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Keeping children 'Fit for School'

A publication in the German Health Practice Collection

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Acronyms and Abbreviations

ARMM	Autonomous Region in Muslim Mindanao	GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
AusAID	Australian Agency for International Development	GSK	GlaxoSmithKline
<i>Barangay</i>	Smallest administrative unit in the Philippines	HDI	Human Development Index
BESRA	Basic Education Sector Reform Agenda	IEC	Information, Education and Communication
BMZ	Federal Ministry for Economic Cooperation and Development, Germany	KfW	KfW Entwicklungsbank
CIM	Centre for International Migration and Development	LGU	Local Government Unit
DepEd	Department of Education	MDG	Millennium Development Goal
DED	Deutscher Entwicklungsdienst gGmbH (now GIZ)	NGO	Non-governmental organisation
EFA	Education for All	NIH	National Institutes of Health (Philippines)
EHCP	Essential Health Care Program	PTA	Parent-Teacher Association
InWEnt	Capacity Building International (now GIZ)	SBM	School-Based Management
FIT	Fit for School Inc.	SEAMEO	Southeast Asian Ministers of Education Organization
GDC	German Development Cooperation (comprising BMZ, GIZ and KfW)	STH	Soil-Transmitted Helminth (intestinal worm)
GDP	Gross Domestic Product	UNICEF	United Nations Children's Fund
		WHO	World Health Organization
		WHOCC	World Health Organization Collaborating Centres

Keeping children ‘Fit for School’

Simple, scalable and sustainable school health in the Philippines

Acknowledgements	4
German Health Practice Collection	5
Executive Summary	6
Preventable diseases and school health	8
Health and education challenges in the Philippines	10
EHCP: from concept to implementation	14
At school: three simple interventions	17
Roles and responsibilities: who does what?	19
Costs of implementing the EHCP	22
Monitoring and evaluation	24
Achievements and challenges	26
Lessons Learnt	28
Peer Review	30
References	32

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Thierry Kühn, Division of Health and Population Policies, BMZ

¹ CIM is an initiative of GIZ and Germany's Bundesagentur für Arbeit.

German Health Practice Collection

Objective

In 2004, experts working for German Development Cooperation (GDC)² and its international and country-level partners around the world launched the German HIV Practice Collection and, in 2010, expanded it into the German Health Practice Collection (GHPC). From the start, the objective has been to share good practices and lessons learnt from BMZ-supported initiatives in health and social protection. The process of defining good practice, documenting it and learning from its peer review is as important as the resulting publications.

Process

Managers of GDC-supported initiatives propose promising ones to the Managing Editor of the GHPC at ghpc@giz.de. An editorial board of health experts representing GDC organizations at their head offices and in partner countries select those they deem most worthy of write-up for publication. Professional writers then visit selected programme or project sites and work closely with the national, local and GDC partners primarily responsible for developing and implementing the programmes or projects. Independent, international peer-reviewers with relevant expertise then assess whether the documented approach represents 'good or promising practice', based on eight criteria:

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

Only approaches meeting most of the criteria are approved for publication.

Publications

All publications in the GHPC describe approaches in enough detail to allow for their replication or adaptation in different contexts. Written in plain language, they aim to appeal to a wide range of readers and not only specialists. They direct readers to more detailed and technical resources, including tools for practitioners. Available in full long versions and summarized short versions, they can be read online, downloaded or ordered in hard copy.

Get involved

Do you know of promising practices? If so, we are always keen to hear from colleagues who are responding to challenges in the fields of health and social protection. You can go to our website to find, rate and comment on all of our existing publications, and also to learn about future publications now being proposed or in process of write-up and peer review. Our website can be found at www.german-practice-collection.org. For more information, please contact the Managing Editor at ghpc@giz.de.

² GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organizations Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Entwicklungsbank (KfW).

Executive Summary

Schoolchildren in the Philippines suffer from a high burden of preventable diseases, with hygiene deficiencies as a common cause, i.e. lack of basic personal hygiene and poor access to sanitation. The main diseases are:

- Hygiene-related infectious diseases: diarrhoea, acute respiratory infections, and pneumonia are the top three killer diseases for children in the Philippines;
- Soil-transmitted helminth (STH) infections: more than 66% of children are infested with intestinal worms;
- Dental infections and toothache: 80-90% of children have caries, and toothache is the most common reason for children missing days from school.

Individually and combined, these diseases can result in or contribute to a variety of debilitating conditions, including malnutrition. There is ample evidence that the main diseases detailed above can be prevented on a large scale using a few simple interventions among schoolchildren.

The Essential Health Care Program (EHCP) implemented by the Department of Education is a response to the serious health problems that Philippine children suffer. It has been supported financially and technically by German Development Cooperation (GDC) since its beginnings. The programme uses simple, evidence-based interventions that can be delivered at low cost in elementary schools:

- Daily supervised handwashing with soap;
- Daily supervised toothbrushing with fluoride toothpaste;
- Bi-annual deworming.

The EHCP started on a limited scale with pilot programmes in 2003, and received its formal launch in 2008. In the first full year of the programme, school year 2008/09, the number of children covered grew to 633,000.

In early 2009, the Department of Education (DepEd) formally adopted the EHCP as a national standard for use in schools across the country. Department orders issued during the course of the year mandated the construction of washing facilities for group activities in all elementary schools in the public education system, and called for all teachers to supervise group handwashing and toothbrushing activities as part of their daily duties.

In the following years, the programme continued to grow rapidly as it was extended to additional Local Government Units (LGUs). By school year 2010/11, just under 1.5 million children in 27 LGUs (24 provinces and three cities) participated in the programme.

In order to support the rapid expansion of the programme, the Philippine non-governmental organisation Fit for School Inc. (FIT) was founded in 2009 with support from Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH on behalf of Germany's Federal Ministry for Economic Cooperation and Development (BMZ). The NGO hired and trained project officers to act as technical staff to assist DepEd as the programme expanded. A number of private and non-governmental organizations such as United Nations Children's Fund (UNICEF), Procter & Gamble and GlaxoSmithKline have also contributed to the programme. After an initial arrangement directly with the LGUs encountered difficulties with procurement and implementation, UNICEF contracted FIT to provide the necessary coordination and technical support.

The three interventions of the EHCP are not new in themselves – in fact they have been used separately before in other countries and in the Philippines for many years. The problem was coverage and fragmentation; despite the best intentions of the national government, the number of children benefitting from such interventions was severely limited, particularly in remote and rural areas. Providing clarity about the roles and responsibilities of each partner has therefore been crucial. Some of these roles are very specific to the Philippines and reflect the country's governmental structure, notably the fact that while the health sector is largely decentralized, the education sector is centrally organized. DepEd defined the roles and responsibilities of school divisions, school administrators, teachers and health personnel in a Department Order signed by the Secretary. The formal foundation of the cooperative intersectoral effort is a Memorandum of Agreement between DepEd, the League of Provinces of the Philippines and FIT at the national level signed in May 2009. This in turn provided the basis for subsequent agreements on the provincial level.

In 2010, the costs of the EHCP in Camiguin Province were analysed in a study commissioned by GIZ. The total *economic cost* (all resources used in an intervention, including

direct money outlays and the value of resources for which no money was spent) of the programme in the province's 56 elementary schools for one year was calculated to be \$68,778 or \$4.78 per child. *Direct costs* were considerably lower at 1.66 per child. Community contribution to costs (chiefly materials and labour used to create and maintain washing facilities, plus the cost of water) was \$0.40 per child. DepEd is the largest contributor, covering 65% of costs (mostly the teacher's salaries). LGUs provide 12%, and the Department of Health 0.4% (for procurement of the deworming drugs). The community contribution is 9%. GIZ and GlaxoSmithKline contributed the remainder of the economic costs through their support to Fit for School Inc.

A four-year study was begun in 2009 to assess the efficacy of the respective interventions of the EHCP. Data have been collected at the 12-month and 24-month mark. At time of writing (mid-2012), preparations are being made to carry out the 36-month data collection, which will allow

definitive conclusions to be drawn about the efficacy of the programme.

At time of writing, the EHCP is benefiting more than 2 million children. It is notable that more than 20 of the 42 provinces currently implementing EHCP – out of the country's overall 80 provinces – have allocated regular budgets to cover the majority of (and in some cases all) material costs involved in delivering the EHCP interventions.

Following interest from other countries in the Southeast-Asian region, GIZ has established a Fit for School Regional Programme, in partnership with the Southeast Asian Ministers of Education Organization (SEAMEO). The three-year programme, started in late 2011, will provide capacity and technical assistance for school health on a regional level, with specific programming for schools in Cambodia, Indonesia and Lao PDR.

Preventable diseases and school health

Every year, about 10 million children die from preventable diseases, almost all them from preventable diseases of poverty. These diseases have a serious impact on children world-wide, resulting in more than 200 million of them not reaching their full physical and cognitive potential (Black et al., 2003; 2010).

Whether at school or at home, poverty, lack of access to safe water and sanitation, and inequities in health care are major underlying factors contributing to the persistent high burden of preventable childhood diseases (WHO, 2008a; Bamba et al., 2010). In many low-income countries, infectious diseases like diarrhoea, respiratory infections, skin diseases and worm infections, and non-communicable diseases like dental caries, are so common amongst children that parents and teachers almost consider them normal and not requiring any medical attention (Black et al., 2010; Bagramian et al., 2009). Such diseases have wider impacts on children's lives, such as reducing their school attendance and academic performance. In turn, chronic ill-health, poor literacy and early dropout from school contribute to a vicious cycle of disease and poverty that, for many of these children, will continue for a lifetime (UNESCO, 2010). In contrast, better education leads to better socio-economic status and lower disease levels in later stages of life (World Bank, 2010a).

'It is clear that without proper education, health suffers. And without proper health, good education is not possible.'

Gro Harlem Brundtland, Director General,
World Health Organization (2000)

Four of the eight Millennium Development Goals (MDGs) focus on health, education and their interrelations (MDGs 2, 4, 5 and 6). Improving health of poor and disadvantaged children is key, but how can this be achieved at a mass scale? Common public health approaches include providing free or subsidized basic health care for children, usually including essential vaccinations and other interventions. Schools have been recognised as places where many children can easily be reached – not just for vaccinations but potentially for much more comprehensive school health interventions.

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The untapped potential of school health programmes

School health often falls between the remits of the health and education sector administrations, so that problems of coordination and mutual understanding hinder large-scale programme implementation. While many countries have plans and policies related to school health, the reality is often different with small programmes and limited capacity of schools to promote child and community health. Reasons for this include the difficulties of intersectoral collaboration between the health and education sectors (from the ministerial



>> Dental caries is so common amongst children that parents and teachers almost consider it normal and not requiring any medical attention.

level down to the local level), administrations trapped in rules and regulations, and a lack of leadership and a shared vision among decision makers (World Bank, 2010b; Bundy, 2011).

In recent years, however, international interest in the domain of school health has increased. This is reflected in global initiatives such as: the Focusing Resources on Effective School Health approach launched at the 2000 World Education Forum in Senegal, by UNICEF, UNESCO, WHO and the World Bank; UNICEF's Child Friendly School programme, and WHO's Health Promoting Schools concept.

Traditionally, school health programmes have tended to rely on cognitive teaching approaches to change pupils' behaviour. More recently, however, the belief that increased knowledge on its own will lead to behaviour change has been challenged as simplistic (Jepson et al., 2010; Hopkins et al., 2007). School health programmes have therefore been moving towards skills-based learning. Thus, models such as the 'settings approach' have been developed which use the school as a platform to establish a healthy environment and positive health habits that can last for a lifetime (Tang et al., 2009; Clift and Jensen, 2005). The settings approach is based in the principles of the Ottawa Charter for Health Promotion which looks at health as being 'created and lived by people within the settings of their everyday life; where they learn, work, play, and love' (WHO, 1986). Thus, the settings approach recognizes and capitalizes the connection between health and the environment. In relation to school health, those environmental and contextual factors are tackled which have a negative impact on health. The holistic

and interdisciplinary approach may encompass changes in the physical and social environment of the settings as well as adaptation of policy and organisational processes.

While basic health and hygiene education feature in the school curricula of most countries, more could be done to build on schools' potential for promoting sustained behaviour change through a combination of learning, teaching and practising of skills and the establishment of simple health and hygiene routines. Schools can even have a catalytic role for better health of the communities surrounding them (Davies & Bridgeman, 2011; Holmgren et al., 2011).

There has been increasing recognition that success of school health programmes depends not just on the approach and the actual content but also on institutional factors. In a high-level WHO Technical Meeting on School Health in June 2007 it was agreed that, based on decades of experience, the core components of an effective school programme include not only skills-based health education and health services, but also a solid policy framework, a supportive social and physical environment, and community partnerships. The meeting's consensus statement noted that, 'Effective, sustainable action to promote school health depends upon formal and consensual sharing of responsibilities between health, education and other sectors. Impressive progress can be achieved when the actions of the different agencies and sectors are harmonized and committed to promoting health and education through schools. This is most obvious where collaboration takes place between local agencies and national ministries of education and health' (Tang et al., 2009).

Brother Armin Luistro, Secretary of Education, Manila, Philippines



I am very proud of Fit for School and the Essential Health Care Program. It helps us to make progress on a number of the MDGs where the Philippines are falling short of the targets. It has become such a success for our country because of the 'three S's': Simplicity, scalability and sustainability. Apart from the very tangible benefits for our children it has resulted in better cooperation between health and education and provides an opportunity for strengthening the interface between schools, parents and communities. And after all, the children enjoy it!

Health and education challenges in the Philippines

The Philippines is a lower-middle income country with a population of approximately 92 million. Two-thirds of the population live in urban areas and one-third in rural districts on the more than 7,000 islands of the country. Over 10 million Filipinos live and work outside the country, and the Philippine economy relies heavily on their remittances, which contribute about 13.5% to the national Gross Domestic Product (GDP).

Whilst Gross National Income per capita is US\$ 1,790, 27% of all Filipinos live below the poverty line and about 50% have an income just above the poverty threshold (World Bank, 2011). According to the World Bank, 'The Philippines exhibits a very unequal – and possibly worsening – distribution of income and consumption' and has the most unequally distributed income among East Asian middle-income countries. Corruption is widespread, with the Philippines ranking 134 out of 178 countries (Transparency International, 2011). The Human Development Index (HDI) lists the country in a medium position of 112 out of 187 countries, yet below the average HDI of the East Asia-Pacific region (UNDP, 2011).

Health care system beset by inequities and fragmentation

The health care system of the Philippines includes both private sector and public sector provision, the latter partly financed by social health insurance. Overall, the system is characterized by serious inequities in terms of service availability, affordability and quality (WHO, 2006). For affluent urban population groups, excellent private health care is available, yet the majority of citizens have access only to basic services, at best (Canlas et al., 2009). More than 82% of all private health expenditures are out-of-pocket expenditures,

making a great deal of health care unaffordable for the majority of the population, particularly for those living near or below the poverty line.

With relatively low total expenditures on health of around US\$ 142 per capita (PPP, 2010), or 3.6% of Gross Domestic Product (GDP), health indicators are among the worst in the region (WHO, 2011). Health outcomes vary widely according to income level and geographic location within the country. Child mortality (age group 0-5 years) among the poorest fifth of the population was more than three times higher than among the richest quintile. Similarly, the coverage of vaccines for diphtheria, pertussis and tetanus – DPT3, which is often used as a measure of service availability – is only 41% in the Autonomous Region of Muslim Mindanao compared to 89% in the National Capital Region (World Bank, 2010a).

Although dental services are available from private dentists in urban areas, the majority of the population cannot afford their services. According to recent estimates, 77% of Filipinos have never been to a dentist in their life (Department of Education, 2008).

One of the challenges the country's health system is facing stems from the devolution of health care to Local Government Units (LGUs) in 1991, which has resulted in fragmentation of services. The Department of Health's role is focused on regulation, technical guidelines, planning, and inspection, while provincial governments are responsible for provincial and municipal hospitals, health centres and health posts, although the funding is not sufficient to match responsibility (WHO, 2011c). Although the Department of Health budget has increased in recent years, local government spending has stagnated in real terms, which has had serious implications for the poor since they are most dependent on the health services administered by LGUs (World Bank, 2010a).



>> Access to clean drinking water remains a problem in some communities.

An education system facing multiple challenges

In contrast to the decentralized system of the Department of Health, the Department of Education – commonly known as DepEd – is centrally managed from Manila.

In terms of coverage, the education system in the Philippines appears to have achieved considerable success. With a school enrolment rate of over 98%, there are 12.8 million children in 38,000 public elementary schools (Department of Education, 2010). However, the Philippine Government spends only about 8% of GNP on education, a rate lower than that spent by many other countries in the region (UNESCO, 2010). Despite comparatively high student-teacher ratios of 35:1 in elementary school and 39:1 in secondary school, there is a widespread shortage of qualified teachers, which contributes to low achievement rates across all subjects and age groups (UNDP, 2009). Completion rates remain low and vary slightly according to family economic status. In the three poorest quintiles less than 50% of children completed elementary school, and at secondary level, a 15-17 year old in the richest quintile is over four times more likely to graduate from high school than one in the poorest quintile (World Bank, 2010a).

In addition to these academic challenges, many schools must cope with insufficient water and sanitation facilities. While there are no official figures, it is estimated that more than one-third of public elementary schools lack functioning toilets and access to water (CAPS, 2010). Even if toilets are available, they are often not adequate for the number of children, not separated for girls and boys or simply not functional or maintained. Open defecation in public spaces is often the only option for many children, and this has serious health consequences for the entire community. DepEd has recognized these facts and has initiated efforts to address them.

The Philippine Government has made significant efforts to improve the performance of the education sector in recent years. Most notably, DepEd announced its Basic Education Reform Agenda (BESRA) in 2006. BESRA aims to provide a coherent conceptual and policy structure for reforming the education system while integrating the targets of the Philippines' *Education for All 2015* (EFA) plans and the Millennium Development Goals. The key reform targets include measures to implement school-based management (SBM) in order to decentralize decision-making (UNDP, 2009). The principles of SBM aim at strengthening schools as well as

their partnerships with communities in order to enhance educational outcomes, and encourage empowerment, ownership and responsibility among actors on the local level. The participatory process of SBM involves various local stakeholders in setting up and implementing a School Improvement Plan and the respective School Operating Budget. This process not only allows local priorities to be addressed but also improves implementation monitoring and accountability in a more inclusive manner (World Bank, 2010a).

Schoolchildren's health: whose responsibility is it?

As in many other countries, child health in the Philippines falls under the national remit of the Department of Health, while DepEd is responsible for school health. In the past, this has resulted in unclear or overlapping responsibilities and in a lack of clear direction and leadership.

DepEd employs doctors, nurses, dentists and dental assistants to provide health care in schools, but the budgets available for activities are too small to reach a significant number of children, and responsibility for financing of health programmes rests largely with LGUs. Moreover, DepEd health staff has to cope with many other 'high priority' tasks mandated by laws and regulations. This is reflected in the DepEd website which lists 14 programmes or projects under its School Health and Nutrition section, ranging from HIV education to nutrition programmes (Department of Education, 2011). Despite the efforts by the school health workforce, most of these activities do not reach more than a few thousand children on a permanent basis and most are based on 'one-off' (i.e., single interventions with no follow-up) or once-a-year education campaigns that rely on simple information transfer or distribution of donated toothpaste, soap or other materials due to a mismatch of mandates and budgets.

Because of the government's policy of decentralisation and devolution down to LGU level, provincial governments play an important role in the provision of health care, providing an alternative source of programme funding but requiring intersectoral coordination. In practical terms, another obstacle to intersectoral school health programmes has been the tendency of health professionals' associations to take a protectionist position against the involvement of non-medical personnel such as teachers in health promotion and school health interventions.

All of these factors underline the fact that implementing a new programme is not just a ‘technical’ task, or one that can be made to happen through the simple declaration of policy or issuing an administrative order. Strong coordination and advocacy efforts targeting key decision makers at different levels are also essential.

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The burden of preventable diseases among schoolchildren

Schoolchildren in the Philippines suffer from a high burden of preventable diseases, with hygiene deficiencies as a common cause, i.e. lack of basic personal hygiene and poor access to sanitation. The main diseases are:

- Hygiene-related infectious diseases: diarrhoea, acute respiratory infections, and pneumonia are the top three killer diseases for children in the Philippines (Black et al., 2010);
- Soil-transmitted helminth (STH) infections: more than 66% of children are infested with intestinal worms (WHO, 2008b);
- Dental infections and toothache: 80-97% of children have caries, and toothache is the most common reason for children missing days from school (Department of Education, 2008).

Individually and combined, these diseases can result in or contribute to a variety of debilitating conditions, including malnutrition. All affect the physical and mental development of children, their quality of life and their ability to learn. Malnutrition is a major issue, particularly among the rural poor, and the Philippines figures among the 20 countries in the world with the highest burden of child malnutrition (World Bank, 2010a).

In 2006, DepEd carried out a National Oral Health Survey, with support from several international institutions including GIZ (Department of Education, 2008). In each of the country’s 17 regions, two rural and two urban schools were chosen at random, providing a sample of 2,030 six-year-old students and 2,022 twelve-year-old students. Using both a clinical examination and a sociological survey, a broad range of data was collected.

The DepEd study showed that an alarming 97% of 6-year-old children suffered from dental caries with 9 decayed teeth on average. Each child had on average 3.4 teeth where the caries process was already causing complications like swelling and pain, difficulties in eating, sleeping, and concentrating on learning. About 20% of the 6-year-old children reported an acute problem in their mouths at the time of the survey. Among the 12-year-old children, caries prevalence was 82%, the mean number of teeth with caries was 2.9, and 16% reported a problem in their mouth at the time of the survey. The care index for both groups (as measured by the presence of fillings, which is an indicator of receiving dental care), was 0%. This highlighted the fact that with its limited resources, the public health system and even the school dental programme with more than 700 dentists were overwhelmed by the high disease level and treatment needs in the traditional curative way. Moreover, the DepEd study noted that no improvement had been made in oral health among schoolchildren since a similar survey in 1998.

The final report contributed to a broad public debate of the issue in the Philippine media. Consequently, the Philippine government resolved to critically review existing oral health programmes and to radically improve the level of dental health among Filipino children (FDI World Dental Federation, 2006).

Effective prevention

There is ample evidence that the main diseases detailed above can be prevented on a mass basis using a few simple interventions among schoolchildren.

Handwashing with soap is one of the most effective measures to reduce respiratory tract infections and diarrhoea (Cairncross et al., 2010). In fact, it is generally accepted to be the single most cost-effective intervention to prevent

the transmission of infectious diseases from one person to another. An analysis of international research estimated that washing hands with soap at 'critical moments' (after using the toilet, before preparing food and before eating) can reduce the incidence of diarrhoea by 42-47%, and can reduce respiratory infections by up to 30% (Curtis and Cairncross, 2003).

Deworming children who are infected by intestinal worms is another highly cost-effective intervention in public health (World Bank, 2008). The cost for the medication itself is low, yet the developmental, health and economic benefits are

huge. According to WHO guidelines, general deworming without prior screening is appropriate in areas with prevalence rates of more than 50% (WHO, 2005). The medication is safe and has virtually no side-effects. Biannual deworming is consistent with and in support of the Department of Health integrated Helminth Control Program (2006).

Finally, prevention of tooth decay using fluoride toothpaste is safe and effective, and has been recognized by the WHO and by the FDI World Dental Federation as the only realistic way to reduce tooth decay on a population basis (Walsh et al., 2010; WHO, 2007).

JJ Romualdo, Governor, Province of Camiguin Island, Philippines



'We were among the first to introduce the Fit for School programme and we are proud to be chosen as the place for the long-term Health Outcome Study. Investing in children and their health is investing in the future. The best education is wasted if a student fails the job interview because their teeth are decayed and stained! Oral health has always been an important topic for my administration and I am glad that the Essential Health Care Program includes prevention of tooth decay. This is why I have no hesitation to put my face on the label of toothpaste dispensers used in our province!'

EHCP: from concept to implementation

The Essential Health Care Program (EHCP) implemented by the Department of Education is a response to the serious health problems that Philippine children suffer. The programme uses simple, evidence-based interventions that can be delivered at low cost in elementary schools. It started on a limited scale with pilot programmes in 2003. The programme was formally launched in 2008 and has seen steady growth since then. It is now estimated to reach more than two million children in elementary schools and day-care centres across the country.

Conception and preparation

In 2002, DepEd created a staff position for a school health expert at the Health and Nutrition Center of the Department of Education in Cagayan de Oro, the capital city of the province of Misamis Oriental in the northern Mindanao region. Upon request, German Development Cooperation (GDC) assisted with the recruitment for that position and seconded an integrated expert through its Centre for International Migration and Development (CIM). With this support, the DepEd set up a pilot programme (2003-2005), promoting oral health education and supervised toothbrushing in selected schools, along with basic oral emergency care according to the WHO-approved Basic Package of Oral Care (Frencken et al., 2002). While the provision of care was found to be unsustainable because of difficult logistics and lack of supplies, the supervised daily toothbrushing in schools worked well. DepEd therefore decided to focus on a preventive approach rather than a demonstrably unfeasible curative approach. The pilot programme also provided insight into the different working cultures of the health and education

sectors and suggested ways that the sectors could work together in a more harmonized way.

Subsequently, the above-mentioned National Oral Health Survey in 2006 became the basis for an advocacy campaign calling for more awareness and focus on oral disease prevention, which received great national and even international attention.

The programme was formally launched in 2008 and has seen steady growth since then. It is now estimated to reach more than two million children in elementary schools and day-care centres across the country.

In January 2007, a strategic planning meeting was held in Cagayan de Oro with Department of Education officials from all 17 regions of the country as well as representatives from Philippine National Institutes of Health (NIH), GIZ, and the World Health Organization Collaborating Centres (WHOCC) in Nijmegen, the Netherlands, and Jena, Germany. It was during this workshop that the EHCP was designed as an intersectoral programme bringing together the health and education sectors. The programme aimed to improve child health and development in the Philippines by institutionalizing three preventive interventions within school settings:

- Daily supervised handwashing with soap;
- Daily supervised toothbrushing with fluoride toothpaste;
- Bi-annual deworming.

Dr Bella Monse, Principal Advisor, Fit for School – GIZ Technical Assistance for Effective School Health, Manila, Philippines



‘One of the most revealing lessons for me at the programme start was the realisation that educating parents and children has little impact if there is no physical environment to practice what has been learnt. Simply put – even if you know you ought to wash hands, it is of no use if there is no washing facility and soap to do it. Therefore it is so important that schools as community centres become model healthy places. But there are many challenges both in the local, but perhaps even more so in the middle and higher levels of administrations. Changing the way administrations think and work is not easy and requires persistence, but also intimate knowledge of their inner workings and personal contacts. My time as CIM expert working in the Department of Education allowed me to understand the system as a prerequisite to change.’

The programme was then field-tested in several schools in selected provinces. The province of Misamis Oriental, which was already experienced in preventive school health programmes, went ahead using its own financial resources. It implemented the programme across the province, reaching 110,000 children in all day-care centres and public elementary schools right from the start.

Initial rollout in 16 provinces

In November 2007, a training module was developed to support the programme's roll-out in the following year. Over the next few months, orientation and training were provided to DepEd executives and staff and participating LGUs, preparing them to coordinate the planning, budgeting and implementation of the programme in 16 provinces. These were so-called 'Formula One' provinces that were already participating in a GIZ-supported Department of Health project to support health sector reforms.

In order to get EHCP activities up and running, funding for pilot projects covering 6,500 children in each of the 16 provinces was provided by GIZ in order to 'kick-start' the work. This was done under the condition that the local government units pledged to allocate sufficient funds for materials and supplies to sustain the project and scale it up after the first year.

A great deal of advocacy and support activities was also carried out in this early period. In recognition of the decision-power held by provincial governors, a meeting under the auspices of the League of Provinces of the Philippines was held in January 2008. This brought together the governors of the 16 participating provinces with 35 senior officials of the Departments of Education and Health, the WHO, the European Commission, GIZ, UNICEF and experts from the University of the Philippines' College of Public Health to discuss the poor state of children's health in the country, and the role that the EHCP could play in improving the situation. At the end of the meeting, all governors signed a pledge committing to financially support and sustain the programme, and expand it to all schools in their respective provinces.

Further planning and capacity-building events were held with key officials such as the Medical Officers and Dentists of the Department of Education, and the Provincial Health

Officers and Provincial Dentists of the participating provinces. In order to overcome institutional barriers between the different administrative structures, Technical Working Groups at provincial level were formed and detailed action plans developed within each province's annual operational plan.

Experienced school health personnel from the pilot province Misamis Oriental and the CIM expert visited each of the provinces at least twice to support the start-up of Technical Working Groups. The visits included courtesy calls to the Governors, Schools Division Superintendents, and other important stakeholders in the health and education sectors. Visits to pilot schools with school health personnel and other members of the Technical Working Groups permitted open and frank discussion of practical issues. These visits and proved to be important tools in the spread of ideas and innovations from different schools and provinces.

The initial rollout was successful in terms of implementation and advocacy, generating a great deal of favourable publicity. The process was reinforced by the simultaneous global advocacy carried out in favour of handwashing, which followed the breakouts of bird flu and H1N1. President Gloria Macapagal Arroyo attended a school launch in 2008, which was aired on national TV channels, demonstrating to the children how to wash their hands properly. By the end of the 2007/2008 school year in March 2008, approximately 190,000 children were participating in the programme.

National rollout

The numbers of children benefiting from the EHCP grew quickly in the first few years, as shown in Table 1. In the first full year of the programme, school year 2008/09, the number of children covered grew to 633,500. In addition to schools funded by the LGUs in that year, other donors contributed to extending the programme in specific areas and even in specific schools. These donors included GIZ, UNICEF and Procter & Gamble, which funded schools in the provinces of Sultan Kudarat and Bukidnon, the 'Live Learn Love' project jointly funded by Unilever and FDI World Dental Federation, as well as the NGOs Save the Children, Channel of Hope, and the Danish Dental Association. (Note that in the early years, not all of these delivered the full programme, with some only carrying out the handwashing intervention.)

In early 2009, the Ministry of Education formally adopted the EHCP as a flagship programme and national standard for use in schools across the country (Department of Education, 2009a; Philippine Daily Enquirer, 2009). Department orders issued during the course of the year mandated the construction of washing facilities for group activities in all elementary schools in the public education system, and called for all teachers to supervise group handwashing and toothbrushing activities as part of their daily duties.

The rapid expansion of the programme coincided with the foundation of the Philippine non-governmental organization

Fit for School Inc. (discussed in more detail below) to act as a proactive, independent partner of DepEd. The NGO hired and trained project officers to act as technical staff to assist DepEd as the programme expanded, notably by supporting training-of-trainers and orientation sessions for DepEd staff.

In the following years, the programme continued to grow rapidly. In succeeding years, it extended to additional LGUs. By school year 2010/11, just under 1.5 million children in 27 LGUs (24 provinces and three cities) participated in the programme.

	School year 2007/08	School year 2008/09	School year 2009/10	School year 2010/11
EHCP funded by LGUs	130,000	460,000	946,000	990,00
EHCP funded by other donors	60,000	170,000	120,000	470,000
Total	190,000	630,000	1,066,000	1,460,000

Source: Fit for School Inc., based on DepEd data

At school: three simple interventions

The essence of the EHCP lies in the everyday routines of elementary schools and day-care centres, as they apply the programme's three interventions. Underlying these routines is the guiding principle that schools can and should provide a healthy environment and establish healthy habits that last a lifetime. Parents often lack time, interest, and education or resources to be good role models for their children. Institutionalising healthy habits into daily life at an early age, when children are most receptive, avoids the more complex challenges of health education and behaviour change among adolescents and adults.

Filipino elementary schools, even those in poor or rural areas, are generally well organized and pupils comparatively disciplined. Children are used to group activities such as lining up every morning for the raising of the Philippine flag and singing the national anthem. The programme approach takes this into account, making the children not only the beneficiaries of the EHCP but also its prime actors. Children are encouraged to develop leadership and to take responsibility for the daily activities.

Each class carries out the group activities of the EHCP throughout the day, according to a schedule developed by the teachers. (Note: readers can see videos of these activities at www.german-practice-collection.org/en/health/keeping-children-fit-for-school).

Daily handwashing with soap

In the first activity, the children leave the classroom and go to the nearest washing facility where they wash their hands using soap. Older children or teachers supervise the group activity. In some schools, they sing 'Happy birthday' twice

while they wash, which ensures that they wash their hands long enough for effective hygienic effect. After washing, hands are dried by shaking the excess water off. No towels are used for drying hands because towels used more than once can themselves be a source of infection.

The activity requires a simple washing facility with material costs about US\$ 40 and which can accommodate between eight and 12 children (and sometimes as many as 20). Ideally, every classroom has its own washing facility, but often several classrooms share a facility. Schools are encouraged to provide piped water access, but depending on local conditions, water can be provided in containers or, even simpler, by using small plastic water bottles (the so called 'Tippy Tap' water bottles that the children bring to school every day).

Daily toothbrushing with fluoride toothpaste

The children brush their teeth after washing their hands, again as a supervised group activity. Toothbrushes for all children are stored in the classroom where the children recognize their brush by a number or a nametag. One child per class (often called the 'Fluoride Patrol') dispenses the toothpaste to the other children, using liquid toothpaste from a container dispenser that releases a standardized amount of fluoride toothpaste on the brush. Children brush their teeth for two minutes and spit out the toothpaste into the washing facility without rinsing their mouths in order to enhance the protective effect of the fluoride contained in the toothpaste. After brushing the toothbrush is briefly rinsed and then stored again in the classroom.



>> *The children wash their hands together, often singing the 'Happy Birthday' song twice to ensure an effective hygienic effect is achieved.*



>> *L. to r.: A student monitor makes sure each child gets the right amount of toothpaste for the morning's brushing.*

>> *Children brush their teeth together under the supervision of their teacher.*

With practice, and the enthusiastic cooperation of the children, the daily group activities of toothbrushing and handwashing take 7-9 minutes per classroom, depending on class size.

Bi-annual deworming

The deworming activity is conducted twice a year, with the ingestion of a single albendazole or mebendazole tablet. Before the activity takes place, parents are asked for written consent, and the school health personnel carry out information meetings to inform the parents and teachers about the deworming activity.

The deworming tablet itself is distributed by teachers, and the activity is supervised by public health nurses visiting the school on the deworming day. Children line up per classroom and the teacher places the tablet into the hand of each child. The children are asked to swallow the pills and the teacher checks if they have been properly ingested. Teachers have to document the procedure in their teacher's record book and forward the detailed records to the school health personnel for reference and statistical purposes.

► You can download the „Manual for Teachers for the Implementation of the Essential Health Care Program in Schools‘ and other resources in the toolbox section for this publication at www.german-practice-collection.org/en/toolboxes/toolbox-keeping-children-fit-for-school



>> *L. to r.: A public health nurse explains deworming to local parents at a meeting about EHCP.*

>> *Teacher inspects children's mouths after administering deworming pill, to verify that it has been swallowed.*

Roles and responsibilities: who does what?

The basic success factor for the EHCP has been the development of trust and alignment across different sectors and organisations.

The three interventions of the EHCP are not new in themselves – in fact they have been used separately before in other countries and in the Philippines for many years. The problem was coverage and fragmentation; despite the best intentions of the national government, the number of children benefitting from such interventions was severely limited, particularly in remote and rural areas. Because of the multitude of different mandated programmes trying to address a broad range of issues none of them could be implemented at scale or with sufficient attention to detail.

Providing clarity about the roles and responsibilities of each partner has therefore been crucial. Some of these roles are very specific to the Philippines and reflect the country's governmental structure, notably the fact that while the health sector is largely decentralized, the education sector is centrally organized.

DepEd defined the roles and responsibilities of school divisions, school administrators, teachers and health personnel in a Department Order signed by the Secretary. The formal foundation of the cooperative intersectoral effort is a Memorandum of Agreement between DepEd, the League of Provinces of the Philippines and FIT at the national level signed in May 2009. This in turn provided the basis for subsequent agreements on the provincial level.

Department of Education

The programme is implemented by the education sector, with the national Department of Education creating a supportive policy environment for the regional and divisional levels, as well as clear guidelines on implementation at the school level. The policy framework under which the EHCP continues to be rolled out in the country – which is part of a larger effort to meet the country's Millennium Development Goals and Education for All objectives – is guided by key departmental orders issued since 2009 and the BESRA strategies.

In particular, DepEd Order 65 mandates all teachers to implement the daily EHCP health activities as part of their duties. The order further instructs all school principals to ensure that handwashing facilities are available in all public

elementary schools. This reinforced a previous order which directs regional directors, all school divisions and their Physical Facility Coordinators to construct water and handwashing facilities in all schools in order to prevent the transmission of Influenza virus H1N1.

In line with these orders, the Department of Education continues to issue policies and guidelines which provide more detailed instructions for the programme's continued implementation. These instructions are cascaded down through the different levels of the public education system and they are integrated in the respective planning and budgeting processes.

Local Government Units (LGUs)

The Philippines' decentralized form of government has devolved many powers to LGUs, which actually include many different structures. While LGU as a collective term can refer to provinces, cities, municipalities and *barangays* (equivalent to a district or ward, the smallest community organization unit), the main institutional partners for the programme are provinces and cities, which have their own health departments.

As agreed in each Memorandum of Agreement on provincial level, the LGUs are responsible for funding and procuring the required supplies for EHCP, including soap, toothpaste and toothbrushes (the exception is deworming tablets, which are procured by the health sector of the national government). This means that LGUs are expected to include the programme costs in their annual budgeting process. For those areas or schools, which receive start-up funding from GIZ or other donors, the LGUs are expected to take over the entire financing during the following years.

School staff and teachers

Schools are in charge of the day-to-day implementation of the programme, with overall responsibility vested in the school principal. The principal's duties include not only supervising his or her own staff but liaising with the *barangay* community leaders and the local Parent-Teacher Association (PTA). Under the School-Based Management (SBM) approach, the principal also ensures that required washing facilities are included in the annual school improvement planning process.

Alex Raoul Villano, Secretary General, League of Provinces, Manila, Philippines



‘Decentralization has been an important process over the last decades, and has given a lot of power to the people who know best about their needs and their resources. This is why the League of Provinces and a growing number of provincial governors support the EHCP – it strengthens the local administration and helps us to use our scarce resources for a meaningful purpose. The challenge will be to convince as many provinces as possible to participate and to ensure that the programme costs become a routine item in the budgeting process.’

Parents

In the Philippines, parents are organized in Parent-Teacher Associations which are involved in many aspects of school life. Their community spirit provides the base for collaboration between schools and surrounding communities. One of their most important functions within the EHCP is to contribute unpaid labour for the construction of the required washing facilities. They also participate in the tri-partite EHCP monitoring with a school health personnel and a *barangay* representative.

Fit for School Inc.

A notable feature in the Philippines is the partnership of DepEd and the League of Provinces of the Philippines with a local non-governmental organisation, Fit for School Inc.

The NGO was created by a group of academics, public sector and civil society representatives from the Philippines, Germany and the Netherlands, managed by a CIM expert and technically supported by GIZ. It was intended that Fit for School Inc. would have flexible administrative and operative structures, be able to react rapidly to opportunities and challenges, and effectively link government agencies, civil society, donors and the academe.

From the beginning, it has focused its efforts on activities that other partners lack the resources or remit to provide, yet which are essential to the success of the EHCP. Its role, thus, is not to implement the programme, but to support the education and health sectors during the implementation process. Its role was formalized in a Memorandum of Understanding with DepEd and the League of Provinces of the Philippines (Department of Education, 2009b).

Liezl O. Cutab, Parent-Teacher Association (PTA) President, Agoho, Camiguin, Philippines



‘Our children often suffer from diarrhoea or toothache, but many parents cannot afford treatment or are too busy working all day. If these problems can be prevented in school we all benefit. Our PTA therefore decided to support the EHCP. We built a number of group washing facilities while our *barangay* provided the material. We also participate in the joint monitoring activities and help to make sure that things are going as planned.’

>> PTA in Agoho, Camiguin (Liezl O. Cutab first from right)

The areas of technical support provided by Fit for School are:

- **Advocacy:** visits by project staff to stakeholders and opinion leaders at the provincial and community levels in order to garner political and financial support for the interventions;
- **Social mobilisation:** formal and informal education, information and communications targeted to the community. Includes the production of Information, education and communication (IEC) materials, videos, etc.;
- **Community participation:** community leaders and parents accept and support the intervention and participate in upgrading the school facilities;
- **Training/capacity building:** training in all aspects of EHCP intervention for education sector staff, provincial government employees, and community volunteers (e.g. parents);
- **Facilitating of procurement:** development of a quality tested package of soap, toothpaste and toothbrush with a sole distributor in the Philippines. This allows simplified procurement and fixed prices all over the country, which strengthens the transparency and accountability of procurement;
- **Monitoring and Evaluation:** routinely scheduled monitoring of programme activities and periodic evaluation both of process and of programme impacts.

From the beginning, Fit for School Inc. has focused its efforts on activities that other partners lack the resources or remit to provide, yet which are essential to the success of the EHCP.

From the offices in Manila and Cagayan de Oro, Fit for School Inc. works in close collaboration with DepEd and LGUs. Project officers are based with their desktops in the offices of the Department of Education in different regions of the country. The NGO provides advocacy and technical advice, facilitates intersectoral collaboration, consults on operational management, and provides monitoring and evaluation services. It now employs over 30 staff.

In compliance with Filipino law, Fit for School is guided by a board of trustees. These are high-profile individuals chosen to represent the key partners including the National Institutes of Health, the public health insurance provider PhilHealth, and the League of Provinces of the Philippines, as well as international partners. Because the NGO is largely financed through contributions from GIZ, corporate partners and service contracts with donor agencies, Fit for School Inc. is both formally and practically an independent organization. This allows it to act as advocate for school health, to provide objective, external feedback to its government partners, and to move quickly when necessary to react to different opportunities and challenges on the way.

The NGO produces a wide range of reports, manuals, IEC materials and videos. Most of these can be seen and accessed on the Fit for School website at www.fitforschool.ph. It also sponsors, supervises and supports research related to the EHCP programme. Finally, it supports the DepEd by assessing programme implementation quality and by recognising outstanding achievements by individual divisions and schools through competitions and awards.

International organisations and private sector partners

A number of partners from the private sector, development agencies and non-governmental organizations have contributed to the programme in various ways. For example, UNICEF and the multinational company Procter & Gamble jointly provided financial support to ten LGUs as they implemented EHCP, targeting approximately 1 million children in 3,000 schools. After the initial approach did not result in the desired quality of implementation, UNICEF and FIT have been jointly providing the necessary coordination and technical support since 2011.

Another major company, GlaxoSmithKline (GSK), funded Fit for School's operations from 2009 until 2011 and particularly supported the development of a monitoring and evaluation tool to monitor EHCP implementation in schools.

Costs of implementing the EHCP

In 2010, the costs of the EHCP were analysed in a study commissioned by GIZ under the direction of an expert from the George Washington School of Public Health and Health Services (Goldman et al., 2010). The study had two primary objectives:

1. To estimate the total economic costs of the EHCP in the Philippines for the year 2010, and
2. to estimate the start-up and running costs of the programme. A secondary objective was to estimate the cost of scaling up the programme to reach all public elementary schools across the country.

The study team collected cost data for all 56 schools on the island province of Camiguin. The province was chosen both because its EHCP activities are well-established and because the longitudinal EHPC Health Outcome Study is being carried out there. Data related to programme management at the provincial level were collected both from DepEd and the Local Government Unit (LGU), and desk research was conducted to gather information on national expenditures.

The study used several measures for costs, including economic costs and direct costs. *Economic* costs are those related to 'all resources used in an intervention, including direct money outlays and the value of resources for which no money was spent.' In contrast, *direct costs* are a more narrow measure covering resources needed to implement the programme, which are additional to the normal operational outlays of DepEd and the LGU. These resources include the intervention package (toothpaste, toothbrush, soap), washing facilities,

and deworming medications, as well as the activities of Fit For School Inc. personnel, but not the salaries of DepEd and LGU personnel, which would be paid whether the programme exists or not. The study report noted that

'Teacher salaries are the biggest cost factor; yet their salaries are already paid so that the related costs cannot be fully attributed to the programme. Similarly, schools are supposed to have adequate water and sanitation facilities by law, thus the costs of establishing them cannot be attributed to the programme alone. The programme initiates and facilitates things, which are supposed to be in place already. With this in mind the real costs of the programme can almost be reduced to the direct costs [...]'

Table 2 presents the costs associated with running EHCP for a year, presented in both Philippine pesos and US dollars. At total of 14,381 children were covered by the programme in Camiguin. The total economic cost of running the programme in the province's 56 elementary schools for one year was calculated to be \$68,778 or \$4.78 per child. Direct costs were considerably lower at \$1.66 per child.

An additional calculation was made of the *community contribution* to costs. This chiefly included materials and labour used to create and maintain washing facilities and toothbrush holders, and the water used by children in daily EHCP activities (some *barangays* provided this free to schools, while others charged for the water supply) and the contribution of communities were calculated to be \$0.40 per child.

Table 2. Running EHCP in Camiguin Province: Direct and economic costs and community contributions in 2010/11

	Total economic cost	Economic cost per child	Total direct costs	Direct costs per child	Community Contribution	Community Contribution per child
Philippine Pesos	3,011,282	216	1,076,550	75	261,880	18
US Dollars	68,778	4.78	23,875	1.66	5,808	0.40

Source: Goldman et al. (2010)

Table 3. EHCP start-up costs in Camiguin Province, 2009/2010

	Total Economic Cost	Economic costs per child	Total direct costs	Direct costs per child	Community Contribution	Community Contribution per child
Philippine Pesos	3,486,043	247	1,075,621	75	709,440	49
US Dollars	78,693	5.47	23,854	1.66	15,733	1.09

Source: Goldman et al. (2010)

Table 3 presents the start-up costs for the programme beginning in June 2009. These costs include supplies for one year, the creation of the washing facilities, and capacity building costs (including manuals provided to teachers). It will be noticed that the contribution of the community to start-up costs is much higher than the annual running costs; this is mostly the result of the community contributing labour to building the washing facilities.

In terms of contributions to the economic costs of implementing the programme, DepEd is the largest contributor, covering 65% of costs (again, mostly the teacher's salaries). When combined with the LGU's 12% and national Department of Health's 0.4% (for procurement of the deworming drugs), the contribution of different levels of government to EHCP implementation was 77.4% of economic costs. The community contribution is 9%. GIZ and GlaxoSmithKline contributed the remainder of the economic costs through their support to Fit for School Inc.

The study team estimated the costs of EHCP across the Philippines in 2010/11, which came to a total economic cost of approximately \$4.2million, or \$3.79 per child. The direct costs came to \$910,660 or \$0.81 per child. The calculations took into account the extension of the programme to just over 1.1 million children in 4,022 participating schools. (N.B. it did not include a separate EHCP intervention covering approximately 1 million children by UNICEF and Procter & Gamble in 2010/11, since that did not feature all of the components supported by the Fit For School approach. As noted earlier, UNICEF has since aligned its EHCP-related programming with Fit for School's.)

The study team also attempted to compare EHCP costs to those of similar programmes in other countries. However, this was not possible to do in any rigorous way since no directly comparable studies are currently available. (Some information is available on deworming programmes in several countries in Asia and Africa, and one study was found that analysed costs in a large-scale urban hygiene promotion programme in Burkina Faso. This suggests a serious gap in the literature, and a useful area for research to be conducted in the future.)

Monitoring and evaluation

The EHCP includes a monitoring component that serves two functions. First, it collects information that can be used to track the quality of implementation on school level and to correct and improve it at different levels of operation. Second, it is designed to work in a participatory way that gives parents and the community a role in shaping the programme at the local level. This secures transparency and accountability while promoting local ownership in line with the school-based management principles promoted by BESRA.

The monitoring tool: a simple three-page form

The three-page monitoring form was developed by DepEd and Fit for School in collaboration with GIZ and UNICEF, and funded by GSK. After parts of it had been piloted on the island of Camiguin in 2009/2010, the monitoring form and process were validated in 23 schools from four divisions across the Philippines in early 2011 (Health Bureau, 2011). This validation study helped to shorten and simplify the form before it was launched nationally by DepEd at the beginning of the 2011/12 school year.

Monitoring teams

Once per school year each school brings together a monitoring team consisting of three members: a DepEd health staff member, a representative from the *barangay*, and a member of the local PTA. The team visits 'their' school together and completes the monitoring form. As well as observing the performance of EHCP activities, they assess the quality of the washing facilities, the availability of materials, the records of the deworming activities, and other aspects of the

programme. No sanctions are associated with the scoring of a school, so the process encourages candid assessment and serves at the same time as a reminder or checklist for the key elements of programme implementation.

No sanctions are associated with the scoring of a school, so the process encourages candid assessment and serves at the same time as a reminder or checklist for the key elements of programme implementation.

Following the observations and completion of the form, the team discusses the results with the school head. The form is designed in such a way that the results clearly indicate areas of strength and aspects in need of improvement. The information provided is then shared with a wider local stakeholder group in the context of regular school meetings (school heads, parents, *barangay* officials) to discuss the strengths and weaknesses of the programme in their school. This includes management, infrastructure and financing issues that can then be addressed accordingly or included in the school improvement plan.

The monitoring activity has a further function in providing an incentive for compliance with the programme. Participation in the monitoring exercise made school divisions eligible for awards that were given at the National School Health and Nutrition Congress.



>> Focus Group with participants from local Parent-Teacher Association and representatives of German Development Cooperation discussing current issues of programme implementation.

Online database

Monitoring data are collected in an Online Monitoring System (OMS) designed especially for EHCP with support from Fit for School. The system summarises data on implementation quality and coverage at all DepEd administrative levels, allowing for easy report generation as needed. Data is entered at the DepEd Division level and can be accessed by DepEd and Fit for School staff.

Evaluating programme impact

A four-year study was begun in 2009 to assess the efficacy of the respective interventions of the EHCP. Called the Health Outcome Study, it is funded by GIZ and carried out jointly by DepEd, Fit For School Inc., Xavier University of Cagayan de Oro, the WHO Collaborating Center for Prevention of Oral Diseases at the University of Jena, Germany, and the Radboud University in Nijmegen, the Netherlands. A related parasitological assessment is being performed by the National Institutes of Health at University of the Philippines.

The study involves a longitudinal clinical research among first graders, aged 6-7 years old, in two provinces. It aims to compare the general and oral health status of the participating children at schools participating in the EHCP (intervention group) and those enrolled in another DepEd health education programme (control group). The baseline research was carried out among 844 children.

Data have been collected at the 12-month and 24-month mark. At time of writing (mid-2012), preparations are being made to carry out the 36-month data collection, which will allow definitive conclusions to be drawn about the efficacy of the programme.

Thelma Navarrez, Director Health and Nutrition, Department of Education, Manila



‘Changing behaviour is difficult, but if it succeeds it has a long-term positive impact. Parents often lack time, patience, interest or education to be good role models for their children. This is where the daily school activities of Fit For School come in and fill the gap with positive and healthy behaviours. The children themselves become agents of change for their families and the community at large.’

Achievements and challenges

Since its formal launch in 2008, the EHCP has recorded rapid growth in coverage, but also had to face some major challenges.

Achievements

Coverage

At time of writing the EHCP is targeted at more than 2 million children, bringing an evidence-based set of effective health interventions to almost 15% of all Filipino elementary schoolchildren.

Policy environment

DepEd has changed the policy environment, which frames and ultimately enables school health programming, in order to promote intersectoral collaboration and involvement of teachers in programme implementation. The DepEd Orders detailed earlier in this document have reinforced the country's drive to meet its relevant Millennium Development Goals and EFA objectives. While other initiatives have also contributed to this momentum, the presence of Fit for School to provide advocacy and technical advice was important in providing clarity, focus and urgency, thus facilitating the rapid and large-scale implementation.

Sustainable financing

The issue of sustainable financing has been a pervasive stumbling block in attempts to improve school health in developing countries, and is particularly difficult in the decentralized governance structures of a country like the Philippines. It is a major accomplishment that more than 20 of the 42 provinces currently implementing EHCP – out of the country's overall 80 provinces – have allocated regular budgets to cover the majority of (and in some cases all) material costs involved in delivering the EHCP interventions.

Evidence

The rollout of the EHCP monitoring process and the creation of the Online Monitoring System mean that stakeholders – from the parents at local schools to the national officials in Manila and their international partners – have access to robust information about the quality and coverage of the programme. The transparency and immediacy of the data contributes both to the improvement of the programme and

its management, as well as to ownership at all levels. The evidence base for the interventions is also being strengthened through activities such as the Health Outcome Study and the cost study, despite the difficulties and challenges associated with applied field research in resource-poor settings.

Information

In close coordination with DepEd, Fit for School Inc. has created a wide range of technical and promotional materials to support the programme. These range from detailed implementation manuals to videos that can be viewed through Facebook and YouTube on the internet. Most are available on the Fit for School Inc. website (www.fitforschool.ph), in an effort to make the programme as transparent and user-friendly as possible.

Institutional recognition

This approach has been adopted by other supporting organizations, most notably the partnership of UNICEF and Procter & Gamble. Having initially supported EHCP in ten LGUs, the partnership has joined up with Fit for School Inc. to provide coordination and technical support.

International recognition

The EHCP and Fit for School Inc. have received a considerable amount of international interest and recognition. Several awards have been received since the programme launch in 2008:

- Award for Best Programme in Paediatric Dentistry and Prevention, International Association for Paediatric Dentistry, Munich, July 2009;
- Award for 'Innovation in Global Health' at the Global South-South Expo, Washington, November 2009. The Expo is held annually under the auspices of a number of organizations including the World Bank, UNDP, and WHO;
- The Edward B. Shils Entrepreneurial Education Fund Award for Outstanding Transformational Leadership in Education, Philadelphia, October 2010;
- Poverty Reduction, Equity and Growth Network (PEGNet) Award for effectively linking research and practice, Hamburg, September 2011.

Challenges

■ **Maintaining quality while scaling-up**

The earlier goal of reaching 50% of all elementary school children in the country by 2012 (approximately 6 million children) is no longer feasible. At time of writing, the programme appears to be on track to reach more than 2 million by the end of 2012; while less than initially hoped for, this is still a substantial number of children being reached in a relatively short period of time. Such rapid scale-up poses major challenges in terms of coordination and communication, and in ensuring that the quality of interventions and infrastructure meet expected standards.

■ **Matching demand and capacity**

The visible activities of the EHCP are very appealing and seem to be simple enough to be replicated. This often leads to an underestimation of the complexities of the programme and the background work required to make things happen in a systematic way. The acquisition of required capacity in school management, intersectoral collaboration and programme knowledge often lags behind the desire to put things into action.

■ **Changing politics and administrations**

Elections and other events result in a constantly changing political environment and different decision makers, who may come with new priorities and agendas. Ensuring continued programme support is a challenge under such

conditions. The deeper a programme is anchored in the Department's programmatic strategies as well as in the sector administration below, the higher the chances of sustainability. So far, three different DepEd administrations have embraced and actively supported the programme. While this may be due to the virtues of the programme itself, it is also likely due in some part to strong support from the League of Provinces in the Philippines as well as its member governors, which provide a degree of balance to agenda of the national government.

■ **Local level obstacles**

Often it is small issues at the local level that can block progress in programme implementation. For example, there have been cases where schools or communities did not pay their water bills, so that there was no water at all at the school and the entire programme was brought to a halt. Some washing facilities were poorly constructed and broke down soon after programme start, and there were cases in which water taps and other equipment were stolen. In such instances, it is the school head and community partners who must be relied on in order to make progress.

Lessons Learnt

The process of creating and rolling out the EHCP has taught a number of important lessons.

■ **Simplicity**

Interventions in school health are more likely to achieve high impact if they focus on a few key diseases and the interventions are packaged to make implementation as easy as possible. The EHCP focuses on three basic interventions implemented by teachers rather than health professionals, again to make the implementation as straight forward as possible for all partners. Clear, concise and reader-appropriate training material and guidelines help in instructing schools and their staff on how to implement the programme.

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■ **Scalability**

Large-scale implementation is facilitated if interventions follow a modular structure and are based on uniform templates. Using existing structures and resources is an essential part of scalability. Supplies come in a pre-packaged set of soap, toothpaste and toothbrush sufficient for eight children for an entire year. This reduces the complexity of the procurement process. Washing facilities in schools vary from very simple bamboo constructions with 'Tippy Tap' water supply to elaborately tiled troughs with piped water and taps. Depending on the availability of resources, facilities can be extremely basic at first and be improved later.

■ **Sustainability**

Simplicity and scalability both contribute to sustainability. However, the four most important contributors to sustainability of the programme in the Philippines are:

- Alignment with existing school management principles, taking full advantage of the concept of school-based management;
 - The long-term financing of consumables (soap, toothpaste, etc.) by local governments, not donors or the private sector;
 - The participation of the community in various ways.
- ### ■ **Overcoming institutional barriers**
- It is essential to invest in promoting intersectoral collaboration between the health and education sectors and between education and health professionals – not just at the beginning, but throughout the implementation of the programme. This was highlighted following the national elections in May 2010, when it was feared that a new executive might want to change priorities. Fortunately, the new government pledged continued support to the EHCP. This suggests that the advocacy effort among a range of stakeholders (along with strong institutional anchoring of the programme through policies and DepEd Orders) had been effective in safeguarding the programme and the approach. To some extent, this was also supported by the advocacy of FIT staff and trustees who jointly with their DepEd and LGU partners were able to promote the programme independently of party politics.
- ### ■ **Providing incentives for participation**
- Different stakeholders, from government departments to community organizations, support school-health programmes for different reasons. Understanding these reasons is crucial; using them to the programme's advantage is possible if these stakeholders perceive benefits from the programme that go beyond immediate programme objectives. Examples of such incentives are the display of the governor's photo on programme supplies such as toothpaste bottles, allowing him or her to showcase the given support to the programme. At a different level, teachers have an incentive to perform well within the programme since it may be included as an indicator in their annual professional appraisal process.
- ### ■ **The value of a 'kick-start' mechanism**
- During the first year of implementing the EHCP in a new province, the financial and technical 'kick-start' from GIZ or other donors is very important. This period helps the local decision makers to understand the process, costs and benefits of the programme better. At the start of the programme, provinces and LGUs had the option of withdrawing from the programme after the first year; however, almost all provinces

and LGUs integrated the programme into their planning agendas, making the EHCP an integral item of the operating budget. This suggests that the benefits and incentives of the programme were compelling enough to over-ride competing claims on budgets.

■ **An independent support structure**

The creation of the NGO Fit for School Inc. responded to a need for an independent and highly flexible organization, which could support DepEd, the LGUs and other implementing partners as the EHCP was rolled out. Though operating with barely a dozen staff in the beginning, it filled in several gaps by providing technical advice, policy formulation and guideline development that no other organization had the financing, in-house expertise or administrative flexibility to do in a timely manner.

Box 1. Fit for School on a regional level

Based on the practices established over the course of DepEd's EHCP implementation in the Philippines, GIZ, Fit for School Inc. and their partners have translated the Philippine experience into a generalized 'Fit for School approach' that can be applied outside of the Philippine setting.

Following interest from other countries in the Southeast-Asian region, GIZ has established a three-year initiative called the Fit for School Regional Programme, in partnership with the Southeast Asian Ministers of Education Organization (SEAMEO). The programme, which started in late 2011, has three components:

1. strengthening health education at a regional level through training and research activities hosted by the SEAMEO Regional Center for Educational Innovation and Technology (SEAMEO INNOTECH);
2. supporting national partners in the design, implementation and evaluation of school health programmes;
3. piloting of the Fit for School approach in selected schools in Cambodia, Lao PDR and Indonesia, with a view to wider implementation as was achieved in the Philippines.

Activities will include the provision of international and local experts on both long- and short-term bases, network development, resource mobilization, and organizational development.

Peer Review

The German Health Practice Collection has established eight criteria that programmes and projects must meet to qualify for publication as part of this series. The two expert reviewers of this report have concluded that the initiatives described here are worthy examples of current practice in school health. As promising practices according to the GHPC criteria, the lessons learnt in these initiatives are of potential benefit to policymakers and practitioners working in the fields of health and education.

The peer reviewers offered the following reflections on the specific criteria used by GHPC to identify promising practices.

Effectiveness

The EHCP was judged effective in terms of rapidly reaching a large number of children in a short time ‘with time-tested interventions that are well-recognized as effective in preventing the relevant health problems.’ The reviewers also noted its success in overcoming institutional barriers between the health and education sectors that had previously been major constraints on the effectiveness of previous school health interventions in Philippines. As regards the programme’s overall effectiveness in reducing the incidence of hygiene-related infectious diseases, both reviewers observed that this was not yet known, but was likely to be confirmed once the results of current impact evaluation.

Transferability

The reviewers felt the EHCP interventions and approach would be easy to replicate and scale up in many different contexts. One reviewer praised the role of the NGO Fit for School Inc. as a critical component in the success of the programme, but wondered if it was generalizable in all other contexts. This reviewer noted, ‘This structure is dependent on the political environment [or] receptiveness in a given country... and so may not be a highly transferable concept without adaption.’ That said, the reviewer felt that this issue would be better understood when the regional programme had been in place for sufficient time.

Participatory and empowering approach

Both reviewers stated that the participatory aspect of the EHCP was one of its particular strengths. One wrote, ‘The involvement of all stakeholders, and especially parents and the parent-teachers association in various aspects of the programme, not only in ensuring service delivery (construction of the hand washing stations) but also in the monitoring process (a member of the PTA is on the monitoring committee) shows a highly participatory approach to implementing the programme and empowers the parents and community stakeholders to be involved in ensuring healthy school children.’

Gender awareness

While noting that the interventions were ‘near-equally relevant’ to both sexes, the reviewers did not find evidence that the EHCP specifically addressed gender issues.

Quality of monitoring and evaluation

The reviewers were impressed with ‘well developed tools for monitoring and evaluation of the programme.’ They highlighted the validation of tools on a small scale prior to national launch, and the creation of three-member teams to visit each school individually. Of the latter, one reviewer commented that these visits provided ‘a valuable opportunity to review strengths and weaknesses and to share this information with the wider group of stakeholders.’ The other reviewer concurred, but cautioned that the consistency and quality of monitoring would depend on how well these teams functioned, since ‘most monitoring processes face hurdles.’ The creation of an online monitoring system was also praised.

Innovation

The reviewers agreed that the innovative nature of the programme was not in the interventions themselves but ‘in

the sense that it brings the three interventions together into a single, low-cost strategy that addresses the commonest health issues among elementary school children.' The creation of an NGO to partner with the public sector was also seen as innovative, subject to the cautions described above. In addition, one reviewer noted that the creation of Technical Working Groups 'shows innovation in addressing the often, widespread problem of a lack of inter-sectoral coordination for the implementation of school health programmes.'

Comparative cost-effectiveness

The lack of comparable programmes in other countries to use as benchmarks, and the general dearth of cost-effectiveness data in the literature made it difficult for the reviewers to comment definitively on this aspect of the programme. However, both felt the reported costs made a good case for cost-effectiveness. The fact that the EHCP has collected its own, apparently robust data in this regard was described by one reviewer as a useful contribution to filling the current literature gap.

Sustainability

Both reviewers were hopeful about the sustainability of the EHCP. One stated that the programme was 'likely to be sustainable because of the low costs involved and the direct involvement of the community in implementation.' The other suggested that DepEd's adoption of EHCP as flagship programme was a hopeful indicator of future sustainability, and also noted that sustainability was strengthened by the fact that so many provinces were now allocating regular budgets to cover the majority of the programme's material costs.

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