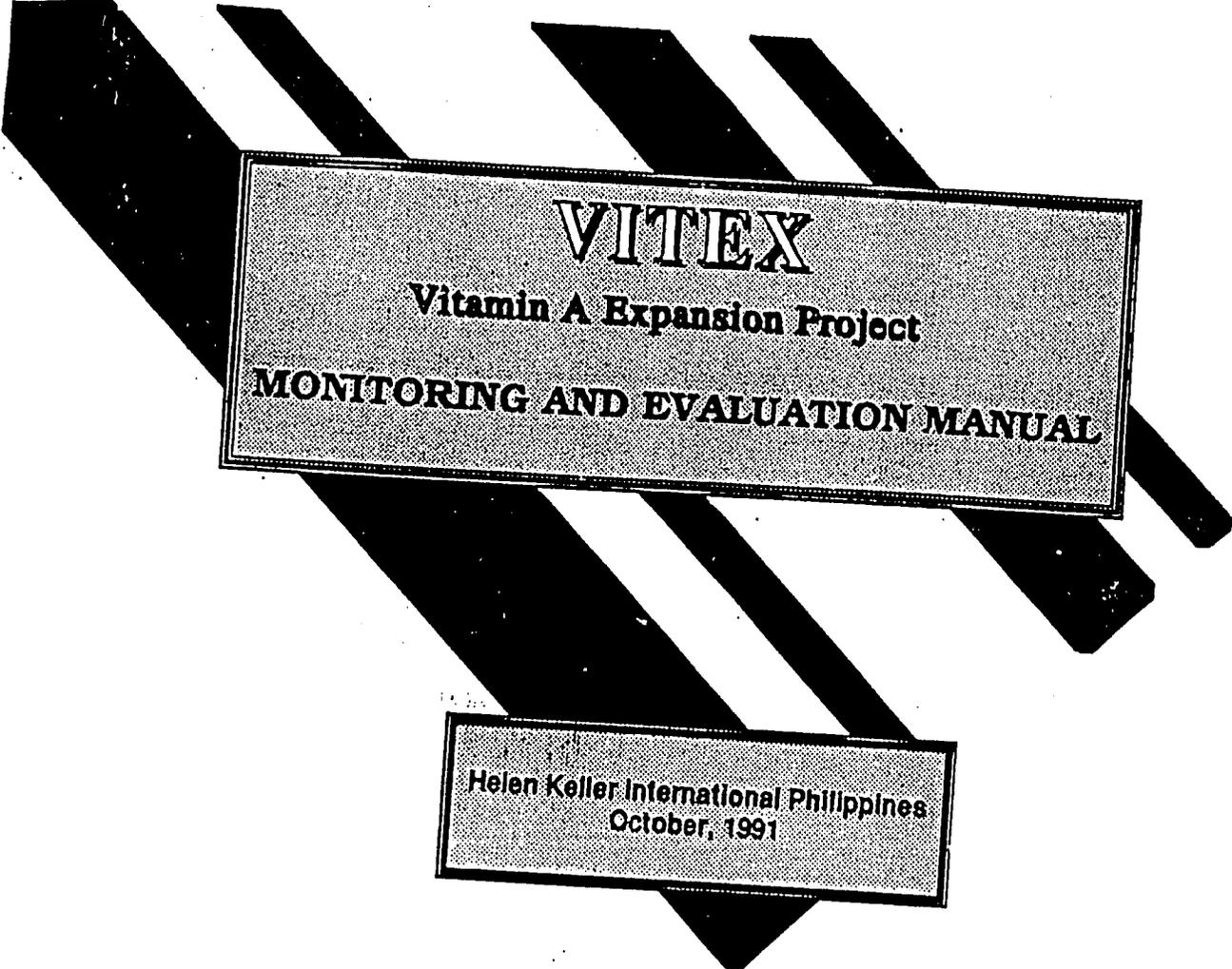
Define the subject matter—the research question or problem—and specify the research objectives. Be sure the research findings are actionable and relevant to program planning or decision making.

Verify the method. Be sure that the objectives of the research are best met by conducting focus groups and not by some other type of research. Refer to the selection grids.

Define the qualifications of the research respondents. Be specific. List all of the factors that can influence the topic (number and age of children in the household, etc.), and then determine which ones are critical for the research.

4. *Establish homogeneous groups.* Determine which respondent variables will affect the research findings, and set up separate groups so that respondents are similar in terms of the key variables. It is advisable to conduct at least two group sessions for each different variable.
5. *Develop the recruiting/screening questionnaire.* In rural areas it may be necessary to have the village chief or another knowledgeable authority select the group respondents rather than to use a questionnaire screening. In such cases it is always advisable to have a member of the research team accompany the village leader on recruiting visits to be sure the respondents meet the group requirements and that the village leader does not bias them or reveal too much information about the subject matter.
6. *Select the focus group moderator and the rest of the team.* It may be necessary to have more than one moderator (male and female) and to have team members who are fluent in different languages, who have specific cultural knowledge, and who have specific technical knowledge (medical practitioners and/or communication specialists, for example).
7. *Select supporting materials for the group discussion.* It may be necessary to use stimulus materials to encourage the discussion. Use two tape recorders if possible—one as a back-up.
8. *Select the focus group sites.* Be realistic about accessibility and receptivity in certain regions. Choose sites where a comfortable, quiet, private group can be set up.
9. *Select the date, time and length of each group.* Be sure there are no conflicts with special days (holidays, market days) or with individual activities (household chores).
10. *Develop the topic guide.* Work with the moderator and the rest of the team to develop a carefully thought-out topic guide or guides. Be sure only questions that relate to the objectives of the study are addressed.
11. *Conduct the focus group.* Be sure that all logistics are handled in advance and that all members of the team—moderator, observer, recorder, etc.—are clear about their responsibilities.
12. *Analyze and interpret the focus group findings.* Reviewing the focus group tapes and constructing the report can be done by the moderator, alone or in conjunction with another team member. It is also advisable to formally present the conclusions, recommendations and key findings to program management.
13. *Translate the research results into an action plan.* Eliminate actions that are not realistic or feasible; pursue actions that are readily implemented and involve minimal risk; further research areas of uncertainty or major risk.

**Monitoring and
Evaluation
Manual of Instruction**



VITEX

Vitamin A Expansion Project

MONITORING AND EVALUATION MANUAL

Heien Keller International Philippines
October, 1991

TABLE OF CONTENTS

	<i>Page</i>
I. RATIONALE	1
II. OBJECTIVES	1
III. WHAT TO MONITOR? (Monitoring & Evaluation Indicators)	2
* Vitamin A Supplementation	3
* Nutrition Education	4
IV. HOW TO MONITOR	6
V. PROJECT MONITORING SCHEME	7
Data Flow Diagram	8
VI. INSTRUCTIONS IN ACCOMPLISHING THE ROUTINE REPORTING FORMS	9
* DOH-Vitamin A Quarterly Form	9
* Form IEC1	12
* Form VAC1	12
* Form T1	12
* VITEX HKI Monthly Report	14
VII. OTHER DOCUMENTS/REPORT REQUIRED BY THE PROJECT	16

APPENDIX -Monitoring Forms

- * DOH-Vitamin A Quarterly Form
(Form 1-A, Form 1-B, Form 1-C)
- * Form IEC1- Worksheet: IEC Materials
Distributed from IPHO
- * Form VAC1 - Worksheet: Vitamin A Capsules
(VAC) Distributed from IPHO
- * FORM T1- Worksheet: Trainings Conducted
- * VITEX HKI Monthly Report

VITEX PROJECT
MONITORING AND EVALUATION MANUAL

3. To maintain and update

I. RATIONALE assist project management
project objectives.

The HKI-DOH Vitamin A Expansion Project in three provinces is designed to ensure effective distribution of Vitamin A capsules to xerophthalmic and high-risk preschoolers and post-partum mothers and to improve infant and child feeding practices.

To monitor and evaluate the implementation, the project included Pre-Post Intervention Surveys, Formative Research, Health Service Provider Survey, Special Monitoring Studies and Routine Reporting. This document discusses the Project Routine Reporting requirements from the field implementors to the project management group.

II. OBJECTIVES

General:

To ensure that all activities of the project are done according to plan towards attaining project objectives.

Specific:

1. To accomplish the prescribed report and monitoring forms accurately and ensure timely submission to designated levels.
2. To provide timely and effective measures for any deviation from planned activities.
3. To maintain and update record-keeping activities.
4. To assist project management by tracking progress toward project objectives.

III. WHAT TO MONITOR?
(Monitoring and Evaluation Indicators)

The key indicators for purposes of evaluation are based on the goals set by the project namely:

1. To reduce Vitamin A deficiency and its associated ocular manifestations, morbidity and mortality in the three project provinces.
2. To increase the proportion of high risk groups receiving a VAC to 60% in the past six months.
3. To increase the mean frequency of consumption of foods containing Vitamin A among pregnant and lactating mothers and children 6-59 months of age.
4. To increase the effectiveness of DOH personnel to plan, implement and manage a VAC supplementation intervention within the 3 project provinces.
5. To increase the effectiveness of DOH personnel to plan, implement and manage nutrition education interventions aimed at promoting change in essential feeding practices related to VAD in the 3 project provinces.

Considering, HKI's role as technical assistance agency, the project objectives are reflected as the project activities planned towards attaining the goals.

To measure the degree to which project goals and objectives have been met, performance indicators have been determined. These indicators have been grouped in three tiers. Tier one measures project inputs, tier two measures project outputs and tier three measures project outcome.

VITAMIN A SUPPLEMENTATION

Indicators will focus on measuring the degree to which Vitamin A supplementation is integrated into existing services and the level of VAC coverage among xerophthalmic and high-risk preschoolers in the project areas.

Tier One (Inputs)

1. Three (3) provincial planning workshops conducted (1 per province).
2. Three (3) provincial VAC distribution plans incorporated into all provincial area-based health plans (1 per province).
3. Three (3) rapid assessments of VAD prevalence, VAC coverage and health worker skills conducted (1 per province).
4. VAC supply procured and delivered in adequate amount and with adequate regularity.
5. VAD trainings conducted for provincial technical staff, hospital and rural health staff, school district nutrition coordinators, hilots and village health workers.
 - ◆ Number and type of trainings conducted
 - ◆ Reported involvement of the community in Vitamin A

Tier Two (Outputs)

1. VAC supply adequate, available and adequately stored at 80% of health clinics and hospitals.
 - ◆ Number of VAC supply distributed
2. 80% of provincial technical staff, hospital and rural health personnel equipped with the skills needed for their respective functions in Vitamin A supplementation.
 - ◆ Number and percent of health workers trained

169

3. 80% of underweight children participating in OPT given VAC supplements.
 - ◆ Number and percent of identified xerophthalmic children given VAC
 - ◆ Number and percent of high-risk children given VAC
4. 60% of underweight children given follow-up VAC dose six months after OPT
 - ◆ Number and percent of children given follow-up dose
5. 80% of post-partum mothers whose birth was attended by a rural health midwife or trained hilot are given a one-time VAC dose.
 - ◆ Number and percent of deliveries and mother given VAC

Tier Three (Outcome)

1. Prevalence of nightblindness and Bitot's spots decreased by 50%.

NUTRITION EDUCATION

Performance indicators for nutrition education may need to be revised based on the data collected during rapid assessments. Key message formulation as well as access, exposure, knowledge and adoption indicators will be tailored to reflect the communication strategies adopted in each province.

Tier One (Inputs)

1. Three (3) provincial planning workshops conducted (1 per province)
2. Three (3) rapid assessments of dietary practices, attitudes and knowledge of mothers conducted (1 per province).]
3. Three(3) provincial communications plan and strategy developed (1 per province)

4. Counselling cards developed and distributed to 100% of health workers in project provinces.
5. Radio spots developed and distributed to 100% of radio stations in project provinces.
6. Trainings conducted on key nutrition messages and message delivery among 100% hospital and rural health staff

Tier Two (Outputs)

1. 75% of trainees know key nutrition education messages for each target group.
2. 50% of mothers of children 0-6 months have received advice on a Vitamin A feeding message by the rural health midwife.
3. 50% of mothers 6-12 months have received advice on weaning food preparation by the rural health midwife.
4. 50% of mothers with underweight 1-3 year olds have received advice on a Vitamin A feeding practice.
5. 50% of mothers attending pre-natal counselling have received advice on a Vitamin A feeding practice.
6. The proportion of children aged 12-36 months of age eating foods containing Vitamin A at least 3 times per week will be increased by 15%.
7. The proportion of infants 6-11 months of age eating lugao or rice mixed with fish, oil and mashed yellow or green vegetable at least 3 times per week will be increased by 20%.

IV. HOW TO MONITOR

The data from the above indicators will be generated from the following activities:

1. Pre-Post assessment surveys
2. Small-scale qualitative studies
3. Special monitoring studies
4. Routine reporting

Separate protocols for items 1-3 have been developed.

For Routine Reporting activity, this is referred to as tracking the project progress using the designed Project Monthly Accomplishment Report. This report would contain the summary of project inputs and outputs for the month to be accomplished by the project area coordinator.

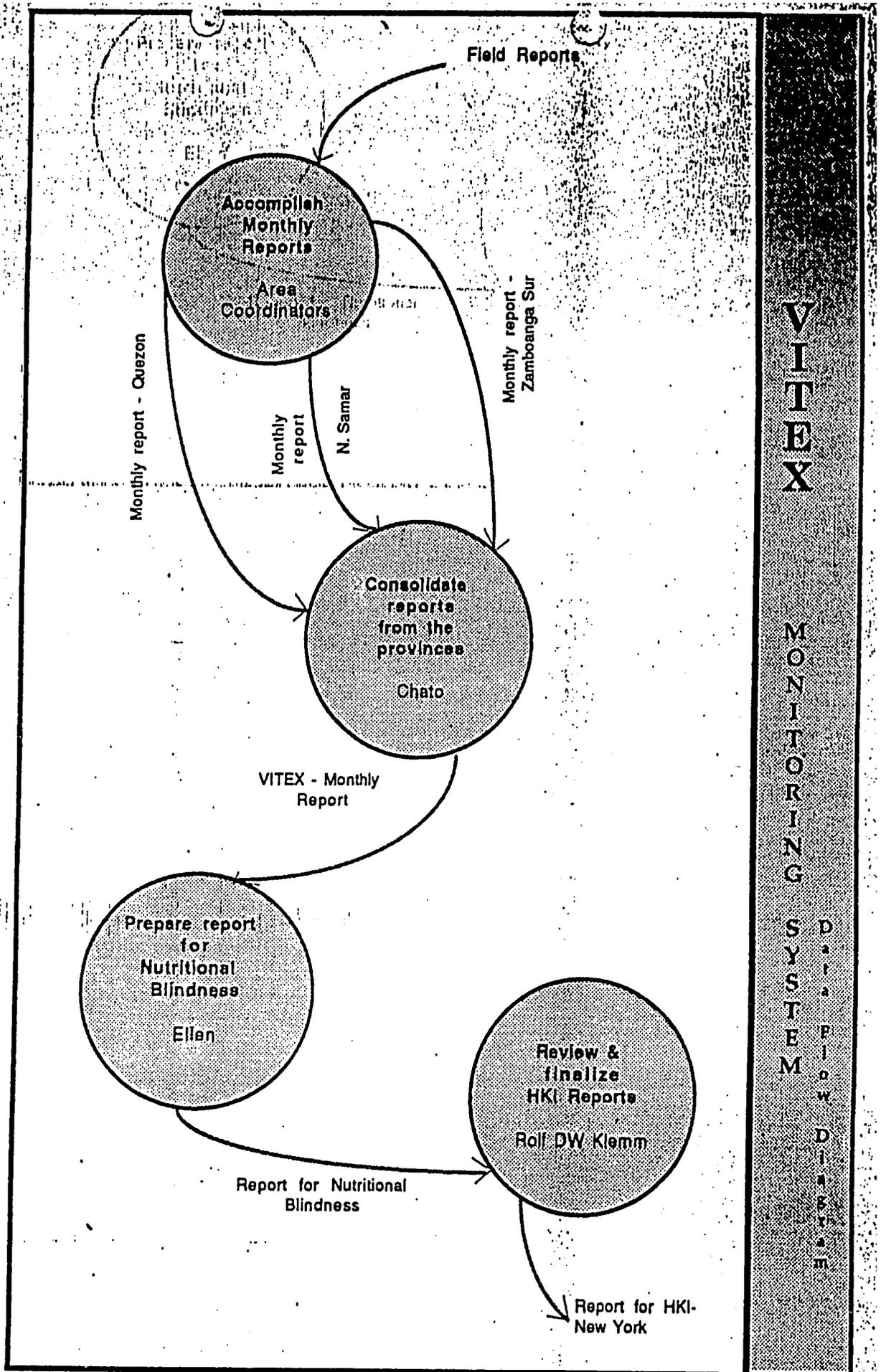
Worksheets have been developed to facilitate recording and consolidation of data generated from the field.

The Monthly Accomplishment Report would include the following information:

1. Major accomplishment (activities) for the month (narrative)
2. Number of VAC supply at the province
3. Number of children examined/weighed
4. Number of children given VAC
5. Number of VAD cases identified and given VAC
6. Number of malnourished cases identified and given VAC
7. Number of deliveries identified and given VAC
8. Total number of VAC distributed
9. Number and type of trainings conducted
10. Number and type of Health Personnel trained
11. Cost of training
12. Number of IEC materials received (type, quantity)
13. Number of IEC materials distributed (type, to whom, quantity)
14. Number of Nutrition education activities conducted

V. PROJECT MONITORING SCHEME

Guide for the Accomplishment and Submission of VAD Report Forms						
Level	Form Number	Form Title	To be Accomplished By	No. of Copies	To whom Submitted	When Submitted
Barangay	Form 1-A	DOH-Vitamin A Quarterly Form	Midwife	2	PH Nurse	
Municipal	Form 1-B	DOH-Vitamin A Quarterly Form	PH Nurse	2	District Nurse	
Provincial	Form 1-C	DOH-Vitamin A Quarterly Form	Dietary Nutritionist	2	NS, AC-HKI	
Provincial	Form IEC1	IEC Materials Distributed from IPHO	Dietary Nutritionist	2	NS, AC-HKI	
Provincial	Form VAC1	VAC Distributed from IPHO	Dietary Nutritionist	2	NS, AC-HKI	
Provincial	Form T1	Trainings Conducted	D.N., VAD Task Force, Area Coordinator	2	NS, Chato	
Provincial		VITEX HKI Monthly Report	Area Coordinator	2	Chato	
Manila		Consolidated Report	Chato	2	Ellen	
Manila		Report for Nutritional Blindness	Ellen	2	Rolf Klemm/ HKI-New York	



VITEX

REPORTING SYSTEM

DATA FLOW DIAGRAM

174

VI. INSTRUCTIONS IN ACCOMPLISHING THE ROUTINE REPORTING FORMS

1. Form 1: DOH-Vitamin A Quarterly Form

❖ Form 1-A	Barangay Level	Area: Barangay
	To be accomplished by the Rural Health Midwife	
❖ Form 1-B	Municipal Level	Area: BHS/Catchment
	To be accomplished by the Public Health Nurse (The Summary of Form 1-A)	
❖ Form 1-C	Provincial Level	Area: Municipality
	To be accomplished by the Dietary Nutritionist (The Summary of Form 1-B)	

A. OPT and VAC Supplementation

Information for this could be obtained from the DOH - Client List for Food and Micronutrients.

Population Children (6-59 months) - Record the total number of children (6-59 months) in the area

UNDERNOURISHED CHILDREN (6-59 months)

OTHER SERVICES - refers to children (6-59 months) who were examined or weighed during regular consultations, EPI Day, UFC or any other DOH activities besides the yearly Operation Timbang (OPT).

No. Examined/Weighed - Record total number of children (6-59 months) examined or weighed during the quarter.

Nutritional Status - Among the children (6-59 months) examined or weighed during the quarter, record the number of undernourished children: 1 - First degree (mild), 2 - Second degree (moderate), 3 - Third degree (Severe).

175

No. Given VAC - Among the children (6-59 months) examined or weighed during the quarter, record the number of children who were given :

• **PD** - 1st Preventive Dose (1 VAC) - Given immediately after treatment

• **DURING OPT** - refers to children (6-59 months) who were examined or weighed during Operation Timbang (OPT). If OPT is not done during the quarter, this portion (shaded area) should not be answered.

No. Examined/Weighed - Record the total number of children (6-59 months) examined or weighed during OPT.

Nutritional Status - Among the children (6-59 months) examined or weighed during the quarter, record the number of children who were identified as undernourished during the last OPT.

Given VAC - Among the children (6-59 months) weighed during the last OPT, record the number of children who were given PD - the 1st Preventive Dose (1 VAC) - given immediately after treatment

• **HIGH RISK** - Other High Risk Conditions - refers to children who had measles, diarrhea or acute respiratory infection (ARI)

No. Seen - Record the number of children examined with high risk conditions during the quarter.

No. Given VAC - Among the children with high risk conditions, record the number of children given 1 VAC.

• **VAD CASES** - refers to children suffering from Vitamin A Deficiency (Xerophthalmia). Record the number of children seen with active Xerophthalmia (XN - Nightblindness, X1B - Bitot's spot, X3 - Corneal Ulcer).

• **DELIVERIES** - Record the number of mothers who have given birth and were given VAC during the quarter.

B. NUTRITION EDUCATION

No. of Mothers with Children 0-24 months - Record total number of mothers who have children between 0 to 24 months in the area.

No. of Mothers Seen this Quarter - Record the total number of mothers who availed the services of the health center during the quarter.

No. of Mothers who Received Weaning Messages - Refers to mothers who:

- ⇒ heard about Weaning Messages through radio spots
(Heard Radio Spots column)
- ⇒ were given IEC materials on Weaning
(Seen Prints column)
- ⇒ attended/participated in any Nutrition Education classes on Weaning (Class column)
- ⇒ availed of Diet counselling
(Diet Counselling column)



2. Form IEC1: WORKSHEET: IEC Materials Distributed from IPHO

Reporting Period - 21st of previous month to 20th of current month

Area - Project Site (i.e., Quezon, Zamboanga Sur, Northern Samar)

Municipality - Record the name of the Municipality where the IEC Materials were distributed.

Type - Record the type of IEC materials (i.e., comics, brochures, etc.) that were distributed in the municipality.

Date Distributed - Record the Month/Day/Year of the distribution

Quantity - Record the number of copies of the materials that were distributed.

3. Form VAC1 - WORKSHEET: Vitamin A Capsules (VAC) Distributed from IPHO

Reporting Period - 21st of previous month to 20th of current month

Area - Project Site (i.e., Quezon, Zamboanga Sur, Northern Samar)

Municipality - Record the name of the Municipality where the VAC were distributed.

Number of Bottles distributed - Record the number of bottles that were distributed to the municipality.

Date Distributed - Record the Month/Day/Year of the distribution

4. Form T1 - WORKSHEET: Trainings Conducted

Reporting Period - 21st of *previous month* to 20th of *current month*.

Area - Project Site (i.e., Quezon, Zamboanga Sur, Northern Samar)

Title - Record the kind of training conducted (i.e., Planning Workshop, Training of Trainers, etc.)

Duration - Record the duration (in *number of days*) of the training.

Place - Refers to the place where the training was held. For trainings held in Manila, write *Manila*. For trainings held in the provinces record the *name of the province*. For trainings held in the municipalities or barangays, record the *name of the municipality/barangay*.

Number of Persons Trained - Record the number of persons trained for each category.

- ◆ **Health Personnel** - refers to the DOH staff in the municipalities or barangays. This includes the Physicians (P), Nurses (N), Rural Health Midwives (R) and Barangay Health Workers (B) who work in the RHU or in the hospitals.
- ◆ **Supervisor (S)** - refers to the IPHO staff other than Resident Physicians. It includes the District Staff like the District Chief of Hospital, Nurses, etc.
- ◆ **Government Offices (GO)** - refers to all participants employed by the government or connected to any Government Organization. For **AGENCY**, record the name of the Government organization.
- ◆ **Non-government Organizations (NGOs)** - refers to all participants employed or connected to any NGO. For **AGENCY**, record the name of the NGO.

Cost of Training - Record the actual cost (in Pesos) of the training.

5. VITEX HKI Monthly Report

Reporting Period - 21st of previous month to 20th of current month. The word "MONTH" in this Guide refers to the Reporting Period. A report for the month of November includes all activities done from October 21 to November 20, 1991.

Area - Project Site (i.e., Quezon, Zamboanga Sur, Northern Samar)

I. Major Accomplishments for the month - Narrative. Write any major activities done or accomplished for the month.

Example: "Conducted three (3) trainings in Lucena City. Most of the participants were _____. The participants found the training to be _____."

II. Outputs - Training - Attach a copy of Form T-1 (Worksheet: Trainings conducted). Base all answers from the worksheet.

For trainings conducted in Manila, record number of trainings conducted under the category HKI-Manila.

For trainings conducted in the provinces, municipalities or barangays, record number of trainings conducted under Field.

III. Outputs - VAC Supplementation

◆ **Total number of VAC on hand (IPHO)** - Record the total number of VAC (in bottles) at the IPHO for the month. This is equal to:

Number of VAC at the beginning of the month
(Old stock)

Plus (+) Number of VAC received this month
(New supply)

Less(-) Number of VAC given/distributed to the RHUs

Attach a copy of Form VAC1

(Worksheet: VAC distributed from IPHO)

IV. Outputs - Nutrition Education

- ◆ **Number of IEC Materials received from HKI-Manila - Record** total number of IEC materials received for the month.

Type - Record the type of IEC materials received (i.e., comics, brochures, etc.)

Quantity - Record the number of copies received per type of material.

Date received - Record the Month/Day/Year when materials were received.

- ◆ **Number of IEC materials distributed from IPHO - Record** total number of materials distributed to the municipalities for the month. Attach a copy of Form IEC1. (Worksheet: IEC Materials Distributed).

V. Issues this Month and Planned Actions to Resolve Issues -

Narrative. Write any pressing issues or problems in the area that hinder the implementation of an activity (i.e., Lack of transportation, lack of materials, etc.) could be written on this section. Possible suggestions on how to resolve issues could also be written like: What could you, as the area coordinator, do to help resolve the issue or how could the HKI-Manila Office help?

VI. Plans for Next Month - Narrative.

Write the activities that you plan to do for the next month. If you plan to hold trainings then write them down. Additional information about the trainings could also be written like: tentative dates or the duration of the trainings, number of participants expected, etc.

VII. Other matters - Narrative.

Write any other issues - or simply use this space to continue your discussions in other sections.

VII. OTHER DOCUMENTS/REPORT REQUIRED BY THE PROJECT

A. Routine Reports required are as follows:

1. Monthly report by HKI area coordinator to project management
2. Quarterly meeting of Vitamin A task forces with project management group (HKI and DOH)
3. Quarterly report to HKI-NY/USAID/W
4. Annual report to HKI-NY and advisory group
5. Terminal report at project completion

B. Terminal Reports - The following technical reports will be produced by the project

1. VAD Community Profile based on data collected during the baseline survey
2. Baseline Survey Operation Manual
3. Training Curriculum for Case Detection and Management of VAD
4. Report on Case Detection by Service Provider Level (MD, PHN, RHM, BHW)
5. Terminal Report

APPENDIX

MONITORING FORMS

DOH-Vitamin A Quarterly Form

Form IEC1 - Worksheet: IEC Materials Distributed from IPHO

**Form VAC1 - Worksheet: Vitamin A Capsules
Distributed from IPHO**

Form T1 - Worksheet: Trainings Conducted

VITEX HKI Monthly Report

NUTRITION EDUCATION CLASSES

NUTRITION EDUCATION CLASSES

BHS/CATCHMENT AREA	No. of Mothers with Children 0-24 months	No. of Mothers Seen this Quarter	No. of Mothers who Received Weaning Messages			
			Heard Radio Spots	Seen Prints	Class	Diet Counseling
1						
2						
3						
4						
5						
6						
7						
8						
TOTAL						

WEANING MESSAGES:

LEGEND

- Heard Radio Spots No. of mothers who heard weaning messages thru radio spots
- Seen Prints No. of mothers who were given IEC materials on Weaning
- Class No. of mothers who participated in Nutrition Education classes on Weaning
- Diet Counseling No. of mothers who availed of Diet Counseling

PREPARED BY: _____
 DESIGNATION : _____

DATE: _____

187

NUTRITION EDUCATION CLASSES

NUTRITION EDUCATION CLASSES

MUNICIPALITY	No. of Mothers with Children 0-24 months	No. of Mothers Seen this Quarter	No. of Mothers who Received Weaning Messages			
			Heard Radio Spots	Seen Prints	Class	Diet Counseling
1						
2						
3						
4						
5						
6						
7						
8						
TOTAL						

WEANING MESSAGES:

LEGEND
 Heard Radio Spots : No. of mothers who heard weaning messages thru radio spots
 Seen Prints : No. of mothers who were given IEC materials on Weaning
 Class : No. of mothers who participated in Nutrition Education classes on Weaning
 Diet Counseling : No. of mothers who availed of Diet Counseling

PREPARED BY: _____ DATE: _____
 DESIGNATION : _____

184

VITEX HKI MONTHLY REPORT

REPORTING PERIOD: 21st of _____ to 20th of _____, 19__

AREA _____

GRANT/PROJECT

54-0

NUTRITIONAL BLINDNESS PROGRAM

I. MAJOR ACCOMPLISHMENTS FOR THE MONTH

II. OUTPUTS - TRAINING

Attach a copy of Form T1

2.1 Number of trainings conducted for the month _____

HKI - Manila _____

Field _____

2.2 Total number of persons trained for the month _____

2.2.1 Number of Health Personnel trained _____

Physicians _____

Nurses _____

RHMs _____

BHWs _____

2.2.2 Number of Supervisors trained _____

2.2.3 Others _____

Government offices _____

Non-government office _____

2.3 Cost of training _____

P _____

III. OUTPUTS - VAC SUPPLEMENTATION

Number of VAC at the beginning of the month _____
 + Number of VAC received this month _____
 - Number of VAC given to RHU's this month _____
 (Attach a copy of Form VAC1)

TOTAL NUMBER OF VAC FOR THE MONTH _____

IV. OUTPUTS - NUTRITION EDUCATION

4.1 Number of IEC Materials received from HKI-Manila _____

Type	Quantity	Date Received
TOTAL		

4.2 Number of IEC Materials Distributed from IPHO _____
 (Attach a copy of Form IEC1)

V. ISSUES THIS MONTH AND PLANNED ACTIONS TO RESOLVE ISSUES

Empty space for reporting issues and planned actions.

VI. PLANS FOR NEXT MONTH

[Empty space for plans for next month]

VII. OTHER MATTERS

[Empty space for other matters]

Submitted By:

Area Coordinator

Date: _____

Noted By:

CHATO S. TUASON
Monitoring/Evaluation Officer

Date: _____

**Quarterly Reports
for Year 1
(3 Reports)**

STATUS REPORT: OCTOBER 1990-MARCH 1991

"EXPANSION OF VITAMIN A SUPPLEMENTATION AND NUTRITION EDUCATION INTERVENTIONS TO THREE PROVINCES IN THE PHILIPPINES"

COOPARATIVE AGREEMENT NO.: DAN-5116-A-00-0074-00

1.0 BACKGROUND

In the Philippines, AID support to HKI helped catalyze a Department of Health (DOH) policy on vitamin A supplementation, the development and approval of a National 5-Year Directional Plan for the Prevention and Control of VAD, and the testing of a delivery system for VAC distribution and nutrition education. Based on lessons learned through joint DOH-HKI pilot projects, the DOH is intensifying and expanding vitamin A services to new provinces and regions. This is being done within the context of the DOH's major thrusts of integrating health services for mothers and children, decentralizing program planning and health service management and promoting child survival.

2.0. PURPOSE, GOALS AND OBJECTIVES

2.1 PURPOSE

The overall purpose of the project is to provide technical assistance to the Philippine Department of Health to expand its vitamin A program and to strengthen its capability to plan and execute services aimed at reducing VAD in the context of integrated health services for child survival.

2.2 GOALS

1. To reduce vitamin A deficiency and its associated ocular manifestations, morbidity and mortality in the three project provinces.
2. To increase the proportion of high risk groups receiving a VAC to 60% in the past six months.
3. To increase the mean frequency of consumption of foods containing vitamin A among pregnant and lactating mothers, and children 6-59 months of age.

197

4. To increase the effectiveness of DOH personnel to plan, implement and manage a VAC supplementation intervention within the 3 project provinces.
5. To increase the effectiveness of DOH personnel to plan, implement and manage nutrition education interventions aimed at promoting change in essential feeding practices related to VAD in the 3 project provinces.

3.0 KEY INTERVENTIONS

3.1 VITAMIN A SUPPLEMENTATION

This intervention aims to provide vitamin A supplementation to xerophthalmic and high risk children, as well as post-partum mothers.

3.2 NUTRITION EDUCATION

This intervention aims to promote increased consumption of foods containing vitamin A in the context of overall nutrition among risk groups for VAD. The primary targets will be mothers of infants and preschoolers, as well as pregnant and lactating mothers. The secondary targets will be community members such as village elders, health professionals and local teachers who help shape food behavior in the community.

4.0 COMPARISON OF ACTUAL VS. PLANNED ACCOMPLISHMENTS

1. Preparation and Submission of Detailed Implementation Plan (DIP): DIP was prepared and submitted to AID, although, later than originally planned. This was due to the following reasons:
 - * DOH was engaged in developing a comprehensive nutrition plan as part of AID/Philippines' Child Survival Project. This plan is to serve as the DOH's overall nutrition plan, and clarify the interventions, target groups, and strategies to be used in the delivery of nutrition services, including vitamin A. In order to conform with the plan, HKI delayed finalizing the DIP.
 - * HKI underwent an evaluation of its Child Survival II grant in November 1990, and wanted to incorporate the recommendations of the evaluation in this new project.

2. Review of Supplementation Strategy and Policy: HKI sponsored a 2 day consultative workshop to revise DOH Implementing Guidelines for the expansion of vitamin A services to other provinces. Participants included key members of the DOH Nutrition Service as well as provincial technical staff from the vitamin A pilot project areas. The workshop resulted in the following recommendations:
- a. Change the age group for VAC supplementation from 6-83 months to 6-59 months to facilitate integration of VAC supplementation with other DOH services targetting children under 5 years of age.
 - b. Include mildly malnourished children (1st degree) as targets for VAC supplementation, with the existing target groups (2nd and 3rd degree malnourished, recent measles, lower respiratory tract infection and chronic diarrhea cases).
 - c. Incorporating a nutrition education section in the Implementing Guidelines.

These recommendations were presented to the DOH Program Directors for discussion, and approved for policy implementation.

3. Formation of Vitamin A Technical Advisory Group (TAG): HKI formed a TAG composed of key DOH program directors to guide project implementation and promote utilization of project findings. The TAG includes the directors of the MCH, Health Education and Nutrition Services. The TAG will widen its representation to include UNICEF, an MSH Child Survival Team member, and the Nutrition Center of the Philippines (NCP). The purpose of such broad representation is to promote vitamin A's importance beyond the traditional nutrition sector, and promote wider donor support and coordination.
4. Formation of Provincial Task Forces and Finalization of Project Agreements
HKI sponsored an orientation meeting for regional and provincial health officers of the project provinces to:
1. Form a core provincial team for project implementation.
 2. Clarify roles and expectations with regard to HKI's technical assistance
 3. Agree to the project framework.
 4. Finalize Project Agreement specifying roles and expectations.

5. Hiring of Project Staff:
HKI has hired a project monitoring and evaluation officer (Ms. Chato Tuason), an Area Coordinator (Ms. Vigil Aguilar) and a project statistical consultant (Dr. Ophelia Mendoza). HKI had hoped to hire two additional area coordinators (one for each project province) and a communications manager by this time, but is still in the process of screening candidates.

6. Field Visits and Preliminary Assessments in Project Areas:
HKI conducted field visits to each of the project areas to:

- a. Brief the provincial technical staff on the project.
- b. Conduct assessment of the status of vitamin A activities and health personnel capabilities with respect to vitamin A skills in the province.
- c. Collect secondary health and nutrition data related to vitamin A deficiency.
- d. Form provincial task forces for vitamin A activities.
- e. Meet with GO and NGO representatives to explore strengthening DOH collaboration with respect to vitamin A services.

A copy of the preliminary findings of this assessment is attached.

7. Preparation of Research Design and Operational Plan:
HKI will assist the DOH to investigate the effectiveness of alternative systems for delivering VAC supplementation and nutrition education messages. The specific research design will be formulated during a workshop scheduled for April. This represents a delay from the original schedule.

8. Preparation of Training Package: HKI has drafted a vitamin A training manual for field-level implementers which is currently being reviewed by the DOH and selected consultants. The training manual includes the following modules: Overview, VAC supplementation, Nutrition Education, Community Organization, VAD Assessment and Planning, and Evaluation. A flip-chart to serve as a training aid and a simple skills manual are currently being drafted to complement the training manual.

5.0 PLANNED ACTIVITIES FOR THE NEXT SIX MONTHS (April-September 1991)

- a. Finalization of Research Design/Pre-Post Intervention Design (data collection tools, sampling frame, sample selection, etc.)
- b. Conduct of pre-intervention surveys which will assess:
 - * Xerophthalmia prevalence
 - * VAC coverage levels among target groups
 - * Key feeding behaviors related to VAD
- c. Conduct of Operational Planning Workshops for health personnel in each province
- d. Finalization of Training package
- e. Development of communication materials for nutrition education.
- f. Orientation and training of newly hired staff.
- g. Convene TAG quarterly.

VITAMIN A PROGRAM AND PROBLEM ASSESSMENT IN PROJECT PROVINCES

Preliminary Findings:

- a. In Zamboanga Sur, about 50% personnel have been trained and on a whole, knowledge levels are high. Specific weak areas, however, are in clinical signs of xerophthalmia and appropriate doses and supplementation schedule for xerophthalmia and high risk children.
- b. In Samar, majority of the personnel have not been trained on VAD, while in Quezon, about 100% of the personnel have been trained. However, poor implementation have been reported due to fears of health personnel in giving the high dose VAC because of its toxicity.
- c. VAC (200,000 IU) available at the Provincial Health Office and in some Rural Health Units, however, the presence of other vitamin A supplement preparation of different dosages at the field units add to the confusion in appropriate dose and supplementation schedule of the targets.
- d. Evidence suggesting a serious VAD problem in the three provinces is strong. Local term for XN ("halap-halap") exist, RHP and PHNs report having seen XN, XIB and X2/X3 in past six months. Low measles coverage and measles outbreak reported in interior districts hard to reach municipalities. The nutritionists report low consumption of foods containing vitamin A among children, late introduction of nutritious weaning foods and food shortages in certain areas.
- e. Very limited IECs for nutrition available.
- f. Many health personnel have received a copy of the DOH vit. A guidelines, however, there is still a fair number (mostly new personnel) who have not been provided with copies.

HKI/PHILIPPINES
QUARTERLY PROGRESS REPORT
APRIL 1 - JUNE 30, 1991
ON
VITEX

QUARTERLY PROGRESS REPORT

PERIOD COVERED: APRIL 1 TO JUNE 30 1991

NAME OF PVO: HELEN KELLER INTERNATIONAL, PHILIPPINES

PROJECT TITLE: VITEX

COOPERATIVE AGREEMENT NO.: DAN-5116-A-00-0074-00

PROJECT NO.: 936-5116

PERIOD OF COOPERATIVE AGREEMENT: OCTOBER 1, 1990 TO SEPT. 29, 1993

TOTAL ESTIMATED AMOUNT:	\$ 900,000*	AID (*ONLY \$500,000 OBLIGATED)
	<u>\$ 225,000</u>	HKI (COST-SHARING)
	\$1,125,000	TOTAL

AID PROJECT OFFICE: S&T/N, F. DAVIDSON

PROJECT PURPOSE:

TO PROVIDE TECHNICAL ASSISTANCE TO THE PHILIPPINE DEPARTMENT OF HEALTH TO EXPAND ITS VITAMIN A PROGRAM AND TO STRENGTHEN ITS CAPABILITY TO PLAN AND EXECUTE SERVICES AIMED AT REDUCING VAD IN THE CONTEXT OF HEALTH SERVICES FOR CHILD SURVIVAL.

PROJECT OBJECTIVES:

1. TO REDUCE VITAMIN A DEFICIENCY AND ITS ASSOCIATED OCULAR MANIFESTATIONS, MORBIDITY AND MORTALITY IN THE THREE PROJECT PROVINCES.
2. TO INCREASE THE PROPORTION OF HIGH RISK GROUPS RECEIVING A VAC TO 60% IN THE PAST SIX MONTHS IN THE THREE PROJECT PROVINCES.
3. TO INCREASE THE MEAN FREQUENCY OF CONSUMPTION OF FOODS CONTAINING VITAMIN A AMONG WEANING AGE CHILDREN.
4. TO INCREASE THE EFFECTIVENESS OF DOH PERSONEL TO PLAN, IMPLEMENT AND MANAGE VAC SUPPLEMENTATION AND NUTRITION EDUCATION INTERVENTIONS.

PROJECT LOCATION:

QUEZON PROVINCE, NORTH SAMAR, ZAMBOANGA SUR

704

ACTIVITIES FOR THE PERIOD

1. Three-day live-in research planning workshop conducted with participation of 17 DOH personnel to draft research objectives and design for vitamin A expansion project.
2. Data collection instruments drafted, translated and pre-tested. Modifications incorporated into final draft.
3. Vitamin A Technical Advisory Group (TAG) convened to review and approve research design.
3. Three Area Coordinators recruited, hired (one for each province) and oriented on project components.
4. Survey teams recruited, hired and trained for conduct of baseline (pre-intervention) survey.
5. Supplies purchased and logistic arrangements made for survey team. Transportation secured, coordination with military and government offices conducted.
6. Social preparation of local department of health midwives and health personnel in survey areas conducted.
7. Baseline survey data collection begun in mid-June.
8. Training manual on micro-nutrients (VAD-IDA-IDD) drafted and reviewed by technical reviewers.
9. HKI Country Director prepared and presented a technical paper at the XIV IVACG meeting in Ecuador.

OUTPUTS

1. Research protocol finalized, approved by the TAG, and printed (see appendix 1).
 2. Three area coordinators in place. Six survey teams trained and conducting the baseline survey. (see appendix 2).
 3. Approximately 25 villages surveyed as of end of June, with approximately 1,400 preschoolers examined.
 4. Draft training micro-nutrient manual produced (see appendix 3).
- 105

5. IVACG paper prepared for presentation in Ecuador (see appendix 4).

ISSUES/PROBLEMS

1. Inability to recruit suitable candidate for Communications Program manager position has delayed start of in-depth qualitative investigations regarding weaning practices and recipe testing.
2. Rains, insurgency and unpassable roads have limited and/or slowed access to some of the baseline survey villages.
3. Lack of available transport either promised by the local DOH or for hire has slowed the data collection during the baseline survey.
4. DOH bureaucratic and budgetary constraints are posing substantial difficulties in obtaining VAC in a timely fashion for vitamin A program expansion provinces.

CONSULTANTS/CONTRACTORS

- Dr. Florentino Solon: served as trainor of the baseline survey team members.
- Dr. Evangeline Santos: served as trainor in the clinical detection of xerophthalmia for baseline team physicians.
- Dr. Fritz Casalan: served as trainor in the clinical detection of xerophthalmia for baseline team physicians.
- Dr. Ophelia Mendoza: provided principal guidance in the development of the research protocol and data collection instrument development
- Kirsten Laursen: provided technical review of micronutrient training manual.
- Josie Caguiao: consolidated and edited draft of micronutrient training manual.

PLANS FOR NEXT QUARTER

1. Complete baseline survey data collection, begin data editing, and encoding.
2. Convene TAG to report on preliminary findings of baseline survey.
3. Conduct small-scale qualitative investigation of weaning foods, weaning practices, and media habits.
4. Develop prototype nutrition education materials.
5. Convene a VAC Procurement technical meeting to address bottleneck in DOH procurement procedures.
6. Send Vitamin A Program Manager to HKI headquarters to finalize draft of micronutrient training manual.
7. Conduct operational planning workshops in each project province.

Prepared by: Rolf D.W. Klemm, MPH
Ellen Villate, BSFN
Date: July 10, 1991

QUARTERLY PROGRESS REPORT
ON "EXPANSION OF VITAMIN A SUPPLEMENTATION"
AND NUTRITION EDUCATION INTERVENTIONS
TO THREE PROVINCES IN THE PHILIPPINES

(JULY 1 - SEPTEMBER 30, 1991)

1.0 BACKGROUND

In the Philippines, AID support to HKI helped catalyze a Department of Health (DOH) policy on vitamin A supplementation, the development and approval of a National 5-Year Directional Plan for the Prevention and Control of VAD, and the testing of a delivery system for VAC distribution and nutrition education. Based on lessons learned through joint DOH-HKI pilot projects, the DOH is intensifying and expanding vitamin A services to new provinces and regions. This is being done within the context of the DOH's major thrusts of integrating health services for mothers and children, decentralizing program planning and health service management and promoting child survival.

2.0 PURPOSE, GOALS AND OBJECTIVES

2.1 PURPOSE

The overall purpose of the project is to provide technical assistance to the Philippine Department of Health to expand its vitamin A program and to strengthen its capability to plan and execute services aimed at reducing VAD in the context of integrated health services for child survival.

2.2 GOALS

1. To reduce vitamin A deficiency and its associated ocular manifestations, morbidity and mortality in the three project provinces.
2. To increase the proportion of high risk groups receiving VAC to 60% in the past six months.
3. To increase the mean frequency of consumption of foods containing vitamin A among pregnant and lactating mothers, and children 6-59 months of age.

4. To increase the effectiveness of DOH personnel to plan, implement and manage a VAC supplementation intervention within the 3 project provinces.
5. To increase the effectiveness of DOH personnel to plan, implement and manage nutrition education interventions aimed at promoting change in essential feeding practices related to VAD in the 3 project provinces.

3.0 KEY INTERVENTIONS

3.1 VITAMIN A SUPPLEMENTATION

This intervention aims to provide vitamin A supplementation to xerophthalmic and high risk children, as well as post-partum mothers.

3.2 NUTRITION EDUCATION

This intervention aims to promote increased consumption of foods containing vitamin A in the context of overall nutrition among risk groups for VAD. The primary targets will be mothers of infants and preschoolers, as well as pregnant and lactating mothers. The secondary targets will be community members such as village elders, health professionals and local teachers who help shape food behavior in the community.

4.0 COMPARISON OF PLANNED VS. ACTUAL ACTIVITIES:

- 4.1 Completion of Baseline Survey data collection. Data editing and encoding started.

Baseline Survey data collection was completed in the three provinces in mid-August. A total of 118 villages in 56 municipalities were covered, and over 11,000 preschoolers were examined.

Preliminary findings indicated a high prevalence of xerophthalmia in each of the provinces exceeding WHO cut-off level. Among the three (3) provinces, Northern Samar had the highest prevalence rate of 6.7% and 2.6% for nightblindness and Bitot's Spot respectively.

67% of the preschoolers who were found to have signs of xerophthalmia and undernutrition (1st, 2nd & 3rd degree by weight for age) were given VAC. A summary of the preliminary findings is attached (attachment 1).

Field visits were conducted to present to the IPHO staff the preliminary findings of the survey. Phil. DataBase Services, Inc. (PDSI) was contracted to encode the baseline data. 100% (11,374) of the preschoolers' records and 30% of the mothers' records have been edited and encoded.

4.2 Convene TAG to report on preliminary findings of Baseline Survey.

The Vitamin A Technical Advisory Group (TAG) was convened on August 8, 1991. Several issues were discussed:

- an update of the preliminary finding on the vitamin A survey
- Formative Research design on weaning practices
- Issues affecting the implementation of the National Vitamin A Program i.e. VAC procurement, toxicity issue with the committee on Drug Formulary etc.

Some concrete steps were recommended by the group to address the major issues. Minutes of the meeting attached. (Attachment 2)

4.3 Conduct small-scale qualitative investigation of weaning foods, weaning practices and media habits.

Data collection in Quezon province completed. Included in the study are mothers of infants 4-12 months, Hilot and Health Workers in 3 selected villages. The team was composed of NS-DOH, Task Force members from the province and HKI.

4.4 Develop prototype nutrition education materials.

Data collection of the formative research on weaning practices in the 2 provinces will be completed by end of October. Consequently, the development of the nutrition education materials has been programmed to start by November.

4.5 Development of the Micronutrient Training Manual

- Draft of the training manual has been field-tested among field implementors.
- Revisions incorporating comments and suggestions are still in progress.

4.6 Send Vitamin A Program Manager to HKI Headquarters

Ms. Ellen Villate, Vitamin A Program Manager sent to HKI/NY (July 8-12, 1991). She worked on the finalization of the training manual and presented the status of the Vit. A project to the technical program staff in NY.

Ms. Villate also met with Dr. Frances Davidson USAID/W to provide feedback on the progress of project implementation.

4.7 Conduct operational planning workshop in each province.

Operational planning workshops have been rescheduled for the next quarter due to other project activities conducted.

4.8 Other project activities conducted:

- One week live-in Training of Trainers for HKI and DOH counterparts involved in implementing training within the vitamin A program.

5.0 OUTPUTS

5.1 Completed Baseline Survey (see attachment 1)

5.2 Minutes of the TAG meeting (see attachment 2)

5.3 Protocol on Formative Research for Weaning Study (see attachment 3)

5.4 Hired and contracted the ff:

- Ms. Eva Puertollano - Communications Manager
- Mr. Ismael Rosa - Area Coord. for Zamboanga Sur

- Dr. Karen Castaneda - Consultant on weaning study. She provided principal guidance in the development of the research protocol and served as trainer in the conduct of in-depth interviews and focus group discussions.

6.0 PLANS FOR NEXT QUARTER

- 6.1 Complete analysis of baseline survey and start of write-up of findings.
- 6.2 Conduct data analysis workshop to assist DOH in the analysis and interpretation of vitamin A baseline survey findings.
- 6.3 Complete analysis and write-up of weaning study as a basis for the development of a nutrition communication strategy.
- 6.4 Development of prototype nutrition education materials and communication plan.
- 6.5 Conduct of planning-workshops to develop provincial action plans to guide project implementation through June 1992.
- 6.6 Field-testing of the revised VAD-IDA-IDD training manual.
- 6.7 Printing of the micro-nutrient training manual and support IEC materials
- 6.8 Conduct of a Training of Trainers for 15 provincial trainers in 3 provinces and training of 500 DOH field implementers.
- 6.9 Development of a monitoring system manual to monitor VAC and Nut. educ. interventions.
- 7.0 Convene TAG to report on progress of project implementation

Prepared by:

Rolf D.W. Klemm
ROLF D.W. KLEMM

Ellen E. Villate
ELLEN E. VILLATE

22

Attachment 1

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BASELINE SURVEY
 PRELIMINARY RESULTS

PROVINCE	START OF BASELINE SURVEY	END OF BASELINE SURVEY	NO. OF MUNICIPALITIES SURVEYED	NO. OF BARANGAYS SURVEYED
QUEZON	JUNE 12, 1991	JULY 30, 1991	20	10
N. SAMAR	JUNE 19, 1991	AUG. 9, 1991	15	36
ZABOANCA SUR	JUNE 18, 1991	AUG. 11, 1991	21	12

PROVINCE	TARGET NUMBER (P. S.)	CHILDREN EXAMINED		XEROPHTHALMIA CASES										NUTRITIONAL STATUS										NUMBER OF CHILDREN GIVEN VAC		NUMBER OF MOTHERS INTERVIEWED	
				XN		X1B		X3		X5		TOTAL		1st Degree		2nd Degree		3rd Degree		MORRAL		OVERWEIGHT					
				No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%				
QUEZON	3220	3392	105.3	62	1.8	28	0.6	1	0.03	7	0.2	90	2.7	1850	54.5	832	24.5	53	1.6	632	18.6	25	0.7	2716	81.0	2,129	
NORTHERN SAMAR	3205	3125	97.5	209	6.7	82	2.6	6	0.2	21	0.7	318	10.2	1698	51.3	692	22.1	19	1.6	655	21.0	20	0.9	965	30.9	1,856	
ZABOANCA SUR	3215	1857	151.1	75	1.5	30	0.6	3	0.06	7	0.11	115	2.1	2659	51.7	1039	21.1	65	1.3	1040	21.6	16	0.9	3955	81.1	2,290	

MINUTES OF THE 2ND TECHNICAL ADVISORY GROUP
 9:00 AM - 12:00 NN
 August 8, 1991
 Helen Keller International

ATTENDEES:

1. Dr. Manuel G. Roxas	OPHS-DOH
2. Mrs. Adelisa C. Ramos	NS-DOH
3. Dr. Ian Darnton-Hill	WHO
4. Dr. Benjamin Loevinsohn	CSP
5. Mr. Rolf D.W. Klem	HKI
6. Ms. Bituin Gonzales	UNICEF
7. Dr. Eva Santos	UP-PGH/KHI
8. Ms. Ellen Villate	HKI
9. Ms. Chato Tuason	HKI
10. Ms. Vigil Aguilar	HKI
11. Dr. Mariella Sugue	NS-DOH
12. Ms. Agnes V. del Rosario	NS-DOH
13. Ms. Cymbeline de Guzman	NS-DOH

Absent:

Dr. Linda Milan	PCU-DOH
Mrs. Crescencia Cruz	PLS-DOH
Dr. Florentino Solon	NCP

I. Meeting Objectives

The meeting was called to order at 9:15 AM. The purpose of the meeting was:

1. To provide an update on the Vitamin A survey being conducted in Quezon, N. Samar and Zamboanga del Sur (methods, problems, preliminary results and conclusions)
2. To critique the qualitative assessment design for the investigation of weaning practices in the 3 project provinces.
3. To discuss issues related to the Vitamin A project implementation.
 - o scheduling of OPT
 - o use of BHW for follow-up dose of VAC
 - o availability of 200,000 I.U. supplementation guidelines
4. To provide an update on issues related to national implementation of the Vitamin A Program.

II. Presentation Made

1. Update on Vitamin A Survey
 - o Methods and Preliminary Results
 - o Impressions in the Field
 - o Recommendations
2. Mt. Pinatubo areas to be included in Vitamin A Expansion Program
3. Weaning Practice Study Design
4. Update on National Implementation of Vitamin A Program
 - o DOH (Central Office) Budget for VAC Procurement
 - o Status of 200,000 I.U. for inclusion in the DOH Drug Formulary
 - o Dissemination of Revised VAC Policy
 - o Status of actions to orient field units on the safety of using VAC 200,000 I.U.
 - o Fortification

Hand-outs Provided: Update on Vitamin A Survey, Baseline Preliminary Results, Vitamin A Program Issues, Letter from National Drug Committee regarding inclusion of VAC 200,000 I.U. in Drug Formulary, Revised Guideline on Vitamin A Supplementation, Department Circulars on the Ban of Purchase of Powdered Vitamin A

III. Issues and Discussions

1. Update on Vitamin A Survey in 3 Expansion Areas
 - A. Methods Used
 - o Kind of survey: Pre-post intervention cross-sectional study survey design
 - o Study Subjects and Form of Assessment
 - a) Preschoolers - Nutritional Status/Clinical Assessment (6-83 months)
 - b) Mothers of Preschoolers - Interview Schedule
 - c) Rural Health Midwives - Interview Schedule
 - d) Barangay Health Workers - Interview Schedule
 - o Sampling Method used was stratified systematic with Probability Proportionate to Size

B. Initial Finding

- o Among the three provinces surveyed, Northern Samar had the highest Xerophthalmia rate. Broken Xerophthalmia rate. Broken down as follows: (most cases were found in Island Municipalities)
 - * Nightblindness - 6.5% WHO Standard is 1.0%
 - * Bitot's Spot - 2.7% " " " 0.5%
 - * Corneal Xerosis - 0.2% " " " 0.01%
 - * Corneal Scar - 0.79% " " " 0.05%
- o Quezon registered highest with the most number of of second degree malnourished children at 24.5% that is 832 out of 3392 children examined.
- o Northern Samar had the highest number of third degree malnourished children at 55.03% or 1690 out of 3071 children seen.

C. Constraints Encountered by Survey Team

- o bad roads
- o bad weather - survey was done during the rainy season
- o not enough interviews^{or} - to interview mothers at survey site resulting to some respondents becoming impatient because they have to wait for a very long time

D. Impressions in the Field

- o There was an absence of high dose Vitamin A Capsules 200,000 I.U. - no supplement for VAD Cases
- o No guidelines on VAC supplementation

Recommendations:

- o Focus more attention to island municipalities because VAD cases are high in these areas.
- o Future survey needs to be conducted during the dry season so as not to hamper and delay survey due to bad weather.
- o A need for more interviewers to accommodate more mothers for interview to prevent bottleneck in the flow of activities.

- o A market Survey has to be done to assess the food situation in the areas of survey to check if the problem is on Food Use or Food Availability.
- o The use of VAC 200,000 I.U. is stressed as a more suitable treatment dose than a multiple low dose VAC such as the powdered 25,000 I.U.
- o A new guideline for Vitamin A supplementation needs to be disseminated in the field to guide health workers in the proper treatment of VAD Cases.

2. Mt. Pinatubo Area (Region III)

- o There is a need to assess the health situation in the evacuation centers of the Mt. Pinatubo areas. The need for Vitamin A Supplementation and other interventions are stressed especially so because of the outbreak of epidemics in these areas.
- o A plan of action for the area is suggested to be developed.
- o Evacuation centers should have live-in RHMs to cater and monitor the needs of the evacuees. An anchor person per province from Nutrition Service is also needed to be put in place.
- o Mr. Benjamin Loevinsohn of Child Survival Program (CSP) offered the use of their vehicle in the monitoring and supervision of activities in the Mt. Pinatubo areas.

3. Weaning Practice Study

- o Importance of Nutrition Education as long-term intervention for mothers was stressed. The early formation of the proper feeding during the weaning stage.
- o The study has to focus on 3-4 workable nutrition messages that will be more effective and it should always include breastfeeding.
- o The focus of the messages should not be the mothers only but should include the whole family especially those who influence them.
- o The need to look into the child care patterns was suggested - such as who looks after the child when mother is working in the field; from whom do mothers get information about health outside the health system; what preventive measures are being observed in the family.

Insomix - a need to reinvestigate this mixture which is nutritious and which may be endorsed as a weaning food. This is made up of rice, beans, dill and some other foods which are low cost and easily available anywhere.

4. Implementation of the National Vitamin A Program

- o The need to allocate from the DOH Budget an amount for the central procurement of Vitamin A Capsules to ensure regular supply.
- o Other agencies may be tapped for donation of VAC, such as USAID, UNICEF, CIDA, AIDAB.
- o Other countries can be tapped also as potential donors of VAC.
- o Difficulty in the use of PHDP grant by NS-DOH in which the World Bank has to give clearance first before procurement can be made. The UNICEF representative said that the World Bank can be informed that procurement made through UNICEF is always through International Bidding, in compliance with World Bank requirements.

5. Inclusion of VAC 200,000 I.U. in the National Drug Formulary

- o The National Drug Committee (NDC) has not included the Vitamin A Capsule 200,000 I.U. to this date on its list because of the belief that it has toxic effects on the consumer.
- o It was agreed that the NDC through its chairman, Dr. Quintin Kintanar, will be invited to be briefed and enlightened on the safe use of high dose VAC. Other people of relevance such as policy makers, the academe, DOH people, the PMA (Philippine Medical Association) Members, obstetricians and pediatricians will also be invited to the briefing.
- o A compilation of Vitamin A studies which indicate the safe use of high dose Vitamin A Capsule will also be distributed.

6. Dissemination of Revised Vitamin A Supplementation Guideline

- o A new guideline on Vitamin A Supplementation has been recently signed by Dr. Alfredo R.A. Bengzon and it will be disseminated in the field soon.

- o A decision has been reached that VAC will be distributed using the following scheme:

- < 1 year old - thru EPI
- > 1 year old - thru OPT (February, July)

UFC may also be an opportunity to distribute VAC (under the Five Clinic)

IV. Agreement Reached

1. Region III be included as a priority/expansion area of Vitamin A following the eruption of Mt. Pinatubo which brought calamities/disasters to the areas around it.
2. OPT and EPI sessions to be the occasions for VAC distribution and a circular to be made to put this into effect.
3. The need for a regular supply of VAC is emphasized and this may be done through the support of other agencies and other countries that can be tapped as donors of the micronutrient.

V. Follow-Up Action Needed from Nutrition Service

1. Letter to the NDC and other relevant bodies/organizations that need to be invited and enlightened on the safe use of high dose VAC.
2. Distribution of the revised guideline of Vitamin A Supplementation to the field health personnel.
3. A circular should be made soon regarding the distribution of VAC during EPI sessions for targets who are less than one year old and the OPT sessions for targets one year and above.
4. Organize a dialogue with the National Drug Committee.
5. Send letters to donors for VAC procurement (e.g. AID, AIRAB, CIDA and UNICEF).

Noted by:

Prepared by:

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QUARTERLY PROGRESS REPORT
ON "EXPANSION OF VITAMIN A SUPPLEMENTATION"
AND NUTRITION EDUCATION INTERVENTIONS.
TO THREE PROVINCES IN THE PHILIPPINES

(OCTOBER 1991 - DECEMBER 1991)

1.0 BACKGROUND

In the Philippines, AID support to HKI helped catalyze a Department of Health (DOH) policy on Vitamin A supplementation, the development and approval of a National 5-Year Directional Plan for the Prevention and Control of VAD, and the testing of a delivery system for VAC distribution and nutrition education. Based on lessons learned through joint DOH-HKI pilot projects, the DOH is intensifying and expanding vitamin A services to new provinces and regions. This is being done within the context of the DOH's major thrusts of integrating health services for mothers and children, decentralizing program planning and health service management and promoting child survival.

2.0 PURPOSE, GOALS AND OBJECTIVES

2.1 PURPOSE

The overall purpose of the project is to provide technical assistance to the Philippine Department of Health to expand its vitamin A program and to strengthen its capability to plan and execute services aimed at reducing VAD in the context of integrated health services for child survival.

2.2 GOALS

1. To reduce vitamin A deficiency and its associated ocular manifestations, morbidity and mortality in the three project provinces.
2. To increase the proportion of high risk groups receiving VAC to 60% in the past six months.
3. To increase the mean frequency of consumption of foods containing vitamin A among pregnant and lactating mothers, and children 6-59 months of age.

4. To increase the effectiveness of DOH personnel to plan, implement and manage a VAC supplementation intervention within the 3 project provinces.
5. To increase the effectiveness of DOH personnel to plan, implement and manage nutrition education interventions aimed at promoting change in essential feeding practices related to VAD in the 3 project provinces.

3.0 KEY INTERVENTIONS

3.1 VITAMIN A SUPPLEMENTATION

This intervention aims to provide vitamin A supplementation to xerophthalmic and high risk children, as well as post-partum mothers.

3.2 NUTRITION EDUCATION

This intervention aims to promote increased consumption of foods containing vitamin A in the context of overall nutrition among risk groups for VAD. The primary targets will be mothers of infants and preschoolers, as well as pregnant and lactating mothers. The secondary targets will be community members such as village elders, health professionals and local teachers who help shape food behavior in the community.

4.0 COMPARISON OF PLANNED VS. ACTUAL ACTIVITIES

- 4.1 Completion of analysis of baseline survey and start write-up of findings.

Editing of Baseline data editing of (clinical records of preschoolers) was completed. Initial marginal and statistical runs were produced for each of the provinces.

100% of the mothers' records were encoded, however, editing for completeness and consistency checks is still on-going. Hence, completion of statistical runs and report writing is rescheduled for the next quarter.

- 4.2 Conduct of data analysis workshop to assist DOH in the analysis and interpretation of vitamin A baseline survey findings.

A 2-day data analysis workshop originally scheduled for December was postponed pending the completion of statistical runs on the base line data.

- 4.3 Complete analysis and write-up of weaning study as a basis for the development of a nutrition communication strategy.

Data collection and consolidation of weaning study data were completed for N. Samar and Zamboanga Sur provinces.

Analysis and write-up for the Quezon data has been initiated by Project Consultant Dr. Karen Castaneda. Completion of analysis and write-up was delayed do to other program priorities (i.e. training activities), Analysis of data will be completed in January.

- 4.4 Develop prototype nutrition education materials and communication plan.

This activity was rescheduled for January, upon completion of weaning study data analysis. Findings from this study will serve as the basis for the communication strategy.

- 4.5 Conduct planning-workshops in the three provinces and HKI project team.

The planning-workshops in the three areas were completed as follows:

- a. Zamboanga Sur - Oct. 15-17, 1991
- b. Quezon - Oct, 23-24, 1991
- c. N. Samar - Nov. 4-6, 1991

Each province developed a provincial action plan to guide project implementation through June 1992; this included the training plan/schedule for field implementors. The workshop was attended by the Provincial Task Force members, Asst. Provincial Health Officer, Technical Chief and representatives from NS-DOH, HKI Area Coordinators and Program Manager.

The HKI VITEX Project team likewise held a 2-day consultative planning-workshop and discussed the implementation activities/plan for the period Nov. 1991 to June 1992. The workshop provided an opportunity for the group to identify individual needs and concerns in relation to work.

- 4.6 Field-testing of the revised VAD-IDA-IDD Training Manual was conducted among 20 midwives from Quezon City on November 5-8, 1991.
- 4.7 Printing of the micronutrient training manual and support IEC materials.
 - o 50 copies of the VAD-IDA-IDD Training Manual were produced (these included Modules and Reference Materials)
 - o 1000 copies of the support IEC materials (i.e. Training handouts of worksheets) were printed.
 - o 1000 sets of training kits were purchased (include training bag, pens, notebooks, etc.)
- 4.8 Conduct of a Training of Trainers (TOT) for 15 provincial trainers in three provinces and training of 500 DOH field implementors.

TRAINING/ORIENTATION ACTIVITIES HELD WERE:

- * A Training of Trainers workshop on VAD-IDA-IDD Prevention Control for the 3 expansion provinces was conducted (Nov. 18-22, 1991). The training team of each province was composed of the Vitamin A Provincial Task Force and supported by the Nutritionist at the Region and Central office, NS. The training team is responsible to hold subsequent trainings among field health personal in its respective province.

	Quezon	N. Samar	Zambo S.	Central Office	Total
Physicians	2	2	2		6
Nutritionist	3	2	2	2	9
Health Educ./Nurse	1	2	1		4
HKI Area Coord./staff	1	1	1	2	5
	7	7	6	4	24

223

The workshop was facilitated by HKI and NS-DOH staff, who participated in the HKI-TOT conducted by Ms. Kirsten Laursen. It adopted as experiential approach to training.

The VAD-IDA-IDD training manual was used to guide participants in facilitating learning exercises and develop facilitators skills.

- * Conducted and facilitated a Vitamin A Symposium in Quezon Province. A total of 55 participants attended the symposium including Government Municipal Health Officers, District Chief of Hospitals and Resident Physicians. Topics discussed were Vitamin A and its importance in child survival, VAD clinical detection, the VITEX project overview and initial findings of the Baseline Survey. The symposium was also attended by Mrs. Adelisa Ramos, Director of NS and the technical staff of IPHO, Quezon.
- * Conducted Training of Trainers at the District level in Zamboanga Sur (Nov. 27-30). 20 participants were trained. These participants will provide support to the provincial training team and facilitate the training of municipal and village health workers.
- * Trained Field Implementors on VAD-IDA-IDD

Province	Target Participants Based on Plant developed	Actual Number Trained by Type of Health Personnel				
		Others	Phy - sician	Nurse	Mid- Wife	Total Trained
Quezon	107	2	8	3	80	93
N. Samar	39					19
Zambo. Sur	247		15	31	198	244
TOTAL	393					

224

A total of 5 training sessions were conducted. A team of NS and HKI provided the technical support and supervision in the conduct of the provincial trainings. Based on feedback from trainees, the training sessions/activities were found effective in conveying skills in detection management and prevention of VAD-IDA-IDD. The provincial trainers have shown great enthusiasm and innovativeness. However, a need for continued feedback among the team and support from the HKI and NS Central staff was expressed. Included in the training calendar is a 4-hour field practicum to reinforce their skills in case detection and management. During the trainings, the findings were:

Preschoolers with Xerophthalmia by Province

XN	-
XIB	-
XB	-
XS	-

Preschoolers given VAC (Xerophthalmic & HR Cases)

A total of _____ PS were given VAC.

- 4.9 Develop a monitoring system manual to monitor VAC and Nutrition Education intervention.

VITEX Monitoring and Evaluation Manual was finalized. This document describes the Project Routine Reporting requirements and reporting system.

- 4.10 Convene Technical Advisory Group (TAG) to report on progress of project implementation.

The 3rd TAG meeting is scheduled for February 92. The agenda for the TAG is as follows:

- a. status of training activities
- b. availability of VAC supply and other micronutrients
- c. presentation and approval of communication plan

4.11 Other Activities and Development:

- * Held meetings with UNICEF representatives to establish a mechanism for collaboration in Zamboanga Sur and Northern Samar in the development and production of locally appropriate teaching aids for VAD and VAC procurement.
- * A total of 325,000 VAC/650 bottles were provided to the 3 project provinces.

5.0 DOCUMENTS DEVELOPED AND PRODUCED:

- 5.1 3 Provincial VITEX Operational Plan and Training Plan
- 5.2 VAD-IDA-IDD Trainer's Manual
- 5.3 Training Handouts and Worksheets
- 5.4 VITEX Monitoring and Evaluation Manual

6.0 PLANS FOR NEXT QUARTER:

- 6.1 Complete analysis of baseline survey and start of write-up of findings.
- 6.2 Complete analysis and write-up of weaning study as a basis for the development of a nutrition education campaign.
- 6.3 Develop prototype nutrition education materials and communication plan.
- 6.4 Complete training of Field Implementors.
- 6.5 Initiate VAC Supplementation thru OPT activities.
- 6.6 Conduct of Monitoring and Supervision Activities.
 - 6.6.1 conduct of field visits in selected area
 - 6.6.2 conduct a quarterly consultative conference in each VITEX province.
 - 6.6.3 convene TAG to report on progress of project implementor.
 - 6.6.4 submit monthly routine report
- 6.7 Finalize the VAD-IDA-IDD Training Manual

Prepared by:

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Ellen E. Villate
Ellen Villate

**Job Descriptions and
Resumes of Project
Staff & Consultant**

VITAMIN A PROGRAM MANAGER

Principal Duties and Responsibilities:

1. Assesses needs and resources available for current program operations.
2. Reviews project needs and resources available for any program expansion.
3. Assesses program support operations in the terms of quick/rapid response (technical, financial and communication).
4. Assesses DOH program planning and implementation of project.

FINANCE / ADMINISTRATIVE MANAGER

Principal Duties and Responsibilities:

1. Acts as financial manager.
2. Oversees and takes charge of all disbursements, cash advances, preparation of payroll, etc.
3. Sets up and maintains office and personnel procedures in coordination with Country Director.
4. Supervises administrative and support staff and coordinates their daily activities.

ACCOUNTANT

Principal Duties and Responsibilities:

1. Prepares journal vouchers for all transactions to be recorded in the general journal.
2. Records official receipts in the cash receipts book.
3. Summarizes monthly transactions in the cash receipts book and general journal.
4. Records advances and payables in their respective subsidiary ledger.
5. Prepares trial balances.

ADMINISTRATIVE ASSISTANT III

Principal Duties and Responsibilities:

1. Responsible for the encoding and output of financial reports and status through computers.
2. Prepares payroll for Manila-based employees.
3. Provides back-up support to Manila-based HKI project or activities when necessary.
4. Coordinates with pertinent agencies in the release/shipment of project materials and equipments.

BOOKKEEPER

Principal Duties and Responsibilities:

1. Records/summarizes transactions in the cash disbursements book every month.
2. Prepares disbursement vouchers and checks for approved expenses.
3. Handles petty cash fund.
4. Assists Finance/Admin. Manager as necessary in financial matters particularly in arranging and sending pouches and financial reports.

SECRETARY

Principal Duties and Responsibilities:

1. Receives, records and disseminates all communications.
2. Sets up and maintains filing systems for communications, project documents and other appropriate files.
3. Xeroxes files and documents as necessary.
4. Provides other clerical service including typing and collating reports.
5. Arranges the sending of pouches and facsimiles.
6. Handles and refers incoming calls to persons concerned.
7. Handles travel arrangements of staff.
8. Provides messengerial functions, as needed, particularly between collaborating offices.
9. Performs other tasks as required by supervisors.

DRIVER

Principal Duties and Responsibilities:

1. Provides back-up support to HKI's projects.
2. Assists and works closely with the HKI main office personnel in the conduct of project operations or activities specifically providing transportation needs.
3. Responsible for the maintenance of the project vehicles.
4. Responsible for packing and transport of field supplies and equipments.
5. Delivers communications, messages and project supplies/materials to project locations.
6. Performs other duties and responsibilities as may be directed by higher authorities.

MONITORING AND EVALUATION OFFICER

Principal Duties and Responsibilities:

1. Assists in the development/design of data collection tools for the Vit. A Expansion project.
2. Develops the editing and coding manuals for the pre-post intervention surveys, the special monitoring studies, etc.
3. Conducts supervisory and monitoring function in the project area with program manager and area coordinator in the aspect of quality control in data management of:
 - * Baseline/Endline data
 - * Routine Monitoring
 - * Special Studies
4. Develops/designs encoding and editing programs.
5. Analyzes and recommends a quality systems file for efficient data handling and analysis.
6. Identifies/recommends appropriate software packages for data analysis application.
7. Assists with computerization needs of other HKI projects as needed.
8. Identifies possible problems/needs in the computerization system.
9. Conducts training to DOH and HKI staff as needed.
10. Assists in the preparation of program updates (HKI monthly, quarterly and annual reports).

237

OPHELIA MENDOZA, Ph.D.
Consultant on Epidemiology and Statistics

Duties and Responsibilities:

1. Assist in the development of the project's research design.
2. Assist in the development of data collection tools.
3. Assist in the development of data analysis plan.
4. Act as resource person and facilitator during workshop with DOH personnel.
5. Assist in the analysis and write-up of project reports.
6. Participate in the project monitoring and evaluation activities.
7. Assist HKI and DOH in presentation of results to appropriate individuals if necessary.

CATHERINE Q. CASTANEDA, Ph.D.
Consultant on Formative Research on Weaning

Duties and Responsibilities:

1. Assist in developing protocol for qualitative research on food habits for weaning age children (research design, questionnaire, framework)..
2. Conduct one-day training for interviewers and FGD moderators.
3. Supervise data collection in field (1-2 days).
4. Assist in analysis and interpretation of data.
5. Review and critique draft of research report.

AREA COORDINATOR

Principal Duties and Responsibilities:

1. Overall coordinator of the Vitamin A project in the province in collaboration with the DOH counterpart and directly responsible and accountable to the Program Manager/Country Director of HKI.
2. Establishes lines of communication with collaborating agencies specifically the Provincial Health Office and other government agencies in the area.
3. Initiates/plans/implements activities for the province that have been discussed with and approved by the Country Director specifically:
 - * assists DOH in the conduct of orientation seminars and consultative workshops .
 - * acts as facilitator/resource person/trainer during seminars, trainings or workshops.
 - * monitors the program activities by continually keeping track of issues/problems encountered and accomplishments for each month.
 - * assists and coordinates activities in the conduct of community assessment surveys.
 - * conducts social preparation activities.
4. Oversees office expenditures for the area and prepares financial reports.
5. Responsible for the preparation of program updates, monthly program reports and other reports that may be required by the program manager or country director.
6. Oversees the project office for the area and takes responsibility for its equipment and their maintenance, supplies purchase, use and inventories.

238