Republic of the Philippines
Department of Health
NATIONAL NUTRITION COUNCIL

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SUBJECT: Early Childhood Care and Development in the First 1000 Days (ECCD F1K) Program in the Context of COVID 19 Pandemic and related emergencies

Background

Recognizing that the COVID-19 public health constitutes a threat to national security, and to prompt a whole-of-government approach in addressing the outbreak. President Rodrigo Roa Duterte declared a State of Public Health Emergency throughout the Philippines by issuing Presidential Proclamation No. 922 on 8 March 2020 and further issued Presidential Proclamation No. 929 declaring a State of Calamity throughout the Philippines and imposed an Enhanced Community Quarantine throughout Luzon.

To enable the efficient and effective government response, Republic Act No. 11469 otherwise known as the "Bayanihan to Heal As One Act" was enacted to direct unified interventions from the whole-of-government so safety nets may be provided to curtail the impact of health and economic emergencies to all vulnerable sectors which include children of formative years and the pregnant women.

The Inter-Agency Task Force for the Management of Emerging Infectious Diseases issued the Revised Omnibus Guidelines on the Implementation of Community Quarantine in the Philippines to harmonize and codify existing policies and defining post-community quarantine scenario as areas where no community quarantine is in place and can be considered as being under the new normal. Under the new normal, guidelines set by the Department of Health (DOH) on Minimum public health standards will be followed.

DOH issued Administrative Order No. 2020 - 0015 on the Guidelines on the Risk-Based Public Health Standards for COVID-19 Mitigation and Administrative Order No. 2020-0016 Minimum Health Standards for COVID-19 Preparedness and Response Strategies outlining the minimum health system capacity standards for each level of the health system and continuous provision of support for vulnerable groups including pregnant, lactating and children below 2 years old covered in the First 1000 Days.

Joint Memorandum Circular No. 1 Series of 2020 of Government Procurement Policy Board (GPPB) and Commission on Audit, Section 3.1 on the Emergency Procurement by the Government During a State of Public Health Emergency Arising from the Corona Virus Disease (2019) to further support the government's efforts to mitigate, if not contain the transmission of COVID 19 in the country, the GPPB issued Resolution Nos. 03-2020 and 05-2020 to simplify and streamline the Rules on Negotiated Procurement (Emergency Cases) modality embodied in Section 53 (b) of RA 9184 and Section 53.2 of its 2016 IRR, as an exemption to Public Bidding under RA 9184 and enable procuring entities to

efficiently and expediently undertake procurement during a State of Public Health Emergency;

In relation to this, the Government Procurement Policy Board (GPPB) issued Resolution No. 17-2016 which approved on 23 September 2016 the customized Community Participation Procurement Manual (CPPM) under the Partnership Against Hunger and Poverty (PAHP), allowing the participation of Agrarian Reform Beneficiaries Organization (ARBOs), Sustainable Livelihood Associations (SLPAs), cooperatives and other qualified farmers' organizations or Community Based Organizations (CBOs) under the PAHP as partners and/or service providers in the feeding programs and related livelihood programs of the government.

Stunting among children under-five years old continues to be a major nutrition problem, affecting millions of children. While the prevalence of stunting among children under-five years old decreased from 33.8% in 2003 to 30.3% in 2018 and then to 28.8% in 2019, the decline has been slow with increases between 2008 (32.2%) and 2011 (33.7%), 2013 (30.3%) and 2015 (33.4%). (Source: DOST-FNRI)

Furthermore, a look at the prevalence of stunting by single-age group would show that even in the first eleven months of life, stunting prevalence is greater than 10% (11.5% among 0-5 month-olds and 15.5% among 6-11 month-olds in 2018). In addition, the prevalence of stunting among one-year olds (36.6%) is more than double that among infants 6-11 months and remains at about the same level for the other single-age groups up to 4 years old.

Poor maternal nutritional status as well as poor infant and young child feeding practices can help explain this trend.

For the former, results of national nutrition surveys have shown that the prevalence of nutritionally-at-risk pregnant women has hovered around the 25% level since 2011 (25% in 2011, 24.8% in 2013, and 24.7% in 2015), with a decrease to 20% in 2018.

For the latter, while exclusive breastfeeding among infants 0-5 months old has been increasing (29.7% in 2003 to 48.8% in 2015 to 59.4% in 2018), the level is low among the 5-month-olds in 2018 (29.0%). Continued breastfeeding among one-year olds was reported to be 50.6% and 33.1% among two-year olds in 2018.

The practice of complementary feeding or the introduction of semi-solid and solid foods with continued breastfeeding has also been very poor. The 2018 Expanded National Nutrition Survey reported a decrease in the percentage of children 6-23 months old with the minimum acceptable diet (18.6% in 2015 to 13.4% in 2018), which is a composite indicator of frequency of feeding and diet diversity. A look at aggregates by income group shows that even among the fifth quintile (highest income level), complementary feeding

practices was poor (18.9% met the minimum acceptable diet). Complementary feeding practices was also poor among infants 6-11 months old with only 4% meeting the minimum acceptable diet.

This situation presents the urgent need for interventions to improve maternal nutritional status and complementary feeding practices. While there have been efforts along these lines particularly along nutrition education (including counseling), direct assistance in the form of food or dietary supplementation has been missing.

In this regard, WHO recommends that "In undernourished populations, balanced energy and protein dietary supplementation is recommended for pregnant women to reduce the risk of stillbirths and small for gestational age neonates." (WHO e-Library of Evidence for Nutrition Actions (eLENA),https://www.who.int/elena/titles/energy_ protein_ pregnancy/en/).

In addition, a commentary on the evidence on interventions to improve complementary feeding practices, Ian Darton Hill (https://www.who.int/ elena/titles/ commentary/ complementary_ feeding/en/ accessed on 18 August 2019) notes the following:

> "Complementary feeding interventions have the potential to improve the nutritional status of children in LMIC. Provision of appropriate complementary foods, with or without nutritional education, and maternal nutritional counselling alone, lead to significant increases in weight and height in children 6-24 months of age; these interventions can also significantly reduce the risk of stunting (2). Complementary feeding interventions, by themselves, cannot change the underlying conditions of poverty that contribute to child undernutrition, and consequently complementary feeding interventions need to be implemented in conjunction with larger strategies that include improved water and sanitation, better health care and adequate housing. Nonetheless, the results of these systematic reviews indicate that programmes carefully designed to the needs of the target population, can substantially improve growth and micronutrient status and may also reduce morbidity and enhance behavioral development. The key challenge is how to implement high-quality programmes that are sustainable when delivered on a large scale (3)."

Continuous provision of essential health services is still mandated under the Code Red alert. The proposed program is NNC's COVID-response and operationalizes RA 11148 or the *Kalusugan at Nutrisyon ng Mag-Nanay* Act by zeroing on one of the needed services indicated in the law that has not been given attention especially the Dietary

Supplementation Program of pregnant women and young children 6-23 months old. This set of guidelines adopted DOH Memorandum 2020-0237 or the Interim Guidelines for the Delivery of Nutrition Services in the Context of COVID-19 Pandemic and complements DOH Memorandum 2020-0092 or the Interim Nutritional Guidelines for Women of Reproductive Age".

Target Users of the Guidelines

Users of the guidelines are the program managers or equivalent functionaries at the national and regional offices of the National Nutrition Council, Department of Health, Department of Social Welfare and Development, the Early Childhood Care and Development Council, local chief executives, nutrition action officers, district/city nutrition program coordinators, members of the local nutrition committees and other local government functionaries in NNC's Tutok Kainan program areas. This may also serve as reference of the program partners such as from the relevant units of DAR, **ARBOs**, DSWD, DOH and DILG, including partners of the Tutok Kainan program from the private sector.

Objective

1. *General objective.* To contribute to the prevention of stunting among children 0-23 months old by improving the quality and quantity of food and nutrient intakes and utilization of related ECCD F1KD services among nutritionally at-risk pregnant women and children 6-23 months old in the target Tutok Kainan program areas.

2. *Specific objectives*

    a. To determine the situation with reference to care of pregnant women and infant and young child feeding in affected priority areas
    b. To provide supplemental food to pregnant women for 90 calendar days and complementary food for children 6-23 months for 180 calendar days with priority to those who are nutritionally at-risk or undernourished to avert the impact of COVID-19 and recent natural disasters (Ulysses, Rolly).
    c. To implement, monitor and evaluate an integrated nutrition program that helps ensure delivery of complementary early childhood care and development services in the first 1000 days pursuant to RA 11148.
    d. To document program experiences and strategies for replication in other local government units of the country

Basic Protocols for a COVID19-safe Delivery of ECCD F1K-related services

All LGU health workers are encouraged to continue serving the health needs of the community, including and with priority to the enrolled ECCD F1KD beneficiaries, provided further, that these health and nutrition services are administered in adherence to the Infection Prevention and Control (IPC) measures issued by the local health authorities and/or DOH, e.g. DOH Department Memorandum No. 2020-0072 Annex A. The IPC practices that should be observed by the health personnel include:

a. Proper and frequent hand hygiene through washing with soap and water and use of alcohol-based hand rubs at point-of-care and other areas inside the health facility;
b. Decontamination, disinfection, and sterilization, and;
c. Physical/Social distancing measures consistent with DOH-issued guidelines.

Based on DM No. 2020-0167, mobilization of health workers and clients seeking care can be done through the following:

a. Utilizing the family health profile, health workers can employ active provision of health services through house visits *(e.g. an infant has a scheduled immunization)*
b. Providing health services simultaneously with other barangay activities (e.g. rationing of food supplies); and
c. Other methods employed by the LGU

2. ECCD F1K Days Program components and activities

Preparatory Phase

1. Conduct of consultation with participating local government units to discuss the details of the dietary supplementation and generate commitment/counterpart from the local government unit through online consultations/meetings

2. Social preparation of LGUs and communities to be involved

   a. Social preparation aims to ensure that all those to be involved in the program, including those to receive the services understand the program's objectives and their respective roles in the program.

b. The NNC regional office, in cooperation with the provincial and city/municipal levels shall organize an online orientation of the provincial, city, municipal nutrition committees on the program.

c. Orientation for all barangays by the C/MNAO with support from the local nutrition committee members will be organized

1) Participants for each barangay shall include:

(a) The punong barangay

(b) A representative of the barangay council preferably but not limited to the *Kagawad* for Health

(c) The barangay nutrition scholar, barangay health worker, midwife, daycare worker, agricultural technician

(d) A community-based organization, preferably represented by a pregnant woman

2) The orientation will involve a presentation of the overview of the program, the proposed mechanics, and personalities involved as well as their respective functions. Orientation is preferred to be done online or a small group meeting strictly following minimum public health standards.

3) During the orientation, each barangay will plan on the specific activities that will be undertaken in the barangay, by when, and who will be in-charge of the activities. The following details should be determined:

(a) Where the packing and storage of rations will be done, e.g. either the barangay health station, the barangay hall, or a covered court or any available space in the barangay. The area must have access to safe water and hand washing facilities, sanitary toilet and areas for waste disposal.

(b) Who will be in charge of the different phases food preparation, food distribution, clearing up, and management of supply inventories for the center-based feeding.

(c) Who will be in charge of packing, and distributing the food for the dry ration especially in isolated *puroks* of the barangay?

(d) What records will be kept and who is in charge of making sure that the records are always updated

3. *Social preparation* will involve NNC-LGU meetings to firm up plans for the project, i.e. activities to pursue to meet program activities. It will also involve meetings with barangay officials and the beneficiaries to firm up plans for the program, e.g. how to select beneficiaries, specifics of feeding operations, roles and responsibilities, to generate support and full engagement. The orientation for beneficiaries will include explaining data privacy and requesting beneficiaries to sign a waiver in this regard. However, program documentation that will be made public will keep identities of beneficiaries confidential. Such meetings may be held online, or face-to-face but observing social distancing measures and wearing of mask/safety measures.

4. Individuals, families, and LGUs shall not accept milk formula, other breastmilk substitutes and breastmilk supplement donations as defined by RA 11148 (*Kalusugan at Nutrisyon ng Mag-Nanay* Act), EO 51 (Milk Code) and its Revised Implementing Rules and Regulations (DOH AO 2006-0012), and the DOH AO 2007-0017, and report violations through the Mother-Baby Friendly Philippines web-based portal http://mbfp.doh.gov.ph/ or through the mobile app available on iOS or Google Play store.

Implementation phase

1. The barangay health station with the assistance of the rural health unit, BNSs, and barangay health workers shall prepare the list of pregnant women who are eligible for the dietary supplementation, i.e. those from poor families (members of 4Ps/ Listahanan of DSWD) and are in their 26th week of pregnancy. This list can be drawn from the masterlist of pregnant women in the barangay and should be updated each time a pregnant woman qualifies for the dietary supplementation. The updating will stop when the target number for the barangay has been reached. Those on their third trimester excluding those who are overweight and obese, and those who are nutritionally-at-risk, regardless of trimester will be prioritized. The workers must also closely monitor those giving birth at private hospitals because they can also be included in the list of beneficiaries.

2. Same list shall be maintained for children with ages 6-23 months i.e. those from poor families (members of 4Ps/ Listahanan of DSWD), children identified as malnourished who are eligible for dietary supplementation program with the assistance of the Barangay Nutrition Scholars.

    a. The use of a common master list of those in the first 1000 days and a common family profile at the barangay level that will build on the target client list for pregnant women, infants, and young children (6-23 months old) of the health system by including other services provided to the families of those in the client list. The barangay nutrition scholar and barangay health workers will work together, in coordination with other barangay-based workers, or other members of the BHERT to prepare this common master list. The midwife and nutrition action officer shall provide technical support as appropriate.

    b. The common family profile will include, among others, the weight and height of children 6-23 months old, which will be measured immediately before the feeding program, the feeding mode in the first 6 months of life, current feeding mode (e.g. if still breastfed, foods given, frequency of feeds, etc) to serve as baseline data for the integrated approach. The family profile will also include cellphone numbers of the primary child giver in the home.

    c. A planning system that will look into not just numbers but actual names and circumstances to determine services that are missing and how these gaps can be addressed. The services referred to are not only those related to maternal and child health and nutrition services, but also services that will help improve physical and economic access to: *1)* a variety of plant- and animal-based food, *2)* sanitary toilet and safe drinking water, *3*) family planning services, *3)* social services and protection, among others. The common family profile will be the main tool for planning at the barangay and city and municipal levels.

3. **Dietary supplementation** as a strategy to prevent stunting and to provide the platform for educating mothers on desirable complementary feeding practices; will also be a platform for integration of nutrition-sensitive approaches through community-based procurement, among others.

    a. Priority groups

    While covering the entire population groups is ideal, the magnitude of resource requirements make prioritization of target groups necessary. Target groups that could be considered are as follows in the following order of decreasing priority:

Pregnant:

1) Nutritionally-at-risk pregnant women in 3rd trimester
2) Pregnant women in 3rd trimester
3) Nutritionally-at-risk pregnant women regardless of gestational age

Children 6-23 months old:

1) Stunted 6-23 months old children
2) Wasted 6-23 months old children

b. Level of supplementation

Target level of daily supplementation for target priority groups

Target group	Level of supplementation per day	Daily Food Cost
Infants, 6-11 mos old	130 – 200 kcal, 5-10 grams of protein, preferably with multiple micronutrient powder (This is NOT in addition to what is regularly distributed)	**Php 23 per child**
Children 11-23 mos old	200 – 300 kcal, 5-10 grams of protein, preferably with multiple micronutrient powder (This is NOT in addition to what is regularly distributed)	
Pregnant women	400 – 700 kcal, 15-20 grams of protein If available, a daily ration of 1 sachet/bar of RUSF providing at least 500 kcal should be given to: a. all adolescent pregnant women. b. adult pregnant women with MUAC ≤21cm	**Php 40 per pregnant woman**

Target group	Level of supplementation per day	Daily Food Cost
	Micronutrient supplementation as recommended by DOH. Multiple Micronutrient Supplements (MMS) containing 15 vitamins and minerals is recommended particularly for undernourished pregnant women in areas where undernutrition is prevalent. Pregnant women provided with MMS will no longer be provided with IFA and iodized oil capsules (IOC).	

c. Duration, timing and time of feeding

i. Estimated duration of feeding is about 90 days for pregnant women and 180 days for children 6-23 months old. Food rations will be provided to the target beneficiaries using the mode authorized by the local health office. Preferably, it will be through daily **on-site feeding**, house-to-house ration, or pick-up of cooked meal/snacks from a strategic location for the **pregnant women**. In areas where this is not feasible, other options may be resorted to after the barangay has exhausted all options: a) due to existing quarantine protocols due to community-transmitted COVID-19 cases, weekly dry ration, and b) geographically-isolated and disadvantaged areas, weekly ration of cooked meal/snacks and dry ration of food commodities and/or fresh food items. **For children 6 to 23 months old, distribution will be done of food.**

1. Rations **of food commodities from NNC will be delivered to the LGUs at least monthly for the non-highly perishable items and daily/biweekly or as applicable for fresh food items through NNC-partner suppliers,** Agrarian Reform Beneficiaries Organizations or ARBOs, beneficiaries of the Sustainable Livelihood Program of the Department of Social Welfare and Development or SLPAs. Onward distribution to the beneficiaries will be coordinated by the nutrition action officer with the concerned barangay nutrition committees.

ii. The barangay will set a specific time everyday for the centralized food preparation and distribution or pick-up of the cooked meals to the beneficiaries following the IPC Guidelines. **The BNS/BHW shall ensure that the hot meals will not become "replacement feeding", but rather, an additional supplementation to the daily diet of target beneficiaries. This may be done by linking the families with interventions designed to increase their food supply or food purchasing power.**

The frequency and level of supplementation is intended to maintain the normal nutritional status of the target population, prevent stunting and wasting and to address the deficit in energy and protein intake that may later on lead to undernutrition.

iii. The food distribution may also be used as platform for the delivery of other related health, agriculture, social protection services. Micronutrient supplements such as micronutrient powder may be given to further improve the quality of the dietary supplementation, when these are available at the local health office

d. Food commodities

Commodities to be included in the Dietary Supplementation Program for pregnant women and 6-23 months old children's food ration should contain age- and culturally-appropriate, clean and diversified nutritious food items. Use of indigenous food items are also being encouraged.

1.1 The food items will be procured from a mix of sources, with preference for FNRI technology adapters *(whenever available), or other nutritious food formulations* served in combination or alternately with locally available food.

1.2 The locally available food items shall be procured locally, preferably from ARBOs, SLPAs of the Department of Social Welfare and Development or from recipients of similar livelihood activities of the implementing LGU or NGO under the Enhanced Partnership Against Poverty (EPAHP) Program.

Food supplies that are not consumed right away (e.g. iron-fortified rice, sugar, cooking oil, etc) should be secured to ensure food safety and security. This could be in the barangay hall, barangay nutrition office or the barangay health station. In cases that such safe spaces can not be guaranteed, the LGU may opt to store it at the LGU nutrition or health office. An inventory person shall be designated by the LGU to record all food receipts and withdrawals using the suggested template (**Annex 1**). The person will also be responsible for ensuring and maintaining the quality of food for preparation. At the barangay level, the BNS shall ensure that the cooked food or food for distribution is always fit for consumption.

1.1 Fresh food items which include dried or fresh legumes/beans, rootcrops and other vegetables, eggs or other protein source food, fortified cooking oil, sugar, iodized salt, shall be used to prepare healthy recipes for the pregnant women and children 6-23 months old consistent with the NNC-approved cycle menu for the LGU.

1.2 Proper food handling techniques, food preparation and food transport/distribution to beneficiaries must always be observed so food is safe for consumption.

1.3 The LGU shall ensure that the cooked meals or snacks per cycle menu and prescribed quantity are received by the enrolled participants daily including weekends. LGU counterpart may include physical transport of the food commodities to be cooked from the point of storage to facility of food preparation and from the said facility to the final beneficiaries.

1.4 The LGU or its partner stakeholders may augment and provide counterpart through addition of other food and non-food items.

2. The NNC and local government unit shall agree on the relevant mode of food preparation and distribution that is feasible and doable in the area. The following schemes may be explored:

2.1 Ration of dry goods (recommended for areas under lockdown, GIDA)

2.1.1 The provincial /city/municipal nutritionist shall provide the central kitchen with the one month cycle menu, recipe with

corresponding market list and serving sizes. It can be iron-fortified rice, root crops, meat/poultry/fish, egg, fruits and vegetables or other locally grown and available products may be considered. It is important to take note of the

Locally available complementary foods may also be utilized for children 6-23 months old and the pregnant women, as long as the serving size can provide the required calorie and protein content. This shall be ascertained by the provincial or city/municipal nutritionist.

2.1.2 The barangay-based workers, volunteers from the barangays or members of the program beneficiaries shall prepare and pack the ration and ensure proper handling for food safety and compliance to the cycle menu of the nutritionist.

2.1.3 Members of the local nutrition committee must oversee the actual conduct of distribution of the ration to ensure that the intended beneficiaries receive the required serving portion and the right frequency and in good condition.

2.1.4 For documentation, each barangay worker who are members of the Tutok Kainan team, e.g. BNS, BHW, barangay officials, volunteers, must submit a daily acknowledgement receipt of ration picked-up and distributed to be consolidated by the BNS.

2.1.5 Sample content of a food ration is shown below:

WEEK	ITEM	**FCT values**	***Estimated price**
WEEK 1	Rice,2kg	**2,580 calories** (129kcal/100g,sinaing)	Php90.00
	Okra, 1/4kg	**75 Calories** (30kcal/100g,boiled)	Php30.00
	Eggplant,1/4kg	**234 calories** (93.6kcal/100g,boiled)	Php12.50
	Squash, 1.5kg	**705 calories**	Php75.00

		(47calories/100g, boiled)	
	Iodized salt, 250g	fortified	Php8.00
TOTAL		**3,594 calories**	**Php215.50**

*https://psa.gov.ph/sites/default/files/PSA%20Media%20Service07212020160329.pdf, https://www.dti.gov.ph/konsyumer/e-presyo/

2.2 ***Centralized kitchen***

2.2.1 The LGU must identify an area within the barangay where the central kitchen will be located. It could be any clean area with facilities and utensils for cooking, supply of clean water for cooking and washing where all food preparation processes will be done.

2.2.2 The LGU must ensure that those preparing the food are trained to handle food to ensure food safety. All personnel involved shall strictly observe food safety and IPC Guidelines for COVID-19 and other possible infections.

2.2.3 The central kitchen in the LGU will prepare, pack, and deliver the hot meals to the barangay health station or where feeding will be held. They will also be in- charge of packing and delivering the dry rations.

2.2.4 The LGU must oversee the actual cooking/packing, daily distribution from Mondays to Fridays and Friday rationing for Saturday and Sunday provision.

2.2.5 The City/Municipal Nutrition Action Officer must ensure that all BNS or in his/her absence, the BHW maintain daily acknowledgment receipt of the hot meals/dry ration distributed and that they are consolidated per barangay for submission weekly to the City/Municipal Nutrition Office.

Implementation of the dietary supplementation program will be complemented by text blasting. Using the usual SMS and messenger, the barangay-based health and nutrition volunteers will remind the beneficiaries of the start and time of the dietary supplementation sessions, and other-related ECCD services, e.g. immunization, prenatal and postpartum checkups, family planning sessions, among others. The messages will follow NNC's key messages depending on the gestational age of pregnancy and/or age of child.

Printed IEC materials related to complementary feeding, proper handling of food, food production and selection may be given, as deemed safe and appropriate.

4. **Nutrition education** may be done during prenatal visits at the health facilities, during immunization or through other means applicable during the ECQ/GCQ based on DOH DM 2020-0237. Some of the important guidelines with appropriate nutrition messages are the following:

    1. *Infant and Young Child Feeding (IYCF)*

        a. Pregnant women beneficiaries should be informed on the benefits of breastfeeding as well as the risks and harm of formula feeding during prenatal visits done at health facilities or through other means during the ECQ or GCQ.

        b. Both the pregnant woman and her health care provider shall discuss the birth plan which shall include early initiation of exclusive breastfeeding following the essential intrapartum and newborn care (EINC) protocol (or *Unang Yakap*) and rooming-in after delivery. Concerns related to COVID-19 should be acknowledged by the health care provider and addressed using standardized, evidence-based messaging.

        c. Practice of continuous Kangaroo mother care (KMC) provides warmth, promotes and sustains exclusive breastfeeding, and promotes brain development for preterm, small for age and low birth weight infants. This also assures the survival of preterm and small babies and nutrition from birth, upon discharge and reaching the household.

        d. Encourage to exclusively breastfeed or continue breastfeeding their infants and young children because of the immune-protective properties of breastmilk. This is also to ensure food security of the infants and young children during the COVID-19 pandemic.

e. Mothers should be encouraged to exclusively breastfeed their infants from birth up to the first six (6) months of age. At six (6) months of age, mothers shall introduce and provide age-appropriate complementary foods to her infants with continued breastfeeding up to 2 years and beyond.

f. Mothers who are asymptomatic, or those who had close contacts, suspect, probable, or confirmed case of COVID-19 who do not have severe illness and/or who are not in respiratory distress, can continue to exclusively breastfeed their infants in the first 6 months or continue breastfeeding their infants 6 months old up to 2 years and beyond, provided that they observe strict infection prevention and control measures (e.g. use of surgical mask, cover her mouth during coughing with disposable wipes and not her elbow, washing of hands with soap and water before breastfeeding and complementary feeding)

g. If the mother is unable to breastfeed or express milk (e.g. due to severe illness), and pasteurized donor milk is available from a human milk bank, donor human milk can be fed to the baby while the mother is recovering.

h. LGUs are encouraged to include fruits and green leafy vegetables, rice and other root crops in the provision of additional complementary food in the food pack, preferably sourced from the local farmers organization, ARBOs, SLPAs and the like.

i. Locally-prepared and commercially developed complementary foods, ready-to-eat foods such as those developed by the DOST-FNRI, can be considered for procurement by the LGU and be included in the food packs with proper nutrition guidance.

j. Families are encouraged to serve a variety of foods and food in season from the basic food groups to their family members, particularly to the nutritionally at-risk. Household members preparing the menu for the whole family should limit the use of salt, sugar, spices and seasoning which may not be healthy to the infant or young child.

k. Breastfeeding and age-appropriate complementary feeding counseling shall be integrated in the pre-natal, postpartum and postnatal care visits, and family planning services provision, during immunization

activities or health facility visits. If the mentioned services are not permitted, SMS or text messaging, telemedicine, virtual counseling through social media platforms, or the use of pre-recorded online videos and other available virtual platforms may be used to provide counseling and support. A mapping and database/listing of existing online support groups shall also be made available.

l. Practice responsive feeding during breastfeeding and complementary feeding, including responsive infant and childcare for early stimulation and learning as part of early childhood care and development (ECCD).

m. The Barangay Health Emergency Response Team (BHERT) shall provide assistance to women with breastfeeding difficulties/challenges (e.g. breasts conditions, newborn concerns, living with HIV and not on ART, etc.) to access pasteurized donor breastmilk from the nearest human milk banks (HMBs) or LGU/community-managed breastmilk storage facilities. The BHERT shall also refer these women to known lactation support groups in the community, wet nurses and breastmilk donors through SMS or text message and/or through social media platforms.

n. Individuals, families, and LGUs shall not accept milk formula, other breastmilk substitutes and breastmilk supplement donations as defined by RA 11148 (*Kalusugan at Nutrisyon ng Mag-Nanay Act*), EO 51 (Milk Code) and its Revised Implementing Rules and Regulations (DOH AO 2006-0012), and the DOH AO 2007-0017, and report violations through the Mother-Baby Friendly Philippines web-based portal http://mbfp.doh.gov.ph/ or through the mobile app available on iOS or Google Play store.

2. *Hygiene and Food Safety*

a. Instruct mothers and caregivers to perform hand washing, especially before and after breastfeeding, food preparation, infant and child feeding, and after using the toilet.
b. Advise mothers to clean the surfaces used for food preparation, play areas of infants and children, and parts of the home frequently touched or used by the household members.
c. Counsel parents and caregivers to thoroughly wash the food items, cook food properly, re-heat and store cooked food correctly and avoid food wastage.

d. Observe and practice proper and safe disposal of solid wastes
e. Inform clients (mothers) on proper handwashing, and practice cough and sneeze etiquette

5. **Other related nutrition-specific interventions**

Prevention of Micronutrient Deficiencies

a. RHUs and Barangay Health Centers shall maintain routine Micronutrient Supplementation targeting infants, children, pregnant and lactating women, adolescent girls, and women of reproductive age aligned with the national guidelines, without compromising the COVID-19 response measures.
b. Among the important commodities to be provided to prevent micronutrient deficiencies during this time are: Vitamin A (retinol palmitate) capsules and multiple Micronutrient Powder (MNP) sachets among infants and children 6 months to 5 years old.
c. Likewise, for pregnant, postpartum and/or lactating women, Iron and Folic Acid (IFA) is needed to prevent anemia and the consequent low birth weight of the unborn infant.
d. Mass supplementation campaign, however, is **NOT** being encouraged at this time but shall be integrated in the house-to-house immunization campaign, pre-natal and postpartum checkups, family planning and other outreach services, feeding programs, food pack deliveries and home visits, where appropriate, following strict infection prevention and control (IPC) guidelines.
e. The City/Municipal Health Officer shall ensure that in no case shall giving of these micronutrient preparations along side dietary supplementation, lead to consumption of toxic levels of any micronutrient.

6. Nutrition-sensitive interventions linking project beneficiaries with relevant sectors, e.g. agriculture for home gardening, for provision of support to improve productivity of participating households involved in farming and fishing; social services for livelihood support as well as protection services as may be needed; provision of safe drinking water and sanitary toilet facilities, family planning.

Community Food Production

a. The city/municipal nutrition committee (C/MNC), spearheaded by the city/ municipal agriculture officer, should discuss and lobby with the local agriculture office to allocate funds for home food production of the

program beneficiaries. The LGU's planning should address and consider the following:

i. What food items will be planted? In deciding this, consider that planted material should focus on a number of nutritious vegetables, e.g. nitrogen-fixing protein-rich legumes like *kadyos*, *paayap*, string beans, sesame and *sigadillas*, leafy greens like *malunggay*, *saluyot*, and carbohydrate-rich roots and tubers like camote, gabi, as well as fruits like papaya and banana

ii. What small animals will be included? Chicken, swine, fish, etc. Egg-laying chicken may be a good option to consider since this could assure a daily supply of a nutritious food.

iii. Who will be targeted in the first round of distribution? Preference is to start with households with any of the following: pregnant women, infants 0-11 months old, young children 6-23 months old, underweight-for-age, or stunted or wasted children less than 5 years old

iv. Who will be targeted next e.g., who will receive the returned seeds/ seedlings from previous beneficiaries?

v. What "repayment" scheme will be applied? The sharing or repayment scheme is mandatory through which beneficiaries of inputs should return a certain quantity for re-dispersal to other families.

vi. If there are issues on water supply, what will be done to address these issues?

vii. If planting space is limited, what will be done?

b. The MNC should also determine how a community garden will be established and maintained. The community garden should be a continuous source of planting materials and small animals for dispersal to ensure sustainability of the intervention.

i. Where will the community garden be situated?

ii. What fruits and vegetables will it grow as planting material?

iii. What small animals will it take care of as source of small animals for dispersal?

iv. Who will take charge of planning the layout of the garden?

v. Who will take charge of caring for the community garden?

vi. How will the produce of the community garden be shared?

7. Growth and Development monitoring and promotion

a. Promotion and monitoring of growth and development of infants and children under five years old shall still be done during health facility visits, community outreach, to the extent the local situation allows, with strict observance of infection prevention and control measures. Parents and caregivers shall also be reminded of responsive feeding, infant and childcare as part of early stimulation, learning and development.

b. Health care providers (HCPs) for this program, the BNS, shall provide positive feedback to parents or caregivers on their breastfeeding and complementary feeding practices, and on maintaining or improving the nutritional status, growth and development of their children.

c. Health care providers (HCPs) for this program, the BNS and/or BHWs, shall encourage and guide parents or caregivers who have breastfeeding or complementary feeding difficulties/challenges, and whose infants and children need further support in the management of acute or chronic malnutrition.

d. The BNS and/or BHWs, shall emphasize the need to breastfeed more frequently or provide more frequent meals during and after the infant or the child's illness to prevent malnutrition.

e. The BNS, shall promote early childhood development through responsive parenting and caregiving during breastfeeding, complementary feeding and/or administration of RUSF or RUTF.

f. Mid-upper arm circumference (MUAC) measurements may be used instead of the usual weight and length/height measurements to assess and monitor the nutritional status of the child, and to also limit health care provider contact with the infant or child.

MUAC measurement	Classification
125 mm or higher (12.5 cm or higher) or the **"green"** category and no bilateral pitting edema	Infant or child is considered with **"normal"** nutritional status.
Between less than 125 mm and more than or equal to 115 mm (<12.5 cm and ≥11.5 cm) or the "**yellow**" category, and **no bilateral pitting edema**	➢ Infant or child is considered with moderate acute malnutrition (MAM). ➢ Infant or child shall be enrolled to the nearest Outpatient Therapeutic Care (OTC) for proper management of MAM.
Between less than 115 mm (<11.5 cm) or the "**red**" category, **with or without edema**, and passed the appetite test	➢ Infant or child is considered with severe acute malnutrition (SAM) with no medical conditions. ➢ Infant or child shall be enrolled in the nearest OTC for management of SAM.
More than or equal 125 mm (≥12.5 cm, "**green**") or less than 125 mm and more than or equal to 115 mm (<12.5 cm and ≥11.5 cm, "**yellow**"), but the infant or child HAS bilateral pitting edema	➢ Infant or child also has SAM. ➢ If the infant or child has appetite and does not have any medical complications, enroll in the nearest OTC facility.
Infant or child has medical complication(s) and/or IMCI danger signs, severe (+3) bilateral pitting edema, or failed the appetite test	Refer to SAM inpatient therapeutic care facility (ITC referral hospital).

g. Length boards may be used as a measurement tool, especially for assessing nutritional status of children 0-11 months old, again ensuring strict observance of IPC protocol.

h. To assess the nutritional status of pregnant women, MUAC may also be used. Priority for the measurement include:

MUAC measurement	Classification/Recommendation

➢ pregnant women with **MUAC <23** ➢ poor weight gain, especially in the first or second trimester, ➢ pre-eclampsia/eclampsia ➢ gestational diabetes mellitus (GDM) ➢ GWG is less than the lower limit for the corresponding pre-pregnancy BMI class	Refer for nutrition management therapy/ dietary supplementation program
➢ pregnant women with **MUAC <21** at any time during pregnancy for management of acute malnutrition.	For management of acute malnutrition They should receive ready-to-use supplementary food (RUSF) rations daily and to be closely monitored. If RUSF is not available, enroll in Dietary Supplementation Program.

**DOH DM 2020-0092 on the Interim Nutritional Guidelines for Women of Reproductive Age (WRA)*

i. Disinfect MUAC tapes and other anthropometric measurement tools after each measurement (DOH DM 2020-0167–Interim Guidelines on the Proper Handling and Disinfection of Non-Critical Items Used in the Management of COVID-19 Patients in All Health Facilities and Temporary Treatment and Monitoring Facilities).

8. *Trainings and Food demonstration*

No trainings will be conducted requiring physical presence of the beneficiaries and the healthcare workers, unless allowed by the local health authorities, to avoid COVID-19 transmission. Face to -face gatherings will only be allowed subject to clearance of local health authorities and observance of strict IPC protocols during the trainings. Different modes of instruction may be employed including but not limited to webinars or online class or use of videotaped modular trainings for the virtual trainings.

9. *Monitoring and evaluation*

This will involve the generation of weekly and monthly reports **(Annex 2)** on the Tutok Kainan as well as other complementary ECCD services following the integrated ECCD delivery approach. Status of the program shall be discussed during the City/Municipal/Barangay Development Council-Nutrition Committee

regular meetings. Meetings may be done online or if needs physical presence, social distancing must be considered, including the proper wearing of PPEs, preferably in open spaces or facilities with good ventilation.

Use of the ECCD F1K Reporting System (http://eccdf1krs.nnc.gov.ph/) developed by NNC in cooperation with the ECCD F1K partners is highly encouraged. Each Province, City, Municipality and Barangay should record collected data in the system, to minimize person-to-person handling of physical documents and to promote sharing of information electronically. Once data are gathered during routine visits with the beneficiaries, the HCPs or assigned personnel may encode the data into the ECCD-RS. NNC will train LGU partners on the use of the ECCD-RS, as needed.

ECCD F1K Provincial Nutrition Coordinators (PNCs)/NNC Regional Office focal person for Tutok Kainan shall continue close monitoring of the program through electronic communication (via online meetings, text messaging, calls) with the HCPs. Technical assistance shall be provided, as needed, using online platforms. Feedback reports using the ECCD TAME report forms **(Annex 3)** are to be submitted for proper documentation and accounting of concerns.

F1K PNCs)/NNC Regional Office focal person for Tutok Kainan are also required to submit Terminal Reports (**Annex 4**) during the 1st quarter of the following year, to document the overall program accomplishment. to include but not limited to the number of pregnant women and children enrolled, completed the DSP, number of nutritionally at-risk at baseline, midline, endline and z-scores at each measurement.

A program implementation review will be done in 2021 to determine the program implementation, successes, challenges and lessons learned.

Institutional Arrangement

The local government unit (LGU) will be the main implementor of the project. The NNC Secretariat will assist the LGU by providing:

1. technical assistance through the hired Provincial Nutrition Coordinator for the ECCD First 1000 Days Program and NNC Regional Office;

2. financial support through the procurement of goods needed for the program, particularly those for supplementary feeding, nutrition education, growth monitoring and promotion, and monitoring and evaluation;

3. technical assistance to integrate the ECCD First One Thousand (1,000) Days comprehensive and sustainable strategy into their respective Provincial Development and Physical Framework Plan (PDPFP), CDPs, LDIPs, and AIPs.

The specific roles and responsibilities of the NNC and partner LGUs will be contained in and agreed mutually between the two (2) parties through a Memorandum of Understanding (MOU). The MOU template is provided in **Annex 5.**

Approved:

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