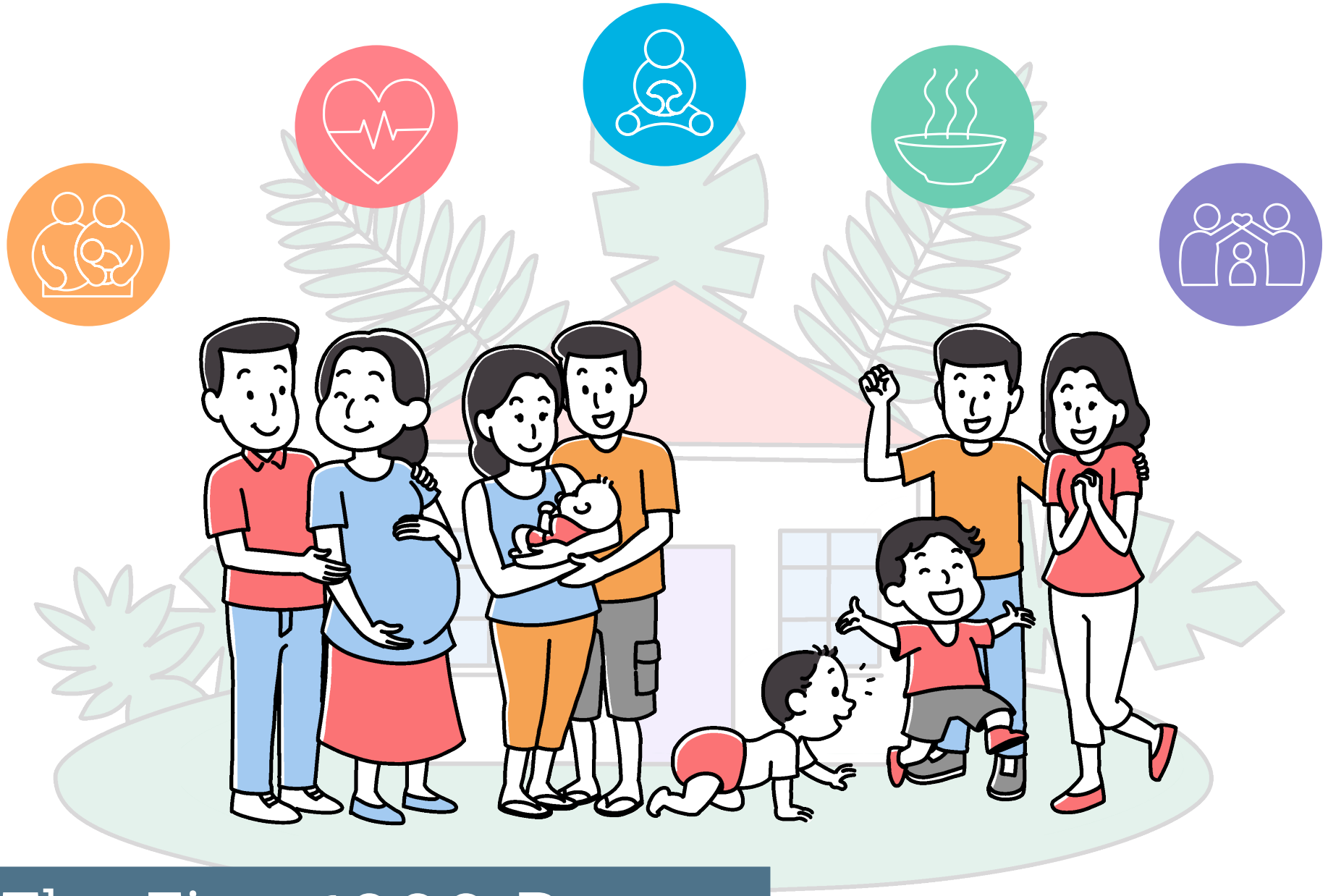

The First 1000 Days

MANUAL OF PROCEDURES

REPUBLIC OF THE PHILIPPINES DEPARTMENT OF HEALTH

NATIONAL NUTRITION COUNCIL 1974

REPUBLIC OF KOREA KOICA

unicef for every child

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Acronyms

AIP	Annual Investment Program
ANC	Antenatal Care
AO	Administrative Order
BHW	Barangay Health Worker
BNS	Barangay Nutrition Scholar
C/PWHS	City-Wide and Province-Wide Health System
C4D	Communications for Development
CARP	Comprehensive Agrarian Reform Program
CDC	Child Development Center
CDP	Comprehensive Development Plan
CDW	Child Development Worker
CHED	Commission on Higher Education
CSC	Civil Service Commission
CSO	Civil Society Organization
CWC	Council for the Welfare of Children
CWD	Children with Disabilities
DA	Department of Agriculture
DAR	Department of Agrarian Reform
DBM	Department of Budget and Management
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOF	Department of Finance
DOH	Department of Health
DOLE	Department of Labor and Employment
DOST	Department of Science and Technology
DRRM	Disaster Risk Reduction and Management
DSWD	Department of Social Welfare and Development
ECCD	Early Childhood Care and Development
ECCD-C	Early Childhood Care and Development Council
ELA	Executive Legislative Agenda
ELP	Early Learning Program
EO	Executive Order
ERPAT	Empowerment and Reaffirmation of Paternal Abilities
F1KD+	First 1000 Days or 0-24 months old + 25-35 months old
FBD	Facility-Based Deliveries
FDA	Food and Drug Administration
FDS	Family Development Sessions
FHSIS	Field Health Service Information System
FIC	Fully Immunized Children
GIDA	Geographically Isolated and Disadvantaged Areas
IMCI	Integrated Management of Childhood Illness
IRR	Implementing Rules and Regulations
ITC	ITC Inpatient Therapeutic Care
LCE	Local Chief Executive
LDIP	Local Development Investment Plan
LGU	Local Government Unit
LNAP	Local Nutrition Action Plan

LNC	Local Nutrition Committee
M/BNC	Municipal/ Barangay Nutrition Committee
MELLPI	Monitoring & Evaluation of Local Level Plan Implementation
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MNP	Micronutrient Powder
MOP	Manual of Operations
MOPr	Manual of Procedures
MSME	Micro, Small, and Medium Enterprise
NAO	Nutrition Action Officer
NAPC	National Anti-Poverty Commission
NCDC	National Child Development Center
NCF	Nurturing Care Framework
NEDA	National Economic and Development Authority
NGA	National Government Agency
NGO	Non-Government Organization
NICU	Neonatal Intensive Care Unit
NNC	National Nutrition Council
Non-BMS	Non-Breastmilk Substitutes
NPAC	National Plan of Action for Children
NYC	National Youth Commission
OPT Plus	Operation Timbang Plus
OTC	Outpatient Therapeutic Care
P/C/M/ BNAP	Provincial/ City/ Municipal/ Barangay Nutrition Action Plan
PAP	Program, Activity, and Project
PDP	Philippine Development Plan
PDPFP	Provincial Development and Physical Framework Plan
PES	Parent Effectiveness Services
PhilHealth	Philippine Health Insurance Corporation
PPAN	Philippine Plan of Action for Nutrition
PRC	Professional Regulation Commission
PSA	Philippine Statistics Authority
RA	Republic Act
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SGA	Small for Gestational Age
SNP	Supervised Neighborhood Play
TESDA	Technical Education and Skills Development Authority
TT	Tetanus Toxoid
TWG	Technical Working Group
UHC	Universal Health Care
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation, and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
ZOD	Zero Open Defecation

Foreword

Republic Act 11148 or the ***Kalusugan at Nutrisyon ng Mag-Nanay***, also known as the First 1000 Days Act, signed in November 2018, consolidates health and nutrition services to make sure that the country's future is secure in the hands of healthy women and children. To better reach them, this Manual of Procedures (MOPr) provides a template of governance strategies for our local government health and nutrition champions—from Chief Executives, Local Health Officers, Nutrition Action Officers, Program Managers, and our implementers in the person of barangay health workers, barangay nutrition scholars, child development workers, and the rest of the community.

Maternal health and nutrition, newborn care, infant and young child feeding, and early childhood care and development services delivered only by the healthcare system will not be able to attain its maximum impact. This MOPr presents a mandated proposition that collaborative health and nutrition governance are also influenced by policies and operational investment in environmental health, agriculture, social welfare, and political leadership. There is local evidence that the first implementers of the First 1000 Days Strategy were driven by Local Chief Executives who had the best interest of their constituents in mind. They started with taking care of pregnant women and their newborns for better health outcomes harnessing technical assistance from the private and public sectors, including development partners, non-government organizations, and civil society organizations.

The Department of Health (DOH), together with the National Nutrition Council (NNC), as lead in the implementation of the First 1000 Days Act, recognizes that we are in a critical position in empowering local government units (LGUs) in taking up health and nutrition as priority investments, especially with the Mandanas-Garcia Supreme Court ruling—which increases the value of their forty (40) percent share from national taxes. The Act and this MOPr propose that funding, among other acts of governance, should be harmonized to fully support the health and nutrition needs of mothers and children, in order to bring about lifelong positive impact not only to individuals but to the community's productivity and economy.

We also thank the United Nations Children's Fund, World Health Organization, Save the Children, Inc., and our development partners in blazing the path in assisting LGUs in adopting the First 1000 Days Strategy. We are all witness to a number of outbreaks, including the 2020 pandemic, and we have always been on our toes ever since. Our partnerships have always emphasized the convergence of multiple services for health, nutrition, adolescent health and nutrition, water, sanitation, and hygiene (WASH), and in the light of the passing of the First 1000 Days Act and Republic Act 11123 (the Universal Health Care Act), health systems integration.

In the pursuit of the implementation of the First 1000 Days Strategy, we take the time to review our plans, milestones, targets, and indicators that will foster this active and fruitful collaboration between the government and the public and private sectors.

We have to keep in mind three points:

(1) our process must focus on the convergence of investments for the continuity of services through integration of critical strategies and interventions, based on the full cycle of life stages within the first 1000 days of life and continued until adolescence;

(2) we should be able to look into our own offices' mandates in ensuring that public health and nutrition services are accessible to Filipino families; and

(3) collaborations are key to innovative, mass-accessible, and palatable strategies to communicate our Implementation Plans to our agencies and our citizens. Let us keep an open mind, free of conflicting interests, in exploring new and efficient avenues of communication in collaboration with diverse sectors in both public and private practice.

The goal of the whole-of-government, whole-of-society approach is to reach the sweet spot of collaborative governance in order to deliver the full range of quality services to Filipinos to support our countrymen in reaching their full potential as citizens. May this MOPr guide you in the implementation of the First 1000 Days Act through the full-scale implementation of universal health care with you at the helm—while we, at the national government, stand to support the delivery of services to Filipino families through policy, technical assistance, and continuous evolution of grassroots-based strategies that fortify high-quality, accessible health and nutrition services.

Mabuhay po tayong lahat!

Francisco T. Duque III, MD, MSc
Secretary of Health
Chair, NNC Governing Board

Messages

The passage of RA 11148 or the First 1000 Days Law provides the enabling environment for the sustained provision of critical early child care interventions for the first 1000 days of a child's life, for optimal growth and development. This ensures that a child's future is protected from the devastating effects of malnutrition. The Manual of Procedures (MOPr) for the First 1000 Days, a product of the partnership between NNC and DOH, is now available for use. The team who developed the MOPr has drawn on the accumulated wisdom of health, nutrition and child development workers and experts at various levels. The MOPr is a document that aims to equip policymakers, program implementers and the frontline workers with the basic knowledge and skills necessary to provide basic services for the first 1000 days following the nurturing care framework. The intended users of the MOPr are encouraged to participate in relevant capacity building activities to support the information gleaned from the Manual. Much more can also be learned from model local government units on how to effectively deliver services for the first 1000 days at scale.

With the MOPr in our hands, I believe that all stakeholders will be provided with invaluable guidance on how to implement efficient First 1000 Days (F1KD+) services that will achieve good outcomes. The MOPr also provides guidance on how to use local and national data to better understand the strengths and limitations of the F1KD+ services and interventions, along with advice on planning and programming following the budget cycle; developing innovations; and in evaluating interventions and projects.

Again, let me express my appreciation and heartfelt gratitude to everyone involved in making this MOPr a reality, an important document in support of the RA 11148 – First 1000 Days Law or the "***Kalusugan at Nutrisyon ng Mag-Nanay Act***." Together, let us continue on the path of providing better quality of services for the first 1000 days.

Azucena M. Dayanghirang, MD, MCH, CESO III
Assistant Secretary and Executive Director
National Nutrition Council

Messages

In 2018, we started the project on the integrated nutrition and health actions in the first 1000 days. Part of the 3 outcomes is to provide a more responsive enabling policy and governance environment at the national and local levels that support the comprehensive approach to maternal, infant and child nutrition and health in the critical first 1000 days window.

One of the initiatives under this project is the development of RA 11148's Implementing Rules and Regulations (IRR) and the Manual of Procedures (MOPr). The recent finalization of the MOPr completes the package of the said law. This was made possible with the strong partnership among the Korean Government through the Korea International Cooperation Agency (KOICA), the United Nations Children's Fund (UNICEF), and the Philippine Government.

This newly developed MOPr for RA 11148 will guide the health workers in providing quality and comprehensive nutrition and health services delivered to women, newborns and children. In addition, KOICA is hopeful that this will serve as a platform to hone and share many best practices among health workers.

On behalf of the Korean Government, I sincerely express my appreciation to UNICEF, the Department of Health, the National Nutrition Council and all our stakeholders for the commitment and dedication they showed for this project despite the ongoing COVID-19 pandemic. Rest assured that KOICA will continuously support the project on the integrated nutrition and health actions in the first 1000 days.

황 재 상

HWANG Jaesang
Country Director
Korea International Cooperation Agency (KOICA)

Messages

The first 1000 days of a child's life is a critical window of opportunity that sets out their future path in life. That's why UNICEF in the Philippines worked to place this important issue on the Philippine agenda, as neglecting this significant period would be a gross injustice to children and their families.

Today, many Filipino children still suffer from malnutrition. A third of them are stunted and/or suffer from deficiencies in essential micronutrients. Less than 10 per cent of Filipino children are consuming the minimum acceptable diet. Because of poverty and exclusion, women and children from the poorest and most disadvantaged communities face the greatest risk for all forms of malnutrition.

I witnessed this in my travels to Albay, Catanduanes, Tawi-Tawi, Basilan and other places in the Philippines. Vulnerable children who are in isolated, typhoon-prone and conflict areas suffer the most.

We advocated with partners to pass Republic Act 11148 or the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act. It provides comprehensive, sustainable, multisectoral strategies and approaches to improve the health and nutrition of newborns, infants and young children, pregnant and lactating women, and adolescent females. It institutionalized the First 1000 days program in all development plans of the national and local government.

National Government Agencies (NGAs) and Civil Society Organizations (CSOs) developed a guide to operationalize RA 11148 to ensure integration and implementation by Local Government Units (LGUs) as they formulate their respective health and nutrition plans.

UNICEF Philippines, with support from the Korea International Cooperation Agency (KOICA), supported the development of this Manual of Operations to guide nutrition workers and other stakeholders. We continue to be inspired by the many hardworking nutrition workers and advocates who work with us to ensure that children not only survive but thrive.

For every child, nutrition.

Oyunsaihan Dendevnorov
UNICEF Philippines Representative

Introduction

This document is the Manual of Procedures (MOPr) for implementing Republic Act 11148 entitled, "An Act Scaling up the National and Local Health and Nutrition Programs through a Strengthened Integrated Strategy for Maternal, Neonatal, Child Health and Nutrition in the First 1000 Days of Life, Appropriating Funds Therefore and for Other Purposes" otherwise known as "***Kalusugan at Nutrisyon ng Mag-Nanay*** Act of 2018" (sometimes also referred herein as "RA 11148" or "the Act") and its Implementing Rules and Regulations (IRR).

This MOPr was developed as a reference and a guide to achieve the main objective of the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act of 2018: to "provide comprehensive, sustainable, multisectoral strategies and approaches to address health and nutrition problems of newborns, infants and young children, pregnant and lactating women, and adolescent females as well as multifactorial issues that negatively affect the development of newborns, infants, and young children."

To be successful, the following areas along Early Childhood Care and Development (ECCD) must be supported:

- Maternal, Neonatal, Child Health and Nutrition (MNCHN)
- Adolescent health and nutrition
- Responsive caregiving and early stimulation
- Integrated Management of Childhood Illness (IMCI)
- Water, Sanitation and Hygiene (WASH)
- Child protection and security

With these areas of concern covered by the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act of 2018, several policies, offices, partner implementers and activities have to be considered. This situation tends to result in an assortment and redundancy of program planning, implementation, and monitoring and evaluation. Thus, the Act calls for a strengthened and integrated strategy especially at the barangay level.

This integrated strategy operates horizontally (i.e., components within and across thematic or sectoral areas, both in the public and private sectors), and vertically (i.e., program components at different administrative levels: national, regional, provincial/ city, municipal, barangay, purok).

The integration must be guided by a family-centered approach, inclusivity, enhanced equity, whole-of-government action, improved multi-sectoral programming, enhanced quality of ECCD services, and stakeholder engagement in all stages of the policy and program cycle.

Fundamental in all of these efforts is the adherence to the Nurturing Care Framework (NCF), which provides a roadmap for action. Its components include adequate nutrition, responsive caregiving, opportunities for early learning, good health, security and safety. The Framework builds on the foundation of universal health care, with primary care at its core, as essential for all sustainable growth and development.[1] The framework will be further explained in the next section of the MOPr.

1 *Nurturing Care for Early Childhood Development, 2018.*

What is the purpose of the MOPr?

The MOPr is designed to aid in strengthening the local government unit's (LGU's) integrated strategy to implement the *Kalusugan at Nutrisyon ng Mag-Nanay* Act of 2018 by:

1. Outlining steps that LGUs and other stakeholders can take to identify their integrated first 1000 days strategy.
2. Providing guidance for program planning, implementation, monitoring and evaluation.
3. Defining roles and responsibilities per stakeholder and across governance levels (national to barangay).
4. Delineating roles and functions among frontline workers.

Who is the MOPr for?

This MOPr is primarily for the direct implementing level, i.e., city/municipality and barangay levels, and program managers and service providers in health, nutrition, social welfare, in these levels, e.g., staff of the rural health unit, nutrition office, social welfare office, barangay health workers, barangay nutrition scholars, and child development workers.

It is also for the other members of the provincial/city/municipal and barangay nutrition committee as well as national government agencies, Local Development Investment Plans, and development partners, to enable them to undertake their roles effectively, especially along supporting the direct implementing levels of the *Kalusugan at Nutrisyon ng Mag-Nanay* Act of 2018.

How is the MOPr structured?

The MOPr is divided in five parts, with each part discussing the following:

1. Overview of *Kalusugan at Nutrisyon ng Mag-Nanay* Act of 2018, highlighting its objectives. The section also identifies the sections of the law but does not provide the specific contents, some of which are presented in **Parts 3 and 4**.
2. Framework for integration that gives an overview of the Nurturing Care Framework, presents challenges in integration.
3. How RA 11148 can be implemented by the LGU at the city/municipal level and barangay levels.
4. Roles and functions of key players at the city/municipal and barangay levels and how the other levels (province, region, national) support the key players.
5. Information resources for implementing RA 11148 that lists related policy issuances and references for actualizing RA 11148.

PART ONE

Highlights of the Kalusugan at Nutrisyon ng Mag-Nanay Act (RA 11148)

This part presents the highlights of the ***Kalusugan at Nutrisyon ng Mag-Nanay Act*** or RA 11148[2]. It shows the objectives of the law, and key provisions. Specifics of the law are elaborated on in the other parts of the MOPr.

The ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act of 2018 is anchored on the Philippine Constitution, various laws, country commitments, medium-term plans, and doctrines as indicated in the law.

It is to be noted that implementation of RA 11148 is part of the National System for Early Childhood Care and Development (ECCD) as mandated by RA 10410 or the Early Years Act.

This national system "is comprehensive, integrative and sustainable, that involves multisectoral and interagency collaboration at the national and local levels among government; among service providers, families and communities, and among the public and private sectors, nongovernment organizations; professional associations and academic institutions."

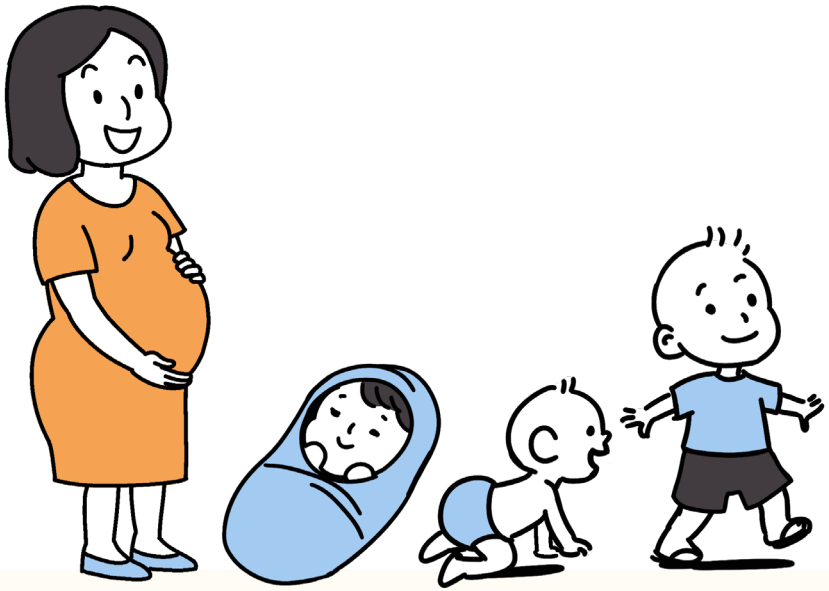
2 *Access the full text of RA 11148 and its IRR through these integrated links:*
https://www.congress.gov.ph/legisdocs/ra_17/RA11148.pdf
https://nnc.gov.ph/phocadownloadpap/userupload/Ro1-webpub/DOH%20MC%202019-0027.pdf

Objectives of RA 11148

RA 11148 aims to:

1. Provide comprehensive, sustainable, multisectoral strategies and approaches to address health and nutrition problems of newborns, infants and young children, pregnant and lactating women, and adolescent females, as well as multifactorial issues that negatively affect the development of newborns, infants and young children, integrating the short-, medium-, and long-term plans of the government to end hunger, improve health and nutrition, and reduce malnutrition;
2. Provide a policy environment conducive to nutrition improvement;
3. Provide evidence-based nutrition-specific interventions and actions which integrate responsive caregiving and early stimulation in a safe and protective environment over the first one thousand days of life as recommended by the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO), as well as nutrition-sensitive mechanisms, strategies, programs, and approaches in implementing programs and projects to improve nutritional status, and to eradicate malnutrition and hunger;
4. Strengthen and define the roles of the Department of Health (DOH), the National Nutrition Council (NNC), and other government agencies tasked to implement nutrition programs for the first one thousand (1000) days of life;
5. Institutionalize and scale up nutrition in the first one thousand (1000) days of life in the national plan on nutrition—particularly the Philippine Plan of Action for Nutrition (PPAN), the Early Childhood Care and Development (ECCD) intervention packages developed by the NNC, the Philippine Development Plan (PDP), the National Plan of Action for Children (NPAC), the regional development plans, and Local Development Investment Plans (LDIP), as well as those for health and nutrition;
6. Ensure the meaningful, active and sustained participation, partnership and cooperation of NNC-member agencies, other national government agencies (NGAs), LGUs, civil society organizations (CSOs), and the private sector in an integrated and holistic manner for the promotion of the health and nutritional well-being of the population, prioritizing interventions in areas with high incidence and magnitude of poverty, Geographically Isolated and Disadvantaged Areas (GIDA), and in hazard and conflict zones;
7. Strengthen enforcement of Executive Order No. 51, series of 1986 (EO 51,s. 1986), otherwise known as the "National Code of Marketing of Breastmilk Substitutes, Breastmilk Supplements and Related Products" or the "Milk Code," and RA No. 10028, otherwise known as the "Expanded Breastfeeding Promotion Act of 2009," to protect, promote, and support optimal infant and young child feeding and maternity protection, and in consultation with the stakeholders in the public and private sectors, consider the new recommendations from the World Health Assembly (WHA) Resolution 69.9 to end the inappropriate promotion of food for infants and young children;

8. Strengthen the implementation of other nutrition-related laws, programs, policies, and guidelines including multisectoral integration, inclusivity, gender equality, and promotion of the UN Convention on the Rights of the Child (UNCRC); and
9. Strengthen family community support systems with the active engagement of parents and caregivers, with support from LGUs, the NGAs, CSOs, and other stakeholders.



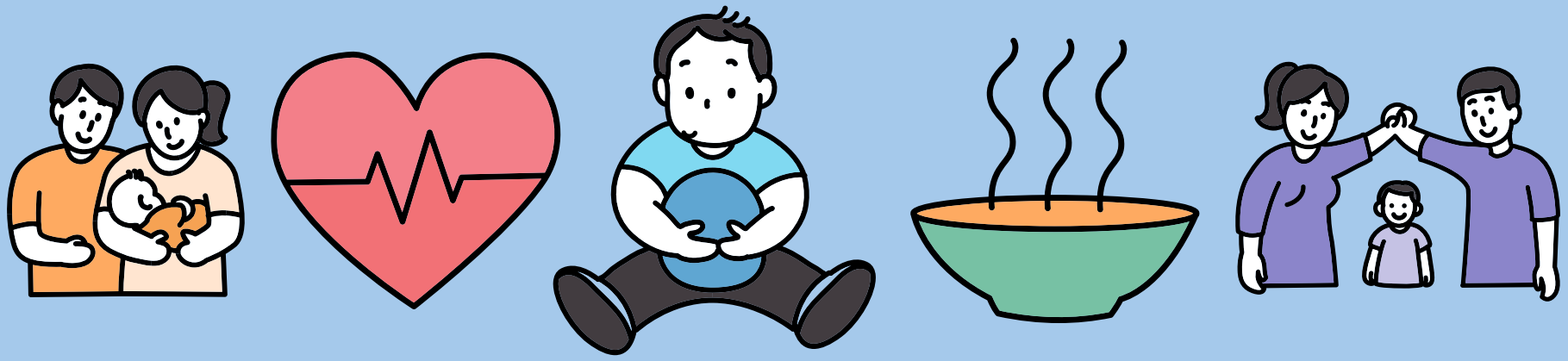
While RA 11148 limits the age group coverage to 0–24 months old, there is wisdom to extend the concern to include those 25–35 months old to ensure that all children are looked after and to be consistent with the Nurturing Care Framework. Thus, this document will use F1KD+ to refer to those in the first 1000 days plus the 25–35 months old age group.

Key Provisions of RA 11148 and its Implementing Rules and Regulations (IRR)

The different sections of the law and their corresponding rules in the IRR specify the following:

1. Coverage of those in the F1KD+, i.e., pregnant women (including pregnant adolescents), children 0-35 months old, and female adolescents.
2. Prioritization and coverage of geographic areas that because of their location, ecology, and socio-economic characteristics, e.g., Geographically Isolated and Disadvantaged Areas (GIDAs), area affected by disasters and emergency situations, and threaten the optimum and holistic development of children.
3. Based on the NCF, the range of services and interventions that need to be provided at the different life stages and in both non-emergency and emergency situations as well as the cross-cutting concerns to enable effective integrated service delivery (**Annex 1)**.
4. Prioritization of services to those in the F1KD+ during disasters and emergency situations, and specific guidelines on the protection of breastfeeding in such situations.
5. Arrangements for monitoring, evaluation, and reporting.
6. Institutional arrangements that focus on roles of agencies, and LGUs as well as mechanisms for coordination.

PART TWO



The Framework for Integration

This part gives an overview of the Nurturing Care Framework (NCF) and its link to RA 11148.

The Nurturing Care Framework

What is the Nurturing Care Framework?

The NCF is a framework "for helping children survive and thrive to transform health and human potential" (**Figure 1**).

Its use enables communities, parents, and caregivers to create a stable environment for children's good health, good nutrition, protection from threats, early learning and responsive caregiving.

Why Nurturing Care?

Nurturing care is needed so that children will survive, thrive, and develop fully. While nurturing care is important throughout life, it is most critical in early childhood or the F1KD+.

The F1KD+ is when a baby's brain grows at a phenomenal rate, creating up to 1000 neural connections per second, a rate that is never again achieved in a lifetime. The growth of the brain depends not only on genetic factors but on the environment, i.e., the availability of nutrients needed as building blocks, protection and stimulation from "talk, play and responsive attention from caregivers."[3]

"For healthy brain development, children need a safe, secure and loving environment, with the right nutrition, and responsive care and early learning activities provided by their parents or other caregivers.[4]"

If these "ingredients" are lacking, brain development will not be optimum, affecting the development of the child, with consequences throughout life. For instance, delays in cognitive development could result in the reduced ability to learn in the school-age period. Delays in the social and emotional domains may result in difficulties "understanding social cues, initiating communication or carrying on two-way communications," and "difficulties in dealing with frustrations or coping with change."[5]

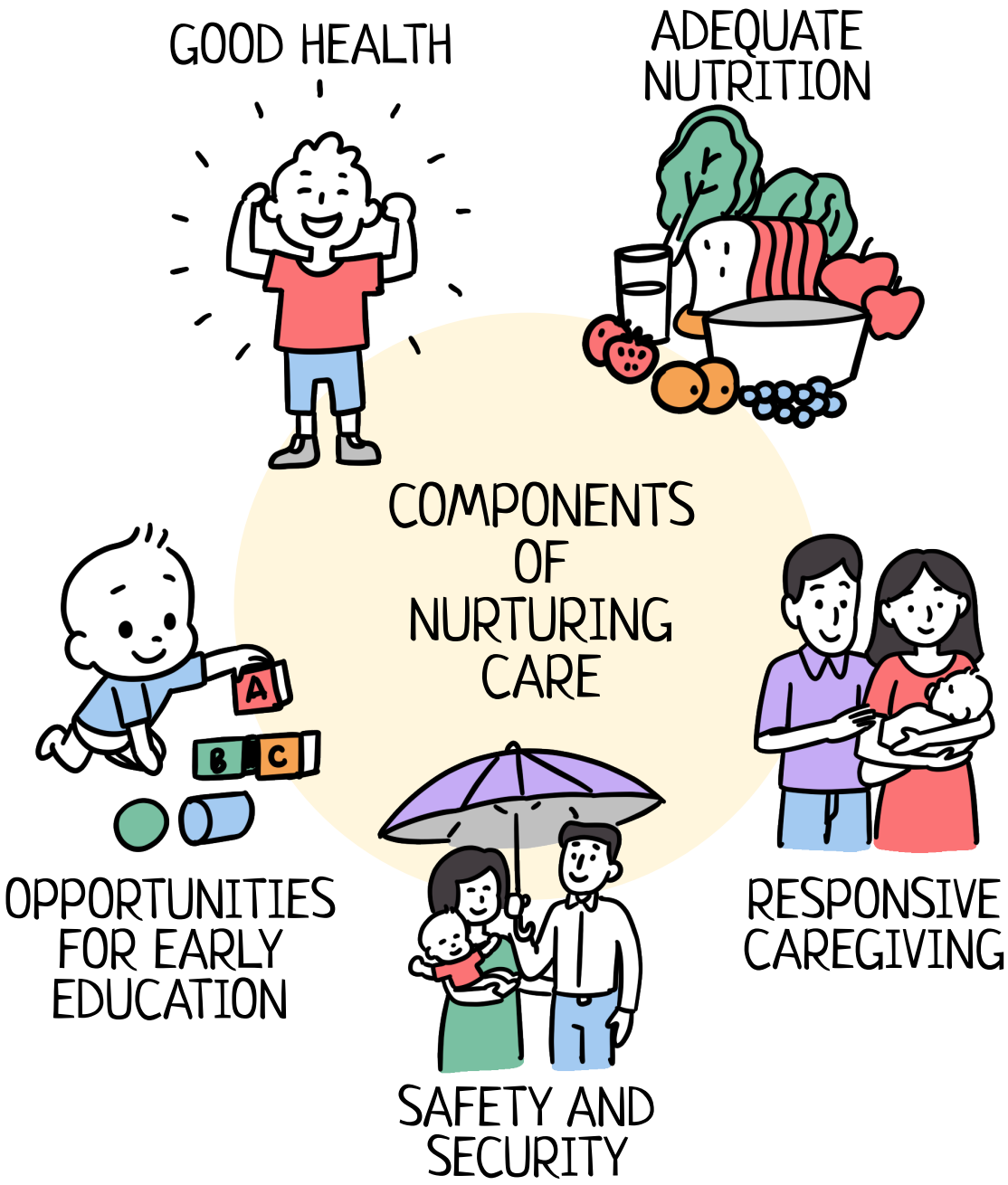
Related to and interacting with brain development is physical development, which is also rapid in the F1KD+. Thus, poor nutrition and poor health in the F1KD+ result in stunting or being short for one's age.

But stunting is not just about physical growth. The WHO notes,

"Stunting in early life – particularly in the first 1000 days, from conception until the age of two – has adverse functional consequences on the child. Some of these consequences include poor cognition and educational performance, low adult wages, lost productivity, and when accompanied by excessive weight gain later in childhood, an increased risk of nutrition-related chronic diseases in adult life. Linear growth in early childhood is a strong marker of healthy growth given its association with morbidity and mortality risk, non-communicable diseases in later life, and learning capacity and productivity. It is also closely linked with child development in several domains including cognitive, language, and sensory-motor capacities."[6]

3 United Nations Children's Fund, 2017
4 From the Nurturing Care Handbook
5 NYU Langone Health, n.d.
6 World Health Organization, 2018

FIGURE 1.
THE NURTURING CARE FRAMEWORK



Components of Nurturing Care

The five components of nurturing care are: good health, adequate nutrition, responsive caregiving, opportunities for early learning, and security and safety (**Table 1**).

These components interact with each other.

For instance, responsive caregiving helps a caregiver recognize and respond to cues that a child is hungry. And feeding the child is important to ensure that he or she gets the nutrients needed for growth and development.

Breastfeeding, while primarily done to provide nourishment, allows eye contact and touch between the mother-baby dyad that helps in strengthening their bond, giving the infant a sense of security. Breastfeeding sessions are also opportunities to talk and sing to the infant, which stimulates the infant's sense of hearing.

On the other hand, a child who is physically and emotionally abused may not have the appetite to eat well, compromising his or her nutritional needs. The same abused child may also be unresponsive to the environment and experience delays in the different domains of child development. A neglected child may not be brought to the health facility for immunization; that makes the child susceptible to disease.

TABLE 1

Components Of Nurturing Care

1. GOOD HEALTH

- Refers to the health and well-being of the children and their caregivers.
- Caregivers should also be physically and mentally healthy to be able to care for children.

CAREGIVER ACTIONS

- ✓ Respond affectionately and well to children's daily needs.
- ✓ Be hygienic and minimize infections among children.
- ✓ Protect children from danger at home and outside.
- ✓ Use health services, both promotive and preventive, e.g., antenatal care, immunization, deworming.
- ✓ Give sick children the right treatment.
- ✓ Monitor how children are, physically and emotionally.
- ✓ Make sure that children get enough physical activity and sleep.

2. ADEQUATE NUTRITION

- Refers to maternal and child nutrition.
- The mother's nutrition during pregnancy affects her health and wellbeing as well as the growth of the fetus. The nourishment of the growing fetus relies on the pregnant woman's food intake.
- After delivery, the mother's nutritional status affects her ability to provide adequate care for her child

CAREGIVER ACTIONS

- ✓ Breastfeed exclusively for the first 6 months.
- ✓ After that, give solid and semi-solid food (complementary foods) in adequate amounts while continuing to breastfeed, up to at least the age of 2.
- ✓ Help children during meals by supporting responsive feeding.
- ✓ Give micronutrients such as vitamin, iron-folic acid, zinc, and multiple micronutrients.
- ✓ Help children transition to eating nutritious family foods.
- ✓ Ensure good maternal nutrition.

3. RESPONSIVE CAREGIVING

- Refers to the ability of the parent/caregiver to notice, understand, and respond to the child's signals in a timely and appropriate manner.
- Responsive caregivers are better able to support the other four components.
- Responsive caregiving helps the child to understand the world around them and to learn about people.

CAREGIVER ACTIONS

Observe and respond to children's movements, sounds, gestures and verbal requests.

- ✓ Feed children when hungry.
- ✓ Protect children against injury and the negative effects of adversity.
- ✓ Recognize and respond to illness.
- ✓ Enrich learning through enjoyable interactions (e.g., talking, singing, smiling, touching, playing).
- ✓ Build trust and social relationships.

4. OPPORTUNITIES FOR EARLY LEARNING

- Refers to any opportunity for the baby, toddler or child to interact with a person, place, or object in their environment.
- Every interaction (positive or negative) or absence of an interaction contributes to the child's brain dev't and lays the foundation for later learning.
- Such early interaction begins as early as conception.

CAREGIVER ACTIONS

- ✓ Use daily routines (e.g., eating, changing diapers, dressing up) to talk to, play, and interact with the child.
- ✓ Engage in activities that encourage young children to move their bodies, activate their five senses, hear and use language, and explore.
- ✓ Tell stories and explore books.

5. SAFETY AND SECURITY

- Refers to safe and secure environments for children and their families.
- Addresses physical dangers, emotional stress, environmental risks (e.g., pollution), and access to food and water.

CAREGIVER ACTIONS

Ensure that children have access to:

- ✓ Safe and nutritious food.
- ✓ Clean water and sanitation.
- ✓ Clean indoor and outdoor air.
- ✓ Good hygiene.
- ✓ Safe spaces to play.
- ✓ Protection from physical punishment, mental/emotional abuse, and neglect.

Integrated Multi-Sectoral Action to Implement RA 11148

The components of the Nurturing Care Framework have been factored in RA 11148.

A significant part of the services mentioned in RA 11148 are related to health and nutrition (e.g., antenatal care, promotion of optimum infant and young child feeding, age-appropriate immunization, micronutrient supplementation, water sanitation and hygiene).

RA 11148 also recognizes the other elements of the NCF, as follows:

- Item k of Section 2 of Rule 8 on Program Components is on "Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, early stimulation, and promotion of early literacy for early childhood development and early detection, identification, referral, and provision of appropriate intervention for developmental delays and disabilities."
- Item m of the same section is on "Protection against child abuse, violence against women and children, injuries and accidents including the provision of first aid, counseling, and proper referrals."

RA 11148 also recognizes the vulnerability of the Philippines to natural and human-induced emergencies and disasters. Thus, Section 11 of RA 11148 notes

> "Areas that are affected by disaster and emergency situations, both natural and man-made must be prioritized in the delivery of health and nutrition, and psychosocial services."

The IRR clarifies that

> "All services included in the program components of this law and IRR shall be immediately provided during emergencies as applicable based on DOH and other related agency guidelines."

From the aforementioned, the importance of the health, nutrition, and social welfare sectors in delivering services related to nurturing care is evident. This calls for closer links among these concerns to ensure that those in the F1KD+ receive services when and where they need them.

However, effective delivery of these services require action from other sectors as well. For instance, since poverty is a main threat to the full development of the child, actions from poverty-alleviation sectors (e.g., agriculture and labor and employment) that are focused on those in the F1KD+ and their families are important. Similarly, ensuring a hygienic environment would require action from the infrastructure sector for the installation of safe water systems.

Thus, to result in holistic child development, integrated service delivery is imperative.

Integrated action inevitably leads to the strengthening of systems, which in turn, translates into sustainable and equitable results for children. From effectiveness, efficiency, sustainability and equity arguments, sectors have the greatest imperative to work together to take full advantage of this period because of the enormous potential gains and the otherwise proportionate losses for every child and the society at large.

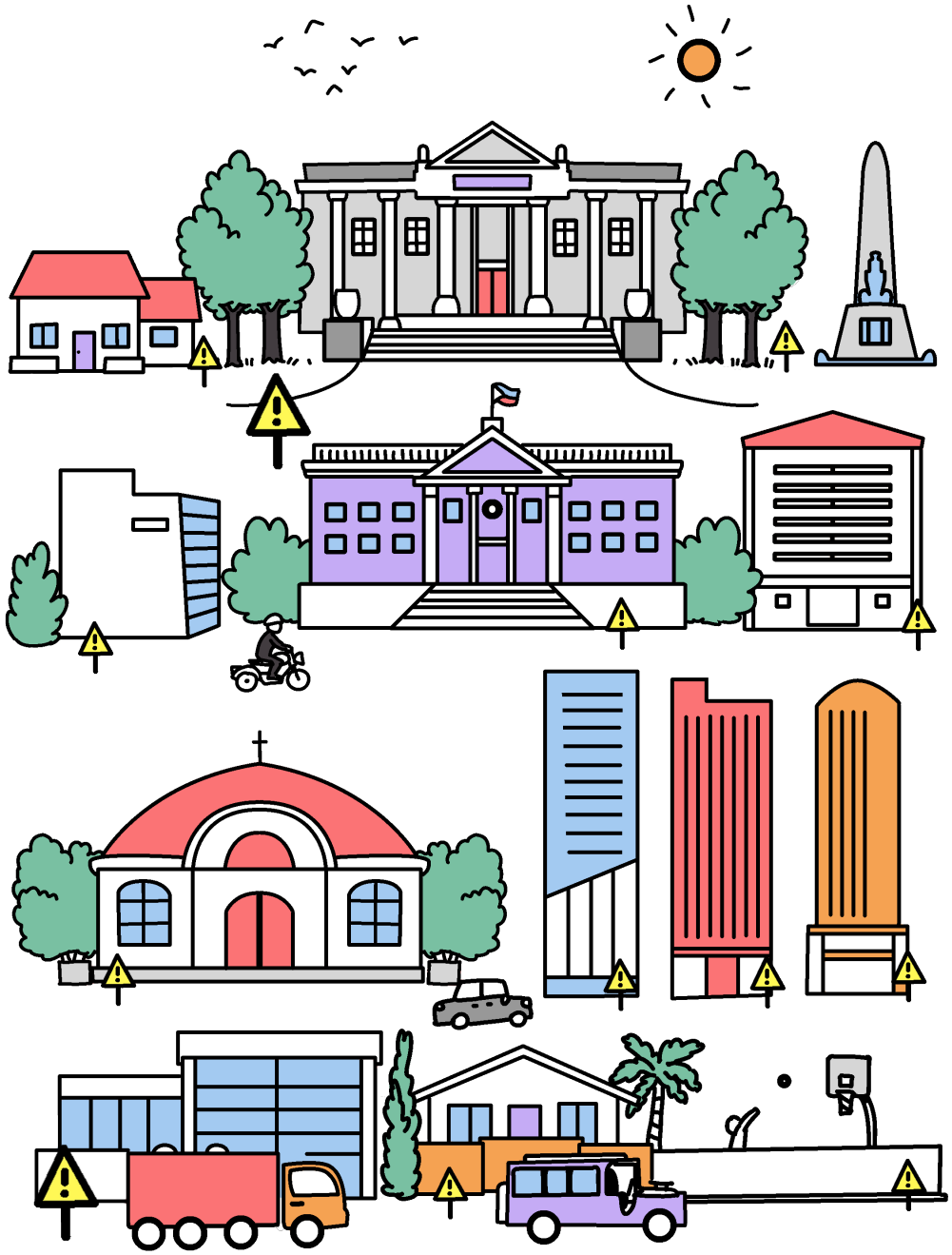
> "The accountability for integrated action of duty bearers across all relevant sectors is never more pronounced than when they can maximally effect change in the life of every child, and that is, during early childhood."

Challenges in Implementing RA 11148

Most of the program components (or services) in RA 11148 are existing programs implemented at varying levels of coverage and quality. However, there is a need to recalibrate and implement these existing programs in an integrated and holistic manner.

In this regard, integrated service delivery is defined as the organization and management of services in health, nutrition, social development, and other related sectors so that those in the F1KD+ "get the care that they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money."[7]

Challenges that hinder integrated service delivery are shown in **Table 2**, together with possible action responses. **Part 3** outlines what LGUs could do to address some of these challenges, while **Part 4** includes roles of different stakeholders along these action responses.



7 *The WHO Technical Brief on Integrated Health Services — What and Why (2008) proposes a definition for integrated health services as, "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money."*

TABLE 2 Challenges In Integrated Service Delivery For F1KD+

CHALLENGE 1

Some services are not available or integrated in existing programs, specifically, those on early stimulation/ learning, responsive caregiving, and security and safety for children, especially for those below 3 years old, and dietary supplementation for pregnant and lactating women and children 6-35 months old.

Action Response

a. DOH and DSWD to issue a policy on how the integration will be done, also inclusion in service packages of the health system.

b. NGA, LGU, or NGO, or development partner to model or initiate related action, and document experiences for possible scaling up.

CHALLENGE 2

Monitoring child development especially for the F1KD+ at the local level is not institutionalized.

Action Response

a. DOH to issue a policy or guidelines on monitoring child development using the ECCD Checklist or an appropriate tool as part of the health system.

b. LGUs to adopt the DOH ECCD Community Risk Targeting scheme (See **Part 3**).

CHALLENGE 3

Several parenting support interventions are being implemented by government and non-government stakeholders with limited coordination and harmonization. The wealth of interventions presents an opportunity for drawing on effective materials and delivery methods, and ensuring better coordination and harmonization.

Action Response

a. Stakeholders at all levels to improve planning and programming, participate in joint budgeting, and share information.

b. Stakeholders at all levels to strengthen coordinative mechanisms like the NNC and nutrition committees to provide the venue for harmonization.

c. DOH and NNC to establish a repository of information resources.

CHALLENGE 4

Variable quality and reach of the different services for the F1KD+ arising from various reasons.

Action Response Would depend on causes of the variability, but possible action responses are:

a. LGUs can improve availability of services that are physically closer to target groups; telehealth strategies can also be considered.

b. Stakeholders at various levels to continually build capabilities of service providers.

c. Program managers at the local level to clarify and delineate roles of various workers within and across sectors.

d. DOH and local government units to improve management of the supply chain and prevent stock-outs.

e. LGUs to adapt services and service delivery according to the situation and cultural acceptability at the local level, e.g., GIDAs or communities of indigenous persons.

f. LGUs to improve the incentive system for community volunteers, and protect these volunteers from political threats.

CHALLENGE 5

Limited funding for F1KD+-related services and programs especially at the local level. There is no policy mandating that a portion of the local budget should be earmarked for nutrition and related programs unlike gender concerns, the protection of children, and others.

Action Response

a. LGUs to include programs on the F1KD+ and their budgetary requirements in the local development plan, local investment plan, and annual investment programs.

b. Identify and tap into mandated budgets, e.g., 5% gender fund, 1% for the protection of children, 5% calamity fund. Consider too, increase in local budget with the Mandanas ruling.[8]

c. LGUs to tap non-government channels, e.g., non-government organizations like the Rotary Club, Lion's Club, Kiwani's, and the like, as well as private foundations and private companies, but with an eye for preventing and managing conflicts of interest.

d. Local government agencies to ensure efficient use of allocated funds to demonstrate absorptive capacity.

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8 The Supreme Court has ruled that all collections of national taxes except those accruing to special purpose funds and special allotments for the utilization and development of the national wealth, should be included in the computation of the base of the just share of LGUs. Thus, the internal revenue allotment of LGUs are expected to increase significantly starting 2022.

CHALLENGE 6

The effectiveness of coordinative structures like councils or their equivalent for planning, financing, and implementation of holistic integrated ECCD services still has to be realized.

Action Response

a. DOH, NNC, ECCD-C, and Council for the Welfare of Children (CWC) to clarify and delineate their roles and how they will work together in the implementation of RA 11148.

b. NNC, ECCD-C, and ECCD to build capacities of their respective focal persons at the local level on effective coordination.

c. Member agencies to include in performance metrics active participation in coordinative structures, e.g., not just attending meetings but pursuing actions to mainstream nutrition concerns in agency policies, programs, & projects.

d. LGUs to create a nutrition office and appoint a full-time nutrition action officer, district/city nutrition program coordinators to facilitate the overall management and coordination of multisectoral nutrition action plan of the LGU.

e. Creation and filling up of a permanent position for Registered Nutritionist-Dietitians.

PART THREE

Implementing RA 11148 at the local level

This section will discuss how the provincial, city/municipal, and barangay levels can implement RA 11148. It is guided by the roles of LGUs as per Section 3, Rule 13 (Role of NNC Member Agencies, Other NGAs, and LGUs) as follows:

"LGUs are encouraged to integrate maternal, neonatal, child, and adolescent health and nutrition programs in the local nutrition action plans (LNAPs), and investment plans for health. For this purpose, the local nutrition action officers (NAOs) designated or appointed by their local chief executives (LCEs) shall facilitate processes for the formulation, approval, coordination, monitoring, and evaluation of the LNAPs and its integration in the Comprehensive Development Plans (CDPs), LDIPs, and Annual Investment Plans (AIPs). They shall coordinate closely with offices/departments of their respective LGUs to ensure the harmonization and integration of efforts for nutrition improvement."

The Mandanas ruling presents an opportunity to increase funding support for the full implementation of RA 11148.

The provincial, city, and municipal governments shall ensure the integrated and multisectoral management of efforts related to the F1KD+, and more specifically,

1. Exercise general supervision and control in the implementation of the F1KD+ Strategy at their respective local levels in coordination with the DOH, NNC, and other NGAs, and promote—as well as enforce—local legislative measures relevant to the Strategy that will aim to strengthen and enhance its implementation in the communities;

2. Integrate the F1KD+ comprehensive and sustainable strategy into their respective Provincial Development and Physical Framework Plan (PDPFP), CDPs, LDIPs, and AIPs with clear and appropriate guidance and extensive support from NGAs, their regional offices;

3. Ensure the effective and efficient delivery of services in the continuum of care;

4. Provide mentoring and supervision for trained staff and service providers so that they can provide quality care, facilitate timely referrals for specialized care as needed, and collect and report quality data;

5. Provide counterpart as necessary that will tap into potential funding sources in addition to other local funds to be utilized to support the implementation of this program, organize and support parent cooperatives to establish community-based programs, and provide counterpart funds for the continuing professional development of their service providers;

6. Provide the facilities and platforms for the implementation of the F1KD+ Strategy, maximizing opportunities for integrated activities; and

7. Ensure functionality and effectiveness of their respective provincial/city/municipal nutrition committees to:

   a. Assess the local nutrition situation.

   b. Oversee the implementation and provide technical support to lower levels to ensure the effective and efficient delivery of services in the continuum of care.

   c. Formulate the LNAPs complementary to and integrated with other plans of the LGU and higher-level plans with focus on the F1KD+.

   d. Coordinate, monitor, and evaluate plan implementation and recommend and adopt appropriate actions related to the F1KD+.

   e. Mobilize resources to ensure the plan is fully implemented.

   f. Hold at least quarterly meetings to report progress on the implementation of the local multisectoral nutrition action plan especially the component on the F1KD+.

   g. Extend technical assistance to municipal and barangay nutrition committees (MNCs/BNCs) on planning, nutrition program management, and related concerns, including the conduct of periodic visits and meetings.

This section presents activities that can be undertaken, and how these can be done. The overriding concern for these activities is to ensure integrated service delivery, i.e., services reach those needing them when needed, produce the intended outcome, with efficient use of resources.

Guiding principles for implementation

The strategic actions should always be contextualized along key principles that guide the various plans (National Objectives for Health, Universal Health Care, Philippine Plan of Action for Nutrition, National Strategic Plan for Early Child Care and Development or the Early Years First) on which RA 11148 is anchored.

These guiding principles include:

1. FAMILY-CENTERED. As noted in the National Strategic Plan for ECCD 2019-2030 or Early Years First, "Families are at the center of young children's survival and optimal development. For most young children, their family members are the people who are most consistently in their lives. To provide supportive and nurturing care for the survival and optimal development of young children, families need information, resources and services, particularly when they are facing adversities and crises. The Government must, therefore, support all families but especially those families who have vulnerabilities and face adversities, so they have access to the knowledge, skills, resources and services they need to provide supportive, protective and nurturing care to their young children."

   Similarly, a guiding principle of the PPAN 2017-2022 notes, "Attainment of nutritional well-being is a main responsibility of families, but government and other stakeholders have the duty to assist those who are unable to enjoy the right to good nutrition."

2. INCLUSIVE TO ENSURE THAT NO ONE IS LEFT BEHIND. This means that services for the F1KD+ should be available to all children and their families regardless of gender, disability, ethnicity, religious affiliation, political affiliation, and socio-economic class.

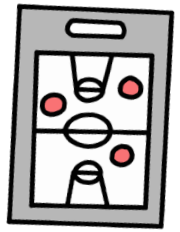
3. EQUITABLE. While services should be inclusive, there should be extra efforts to reach out to the marginalized and vulnerable, e.g., poor families and communities; those in GIDAs; areas, communities and families affected by emergencies/ calamities; children with delays and disabilities, etc.

4. INTEGRATED AND MULTISECTORAL. This means that children and their families receive the services as indicated in RA 11148 when they need it, where they are, in ways that uphold their human dignity, to allow for optimum child development. Achieving integrated service delivery will require a whole-of-society and whole-of-government approach. Thus, various stakeholders at all levels of governance have roles to play in child development.

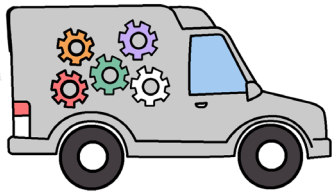
ACTIVITIES TO UNDERTAKE

Conduct an F1KD+ situational analysis

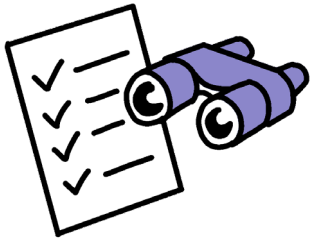
Strengthen planning and budgeting mechanisms



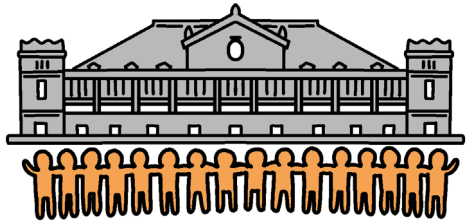
Identify how F1KD+ services will be integrated



Strengthen Service Delivery



Strengthen monitoring and evaluation



Advocate for whole-of-government action

Conduct an F1KD+ Situational Analysis

A first step in implementing RA 11148 is assessing the F1KD+ situation. This involves having a shared (among all those to be involved in delivering services in the F1KD+) view on issues affecting children, causes of these issues and priority actions that should be pursued. The situational analysis can also look into good practices in service delivery, capacity building, management and coordination and other concerns.

The NNC has tools and sample situational analysis in its website (Ensuring Nutrition Priorities in Local Development Plans and Budgets)[9] that can be referenced and tweaked to cover the concerns of the F1KD+.

Who should do the situational analysis?

For the assessment to be meaningful, it should be done by a team that, at the least, includes representatives from the health office, the nutrition office, social welfare and development office, agriculture office, planning and development office, and at least one civil society organization, preferably a women's group or organization, operating in the area. Other members of the local nutrition committee may be added as needed.

This team can be ad hoc (specific to the situational analysis), or a more permanent structure under the local nutrition committee. The functions of an ad hoc situational analysis team could be as follows:

1. Define the scope of the assessment as well as data requirements and sources.
2. Collect, process, and analyze data.
3. Prepare the assessment report that should include the results of the assessment as well as recommendations to address the findings of the assessment.
4. Lead in the dissemination of the results of the situational analysis.

On the other hand, the functions of a more permanent structure could be as follows:

1. Facilitate the integration of services across sectors to ensure the delivery of needed services in the F1KD+.
2. Formulate medium-term and annual plans on the F1KD+ (for integration in "mother plans," e.g., LIPH, PPAN, and eventually in the CDP and AIP).
3. Monitor the progress of implementation of the plan referred to in item 2 and attend to corrective actions as needed.
4. Prepare reports on the F1KD+ as may be needed.
5. Evaluate the effectiveness of the plan formulated in item 2.

Whatever, the form, having an appropriate policy instrument, e.g., city/municipal executive order for the creation of the team is important. The policy instrument should indicate the name of the team, the composition (preferably expressed as position title rather than names of persons), the functions of the team, the relationship with existing structures, and other provisions that will define how the team will operate. See **Annex 2** for a template for the policy instrument.

In addition, the sector representative in this team should facilitate intra-sector or agency coordination. For instance, there is no single person in the health office that works on all the health services for the F1KD+. Thus, the representative of the health sector should coordinate with colleagues in the health office along with the tasks of the assessment team.

The organization of the team should be initiated by the city/municipal nutrition action officer.

9 *https://www.nnc.gov.ph/component/phocadownload/category/223-ensuring-nutrition-priorities-in-local-development-plans-and-budgets*

When should the situational analysis be done?

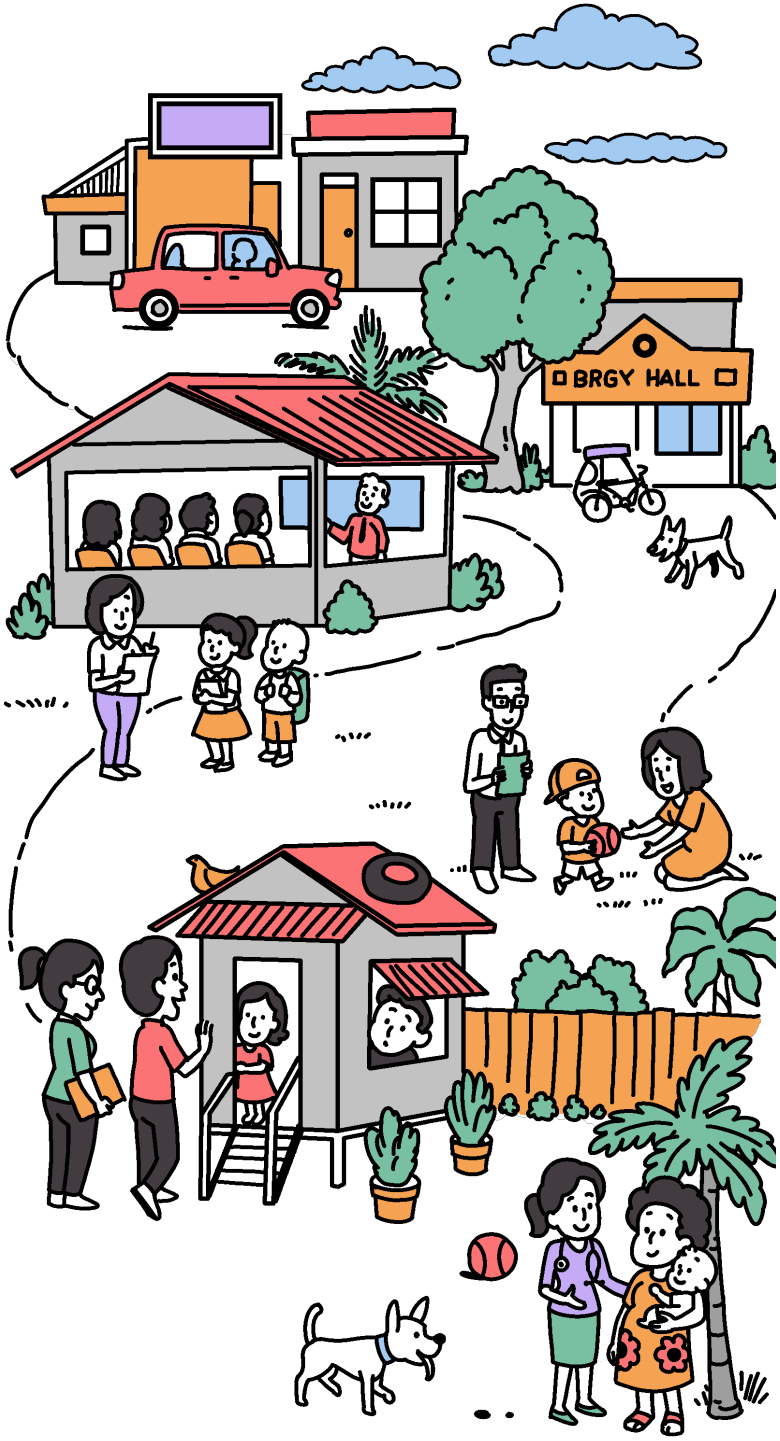
The assessment can be done in any phase of the program management cycle. It can be done to respond to a finding or monitoring of an emerging concern. In this case, the assessment can cover a specific area of concern for the assessment.

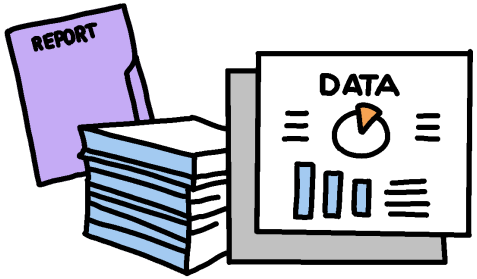
It can also be done when an emergency/disaster happens, especially for those that are estimated to be protracted. For this, there is more specific guidance as contained in Administrative Order (AO) 2017-0007 on the Essential Health Service Package during Emergencies and Disasters. The AO specifies when assessments should be done after an event that could lead to an emergency/disaster. In addition, the Information Management for Nutrition in Emergencies for Local Government Units Participant's Manual can be referred to for nutrition assessment in emergencies.

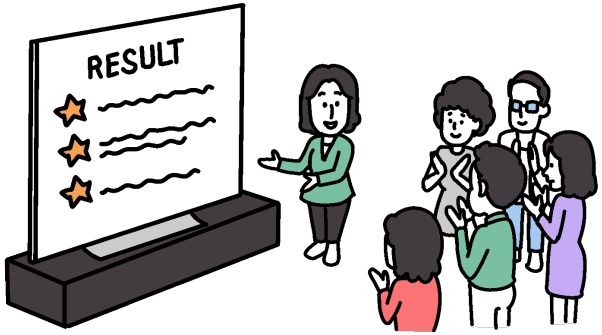
However, a comprehensive assessment should be done for the formulation of the Provincial/City/Municipal/Barangay Nutrition Action Plan (P/C/M/BNAP) and P/C/M Investment Plan for Health (P/C/MIPH).

Per NNC Guidelines, the P/C/MNAP is ideally formulated in the first quarter of an election year. This will make available an agenda for nutrition action that can be submitted for consideration in the formulation of the executive legislative agenda (ELA) and the comprehensive development plan. It is to be noted that the ELA should be done within one month after the assumption to duty of the LCE. Thus, formulating the P/C/MNAP way ahead (i.e., first quarter of the election year or earlier) is a pro-active strategy for putting nutrition in the agenda for local development.

An assessment can also be done when a new program or project is being developed.







How can the situational analysis be done?

The main effort is to generate and analyze information. Information can be generated using both quantitative and qualitative methods, which can be either primary or secondary.

The assessment can thus involve the following:

1. **Generation of information**
   a. Desk review of existing information, usually from administrative reporting systems like the Field Health Service Information System (FHSIS), Operation Timbang Plus (OPT Plus), Monitoring and Evaluation of Local Level Plan Implementation (MELLPI) Pro, or from existing plans like the CDP or LNAP or LIPH that already have a situational analysis, or from published studies.
   b. Key informant interviews that can cover the range of those involved in program/ project planning and implementation, e.g., program manager, those who deliver the services including volunteers, and the mothers, fathers, and caregivers themselves.
   c. Focus group discussions to tackle a specific concern
   d. Others
2. **Analysis of information generated** to understand the situation
3. **Consultation with stakeholders** on the initial analysis
4. **Finalizing the analysis**
5. **Writing the report** that can include the following:
   a. Introduction
   b. Objectives of the situational analysis
   c. Methodology
   d. Findings that answer the questions listed in **Annex 3.**
   e. Recommendations
6. **Disseminating the results of the assessment**

Annex 3 contains further details on doing the situational analysis.

How can results of the analysis be used and disseminated?

A situational analysis is meaningful only if its results are used. These uses can include:

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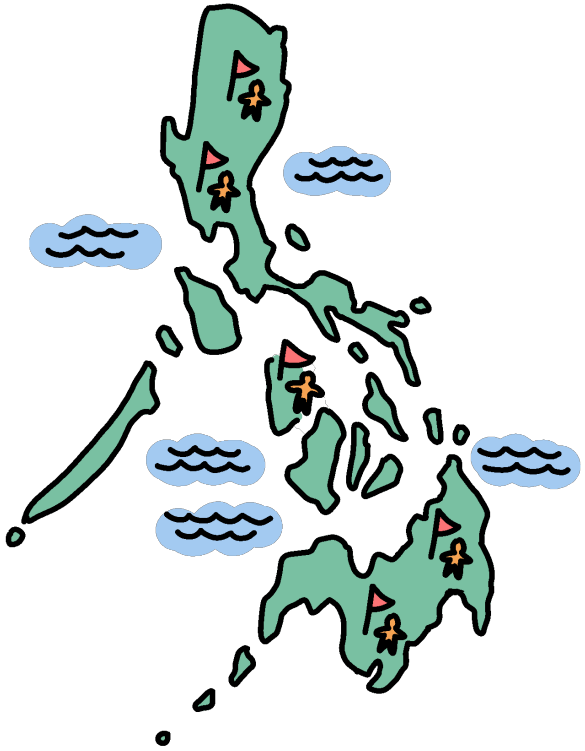
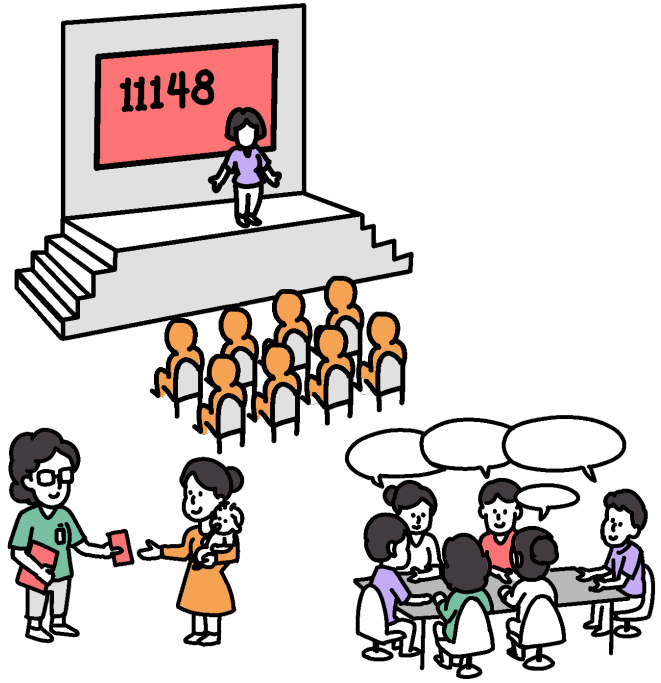
1. In making strategic decisions, e.g., what would be priority geographic areas or target groups or components, what new programs, projects or approaches to develop and their design.
2. For formulating ordinances that may be needed to address the situation.
3. For convincing stakeholders to adopt certain behaviors and development, and execution of advocacy campaigns to strenghten F1KD+ governance in LGUs.



Closely linked with using the results of a situational analysis is the purposive dissemination of the results of the assessment, especially to those who can use the results.

Dissemination can be done in various ways, as follows:

1. Writing up and publishing the situational analysis and giving copies to key stakeholders.
2. Preparing and distributing flyers or simplified materials on the assessment results .
3. Preparing information bites from the assessment that can be featured in the LGU social media account.
4. Holding meetings or forums not only to present the results of the assessment, but also to generate commitments in pursuing the assessment recommendations.



Strengthen Planning And Budgeting Mechanisms

To be effective and to ensure appropriate financing, concerns on the F1KD+ should be integrated in the Comprehensive Development Plan (CDP), the Executive Legislative Agenda (ELA), and the local development investment plan, which are the bases for the annual investment program and ultimately the budget of the LGU.

The investment plans for health, and the nutrition action plan, are formulated to allow a close look at health and nutrition issues. F1KD+ concerns should be in these thematic plans, and eventually integrated in the CDP.

Figure 2 shows the link of these two thematic plans with the local development plan.

How can these Planning and Budgeting Systems be Strengthened?

1) Ensure integration of F1KD+ concerns in the local development plan.
Prepare the LIPH and LPAN way before the LGU formulates its CDP, ELA, LDIP, and AIP.

For instance, per NNC guidelines, LPANs should be formulated in the first quarter of an election year. This will allow the availability of a nutrition agenda that will, in turn, facilitate the integration of nutrition concerns in the CDP.

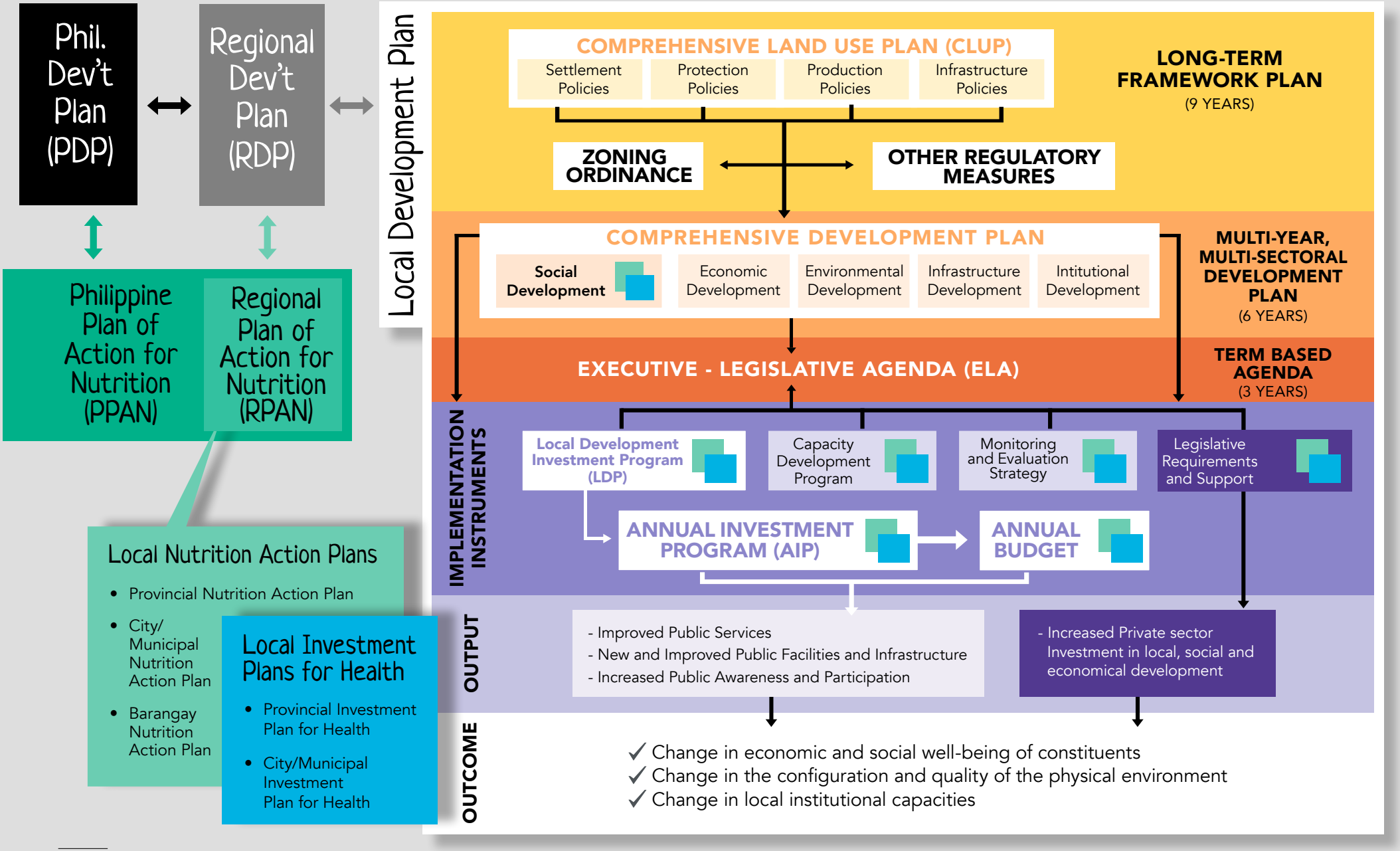
Important dates to remembers and their respective milestones as per Joint (DILG, DBM, NEDA, DOF) Memorandum Circular No. 1, series of 2016 and possibilities for integrating F1KD+ concerns in each phase are shown in **Annex 4.**

The DILG "Local Planning Illustrative Guide," and the "Budget Operations Manual for Local Government Units" can be used as references in understanding the local planning and budget process.

For barangay development planning, the "Primer on Barangay Development Planning" can be a reference. A related document developed recently is on "Ensuring Nutrition Priorities in Local Development Plans and Budgets" could also be referred to, and adapted to cover the entire range of F1KD+ services and interventions.

Since the local nutrition committee is the main mechanism for harmonization, the provincial, city, municipal, and barangay nutrition action plans should be revised to include all services related to F1KD+ either as a nutrition-specific or nutrition-sensitive component.

FIGURE 2 Relationship Of City/Municipal Plans & Instruments[10]



10 Adapted from the DILG Local Planning Illustrative Guide and the eLearning Course on Local Nutrition Program Management Course Guide of NNC with revisions to include local health and nutrition plans

2) Ensure consistency across plans.
Similar information (data or indicators, targets, elements) used in all the plans should be the same.

3) Ensure regular communication across and within agencies as sectoral plans are being formulated.
This will allow the identification of points of coordination and complementation of activities and budgets.

4) Share final plans with stakeholders.

5) Work with the LCE and the local development planning office so that:

a. Budget calls and guidelines for the preparation of budget proposals will indicate that agencies are required to specify what they will do for those in the F1KD+ and their families. The budget call can also require a form of joint budgeting among, at the least, the health, nutrition and social welfare and development sectors.

b. Reviewers of agency budgets at the provincial level purposely look for and ask what the agency has planned or budgeted for the F1KD+. They can also probe on the extent to which the different LGU offices "talked" to each other and harmonized their budgets for the F1KD+.

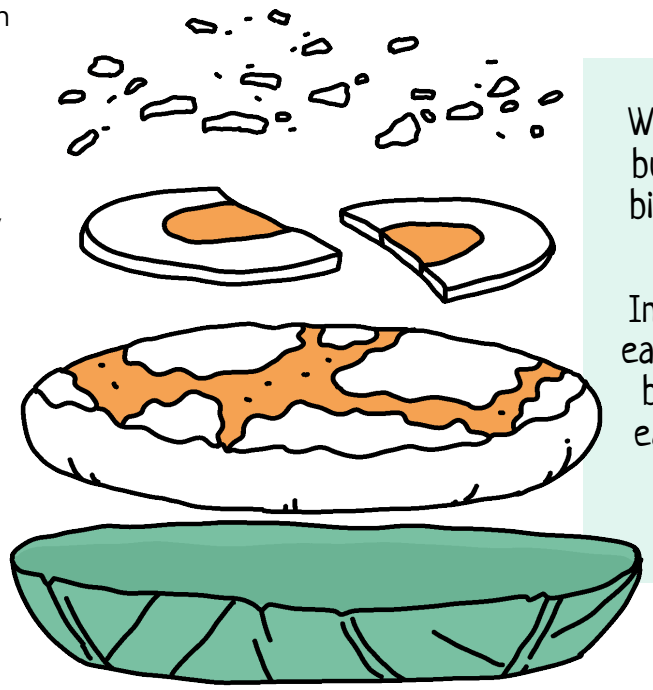
c. Budgets related to F1KD+ services are tagged.

Having a joint planning and budgeting session for agencies (at the least health, nutrition, social welfare and development, agriculture) has been challenging due to constraints in time as well as human resource. In many instances, sectors or agencies plan separately and these plans are put together in a plan. However, for integration to happen, joint planning and budgeting should be done.

A possibility is to have at least one meeting during which all agency plans and budget for the F1KD+ are discussed. Staff work is needed for this not just in putting information together for the agency activities, targets, and budgets, but in identifying talking and action points.

Working with the SP/SB committee on health could help also in ensuring budgetary allocation for the nutrtion action plan.

Possible talking and action points are shown in **Table 3**.
If convening a meeting is challenging, one-on-one discussions between agencies could be considered.



While bottom-up planning and budgeting is ideal, adopting a bibingka approach to planning is more realistic.

In the BIBINGKA APPROACH, each level plans simultaneously but have consultations with each other so that concerns can be reconciled and integrated in the plans.

TABLE 3

Talking Points For Discussions On F1KD+ Plans

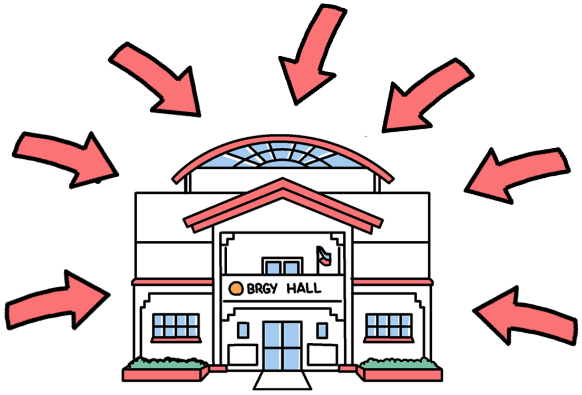
CONCERNS	TALKING/ACTION POINTS
1. Barangays that have high levels of problems in the F1KD+ and low coverage of services are not targeted by all agencies.	Can agencies involved in the F1KD+ redirect services (best if identified) agree to adopt the same priority barangays and re-direct services accordingly?
2. The target of a service is low compared to the identified needy population.	Can the agency/ies increase budget allocation for increased coverage of the needy population? What will be the fighting target coverage?
3. Some services are missing.	Can the agency/ies develop a program or project or activity that will address this gap?
4. Budgets are allocated for services and activities that, by evidence, are not as effective.	Can this budget be rechanneled to other services that are more effective and give more value for money?

Identify How F1KD+ Services will be Integrated

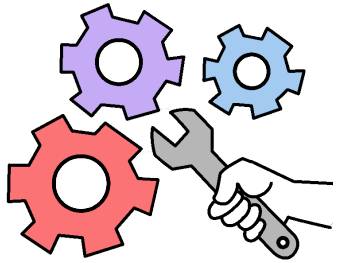
The health sector is the anchor sector for the F1KD+ since most of the services for those in the F1KD+ are delivered through the health system.

Thus, it should ensure horizontal (within one level, e.g., the city/municipal level) and vertical (across levels, e.g., from the national down to the barangay level) integration within the health sector, and with other sectors, especially that of social welfare and development. It should be an effective gatekeeper for services to those in the F1KD+.

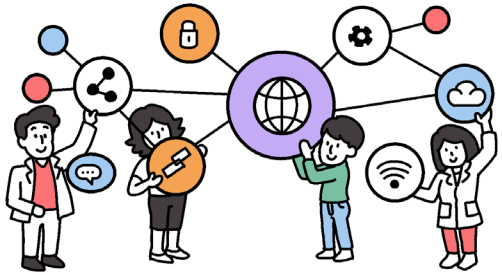
Ensuring integrated service delivery can be achieved using a mix of strategies according to the situation of the LGU. These strategies are discussed in this section.



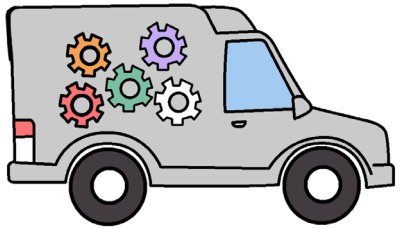
Converge in the same priority barangays and households



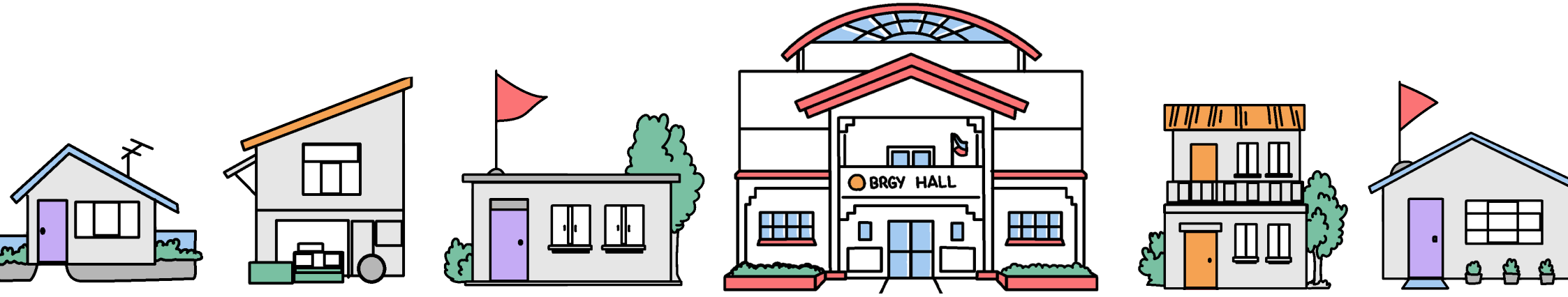
Add or modify a component of the F1KD+ services



Establish referral systems



Synchronize service delivery schedules within and across sectors



Converge in the same priority barangays and priority households

Data from the situational analysis can help identify cities, municipalities, and barangays that need to be focused on. Priority areas can be identified using one or more indicators, e.g., population size, average household size, number (or percentage) of stunted children, number (or percentage) of wasted children, coverage of one or more services, percentage of households with sanitary toilets, etc., depending on the purpose of the prioritization.

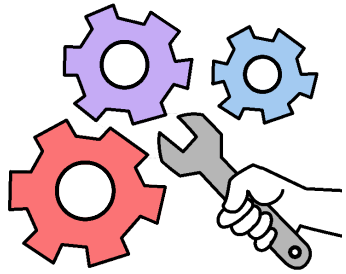
If the intent is to choose barangays with a higher need for F1KD+ services, a mix of outcome indicators and service indicators can be used. If the intent is to choose priority barangays for a particular intervention, a single indicator related to the intervention can be used.

The local nutrition committee (as the mechanism for coordination and partnerships per Section 7 of the IRR of RA 11148) can decide on the indicators to use for prioritizing barangays, and how these indicators will be processed for the selection process.

While using prevalence rates or percentages is a usual practice, there is also a need to consider the equivalent numbers for these rates or percentages. For instance, consider two barangays, one has 100 under-five children, the other 1000. A prevalence rate of 10% for say, stunting, in the former is equivalent to 10. On the other hand, a prevalence rate of 5% in the latter translates to 50 children. In such a situation, choosing the barangay with the lower prevalence rate is more judicious.

Within the barangay, frontline workers should agree on which households will be prioritized for certain interventions.

Add or modify a component of the F1KD+ services



If based on the assessment, one or more components of the F1KD+ services is not present in the province/city/municipality, and that component is crucial given the situation of children, then an action line would be to develop a project or activity related to the component.

The following are examples of components to add in existing services. The LGU can identify others based on its situation.

1. ECCD Community Risk Targeting (**Annex 5**) that will involve an initial assessment by the Barangay Health Worker (BHW) and Barangay Nutrition Scholar (BNS), and a system for referral to the local health office for further assessment, and developmental specialists through the levels of care.
2. Responsive caregiving and early stimulation in contacts with the mother and caregiver through one-on-one consultations and group learning session. **Annex 6** provides key points for promoting responsive caregiving and early stimulation based on the WHO Care for Child Development Module. The Idol Ko si Nanay Learning Sessions developed by NNC that contains modules on responsive caregiving can be used for group sessions.
3. Dietary supplementation of pregnant women and children 6-35 months old that can adapt the NNC "Guidelines on Early Childhood Care and Development in the First 1000 Days (ECCD F1KD+) Program in the Context of COVID-19 Pandemic and Related Emergencies."
4. Projects or service packages for adolescents that include not only prevention of pregnancy, but overall health and nutritional well-being.
5. Activities that will increase the participation of fathers in maternal and child care. These activities can include holding health and nutrition classes for fathers, requesting the agriculture sector to include a health and nutrition topic in farmers' classes, including health and nutrition topics in Parent Effectiveness Services (PES) and Family Development Sessions (FDS). The Idol Ko si Tatay modules developed by NNC and the Empowerment and Reaffirmation of Paternal Abilities (ERPAT) of the DSWD are resources that can be tapped.
6. Activities that will increase the participation of other caregivers in maternal and child care.
7. Having toys in waiting areas of health facilities including facilities for outpatient treatment care for acute malnutrition, but ensure that these toys are made of safe materials and that they are sanitized regulary.
8. Regular checking of physical facilities to ensure that there are no materials on infant formula.
9. Regular checking and fixing of health facilities, nutrition centers, and other points of service delivery to ensure that there are no threats to physical safety, e.g., no beams, doors, or walls in danger of falling on people, no protruding nails, clear corridors and walking spaces to prevent tripping, etc.

Establish referral systems within the health system and with other sectors

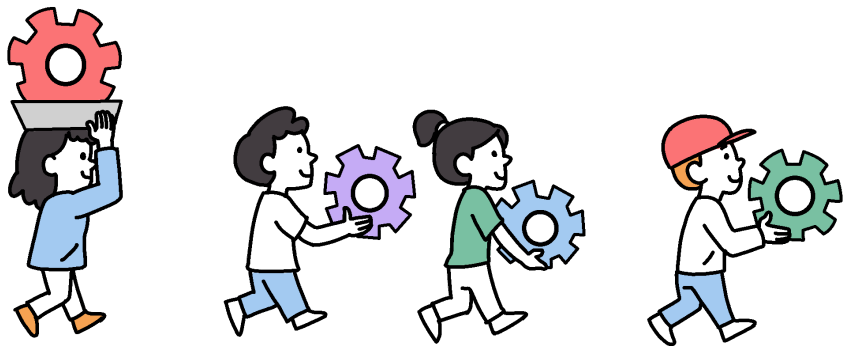
If the City-Wide and Province-Wide Health System (C/PWHS) has been defined, then the presence of a system for referring cases from the primary care to the secondary and tertiary care levels can be safely assumed.

If the C/PWHS has not been defined, the recommended referral system and tools as per DOH Administrative Order No. 2020-0020, "Guidelines on Integration of the Local Health Systems into Province-Wide and City-Wide Health Systems (P/CWHS)" can be adapted. The city/municipal health office can also advocate with the provincial health office to organize the C/PWHS to facilitate integrated service delivery within and across levels of health care.

A similar referral system could be established for referral to services across sectors. For instance, health care providers should know to whom and where to refer cases of violence against women and children at each administrative level.

In the same way, social welfare and development workers should know to whom and where to refer cases that they encounter who need health services.

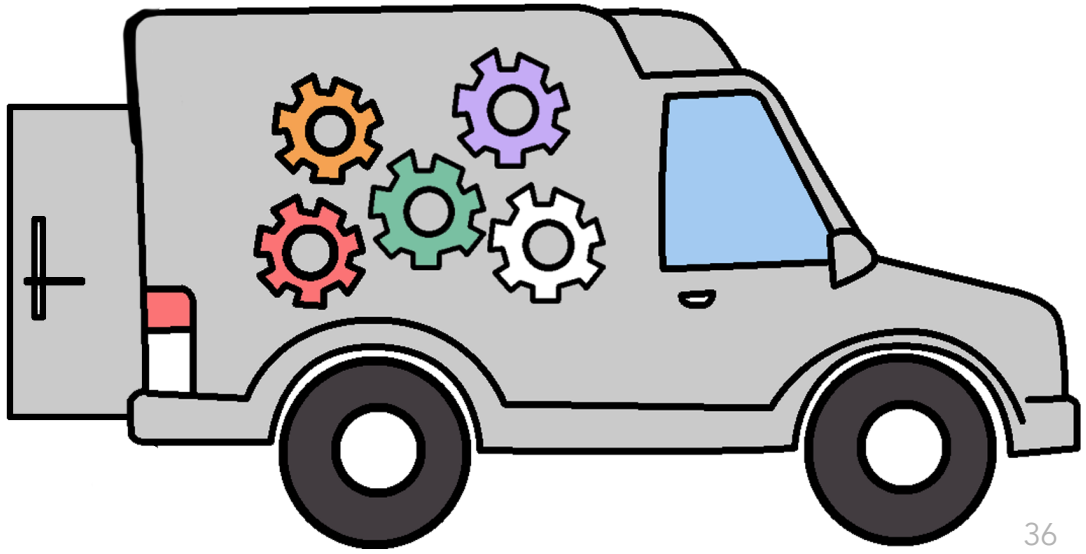
The needed mechanisms to "formalize" the referral across sectors should also be developed.



Synchronize service schedules within and across sectors

This can be done to maximize contacts with those in the F1KD+. For example, health outreach activities on measles immunization could include the administration of vitamin A supplements and the distribution of micronutrient powders.

Community outreach activities can include various services delivered in a common place, e.g., birth registration, delivery of health services (ante-natal care, growth monitoring, check-up, oral care, reproductive health services, etc.), provision of social welfare support, distribution of planting materials, and small animals, parenting support sessions, and many more.

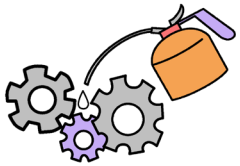


Strengthen Service Delivery

Service delivery can be strengthened through strategies that will increase both the demand for and the availability and quality of services. Since most of the services in the F1KD+ are delivered through the health system,
the MNCHN Manual of Operations (MOP) can be referred to.

Guided by the results of the situational analysis, the following can be done:

Increase demand and use of services



Improve services

Ensure the delivery of services in emergencies/disasters

Adopt local policies to facilitate implementation

Increase Demand and use of services

Based on the situational analysis, and as indicated in the MNCHN MOP, increasing demand can involve:

1. Organizing and mobilizing community health teams or community F1KD+ teams, which can be composed of the midwife, barangay health workers, barangay nutrition scholars, child development worker, and representative of the 4Ps or parent-leaders.
2. Organizing a transportation and communication system to facilitate access to health facilities.
3. Conducting outreach activities.

In addition, the community and target population groups should be constantly reminded of services available, where they are available and when.

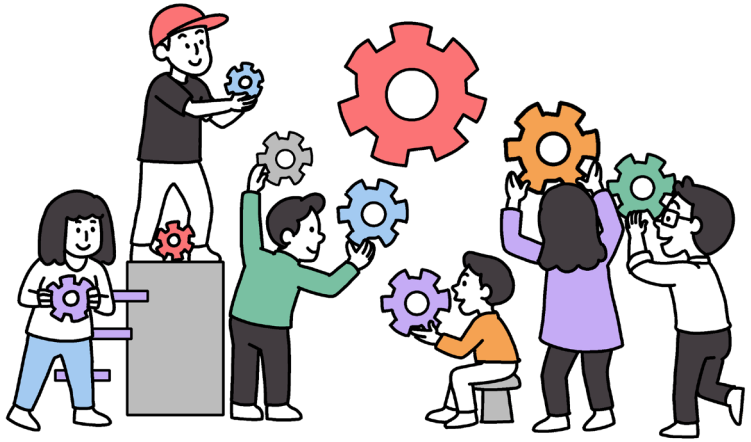
Points of resistance to services should be identified and ways to break through the resistance implemented.

Improve services

The main principle for improving services is addressing gaps along the human resources, infrastructure and equipment, and supplies and logistics. Again, the MNCHN MOP has extensive guidance on this concern. In addition, following the DOH guidance on C/PWHS, Health Care Provider Networks (HCPN), as well as the standards for primary care facilities is important to improve the supply of services.

In the context of RA 11148, the following can be considered:

1. Capacity building of service providers, including community workers and volunteers along the following:
    a. Effective delivery of antenatal care, essential maternal and newborn care and lactation management, among others.
    b. Working with others, breaking down turfs, and keeping communication lines open.
    c. Improving processes related to Operation Timbang Plus.
    d. Effective health/nutrition education, with emphasis on listening and learning; building confidence and giving support skills.
    e. Knowledge on the components of the NCF, e.g., social welfare staff should know more about health and nutrition, those in the health system should know more about social protection, community volunteers should know and understand concepts on WASH and the sanitary inspector about nutrition, etc.
    f. Supportive supervision and mentoring.



2. Ensuring availability and use of supplies such as calibrated weighing scales, validated height boards, mid-upper arm circumference tapes, mother-baby books, checklist on developmental milestones, health/nutrition education cards, vaccines, deworming medicines, supplements (vitamin A capsules, iron-folic acid tablets, micronutrient powder, zinc), ready-to-use supplementary food, among others.
    a. Manage the supply chain, e.g., improve processes to estimate supply requirements, set reasonable cut-off points to trigger re-ordering or re-requesting for supplies, factor in turn-around time for procurement.
    b. When feasible and applicable, tap into community participation in procurement. The "Manual on Community Participation in Government Procurement" and GPPB Resolution 28-2016 can be used as references.
3. Harmonization of parenting support interventions not only to ensure consistency of messages but also to keep stakeholders informed of their related initiatives

Ensure the delivery of services in emergencies/disasters

An emergency is any actual threat to public safety. It is a situation where there is imminent or actual disruption or damage to communities. It is the period characterized by chaos, death, injuries, damage to properties, displacement of families, and inadequate or lack of basic supplies. A disaster, on the other hand, is a serious disruption of the functioning of a community or a society involving human, material, economic, or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources.

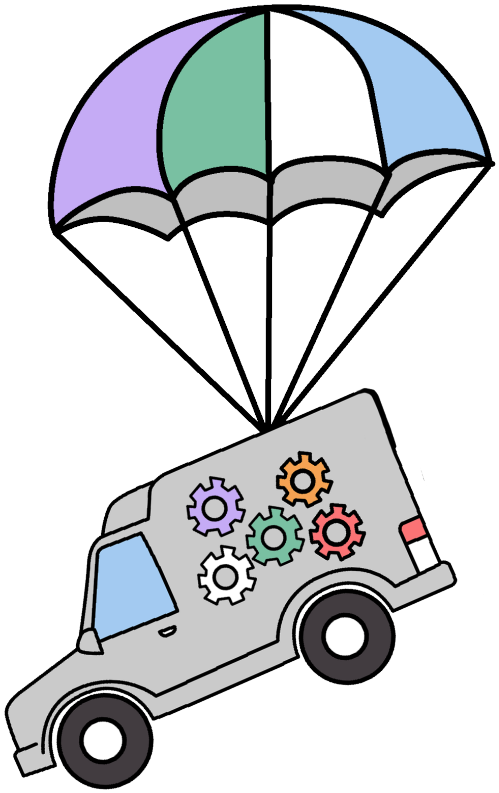
Emergencies and disasters are not new in the Philippines, the country being in the Pacific Rim of Fire and in the pathway of typhoons. The COVID-19 pandemic has added to country experiences related to a long-term medical emergency.

With RA 10121 (2010), or the Philippine Disaster Risk Reduction and Management (DRRM) Act, the Philippines has adopted an approach that is holistic, comprehensive, integrated, and proactive in lessening the socio-economic and environmental impacts of disasters including climate change and promotes the involvement and participation of all sectors/stakeholders concerned.

The same principle is applied to F1KD+ services. Thus, concerns on the F1KD+ should be integrated in DRRM plans and operations.

In emergencies/disasters, services for the F1KD+ should continue to be delivered, with guidance from the following:

1. RA 10821 (2015), "Children's Emergency Relief and Protection Act" and its IRR
2. DOH AO 2017–0007, "Guidelines in the Provision of the Essential Health Service Packages in Emergencies and Disasters"
3. DOH AO 2016-0005 National Policy on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in Health Emergencies and Disasters
4. NNC Governing Board Resolution No. 1, S 2009 on Adopting the National Policy on Nutrition Management in Emergencies and Disasters



During the COVID-19 pandemic, DOH and NNC issued several issuances that call for the continued delivery of services but with appropriate infection control measures.

These issuances are:

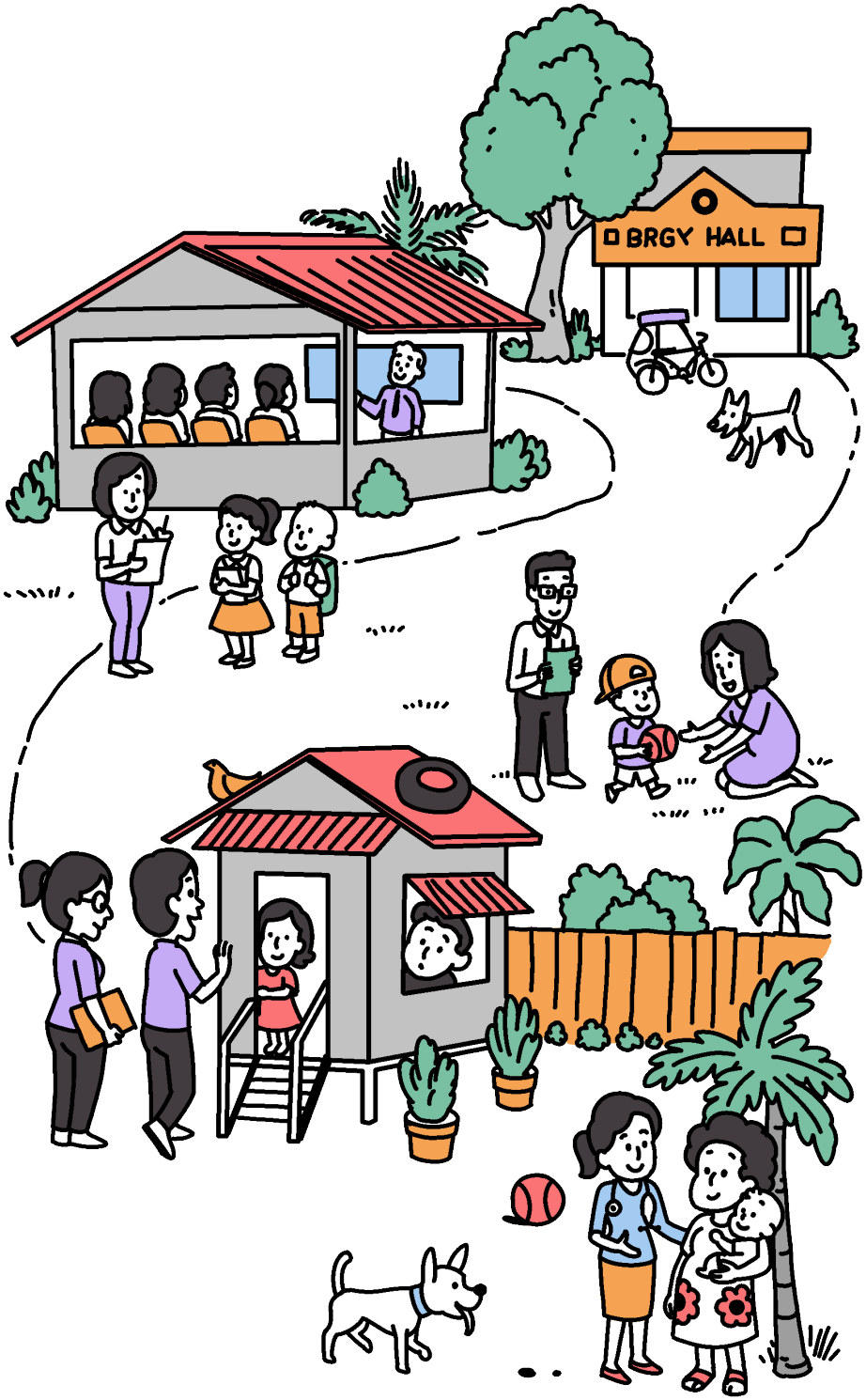
1. Department Circular No. 2020-0167 on the Continuous Provision of Essential Health Services During COVID-19 Epidemic
2. DM 2020-150 - Interim Guidelines for Immunization Services in the Context of COVID-19 Outbreak
3. Department Memorandum (DM) 2020-0237 - Interim Guidelines for the Delivery of Nutrition Services in the Context of COVID-19 Pandemic
4. DM 2020-0341 - Interim Guidelines on Continuous Provision of Adolescent Health Services During COVID-19 Pandemic
5. DM 2020-0319 - Interim Guidelines on COVID-19 Management of Pregnant Women, Women About to Give Birth and Newborns
6. Nutrition Cluster Advisory 1 - Nutrition Cluster Guidelines on LGU Nutrition Actions Relative to COVID-19
7. Nutrition Cluster Advisory 2 - Nutrition Cluster Recommendations on Healthful and Nutritious Family Food Packs and Sustainable Food Sources

To implement Section 11 of RA 11148, section 5, of Rule 9 of the IRR reiterates policies on donations of milk breastmilk substitutes, and/or products covered by the Milk Code, as follows:

1. Such donations, without the approval of the Inter-agency Committee created under EO 51, 2 1986 are prohibited before, during, and after a disaster.
2. Donations of non-breastmilk substitutes (non-BMS) and non-BMS-related products from the private sector with no conflict of interest and not involved in the manufacture of products under EO 51 shall be allowed immediately in the aftermath of disasters and calamities.
3. Provisions of EO 51 will be upheld and options for mothers with breastfeeding problems will be provided.

In relation with the Milk Code and in the context of emergencies, and disasters, the DOH also issued the following:

1. AO 2007-0017 – Guidelines on the Acceptance and Processing of Foreign and Local Donations During Emergency and Disaster Situations. Item VI B of the AO specifies that "Infant formula, breastmilk substitute, feeding bottles, artificial nipples, and teats shall NOT be items for donation. No acceptance of donation shall be issued for any of the enumerated items."
2. DM 2020-0231 – Guidelines on the Standardized Regulation of Donations, Related to Executive Order 51, series of 1986 (The Philippine Milk Code), to Health Facilities and Workers, Local Government Units, Non-Government Organizations, and Private Groups and Individuals in Support to the Response to Emergencies, Disasters, and Situations Where Health and Nutrition of Mothers, Infants, and Young Children are Affected.
3. DC 2020-0217 – Reiteration of DOH DM 2020-0231.



Adopt local policies to facilitate implementation

Section 2, Rule 7 (Program Implementation) of the IRR of RA 11148 indicates that "implementation of the First One Thousand Days Strategy shall be supported by a local resolution or policy form their respective Sangguniang Bayan, Sangguniang Panlunsod, and Sangguniang Barangay.

Local ordinances on the F1KD+ should be informed by the results of the situational analysis, and best practices from other cities. On the next page is a suggested template for a local ordinance on RA 11148.

Some LGUs have adopted their respective ordinances on RA 11148. Two examples that can be referred to are:

1. Malabon City Ordinance No. 08-2018

An Ordinance Providing Strategic Focus on Nutrition for the First 1000 Days of Life Through a Strengthened and Integrated Strategy for Maternal, Newborn, and Child Health and Nutrition and Appropriating Funds Therefore and for other Purposes. Available at: **https://www.nnc.gov.ph/images/abook/NCR_4_Ordinance%20No.%2008-2018_Malabon_NCR.pdf**

2. Navotas City Ordinance No. 2018-02

An Ordinance Creating the Navotas First 1000 Days of Life Program (N1k) and its Adoption in All Barangays of the City of Navotas; available at **https://www.nnc.gov.ph/images/abook/NCR_7_Ordinance%20No.%202018-02_Navotas_NCR.pdf**

A Suggested Template For An Ordinance To Localize RA 11148[11]

Local Ordinance Sections

1. Title
2. Declaration of Policy
3. Objectives
4. Coverage
5. Definition of Terms
6. Responsibilities of the Parties
7. Description of First 1000 Days Plus
8. Programs and Services for F1KD+
9. Nutrition in the Aftermath of a Natural/Human-Induced Emergency and Disaster
10. Capacity Building of Barangay Health and Nutrition Workers and the F1KD+
11. Implementing Rules and Regulations
12. Appropriations
13. Separability Clause
14. Repealing clause
15. Effectivity

Section 1 Title

This section simply contains the title of the ordinance.

Example:
Adoption of the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act in (name of city/municipality).

Section 2 Declaration of Policy

This section provides the rationale and policy basis for the proposed ordinance. Either add the whole of Section 2 of RA 11148 or have a statement, "As per Section 2 of RA 11148."

This section could also include related ordinances on which the ordinance on RA 11148 could be anchored on.

Section 3 Objectives

This section contains the aims of the ordinance.

The LGU may choose to localize objectives of RA 11148, e.g., rephrase so that the reference is to the city/municipality and not the national level. Also, references to the age group 0-24 months old can be modified to 0-35 months old.

Section 4 Coverage

This section contains the target beneficiaries and geographic coverage of the F1KD+ programs.

Please note that the coverage by population group cannot be changed. However, the LGU may indicate the need to prioritize barangays, and the basis for prioritization, etc.

Also, ensure that the age coverage is "0-35 months old."

Section 5 Definition of Terms

This section may be lifted from the F1KD+ IRR but updated to include other terms referred to in the ordinance.

11 Adapted from the templates developed by Save the Children as part of its efforts in localizing the implementation of RA 11148

Section 6 Responsibilities of the Parties

This section should detail the roles and responsibilities of the different stakeholders with regard to the F1KD+ strategy.

These include the following:

1. City/municipal mayor
2. City/municipal health officer
3. City/municipal nutrition action officer
4. HCPN of the city/municipality
5. Health care facilities in the City-wide, province-wide health system (particularly the portion of the municipality)
6. City/municipal health board
7. City/municipal nutrition committee
8. Specific offices or departments of the city/municipality, e.g., member agencies of the local nutrition committee
9. Sangguniang Panlunsod/ Panlalawigan/Bayan/Barangay
10. Civil society organizations
11. Private sector

Section 7

Description of First 1000 Days Plus

This can be lifted from the F1KD+ Law IRR.

Section 8

Programs and Services for F1KD+

This contains the health and nutrition programs and services that must be provided by the LGU up to the barangay level. This includes F1KD+ programs and services during emergency situations. Refer to **Annex 1** for the list of program components (or services) indicated in RA 11148.

Section 9

Nutrition in the Aftermath of a Natural/ Human-Induced Emergency & Disaster

This section details the priority F1KD+ services that have to be delivered in emergencies and disasters

Section 10

Capacity Building of Barangay Health and Nutrition Workers and the F1KD+

This section highlights the need for capacity building programs for F1KD+ personnel, particularly those working at the barangay level.

Section 11 Implementing Rules and Regulations

This section would indicate that IRR will be developed, who will develop them, and by when.

Section 12 Appropriations

This section details the budget needed for the implementation of the F1KD+-related programs and projects as well as funding sources.

Section 13 Separability Clause

This indicates that the provisions of the ordinance are severable, i.e., an invalid section does not invalidate the entire ordinance.

Section 14 Repealing Clause

This is a clause that states that the local ordinance repeals other issuances, ordinances, executive orders, and administrative orders that are inconsistent with the provisions of the ordinance.

Section 15 Effectivity

This section details the effectivity of the ordinance. It can also include provisions for review of implementation every five years.

There should also be efforts to ensure that the ordinance is passed. These efforts could include the following:

1. Identify a potential sponsor in the Sanggunian
2. Work with the sponsor and his/her staff in crafting and refining the ordinance
3. Provide technical assistance in hearings
4. Identify potential non-supporters and find ways to reach out to convince them to support the proposed ordinance
5. Prepare policy and program briefs on background information on proposed issuances for the LCE, and members of the local Sanggunian
6. Generate position papers and statements of support from various stakeholders
7. Follow closely the progress of a proposed ordinance or resolution, and pursue actions to hasten adoption

The city/municipal nutrition action officer should anchor the efforts to push for the approval of the ordinance.

A related effort is to determine if additional ordinances are needed to improve the integrated delivery of F1KD+ services.

The NNC has a Compendium of Local Ordinances and Issuances on Nutrition (**https://www.nnc.gov.ph/policy-database**) that can serve as a reference if and when LGUs decide to have an ordinance on nutrition.

Knowing rules, regulations, and procedures related to local legislation as defined by the Local Government Code of 1991, specifically Chapter 3 on Local Legislation will be helpful.

Strengthen Monitoring and Evaluation

There are existing mechanisms for monitoring concerns on the F1KD+ in the different sectors. These include the FHSIS, the LGU Health Scorecard, MELLPI Pro, and the required quarterly reporting on nutrition programs per DILG MC 2018-42. Related information from these systems can be put together to have a view of the evolving situation on the F1KD+.

Who will be the main monitor?

Since local nutrition committees have been assigned to provide the basic mechanism for sectoral collaboration and partnership in the implementation of the F1KD+ strategy (IRR of RA 11148, item d of Rule 6 on Cross-Cutting Components), they shall be the main monitor. As such, reports on F1KD+ concerns should be submitted to the Provincial/City/Municipal Nutrition Committee through the Provincial/City/ Municipal Nutrition Action Officer (P/C/MNAO).

What questions should monitoring and evaluation answer?

Monitoring should answer the following questions.

1. What is the status of services being delivered compared to the target? Plan?
2. What specific services are not being delivered as desired and as targeted?
3. What specific population groups and geographic areas are not being covered adequately by which specific services?
4. What factors are hindering the delivery of services?
   - Supply of service?
   - Demand for service?
   - Breakdown in the HCPN?
   - Breakdown in the C/PWHS?
   - Lack of coordination across sectors?
5. How much funds were allocated for the F1KD+ services? How much of the allocated funds used?
6. What should be done to correct the situation in the next quarter? Who will be in charge?
7. Are longer-term measures needed? If so, what are these? Who will be in charge?

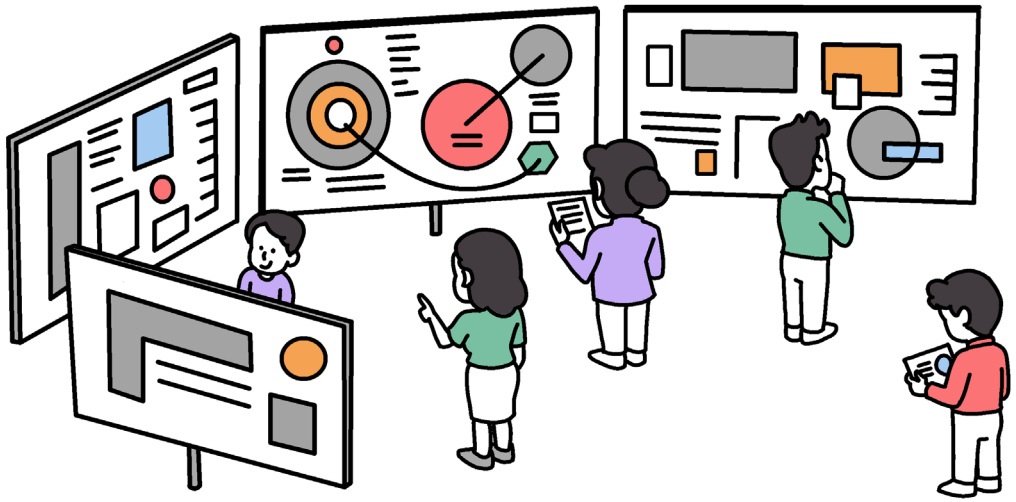
Evaluation, usually done at the end of the year, looks into the extent to which outcome targets have been achieved. Evaluation processes also look into the same concerns as monitoring. They should also identify corrective measures that should be applied in the next implementation cycle.

What indicators will be monitored?

Table 4 lists a set of indicators that should be monitored for which reports should be prepared and submitted to the P/C/M/BNC. The indicators in the list are outcome, sub-outcome, and some output indicators. The LGU may identify additional indicators to add in the list. It is also to be noted that these are indicators related to the F1KD+ and could be considered a sub-set of the indicators monitored by the P/C/M/BNC. Furthermore, the national level is constantly reviewing and revising indicator systems and such changes should be noted and adopted at the city/municipal level.

What is the flow of reporting?

Since indicators are generated by existing systems, the vertical flow of data through these systems should be followed. However, such data are shared with the corresponding local nutrition committee and the NNC (**Figure 3**).



How can monitoring be strengthened?

Monitoring of F1KD+ services can be strengthened in several ways as follows:

1. Improve the quality (completeness, correctness) of data recording tools of data sources by doing regular data quality audits.
   Annex C of the MNCHN MOP can be referred to for data quality checks. Similar checks for OPT Plus is being developed and will be shared once available.
2. Ensure submission of reports as per agreed schedule.
3. Prepare reports regularly and disseminate accordingly.
4. Within each agency, conduct internal reviews that will answer the questions listed in the section on "What questions should monitoring and evaluation answer?".
5. Include in the agenda of quarterly meetings of the C/MNC an agenda item on the status of F1KD+ services. See **Annex 4** for a suggested way of handling the agenda item.
6. Conduct field monitoring.
   Having an inter-agency team for field monitoring is ideal to allow a shared view of the situation at the ground level. Field monitoring helps identify issues affecting service delivery that numbers do not capture. In addition, troubleshooting of issues will also be facilitated. These field monitoring activities can also be used for supportive supervision. Having a monitoring checklist is also useful.
7. Ensure that issues identified by monitoring are linked with corrective measures and that the implementation of these corrective measures are also monitored. **Annex 5** provides a list of possible action lines for common service delivery issues.

TABLE 4

Indicators for Monitoring F1KD+ Services

GOOD HEALTH

Indicator	Report source	Frequency of reporting to LNC
1. Number of maternal deaths	Local FHSIS	Semi-annually
2. Number of deaths among under-fives	Local FHSIS	Semi-annually
3. Number of deaths among infants	Local FHSIS	Semi-annually
4. Number of deaths among newborns	Local FHSIS	Semi-annually
5. Proportion of pregnant women who received four or more antenatal care visits	Local FHSIS	Quarterly
6. Proportion of pregnant women who were dewormed	Local FHSIS	Quarterly
7. Proportion of pregnant women who received 2 doses of tetanus-containing vaccines	Local FHSIS	Quarterly
8. Proportion of live births that are Facility-Based Deliveries (FBD)	Local FHSIS	Quarterly
9. Proportion of mothers with at least 2 or more postpartum visits to a health facility	Local FHSIS	Quarterly
10. Number of current users of modern contraceptive prevalence rate	Local FHSIS	Quarterly
11. Number of adolescent pregnancies, 10-14 years old	Local FHSIS	Semi-annually
12. Number of adolescent pregnancies, 15-19 years old	Local FHSIS	Semi-annually
13. Proportion of newborns who underwent newborn screening	Local FHSIS	Semi-annually
14. Proportion of children fully immunized (FIC)	Local FHSIS	Semi-annually
15. Proportion of cases of diarrhea among 0-59 months old receiving oral rehydration salts with zinc	Local FHSIS	Quarterly
16. Proportion of cases of pneumonia among 0-59 months old completing treatment	Local FHSIS	Quarterly

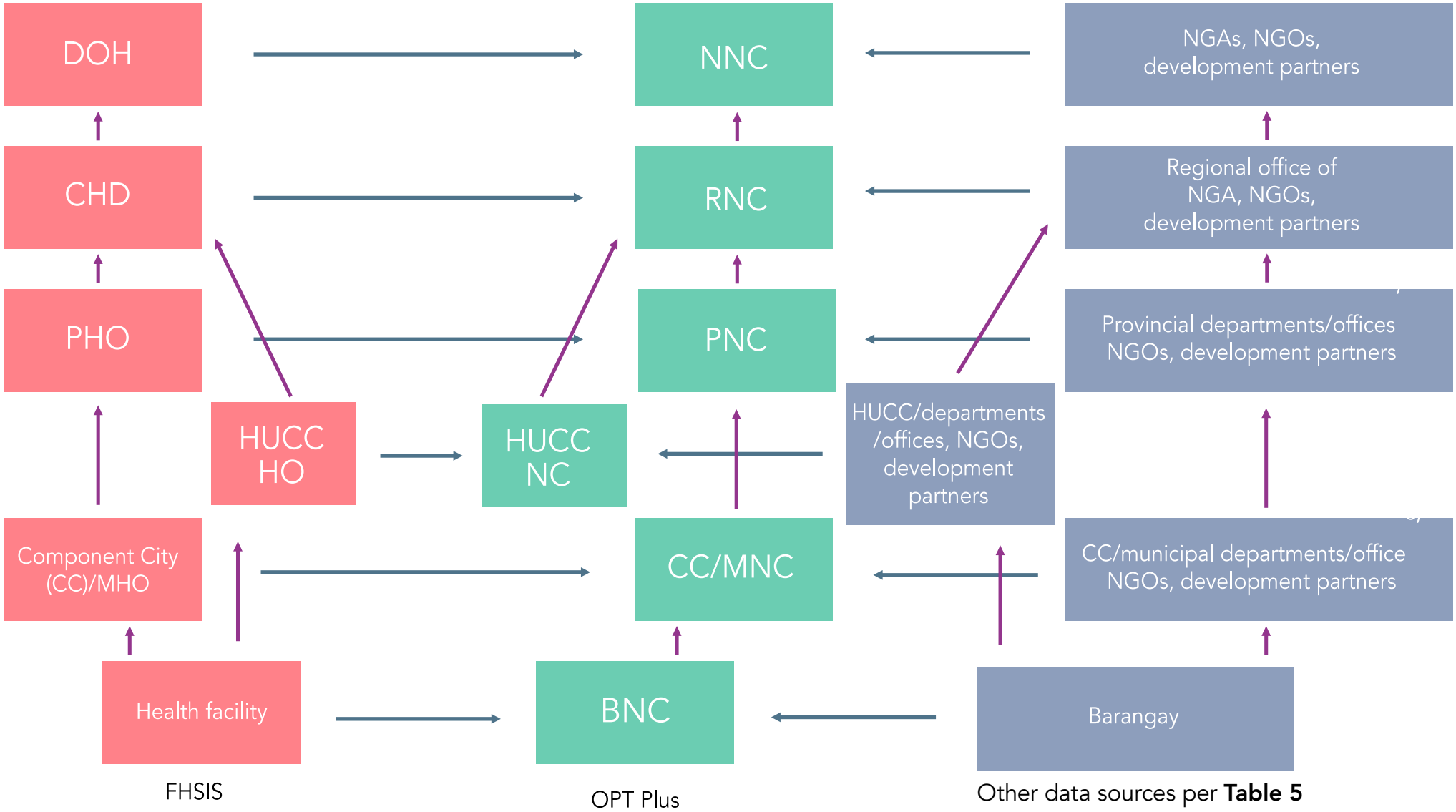
ADEQUATE NUTRITION

Indicator	Report source	Frequency of reporting to LNC
17. Number and prevalence of stunting among children 0-35 months old	OPT Plus	Annually
18. Number and prevalence of wasting among children 0-35 months old	OPT Plus	Annually
19. Number and prevalence of overweight and obesity among children 0-35 months old	OPT Plus	Annually
20. Proportion of newborns initiated on breastfeeding immediately after birth for at least 90 minutes	Local FHSIS	Semi-annual
21. Proportion of infants exclusively breastfed until 6th month	Local FHSIS	Semi-annual
22. Proportion of infants who continued breastfeeding and were introduced to complementary feeding beginning at 6 months of age	Local FHSIS	Semi-annually
23. Proportion of pregnant women, 10-14 years old with low BMI	Local FHSIS	Quarterly
24. Proportion of pregnant women, 15-19 years old with low BMI	Local FHSIS	Quarterly
25. Proportion of pregnant women, 20-49 years old with low BMI	Local FHSIS	Semi-annually
26. Proportion of pregnant women, 10-14 years old with high BMI	Local FHSIS	Quarterly
27. Proportion of pregnant women, 15-19 years old with high BMI	Local FHSIS	Quarterly
28. Proportion of pregnant women, 20-49 years old with high BMI	Local FHSIS	Quarterly
29. Proportion of live births who weigh less than 2500 grams as a percentage	Local FHSIS	Quarterly
30. Proportion of infants born preterm or with low birth weight given iron supplements	Local FHSIS	Quarterly
31. Number of pregnant women who completed the dose of iron-folic acid supplementation	Local FHSIS	Quarterly
32. Number of post-partum women with post-partum vitamin A supplementation	Local FHSIS	Quarterly
33. Proportion of infants/children (6-23 months old) who completed Vitamin A supplementation	Local FHSIS	Quarterly
34. Proportion of high-risk infants and children with measles and/or persistent diarrhea who received Vitamin A capsule aside from routine supplementation	Local FHSIS	Quarterly
35. Proportion of infants 6-11 months old and children 12-23 months old who completed micronutrient powder (MNP) supplementation	Local FHSIS	Quarterly
36. Percent of nutritionally-at-risk pregnant women completing dietary supplementation	LGU implementing agency	Quarterly
37. Percent of infants 6-23 months old completing dietary supplementation	LGU implementing agency	Quarterly
38. Percent of pregnant women, and mothers, fathers or caregivers of infants 0-35 months old completing the Idol Ko si Nanay Learning Sessions or similar learning sessions	LGU implementing agency	Quarterly
39. Percent of wasted infants and young children 0-59 months old admitted in OTC or ITC	Local FHSIS	Quarterly

Indicator numbers 36-38 to be monitored only if the LGU has planned for these activities.

Indicator	Report source	Frequency of reporting to LNC
RESPONSIVE CAREGIVING		
40. Proportion of children under 12 months old who are on track with respect to developmental milestones	C/MHO	Semi-annually
41. Proportion of husbands/partners of pregnant women, and fathers of infants and children 0-35 months old participating in ERPAT, FDS, PES, and other related or similar activities	LGU social welfare and development office and CSOs operating CDCs, SNP, and other forms of ELPs	Quarterly
42. Percentage of children between 0 to 35 years old who are identified with a disability, and are referred to appropriate disability services	C/MHO	Semi-annually
EARLY LEARNING		
43. Participation rate of 24-35 months old in Early Learning Programs (ELPs), Child Development Centers (CDC), Supervised Neighborhood Play (SNP), and other alternative forms of ELPs	LGU social welfare and development office and other local agency or CSO providing livelihood assistance	Quarterly
SAFETY AND SECURITY		
44. Proportion of households with those in the first 1000 days that receive inputs for livelihood assistance (inputs refers to training, seed capital or inputs to improve existing livelihood activities)	LGU social welfare and development office and other local agency or CSO providing livelihood assistance	Quarterly
45. Proportion of households with those in the first 1000 days that receive inputs for home gardening	Local agriculture office	Quarterly
46. Proportion of households with those in the first 1000 days that receive support in crisis situations	Local social welfare and development office	Quarterly
47. Proportion of households with access to basic safe water supply	Local FHSIS	Semi-annually
48. Proportion of households using safely managed drinking-water services	Local FHSIS	Semi-annually
49. Proportion of households with basic sanitation facility	Local FHSIS	Semi-annually
50. Proportion of households using safely managed sanitation services	Local FHSIS	Semi-annually
51. Proportion of barangays declared Zero Open Defecation (ZOD) areas	Local FHSIS	Semi-annually

FIGURE 3 Flow of Reporting for Monitoring F1KD+ Services

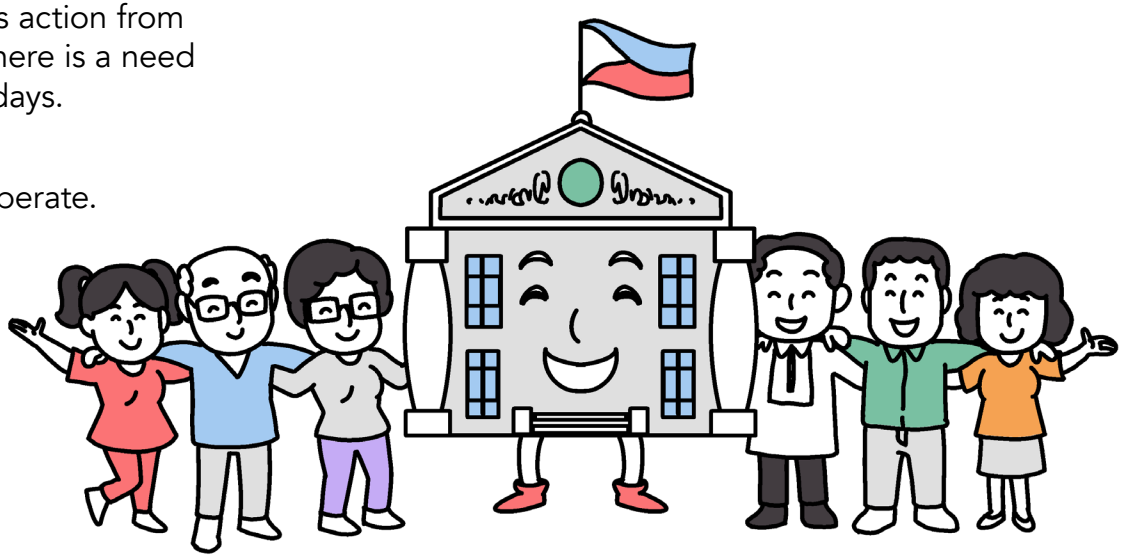


Advocate for Whole-of-Government Action

Implementing RA 11148, like all development programs, requires action from the whole of government and the whole of society. Therefore, there is a need to constantly make a case for needed actions for the first 1000 days. Thus, advocacy is integral to the implementation of RA 11148.

Advocacy activities, to be effective, should be planned and deliberate. The following is a framework that can be used in planning and implementing these advocacy efforts.

The advocacy action should start with the identification of the issue that needs to be resolved and can be resolved with the help of advocacy. When such has been identified, the following can be used to plan and implement the advocacy effort.



A. Identify and characterize the audience or the person, institution or stakeholder that can act on the issue.

B. Determine and be clear on the specific behavior (e.g., not just support F1KD+ strategy but more specific behaviors indicative of support, e.g., issue an executive order, or allocate funds or hire more community workers, etc. requested of the audience)

C. Determine information that needs to be conveyed to the target audience. In many cases, information on the situation of those in the F1KD+ is needed, together with information on the consequences of the situation.

D. Determine the design of the advocacy or how the information will be communicated to the target audience. This can be through mix of face-to-face interaction that use compelling audio-visual support, and use of other channels like television, radio, social media. Design of the advocacy includes determining the tone that will be used, e.g., Logical? Emotional? Mix of logical and emotional?

E. Evaluate the advocacy effort by determining if it resulted in the desired behavior. If not, assess why not and adjust accordingly.

Annex 9 shows how this framework can be used.

PART FOUR

Roles and Responsibilities

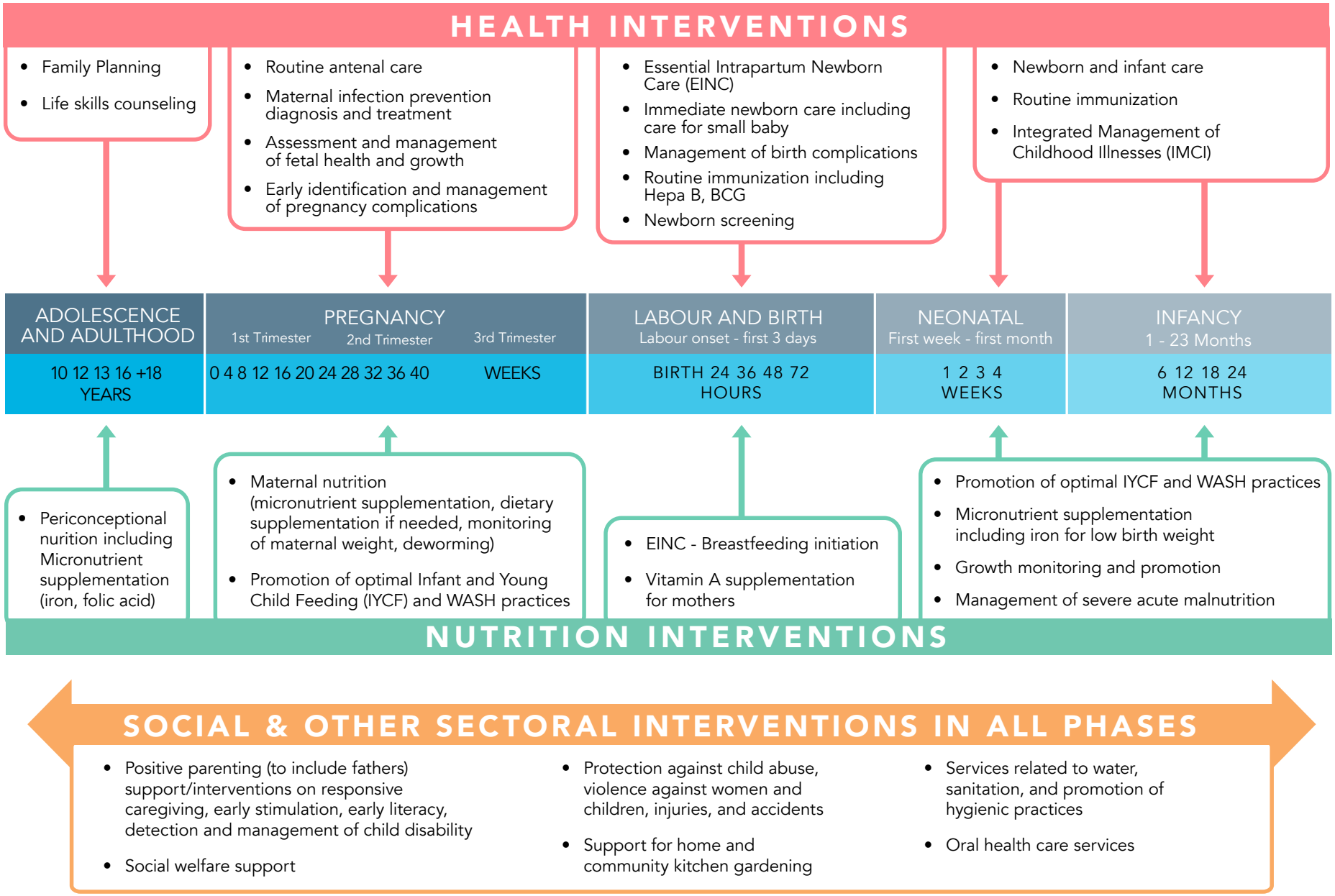
This section discusses the roles and responsibilities of stakeholders involved in implementing RA 11148. It presents the roles and responsibilities for the city/ municipal and barangay levels and for the other levels to support the implementing levels.

The specification of roles and responsibilities continues to be in the context of integrated service delivery, i.e., ensuring that those in the F1KD+ receive the services they need when they need the service, "in ways that are user-friendly, achieve the desired results, and provide value for money."

As a review, **Figure 4** shows the range of health and nutrition services that are needed through the F1KD+. It also includes all the services through all the stages of the F1KD+. Specifics of these services are found in **Annex 1.**

FIGURE 4

Overview Of Program Components By Life Stage

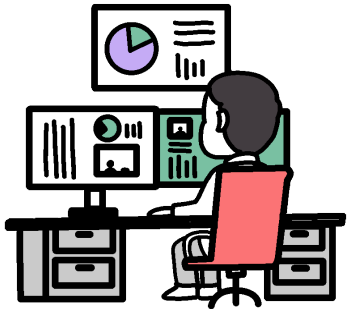


Roles And Responsibilities At The Barangay Level

Barangay Nutrition Committee

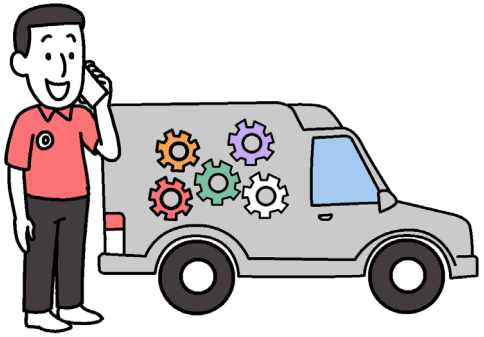
Under the leadership of the barangay chairperson,

1. Formulate the barangay nutrition action plan that should include all related services as per RA 11148. While there are no guidelines for barangay nutrition planning, the guidelines for city/municipal nutrition action plans can be adapted to the situation of the barangay.



2. Monitor the implementation of the barangay nutrition action plan by preparing and reviewing quarterly progress reports, holding quarterly meetings to discuss progress, and conducting on-site visits of projects.

3. Coordinate the implementation of the barangay nutrition action plan by making sure that responsibilities are clearly delineated among the frontline workers, resolving implementation issues that may arise.



4. Reach out to other groups in the barangay for the delivery of complementary services.

Barangay Health Station

1. Deliver quality health and services for the F1KD+, and ensure the following:
   a. Compliance to DOH guidelines on primary care
   b. Compliance to DOH guidelines on specific services
   c. Connection with the other health facilities in the city-wide health system or the province-wide health system
   d. Compliance to the Milk Code, e.g., no paraphernalia (ballpen, calendar, poster, other merchandising materials) on infant formula in the barangay health station
   e. Availability of supplies such as calibrated weighing scales, validated height boards, mid-upper arm circumference tapes, mother-baby books, checklist on developmental milestones, health/nutrition education cards, vaccines, deworming medicines, supplements (vitamin A capsules, iron-folic acid tablets, micronutrient powder, zinc), ready-to-use supplementary food, among others
   f. Availability of toys and other learning materials for infants and young children
   g. Safety and security in the barangay health station

2. Conduct campaigns to improve use of health and nutrition services
3. Coordinate with barangay officials on concerns to improve use of health services, e.g., transport facilities for pregnant women about to deliver; also, to refer cases of suspected maternal or child abuse
4. Record services in DOH-prescribed recording tools
5. Prepare and submit FHSIS reports to RHU and the BNC, and more importantly review of these reports to help improve service delivery

Frontline Workers

In the Philippines, there are three main frontline workers involved in the F1KD+ —the Barangay Nutrition Scholar, Barangay Health Worker, and Child Development Worker.

The Barangay Nutrition Scholar (BNS) is a trained community worker who voluntarily renders nutrition services and other related activities in the barangay.

There should be at least one BNS/barangay.

The Barangay Health Worker is a trained community worker who voluntarily renders primary health care services and other related activities in the community.

There should be one BHW for every 25 households.

The Child Care Worker in child development centers is a community worker trained to provide supplemental parental care and early childhood enrichment activities to ensure that physical, cognitive, social, and emotional needs of children are being addressed.

Table 5 shows activities that these frontline workers undertake in the context of the F1KD+. The list is not complete. In addition, these activities are done in a particular context, i.e., the situation of the barangay and how F1KD+ services are delivered.

Many of the possible activities of the BNS and BHW are the same. Thus, there is a need to ensure that their activities do not overlap, cause unnecessary conflicts among workers, and confuse the target groups. Certain actions should be done consciously to maximize the participation of frontline workers in implementing the law.

Thus, these frontline workers can do one or more of the following:

1. Constantly be in touch with each other. They could hold regular meet-ups, exchange information via SMS, and in some instances even have a Viber group or Facebook Group Chat. Being in touch could also include the midwife or a health service provider (In fact, the meet-ups could be organized by the midwife) to facilitate referral and related concerns. Being in touch can cover specific concerns:

    a. Agreeing on who will do what, when, and how often. This can help delineate what specific activity each one will do. The delineation can also be in terms of specific areas in the barangay to cover. For example, BHWs may be assigned to do home visits in their respective 25-household groups. BNSs may be assigned to do reinforcement visits to those needing more assistance. The delineation can also be on agreeing schedule of deployment in the healthy facility.

    b. Sharing progress of assisting the target population that can cover high points, e.g., successes in making caregivers adopt desired behaviors, or low points, e.g., challenges in making caregivers adopt desired behaviors, and strategies that can be done to address these challenges.

    c. Identifying who are not availing of services as desired and agreeing on what can be done to correct the situation.

    d. Sharing areas of expertise as appropriate.

2. Use a common family profile to allow each frontline to see the holistic needs of a family with a member who is within the first 1000 days.

3. Use a common tool for recording home visits.

TABLE 5 F1KD+-Related Activities Undertaken By Frontline Workers

ANTENATAL

BARANGAY NUTRITION SCHOLAR

1. Assist in identifying pregnant women and coordinate with the BHW and midwife on updating the Pregnancy Tracking Form and Master List of Pregnant Women
2. Assist the BHW and midwife in encouraging pregnant women to go to the health center for antenatal care
3. Identify from the master list the nutritionally-at-risk pregnant women and enroll them to dietary supplementation program, if available
4. Assist in weighing and measuring height of pregnant women in health centers during antenatal care visits, also in recording information in the appropriate form as may be assigned
5. Assist in activities related to dietary supplementation of pregnant women, e.g., identify targets, hold dialogues with beneficiaries on the design of the program, packing and distribution of food packs, buying, preparing and serving food, keeping feeding center clean, weighing and measuring height of pregnant women enrolled in dietary supplementation program
6. Assist the BHW and midwife in educating pregnant women on good nutrition during pregnancy and in encouraging them to breastfeed their babies, perform early stimulation of the fetus, avoid risk-taking behaviors, smoking cessation, adopt healthy lifestyle practices, and avail of family planning services
7. Assist in packing iron-folic acid supplements for distribution to pregnant women
8. Assist BHW in conducting home visits to check on use of iron-folic acid supplements and multiple micronutrient powders and in encouraging regular use of these commodities

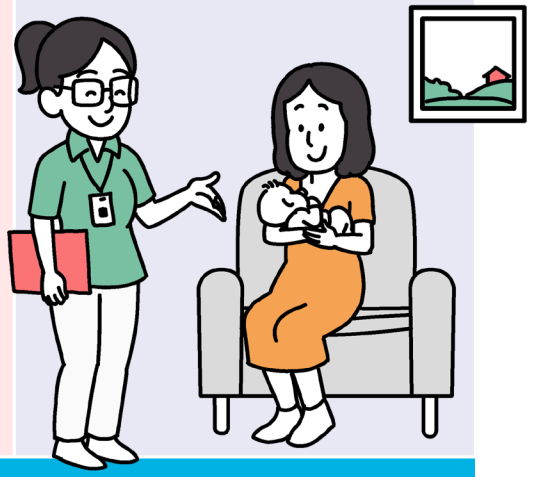
BARANGAY HEALTH WORKER

1. Assist in identifying pregnant women and coordinate with the BNS and midwife on updating the Pregnancy Tracking Form and Master List of Pregnant Women
2. Encourage pregnant women to go to the health center for antenatal care
3. Coordinate with the BNS regarding the enrollment of nutritionally-at-risk pregnant women to dietary supplementation program, if available
4. Assist in weighing and measuring height of pregnant women in health centers during antenatal care visits, also in recording information in the appropriate form
5. Assist the midwife in educating pregnant women on good nutrition, preparations for breastfeeding, avoidance of risk-taking behaviors, smoking cessation, adoption of healthy lifestyle practices, early stimulation of the fetus during both ante-natal visits and home visits and possible post-partum family planning method to use based on felt need
6. Assist in packing iron-folic acid supplements for distribution to pregnant women
7. Track consumption of and encourage regular use of iron-folic acid supplements, multiple micronutrient powder, and other commodities intended for pregnant women and children 6-35 months old especially during home visits

CHILD CARE WORKER

1. Know who of the mothers or caregivers of children in CDCs or day care centers are pregnant
2. Inform the BNS and BHW of the name of the pregnant women
3. Advise the pregnant woman to go to the health center for antenatal care
4. Include in Parents Effectiveness Sessions reminders to pregnant women to go to the health center for antenatal care
5. Assist BHWs and BNSs on messages to pregnant women on early stimulation of the fetus
6. Advise pregnant women visiting CDCs to take in daily their iron-folic acid supplement

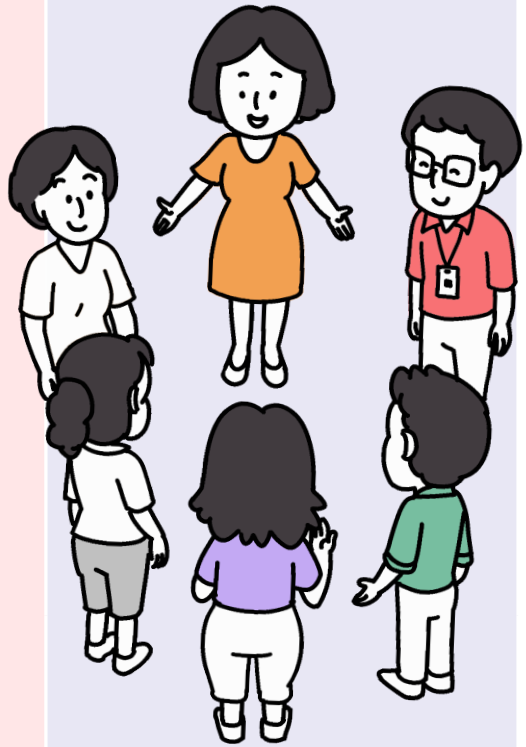
BIRTH AND NEWBORN PERIOD

BARANGAY NUTRITION SCHOLAR	BARANGAY HEALTH WORKER	CHILD CARE WORKER
9. Assist in LGU birthing facilities, as may be assigned, e.g., assist mothers in initiating breastfeeding 10. Visit mothers within the first month of delivery to assist in breastfeeding concerns as needed, integrate too messages on how breastfeeding sessions can be used for early stimulation of the infant through talking and singing, etc.; remind and encourage the mother to bring infant to health center for immunization	8. Assist in LGU birthing facilities, as may be assigned, e.g., assist mothers in initiating breastfeeding 9. Visit mothers within the first month of delivery to assist in breastfeeding concerns as needed, integrate too messages on how breastfeeding sessions can be used for early stimulation of the infant through talking and singing, etc.; remind and encourage the mother to bring infant to health center for immunization	

FIRST SIX MONTHS OF INFANCY

11. Assist in the organization of IYCF support groups in the barangay 12. Assist BHW in holding dialogues and meetings with IYCF support groups to share experiences and address issues and concerns that arise 13. Visit mothers with infants in the first six months of life for breastfeeding education and follow-up, also for education on good nutrition for the lactating mother; visits could also cover how breastfeeding sessions can be used for early stimulation of the infant through talking and singing, etc.	10. Lead in the organization of IYCF support groups in the barangay 11. Assist in holding dialogues and meetings with IYCF support groups to share experiences and address issues that arise, remind pregnant women of need for the continuous consumption of iron-folic acid tablets 12. Visit mothers with infants in the first six months of life for breastfeeding education and follow-up, also for education on good nutrition for the lactating mother; visits could also cover how breastfeeding sessions can be used for early stimulation of the infant through talking and singing, etc.	

INFANTS 6 MONTHS UP TO TWO YEARS OF AGE

BARANGAY NUTRITION SCHOLAR	BARANGAY HEALTH WORKER	CHILD CARE WORKER
14. Assist the BHW in sustaining the activities and meetings of the IYCF support groups in the barangay especially holding dialogues and addressing issues that arise 15. Visit mothers with children 6-35 months old and educate on appropriate complementary feeding practices with continued breastfeeding, e.g., visits to mothers with infants 6 months old could initially focus on the message of start giving other solid-or semi-solid foods with continued breastfeeding and subsequent visits could focus on specific messages depending on the situation of the family, e.g., ensure thickness of lugaw or porridge, add other food items, how to practice responsive feeding, how to use feeding sessions for early stimulation. Visits could also include other suggestions to mothers on early stimulation of the infant as well as reminders and encouragement to avail of immunization, vitamin A supplementation, deworming, oral health, and growth monitoring	13. Lead, under the supervision of the midwife, in sustaining the activities and meetings of the IYCF support groups in the barangay especially holding dialogues and addressing issues that arise 14. Visit mothers with children 6-35 months old and educate on appropriate complementary feeding practices with continued breastfeeding, e.g., visits to mothers with infants 6 months old could initially focus on the message of start giving other solid-or semi-solid foods with continued breastfeeding and subsequent visits could focus on specific messages depending on the situation of the family, e.g., ensure thickness of lugaw or porridge, add other food items, how to practice responsive feeding, how to use feeding sessions for early stimulation. Visits could also include suggestions to mothers on early stimulation of the infant; follow up on immunization, Vitamin A supplementation, deworming, oral health and growth monitoring	 

THROUGHOUT THE F1KD+

BARANGAY NUTRITION SCHOLAR

16. Weigh and measure height of children 0-35 months old as part of annual Operation Timbang Plus, growth monitoring, or activities related to nutrition in emergencies
17. Determine weight and height status of children measured
18. Prepare relevant OPT Plus report
19. Assist in administering the Nurturing Care Risk Factor Checklist for Early Childhood Development and the Core Development Milestones Checklist for children 0-35 months old and refer cases to the midwife so the case can be referred to the RHU doctor for further assessment

20. Assist parents in identifying activities for play for early learning using community and indigenous resources
21. Assist in activities related to dietary supplementation of young children 6-23 months, e.g., identify targets, hold dialogues with beneficiaries' caregivers on the design of the program, packing and distribution of food packs, buying, preparing and serving food, keeping feeding center clean

BARANGAY HEALTH WORKER

15. Assist in weighing and measuring height of children 0-35 months old as part of annual Operation Timbang Plus and of growth monitoring
16. Determine weight and height status of children measured
17. Assist in administering the Nurturing Care Risk Factor Checklist for Early Childhood Development and the Core Development Milestones Checklist for children 0-35 months old and refer cases to the midwife so the case can be referred to the RHU doctor for further assessment
18. Assist parents in identifying activities for play for early learning using community and indigenous resources
19. Assist parents in identifying activities for play for early learning using community and indigenous resources
20. Assist in activities related to dietary supplementation of young children 6-23 months, e.g., identify targets, remind mothers to regularly participate in the dietary supplementation program

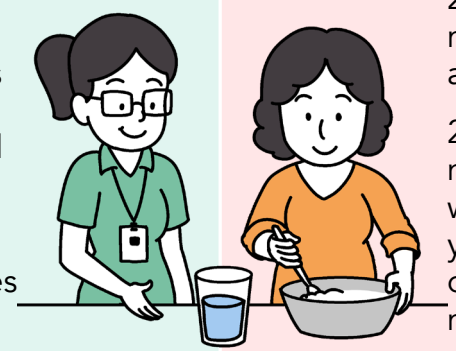
CHILD CARE WORKER

7. Assist in administering the Nurturing Care Risk Factor Checklist for Early Childhood Development and the Core Development Milestones Checklist for children 0-35 months old and refer cases to the midwife so the case can be referred to the RHU doctor for further assessment
8. Assist BNSs, BHWs, and parents in identifying activities for play for early learning using community and indigenous resources

THROUGHOUT THE F1KD+

BARANGAY NUTRITION SCHOLAR

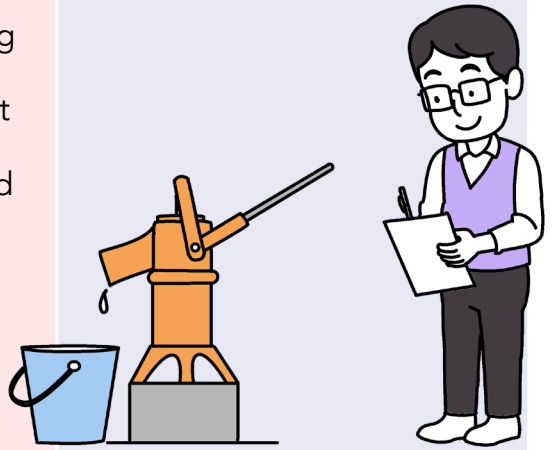
22. Assist wasted children in accessing outpatient care facilities for management of acute malnutrition, assist in the subsequent distribution of RUTF or RUSF and other activities of the OTC as may be needed, also in the follow up of child at home to measure height and weight or MUAC, as may be assigned
23. Refer to sanitary inspector families visited not having access to water supply, handwashing facilities, and sanitary toilet
24. Coordinate with city/municipal level on organizing nutrition classes for pregnant women or mothers with children 0-3 years old
25. Watch out for signs of abuse among women and children, e.g., presence of bruises and refer to barangay chairperson for further action
26. Coordinate with the appropriate organization or person on various complementary services:
    a. Home gardens for priority families, getting seeds and other planting materials
    b. Cash assistance in distressed conditions
    c. Opportunities for income generation



BARANGAY HEALTH WORKER

21. Assist in managing OTC facility for managing acute malnutrition, e.g., getting information on the child, weighing and measuring height or MUAC, administering appetite test, distributing RUTF or RUSF, following up child in home, and others as may be assigned
22. Assist the sanitary inspector in monitoring access to water supply and sanitary toilet
23. Assist the BNS in organizing nutrition classes for pregnant women or mothers with children 0-3 years old, including the invitation of resource persons from the city/ municipal health office, as needed
24. Watch out for signs of abuse among women and children, e.g., presence of bruises and refer to barangay chairperson for further action
25. Coordinate with BNS for referral of patients or families to the appropriate organization or person on various complementary services:
    a. Home gardens for priority families, getting seeds and other planting materials
    b. Cash assistance in distressed conditions
    c. Opportunities for income generation

CHILD CARE WORKER



9. Watch out for signs of abuse among women and children, e.g., presence of bruises and refer to barangay chairperson for further action

AT THE CITY/MUNICIPAL LEVEL

The city/municipal mayor provides leadership and guidance in implementing RA 11148. He or she ensures that all department and offices of the city/municipality identify, pursue, and report on their specific accountabilities in implementing the law. Mayors also ensure that funds for F1KD+ services and activities are not only available, but actually released and used in the most efficient and effective way.

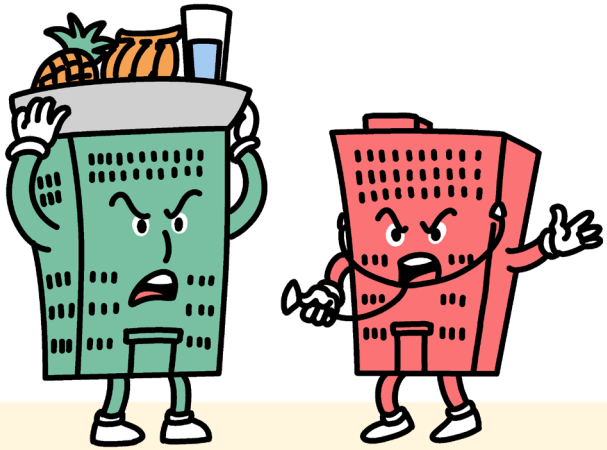
City/Municipal Health Office

The city/municipal health office shall be the lead in the delivery of individual- and population-based services in the F1KD+ being the sector that has the most contact with the population group covered by the F1KD+. As such, the city/municipal health officer has the responsibility and accountability in ensuring that the city/municipal health office undertakes its roles efficiently and effectively.

Specific roles of the C/MHO as lead in service delivery are as follows:

1. Organize the CWHS (for highly urbanized cities), and work with the PHO on the organization of the PWHS (for components cities and municipalities)
2. Develop guidelines, protocols, programs and projects to operationalize the Policy Framework for Primary Care
3. Work with the PHO on the organization of the HCPN, including the Primary Care Provider Network (PCPN). It will ensure that specific services and tasks related to the delivery of the services are identified, and quality standards, and persons-in-charge defined at both the barangay and city/municipal levels
4. In coordination with the city/municipal government as well as the provincial government, establish a mechanism for registration of the residents of a city/municipality to a health care provider
5. Ensure compliance to DOH Guidelines on Primary Care
6. Ensure that out-patient benefit packages include those related to the F1KD+ and that these services are available even in situations of emergencies
7. Establish a timely, effective, and efficient preparedness and response to public health emergencies and disease
8. Coordinate with secondary care health facilities in the C/PWHS to ensure the seamless delivery of services related to high-risk pregnancies, newborns with complications, and management of childhood illnesses, including acute malnutrition.
9. Monitor the city's/municipality's performance in service delivery and institute corrective measures as needed
10. Monitor compliance of 4Ps beneficiaries to health and nutrition conditionalities

11. Undertake activities related to the implementation of nutrition and related laws, e.g., EO 51, RA 10028, RA 8172, RA 8976, among others, in coordination with the city/municipal nutrition office
12. Implement programs, projects, and activities to continually capacitate the PCPN, including BHWs, to provide quality services in the F1KD+
13. Establish mechanisms for improved coordination with other offices or organizations of the city/municipality, including the local nutrition committee and local council for the protection of children



In some cases, conflicts have arisen between a nutrition office and the health office. These conflicts can be prevented by clear delineation of responsibilities and accountabilities.
When the delineation may not be as obvious, the best option is to dialogue and negotiate, agree, and pursue the agreement.

In the final run, the rule should be "eyes on the ball," and the ball is ensuring the seamless delivery of F1KD+ services.

City/Municipal Nutrition Office, if present

Some cities and municipalities have a separate nutrition office. The nutrition office acts as the executive arm of the C/MNC. It provides both technical and secretariat support to the C/MNC. In some instances, it implements one or more nutrition programs or projects of the city/municipality. It is headed by the city/municipal nutrition action, who has the responsibility and accountability of ensuring that the city/municipal nutrition office fulfills its roles effectively and efficiently.

Specific roles of the city/municipal nutrition office are:

1. Advise the local nutrition committee on nutrition program matters
2. Coordinate the conduct of the F1KD+ situational analysis
3. Coordinate the formulation of the local nutrition action plan and the integration of nutrition concerns in the CDP and AIP
4. Coordinate the formulation of the local nutrition in emergencies and plan its integration in the local DRRM-health plan
5. Monitor and evaluate the city/municipal nutrition action plan, including the integrated delivery of F1KD+ services as described in the section on "Strengthen Monitoring and Evaluation" in **Part 3** of this MOPr
6. Provide technical assistance to local agencies on integrating nutrition and related concerns in their programs, projects, and activities

7. Provide technical assistance to barangays on nutrition program management
8. Provide technical andand, to the extent possible,logistical and other forms of support to barangay nutrition scholars
9. In coordination with the city/municipal health office and other offices of the LGU, implement specific projects and activities of the LNAP, as may be assigned
10. In coordination with the city/municipal health office, undertake activities to ensure implementation of nutrition and related laws, e.g., EO 51, RA 10028, RA 8172, RA 8976, among others
11. Coordinate nutrition-related concerns in DRRM as a component of DRRM-health
12. In coordination with the C/MHO, implement programs, projects, activities to continually capacitate the BNS to provide quality services in the F1KD+
13. Establish mechanisms for improved coordination with other offices or organizations of the city/municipality, including the local council for the protection of children

Secondary + Tertiary Levels Of Health Care

1. Ensure that care for those at the F1KD+ are available
2. Organize and maintain a Public Health Unit to facilitate the implementation of population-based health services and seamless patient navigation within the HCPN

Local Social Welfare + Development Office

The local social welfare and development office shall:

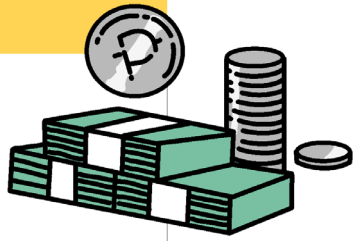
1. Ensure that related social welfare services as per RA 11148 and its IRR are available and accessible to those in the F1KD+
2. Ensure that concerns related to the F1KD+ are integrated in parental support activities, e.g., PES, FDS, ERPAT
3. In coordination with the C/MHO and C/MNO, establish and maintain a bi-directional referral system, e.g., cases needing health and nutrition services encountered in social welfare contacts with the population are referred to the primary care network, and cases needing social welfare support (including those related to maternal and child abuse) encountered in health sector contacts within the population are referred for social welfare services
4. Establish mechanisms for improved coordination with other offices or organizations of the city/municipality, including the local nutrition committee and local council for the protection of children

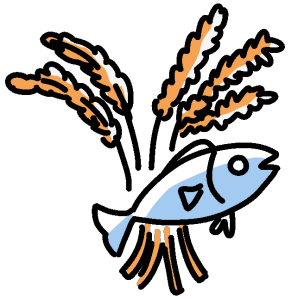
Other City/Municipal Government Organizations And Offices

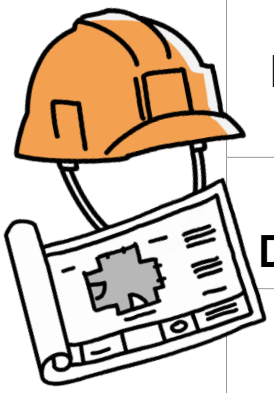
The other LGU departments and offices should integrate F1KD+ concerns in their respective programs and projects, e.g., in targeting and as platform for service delivery. Examples of such integration are shown in the next section.

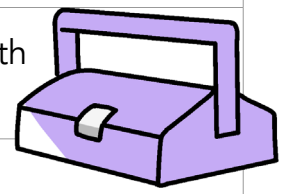
TABLE 6

Sectoral Involvement in F1KD+ Concerns at the City/Municipal Level



LGU OFFICE	SAMPLE ACTIONS FOR INVOLVEMENTS/COMMITMENTS
SANGGUNIANG BAYAN	• Enact ordinances related to F1KD+, e.g., localization of RA 11148, comprehensive nutrition action in the city/municipality • Ensure that approved local budgets have provisions for F1KD+ services
AGRICULTURE, FISHERIES 	• Support farmers and fisherfolk with wives who are pregnant or lactating and children 0-35 months old to improve productivity and incomes, e.g., financing, agriculture inputs, technology transfer, improved irrigation, fishnets, fishing boats, etc. • Integrate parenting skills related to F1KD+ in classes of farmers and fisherfolk • Provide inputs for home and community food gardening with priority to households with members in the F1KD+ • Submit reports of accomplishments to the city/municipal nutrition committee
RELATED TO EMPLOYMENT	• Identify employment opportunities for members of households with members in the F1KD+
ENGINEERING	• Assist in calibrating weighing scales and verifying height boards • Assist local offices to ensure safety of facilities especially for women and children
PLANNING & DEVELOPMENT	• Ensure that F1KD+ concerns are integrated in the CDP, ELA, LIDP, and capacity building agenda
DRRMO	• Ensure that F1KD+ concerns are integrated in the City/Municipal DRRM Plan and in response, recovery, and rehabilitation phases

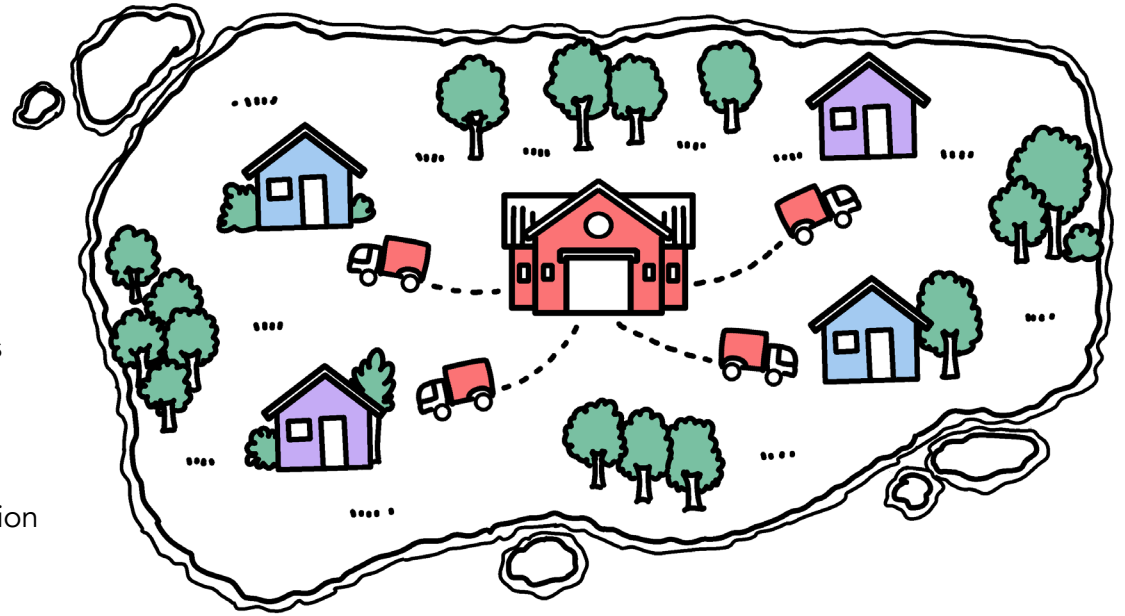




At the Provincial Level

As in the city/municipal level, the provincial governor provides leadership and guidance in implementing RA 11148 in the province. He or she ensures that all departments and offices of the province identify, pursue, and report on their specific accountabilities in implementing the law. Governors also ensure that funds for F1KD+ services and activities are not only available, but actually released and used in the most efficient and effective way.

Specific roles and the corresponding office or organization in the provincial government are shown below.



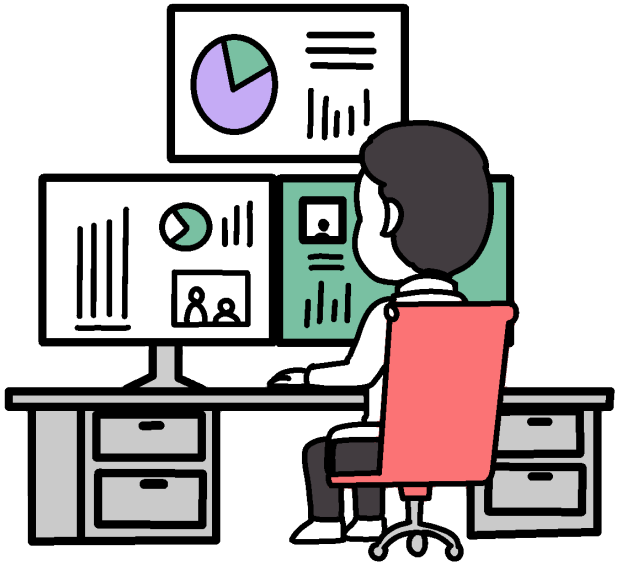
Actions of Provincial Offices related to F1KD+

Provincial health office

1. Organize the PWHS
2. Organize the HCPN in the province
3. Ensure that services related to the F1KD+ are integrated in program packages
4. Monitor and ensure compliance of the province, cities, and municipalities to DOH guidelines related to the implementation of the UHC Law
5. Undertake activities related to the implementation of related laws, e.g.,
   a. Regular monitoring on compliance to EO 51
   b. Certification of lactation stations
6. Undertake activities to build the capacity of the health system not only to deliver services, but also to work effectively with other sectors, as well as improve health information systems
7. Develop and implement integrated C4D (Communications for Development) strategies and materials
8. Participate actively in the formulation, monitoring, evaluation, and coordination of the provincial nutrition action plan

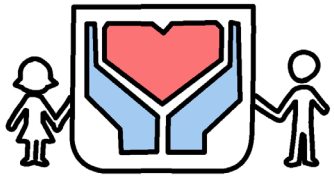
Provincial Nutrition Office

1. Advise the provincial nutrition committee on nutrition program matters
2. In coordination with the provincial offices and cities and municipalities, coordinate the conduct of the F1KD+ situational analysis
3. Coordinate the formulation of the provincial nutrition action plan and the integration of nutrition concerns in the Provincial Physical Framework and Development Plan, the Provincial Local Development Investment Plan, and the Annual Investment Program
4. Coordinate the formulation of the provincial nutrition in emergencies plan and its integration in the provincial DRRM-health plan
5. Monitor and evaluate the provincial nutrition action plan, including the integrated delivery of F1KD+ services as described in the section on "Strengthen monitoring and evaluation" in **Part 3** of this MOPr.
6. Provide technical assistance to local agencies on integrating nutrition and related concerns in their programs, projects, and activities
7. Provide technical assistance to cities, municipalities and barangays on nutrition program management
8. In coordination with the city/municipal government, provide technical and and, to the extent possible, logistical and other forms of support to barangay nutrition scholars
9. Lead in the development and implementation of province-wide activities on nutrition promotion



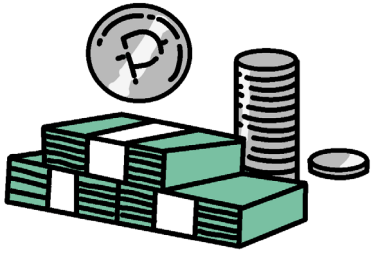
10. In coordination with the city/municipal health office and other offices of the LGU, implement specific projects and activities of the PNAP, as may be assigned
11. In coordination with the provincial health office, undertake activities to ensure implementation of nutrition and related laws, e.g., EO 51, RA 10028, RA 8172, RA 8976, among others
12. Coordinate nutrition-related concerns in DRRM as a component of DRRM-health
13. In coordination with the city/municipality, implement programs, projects, activities to continually capacitate the BNS to provide quality services in the first F1KD+
14. Establish mechanisms for improved coordination with other offices or organizations of the province, including the local council for the protection of children

SOCIAL WELFARE + DEVELOPMENT



1. Build capacities of city/municipal social welfare and development offices in carrying out their roles related to F1KD+
2. Provide augmentation funding support especially to poor cities/municipalities for services related to the F1KD+

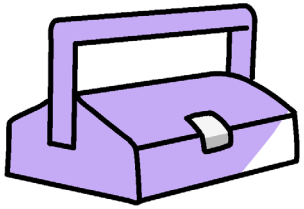
SANGGUNIANG BAYAN



1. Enact ordinances related to F1KD+, e.g., localization of RA 11148, comprehensive nutrition action in the province
2. Ensure that approved provincial, city, and municipal budgets have provisions for F1KD+ services

AGRICULTURE, FISHERIES

1. Build capacities of city/municipal agriculture offices on integrating F1KD+ concerns in their programs and projects, e.g., by
   a. Supporting farmers and fisherfolk with wives who are pregnant/lactating or children 0-35 months old to improve productivity and incomes, e.g., financing, agriculture inputs, technology transfer, improved irrigation, fishnets, fishing boats, etc.
   b. Integrating parenting skills related to F1KD+ in classes of farmers and fisherfolk
   c. Providing inputs for home and community food gardening with priority to households with members in the F1KD+
2. Submit reports of accomplishments to the city/municipal nutrition committee

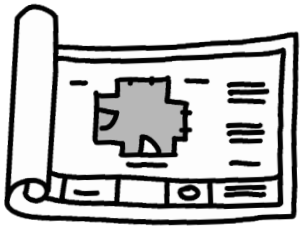


RELATED TO EMPLOYMENT

Identify employment opportunities for members of households with members in the F1KD+

ENGINEERING

1. Assist in calibrating weighing scales and verifying height boards
2. Assist local offices to ensure safety of facilities especially for women and children



PLANNING + DEVELOPMENT

Ensure that F1KD+ concerns are integrated in the PFDP, ELA, LIDP, and capacity building agenda

DRRMO

Ensure that F1KD+ concerns are integrated in the Provincial DRRM Plan and in response, recovery, and rehabilitation phases

At the Regional and National Level

As provided for by item d of Section 6, Rule 7 of the IRR of RA 11148, "the NNC, the regional nutrition, committee, and local nutrition committees shall provide the basic mechanism for sectoral collaboration and partnership for the implementation of RA 11148."

THE NATIONAL NUTRITION COUNCIL

1. Formulate national nutrition policies, plans, strategies, and approaches for nutrition improvement, including strategies on women, infant and young children, and adolescent nutrition;

2. Oversee and serve as a focal point in the integration of nutrition policies and programs of all member agencies and instrumentalities charged with the implementation of existing laws, policies, rules, and regulations concerning nutrition;

3. Coordinate, monitor and evaluate nutrition programs and projects of the public and private sectors and LGUs to ensure their integration with national policies;

4. Receive grants, donations, and contributions in any form from foreign governments, private institutions, and other funding entities for nutrition programs and projects: provided, that no conditions shall be made contrary to the policies or the provisions of this Act and its IRR, and with special reference to EO 51, s. 1986 and WHA Resolution 69.9;

5. Coordinate the joint planning and budgeting of member agencies to ensure funds for relevant nutrition programs and projects; to secure the release of funds in accordance with the approved programs and projects; and to monitor implementation and track public expenditure on these programs; and

6. Call upon any government agency and instrumentality for such assistance as may be required to implement the provisions of this Act and its IRR

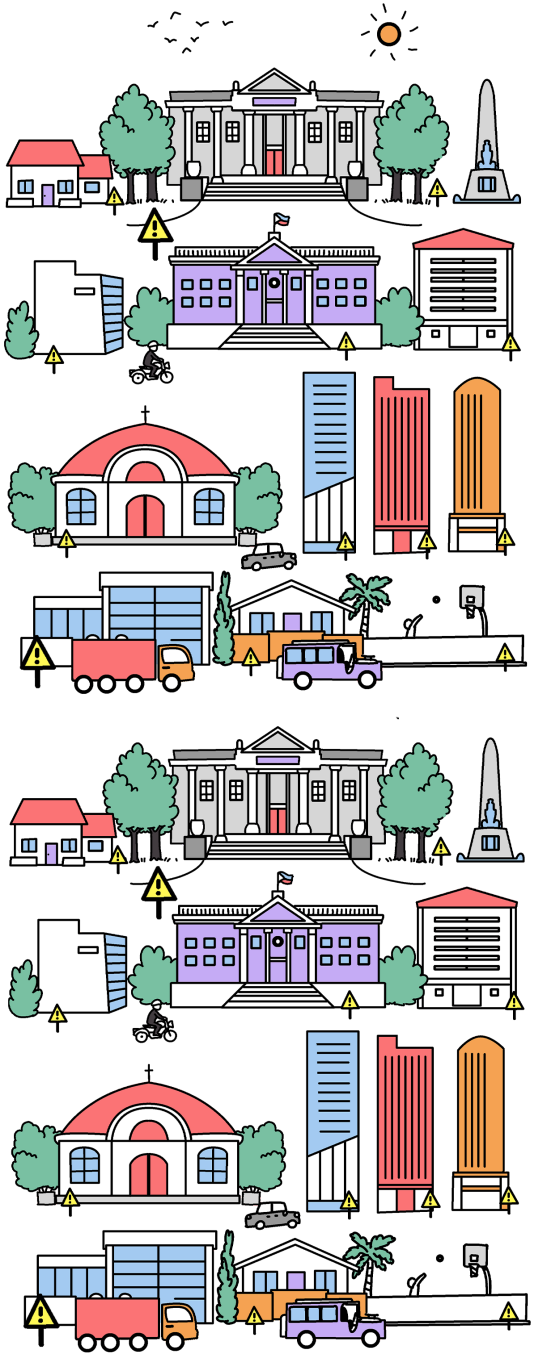
Supporting the NNC Governing Board is the NNC Technical Secretariat. Specific to the implementation of RA 11148, the NNC Secretariat shall:

1. Be the overall coordinator for F1KD+ concerns
2. Facilitate annual convergence planning and budgeting at the national level
3. Ensure the dynamic flow and exchange of information on policy and program implementation
4. Prepare quarterly status reports for submission to demand agencies

NATIONAL GOVERNMENT AGENCIES

Rule 13, Section 1 of the IRR of RA 11148 lists the following as roles of national government agencies.

1. Prioritize programs and projects in the F1KD+ Strategy in long-term plans, programs, and annual budgets;
2. Formulate joint issuances along the promotion, integration, and implementation of the programs;
3. Actively participate in the collaborative activities of the NNC and its member agencies;
4. Review and develop/update relevant policies, guidelines, strategies, tools, and training packages to support integration of F1KD+ Strategy Components across all levels and sectors of government to facilitate the implementation of the law and these rules;
5. Prepare a long-term F1KD+ financing strategy to build on available funding streams that already support the different components of the program and provide additional resources in any form, including technical assistance, sourced from the budget in support of local nutrition programs;
6. Strengthen public financial management to increase allocation and efficiency of spending;
7. Regularly review and update competency profiles of all service providers to strengthen workforce capacities on health, nutrition, child development, child protection, responsive caregiving, early stimulation, and social protection;
8. Work closely with the academe, professional societies, and organizations from different sectors, the Commission on Higher Education (CHED), and the Professional Regulation Commission (PRC) to update both pre-service and in-service curricula;
9. Prioritize systems strengthening including the harmonization and updating of information or surveillance systems, logistics and supply chain management systems, and referral systems or service delivery networks;
10. Provide leadership in identifying the monitoring, evaluation, and research priorities, make resources available for implementation of research, and foster collaboration among program implementers, researchers, and scientists to develop national and local evidence-based platforms for research and learning of the F1KD+.



Specific agency roles identified in the IRR of RA 11148 are as follows:

The Department of Health (DOH) as lead technical agency for the F1KD+ strategies and services shall:

1. Provide technical assistance at all levels for plans, policies, and program development as may be needed for health, nutrition, early childhood development, and adolescent health, and development concerns
2. Provide augmentation support to identified priority LGUs, including—but not limited to—funding and supplies relevant to the program and consistent with related guidelines on contracting city- and province-wide health systems
3. As Chair of the NNC Governing Board, shall lead in providing oversight for the F1KD+ Program with technical support from the NNC Secretariat

The Department of the Interior and Local Government (DILG), as Vice-Chair of the NNC Governing Board, shall:

1. Provide technical support to LGUs in the implementation and monitoring of the law through issuances encouraging all LGUs to fully support the implementation of this Act and its IRR, through
   a. Enactment of local policies and ordinances
   b. Participation of LGUs in the trainings and seminars to be conducted by NNC Member Agencies
2. Ensure that the implementation of this Act is integrated in the local development plans and investment plans of LGUs
3. Monitor LGU compliance using the standard and innovative monitoring tools
4. Support the engagement of leagues of local governments and F1KD+ champions and form communities of practice to enable peer learning and exchange for LGUs to share good practices and address implementation problems

The Department of Agriculture (DA) as Vice-Chair of the NNC Governing Board, shall be the co-lead agency and shall:

1. Provide technical assistance to the DOH and to other agencies on matters related to food security and food systems
2. Provide technical assistance and augmentation support to LGUs in strengthening food systems towards becoming resilient and nutrition-sensitive
3. Build capacities of local agriculture officers in supporting the effective and integrated delivery of the program

The Department of Agrarian Reform (DAR) shall:

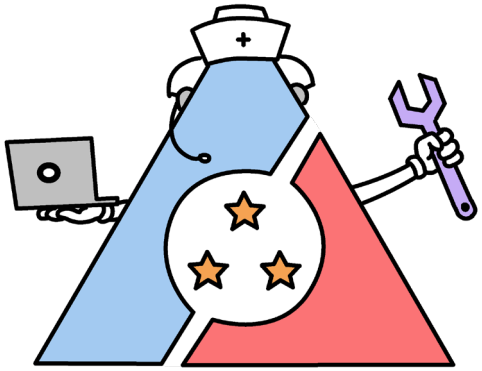
1. Lead in the review, implementation, and monitoring of the Comprehensive Agrarian Reform Program (CARP) to support the design and coordinated delivery of nutrition-sensitive support services and prioritizing vulnerable groups with land tenure security issues
2. In coordination with the DOH and other concerned government agencies, provide technical support in building capacities and awareness of beneficiaries and service providers to prioritize interventions for F1KD+
3. Mobilize and capacitate Agrarian Reform Beneficiaries Organizations to participate in F1KD+ programs

The Department of Budget Management (DBM) shall:

1. Support member agencies in determining appropriate allocations for the program
2. Ensure timely release of funds needed for the program
3. Provide technical assistance on financial management and monitoring and evaluation of the program

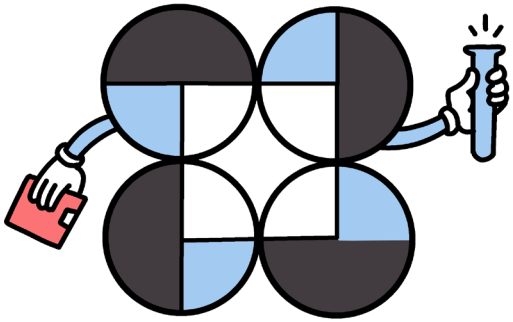
The Department of Education (DepEd) shall:

1. Review and develop modules on key core health and nutrition messages for the F1KD+ for integration into the curriculum, as well as support to parent and community education activities in schools
2. Implement nutrition-specific and nutrition-sensitive initiatives for the adolescent female and at-risk population in schools and the alternative learning system/ alternative delivery mode structures of the agency
3. Collaborate with the academe in reviewing and updating relevant pre- and in-service curricula to integrate nurturing care



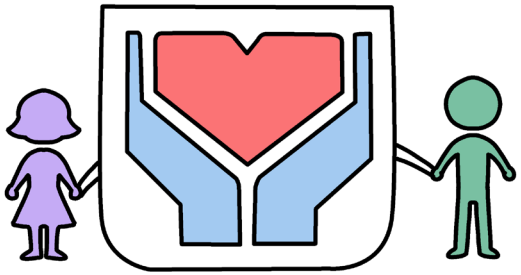
The Department of Labor and Employment (DOLE) shall:

1. Lead in the review, updating, implementation and monitoring of labor and employment-related policies and programs in accordance to these rules
2. In coordination with the DOH and other NGAs concerned, issue related guidelines and communicate the maternity protection provisions of these rules to employers and workers in the private sector



The Department of Science and Technology (DOST) shall:

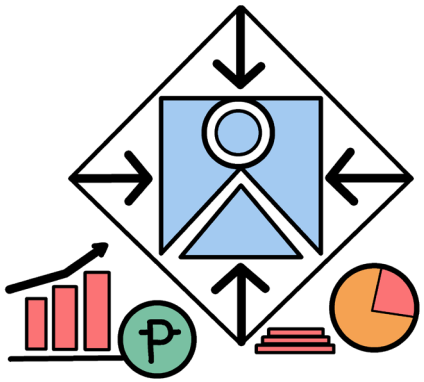
1. Provide central direction, leadership, and coordination of scientific and technological efforts and ensure that the results therefrom are geared and utilized in areas of maximum economic and social benefits for the F1KD+
2. Review and update existing surveys and tools to support generation and analysis of key indicators on the F1KD+, in line with global and national standards



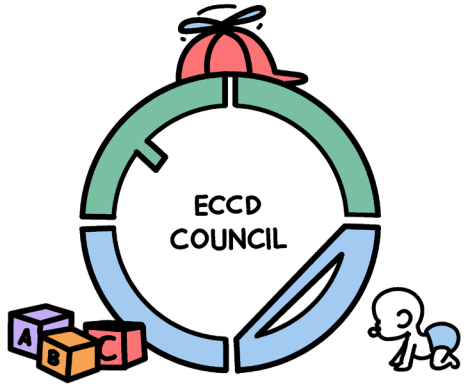
The Department of Social Welfare and Development (DSWD), shall:

1. Be responsible for strengthening social welfare and child protection services and programs
2. Provide technical assistance to NGAs and LGUs in integration and improved delivery of parenting, early childhood care and development, and responsive care services
3. Build capacities of local social welfare and development officers, CDWs, and municipal links along organizing and managing FDS, parenting programs (e.g., PES, ERPAT, etc), and SNPs, among others

The Department of Trade and Industry (DTI) shall be responsible in the review, updating, implementation, and monitoring of policies, standards, and programs to improve consumer awareness on their rights and responsibilities, and ensuring consumer welfare and protection relevant to the F1KD+



The National Economic and Development Authority (NEDA) shall provide policy and monitoring support, technical assistance, and augmentation of resources to build evidence and policy-related researches in support of the Program



The Early Childhood Care and Development Council (ECCD-C) shall:

1. Provide technical and funding support on matters related to ECCD, including early stimulation and early learning
2. Establish National Child Development Centers (NCDCs) in identified priority areas,
3. Provide technical support that may come in the form, but not limited to the following:
    a. capacity building for ECCD service providers, and
    b. provision of ECCD packages to CDCs in the priority areas

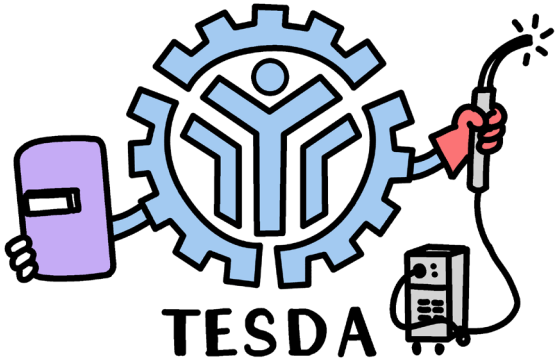
The Food and Drug Administration (FDA), as its primary mandate, shall:

1. Ensure the safety, efficacy or quality of health products as defined by RA No. 97111, otherwise known as "The Food and Drug Administration Act of 2009"
2. Uphold and enforce laws and standards on food regulation, safety and fortification, and its other mandates provided for by relevant laws that directly or indirectly affects the implementation of this Act
3. Investigate, verify reports of EO 51, s. 1986 violations, and when appropriate, apply administrative sanctions against the violators and/or file criminal complaints against persons and entities found to have violated, singly or repeatedly, the provisions of the Code or its current IRR
4. Ensure that the labels of food products covered by the scope of the Philippine Milk Code shall conform to the rules and regulations of the FDA and the Milk Code's current IRR

The Philippine Health Insurance Corporation (PhilHealth) shall:

1. Cover mothers and children under the National Health Insurance Program
2. Incorporate in its benefit packages the health services for maternal and child health and nutrition
3. Enable mothers and children to have access to health services covered by its benefit packages according to its existing rules and regulations

The Philippine Statistics Authority (PSA) shall provide technical support in harmonizing data and information and in reviewing and updating existing surveys and tools to support generation and analysis of key indicators on the F1KD+ in line with global and national standards



The Technical Education and Skills Development Authority (TESDA) shall:

1. Review and update the National Technical Education and Skills Development Plan and all relevant standards, tests, and systems to reflect needed reforms in integrating skills development programs relevant to or that can support the effective implementation of these rules
2. Contribute directly to improved economic status of trained graduates, food and nutrition security, increased access to other basic social services, and better quality of life for their families.
3. Collaborate with the academe in reviewing and updating relevant pre- and in-service curricula to integrate nurturing care;

The Civil Service Commission (CSC) shall:

1. Provide technical support in reviewing and updating policies and standards for the economical, efficient, and effective personnel administration in government, in formulating, administering, and evaluating programs relative to the development and retention of qualified and competent workforce
2. Inspecting personnel actions and programs of departments, agencies, bureaus, offices, and local government, including government-owned or controlled corporations;
3. In coordination with DOH and other NGAs concerned, communicate the maternity protection provisions of the law and these rules to the public sector workers

The Commission on Higher Education (CHED) shall lead in reviewing and updating relevant pre- and in-service curricula in coordination with NGAs, professional societies, the academe, and stakeholders

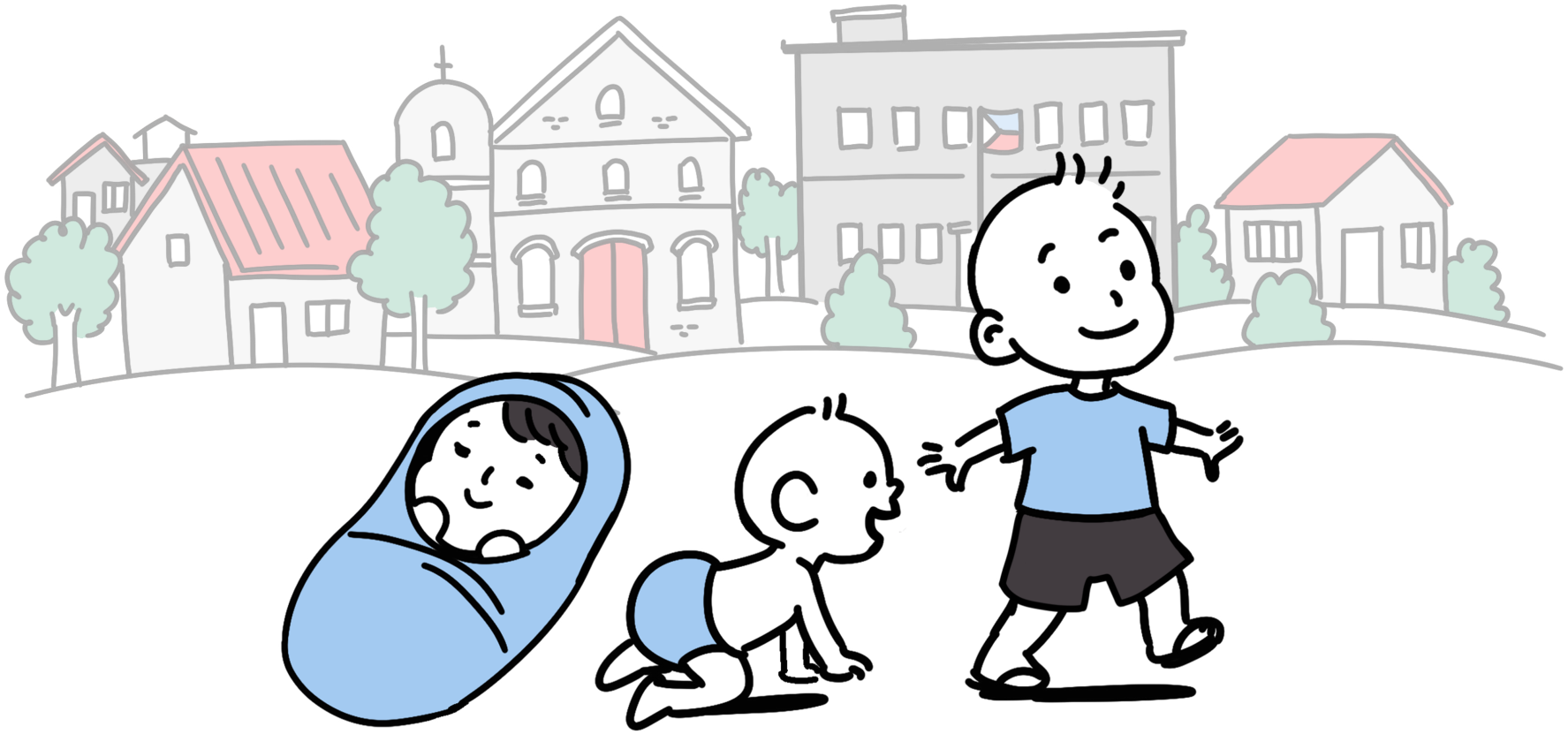
The National Youth Commission (NYC) shall:

1. Provide leadership, technical and funding support as the policy-making coordinating body on matters related to youth and adolescent programming
2. Engage and encourage youth leaders through the Sangguniang Kabataan and build their capacities and awareness to prioritize interventions related to the F1KD+

The National Anti-Poverty Commission (NAPC) shall:

1. Coordinate and ensure the active and meaningful participation of the basic sectors
2. Recommend policies and other measures to guarantee the responsive implementation of the law
3. In coordination with DOH and other concerned government agencies, help along strategies to strengthen provision of maternity protection for workers in the informal economy, including workers in the informal sector, as well as workers in MSMEs

The Professional Regulation Commission (PRC) shall administer, implement, and enforce the regulatory policies of the national government with respect to the regulation and licensing of the various professions and occupations under its jurisdiction, including the enhancement and maintenance of professional and occupational standards and ethics, and the enforcement of the rules and regulations relative to the F1KD+ Strategy



Civil society organizations, state universities and colleges, private sector, and development partners

1. Support one or more aspects of the F1KD+, e.g., capacity building, service delivery, research, monitoring and evaluation, as applicable, and as will be agreed with the national and regional levels, as well as the provincial, city, municipal, and barangay levels
2. Establish mechanisms for improved coordination with the national and regional levels, as well as the provincial, city, municipal, and barangay levels

Capacity Building and Development

Section 12 of RA 11148 stipulates that "The DOH and the NNC, in coordination with LGUs, shall provide practical and effective training courses to BNSs, BHWs, CDWs, and other personnel concerned to upgrade their skills and competence in the implementation of services and interventions for the health and nutrition of women and children."

The following is a partial list on areas of concern to be covered by capacity building:

a. Effective delivery of antenatal care, essential maternal and newborn care and lactation management

b. Effective health/nutrition education, with emphasis on listening and learning; building confidence and giving support skills

c. Integrating concerns on responsive caregiving, early learning, safety and security in services

d. Designing, implementing, monitoring, and evaluating effective behavior change programs for the F1KD+

e. Improving processes related to Operation Timbang Plus, e.g., correct techniques in weighing, recording, etc.

f. Use of the tools and application of processes related to ECCD Community Risk Targeting

g. Policy formulation and advocacy

h. Multisectoral and joint planning and budgeting

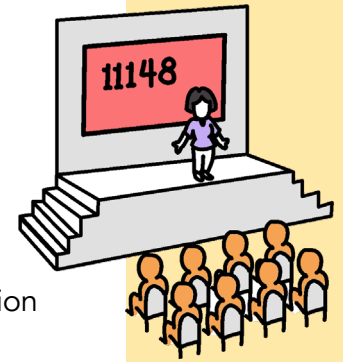
i. Supportive supervision and mentoring

j. Supply chain management

k. Skills related to adapting to the fourth revolution, e.g., navigation of the internet, use of internet-based platforms for service delivery, capacity building, promotional efforts

l. Working with others, breaking down turfs, and keeping communication lines open

m. Knowledge on the components of the NCF, e.g., social welfare staff should know more about health and nutrition, those in the health system should know more about social protection, community volunteers should know and understand concepts on WASH and the sanitary inspector about nutrition, etc.



Identifying the knowledge, attitudes, and skills needed for the implementation of RA 11148 can be facilitated through a formal training needs analysis exercise.

Capacity building programs can include but are not limited to the following:

- ✓ Training programs
- ✓ Continuing education programs
- ✓ Development of job aids
- ✓ Development of certification programs
- ✓ Supportive supervision

PART FIVE

REFERENCES

Information Resources For Implementing RA 11148

Presented on the next pages are some references
that can be consulted if detailed instructions are needed.

LIFE STAGE/SERVICE	REFERENCE
Antenatal Care	AO 2008-0029 – Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality AO 2016-0035 Guidelines on the Provision of Quality Antenatal Care in All Birthing Centers and Health Facilities Providing Maternity Care Services Maternal, Newborn, and Child Health and Nutrition (MNCHN) Manual of Operations
Birth and emergency planning	WHO's Standards for Maternal and Neonatal Care Maternal, Newborn, and Child Health and Nutrition (MNCHN) Manual of Operations JICA's Guidebook for Community Health Teams
Women about to give birth and immediate post-partum	WHO Early essential newborn care clinical practice pocket guide Maternal, Newborn, and Child Health and Nutrition (MNCHN) Manual of Operations DM 2020-0319 – Interim Guidelines on COVID-19 Management of Pregnant, Women, Women About to Give Birth and Newborns
Kangaroo Mother Care	WHO's Kangaroo Mother Care: A Practical Guide
Infant and Young Child Health and Nutrition	Harmonized Maternal, Newborn, Infant, and Young Child Health and Nutrition (MNIYCHN) Training Package, including IYCF-ECCD Counseling Cards DOLE Department Order No.143, Series of 2015, Guidelines Governing Exemption of Establishments from Setting Up Workplace Lactation Stations (includes prototypes for lactation stations) DOH DC 2011-0365: Guidelines for the Mother and Baby-Friendly Workplace Certification DOH AO 2006-0012: Revised Implementing Rules And Regulations (RIRR) of Executive Order No. 51, Otherwise Known as The "Milk Code," Relevant International Agreements, Penalizing Violations Thereof, and for Other Purposes

LIFE STAGE/SERVICE	REFERENCE
Immunization	Manual of Operations on Immunization DM 20200-150 - Interim Guidelines for Immunization Services in the Context of COVID-19 Outbreak
Assessment and Management of Sick Children Care for Child Health and Development (combined IMNCI & CCD)	DOH Administrative Order 2015-0055, National Guidelines on the Management of Acute Malnutrition for Children under 5 years National Guidelines on the Management of Severe Acute Malnutrition for Children Under Five Years Old Manual of Operations National Guidelines on the Management of Moderate Acute Malnutrition for Children Under Five Years Old Manual of Operations WHO's Guidelines for Integrated Management of Childhood Illnesses (IMCI)
Micronutrient Supplementation	Administrative Order No. 2010-0010, Revised Policy on Micronutrient Supplementation to Support Achievement of 2015 MDG targets to Reduce Under-five and Maternal Deaths and Address Micronutrient Needs of Other Population Groups Manual of Operations on Micronutrient Supplementation
Oral Health	DOH Administrative Order 2007-0007 Guidelines on the Implementation of Oral Health Program for Public Health Services
Services and Interventions for Adolescent Females	DM 2020-341 Interim Guidelines on Continuous Provision of Adolescent Health Services during the COVID-19 Pandemic DOH's Adolescent Health and Development Program Manual of Operations

LIFE STAGE/SERVICE	REFERENCE
Health & Emergencies and Management of Local & Foreign Donations for Normal & Emergency Situations	DOH Administrative Order No. 2017-0007, Guidelines in the Provision of Essential Health Service Packages in Emergencies and Disaster Department Circular No. 2020-0167 on the Continuous Provision of Essential Health Services During COVID-19 Epidemic DOH AO 2020-0001 Guidelines in the Importation, Facilitation and Management of Foreign Donations involving Health and Health-Related Products DOH DC 2020-0217 Reiteration of the DOH Department Memorandum 2020-0231: Guidelines on the Standardized Regulation of Donations, Related to Executive Order 51, series of 1986 (The Philippine Milk Code), to Health Facilities and Workers, Local Government Units, Non-Government Organizations, and Private Groups and Individuals in Support of the Response to Emergencies, Disasters, and Situations Where the Health and Nutrition of Mothers, Infants, and Young Children are Affected
Nutrition in the Aftermath of Natural Disasters and Calamities	NNC Governing Board Resolution No. 1, S2009, Adopting the National Policy on Nutrition Management in Emergencies and Disasters Training Manual on Nutrition in Emergencies Training Manual on Nutrition in Emergencies Information Management Department Memorandum (DM) 2020-0237 - Interim Guidelines for the Delivery of Nutrition Services in the Context of COVID-19 Pandemic Nutrition Cluster Advisory 1 - Nutrition Cluster Guidelines on LGU Nutrition Actions Relative to COVID-19 Nutrition Cluster Advisory 2 - Nutrition Cluster Recommendations on Healthful and Nutritious Family Food Packs and Sustainable Food Sources

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ANNEXES

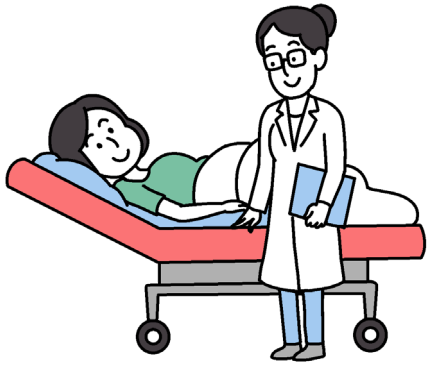
Program Components By Life Stage (per RA 11148)

Pregnancy, first 270 days (Antenatal care)

1. Pregnancy tracking and enrollment in ANC
2. Regular follow-up to complete the recommended minimum number of quality ANC care visits
3. Proper referral for high-risk pregnancies, including adolescent mothers
4. Maternal immunization (tetanus and diphtheria toxoid, others as needed)
5. Preparation of birthing plan, including plans for obstetric and newborn emergencies and complications, and appropriate plans for breastfeeding and rooming in; including counseling
6. Counseling on maternal nutrition and infant and young child feeding practices
7. Early identification and management of nutritionally-at-risk pregnant women and provision of dietary supplementation using Ready-to-Use Supplementary Food (RUSF) or other nutrient-dense food, as appropriate
8. Maternal micronutrient supplementation (iron-folic acid, calcium, iodine, others)
9. Promotion of the consumption of iodized salt and fortified foods
10. Assessment of risk for parasitism and provision of anti-helminthic medicines
11. Provision of oral health services, including oral health assessment
12. Counseling on proper handwashing, environmental sanitation, and personal hygiene
13. Counseling on, and utilization of responsible parenthood and family health services
14. Counseling on nutrition, smoking cessation, and adoption of healthy lifestyle practices
15. Philippine Health Insurance Corporation (PhilHealth) enrollment and linkage to community-based health and nutrition workers and volunteers
16. Social welfare support to improve access to health and nutrition services such as, but not limited to, dietary supplementation, healthy food products, and commodities for nutritionally-at-risk pregnant women belonging to poor families, and those with disabilities
17. Maternity protection (upholding the rights of pregnant women at work as stipulated in existing labor, civil service, and other related laws and regulations)
18. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, and early stimulation for child development
19. Provision of counseling and psychosocial support to parents and caregivers with priority to high-risk pregnant women and adolescent females belonging to the poorest of the poor families

Women about to give birth and immediate post-partum period

1. Adherence to the couple's birth, breastfeeding, and rooming-in plans
2. Provision of mother-baby friendly practices during labor and delivery
3. Monitoring the progress of labor and well-being of both mother and fetus and provision of interventions to any health issue that may arise
4. Identification of high-risk newborns that will be delivered: the premature, small for gestational age (SGA) and/or low birth weight infants and the provision of preventive interventions to reduce complications of prematurity or low birth weight
5. Coverage and utilization of PhilHealth benefit packages for maternal care
6. Nutrition counseling and provision of nutritious meals
7. Provision of lactation management services to support breastfeeding initiation and exclusive breastfeeding for six (6) months, most especially for caesarian delivery
8. Counseling on proper handwashing, environmental sanitation and personal hygiene
9. Counseling on and utilization of modern methods of family planning and access to reproductive health services
10. Maintenance of the non-separation of the mother and her newborn and rooming-in for early breastfeeding initiation
11. Assurance of women-child friendly spaces during calamities, disasters, or other emergencies
12. Provision of support to fathers and caregivers to ensure their commitment to support the mother and child on proper health and nutrition care and provide necessary counseling and positive parenting support interventions
13. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, and early stimulation for child development



Post-partum and lactating women

1. Follow-up visits to health facility
2. Home visits for women in difficult-to-reach areas
3. Lactation support and counseling, including women who will return to work, women in informal economies, and those with breastfeeding difficulties
4. Nutrition assessment and counseling to meet the demands of lactation in health facilities and workplaces
5. Identification and management of malnutrition among post-partum and lactating women and provision of RUSF in addition to dietary supplementation, as appropriate
6. Organization of community-based mother support groups and peer counsellors for breastfeeding in cooperation with other health and nutrition workers
7. Maternity protection and lactation breaks for women in the workplaces including Micro, Small, and Medium Enterprises (MSMEs).
8. Availability of lactation stations in workplaces, both in government and in the private sector, informal economy workplaces, and in public places and public means of transportation as stipulated in RA No. 10028, and its IRR
9. Organization of breastfeeding support groups in workplaces, in cooperation with occupational health workers and human resource managers trained in lactation management for the workplace
10. Provision of micronutrient supplements (iron-folic acid, and vitamin A)
11. Promotion of the consumption of iodized salt and fortified foods
12. Provision of oral health services
13. Counseling on and utilization of modern methods of family planning and access to reproductive health services
14. Social welfare support for access to health and nutrition services for nutritionally-at-risk post-partum and/or lactating women belonging to the poorest of poor families
15. Assurance of women-child friendly spaces where mothers and their infants will be able to continue breastfeeding during calamities, disasters, or other emergencies
16. Provision of support to fathers and caregivers to ensure their commitment to support the mother and child on proper health and nutrition care and provide necessary counseling and positive parenting support interventions
17. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, and early stimulation for child development

Birth and newborn period

1. Administration of newborn screening and newborn hearing screening

2. Maintenance of non-separation of the mother and her newborn from birth for early breastfeeding initiation and rooming-in for exclusive breastfeeding

3. Provision of early and continuous skin-to-skin contact to all full-term babies and continuous kangaroo care for small babies born preterm and with low birth weight, in compliance with the newborn protocol of the DOH in all facilities providing birthing services.

4. Availability of human milk pasteurizer for strategic level two (2) and level three (3) facilities with Neonatal Intensive Care Units (NICU) to ensure breastmilk supply for small babies born preterm and low birth weight within its facility, the service delivery network it serves, and for use of infants and young children during emergencies and disasters, in accordance with DOH guidelines

5. Provision of routine newborn care services such as eye prophylaxis, Vitamin K supplementation, and immunizations

6. Availment and utilization of PhilHealth benefit packages for the newborn including the preterm, low-birthweight, and small babies

7. Provision of early referral to higher level facilities to manage illness and/or other complications

8. Assurance of child-friendly space where exclusively breastfed infants will be able to continue breastfeeding during calamities, disasters, or other emergencies

9. Social welfare support for access to health and nutrition services for the newborn belonging to poor families, and those with disabilities

10. Facilitate the prompt birth and death registration, including fetal deaths, restoration and reconstruction of birth and death registration documents destroyed during disasters.

11. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, and early stimulation for child development

12. Provision of support to parents and caregivers on early stimulation and responsive care for children

First six months of infancy or 180 days

1. Provision of continuous support to mother and her infant for exclusive breastfeeding including referral to trained health workers on lactation management and treatment of breast conditions

2. Provision of appropriate and timely immunization services integrated with assessment of breastfeeding, early child development, growth monitoring and promotion, and infant and young child feeding

3. Growth and development[12] monitoring and promotion for all infants less than six (6) months old, especially those who had low birth weight, are stunted, or had acute malnutrition

4. Counseling of household members on hand washing, environmental sanitation and personal hygiene

5. Identification and management of moderate or severe acute malnutrition among infants less than six (6) months old and provision of lactation management services and management of medical conditions contributing to malnutrition

6. Provision of early referral to higher level health facilities to manage common childhood illnesses including acute malnutrition

7. Counseling and support to parents and caregivers on parent/caregiver-infant/child interaction for responsive care, and early stimulation for early child development

8. Social welfare support to improve access to health and nutrition services for the newborns belonging to the poorest of the poor families

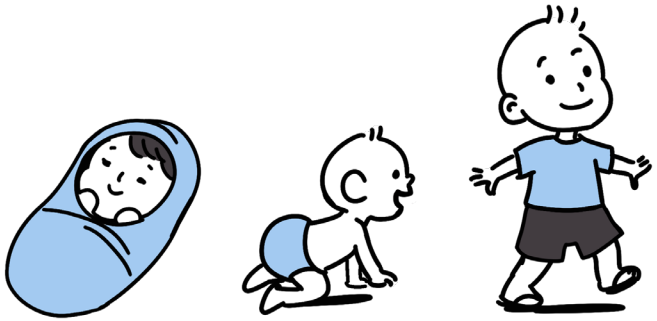
9. Provision of support to fathers and caregivers to ensure their commitment to support the mother and child on proper health and nutrition care and provide necessary counseling and positive parenting support interventions

10. Assurance of women-child friendly spaces during calamities, disasters, or other emergencies where health and nutrition services of children shall be provided

12 When the law was being drafted the inclusion of "development" in the service of child monitoring was referring to the monitoring of child developmental milestones

Infants six (6) months up to two (2) years of age

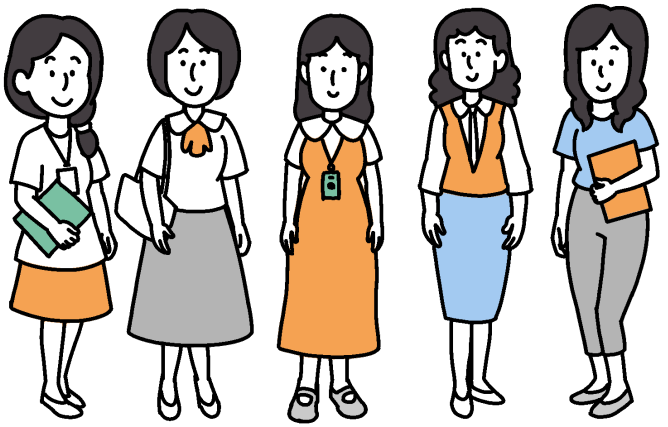
1. Timely introduction of safe, appropriate, and nutrient-dense quality complementary food with continued and sustained breastfeeding for all infants from six (6) months up to two (2) years of age, with emphasis on the use of suitable, nutrient-rich, home-prepared, and locally available foods that are prepared and fed safely
2. Provision of nutrition counseling on complementary food preparation and feeding to mothers and caregivers
3. Dietary supplementation of age-appropriate and nutrient-dense quality complementary food
4. Growth and development* monitoring and nutrition in health facilities and at home
5. Provision of routine immunization based on the latest DOH guidelines
6. Provision of micronutrient supplements (e.g., vitamin A, micronutrient powder) deemed necessary
7. Management of common childhood illnesses based on WHO and DOH guidelines
8. Identification and management of moderate and severe acute malnutrition using national guidelines and proper referral to higher level facilities, as appropriate, for treatment and management, especially those with serious medical complications
9. Provision of oral health services including application of fluoride varnish to prevent dental caries
10. Provision of anti-helminthic tablets for children 1-2 years old as appropriate



11. Availability of potable source of water, counseling of household members on handwashing, environmental sanitation, and personal hygiene, and support for sanitation need of households to reduce food, water, and vector-borne diseases
12. Counseling and support to parents and caregivers on parents/caregiver-infant/child interaction for responsive care and early stimulation for early childhood development, and referral for developmental delays and other disabilities for early prevention, treatment, and rehabilitation
13. Social welfare support for access to health and nutrition services, and referral for developmental delays and other disabilities for early prevention, treatment, and rehabilitation for infants six months and above who belong to the poorest of the poor families
14. Support for home gardens wherever feasible
15. Provision of locally available grown crops, vegetables, and fruits in addition to other agricultural products to be used in complementary feeding and dietary supplementation
16. Protection against child abuse, violence against women and children, injuries, and accidents including the provision of first aid, counselling, and proper referrals

Adolescent females

1. Assessment of health and nutrition status and identification of nutritionally-at-risk adolescent females, especially in circumstances where dietary intakes are suboptimal, micronutrient deficiencies and anemia are high, and when pregnancy imposes inordinate demands on the adolescents' own growth and development, as well as provision of Ready-to-Use Supplementary Food (RUSF), Ready-to-Use Therapeutic Food (RUTF), or other nutrient-dense food for nutritionally-at-risk but non-overweight or non-obese adolescent females as appropriate
2. Provision of age-appropriate immunization based on the latest DOH guidelines
3. Provision of oral health services including oral health assessment
4. Provision of anti-helminthic drugs for deworming
5. Counseling on proper handwashing, environmental sanitation, and personal hygiene
6. Provision of micronutrient supplements according to the guidelines of the DOH and DepEd (e.g., weekly iron-folic acid supplementation)
7. Promotion of the consumption of iodized salt, and fortified foods
8. Referral to appropriate health facilities to manage menstruation irregularities or abnormalities that contribute to anemia and blood loss, and manage complicated illnesses, including moderate or severe acute malnutrition
9. Counseling on proper nutrition, mental health, avoidance of risk-taking behaviors, smoking cessation, adoption of healthy lifestyle practices, and family health



Templates For A Local Policy Issuance On An F1KD+ Team

Template 1. For adhoc group [13]

Executive Order 12 No. ___

An Order Creating the First 1000 Days Situational Analysis Core Group

WHEREAS, the (name of LGU), recognizes that its children are its prime resource to drive its full development;

WHEREAS, the (name of LGU) is committed to ensure the holistic development of its children;

WHEREAS Republic Act No. 11148 or the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act aims to ensure the holistic development of children, with focus on the first one thousand days (F1KD+);

WHEREAS the full implementation of RA 11148 in (name of LGU) is consistent with its vision;

WHEREAS, such full implementation is best undertaken after taking stock of the situation in (name of LGU);

NOW THEREFORE, by the powers vested in me by law, I, (name of mayor). (name of LGU), hereby order the constitution of the Ad Hoc Technical Working Group (TWG) on the First One Thousand Days (F1KD+) Situational Analysis, with the following stipulations:

SECTION 1. COMPOSITION

Chairperson: Nutrition Action Officer

Members: Permanent representatives from the following departments/offices:

- Health Office
- Nutrition Office
- Social Welfare and Development
- Agriculture Office
- Non-Government Organization (specify which one)
- Others added as the LGU may decide

13 Adapted from an executive order of the City of San Fernando

SECTION 2. FUNCTIONS OF THE TWG F1KD+ SITUATIONAL ANALYSIS

1. Define the scope of the assessment as well as data requirements and sources
2. Collect, process, and analyze data to establish the situation of the city/municipality with regard to the F1KD, extending the age group coverage to include the 25–35-month-olds (F1KD+)
3. Prepare and submit to the Office of the Mayor the assessment report that should include the results of the assessment as well as recommendations to address the findings of the assessment
4. Lead in the dissemination of the results of the situational analysis

SECTION 3. THE DUTIES AND RESPONSIBILITIES OF THE SECRETARIAT

The (name of the LGU) Nutrition Office (if present. Otherwise, the local health office can be designated as the secretariat) shall provide secretariat services to the TWG F1KD+ Situational Analysis. It shall:

1. Record and document discussions of TWG meetings
2. Arrange interviews, meetings, consultations, and related activities that the TWG will undertake
3. Arrange meals and travel arrangements that may be needed
4. Perform other functions as may be assigned

SECTION 4. OTHER PROVISIONS

All departments and offices of (name of LGUs), as well as barangay chairpersons are directed to assist the TWG as may be needed.

SECTION 5. EFFECTIVITY

This Executive Order shall take effect immediately and shall be in force until one month after the submission of the TWG's final report.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the (name of LGU) this __th day of (month) (year) in (name of LGU).

Template 2. For a more permanent structure [14]

Executive Order 13 No. __

An Order Creating the Technical Working Group (TWG) on the First 1000 Days

WHEREAS, the (name of LGU), recognizes that its children are its prime resource to drive its full development;

WHEREAS, the (name of LGU) is committed to ensure the holistic development of its children;

WHEREAS Republic Act No. 11148 or the ***Kalusugan at Nutrisyon ng Mag-Nanay*** Act aims to ensure the holistic development of children, with focus on the first one thousand days (F1KD);

WHEREAS the full implementation of RA 11148 in (name of LGU) is consistent with its vision;

WHEREAS, such full implementation is best undertaken with a core group;

NOW THEREFORE, by the powers vested in me by law, I, (name of mayor) of (name of LGU), hereby order the constitution, under the local nutrition committee, the Technical Working Group (TWG) on the First One Thousand Day (F1KD), extending the age group coverage to include the 25-35 month-olds (TWG F1KD+), with the following stipulations:

SECTION 1. COMPOSITION

Chairperson: Nutrition Action Officer

Members: Permanent representatives from the following departments/offices:

- Health Office
- Nutrition Office
- Social Welfare and Development
- Agriculture Office
- Non-Government Organization (specify which one)
- Others added as the LGU may decide

14 Adapted from an executive order of the City of San Fernando

SECTION 2. FUNCTIONS OF THE TWG F1KD+

1. Conduct a situational analysis on the F1KD+
2. Facilitate the integration of services across sectors to ensure the delivery of needed services in the F1KD+
3. Formulate and update the local nutrition action plan (LNAP) to integrate concerns of RA 11148, ensure its integration in the CDP and AIP
4. Monitor the progress of implementation of the LNAP and attend to corrective actions as needed
5. Prepare reports on the F1KD+ for submission to the local nutrition committee quarterly
6. Evaluate the effectiveness of the LNAP

SECTION 3. THE DUTIES AND RESPONSIBILITIES OF THE SECRETARIAT

The (name of the LGU) Nutrition Office (if present. Otherwise, the local health office can be designated as the secretariat) shall provide secretariat services to the TWG F1KD+. It shall:

1. Record and document discussions of TWG meetings;
2. Attend to the administrative and technical requirements of the TWG F1KD+;
3. Organize and maintain the records of the TWG F1KD+for integration with those of the local nutrition committee
4. Perform other functions as may be assigned

SECTION 5. OTHER PROVISIONS

All departments and offices of (name of LGUs), as well as barangay chairpersons are directed to assist the TWG as may be needed.

SECTION 4. EFFECTIVITY

This Executive Order shall take effect immediately and shall be in force until rescinded.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the (name of LGU) this __th day of (month) (year) in (name of LGU).

Notes on Doing the F1KD+ Situational Analysis

What should the situational analysis cover?

The F1KD+ situational analysis should cover the key deprivations that affect children 0-35 months old, the reasons for these deprivations, and what are being done to address these deprivations. As noted earlier it can cover a specific dimension or it can be comprehensive, covering the range of concerns of services for the first 1000 days.

Whether limited in scope or comprehensive, the decisions to be made as a result of the assessment should be clear even at the assessment planning stage. Such decisions could be along one or more of the following concerns:

1. Areas, population groups, and persons to prioritize
2. Services to be added, removed, modified, improved
3. Building blocks to focus on for strengthening, e.g., service delivery, human resource, logistics management, financing, leadership and governance, information management
4. Strategic allocation of human, material, financial, and other resources
5. Priority policies to formulate

The range of questions that assessment should answer could include the following:

1. What is the situation in terms of outcome indicators, nutritional status, mortality situation (maternal, newborn, infant, and under-five), situation on child development (indications of developmental delays, abuse, etc.)?
    a. Who are more affected? By age and physiologic group? By income classification,By occupational grouping?
    b. How many are affected?
    c. Where are they located? Do they cluster in specific geographic areas? Or ecological settings (upland, lowland, inland, coastal, island), or in communities of indigenous people, or in Geographically Isolated and Disadvantaged Areas (GIDA), or areas affected by natural and human-induced calamities and disasters?
    d. What has been the trend in the situation?
    e. How does the current situation compare with the targeted situation indicated in the LGU plans?
    f. What are causing this situation, classified as immediate causes, underlying causes, and basic causes

2. What services are being delivered for good health? Adequate nutrition? Security and safety? Early stimulation? Responsive caregiving?
    a. What is the coverage of each service? Does the coverage meet the target coverage? What segment of the affected population is not being reached adequately?
    b. Does the service follow quality standards? If not, which service is falling below standards? What specific component of the standard is not being met?
    c. Are services being delivered in disaster/emergency situations? Are those in the F1KD+ being reached by these services? Are the services being delivered in a timely manner?
    d. To what extent are male members of the family and community engaged?
    e. Are the services being provided by more than one agency? If so, are the initiatives harmonized?
3. What explains the deficiencies in services being delivered? Is it because the targets are not accessing the service or is it because there is no or limited service? What is causing the situation? Lack of funds? Lack of supplies? Poor management of the supply chain? Lack of human resources in terms of number and capacity? Lack of physical facility in terms of number and capacity? Lack of good quality data for informed decision-making? Lack of policy, guidelines, or tools? Lack of information on services? Others?
4. What are good practices in delivering services? In generating demand and use of services? In improving the quality of services?
5. Has the local health system been organized into a city-/province-wide health system? Have Primary Care Provider Networks been organized? Have the Health Care Provider Networks been organized? Do these networks cover services in the F1KD+ adequately? (Answering this question is linked with answering question number 3.)
6. Is there a system to facilitate integration and coordination among various sectors? Are inter-agency structures (e.g., local health board, local nutrition committee, local council for the protection of children) present? Are these structures functional? Do they relate and coordinate with each other? If not, why not?

It is to be noted that the assessment for local nutrition planning and for local investment planning for health already cover those related to health and nutrition services. These assessments can be referred to. In addition, the DOH has developed templates that can help in the assessment of the supply side of health care. These templates are contained in the MNCHN MOP.

However, there is a need to purposely look into what is being done along ensuring child security and safety, early stimulation, and responsive caregiving.

In addition, the assessment usually looks into the situation among children 0-59 months old. Thus, there is a need for the assessment to zero in on children 0-35 months old.

While national government agencies will eventually modify their related guidelines, the LGU should already include these concerns in their assessments even while waiting for national guidance.

How can questions of the situational analysis be answered?

There are many ways of analyzing information generated for the assessment. These can include:

1. Comparing against a certain standard.
    a. For instance, stunting rates can be compared to standards set by the WHO for public health significance.
    b. Adequacy of the number of human health resources can be expressed in relation to the population and compared to DOH standards.
    c. Coverage of immunization can be benchmarked against the 80% coverage indicative of the achievement of herd immunity.
    d. Coverage of nutrition services can be assessed against the target of 90% coverage of needy population; the 90% coverage has been identified as the level of coverage that can impact on nutrition outcomes.
    e. Primary care facilities can be compared against standards as per the DOH Manual of Standards for Primary Care Facilities.
2. Comparison with the national, regional, provincial, city, and municipal data to make a judgement if something is high or low.
3. Observation of trends over the years or across climate seasons in a year or critical events in a year (e.g., lean months).
4. Mapping of certain characteristics to see clustering in a particular area or ecologic type.
5. Cross-tabulating two indicators. For example, prevalence of stunting can be cross-tabulated with average household size.

An important aspect of analyzing information is on determining why a particular situation exists. In this regard, asking a series of whys is important to determine the chain of causality. This can, in turn, be helpful in identifying appropriate intervention responses.

The assessment should make value judgements if a problem or situation is good or bad, if a service is adequate or inadequate, or based on objective measures. In some instances, there may be no hard data support, in which case wisdom and experience would have to be tapped into.

In some instances, organizing the chain of causality in a problem tree can help to further understand the situation.

Annex Table 1 shows an example for analyzing and making a statement on a nutrition problem, using the prevalence of stunting as example.

Annex Figure 1 shows a sample problem tree for an F1KD+ situational analysis, and how it can be turned into a solution tree and give insights on possible interventions.

Annex Table 1 shows an illustration of how data for F1KD+ situational analysis can be analyzed.

The following shows a sample analysis for data on prevalence of stunting among children 0-3 years old.

The analysis can be adapted for the other indicators.

SAMPLE ANALYSIS

What is the nature of the nutrition problem?

Compare with known standards and WHO definition of public health significance

	Stunting prevalence	Wasting/ Overweight prevalence
Very low	<2.5	<2.5
Low	2.5 to <10	2.5 to <5
Medium	10 to <20	5 to < 10
High	10 to <30	10 to < 15
Very High	≥30	≥15

WHO ARE MORE AFFECTED?

Compare prevalence by age group or by occupation group or by some other characteristic.

The prevalence rate of stunting among children 0-35 months old is highest among children 12-23 months old, girls, and in households with 4 or more in Municipality Ganda.

Characteristic	Prevalence of stunting
Age group	
- Infants	0.0
12-23 months old	4.5
24-35 months old	5.0

SAMPLE STATEMENT

The prevalence rate of stunting among children 0-35 months old in Municipality Ganda is 5%. This is low compared to the WHO cut-off for public health significance and the provincial prevalence rate of 8%.

However, even if the prevalence is low, it still translates to 1000 children whose future is already compromised.

Over the past three years, the trend has been increasing.

WHAT AREAS ARE MORE AFFECTED?

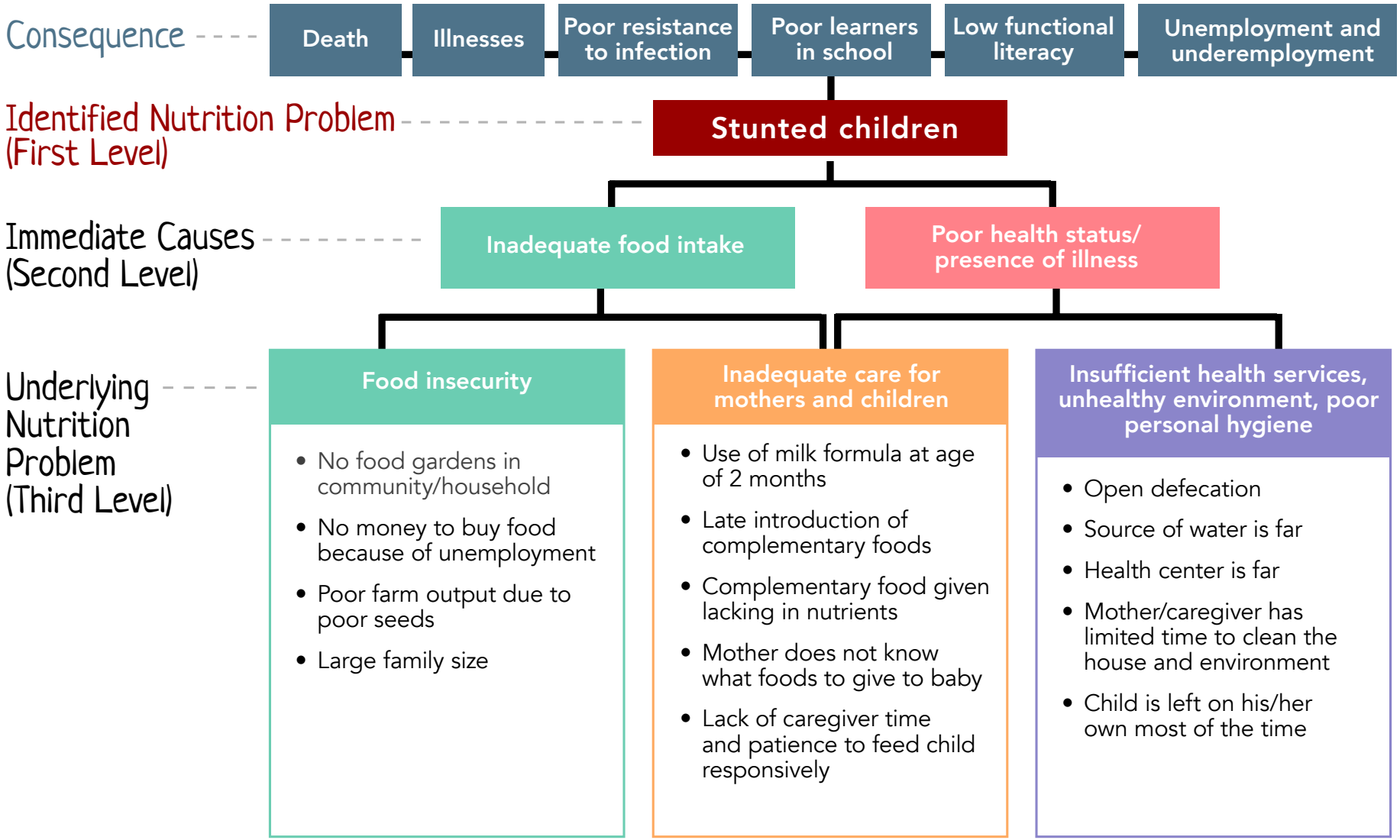
1. **Rank barangays by prevalence of stunting.** Get the top 25% (or any top portion), observe if these barangays tend to cluster in a part of the municipality and if these parts share some common characteristics, e.g., upland, or coastal.
2. **Map prevalence of stunting by barangay**
   a. Assign color codes, e.g. red for municipalities with high level of the problem, yellow for those with medium level and green for low level.
   b. Using a municipal map, color the barangays according to the color code.
   c. Observe if similar colored-barangays tend to cluster in a part of the municipality and if these parts share some common characteristics, e.g., upland, or coastal.
3. At the barangay level, using a spot map, mark households with stunted children. Observe if households with stunted children tend to cluster in certain parts of the barangay.

The top 10 barangays with the highest prevalence of stunting are: (List the barangays here). Almost all these barangays are by the coastal area.

Note: Sample maps can be inserted here.

ANNEX FIGURE 1

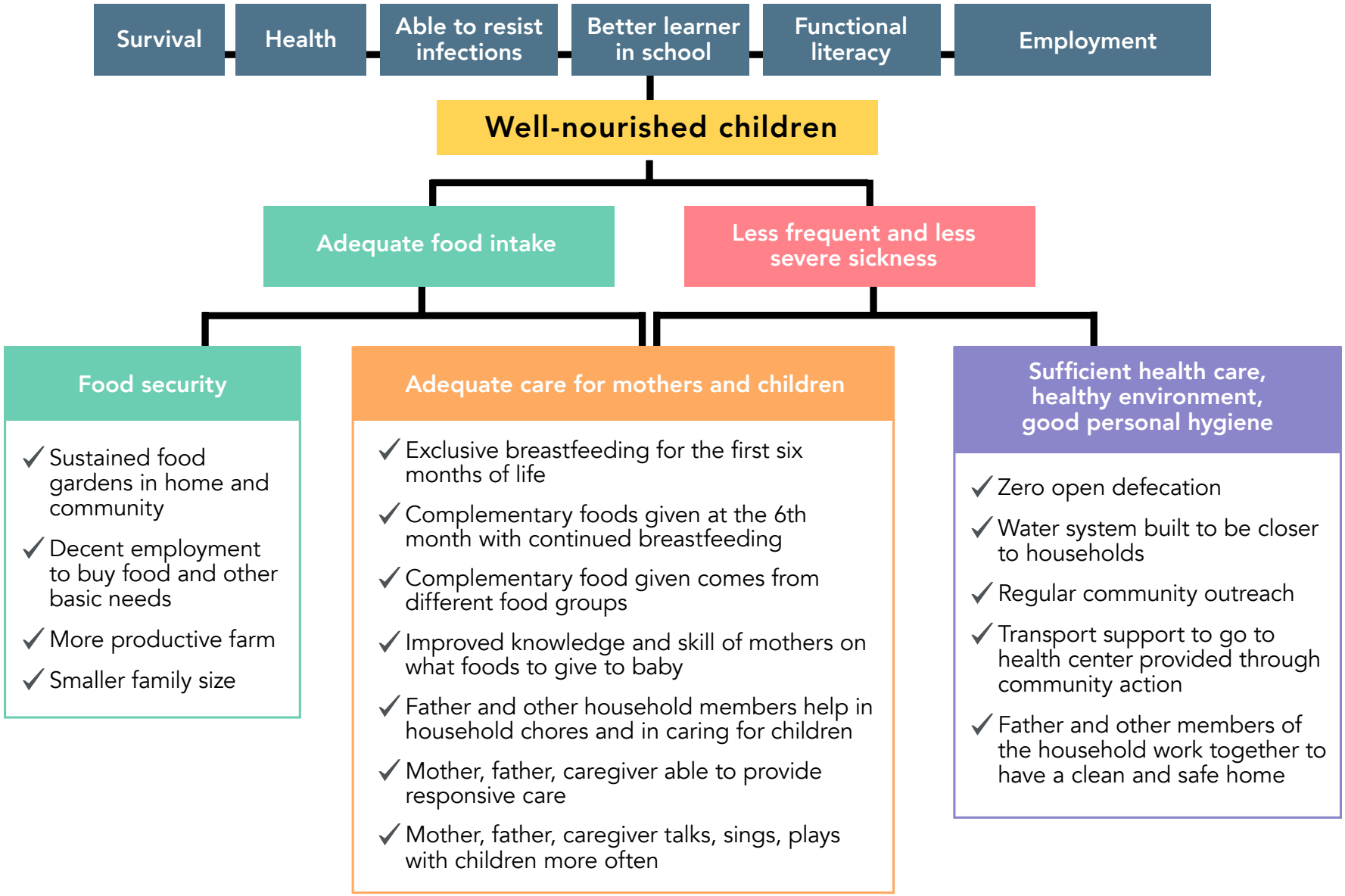
Problem Tree for F1KD+ Situational Analysis[15]



15 Adapted from the NNC eLearning Course on Nutrition Program Management

ANNEX FIGURE 2

Solution Tree for F1KD+ Situational Analysis[16]



16 Adapted from the NNC eLearning Course on Nutrition Program Management

Integrating F1KD Concerns in Comprehensive Development Planning[17]

CDP PREPARATION STEP 1

Revisit existing plans & review LGU vision

- Know who are the representatives of the local health, nutrition, social welfare and development office in the CDP Planning Team.
- If not yet a member, request for the inclusion of the NAO in the CDP Planning Team.
- Orient the CDP Planning Team on the importance of actions on F1KD+.

JULY OF ELECTION YEAR

CDP PREPARATION STEP 2

Organize and mobilize the planning team

- Include the LNAP and LIPH in the inventory of existing local plans for review by the CDP Planning Team.
- Review the existing LGU vision statement with members of the local nutrition committee or the F1KD+ team, see how it can be made more responsive to F1KD+ and present to CDP Planning Team for consideration.
- Consider working for inclusion of words like "healthy," "well-nourished," "secure," "food-secure."
- Review the LNAP and LIPH and check consistency with existing plans, and adjust as needed.
- Ensure that F1KD+ PPAs are included in the list of CDP PPAs. A possibility is suggesting a PPA on "F1KD+ Program" that will cover programs related to the components of the NCF.

AUGUST OF ELECTION YEAR

CDP PREPARATION STEP 3

Prepare ecological profile & structured PPAs

- Ensure that F1KD+ indicators (nutrition, health, child development) are integrated in the LDIS/RaPIDS with data disaggregated by sex and age. These indicators can be picked up from Table 5.
- Advocate and secure support from key members of the CDP Planning Team and the LCE for the inclusion of PPAs related to F1KD+ in the Structured List of PPAs.

AUGUST – NOVEMBER OF ELECTION YEAR

CDP PREPARATION STEP 4

Prepare the Local Development Investment Plan (LIDP)

- Prepare project briefs for proposed F1KD+ related PPAs.
- Advocate for support from key members of the CDP Planning Team and the LCE for the inclusion of F1KD+-related PAPs in the Ranked List of PPAs for investment planning.
- Participate actively in the prioritization of PPAs, and be ready with arguments for prioritizing F1KD+.

DECEMBER OF ELECTION YEAR UP TO **JANUARY** OF FOLLOWING YEAR

CDP PREPARATION STEP 5

Prepare needed implementation instruments

Advocate and secure integration in the following:

- F1KD+-related PPAs in the Annual Investment Program (AIP).
- F1KD+ concerns in the legislative agenda, e.g., ordinance on the F1KD+ as discussed on page ___.
- F1KD+ concerns in the capacity building agenda.
- F1KD+ indicators in the monitoring and evaluation strategy.

NOT LATER THAN MARCH OF YEAR AFTER ELECTION

17 *Adapted from Ensuring Nutrition Priorities in Local Development Plans and Budgets: A Thematic Guide and companion document to the CDP Illustrative Guide, National Nutrition Council, 2021*

ECCD Community Risk Targeting

ECCD Community Risk Targeting involves the mobilization of frontline workers and parents to watch out for signals of developmental delays, and when needed, refer the child to the Rural Health Unit (RHU) for further assessment (**Annex Figure 3**).

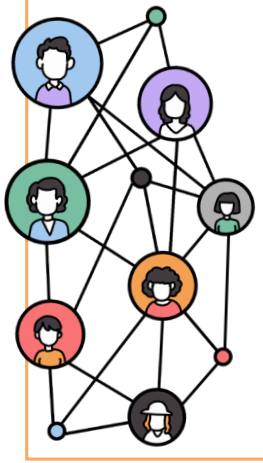
At the RHU, the doctor or nurse should administer the full ECCD Checklist, specifically Child Record 1. As needed, children should be referred to higher levels of care. The PhilHealth Package Z for CWDs can be used for financing the needed care.

For the prescreening, the following should be done:

1. The BNS, BHW, and CDW, under the mentorship of the midwife, can work together (e.g., each one can be assigned to assess a number of children) in assessing the risk of ALL children 0-35 months old using the tool in **Annex Figure 5**.
2. The BNS, BHW, CDW, under the mentorship of the midwife, can work together (e.g., each one can be assigned to assess a number of children) in assessing the achievement of core developmental milestones using the Developmental Milestones Chart shown in **Annex Figure 5**.
3. Parents and caregivers take part in monitoring the development of their children. They can use the tool in **Annex Figure 6** for this purpose.

Community

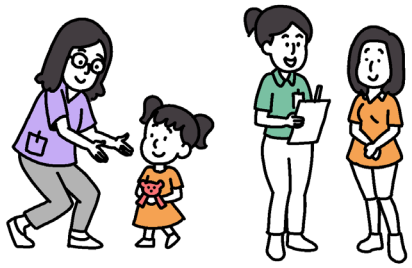
Patient identification by members of CHT using ANY of the following Prioritization or Pre-screening Criteria:



1. Known Risk Factor using The Nurturing Care Risk Factor Checklist for ECD
2. Findings in the Core Developmental Milestones Chart
3. Expressed concern from primary caregivers especially with reference to the EC List of Red Flags

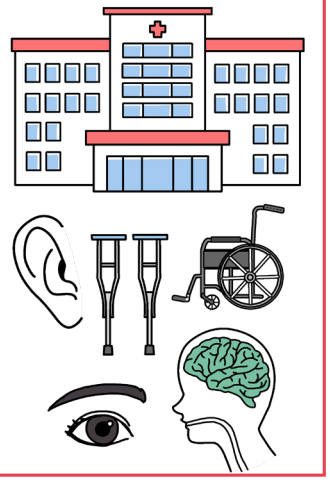
Primary Health Facility

Administration of ECCD Checklist Child's Record 1 by Health Center Staff (RHU Physician, Nurse, Midwife)



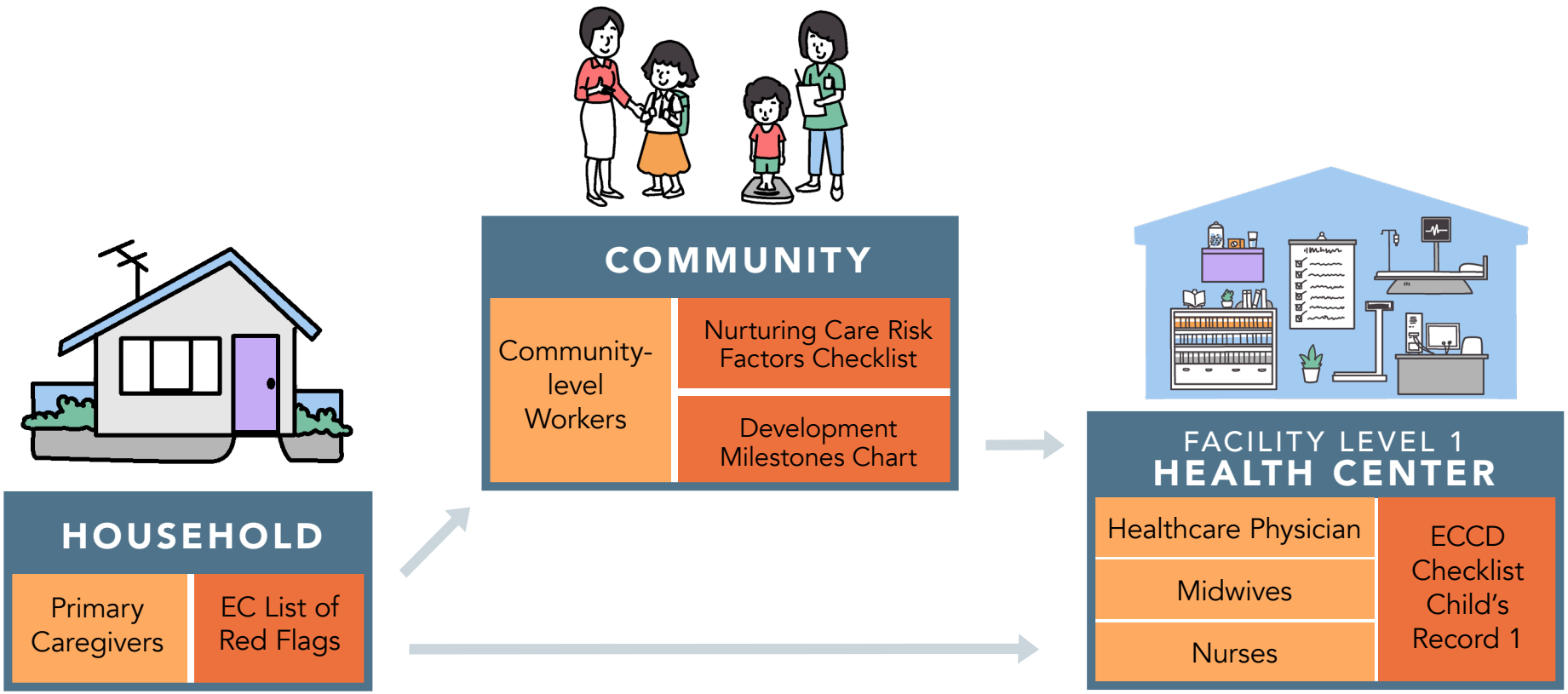
Referral

Higher level of care



ANNEX FIGURE 3

Flow for ECCD Community Risk Targeting



ANNEX FIGURE 4

Nurturing Care Risk Factor Checklist for ECCD

FILIPINO VERSION (ADAPTED)

PAALALA SA GAGAMIT:

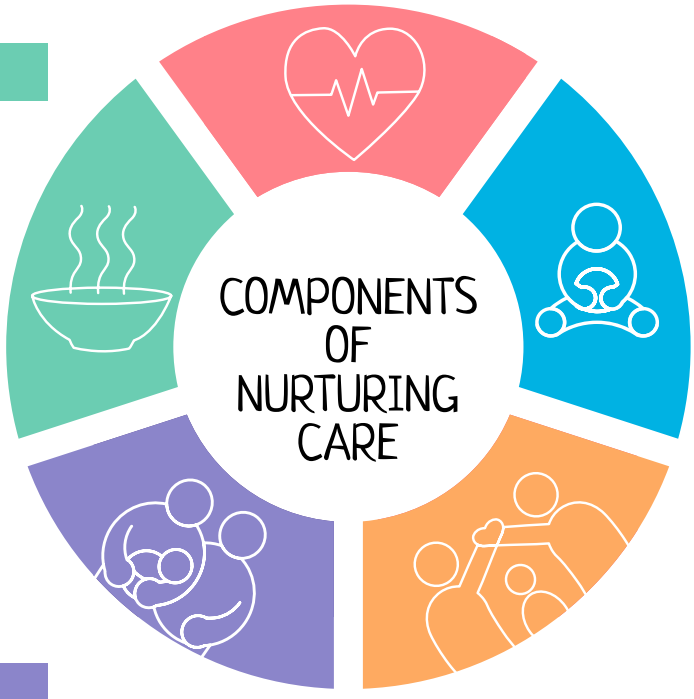
1. Ang listahang ito ay maaaring hindi kompleto at ginawa para magamit ng mga health workers sa komunidad lakip ang Core Developmental Milestones (tignan sa likod nito) para silang matukoy ang mga batang 0-3 taong gulang na mangangailangan ng referral sa health center o sa daycare upang mapangasiwaan ng ECCD Checklist Child's Record 1.
2. Ang checklist na ito ay pupuwedeng gamitin bago o pagkatapos ng Core Developmental Milestones Chart. Panuto:
   a. Lagyan ng "X" ang mga kahon na nag-aaply
   b. I-refer ang bata sa health o daycare center kapag:
      i. Merong marka kahit isang kahon sa pahinang ito.
      ii. Mayroong pag-aalala o pag-aalinlangan ang magulang, tagapangalaga, o ang health/day care worker sa development ng bata.
      iii. Ang linyang ginuhit sa Core Developmental Milestones Chart (sa likod nito) ay hindi diretso o hindi tugma sa edad ng bata.

GOOD HEALTH

- ☐ Pagkakaroon ng malubhang sakit o sakit mula pagkapanganak
- ☐ Pagkakaroon ng kapansanan sa bata o sa pamilya: pisikal, paningin, pandinig, etc.
- ☐ Mag kamag-anak ang mga magulang ng bata
- ☐ Delikadong Pagbubuntis:
  - ☐ Edad ng magulang <18 o >35 taong gulang
  - ☐ Sakit/impeksyon/kamatayan ng nanay
  - ☐ Pagkaexpose sa alak, yosi/tobacco, at droga ng nanay
  - ☐ Hindi naalagaan ang pagbubuntis
- ☐ Mababa ang APGAR Score o hindi umiyak agad ang bata pagkapanganak
- ☐ Premature o kulang sa timbang
- ☐ Positibo sa Newborn Screening
- ☐ Positibo sa Newborn Hearing Screening
- ☐ Nagkaroon ang bata ng matinding paninilaw o kombulsyonna nangangailangan i-ospital lalo na sa unang buwan nang pagkapanganak

ADEQUATE NUTRITION

- ☐ Labis na kapayatan (Wasted)
- ☐ Pagka-bansot
- ☐ Kasaysayan ng micronutrient deficiency sa bata: Vit A, Iron, or Iodine
- ☐ Ang nanay ay nanganaganib ang kalusugan habang nagbubuntis
- ☐ Hindi nakatanggap ng suplementong micronutrient ang nanay habang siya ay nagbubuntis
- ☐ Nagkaroon ng labis na katabaan (obesity) ang nanay o ang bata



OPPORTUNITIES FOR EARLY EDUCATION

- ☐ Bihirang kausapin at kalaruin ang bata ng nag-aalaga
- ☐ Madalas na iniiwang mag-isa habang nanonood ng TV o gumagamit ng gadget sa bahay
- ☐ Madalas na inaalog, pinapagalitan, sinisigawan, o pisikal na sinasaktan ang bata.

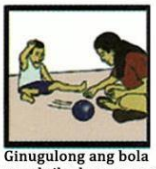
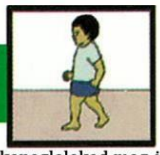
SAFETY AND SECURITY

- ☐ Pagka-expose sa karahasan sa bahay/domestikong karahasan
- ☐ Hindi maipaliwanag/kaduda-dudang pasa/pinsala, (pwedeng may bukol sa ulo o pamumula sa paligid ng mata)
- ☐ Pinaghihinalaang naabuso ang bata o pinapabayaan
- ☐ Labis na pagka-takot sa nagbabantay o sa ibang matatanda
- ☐ Ang bata ay kadalasan iniiwan mag-isa o sa pangangalaga ng isa pang bata (<10 taong gulang) lagpas isang oras.
- ☐ Kasaysayan ng malubhang pinsala sa bata (pagkalunod, naaksidente sa kalsada, nahulog, nalason, atbp.)

RESPONSIVE CAREGIVING

- ☐ Hindi planado/gustong pagbubuntis lalo na kapag ito ay dahil sa rape/inses
- ☐ Solong Magulang/Solo-Parent
- ☐ Ang Magulang/Tagapag-alaga ay may kasaysayan ng:
  - ☐ Pang-aabuso noong kanyang kabataan
  - ☐ Naakusahan o napatunayang nang- aabuso ng mga bata o karahasan sa bahay/domestikong karahasan
  - ☐ Pang-aabuso ng mga bawal na sangkap (alak, droga)
  - ☐ Pagkalulong sa sugal

Core Developmental Milestones ng mga Batang Pilipino

	MOTOR	SELF-HELP	LANGUAGE	COGNITIVE	SOCIO-EMOTIONAL
60 buwan 5 taon	 Hinahagis ang bola paitaas na may direksyon	 Naliligo na walang tumutulong	 Kinukuwento ang mga katatapos na karanasan (kapag tinatanong/ diniktahan) na naayon sa pagkakasunod-sunod ng pangyayari gamit ang mga salitang tumutukoy sa pangnakaraan (past tense)	 Tinutugma ang malalaki at maliliit na mga titik	 Gumagamit ng mga kilos na nararapat sa kultura na hindi na hinihiling/ finifiktahan (hal. pagmamano, paghalik)
48 buwan 4 taon	 Gumuguhit ng bahay gamit ang iba't-ibang uri ng hugis (parisukat, tatsulok)	 Pumupunta sa tamang lugar upang umihi o dumumi ngunit paminsan-minsan ay may pagkakataong hindi mapigilang maihi o madumi sa shorts	 Nagtatanong ng ano, sino, at bakit	 Inaayos ang mga bagay mula sa pinakamaliit hanggang sa pinakamalaki	 Naglalaro ng maayos sa mga pang-grupong laro (hal. hindi nandadaya para manalo)
36 buwan 3 taon	 Tumatakbo na hindi nadadapa	 Hinuhubad ang shorts na may garter	 Nagsasalita sa tamang pangungusap na may 2 – 3 salita	 Tinutugma ang mga larawan	 Ginagaya ang mga ginagawa ng mga nakatatanda (hal. pagluluto, paghuhugas)
24 buwan 2 taon	 Nahahawakan ang krayola ng lahat ng daliri ng kaniyang kamay na parang kamao (hal. palmar grasp	 Nakaiinom sa baso nang walang tulong, na may kalat	 Napapangalanan ang mga bagay sa larawan	 Nagpapakita ng mga payak na dula-dulaan (pagpapakain, pinatutulog ang manika)	 Ginugulong ang bola nang aktibo kasama ang magulang/caregiver/ eksaminer
18 buwan 1 taon at 6 buwan	 Nakapaglalakad mag-isa, minsan lamang matumba	 Napakakain ang sarili gamit ang kutsara nang may kalat	 Pinagsasama ang mga isang salita at galaw upang malaman ang gusto (hal. "labas" habang nakaturo sa pinto)	 Hinahanap ang mga bagay na nakatago	 Mapagkaibigan sa mga hindi kakilala ngunit sa simula ay maaaring magpakita ng ilang o hiya
12 buwan 1 taon	 Nakatatayo nang may minimum na suporta	 Napapakain ang sarili ng mga finger food (hal biskuwit, tinapay) gamit ang mga daliri	 Ginagamit ang tunog nang may kahulugan upang tumukoy sa tiyak na bagay/tao (hal. "Mama" sa kaniyang ina; "mamam" para sa tubig	 Tumitingin sa direksiyon ng nahuhulog na bagay	 Umiiyak kapag umaalis ang caregiver
8 buwan	 Nakauupo nang mag-isa ang sanggol	 Nagsisimulang kumain ng solidong pagkain ang sanggol	 Lumilingon kapag tinatawag ang pangalan, tumititig sa mata	 Inaalam ng sanggol ang mga bagay sa pamamagitan ng pagkagat, paghawak, pagtingin dito	 Nagbibigay ng reaksiyon ang sanggol sa mga pamilyar na sitwasyon
4 buwan	 Naiaangat ng sanggol ang kaniyang ulo nang matatag	 Sinusubo ng sanggol at umiinom ng gatas mula sa suso o bote	 Lumilingon ang sanggol tungo sa tunog	 Tumitingin nang dahan-dahan ang sanggol sa mga gumagalaw na bagay/tao	 Iniaangat ng sanggol ang kaniyang mga bisig upang batiin ang mga pamilyar na tao

ANNEX FIGURE 6. SIGNALS OF POSSIBLE DEVELOPMENTAL DELAY

ANG MGA MAAGANG PAMAMARAAN NG PAGSUSURI SA BATA

Adapted from Coordinator's Notebook, an International Resource for ECD

- Ikaw at ang iyong asawa o iba pang mga tagapangalaga na bahagi ng pang araw-araw na buhay ng bata ay maaaring gawin ang mga ganitong antas ng pagsusuri.
- kung sakaling ipinamamalas niya ang alin man sa mga sumusunod na palatandaan o pag-uugali.
- Kung ang inyong anak ay nakitaan ng mga problema o diperensya, dapat mong ipasuri ito agad sa mga doctor o *health worker.*

Ang mga sumusunod ay isang simpleng pamamaraan ng pagsusuri na maaaring gamitin mo, ng iyong asawa o sino mang tagapangalaga. Lagyan ng markang tsek **(√)** ang naayong kahon kung nakikitaan ninyo ang inyong anak na nagtataglay ng ganitong problema. Tandaan na agad kumonsulta sa doctor o *health worker* kung nakitaan ng deperensya.

PANDINIG (HEARING) – kung ang inyong anak:

- ☐ Hindi lumilingon sa mga pinagmumulan ng tunog o boses
- ☐ Madalas may impeksyon ang tainga (may tumutulo/lumalabas o masakit ang tainga)
- ☐ Hindi tumutugon kapag tinatawag maliban na lamang kung makita kayo
- ☐ Tinitingnan ang inyong mga labi habang ika'y nagsasalita
- ☐ Nagsasalita na ubod ng lakas o mahina ang tinig

PANINGIN (SEEING) – kung ang inyong anak:

- ☐ Kadalasan ay hindi nakikita ang mga maliliit na bagay na nalaglag
- ☐ May pamumula o matagal ng may lumalabas sa mata (tubig, nana, dugo), parang may anyong ulap sa mata o kadalasan ay kinukusot o masakit
- ☐ Madalas na nababangga sa mga bagay na nasa paligid sa kanyang pagkilos
- ☐ Ang ulo ay wala sa tamang posisiyon kapag may tinitingnang bagay
- ☐ Minsan o kadalasang naduduling ang isa o dalawang mata (makalipas ang edad na 6 na buwan

PANANALITA (TALKING) – kung ang inyong anak:

- ☐ Hindi nagsasalita ng mama/*mommy*/nanay sa edad na isang taon at kalahati (18 na buwan)
- ☐ Hindi masabi ang ngalan ng mga pangkaraniwang bagay o tao sa edad na 2 taon
- ☐ Hindi magaya ang mga simpleng kanta o himig sa edad na 3 na taon
- ☐ Hindi nagsasalita ng maiksing pangungusap sa edad na 4 na taon
- ☐ Hindi maintindihan ang mga taong hindi niya kapamilya sa edad na 5 na taon
- ☐ Kakaibang magsalita kung ihahalintulad sa mga batang kasing edad niya

PANG-UNAWA (UNDERSTANDING) – kung ang inyong anak:

- ☐ Hindi kumikibo kapag tinatawag ang kanyang pangalan sa edad na 1 na taon
- ☐ Hindi masabi ang mga bahagi ng mukha sa edad na 3 na taon
- ☐ Hindi makasagot sa mga simpleng tanong sa edad na 4 na taon
- ☐ Hindi makasunod sa mga simpleng kwento sa edad na 5 na taon
- ☐ Nahihirapan sa pag-unawa ng mga bagay na sinasabi mo kung ihahambing sa ibang bata na kasing edad niya

PAGLALARO (PLAYING) – kung ang inyong anak:

- ☐ Hindi nasisiyahan sa mga laro, gaya ng pagkaway-kaway sa kanya sa edad na 1 taon
- ☐ Hindi naglalaro ng mga pangkaraniwang bagay (tulad ng kutsara at palayuk-palyokan) sa edad na 3 na taon
- ☐ Hindi sumasali sa mga laro ng ibang bata (tulad ng habulan, taguan) sa edad na 4 na taon
- ☐ Ayaw makipaglaro sa mga batang kasing edad niya

PAGGALAW (MOVING) – kung ang inyong anak:

- ☐ Hindi makaupo ng mag-isa sa edad na 10 buwan
- ☐ Hindi makalakad ng walang tulong sa edad na 2 na taon
- ☐ Hindi makatayo sa isang paa kahit na sandali sa edad na 4 na taon
- ☐ Kakaiba ang pag galawa kung ihahalintulad sa mga batang kasing edad niya

Notes On Promoting Responsive Caregiving And Early Stimulation

Early childhood psychosocial stimulation refers to sensory (seeing, hearing, and touch) and emotional stimulation provided through an affectionate mother-child or caregiver-child bond.

Thus, parents and caregivers can be encouraged to maximize opportunities and manifestations on responsive caregiving and early stimulation. Such encouragement can be integrated in contacts with parents and child caregivers, e.g., during consultation visits in health facility, home visits, and group gatherings, etc.

The following points, from the *Idol Ko si Nanay* Learning Sessions can be shared during these contacts.

1. The mother-child or caregiver-child bond begins at birth and provides warmth and affection, and sensitivity and responsiveness to the needs of the child. It facilitates the child's learning to develop physical, cognitive, emotional, social and other skills.

2. Play and communication activities between mother/caregiver and child provide opportunities for psychosocial stimulation. Play and communication can happen during feeding, dressing, and other daily tasks. Play gives children opportunities to think, test ideas, and solve problems.

3. Paying attention to babies, playing with them and seeing how they respond to the attention will also help mothers/caregivers become more active and confident in their child caring role.

4. Examples of play and communication activities:
   a. Playing peek-a-boo helps mother and child pay attention to each other
   b. During breastfeeding, a mother can encourage her baby to learn by looking at him/her and respond to his/her movements and sounds with gentle touches and talking to the baby
   c. A mother/caregiver playing with a child on how to stack bowls of different sizes, stimulate several child skills like motor, cognitive, communication, and emotional

5. WHO recommendations for childcare and development are shown in **Figure 7**.[18] While there are still no guidelines or tools on promoting responsive caregiving and psychosocial stimulation in the first 1000 days, the city/municipality can adapt these recommendations.

18 Source: WHO, WHO - Recommendations for Care for Child Development

ANNEX FIGURE 7

WHO Recommendations for Care for Child Development

Newborn, Birth up to 1 week	1 week up to 6 months	6 months up to 9 months	9 months up to 12 months	12 months up to 2 years	2 years and older
 **Your baby learns from birth**					
• **Play** Provide ways for your baby to see, hear, move arms and legs freely, and touch you. Gently soothe, stroke and hold your child. Skin to skin is good	• **Play** Provide ways for your child to see, hear, feel, move freely, and touch you. Slowly move colorful things for your child to see and reach for. *Sample toys: shaker rattle, big ring on a string.*	• **Play** Give your child clean, safe household things to handle, bang, and drop. *Sample toys: containers with lids, metal pot and spoon*	• **Play** Hide a child's favorite toy under a cloth or box. See if the child can find it. Play peek-a-boo	• **Play** Give your child things to stack up, and to put into containers and take out. *Sample toys: Nesting and stacking objects, container and clothes clips*	• **Play** Help your child count, name and compare things. Make simple toys for your child. *Sample toys: Objects of different colors and shapes to sort, stick or chalk board, puzzle*
					
• **Communicate** Look into baby's eyes and talk to your baby. When you are breastfeeding is a good time. Even a newborn baby sees your face and hears your voice	• **Communicate** Smile and laugh with your child. Talk to your child. Get a conversation going by copying your child's sounds or gestures	• **Communicate** Respond to your child's sounds and interests. Call the child's name, and see your child respond	• **Communicate** Tell your child the names of things and people. Show your child how to say things with hands, like "bye bye". *Sample toy: doll with face*	• **Communicate** Ask your child simple questions. Respond to your child's attempts to talk. Show and talk about nature, pictures and things	• **Communicate:** Encourage your child to talk and answer your child's questions. Teach your child stories, songs and games. Talk about pictures or books. *Sample toy: book with pictures*

• Give your child affection and show your love • Be aware of your child's interests and respond to them • Praise your child for trying to learn new skills

A Way Of Discussing Agenda On The Status Of F1KD+ Services In Meetings Of The Local Nutrition Committee

Discussions in meetings of the LNC on the status of F1KD+ services aim to determine if the LGU is on track in delivering related services. It aims to identify bottlenecks in implementation and specific action lines that should be pursued to address these bottlenecks.

To make discussions more directed and effective the following are suggested:

1. **Collect and collate reports from agencies concerned.**

2. **Review each report and validate with the agency concerned.** Validation is needed if the target numbers are not consistent across reporting periods. Validation is also need for accomplishments that are low and the agency could be asked on possible reasons for the low accomplishment. If validation is not possible, notes on points for validation should be prepared and discussed in the meeting, if needed.

3. **Prepare the consolidated report** (see below for a possible template.)

4. **Analyze the report and identify which services are doing well.** The consolidated report can then be recast by regrouping services that are on track, services that are lagging. The latter can be further broken down by level of performance, e.g., ≥75% and <90%, ≥50% and <75%, <50%. The cut-offs could vary depending on the quarter covered by the report.

5. **Prepare the PowerPoint presentation** that for this agenda item could include
   a. **Purpose of the presentation:**
   b. **Method of collecting and validating data**
   c. **Agencies with inputs for the report**
   d. **Results**
      i. **Overall performance** (can be an average of all performance scores)
      ii. **Services that are doing well** (smileys could be used to convey the message)
      iii. **Services that are lagging** and indicative reasons for the lag
   e. **Recommendations** - Discussions should result in clear action lines, to be done by whom, and within what period. Action on these agreements can then be the starting point for discussions in the next meeting.

Life stage/ service/ indicator	Total estimated number	Annual target	Accomplishment		Percent of target accomplished		Remarks
			For the quarter	As of the quarter	For the quarter	As of the quarter	

Possible Action Lines For Observed Gaps And Deficiencies In Service Delivery

Observed gap or deficiency	Possible corrective actions	
1. Service is available, but targets not availing of services due to:		
a. Distance	1) Organize outreach activities 2) Organize and mobilize network of transportation providers 3) Strengthen scheme for home visits	4) Use existing structures that are closer to targets as point of service delivery 5) Build new structures
b. Not knowing of the available services	6) Tap the barangay council and community-based organizations and leaders to inform the community on services available	7) Use social media and other forms of media (e.g., posters, billboards in public places) to communicate services available
c. Service providers or point of service delivery not friendly to users	8) Define behavioral parameters for friendly service delivery and build capacity of workers to achieve these standards	
2. No or limited supply of services because:		
a. No funds	9) Include in budget proposal, identify savings that can be used and re-channel budget of non-moving projects/ activities	10) Find partners from the NGO community, private sector (watch out for conflict of interest), and development partners
b. Problems in supply chain	11)Improve procedures for estimating requirements, e.g., review history of use of supplies 12) Set, review, and revise threshold levels to trigger procurement of stocks to replenish	13) Procure early, e.g., consider when supplies are needed and the turn-around time for procurement process 14) Improve inventory recording processes 15) Have additional storage space
c. Inadequate number of service providers	16) Advocate for hiring of additional staff	17) Find partners from the NGO community, private sector (watch out for conflict of interest), and development partners that can provide additional human resources or funds for additional human resources
d. Limited capacity of service providers	18) Build capacity of service providers through trainings, refresher courses, provision of job aids, supportive supervision	
3. Lack of coordination among workers and agencies		
	19) Define and clarify roles, responsibilities, and accountabilities	20)Dialogue with head of office 21) Institute a system for regular sharing of information

Illustration of the use of the ABCDE framework for advocacy

Situation. The F1KD+ situation is far from optimum and services to addresses the situation are challenged by lack of funding support. Working for a local ordinance on F1KD+ and adapting RA 11148 in the LGU can address this situation.

1. A - Identify and characterize the audience or the person, institution or stakeholder that can act on the issue.
    - LCE, the vice-mayor, a member of the Sanggunian who will introduce and champion for the ordinance, the other members of the Sanggunian, the community and other stakeholders
2. B - Determine and be clear on the specific behavior
    - LCE – have an issuance indicating that an ordinance on the F1KD+ is a priority concern
    - A member of Sanggunian – introduce and champion for the ordinance on F1KD+
    - Vice-mayor: Schedule the proposed ordinances in deliberations
    - Other members of the Sanggunian – Vote yes for the ordinance
    - Community and stakeholders – Tell your kagawad that the proposed ordinance is important and should be passed, send letters of support for the ordinance on F1KD+
3. C - Determine information that needs to be conveyed to the target audience.
    - Information that can be shared can come from the situational analysis, e.g., nutrition situation, mortality and morbidity, low outreach of services due to funding constraints. In many instances, highlighting the impact of the F1KD+ on brain development is convincing.
4. D - Determine the design of the advocacy or how the information will be communicated to the target audience. This can be through:
    a. Face-to-face meetings with the target (mix of one-on-one and group) to present the case for the ordinance
    b. Sending letters of support to the members of the Sanggunian and asking others to do so
    c. Participation in hearings to provide technical assistance as needed
    d. Radio and television interviews on the importance of the F1KD
    e. Distribution of policy briefs for the audience that highlight why there is a need for the ordinance
    f. Any other method to reach out to the target. Whatever the channel of communication, the message should be clear, consistent, constant, and actionable
5. E - Evaluate the advocacy effort by determining if it resulted in the desired behavior.
    - Monitor if the desired behavior has been done. If not, assess why not and take action accordingly. For example, if the vice-mayor has not scheduled the draft ordinance on the F1KD+ for deliberations, a quick one-on-one meeting can be held to convince the vice-mayor to include the proposed F1KD+ ordinance in the agenda.

The First 1000 Days

MANUAL OF PROCEDURES

REPUBLIC OF THE PHILIPPINES · DEPARTMENT OF HEALTH · KAGAWARAN NG KALUSUGAN

NATIONAL NUTRITION COUNCIL · 1974

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