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**Working Paper**

## Situation analysis of ECCD-F1KD initiatives in the province of Samar

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DISCUSSION PAPER SERIES NO. 2019-30

# Situation Analysis of ECCD-F1KD Initiatives in the Province of Samar

*Aubrey D. Tabuga and Carlos C. Cabaero*



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# Situation Analysis of ECCD-F1KD Initiatives in the Province of Samar

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PHILIPPINE INSTITUTE FOR DEVELOPMENT STUDIES

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## **Abstract**

Children are more likely to develop and reach their full potential when they are protected from disease, provided proper nutrition, and live in stimulating and safe environments. Unfortunately, many children are deprived of nurturing care and favorable environment. In the Philippines, one-third of children under five years old were stunted based on 2015 estimates. This study aims to contribute in determining appropriate strategies for early childhood care and development interventions (ECCD) for the first 1000 days in a child's life by conducting a situation analysis in selected local government units in the province of Samar. It aims to examine the contextual factors underlying ECCD-F1KD interventions with emphasis on the policy and governance, the inputs and processes of planning and implementation of ECCD-F1KD programs and services, and the nurturing care practices of parents and caregivers. Results from the study emphasize, among others, the need for greater focus and resources to address current malnutrition problems and prevent malnutrition among children in the future. Likewise, there is a need for more integrated planning amongst local offices and clearer delineation of roles for ECCD F1KD initiatives. There is also a need to establish objective metrics during planning and implementation, as well as capacitation of LGUs to conduct monitoring and evaluation. The capacity of the human resources and health infrastructure must also be improved through ample capacitation and compensation for personnel, as well as rethinking deployment of health workers and positioning of health facilities to improve access to health and nutrition services. Finally, initiatives must be designed to improve health and nutrition knowledge of parents, to provide safe environments for children, and to promote sustainable livelihoods so that households can better provide nurturing care.

**Keywords:** early childhood care and development, children, nurturing care practices, policy and governance, program and service delivery

## **Acknowledgement**

It is often said that children are the future. Indeed, a significant part of what defines a person comes from the care and resources invested in them by the family and the state. It is in this breath that the Early Childhood Care and Development Act was created, thus emphasizing the necessity of its effective formulation and implementation across the country, especially in its most vulnerable regions.

In line with this, the research team would like to thank the United Nations Children's Fund (UNICEF) and the Korean International Cooperation Agency (KOICA) for their generous and ever-constant support in the conducting of the various case studies in Northern Samar, Western Samar and Zamboanga del Norte.

We would also like to thank our various local consultants who assisted us in arranging the case studies as well as interviewing the numerous stakeholders for the ECCD F1KD situation analysis. Their expertise and dedication proved essential to ensuring that the smooth and productive field studies in the various provinces.

Furthermore, we would like to thank the local government units for their warm welcome and complete cooperation with us during the conduct of the research, including the provincial office of Northern Samar, Western Samar, and Zamboanga del Norte. We would also like to extend our thanks to the local offices of Catarman, Lope de Vega, Catbalogan, Calbayog, Dipolog, Leon Postigo and Sindangan for extending us the same graces. Their patience and vigor in providing data, accommodating logistical requests and making time in their busy schedules for interviews were invaluable in our research.

Finally, we would like to extend our most heartfelt gratitude to the various program managers, doctors, nurses, midwives, and barangay workers, not only for their valuable insights but perhaps more so for their untiring service dedicate to the health and nutrition of children and their parents.

It is our hope that this research will prove beneficial to the effective formulation and implementation of ECCD F1KD strategies towards the achievement of health and nutrition for all.

# Situation analysis of ECCD-F1KD initiatives in the province of Samar<sup>1</sup>

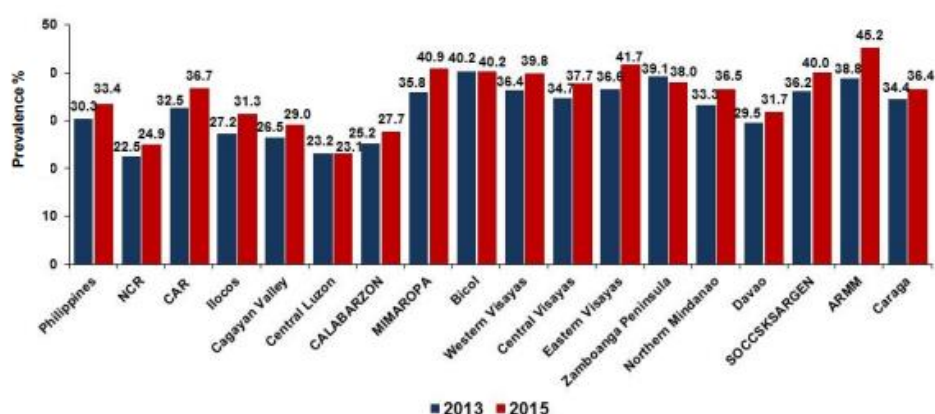
*Aubrey D. Tabuga and Carlos C. Cabaero<sup>2</sup>*

## Introduction

The role of leaders, implementers, and frontline workers at the local level is vital to efforts related to promotion of health and nutrition in communities. Similarly, the ability of parents and caregivers to nurture the growth of infants and young children and seek help and education as the need arise are likewise important. Furthermore, the need to identify and address any contextual barrier towards effective delivery of programs and services on the ground cannot be overemphasized.

Despite the sustained economic growth in recent years, the Philippines has relatively high levels of stunting, at 33%, among children under five years old in 2015 (Figure 1). This is far off the regional averages in the East Asia and Pacific (11% stunting prevalence). Childhood wasting affects about 7% of all children under five years old. Malnutrition problem in the country as with many other parameters of development is characterized by wide regional disparities reflecting evident inequality across the sub-national regions.

**Figure 1 Prevalence of stunting among children aged below 5 years**



Source: 2015 Updating of the Nutritional Status of Filipino Children and Other Population Groups, DOST & FNRI

In the Philippines' country profile<sup>3</sup> at [nurturing-care.org](http://nurturing-care.org), the support and services for early childhood development specifically nurturing care shows that 87 percent have antenatal care (4 or more visits) while 86 percent have postnatal visits (Figure 2). However, much remains to be done in treating HIV-infected pregnant women, in care-seeking for child pneumonia, and in the ECCD's nutrition component particularly exclusive breastfeeding. There is no data which allows one to examine those with minimum acceptable diet. Considerable progress is observed in the ECCD's security and safety component with 9 out of 10 births registered and 9 out of 10 households have basic drinking water. Sanitation remains an issue, however, with only 77% having access to basic sanitation. No data are available to shed light on how the

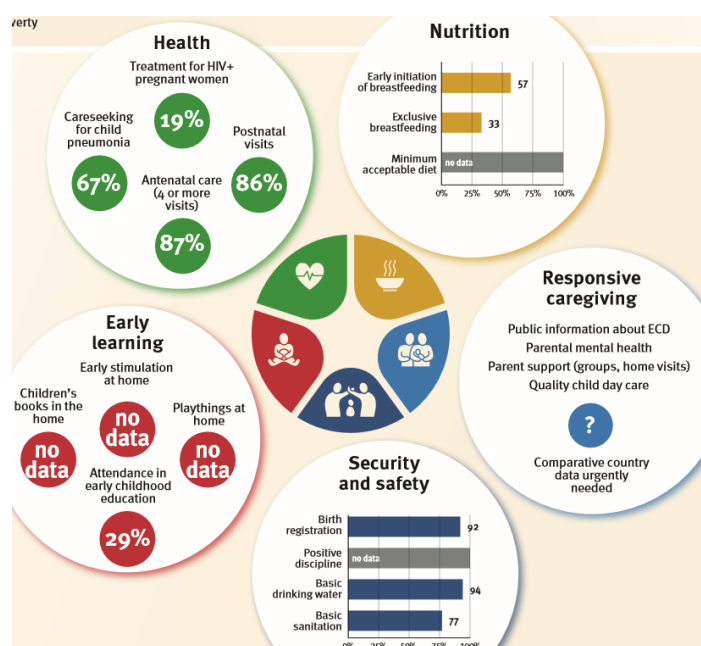
<sup>1</sup> This research is part of a bigger study that extends to other two provinces namely Northern Samar and Zamboanga del Norte.

<sup>2</sup> Research Fellow and Research Analyst, respectively, PIDS; the authors wish to acknowledge the excellent research assistance of Bless Mondez, Senior Research Specialist, PIDS, Darlyn Carnalan and Darmark Carnalan, Local Consultants. The usual disclaimer applies.

<sup>3</sup> <https://nurturing-care.org/wp-content/uploads/2019/09/Philippines.pdf> Retrieved Nov. 13, 2019

country performs in terms of the early learning and responsive caregiving components. This reflects the need for aggressive data collection to address these gaps.

**Figure 2. ECCD profile in the Philippines**



Source: Nurturing-Care.Org

<https://nurturing-care.org/wp-content/uploads/2019/09/Philippines.pdf> Retrieved Nov. 13, 2019

Studies found various factors that hamper people's access to health and nutrition services. The lack of income is a limiting factor.<sup>4</sup> A separate study concurs and found that parents and caregivers face economic constraints and such contributed to the malnutrition among women, infant and young children in five UNICEF partner municipalities.<sup>5</sup> Similarly, LGU's ability to address health challenges is constrained by limited budget and inadequate human resource (Ibid.). LGUs with limited resources face obstacles in providing service to geographically isolated areas.<sup>6</sup> In a paper that examined the management of SAM (severe acute malnutrition) in the country, the same challenge of lack of resources was emphasized (Garg, et al, 2016). Even supplies that come from higher levels are not adequate. To name one example, the standard protocols of the Philippine Integrated Management of Acute Malnutrition (PIMAM) were found to be difficult to operationalize due to lack of essential supplies like the RUTF (Ibid.).

With regard to governance, Garg et al (2016) found that there is lack of knowledge in implementing adequate, evidence-based management and monitoring of malnourished children. Procurement concerns of the DOH also constrain implementation (Ibid.). The 2018 Country Report of the UNICEF also identifies the following governance-related gaps. First, there is limited availability and quality of data, especially at the subnational level. Second, though key coordination structures are existent, these were non-functional.

There are bottlenecks in LGU planning brought about by the demands from the national level. LGUs tend to be hampered by the numerous guidelines and directives from various NGAs and

<sup>4</sup> De la Salle University-Social Development Research (n.d)

<sup>5</sup> See Integrative Competitive Intelligence Asia (n.d.)

<sup>6</sup> UNICEF 2018 Country Report



councils. Lastly, there is lack of clarity in terms of roles and leadership in integrating the program.

Aside from these economic, governance, and human resource constraints, external factors like natural calamities, safety and security issues, and inaccessibility of the areas also affect the service delivery. Typhoon Haiyan, one study notes, has raised the urgency of having standardized national protocols for combatting malnutrition (Ibid).

An assessment conducted by UNICEF to evaluate the success of its technical assistance to LGUs with respect to F1KD programs found that the delivery of these programs are stifled by the lack of capacity and understanding of the LGUs. For this, UNICEF responded through capacitating officials to more effectively plan and implement programs through evidence-based planning and budgeting workshops. This is complemented by situation analysis of children from Project CHILD (Children Information and Local Database). There is also an emphasized need to collect more quality data on various parameters of the F1KD such as data on child protection and disabled children. Furthermore, it is essential to institutionalize planning mechanisms and promote regional and provincial engagement to sustain F1KD initiatives. Crucial to achieving this are planning and prioritization of F1KD at the LGU level, use of data for planning and training, and the capacitation of frontline workers. The study also found a disparity in the effective integration and implementation of F1KD programs between LGUs with prior experience of maternal and neonatal interventions/ strong leadership commitment to F1KD over others.

Nevertheless, the UNICEF integrated strategy proved effective in strengthening coordination among different councils and organizations, thereby creating a protective environment for children. However, the sustainability of the program strategy widely depends on a) collaboration with regional, provincial and national government and b) continued prioritization and budgeting of F1KD programs in the LGU level. Moving forward, integrating multiple sectors can yield positive benefits for child nutrition, provided that clearer roles and delineations of roles are provided between stakeholders and developing and monitoring F1KD activities. Furthermore, this should be complemented with greater community engagement to influence positive changes in health and sanitation practices.

Amidst the challenges faced by LGUs, it is found that there is interest in the LGUs with respect to the implementation of ECCD-F1KD programs (Herrin et al, 2018). Furthermore, various issues on governance and health systems and existing gaps in health and nutrition program can be addressed by coordinated efforts (Ibid.). Moreover, it was emphasized that integrating national protocols into LGU community-based approaches is necessary to address malnutrition (Garg et al, 2016). The UNICEF 2018 Country Report also noted the following lessons that were gathered through consultations. Though implementation of project can be made separate, integration must happen in key stages of programming, such as planning, monitoring and review. Prioritization is paramount, given the limited time and resources available to LGUs. There is also a benefit in engaging multiple levels of government beyond the local level. This allows for greater coordination and scalability of program interventions.

This situation analysis aims to inform the development of strategies to improve health and nutrition interventions particularly those related to the first 1000 days of children's lives in Samar Province, one of the UNICEF-KOICA areas. The specific objectives are: 1) to assess the profile of selected LGUs in Samar with respect to health and nutrition outcomes using the Continuum of Nurturing Care Results Framework as basis, and other contextual factors and socio-economic characteristics; 2) to discuss the processes of planning and implementation of,

and access to ECCD-F1KD-related initiatives, taking into account the inputs and processes under the Building Blocks of Nurturing Care System and focusing on the policy and governance, and supply of and demand for ECCD-F1KD; 3) document barriers or challenges, as well as promising and good practices related to ECCD-F1KD; and 4) draw insights and recommendations for improving strategies in ECCD-F1KD.

The case of Samar is vital in understanding the contextual factors that influence the delivery of Early Childhood Care and Development - First 1000 Days (ECCD-F1KD) initiatives at the local level. The province has the highest stunting prevalence in the entire Eastern Visayas region. Based on the 2017 OPT, 31 percent of children aged under five years in Samar is considered stunted. This is more than twice that of Southern Leyte which has the lowest stunting rate in the region. The poverty incidence in the province is also one of the highest. Based on the 2018 first semester estimates of the Philippine Statistics Authority, nearly one-third of all families in the province fall below the poverty line.

To gain a closer look at what is happening in Samar, two LGU cases were examined – Calbayog City and Catbalogan City. These two cities provide a good contrast for purposes of analyzing the situation of ECCD-F1KD initiatives in the province. While both Catbalogan and Calbayog are coastal areas and face similar constraints posed by the presence of GIDA, one's stunting prevalence is twice that of the other. Catbalogan City is a 5<sup>th</sup> class city but with a stunting prevalence that is relatively lower (i.e. 10.6%) while Calbayog City is a first-class city having a high stunting prevalence (22.9%). This study aims to probe into this variation by examining the contextual factors focusing on three (3) key aspects – 1) policy and governance, 2) program and service delivery, and 3) nurturing care practices.<sup>7</sup>

The following sections discuss the objectives of the study followed by the methodology and description of the study sites. The findings contain the results of the key themes that this study investigated – policy and governance, program and service delivery, and nurturing care practices. These are then followed by the recommendations.

## **2. Objectives of the Study**

This study aims to undertake a situation analysis that will inform the design of strategies for improving ECCD-First 1000 Days (F1KD) outcomes in select provinces and municipalities. Specifically, it seeks to understand the contextual factors surrounding local mobilization of ECCD-F1KD interventions focusing in the aspects of 1) policy and governance, 2) program and service delivery, and 3) nurturing care practices of parents and caregivers. Under policy and governance, this study examines the aspects of priority setting, planning, financing, and monitoring and evaluation (M&E) in the localities under study and how such aspects matter in the implementation of ECCD-F1KD efforts. Under program and service delivery, the program components pertaining and related to ECCD-F1KD as well as the inputs and processes under the Building Blocks of Nurturing Care System are examined. Owing to the crucial role of caregivers, this study also analyzes the nurturing care practices of parents and caregivers. In addition, the study discusses best and/or promising practices as well as gaps and challenges and provides recommendations for improving implementation of ECCD-F1KD programs and services.

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<sup>7</sup> See Annexes for the brief profile of Calbayog and Catbalogan City.

### 3. Methodology

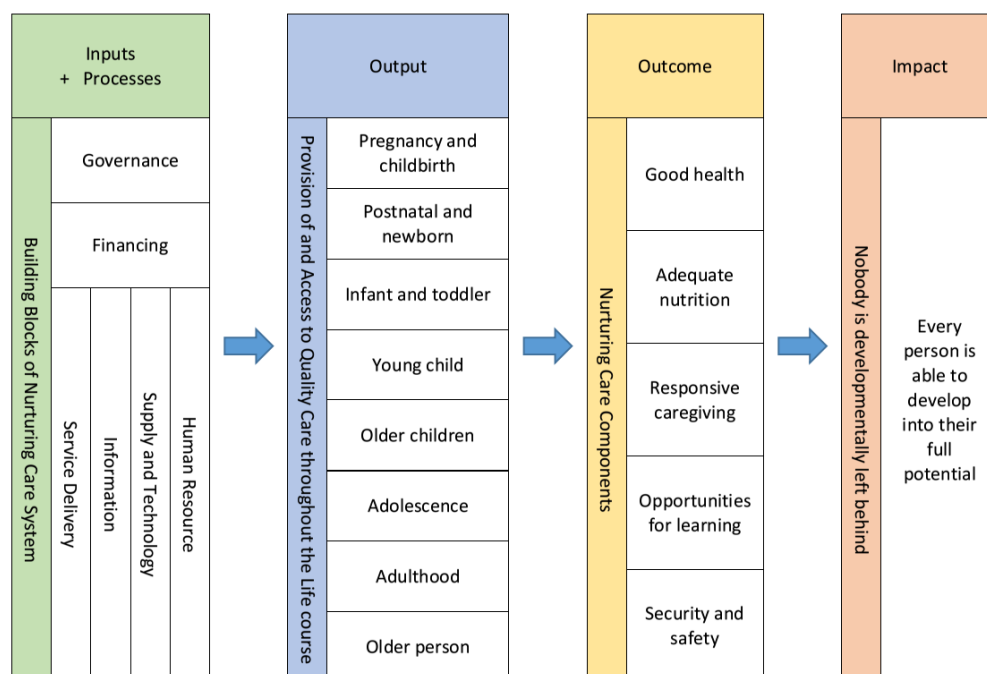
The situational analysis is guided by a results framework that the study team developed based on the frameworks elaborated in World Health Organization [WHO] (2007), and in WHO, UNICEF, and World Bank (2018). The proposed framework integrates the building blocks of health systems as inputs and process that are necessary in the provision and accessibility of the continuum of quality care throughout the life course. This then results in components of nurturing care, which contributes to the long-term goal of attaining full potential for all. A schematic diagram of the framework is depicted in Figure 3.

The provision of the continuum of care necessitates the mobilization of resources. This requires ensuring that a cadre of human resources are available to provide the services. The human resources, in turn, need to be supported by other resources, such as health and education supplies and technology, information systems, and finances, which are all governed by strategic policy frameworks to ensure that services are delivered efficiently and effectively.

The continuum of care highlights the need for age-appropriate interventions to allow each child to remain developmentally on track. In the situational analysis, the focus is on services relevant to the first 1,000 days of life, i.e., from prenatal to immediate postpartum to postpartum period and from infancy up to age two of children, as well as adolescence of women.

The provision of these nurturing care environment is expected to contribute to good health and adequate nutrition among children and child caregivers, opportunities for early learning among infants and toddlers, responsive caregiving among child caregivers, and security and safety among families.

**Figure 3 Continuum of Nurturing Care Results Framework**



Source: Based on WHO, UNICEF and WB (2018), and WHO (2007)

The study covered the UNICEF project-site province Samar (Western Samar) where the cases of Catbalogan and Calbayog City were examined in greater details. This research is part of a bigger study that extends to other two provinces namely Northern Samar and Zamboanga del

Norte. As an approach, it employed both primary and secondary data to generate insights on the various factors that affect the delivery of services by local government units and access to services among households, which ultimately influences the nurturing care outcomes among the population. The primary data were gathered from the key informant interviews (KIIs) and focus group discussions (FGDs) in the target LGUs – Catbalogan City and Calbayog City. To supplement the information from these interviews and discussions, key administrative and planning documents were collected from local government units (LGUs). The study also examined some quantitative data from administrative databases like Operation *Timbang* (OPT) by the National Nutrition Council (NNC) and population censuses and surveys by the Philippine Statistics Authority (PSA) to provide objective measures of local health outcomes in the study sites.

The FGDs and KIIs were implemented following a semi-structured questionnaire as guide. Separate guide questions were designed for each of the target resource groups: (a) local executives and policymakers, (b) program managers, implementers and front-line workers, and (c) household childcare providers (Table 1). In each of the FGD/KII instruments, questions concerning the target resource groups’ knowledge, attitudes, beliefs and behaviors in their roles in the provision of nutrition and health services, particularly those related to the first 1000-days of life were asked. In addition, targeted questions concerning each resource group were developed in order to probe and highlight specific themes as follows. The study team facilitators/interviewers solicited details from respondents with regard to the processes, inputs, opportunities, and challenges related to promoting the well-being of the target population.

**Table 1. Resource groups and discussion themes**

Target Resource Group	Discussion Themes
Local executives and policymakers	<ol style="list-style-type: none"> <li>1. Policy directions</li> <li>2. Resource mobilization</li> <li>3. Program Monitoring and Evaluation</li> </ol>
Program managers, implementers, and front-line workers	<ol style="list-style-type: none"> <li>1. Services provided</li> <li>2. Government support</li> <li>3. Work satisfaction</li> </ol>
Household childcare providers	<ol style="list-style-type: none"> <li>1. Accessibility of publicly provided services</li> <li>2. Customer satisfaction</li> <li>3. Nurturing care practices at home</li> </ol>

The local chief executives and policymakers included were city mayors, and members of the LGU planning team, such as planning officers, budget officers, and LGU engineers. Program managers, implementers, and front-line workers included the provincial and municipal nutrition action officers, social welfare officers, health officers, midwives, day-care workers, and barangay nutrition scholars and barangay health workers. Finally, household childcare providers included those who provide care to children, such as parents and caregivers/nannies as well as expectant parents. For household childcare provider-respondents, special attention was given to allow respondents from different socio-economic backgrounds to be represented, e.g. 4Ps and non-4Ps beneficiaries, and households from different barangays.

The study case sites in Samar were selected based on (1) the capacity of local governments to provide and households to access health care services, and (2) health outcomes, particularly among children. The study used the income classification of LGUs as proxy for local economic capacity of both LGU and households. For instance, LGU income class is positively correlated

with LGU expenditure on health, nutrition, and population services, and the availability of government health stations in barangays, while negatively correlated with poverty incidence among the population (see Table 2). For health outcomes, stunting prevalence among under-5 year-old children from 2017 OPT results by the NNC was used. As shown in Table 2, stunting prevalence is positively correlated with other mal/under-nutrition measures underweight and wasting prevalence, at least in the UNICEF study sites shown. Among the three related health indicators, the study used stunting prevalence as primary child health indicator since stunting has been shown to be the result of long-term nutritional deprivation which ultimately impinges on children's development potentials (e.g. Perkins, et. al., 2017).

**Table 2. Key economic and child nutrition indicators in UNICEF project areas**

Province	Municipality/City	LGU Income Class (as of December 2018)	Health, Nutrition and Population Services (PhP)		Barangays with Health Stations (%), 2010 CPH	Poverty Incidence (%), 2012 SAE	2017 OPT Results (% of under-5 children)			Population (Thousands), 2015 PopCen
			Total (Millions)	Per Capita (Thousands)			Stunted	Underweight	Wasted	
Samar	Calbayog City	1st	68.9	375	28.0	24.9	22.9	9.9	10.3	183.9
	Catbalogan City	5th	28.3	273	43.9	52.7	10.6	4.3	2.9	103.9
	Gandara	2nd	9.8	285	26.1	46.4	43.6	19.0	7.4	34.4
	Pagsanghan	5th	1.6	207	0.0	38.0	25.2	19.1	7.9	7.9
	San Jose de Buan	4th	3.8	483	0.0	43.2	45.1	21.9	7.4	7.8
	Sta. Margarita	4th	4.4	167	38.9	33.1	29.9	16.1	10.3	26.3
	Tarangnan	4th	6.3	251	39.0	47.5	20.3	14.3	5.8	25.0
Northern Samar	Bobon	4th	4.1	172	50.0	40.1	5.0	3.6	2.3	23.7
	Catarman	1st	14.5	154	69.1	34.8	3.3	2.2	2.4	94.0
	Gamay	4th	5.8	246	34.6	51.4	16.3	5.9	3.5	23.5
	Lapinig	5th	5.0	386	20.0	55.4	23.3	11.2	6.3	13.0
	Lope de Vega	4th	5.1	345	50.0	63.3	41.2	11.8	4.0	14.7
	Mapanas	5th	4.8	340	15.4	53.3	31.7	15.1	7.4	14.0
	Mondragon	3rd	4.8	123	25.0	53.6	25.4	9.7	8.6	38.7
	San Jose	5th	3.1	176	43.8	48.1	17.2	10.4	8.5	17.6
Zamboanga del Norte	Godod	4th	4.5	255	47.1	60.8	19.8	9.2 ...		17.4
	Leon B. Postigo	4th	5.1	195	94.4	54.2	8.8	5.8	2.7	26.2
	Siayan	2nd	8.1	232	95.5	70.5	10.0	7.2	6.0	35.0
	Sindangan	1st	18.4	185	94.2	46.9	4.3	4.0	13.5	99.4

Sources: LGU income classification and population are from the Philippine Statistics Authority [PSA] (2018) Philippine Standard Geographical Codes. LGU expenditures are from the Department of the Interior and Local Government Bureau of Local Government Finance (2016) Statement of Revenue and Expenditures. The 2017 OPT results are from the NNC (2018). The 2012 small-area poverty incidence are from the PSA (2016). Proportion of barangays with health stations are calculated from public-use file of the 2010 Census of Population and Housing by the PSA (2014).

Based on the above two-fold criteria, the municipalities and cities in Table 3 were purposively selected and proposed as case sites. The study sites in Northern Samar were selected to highlight the conventional wisdom that health outcomes are directly related to the availability of resources. In this case, high-income LGU Catarman has significantly lower child stunting prevalence rate (3.3%) compared to its low-income LGU neighbor, Lope de Vega, with 41.2% stunting prevalence. The study sites in Samar (Western Samar), on the other hand, are selected to compare and contrast two cities, i.e., Calbayog and Catbalogan, in order to understand why the availability of resources may not be enough to improve health outcomes. In the case of these two cities, high-income Calbayog City has higher stunting prevalence (22.9%) relative to the low-income Catbalogan City (10.6%). Finally, the sites in Zamboanga del Norte are selected to probe into how two different municipalities in one of the poorest provinces in the Philippines are able to achieve low stunting prevalence. In both Sindangan and Leon B. Postigo (Bacungan) municipalities, stunting prevalence rate are both below ten percent among children below five years of age. This study covers the Samar (Western Samar) leg of the research project.

**Table 3. PIDS-UNICEF F1KD-ECCD Project Fieldwork Sites**

	LGU Income Class	Stunting Prevalence
Northern Samar		
Catarman	High (1 <sup>st</sup> )	Low (3.3%)
Lope de Vega	Low (4 <sup>th</sup> )	High (41.2%)
Samar (Western Samar)		
Calbayog City	High (1 <sup>st</sup> )	High (22.9%)
Catbalogan City	Low (5 <sup>th</sup> )	Low (10.6%)
Zamboanga del Norte		
Sindangan	High (1 <sup>st</sup> )	Low (4.3%)
Leon B. Postigo	Low (4 <sup>th</sup> )	Low (8.8%)

The analyses are primarily descriptive. LGU administrative plans were examined mainly with respect to the narrative and numerical data to deduce the LGUs' priorities. Qualitative data obtained from the FGDs and KIIs were examined and summarized through a content analysis using the software NVivo. Results from this content analysis were supplemented with analyses of objectively verifiable measures of LGU service capacity, e.g. human resource, financing, and facilities, etc., and health outcomes, e.g., stunting, underweight and wasting prevalence, child immunization rates, etc.

#### 4. Study Sites

Samar is a province belonging to the Eastern Visayas Region. It comprises two-fifths of the entirety of the island of Samar (alongside Northern and Eastern Samar), covering a total of 6,048.03 square kilometers (2335.16 sq mi). It is bordered on the west by bodies of water such as the Leyte Gulf, opening out towards the West Philippine Sea (see Figure 4). Most of the cities and municipalities in Samar are located along the coastline, while its land area consists mostly of rugged hills and small lowlands. Moreover, it is found inside the typhoon belt of Eastern Visayas, which exposes the province to unfavorable weather conditions.

Most of Samar is considered rural, with 101,954 hectares of farmland being cultivated. Hence, the province heavily relies on agricultural products. Its top producing agricultural crop is coconut (260,420 metric tons), followed by palay (149,307 metric tons) and banana (103, 271 metric tons). Its top livestock consists of chicken (612,091) and carabao (28,930). Further,

Samar is the second major fish-producing province in the region, with its major industries including smoked fish (tinapa) and mussel (tahong).

**Figure 4. Map of Samar Province**



The 2015 Census of Population of the Philippine Statistics Authority (PSA) lists a population of 780,481 people in Samar, distributed amongst two cities and 24 municipalities. The population of the province saw an annual population growth rate of 1.19% from 2010 and 2015. Of these, 52,468 are 0 to 2 years old, and 56,109 are children ages three to five years old.

According to first semester estimates of poverty incidence amongst families, Samar has a 32.2% poverty rate, second only to Eastern Samar (43%) and higher than the regional average (30.4%). But based on the full year estimates from the FIES, the poverty rate of the region has been on the rise from 41.5 in 2006 to 48 percent in 2015. The trend is similar for the Samar province which saw its proportion of poor population increase from 40 to nearly 52 percent. Of its 26 cities/municipalities, only 5 managed to show reduced poverty incidence of its population within the same period (Table 4). Based on results from the 2017 Operation Timbang (OPT), the province has a 31.01% stunting rate amongst children aged 0-59 months. Among these children, 12.46% are found to be severely stunted (Table 5).

**Table 4. Poverty incidence of Samar province and cities/municipalities**

Poverty incidence among population (%)	2006	2009	2012	2015
Philippines	26.6	26.3	25.2	27.6
<u>Region VIII</u>	41.5	42.6	45.2	48.0
Western Samar	40.4	42.5	50.0	51.8
Almagro	28.5	39.5	48.1	39.8



Basey	30.9	39.1	34.8	36.6
Calbayog City	28.8	38.7	24.9	35.8
Calbiga	40	39.0	37.4	37.4
Catbalogan City	21.1	33.6	17.9	27.0
Daram	47.2	51.2	52.7	50.6
Gandara	37.9	43.8	46.4	45.9
Hinabangan	36.1	43.8	34.0	39.4
Jiabong	48.4	41.7	37.1	44.0
Marabut	35	44.4	37.2	37.4
Matuguinao	64.2	57.5	51.8	60.3
Motiong	60.6	45.9	42.0	48.5
Pinabacdao	39.1	45.0	47.0	45.5
San Jose de Buan	55	57.8	43.2	55.7
San Sebastian	49	43.0	40.8	41.0
Santa Margarita	36.1	40.7	33.1	36.4
Santa Rita	42	41.3	48.2	45.0
Santo Niño	38.6	45.3	40.0	46.0
Talalora	37.7	47.0	45.4	47.1
Tarangnan	44.9	46.3	47.5	43.4
Villareal	36.5	42.1	42.8	44.7
Paranas (Wright)	38.3	42.5	31.8	39.2
Zumarraga	46.1	49.9	49.5	49.9
Tagapul-an	38.3	42.5	49.5	50.9
San Jorge	36.6	42.3	41.1	45.5
Pagsanghan	31.8	40.6	38.0	37.3

Source: Family Income and Expenditure Survey (regional estimates); Poverty Statistics, Small Area Estimates (PSA)

**Table 5. Number and prevalence of stunted children in Samar and cities/municipalities**

LGU	Stunting Data (2017 OPT)					
	Stunted (Number)~	Stunted (Prev )~	Severely Stunted (Number)~	Severely Stunted (Prev )~	Total Stunted (Number)~	Total Stunted (Prev )~
Western Samar	8,153	18.56	5,474	12.46	13,627	31.01
ALMAGRO	109	13.51	90	11.15	199	24.66
BASEY	659	19.53	647	19.18	1,306	38.71
CITY OF CALBAYOG	2,458	15.35	1,203	7.51	3,661	22.87
CALBIGA	309	15.56	219	11.03	528	26.59
CITY OF CATBALOGAN (Capital)	1,103	7.19	517	3.37	1,620	10.56
DARAM	982	23.43	586	13.98	1,568	37.4
GANDARA	681	25	507	18.61	1,188	43.61
HINABANGAN	273	21.28	122	9.51	395	30.79
JIABONG	252	17.32	162	11.13	414	28.45
MARABUT	268	14.85	53	2.94	321	17.78
MATUGUINAO	159	21.57	91	12.35	250	33.92

MOTIONG	57	4.91	303	26.08	360	30.98
PINABACDAO	341	19.49	200	11.43	541	30.91
SAN JOSE DE BUAN	174	24.75	143	20.34	317	45.09
SAN SEBASTIAN	114	18.81	113	18.65	227	37.46
SANTA MARGARITA	439	18.38	274	11.47	713	29.86
SANTA RITA	972	21.68	494	11.02	1,466	32.7
SANTO NINO	140	15.07	43	4.63	183	19.7
TALALORA	47	4.33	9	0.83	56	5.16
TARANGNAN	245	10.33	236	9.95	481	20.28
VILLAREAL	722	23.31	473	15.27	1,195	38.57
PARANAS	421	14.99	153	5.45	574	20.44
ZUMARRAGA	258	19.3	270	20.19	528	39.49
TAGAPUL-AN	86	11.85	29	3.99	115	15.84
SAN JORGE	307	21.19	224	15.46	531	36.65
PAGSANGHAN	138	20.29	33	4.85	171	25.15

Source: OPT 2017, NNC

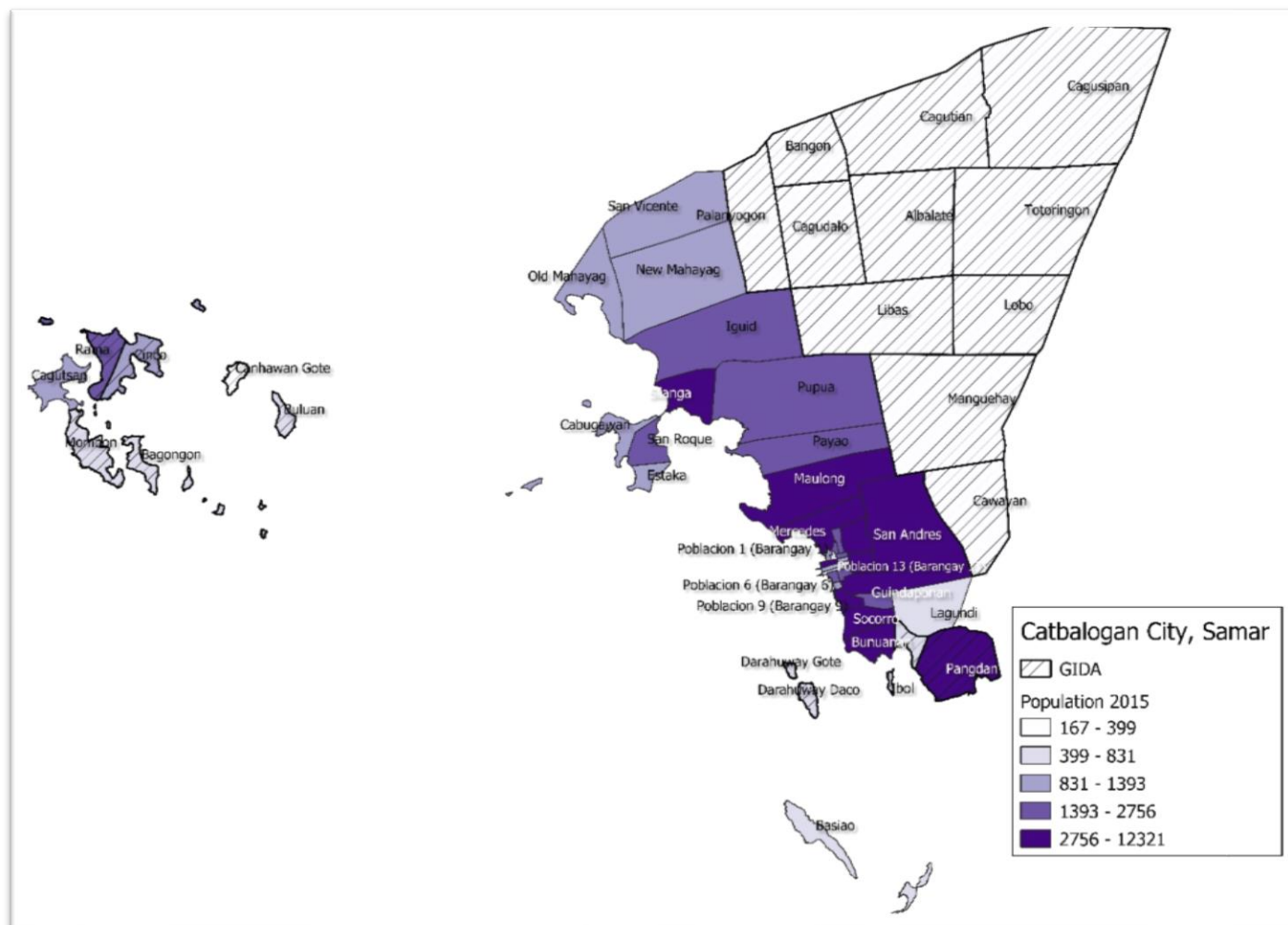
#### Catbalogan City

The city of Catbalogan is the provincial capital of Samar. It is a 5<sup>th</sup> class city with a population of 103,879. Its 2017 Statement of Receipts and Expenses (SRE) shows that the local government of Catbalogan has an income of PhP 606 million for that year. Dividing this amount to its population shows roughly an LGU income of PhP5,857 per person. The city's poverty incidence of 27.03 percent is the lowest in the entire province of Samar based on 2015 Small Area Estimates.

Catbalogan has a total of 57 barangays mostly found along the coast of Leyte Gulf, with some barangays located in separate islands (see Figure 5). Most of the population of Catbalogan is concentrated in the areas covering Brgy. Mercedes, San Andres, Maulong and Poblacion 1, Poblacion 7 and Poblacion 8. Of its 57 barangays, 22 are considered GIDA barangays based on information provided by the LGU. These are Albalate, Cagutian, Libas, Cinco, Cagutsan, Mombon, Lobo, Cawayan, Palanyogon, Cagusipan, Pangdan, Rama, Canhawan, Darahuway Daco, Totoringon, Bangon, Cagudalo, Ibol, Bagongon, Buluan, Darahuway Guti, and Manguihay. These 22 barangays comprise 13.2 percent (13, 776) of the population of the city in 2015.

The city has a total of 6,980 infants and young children aged 0 to 2 years old and 7,099 children aged three to five years old based on 2015 Census. Data for 2017 shows that Catbalogan has a stunting rate of 10.56 percent amongst children aged below five years which is the lowest rate amongst the cities and municipalities in the province of Samar.

Figure 5. Population by barangay, Catbalogan City



Source: 2015 Census of Population (PSA), National Health Facility Registry Ver 2.0

## Calbayog City

Calbayog is a 1<sup>st</sup> class city in Samar, with a total population of 183, 132 in 2015. Based on its SRE in 2017, the city government has an income of PhP 1.17 billion or PhP 6,395.47 per capita. The city is the third largest city in the country in physical area having 90,300 hectares. It is subdivided into 157 barangays, 24 of which are GIDA barangays according to recent records of the LGU. The GIDA in the hilly areas are Olera, Himalandong, Pinamorotan, Mabini I, Calocnayan, San Antonio, and Higasaan. Those located in the upper valley areas are Helino, Dinawacan, Tanval, Mancol, Gasdo, Buenavista, Canhumadac, Rizal I, San Isidro, Jacinto, Kalilihan, Nag-uma, Tigbe and Salvacion. There is one GIDA in Oquendo area (Brgy. Cag-anahaw) and two in Calbayog area – Cagbanyacao and Esperanza. These GIDA barangays comprise 5.5 percent (10,116) of the city's total population. Figure 6 shows the distribution of the population of the city per barangay with the dark-shaded one having larger number of population and the lightly shaded ones having fewer inhabitants. It also shows that the population of Calbayog is dispersed, concentrating in mostly the coastal areas. The population in the upland, GIDAs is relatively smaller.

Despite its status as a 1<sup>st</sup> class city, Calbayog City has a poverty rate of 35.8%, a significantly higher rate relative to Catbalogan City based on 2015 Small Areas Estimates. In terms of population of children, the city has 11,798 young children aged 0 to 2 years old and 12, 444 children from three to five years old. Calbayog registers a relatively high stunting rate of 22.87 percent, which is almost double the stunting rate of Catbalogan City. Its proportion of severely stunted at 7.51% is also twice that of Catbalogan City.

**Calbayog City, Samar**

[Hatched Box] GIDA  
 Population 2015  
 61 - 330  
 330 - 538  
 538 - 808  
 808 - 1790  
 1790 - 6388

19

## 5. Results

### 5.1. Policy, Leadership and Governance

#### 5.1.1. Priority setting

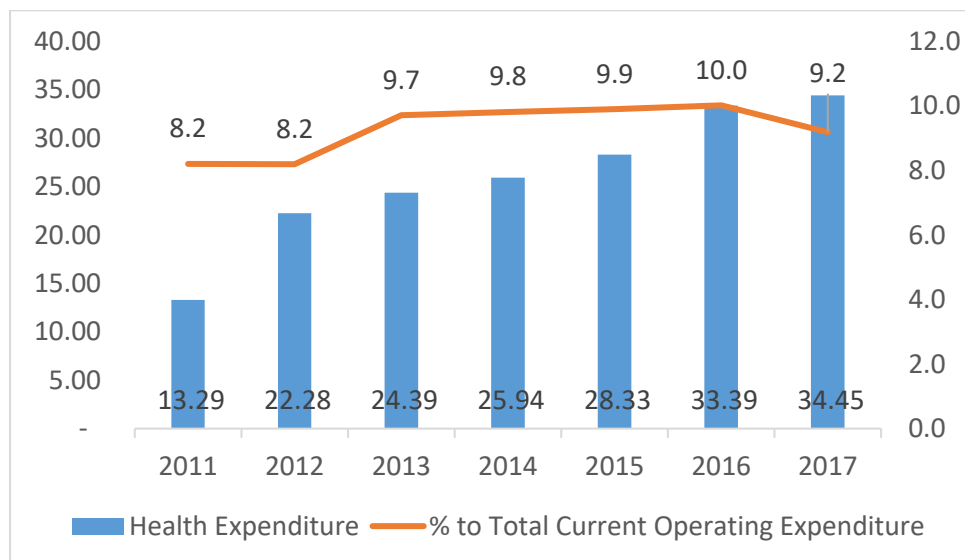
It is important to examine how local governments set their priorities to understand the policy context that may influence the extent to which LGUs prioritize health and nutrition programs, in general, and ECCD-F1KD programs, in particular. It aims to answer the following questions – How are priorities determined and who are the prominent actors involved? To what extent is health and nutrition being prioritized? What are the factors that influence priorities or the ability to set agenda?

**While different sectoral committees and barangays prepare, deliberate, and carry out consultations to determine the programs, projects and activities, the upper hand on which programs are included and funded rests on the local chief executive.** Programs that go into the local plans are determined at the level of councils (i.e. Development Council, City Nutrition Council, Gender and Development Council) the policymaking bodies for the different sectors. In these bodies, government and non-government representatives identify the projects and activities based on what they deem as needs and formulate them into proposals. Barangays also come up with their own proposals. These proposals and plans are deliberated at the council level and with the local chief executive. The City Development Council is the city government's key planning body which is composed of department heads, barangay officials and civil society representatives. The development council conducts sectoral consultation to gather inputs. It also ensures that national government's visions are linked to the local plans. Upon deliberation, these proposals are tackled at the budget hearing where funds are allocated. Outside mandatory allocations such as 5% for gender and development, 5% for disaster risk reduction, 1% for children, and 20% for local development, prioritization is said to be based on the needs. The City Nutrition Council is the body that formulates plans and programs including F1KD interventions that address the nutrition needs of the population while the City Health Office develops the plans for the health interventions. The final decision on which should be the focus is on the local chief executive. In some instances, the LCE selects priorities based on the recommendations of a particular department. There are also times when barangays go to the LCE directly or the members of councils go to the budget officer to lobby for their proposals.

**Based on qualitative data, the study found that the LGUs prioritize to some extent health and nutrition and allocate funds to its programs although these are not the top priorities. This is validated by local government expenditure data that show increasing trend in the resource allocation.** The study found that the Catbalogan's top agenda are expansion or decongestion of the city and construction of city hall building. Nevertheless, promoting the welfare of women and children is one priority as shown by a significant amount of funding going to health services and social services. It is also noteworthy that the LGU's health services have received recognitions. Furthermore, there is some awareness that malnutrition, maternal health, and lack of livelihood and poverty are among the most pressing issues the LGU is currently facing. It was noted that in comparison to previous years, Catbalogan now has greater focus on nutrition with better tools such as the use of forms for monitoring and documentation purposes. The increasing importance of health can be gleaned from the trend of current expenditures. The share of health in the current expenditures of the LGU has increased from

8.2. percent in 2011 to 9.2 percent in 2017. Within this period, health expenditures expanded from only PhP13.29 million to PhP 34.45 million, a 159-percent increase in absolute terms (see Figure 7).

**Figure 7. Health expenditures, Catbalogan City**



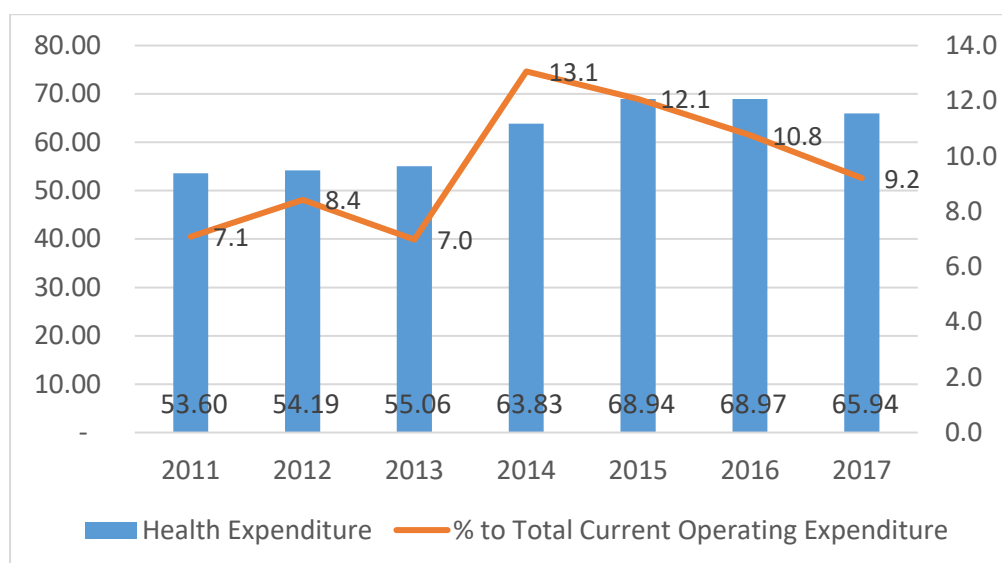
Source: Statement of Revenue and Expenditures, BLGF

**The case of Calbayog is similar in the sense that health and nutrition and ECCD-F1KD-related programs are not among the top priorities but these received significant amount of resources for program and service delivery.** The LGU's top priorities are the agriculture sector, infrastructure, urban renewal and expansion of the city. Moreover, while the LGUs can get funding from various sources like the DBM's LGSF, Congressmen and the national government, the programs that the city requested funding for were usually road projects, agricultural projects, and other infrastructure. Nevertheless, officials are aware of the LGU's key problems in health which are dengue (because the city was battling a dengue outbreak at the time of the study), gastro-intestinal diseases, lungs diseases, and malnutrition. There is also awareness that although the city in general is exhibiting some improvement in malnutrition, the improvement is not uniform and that those in GIDAs are more likely to have higher rates of malnutrition.

**Expenditure data show improved allocation for health through the years.** In 2018, based on current year appropriations, health services comprise 5.29 percent of the total obligations (or PhP 60.7 million). It received one of the highest obligations in 2018 – next to Other Purposes (PhP 567 million), General Public Services (PhP 368 million), and Economic Services (PhP 91.9 million). Meanwhile, the share of social welfare services which may include services for the city's indigent is at 3.63 percent. Some of the programs under the CSWDO with obligations during the said year are 1) youth welfare program, 2) women's welfare program, 3) family welfare program, 4) early detection prevention and disabilities, and 5) crisis response center for women and children. There is also an additional 2.44 percent of the special purpose appropriations or a total of PhP 10.87 million that was obligated for the following: child welfare and development (PhP6.235 million), GAD (PhP 10,000), and stipend/other activities for BHWs and BNS (PhP 4.626 million). Historical data also shows that health expenditures have increased through the years from only 7.1 percent of the total current operating expenditure in

2011 to 9.2 percent in 2017. The expenditures for health in 2017 was PhP 65.94 million, 23 percent higher than that in 2011 (Figure 8).

**Figure 8. Health expenditures, Calbayog City**



Source: BLGF Statement of Returns and Expenditures

**With respect to ECCD-F1KD, it was noted that the allocation for women or children are not big in terms of percentage but that all the programs brought to the budgeting process are provided with funding.** It was noted that health and nutrition is a big part of Calbayog's development agenda and the first sector tackled by the LCE upon looking at the data. To address malnutrition problems and ensure greater focus on nutrition (amidst an overburdened city health office), the sector that usually covers ECCD-F1KD program components, a new City Nutrition Action Officer was appointed under the direct supervision of the Office of the Mayor. The CNAO holds office at the Nutrition Center, an office that is separate from the City Health Office and is equipped with staff and funding from the Office of the Mayor.

**It is however difficult to examine how high ECCD-F1KD is within the health and nutrition agenda because its budget is lumped within the program components of the different LGU departments.** In the city health office, allocation for F1KD programs are lumped inside the nutrition budget. Medical supplies for all F1KD interventions are part of the broader line item of medical supplies. Funding for advocacy concerning F1KD is within the general category of advocacy funds. The resources that go to seedlings dispersed by the agriculture office to families of malnourished children for purposes of enhancing nutritional outcomes are lumped within their seedling dispersal program.

**The support of the LCE is very crucial in getting programs like the ECCD-F1KD funded and implemented.** In Calbayog City, the incumbent Mayor's support for nutrition and health has been affirmed in the interviews because of his openness to provide funds for programs related to health and nutrition. In fact, the CNAO implements the nutrition programs of the Office of the Mayor which the latter separately funds from the appropriation provided to nutrition programs of the CHO. In Catbalogan City, it was also found that it was relatively easy to get funds/support for nutrition programs from the Office of the Mayor. In the past, the CNAO budget was under the ambit of the Office of the Mayor. The new local chief executive specifically noted that health is one of his priorities.



**Perceptions and level of awareness of key officials on ECCD-F1KD issues are important in identifying priorities. The study found that while there is some awareness on the extent of malnutrition problem, the perception gathered is not to the level that merits urgency and high priority in the local government agenda.** While there is a consistent view that malnutrition is an issue, officials and implementers perceive that children in their locality are generally healthy. There is also variation in the level of awareness of local leaders and policymakers on this issue. The health and nutrition officials and staff, as expected, have a much deeper appreciation of the issues surrounding malnutrition. Notwithstanding the relatively high rate of malnutrition, the city (particularly, the non-GIDA) is said to be still better off than its surrounding municipalities when it comes to nutrition status of young children. The other officials' extent of awareness, however, varies from knowing some data on malnutrition to a more general view that "children are healthy since they eat three times a day" and that 4Ps families are diligent to the conditionalities that include going for pre-natal check-ups. Generally, the representatives of LGU officials are aware of local initiatives for health and malnutrition as they tend to cite these in their assessment of the issues. Also, despite their general view of a healthy children population, many of them are aware of the challenges such as the problems in parents' attitudes and the large disparities across units with the GIDAs being at a disadvantage. While some top officials do recognize the importance of addressing the malnutrition problem in their locality, there is a need to improve their awareness on the extent and consequences of existing malnutrition problem and the importance of preventing malnutrition in the future. The lack of awareness in some may be attributed to the lack of centralized data monitoring system from which information can be obtained.

#### 5.1.2. Planning

This section examines the planning process, particularly of the local nutrition action plan, and identifies gaps that must be addressed to ensure that the planning process is based on evidence and that it takes into account the urgent and pressing needs of the target population. It seeks to answer the questions - How are the Local Nutrition Action Plans (LNAP) formulated? Who are the key officials and stakeholders in the formulation of plans? What are the issues pertaining to the planning process in the context of ECCD F1KD implementation?

**The local nutrition council in the cities under study (i.e. the City Nutrition Council) is the key policymaking body for nutrition tasked to formulate the local nutrition action plan (LNAP).** The CNC is headed by the LCE and is composed of officials/staff the LCE appointed. In one LGU, the CNC is composed of the health officer, agricultural officer, city veterinarian, budget officer, and representatives from the social welfare office, DepEd, POPCOM, NGOs and volunteer health workers. The local nutrition action officer's roles are usually to 1) facilitate and coordinate the activities and projects of the CNC, 2) prepare reports/situationers on issues, and 3) outlines the PPAN including the needed interventions. The CNAO is also tasked to consolidate the finished LNAP. The study found that there are instances (as in the case of one LGU) where the CNC fails to convene and the nutrition action officer single-handedly craft the LNAP by gathering inputs from various departments' plans and reports.

**The inability to convene and jointly determine the plans is partly attributed to political transition wherein there were changes in the LCE because the former Mayor has been**

**suspended.** Unfortunately, it casts doubt on the CNC's ability to deliver on its mandate. Since the CNC does not convene, problems are not discussed properly among all members. Hence, the CNAO remedies this by going to the coordinator in each department to inform them of any problem which is an effort that is quite inefficient. Furthermore, the lack of interaction with other implementers limit the CNAO's ability to promote initiatives for ECCD-F1KD. While both CNAOs are not heads of office and are not members of the CNC, that in one LGU is more directly involved in the planning process being the facilitator of the CNC that conducts regular meetings. Though this role is similar with that of the other LGU, the lack of meeting in this LGU limits its CNAO's ability to directly engage with the CNC members in the planning process to promote programs and advocacies the person deems essential for young children.

**The composition of the CNC varies across the two LGUs under study.** While one LGU has a wider and equal representations from the different departments, the other has some departments having more representatives in the council than the other units. Wider representation is important in gathering information from the ground. Having the BNS president sits in the CNC, for instance, improves the chance that inputs from volunteers as well as from the barangays are collected. The variation in the composition suggests the lack of clarity and consistency in the criteria for selecting or appointing members of the local nutrition council. The LCEs are given the power to create committees including the local nutrition council.

**The standard planning process is for the departments to conduct their own internal planning and due to lack of time, they are unable to conduct integrative planning that can enable them to effectively share in the accountability and responsibility for delivering desired outcomes.** Programs that go into the LNAP in both LGUs are merely collated from the different departments which are implementing nutrition-related programs or projects. The only difference is that in one LGU, their programs have not been presented nor deliberated in a venue where all current CNC members are present. In the other case, the details of the CNAP, in some instance, goes through deliberation during regular meetings of the council. It was noted that in such meetings, there is really an opportunity to scrutinize the programs. But without integrative planning, targets may not be properly set and roles may not be well-delineated. This clearly points out the need for LGUs to invest more time and resources for joint planning and targeting particularly with respect to ECCD-F1KD.

**In one LGU being studied, its CNAP goes through a robust process.** The CNAP process starts with a study conducted by the CNAO that outlines the interventions needed. The official also presents the PPAN to the members to show aspects that are nutrition-sensitive and the corresponding agencies that should implement and fund the programs. Then the template for creating the plan for each department is provided. This is then followed by each unit coming up with plans and programs which it will implement and provide funds for. The plans and programs along with the estimated budget are then presented and deliberated in the City Nutrition Council (CNC) meeting. Upon deliberation, the CNC approves the plans. Given limited resources, priority areas which are the nutritionally depressed barangays based on OPT data are usually targeted. It is noted that while the PPAN is the basis for much of the nutrition plans, only those that the LGU is able to fund are included. Upon approval, the CNAO will then consolidate these into the CNAP. The agencies would then include the approved plans and programs in their own department plans. A copy of the CNAP which contains the consolidated programs is then provided to the CPDO for integration.

**The study also found that the planning process is mired with delays.** In particular, lags were identified between the planning and budgeting processes and that sometimes, plans are not ready even at the budgeting stage. In fact, planning is said to become a matter of compliance, for merely meeting deadlines. This is a significant deficiency that must be addressed.

**Usually, the OPT results and data from FHSIS are used in the drafting of local needs and priorities in the LNAP.** At the provincial level, the planning process is informed by on-ground feedback aside from OPT data. This is manifested through quarterly meetings with MNAOs/CNAOs where concerns, needs and priorities are raised. These inputs are used to prepare a draft nutrition plan, which obtains individual priorities and targets by each department.

**The ability of the CNAO and the CHO to push for improvement/expansion of ECCD-F1KD programs is crucial.** The CNAO and CHO are officials who have direct knowledge on gaps and challenges pertaining to ECCD-F1KD and are therefore in a better position to lobby for greater amount of resources.

### 5.1.3. Financing

This subsection examines the sources of funding for ECCD-F1KD, the manner by which funds are allocated and the issues and challenges associated with financing.

**Health and nutrition funding comes from various sources.** For the province, the pool of financial resources that can be utilized for ECCD-F1KD-related efforts come from the Office of the Governor and trust fund of the DOH. Other additional support from the provincial government going into health-related projects and activities is coursed to the Provincial Health Office – Technical Division through the Samar provincial hospital. This funneling causes added bureaucratic delays. At the city level, resources for nutrition and health projects come from the CHO general fund, Office of the Mayor, and NGOs. The agricultural department, city veterinary, social welfare and development office, and sanitation office, among others, also spend some resources for the benefit of malnourished children and their families. Meanwhile, training of trainers is usually carried out and funded by the NNC while the supplies such as the micronutrient, PIMAM supplies, RUTF, among others come from the DOH. The ability of the implementing officer such as the CHO in seeking for additional funding source was found to be very beneficial.

**The bulk of health and nutrition funding (in one LGU) comes from the gender and development fund (GAD) fund and not from the regular funds of the departments because this regular fund per department is affected in the event that the target local income is not realized.** The health and nutrition funding is lodged to the GAD to ensure continuity. In addition to the GAD fund, the Council of Protection for Children Fund is also utilized by both LGUs to finance programs for the benefit of women and children.

**The lumped budgeting system makes it difficult to ascertain the actual amount and percentage of resources going into ECCD-F1KD efforts.** For instance, the funding for advocacy and IEC for mothers and caregivers is lumped within the CHO's total budget for advocacy and IEC. The resources that the city veterinary office spends on providing some livestock to the families of malnourished children are incorporated into their general allocation

for livestock dispersal. Therefore, it is challenging to take stock of the extent of ECCD-F1KD efforts through the amount of resources that are spent by the LGUs.

**There are instances where the planning and budgeting processes are not synchronized.** Delays in the planning process were noted in the study wherein the outcome is that budgets are set even without the plans. This is something that must be addressed to ensure that resources are properly and efficiently allocated.

**It is common for departments to base the current year's nutrition and health budget on the previous year's budget.** This suggests that despite the increasing needs for interventions, such as capacity building for increasing number of volunteer health workers, the departments have to work on roughly the same amount of resources each year. This may adversely affect their ability to carry out programs and services if they are unable to make adjustments in their spending. It is, therefore, important to examine the consequences of such practice and to come up with more evidence-based mechanisms for setting the budget. One important deficiency is the lack of monitoring and evaluation particularly of inputs, activities, and outputs. Although the LGUs rely on the OPT outcomes to understand their needs, the OPT results are mired with low coverage, inconsistency and delays. Using the abovementioned example, an increased number of volunteer health workers requires greater amount of resources to be spent on their training and equipment.

**Despite the presence of various funding sources, there is lack of resources that go into the implementation of ECCD-F1KD, whether this is due to lack of financial base or lack of funds going to ECCD-F1KD from the resource base. The budget for ECCD F1KD in the LGUs under study is not enough to cover target beneficiaries.** The funds for implementing nutrition programs alone do not meet the required amount to 1) conduct sustained feeding programs for identified malnourished children in the locality, and 2) to provide all necessary equipment for use in OPT. Calbayog, for instance, uses a software for computing the resource requirement of covering all the malnourished children (aged 6 to 23 months old) in the areas identified through the OPT results. Often, the resource requirement is so high that it is really not feasible. This lack of resources is the key reason as to why the LGU is not able to meet its targets in feeding alone. Given this limitation, the LGU targets only selected barangays for its feeding programs. While DepEd is able to meet its targets in supplementary feeding of relatively older children because the funding comes from the national government, the LGUs are unable to meet theirs (for children aged 6 to 23 months) because of lack of LGU resources. Policymakers, therefore, must understand the need to allocate adequate resources into F1KD efforts to address existing gaps and prevent the persistence of malnutrition.

**Apart from lack of resources allocated to ECCD-F1KD, procurement procedures also inhibit LGUs from responding to sudden and urgent needs of women and children.** The demands for the programs and services are urgent yet the LGUs cannot act on these demands right away because the procurement process takes time. The problem emanates from lack of qualified suppliers which are required to secure a PHILGEPS number. There is a very limited choice for the suppliers because there are not many establishments willing to obtain the PHILGEPS requirement. Another hurdle is the need to pay the supplier first prior to the release of the goods needed. Getting the payment requires the signature of members of the Bids and Awards Committee (BAC). These BAC members, in some instances, are not always present which further delays the process. Furthermore, these hurdles are complicated by strict rules of liquidation by the Commission on Audit (COA). Admittedly, the LGU has some ways to expedite the process through some special mechanism but which involves immediate

liquidation upon release of the money. However, this, too, needs documentation such as a council resolution. The frequent delays indicate that even alternative modes may not be effective. It is therefore crucial to urgently explore effective ways to simplify these procedures if not exempt some initiatives like feeding programs for malnourished children to address problems of malnutrition.

**The nutrition budget in one LGU does not include an item for training of volunteers; the LGU merely relies on the provincial and regional levels for capacity building.** Their budget covers only the honorarium of the city nutrition committee, the compensation of the BNS and BHWs, supplies, training kits, weighing scale and height board. Despite increasing trend in the overall health expenditures, the budget for nutrition per se has been cut in the current year.

#### 5.1.4. Monitoring and Evaluation (M&E)

This section looks into the LGUs' capacity for M&E, the tools they use, and the issues pertaining to the conduct of M&E.

**LGUs use various tools for monitoring health and nutrition outcomes.** One of these is the OPT or E-OPT. One LGU noted that it also uses the FHSIS data that they submit to the national level for monitoring purposes. Another noted that in the monitoring of the CNAP objectives, they do conduct process monitoring every quarter which is used during the annual reporting process. In this annual reports, accomplishments in percentages of every agency are compared to the targets and are presented to the nutrition council. The LGU also uses a software wherein information based on documents is encoded into the system and one gets a rating. This is used by the regional office for evaluation of needs. For this, a nutrition staff has been trained to use the E-OPT. Interestingly, some evaluation or studies are done as part of the CNAP process when there is a need to conduct a profiling of the nutritional status of the target population.

**Both the CNPC and CNAO of at least one LGU are trained in monitoring and evaluation.** The said M&E training was part of the nutrition program management training which has components of planning, implementation, monitoring and evaluation. In Catbalogan, it was noted that all programs have their system of monitoring and evaluation. The quality of such system, however, needs to be examined further. In the checklist of ECCD-F1KD programs accomplished by its representatives, it was noted that it does not carry out monitoring in the ECCD-F1KD interventions that it implements. Nonetheless, this LGU exhibited its initiative to monitor program implementation and nutritional status of children and pregnant women through the use of forms that they devised. These forms collect information like weight, height, some computations, and remarks (like if the person is at risk or not). The forms were developed because it was noted that no such forms were endorsed to the current CNAO. Such forms help them in consolidating and monitoring data needed for counseling.

**Monitoring and evaluation are not carried out in the barangay because the BNS are not computer literate.** For now, the BNS use paper-based documentation which is then transferred into the system by a midwife that is currently being trained.

**In one LGU, the challenges in monitoring emanates from delays in getting the accomplishment reports from the different agencies doing nutrition-related programs.** The delay is at the level of the staff in charge of doing the accomplishment report except for those (e.g. the agriculture office) which conducts reporting on a monthly basis. The unit which incurs delays in submission is the DepEd because they are usually busy with many other things.

**Based on KIIs, the ECCD checklist, which is a prescribed monitoring tool, is quite new in health.** What they have is the mother and child book as the counterpart that tracks development milestones. Unfortunately, some shortages were noted wherein mothers merely photocopy the document. Any procurement by the city government for such is not known because the supplier and template are not known. So while the LGUs wait for such checklist from the national government, what the midwives and the parents do is to photocopy it. Sometimes the midwife shoulders the cost, sometimes the parents do. The usual problem is that they sometimes could not afford the cost and therefore, unable to comply, constraining the ability for proper monitoring.

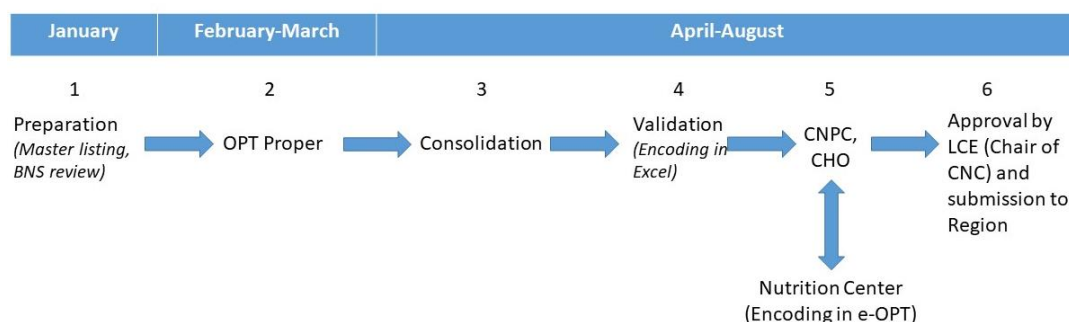
**Another factor that affects monitoring capacity of LGU is the CNAO being a mere designation despite the heavy workload.** Given such designation, CNAO activities and roles are additional tasks that have to be juggled with other equally important roles. These additional tasks are non-negligible that CNAOs need to juggle along with their original tasks. For instance, CNAO in Catbalogan City also works as a nurse in the main health facility of the city which usually encounters shortage in human resource. The CNAO noted that she is overloaded with all these tasks. Similarly, the CNAO in Calbayog City is a medical doctor by profession and also takes charge of the City Blood Bank. Although the CNAO's job is for monitoring/coordinative work, the CNAO is simply unable to monitor all 157 barangays and evaluate activities of the Barangay Nutrition Committees because there simply isn't enough time. As head of the City Blood Bank, the CNAO goes to different barangays conducting mass blood donation wherein he himself screens the blood donors. In addition, he also mans the Outpatient Department at the Sports Center wherein he conducts medical check-up every Friday. The CNAO's heavy workload affects their ability to conduct adequate monitoring and coordination for all the barangays.

**The importance of research generation for policy formulation purposes was recognized.** However, LGUs 1) do not conduct their own research using the data they get from their forms, and 2) are unable to properly document activities. Although one LGU noted they also have data at the individual data which is the TCL (target client list), such is not encoded. Only the consolidated data are encoded, and these are at the barangay level. For nutrition, they maintain individual-level data because of OPT but not for other programs. One issue in monitoring is the attitude of some nurses and midwives who sometimes fail to properly document their activities which affect the reliability of the TCL. But even with the existing data that result from M&E initiatives, there is a need for promoting their utilization in policymaking processes. Currently, these are being used for advocacy and awareness-raising campaigns.

**The LGU's main tool for monitoring health and nutrition outcomes for infant and young children is the OPT.** In Calbayog City, the CNPC narrated the process of the Operation *Timbang* (OPT). The first step entails some preparatory works which comprise of master listing and review of the BNS on the proper weighing and measuring of height. The master listing is usually done by the midwife assigned in a cluster of barangays. To ensure that BNS are capacitated to carry out the OPT tasks, a review is also carried out. This is usually done in January each year. The next step is the OPT proper where BNS and BHWs, under the supervision of the midwives, conduct the measurement of weight and height of target children. The third step is the consolidation which is a long and tedious process of filling up a total of three forms. The next step is the validation conducted by the midwife which also entails encoding the data from the forms into a spreadsheet. The CNPC under the CHO will then consolidate these submissions then turn it to the Nutrition Center for encoding in the Electronic

OPT (e-OPT), the platform used for surveillance, faster report preparation and submission, and aggregating OPT results. After this step, the CNPC will then secure the signature of the chair of the CNC who is the City Mayor, and then submit both the soft and hard copies of the results to the regional level. The whole process takes about eight (8) months to accomplish (see Figure 9). At the time of interview (i.e. August 29, 2019), the CNPC noted that they were scheduled to submit the 2019 OPT results by the end of August. In Catbalogan, the OPT results for 2019 were still being encoded as of the time of study visit. The current OPT results available are for 2016.

**Figure 9. The process of Operation Timbang in Calbayog City\***



\*Authors' illustration based on KII with CNPC, Calbayog City

**The OPT process suffers from delays which adversely affects LGU's ability to conduct timely monitoring.** The main bottlenecks in the OPT process are the conduct of the OPT itself because of lack of anthropometric equipment, the long encoding process which is caused by the lack of computer for encoding (staff would share computer for different purposes), and the process of documenting, recording, and consolidating given the many forms that volunteers have to accomplish and midwives have to validate. The process can also get stalled when people need to conduct validation in GIDA barangays.

**The OPT also suffers from low coverage.** The presence of many GIDA in Calbayog is also the key reason why the coverage rate of OPT is quite low. Based on interviews, the estimated OPT coverage for 2019 is around 52-53 percent which is lower than that in the past.

**There could also be measurement errors or inconsistency in anthropometric measurements.** It was further noted that since a lot of volunteer health workers are new to the OPT, they may lack the training to properly measure weight and height. Moreover, the equipment used in OPT is not uniform; while some used the prescribed equipment, others used improvised weighing and height measurement apparatus.

**There are also issues with measurement and documentation that cast a doubt on the accuracy of data collected in locality not only in OPT but in other data as well.** It was noted in one LGU that sometimes, health staff (nurses and midwives) forget to properly document their activities, particularly in vaccination. Many of the volunteer workers are still in need of training or re-training in basic courses. The number of BNS in Calbayog, for instance, increased from 97 to 156 this year, yet the training of many of these is yet to be conducted in September and October (2019). The complaints that officials get from the new BNS about difficulty of measuring weight and height indicates that there is a need for these trainings. One top official even noted that they need to validate the truthfulness of their data which at times are partial. This official expressed her desire to have realistic data – referring to

high rate of teenage pregnancy drawn from report of NDP (Nurse Deployment Program) nurses assigned in their locality.

## *5.2. Program and Service Delivery*

### *5.1.5. Programs and services*

To obtain the roster of F1KD programs currently being implemented in each of the LGU, the study team used the ECCD-F1KD checklist which representatives from the LGUs accomplished. The prescribed components, shown in Appendix 1, pertain to interventions during/for pre-natal, immediate post-partum, post-partum and lactation, birth and newborn, first six months of infancy, infants aged six months up to two years, and adolescent females. Under each component are specific programs or activities. Further, the list shows whether the LGU provides (A), and monitors (B) these programs. It also shows the key responsible officials. The discussion is complemented with information on other local initiatives gathered through the interviews with officials in the study areas.

**Catbalogan provides all the pre-natal period services and programs but does not monitor these. This is also the case for Calbayog except for PHIC enrolment and linkages to community-based health workers and volunteers.** The prescribed programs during prenatal period are: 1) pregnancy tracking and antenatal care enrolment, 2) regular antenatal care follow-ups, 3) provision of maternal immunization, 4) preparation of birth and emergency plans (including breastfeeding, rooming in, and counseling), 5) maternal nutrition counseling and child feeding practices, 6) identification and supplementary feeding of nutritionally at-risk pregnant women, 7) provision of micro-nutrient, 8) promotion of micro-nutrient fortified food, 9) parasitism assessment and anti-helminthic medicine provision, 10) oral health care assessment and provision, 11) counseling on personal hygiene and environmental sanitation, 12) counseling on responsible parenthood and family health services, 13) counseling on nutrition and healthy lifestyle practices, 14) PHIC enrolment and linkages to community-based health workers and volunteers, 15) social welfare support for poor nutritionally at risk pregnant mothers, 16) maternity protection during pregnancy, 17) counseling to parents/caregivers on responsive care and stimulation for infants/children, and 18) counseling and psychosocial support for parents and caregivers. As part of the abovementioned programs, Catbalogan conducts the ‘Buntis’ Congress which is an annual activity held in a selected barangay. In this Congress, pregnant mothers and BNS from various barangays are invited to attend talks on health such as the importance of prenatal and postnatal checkup. There are also speakers from other departments that talk about other city projects. This is accompanied by satellite services such as birth registration and feedings.

**For immediate post-partum period, Calbayog provides and monitors all programs. Similarly, Catbalogan LGU also provides these programs except 1) nutrition counselling and provision of nutritious food and meals for mothers, and 2) counselling to parents/caregivers on responsive care and stimulation for infants/children. Catbalogan also does not monitor any of the programs it provides.** The prescribed programs during immediate postpartum period are: 1) adherence to couple’s birth, breastfeeding and rooming-in plans, 2) provision of mother-friendly practices during labor and delivery, 3) monitoring and (possible) interventions for well-being of mother and fetus, 4) identification and preventive interventions for high-risk newborns, 5) coverage and utilization of PhilHealth benefit packages for maternal care, 6) nutrition counseling and provision of nutritious food and meals



for mothers, 7) lactation management services, 8) counseling on personal hygiene and environmental sanitation, 9) counseling on modern family planning and access to reproductive health care, 10) maintenance of non-separation of mother and newborn during rooming-in and breastfeeding initiation, 11) women and child-friendly spaces during calamities/emergencies, 12) support and counseling for fathers and caregivers in supporting mother and the child, and 13) counseling to parents/caregivers on responsive care and stimulation for infants/children.

**With regard to postpartum and lactation, Calbayog City government provides and monitors all the programs and services in the checklist except for 1) lactation breaks for women in the workplace which is implemented only in a few instances, 2) the provision of lactation stations in the workplace, and 3) organization of breastfeeding support groups in workplace. These similar initiatives are also not being implemented yet in Catbalogan City.** The rest are already being provided. The list of prescribed programs during postpartum and lactation include: 1) follow-up visits to health facilities, 2) home visits for women in difficult-to-reach communities, 3) lactation support and counselling from birth up to two years old, 4) nutrition assessment and counselling for lactation demands in health facilities and workplaces, 5) identification and provision of dietary supplementation for chronically energy deficient (CED) and nutritionally-at-risk women, 6) organization of community based mother-support groups for breastfeeding, 7) lactation breaks for women in the workplace, 8) lactation stations in workplaces, 9) organization of breastfeeding support groups in the workplace, 10) provision of micronutrient supplements, 11) promotion of micro-nutrient fortified food, 12) oral health care assessment and provision, 13) counselling on modern family planning and access to reproductive health care, 14) social welfare support for poor nutritionally at risk pregnant mothers, 15) women and child-friendly spaces during calamities/ emergencies, 16) support and counselling for fathers and caregivers in supporting mother and the child, and 17) counselling to parents/caregivers on responsive care and stimulation for infants/children. The organization of community-based mother support groups for breastfeeding is yet to be reactivated in Catbalogan. Again, it is important to note that although Catbalogan provides almost all of these services and programs, it does not have yet the tool for monitoring progress in its implementation.

**All the prescribed programs and services during birth and for the newborn are being provided and monitored by Calbayog City except for the early and continuous skin-to-skin contact and kangaroo mother care for babies in facilities with birthing services.** The LGU also does not provide 1) baby-friendly practices during delivery, and 2) human milk pasteurizer with neonatal ICUs to ensure breastmilk supply for children and infants but noted that these are being monitored. The programs during birth and for newborn are 1) provision of baby-friendly practices during delivery in line, 2) early and continuous skin-to-skin contact and kangaroo mother care for babies in facilities with birthing services, 3) maintenance of non-separation of mother and newborn during rooming-in and breastfeeding initiation, 4) routine newborn care services (eye prophylaxis, Vitamin K, immunizations), 5) administration of newborn screening and hearing screening, 6) availment and utilization of appropriate PhilHealth package for newborns, 7) early referral to higher level facilities to manage illness, 8) human milk pasteurizer with neonatal ICUs to ensure breastmilk supply for children and infants, 9) child-friendly spaces for breastfeeding during calamities and disasters, 10) social welfare support for poor newborns, 11) facilitation of prompt birth and death registrations, 12) support and counselling for fathers and caregivers in supporting mother and the child, and 13) counselling to parents/caregivers on responsive care and stimulation for infants/children.

**Catbalogan provides all the prescribed programs and services during birth and for newborn except for human milk pasteurizer with neonatal ICUs.** Apart from these, the LGU has also institutionalized the provision of 1) a cash incentive of PhP1,000, and 2) a starting kit composed of baby's supplies to women for fulfilling the minimum 4 pre-natal check-ups and giving birth at any birthing facility. This incentive is meant to encourage expectant mothers to undergo regular pre-natal consultation and provide proper childcare. In addition, under the CHO's Maternal and New-born Child Health and Nutrition, the LGU provides for safe blood for women giving birth in need of blood. There is also a local policy that holds any local midwife or *hilot* accountable for assisting home delivery in the event of maternal death. The city government also provides the *hilot* an incentive for referring the pregnant woman to the birthing facility. Also, to reduce maternal death, one official noted that the LGU has constructed birthing and infirmary facilities.

**It is noteworthy that both LGUs provide all the needed interventions for the first six months of infancy and for infants aged six months up to two years.**<sup>8</sup> Again, while Calbayog does monitor these interventions, Catbalogan does not. Among the prescribed programs and services for adolescent females, only the promotion of micro-nutrient fortified food is not implemented by the Calbayog LGU. In Catbalogan, all of these prescribed interventions are being provided or implemented by the LGU. The prescribed programs for delivery during the first six months of infancy are: 1) continuous support for exclusive breastfeeding, 2) immunization services integrated with other ECCD F1KD programs, 3) growth and development monitoring and promotion for infants less than six months, 4) counselling of household members on personal hygiene and environmental sanitation, 5) early referral to higher level facilities to manage common childhood illness, 6) identification and management of moderate to severe acute malnutrition among infants less than six months, 7) counselling to parents/caregivers on responsive care and stimulation for infants/children, 8) social welfare support for poor newborns, 9) support and counselling for fathers and caregivers in supporting mother and the child, and 10) women and child-friendly spaces during calamities/ emergencies.

Meanwhile, the programs and services that must be provided to infants six months up to two years old are - 1) introduction of safe and nutritious complementary food with continued breastfeeding for all infants from six months to two years of age, 2) nutrition counselling on complementary food preparation and feeding, 3) supplementation of nutritious and age-appropriate complementary food, 4) growth and development monitoring and promotion in health facilities and at home, 5) routine immunizations as per DOH guidelines, 6) provision of micronutrient supplements, 7) management of common childhood illnesses, 8) management and proper referral to higher level health facilities for moderate and severe acute malnutrition cases, 9) oral health care assessment and provision, 10) anti-helminthic tablets for children one (1) to (2) years old as appropriate, 11) availability of potable water, counselling of households members on sanitation and hygiene, and reduction of food, water and vector-borne diseases, 12) counselling to parents/caregivers on responsive care and stimulation for infants/children, as well as referral for development delays for early treatment, 13) social welfare support for poor newborns (including supplementation, complimentary food, development delay interventions), 14) support for home kitchen gardens, 15) locally available crops, fruits and

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<sup>8</sup> For relatively older children (i.e. those in daycare centers), Catbalogan City has institutionalized a local ECCD policy which protects daycare workers from being removed in the event of an administration change. The city government also allocates an annual budget of PhP6 million for the honorarium of daycare workers and PhP 1 million for supplies. There are also regular feeding programs by the CSWDO at daycare centers and by DepEd at elementary and high school level.

vegetables to be used in complementary feeding and dietary supplementation, 16) Protection against child abuse and accidents, 17) ECCD Programs (i.e. daycare services, community development programs, workplace related childcare/education), and 18) ECCD Programs (i.e. neighborhood-based play groups, family childcare programs, home visiting).

**In addition to the abovementioned programs and services, the city government of Calbayog also conducted various initiatives for nutrition.** These include the training of healthcare providers in the Philippine Integrated Management of Severe Acute Malnutrition (PIMAM). Since the CNAO is a medical practitioner and a trainer in the PIMAM, he was able to train all healthcare providers in the city. It was also noted that the city's Outpatient Therapeutic Care (OTC) facilities are now functioning and already have supplies. Hence, Calbayog City is said to have met these PIMAM requirements. The LGU has also created a Nutrition Cluster. For IEC, the city government celebrated the Nutrition Month, and Breastfeeding Awareness Month. It also conducts capacity building of the healthcare workers and BNS. The CNAO takes part in the capacity building of healthcare workers with respect to infant and young child feeding (IYCF) and the PIMAM. For the BNS, the programs are provision of basic course, training in acute malnutrition case finding and counselling. The city has also already provided for training of two batches of BNS.

**In terms of programs for adolescent females, Catbalogan City noted that it provides all the components prescribed under it. Calbayog City also does except for the promotion of micro-nutrient fortified food, although it monitors its practice in the locality.** The prescribed programs for adolescent females for LGU implementation are - 1) assessment food supplementation of health and nutrition status of nutritionally-at-risk adolescent girls, 2) provision of age-appropriate immunizations, 3) oral health care assessment and provision, 4) anti-helminthic drugs for deworming, 5) counselling on personal hygiene and environmental sanitation, 6) provision of micronutrient supplements in partnership with DepEd, 7) promotion of micro-nutrient fortified food, 8) referral to health facilities for management of menstruation irregularities and management of illness and malnutrition, and 9) counselling on proper nutrition, mental health, risky behaviors, healthy practices and family health.

**Despite the provision of programs for adolescent females, there is less focus on this segment as there is currently no agency which looks at this dimension.** In fact, it is not clear who is looking at this group's welfare – whether it is the CSWD, POPCOM or Health Office. Likewise, although POPCOM has some programs for this group, more concrete services and funding are needed.

**There is also a need for nutrition intervention and nutritional assessment for pregnant women as well as monitoring of teenage pregnancy, one key health official noted.** The study found that at least one LGU is in need of nutrition intervention for pregnant women like supplementary feeding. Moreover, there is a need to implement the program on nutritional assessment of pregnant women. Furthermore, there is currently no methodology or monitoring system for teenage pregnancy; the structure is also not clear as to who should focus on this group. An official emphasized that tracking and improving health and nutrition of adolescent and pregnant women is the first step in the F1KD program.

**It is important to note that the ECCD-F1KD is not yet formally institutionalized at the LGU level.** Currently, the components which have been existing in many years are distinct projects and are not consolidated yet into the ECCD-F1KD program. In Catbalogan, it is said

that this is going to be the focus come 2020. In Calbayog, the F1KD program is yet to transcend to the local policymaking body for it to have some legitimacy among the barangays.

#### 5.1.6. Inputs and processes

Understanding the structure and roles in the organizations that implement health and nutrition program are essential in examining the inputs and processes surrounding ECCD-F1KD programs and services.

**At the provincial level, the Provincial Nutrition Action Officer (PNAO) and the Provincial Health Officer (PHO) are the key program managers with respect to programs related to ECCD-F1KD. The key policymaking body is the Provincial Nutrition Council (PNC), the provincial counterpart of the NNC. The province of Samar also has a technical working group (TWG) – comprising of the core group within the PNC that directly and regularly works for nutrition programs and activities.** The PNAO serves as the secretariat of the PNC, coordinates with all agencies implementing nutrition interventions (e.g. provincial health office, education department, etc.), and focuses on the enabling processes of local nutrition program implementation which are assessment, planning, monitoring and evaluation. The PNAO's role can be summed up into - organizer, catalyst, evaluator, key person for technical assistance, and service provider for nutrition and the PPAN. The PNAO in Samar Province is a nutritionist by profession. Meanwhile, the role of the PHO, who holds office at the provincial health office technical division (PHO-TD) is the provision of technical assistance and overall supervision and evaluation of all DOH programs in the province including nutrition. In terms of structure, the PNAO is under the Office of the Governor where funding comes from and is not under the purview of the PHO. The PHO, on the other hand, gets funding from the DOH and provincial government. These two offices, however, coordinate with each other when they carry out programs and as they interact in the Technical Working Group for nutrition.

**At the city level, the city health officer (CHO), nutrition action officer (CNAO) and nutrition program coordinators (CNPC) are the key program managers/coordinators for ECCD-F1KD efforts.** Though other departments in the LGU (such as the CSWD and Agriculture Office) implement F1KD-related programs, they implement supplemental programs in addition to the direct F1KD interventions which the CHO, CNAO, and CNPC implement.

**There is variation in the current organizational structure for delivery of nutrition programs reflecting changing local governance dynamics.** The case of Calbayog is now similar to that of the province where the CNAO is a separate office from the CHO and is under the Office of the Mayor. In contrast, that in Catbalogan is now centralized where the CNAO works under the purview of the CHO. It should be noted that these structures are relatively new and are evident of either the LGU's tendency for transition or ability to adjust, or both.

**The Calbayog CNAO's functions are to coordinate nutrition-related activities implemented by different departments in the LGU, serve as the secretariat and facilitator of the City Nutrition Council, and implement nutrition programs (mostly feeding programs) of the Office of the Mayor.** The CNAO also facilitates and directly conduct capacity building and also monitors the volunteer health workers BNS. In the past, the CNAO, a designation held by the same person serving as the Nutrition Program Coordinator used to be under the CHO. Recently, the LCE designated a new CNAO under its direct supervision to ensure that there is greater focus on nutrition programs. The position is a designation, though,

not a permanent item. The new CNAO, a medical officer, is tasked to head the city's Nutrition Center, with the aid of some staff.

**The Calbayog CHO is the main implementer of various health programs including F1KD-related interventions.** In projects where CNAO and CHO coordinates, the final decision rests on the CHO. The CHO and CNAO also interacts through the regular meetings of the CNC. For the nutrition programs, the key person overseeing the implementation is the City Nutrition Program Coordinator (CNPC) who is under the direct supervision of the CHO. The CNPC coordinates with the CNAO and therefore links the CNAO and the CHO. It also coordinates with other LGU departments regarding nutrition activities and projects. The CNPC handles the Barangay Nutrition Scholars and is responsible for giving technical skills to these volunteer health workers. The coordinator also conducts monthly, quarterly and emergency meeting, extends one-on-one mentoring to the BNS, and monitors the annual Operation *Timbang* (OPT).

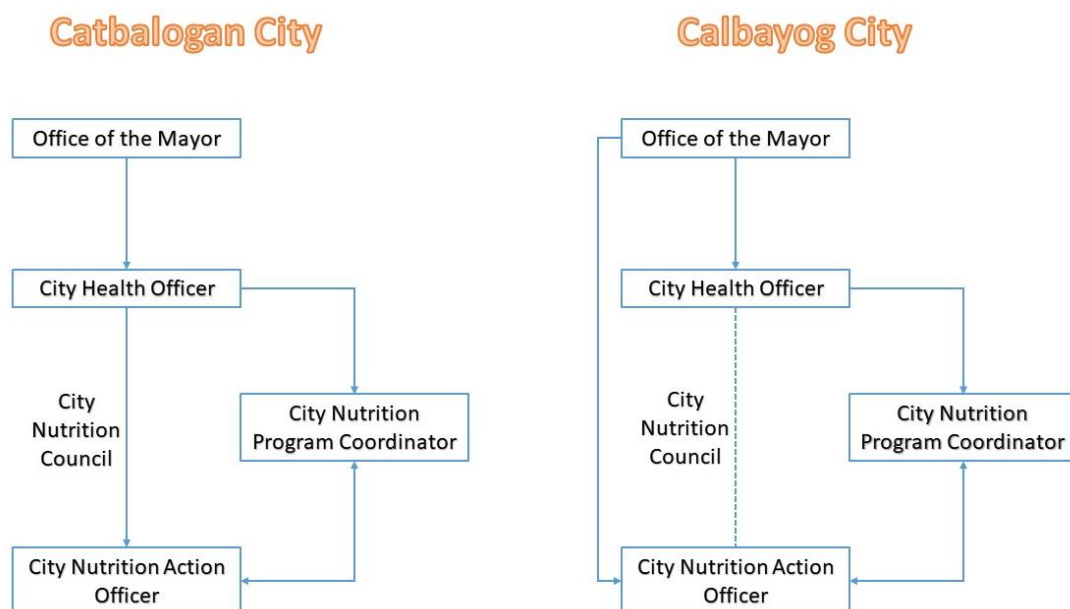
**The frontline workers for health and nutrition including ECCD-F1KD efforts in the barangays consist of the midwives and the volunteer health workers – BNS and BHWs. It was noted that much of the workload are with the frontline workers because they directly engage with the target population on the ground.** The midwives regularly man the barangay health stations and conduct check-ups, counseling, and other programs and services at the BHS and in barangay health centers once a week. The BNS assists in implementing nutrition programs and conducts the OPT. BHWs, on the other hand, are utilized for all health programs. Both BNS and BHWs assist the midwife in implementing programs and services at the barangay level.

**While there is coordination among key nutrition and health officials, the organization structure for the implementation of ECCD-F1KD has become quite disperse.** While such arrangement has provided focus on nutrition efforts and unloaded some of the CHO's tasks, it can also lead to confusion and inconsistency owing to the additional layer of coordination. Indeed, one official attributed some implementation issues on the separation of the nutrition office and the health office. Monitoring and evaluating various separate efforts are likely to pose challenges as well. The challenge, therefore, is in coordinating various efforts to ensure that these are providing the desired outcome. The organizational structure for nutrition in Calbayog is shown in Figure 10, on the right panel. The solid lines that link offices show the relationships in the power structure. The one on the receiving end of the arrow is at the lower rank. For instance, both offices – CHO and CNAO are under the Office of the Mayor. The broken undirected line connecting CHO and CNAO illustrates that neither one of them supervises the other. The line that connects CHO and CNPC with an arrow in both ends shows that these two coordinate in a regular manner.

**In contrast, the structure for Catbalogan can be described as relatively centralized because the CNAO was put under the purview of the CHO.** In the past, the CNAO was a designation under the Office of the Mayor. Figure 10 (left panel) illustrates this change with a solid line emanating from the CHO to the CNAO. This new arrangement, one official noted, led to the CNAO having less autonomy on the disbursement of funds for implementing nutrition-related activities like the Nutrition Month celebration, an important awareness-raising activity. When the CNAO worked under the supervision of the Office of the Mayor, there was greater discretion on the part of the official to decide on program and service implementation.

The effort to consolidate the decision-making power over health and nutrition within the health office is likely to lead to better coordinative approaches and greater capacity to monitor programs. However, the result for Catbalogan as of the study period shows that this led to less discretion on the part of the nutrition action officer who is directly overseeing the efforts on the ground and has even resulted in lower budget allocation for nutrition.

**Figure 10. Core Organizational structure\* for nutrition in Catbalogan City and Calbayog City**

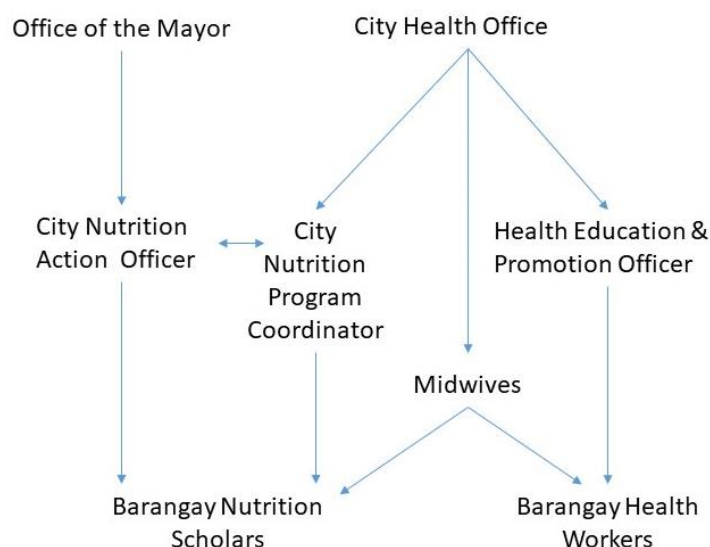


\*Authors' illustration

**The fragmented structure of organization was also observed in the management of volunteer health workers.** At the barangay health station/center, the midwife directly supervises the BNS and BHWs but these are two separate groups. While the structure for Catbalogan is quite simpler with both BNS and BHW reporting under the CNAO in the city health office,<sup>9</sup> that for Calbayog is different. The BNS and BHWs are handled by different officers under the city health office. The BNS is handled by the CNPC (see Figure 11) while the BHWs are under the Health Education and Promotion Officer (HEPO). The CNPC directly mentors the BNS especially in relation to OPT. The HEPO, on the other hand, oversees the capacity building for BHWs and facilitates their registration and formal organization. Since the Office of the Mayor implements nutrition programs through the CNAO other than those implemented by the CHO, the CNAO also directly interacts with the BNS through its meetings with BNS officers and through the capacity building activities this office conducts for the BNS. Again, this disperse structure can potentially pose challenges in coordinating efforts. Clearly, there is need for more effective coordination mechanisms and clear delineation of roles and accountability.

<sup>9</sup> However, the compensation and training for BNS are charged against the Nutrition fund of the City Nutrition Council, while those for BHWs are from the CHO.

**Figure 11. Organizational structure concerning volunteer health workers, Calbayog City\***



\*Authors' illustration based on KII

This study highlights the structure for nutrition because F1KD efforts in the LGUs under study are within the nutrition sector. The above discussion indicates that the organizational structure for nutrition across LGUs vary depending on political dynamics. While this is understandable because of the power accorded to LCEs in areas that may have varying contexts, what is more concerning is the tendency to change over a short period of time. Frequent or unanticipated changes can adversely affect LGU's capacity for long-term program planning and implementation.

### *Human Resource*

The delivery of ECCD-F1KD efforts rests largely on the quantity and quality of human resource that LGUs can deploy. This section discusses the profiles of program managers and frontline workers including the challenges that the LGUs face to better understand the situation of the case studies.

**The program managers and coordinators have the necessary background and experience to manage ECCD-F1KD efforts.** As mentioned earlier, the program managers and coordinators involved in ECCD-F1KD are the CHOs, CNAOs, and CNPCs. The CHOs in both LGUs are medical officers; they implement and manage health programs including nutrition and supervise the public health human resource in the areas. In Catbalogan, the CNAO is a public health nurse, and currently holds the position of Nurse 2. She was designated as a CNAO in 2017. Apart from doing coordinative works and implementing treatments programs as a CNAO, she also works in the birthing facility, and as a nurse doing duties on a regular basis. On the other hand, the CNAO of Calbayog is a medical officer. His current item is Medical Officer 4. In addition to being CNAO, he is also a Medical Officer in-charge of the City Blood Bank. Prior to this, he worked as a medical officer of one district (RHU) in the same city. Apart from doing coordinative and monitoring tasks as CNAO, he also conducts capacity building for frontline workers. He is also tasked to implement the nutrition programs of the Office of the Mayor. In addition, the CNAO conducts out-patient medical check-up every Friday in the

City's Sports Center.<sup>10</sup> In Calbayog, there are two CNPCs who serve as the point person of the city health office for nutrition programs. One is a nutritionist and the other is a nurse.

**The CNAOs in both LGUs describe their workload as heavy.** For CNAO in Calbayog, his workload is described as sometimes heavy because apart from being CNAO, he is also a medical officer and head of the City blood bank. As CNAO, he is unable to carry out his monitoring task because of the difficulty in going to all 157 barangays while also overseeing the blood bank. In this job, the CNAO also goes to the different barangay during mass blood donation. He, himself, carries out the screening of the blood donors. For the CNAO in Catbalogan, the regular nurse duties alone are quite heavy, which may influence her ability to carry out her monitoring and coordinative roles. Notwithstanding the heavy workload, both CNAOs are optimistic in their position for at least the next three years. In terms of compensation, both officials are quite satisfied.

**There is a shortage in medical officers and a need to empower the current ones.** The difficulty of attracting medical doctors to serve in public health facilities has been highlighted. Despite the call for applications, there are simply no takers. Another aspect that requires attention is the need to empower the medical officers in the hospitals. Based on an interview with a health manager, some doctors are not confident to implement programs and services, and man the staff in the hospitals. The strategy has been to train the assistants of these medical officers to aid in the management aspect.

**There is a need to augment the current pool of midwives to provide health and nutrition services in the barangays.** Midwives are overwhelmed with their heavy workload. Apart from delivering services like vaccination, community health sessions, counseling, and deworming, among others, midwives also conduct documentation and recording/encoding of these activities, and prepare reports. It was found that the hurdle is not lack of capacity of midwives but the overwhelming amount of work they do. In Calbayog, one midwife is assigned to a number of barangays with a total population that is above 10,000. There is really an urgent need to increase the number of midwives.

**The lack of plantilla positions at the LGU constrains the hiring of additional midwives.** In Calbayog, for instance, all plantilla positions are already filled up. Because of this, one needs to wait for the existing personnel to retire before the LGU can hire new ones. For example, if a dentist at the public facility retires, two positions can be created out of it – nurse and midwife or two midwives.

**While it is difficult to hire more midwives, increasing the number of volunteers can help alleviate the shortage of manpower in the barangays.** The table below shows the number of health workers and volunteers in the two LGUs. Calbayog City, which has 157 barangays, has 36 midwives and 330 volunteers (BNS and BHWs). If these workers were to be distributed evenly, there are 4 barangays being served by each midwife, while there is an average of only two volunteers per barangay. Catbalogan, with nearly one-third the number of barangays that Calbayog has, has relatively more frontline workers especially volunteers – with 15 midwives and 336 volunteers. Again, if this set of workers were to be distributed evenly to all the 57 barangays in the city, there would be around 4 (3.8) barangays for every midwife while there would be some 6 volunteers in every barangay on the average. It is important that Calbayog

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<sup>10</sup> Medical officers/doctors take turns in conducting these medical check-ups in the Sports Center, located near the Nutrition Center.



augments its volunteers to be able to deliver better health and nutrition services to the population.

**Table 6. LGU health workers in Catbalogan and Calbayog**

Health Worker	Calbayog City (157 barangays)			Catbalogan City (57 barangays)		
	Permanent/ Plantilla Workers	Contractual/ Contractor/ Job Order/ Temporary Hire	Total Employed	Permanent/ Plantilla Workers	Contractual/ Contractor/ Job Order/ Temporary Hire	Total Employed
Physicians	6		6	2		2
Dentists	9		9	1		1
Nurses	13	1	14	11		11
Midwives	23	13	36	13	2	15
Barangay Nutrition Scholars	-	157	157	-	130	130
Barangay Health Workers	-	173	173	-	206	206
Social Workers	11	3	14	4		4
Daycare Teachers/ Workers	20	92	112	-	77	77

Note: There were 21 NDP nurses in Catbalogan at the time of study; Physicians include the CHOs who are medical doctors themselves

**Aside from the lack of frontline workers, the study found that there is an urgent need to capacitate the current pool of frontline workers (midwives, BNS/BHWs) with basic tasks of weighing and measuring, infant and young child feeding (IYCF), providing and monitoring micronutrient, facilitating peer councilors, documentation and use of computer for encoding.** Furthermore, one official noted the importance of capacitating frontline workers with nutritional assessment. The midwives and volunteers must master how to assess whether the child is healthy, moderately malnourished or severely malnourished. As of the study period, Calbayog City is preparing for the training of two batches of BNS on the BNS basic course and health care providers on the PIMAM.

**Lastly, there is a need to increase the compensation of volunteer health workers.** Although these are volunteers, the amount of work expected of them is getting more challenging. Apart from conducting the basic tasks of weighing and getting height measurements for the OPT, they are required to accomplish a complex set of documents (the OPT forms) and assist in the provision of all health and nutrition services and programs in the barangays and are at the forefront of information dissemination campaigns.

#### *Implementation Processes and Gaps*

This sub-section discusses the detailed implementation process of some ECCD-F1KD programs for purposes of identifying good or best practices as well as gaps and challenges.

**Close coordination with the barangays is a vital part of the implementation of city government programs.** In the communities, the general process of service delivery begins with the volunteers (i.e. BNS and BHWs) going around their assigned areas to inform people of the program/service, urging them to participate. People living near the main health center

and barangay health stations are usually at an advantage because these are the main facilities for the delivery of health programs and services in the locality. For those who are unable to access such facilities for various reasons, they can visit the barangay health center during the schedule of visit by the midwife (usually once a week).

**Frontline workers (i.e. midwives and volunteers) play a crucial role in service delivery.** In many instances, volunteers act as resource persons for those in the communities who do not have the means to access private healthcare services or the main health center, or when the midwife is not available at the health center. In deworming, frontline workers ensure that all targeted children get the deworming pills/medicines by conducting house visits. Similarly, in supplementary immunization, if the target recipients do not pay a visit to the barangay health center, the volunteers themselves go to the houses of children in their master list of target beneficiaries. When necessary, even the midwife carries out house-to-house visit. This is said to be the standard protocol that is being followed. However, problems still exist because one LGU is not able to meet its target of 80-90 percent coverage.

**Inadequate supplies sometimes hamper its ability to fully implement the immunization program.** As a remedy, the local health staff ensures that once the supplies arrive, they recall and vaccinate those who have not yet received the vaccines. But since proper timing is essential, it is unlikely that some target beneficiaries do get the vaccines at the prescribed time.

**The usual process of delivering ante-natal care services for pregnant women starts with the recording of the basic information including height, weight, and blood pressure. This is followed by counseling. In case of some health issues, a referral to the doctor is made.** Otherwise, the pregnant woman proceeds to receive the tetanus toxoid injection. It is noteworthy that all programs mandated by the national government such as provision of iron, folic acid, and tetanus toxoid are implemented and are being provided to pregnant women up to post-partum. In the ECCD-F1KD checklist accomplished by both LGUs, most of the ante-natal care programs are being provided.

**Catbalogan does not conduct supplementary feeding for pregnant mothers but has an initiative that provides social assistance to indigent pregnant women who are at high risk of low birth weight.** In this LGU, the CHO through the CNAO partners with the CSWDO in the provision of free supplementary food (i.e. milk for indigent pregnant women) in an effort to increase the mother's weight. Such approach, however, is not the norm because the city has low rate of low birth weight. Others who are at high risk of low birthweight but can afford to buy their own milk are required to do so.

**Counselling is provided during visits of the pregnant woman to the health facility.** In Calbayog's main health office, the counseling is done by nurses. In the BHS or BHC, the midwives and available NDP nurses conduct the counselling. The study found though that not all midwives do counseling and that sometimes, some BNS do.

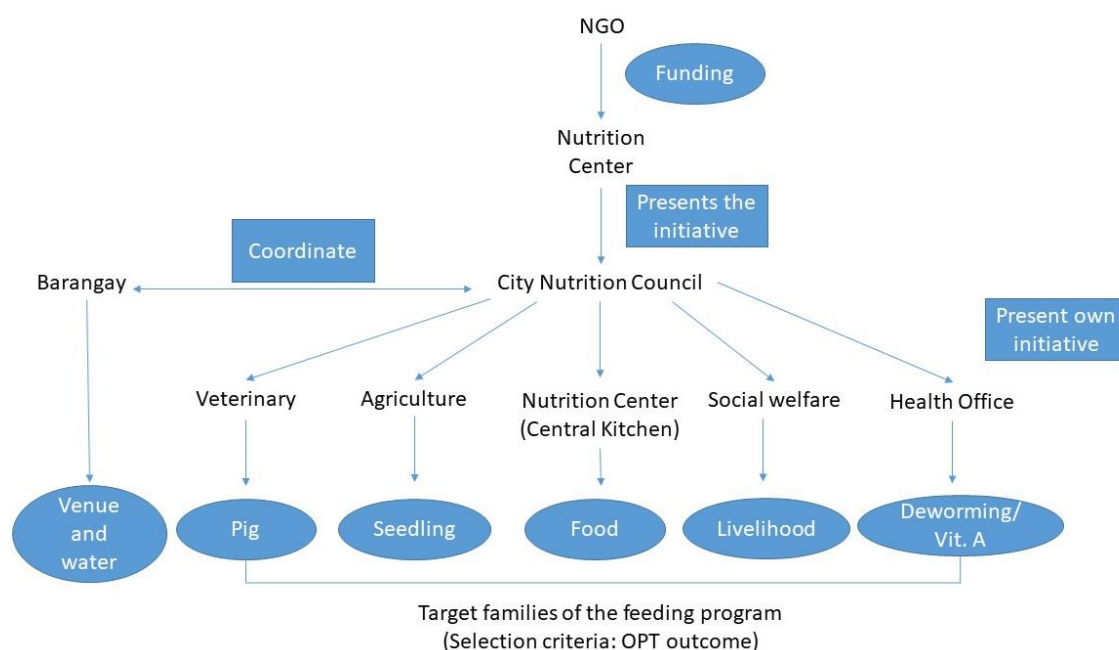
**Though measurements of basic anthropometric information of pregnant women are supposedly done at every visit, it was noted that some midwives in one LGU conduct measurements only during the first trimester.** It seemed that doing such at every visit was not the standard process. This gap has been recognized and so the current protocol imposed by the CNAO since is to measure especially the weight at every visit or for the whole nine months of pregnancy for the health staff to understand the complete nutritional status of the mother and ensure that proper counseling is provided.

**OPT results are used by the LGU to select the ten (10) most nutritionally depressed barangays as its priority areas.** It ranks the barangays based on which are consistently high in the numbers of children who are stunted, wasted, and underweight. The target beneficiaries in the feeding activities are limited to 50 moderately malnourished children aged 6 to 23 months old, in each of these 10 priority barangays. The targeting and finalizing of the beneficiaries are part of the activity planning process which takes about a month prior to the conduct of the activity and is carried out by the Nutrition Center headed by the CNAO and participated by the BNS.

**The feeding program implementation in Calbayog is characterized as collaborative and integrative.** This is an effective strategy of securing the target population's cooperation. In its most recent feeding program, the Nutrition Center received funding from a religion-based NGO (David Livingston Foundation). Initiatives of this kind are discussed during meetings of the City Nutrition Council (CNC) held on a quarterly basis. During the launching of the project, the different members of the CNC offered their own complementary programs like livelihood program (City Social Welfare Department), hog dispersal (City Veterinarian), seedling dispersal (Agriculture Department) and deworming drugs and Vitamin A (City Health Office). For its part, the Office of the Mayor procures for the cook who then prepares the food and is assisted by two BNS staff at the Nutrition Center. The city government has a central kitchen located in the Nutrition Center for use in its feeding programs. The BNS assigned in the barangay implements the feeding program at the barangay level. Prior to this, the Nutrition Center coordinates with the barangay which secures the venue of the activity and ensures there is water for use during the activity in the barangay (see Figure 12). The feeding activities are scheduled at around 2 to 3 o'clock in the afternoon to ensure that parents are less preoccupied. Also, the feeding activity is a mere supplementary feeding that is why it is given after lunchtime. While the delivery approach of delivery by the LGU is promising, the effectiveness of the program is hampered by the difficulty of obtaining continuous support and cooperation from parents and families for their children's feeding and difficulty in sustaining efforts to improve the nutritional status of all malnourished children in the locality due to financial constraints.

**Indeed, Calbayog did not reach its target for feeding due to budget constraints.** The local government takes responsibility for feeding the age group 6 to 23 months because this has been identified as a gap in the PPAN. DSWD already takes care of children aged 24 months to five years while DepEd looks after children aged five and above. In 2018, the feeding program covered only six barangays with 30 beneficiaries each as opposed to the ten target barangays with 50 beneficiaries per barangay. In each round of feeding, some 3 to 4 priority barangays are first selected. After implementing the program in this set of barangays, the LGU selects another set of 3 to 4. The food distributed to moderately malnourished children contains micro-nutrient powder (MNP) and they are fed 5 days a week for a minimum period of 90 days up to a maximum period that lasts 120 days. The monitoring of weight of beneficiaries is conducted every month.

**Figure 12. Process of program delivery of feeding program, Calbayog City\***



\*Authors' illustration

**Also, most of the time the target number of children is not met because some mothers are not willing to participate.** This is despite the conduct of counseling as part of the preparatory process. Others, though expressed willingness and are able to participate in some sessions, are unable to sustain their participation. The purpose of the feeding program is forfeited if the child is fed only for a few days and not for the entire duration of the program. The common reason for non-participation is the presence of work, the absence of someone to care for the children's siblings, and there is simply no time to go to where the feeding program is carried out. In cases where the target number of children is not met, the LGU usually expands the coverage to include even children over two years old and under five years old.

**Children who missed the scheduled feeding activities are usually from families with limited means. It was noted that most of the parents of these recipients are not formally employed.** What the LGU does to encourage greater participation is similar to that which was described earlier where other department simultaneously offer other interventions like seedling and swine distribution, lecture on hygiene and nutrition, among others. This approach is implemented in the LGU's feeding programs in all the target barangays. In lectures on hygiene, health and nutrition, non-beneficiaries are also usually invited to participate. Currently, such efforts still lack effectiveness in obtaining full cooperation of target families. It is important to conduct more in-depth analysis to explore what works and what needs further improvement.

**Interventions for the severely-acute malnourished (SAM) children is hampered by delays in the supplies of ready-to-use therapeutic food (RUTF).** The LGU allocates one box of ready-to-use therapeutic food (RUTF) for each SAM child through the Barangay Health Station which has the jurisdiction. Meanwhile, those who are SAM with complications are referred to the hospital.

**Some of the problems in accessing services at the barangay health centers emanate from the lack of regularity in the schedule of the midwife in going to the barangays.** It was noted that the LGU recently addressed this by ensuring the midwives have allotted regular schedule of manning the health center or visiting the barangays. If the midwife is not present, others like the NDP nurses can serve in the event instead. Hence, the schedule must be made integrative. This ensures that the people will know when to reserve days to visit the health center or participate in barangay health visit.

**Service delivery is hampered by lack of financial resources, that is why LGUs target only several barangays.** LGU resources are not adequate to cover all the demands for feeding alone based on computation by the CNAO. Although they get some support from non-government organization donors, the funding is not guaranteed to sustain local efforts.

**This lack of resources is also often the issue in the barangays which affects local implementation at that level.** Although the barangays are receptive of the nutrition information provided by the LGU and the BNAP contains some health and nutrition services with some budget allocation, such services are not always implemented. For instance, while funds were allocated to cover volunteers' transport expense in going to regional meetings or events, volunteer workers do not get these allocations. They instead shoulder the cost themselves. Feedback also shows that despite the need for feeding, the barangays fail to allocate budget for feeding although such intervention is included in the BNAP. There are plans but often there is no actual implementation. In other cases, the barangays are not aware of how to intervene. In Calbayog, the LGU addressed this through the conduct of a health and nutrition summit. There was also a separate meeting between the LGU and the officials in nutritionally depressed barangays. The LGU's intervention was to provide a shopping list for the barangays on what intervention they can include in the BNAP to address the problem.

**Others attribute the lack of implementation at the barangay level to lack of legitimacy.** Usually, when programs are implemented by the city government at the barangay level, the barangays would ask for its legal basis and objectives. It was noted that with legal basis (like local ordinance), implementation is much faster. As of interview date, the legal basis of the F1KD is yet to transcend to the local level, in local ordinance form.

**The delivery of services in GIDA is much more challenging. To address this, midwives are assigned to the GIDAs (e.g. island barangays) in Catbalogan on a regular basis particularly for Bagongon and Rama BHS.** There is also a multi-purpose clinic held twice a month in the upland barangays. If additional medical missions are needed, the midwives may coordinate with the CHO for such additional activities. BNS oversee the feeding programs in these events.

**In Calbayog, however, there are no midwives assigned to the GIDA and volunteers do not go there on a regular basis due to security concerns.** While there are Barangay Health Stations in a couple of GIDA, these are not functional. What the city government does is to cluster barangays prior to sending a team of health workers. They call them "Team Baktas" because they go there by foot and stay in these upland areas for 10 days. The total cost for sending the Baktas is roughly Php 1 million and is shouldered by the LGU through the City Health Office. This covers the transportation and food of the health workers. In the visit to GIDAs, the health workers also bring with them people to conduct other services like family planning. The feedback, however, is that it doesn't seem equitable if lots of resources are poured into such initiative because the population in these areas is quite small and many of

them actually found work already in the city. The strategy implemented by the CHO is to cluster these areas and schedule the operation every quarter and if not feasible, twice a year, except during health emergencies like outbreak wherein the LGU sends a team immediately.

**It is noteworthy that the LGUs realize the crucial role of barangay visits and the need for an integrative approach of delivery that attracts greater participation.** One LGU specifically identified that although they already have what they need to conduct barangay visits, there is a need to organize the midwives who are usually overloaded with so many responsibilities. They are working on a strategy that entails scheduling health and nutrition programs each month or at a time interval that is feasible and relevant. In each monthly scheduled visit to the barangay health center, other interventions must be made available which cater to the needs of other members of the household. For instance, if an infant member is scheduled for vaccination, other members of the household can avail of other services like dental check-up or nutrition intervention. Fathers can accompany these members where they may also attend sessions like proper parenting or proper hygiene. In other words, the baby/infant/pregnant woman visit to the health facility is the gateway to also promote dental health for other members of the family, to promote exclusive breastfeeding through lectures, promote nutrition through consultations with nutrition officers, to enhance reading skills of children, etc. Since the visit is made more frequent, the developmental milestones of the infant is assessed in a more effective way. In this approach, different interventions are provided for the beneficiaries through the course of the first 1000 days free of charge. Such packages also motivate them to participate and improve their health-seeking behavior. This approach has already established some grounds in Calbayog City through its feeding program. What the LGU needs to do is firm up the details and schedules. The presence of such proposal indicates that the LGU is finding ways to improve its program approaches. And while this is promising, it is important to monitor and evaluate its execution in the future.

**Some LGUs in Samar have best practices for service delivery that LGUs can emulate.** San Jose de Buan, a GIDA, used the service delivery network (SDN) approach whereby *duyan* (cradle or hammock) is used in areas that ambulance cannot reach. The *duyan*, an initiative of the Municipal Health Officer with full support of the Mayor, ferries the patients to where there is available ambulance for transporting into the nearest health facility. In the *duyan* system, the barangays recruited male volunteers to carry the *duyan* aided by BNS and BHWs. All barangays in San Jose de Buan implement this *duyan* system. Whenever there is a need for such, there is a group that people can call for help. Volunteers in this program receive incentive from the Office of the Mayor. Paranas also has a *habal-habal* (single motor) system used in their referral system to carry people in remote areas to the health facility. The volunteers also receive incentives for being part of the initiative. Provincial officials attribute the reduction in maternal deaths in the province to these local innovations.

### *Health Facilities*

The adequacy and accessibility of public health facilities are crucial in improving health status of the population especially the poor and marginalized because of their inability to access private healthcare services. These health facilities include RHUs, barangay health stations, and barangay health centers.

**To cover its vast land area and relatively large population, Calbayog has five main health centers.** RHUs are defined by DOH as providers of “primary healthcare services which include health education; control of locally endemic diseases such as malaria, dengue, schistosomiasis; expanded program of immunization (against tuberculosis, polio, measles, diphtheria, whooping

cough, and tetanus); maternal and child health and family planning; environmental sanitation and provision of safe water supply; nutrition; treatment of common diseases; and supply of essential drugs. RHUs usually have general practitioners and nurses to attend to patients, and are required in cities and municipalities.” In addition, the main health centers’ role includes maintaining health records of residents in the barangays under its jurisdiction.

**Each RHU covers four to six barangay health stations (BHS).** A BHS is a health facility manned by a midwife and assisted by volunteer workers like BNS and BHWs. Barangay Health Stations are also providers of primary healthcare services; though general practitioners are not permanently stationed in these facilities (DOH LGAMS 1993). Each BHS covers a number of barangays which do not have their own BHS though these may have Barangay Health Centers, which are usually located within the Barangay Halls. BHC and BHS are open from 8 in the morning up to 5 in the afternoon, though personnel are always on call for emergencies. Barangay Health Centers are distinct from BHS by having only BNS and BHW in the area.

**Midwives are expected to visit each of their assigned BHCs once a week. However, an interview with Calbayog staff/official reveals that midwives do not go to where the residents are located to provide health services and implement programs.** The residents in the barangays are typically the ones who visit their assigned BHS if needed. During implementation of feeding programs, barangay halls and big public areas are used venues of assembly.

**Based on recent LGU data, there are 25 BHS in the Calbayog City including those housed in the main health centers (RHUs).** The table below shows the 5 main health centers of Calbayog City and the BHS they oversee. Note, however, that although Olera and Patong have BHS, these are unstaffed due to their being GIDAs. An interview shows that medical missions to these BHS are carried out 1 to 2 times a year. Appendix 2 shows the barangays under the jurisdiction of each BHS. The distribution of these public health facilities or centers throughout the barangays are shown in Appendix 5. The barangays are also colored based on their stunting prevalence. Darker red shaded barangays have higher stunting rate than those colored in light red. Note though there is no data for the GIDA areas, herein, shown in white shade. Therefore, there is no way to determine their situation. The map shows that there is a barangay health center in each of these areas though these are not functional and do not have regular volunteers.

**Table 7. Public health facilities and their assigned BHS and population covered, Calbayog City**

Health Facility	BHS	2015 Population per BHS*
<b>Main Health Center 1 (Balud)</b>	Balud	8695
	Tabawan	4671
	Nijaga	10753
	Carayman	10166
	Rawis	11591
<b>Main Health Center 2 (Capoocan)</b>	Capoocan	9814
	Matobato	5486
	San Policarpio	10589
	Carmen	12375

	Trinidad	11119
<b>Main Health Center 3 (Migara)</b>	Migara	5600
	Villahermosa	2654
	Patong	2730
	Olera	2341
<b>Tinambacan Main Health Center</b>	Tinambacan	8166
	Malajog	8139
	Binaliw	7656
	San Joaquin	9934
	Pena	7718
	Malaga	6840
<b>Oquendo Health Center</b>	Oquendo	7260
	Mag-ubay	7423
	Tarabucan	8080
	Cabatuan	6926
	Pilar	6707

Source: Calbayog LGU, as of Oct. 2019; \*Computed based on the population of the barangays under the jurisdiction of the BHS

**The data show highly differentiated jurisdiction of BHS in terms of population. The assigned population ranges from less than 3000 (e.g. Olera, Villahermosa, Patong) to more than 10,000 (Carayman, San Policarpio, Nijaga, Trinidad, Rawis and Carmen).** While some facilities may be more efficient than others, this differentiated jurisdiction shows that there is room for adjustment so that facilities can have more equalized workload. Since each BHS is supervised by one midwife, one can also assume that the population figures are proportional to the workload of each midwife.

**One particular observation that must be noted is the extended coverage of some BHS to include barangays with no health stations or barangay health centers or those located in GIDA areas. This is emphasized in the BHS/Main Health Center in Migara.** Aside from its ordinary barangay area coverage, with a total population of 5,600 to serve, Migara also caters to residents from barangays under the Patong and Olera BHS. This is because these stations are found in GIDA areas and are unmanned, despite the presence of a structure for health services. Consequently, barangay residents from these areas (with a total population of 5,071) must travel to Migara for treatment. Migara, therefore, needs to cater to the health needs of nearly one-third of the city in terms of land area and nearly all GIDAs. The map of Calbayog (in Appendix 5) indeed shows that Migara is the nearest main health center.

**With heavy workload, it is understandable that the midwife/midwives<sup>11</sup> assigned in Migara are unable to conduct regular visits in all the assigned barangays.** As mentioned earlier, public health staff visit these areas only once or twice a year. People in need of more frequent, regular health checks like pregnant women, infants and young children would need to travel all the way to Migara. The map shows the difficulty of accessing Migara main health center if one comes from the farthest GIDA – Salvacion, Naguma, and Higasaan, to name a few. If it is not feasible to make operational the existing BHS in Olera and Patong, it is crucial for the Calbayog LGU to conduct either more frequent visits or come up with well-designed,

<sup>11</sup> Calbayog has 36 midwives including those hired on a contractual basis but has only 25 BHS which means that in some cases, there may be more than one midwife in each BHS.



and possibly innovative, ways to address the health and nutrition needs of populations supposedly covered by these BHS.

**In addition to the need to re-examine the assigned population per facility, there might be a need to revisit the manner by which barangays are clustered per BHS.** The current clustering is illustrated by color in Appendix 6. Each color corresponds to one cluster which is covered by one Barangay Health Station. While most clusters comprise of barangays situated adjacent to each other as expected, some clusters have rather disperse barangays. There are a few who are in fact very distant from most parts of the clusters. Such disperse assignment is likely to affect accessibility of the facility by the inhabitants of farther barangays and is also likely to diminish the health staff's ability to reach these areas.

**In contrast to Calbayog which has 5 main health centers, Catbalogan has only one main health center.** There are a total of 13 barangay health stations, which all have one midwife and some volunteers stationed. In addition to the BHS, there are also barangay health centers manned by BNS and BHWs in areas where there are no BHS. The table below shows that there are 36 barangays (63% of total 57) with either Barangay Health Center or BHS. Midwives make their rounds to these health centers on a regular basis. All 36 barangays (or 63%) have each either a BHS or a Barangay Health Center that is regularly manned by BNS/BHWs. The rest of the barangays (21 barangays) without any of these facilities are assigned in the nearby barangays with either BHS/BHC. These barangays use the Barangay Halls when the midwife and other health workers conduct health services in the area.

**Like in Calbayog's case, the same differentiated jurisdiction of BHS population-wise can be observed in Catbalogan.** The assigned population for each BHS is as low as less than 2000 to 3000 (e.g. Albalate, Bagongon) to more than 10,000 (Main health center, Maulong, Silanga, Guinsorongan, Canlapwas, and Mercedes) (Table 8). Some of the burden can be eased by the presence of barangay health centers in the barangays (see Appendix 7). If the population in these barangays covered within each BHS or BHC are to be distributed evenly in these facilities, one can assess the average workload (total population to be served) in each facility. For example, Guindapunan is expected to cater to the needs of 9,665 inhabitants but since there is a barangay health center in all the four barangays under its jurisdiction (including the barangay where the BHS is located), there is only an average of 2,416 (that is 9,665 divided by 4) per facility. With such simple calculation, it is found that the workload per facility (or per midwife man hours) ranges from as low as 1,295 to as many as 12,906. This means that the workload of some facilities/midwives is ten times those of others. Canlapwas BHS has nearly 13,000 people under its jurisdiction while Main Health Center I has an average of only 1,295 people because all the 8 barangays under it have either a BHS or BHC. Again, there may be room for adjustment so that these facilities can have more equalized jurisdiction.

**Table 8. Barangay Health Stations and their assigned population, Catbalogan City**

BHS	Population per BHS*
Main Health Center I	10361
Main Health Center II	10771
Guindapunan	9665
San Andres	6206
Maulong	11278
Silanga	10366

Guinsorongan	10321
Rama	3946
Bagongon	2723
Canlapawas	12906
Bunu-anan	8154
Albalate	1938
Mercedes	10177

Source of basic data: Catbalogan LGU; \*the population being served by main health office is divided into two, hence the labels – main health center I and II

**People living in GIDAs in Catbalogan may have better access to health and nutrition services because of the presence of public health facility (e.g. barangay health center or BHS) than those in GIDAs in Calbayog.** The distribution of the public health facilities in Catbalogan throughout the barangays are shown in Appendix 8. Again, the barangays are also colored based on their stunting prevalence. Darker red shaded barangays have higher stunting rate than those colored in light red. The map shows that there is at least a Barangay Health Center in almost all barangays with relatively higher stunting rate, with the exception of Totoringon and Palanyogon. Also, unlike in Calbayog where there are no functioning BHS/BHC within the GIDA, the map shows that there are BHS/BHC among the GIDA in Catbalogan whether among the island barangays or the upland. The population in Catbalogan is also less disperse and more concentrated in areas near the city center. This presents opportunities for easier delivery of health and nutrition services. Nevertheless, empowering and capacitating, and expanding even, the health staff and volunteers serving the GIDA are very crucial in ensuring that all the relevant segments are reached by local interventions more effectively and efficiently.

**The clustering of barangays in Catbalogan is not as dispersed as some of those seen in Calbayog.** Note that the clusters are composed of adjacent barangays (shaded in a single color). Nonetheless, there is still a need to re-strategize in terms of the assignment of the BHS. For example, the GIDA barangay Totoringon is assigned in San Andres BHS, which is very far from it, whereas there is a BHS in Albalate, its neighboring barangay (see Appendix 9). The LGU therefore must explore the possibility of assigning Totoringon to Albalate BHS rather than in San Andres BHS. If such more is feasible, it can ease some of the burden of the midwife assigned in San Andres in trying to reach the area and at the same time, residents in Totoringon will have better access to health and nutrition services in Albalate, assuming that there is no significant physical barrier (like a major river or mountain) between Albalate and Totoringon.

**In summary, LGUs must re-draw their strategies in clustering for improving people's access to health and nutrition services and programs.** Such initiative does not need additional resources and is something that can be done easily and immediately. But if new health facilities are on the pipeline, as is the case in Catbalogan, determining the strategic location is very important.

**Calbayog's Nutrition Center is considered by one official as a good practice because it shows that the LGU really has focus on nutrition.** The Nutrition Center has its own staff consisting of one nutritionist (who is yet to pass the board exam) and two BNS, employed as contractual employees, under the supervision of the CNAO. As a structure, the Nutrition Center houses the LGU's central kitchen used in cooking food for its feeding programs and the office of the BNS organization. The proximity between the CNAO nutrition staff and the BNS office enables for an efficient feedback system which the official also noted as another good practice.

With such, problems on the ground are communicated immediately to the managers for appropriate response. The city is also known for its advocacy for health and nutrition. In fact, the city was awarded last year for its advocacy through its Health and Nutrition Summit wherein the LGU invited barangays officials (especially those from nutritionally depressed areas) to increase their awareness and provide ways to improve the health and nutrition status of the population.

### *Equipment and Supplies*

The use of standard and well-calibrated equipment ensures proper anthropometric measurement. Similarly, adequate supplies are essential in the implementation of F1KD programs.

**The study team found that Calbayog is unable to provide for adequate anthropometric equipment (i.e. weighing scale and height board).** The LGU attributes this to lack of resources to provide for all its 157 barangays. During OPT season, volunteer workers noted that they have to take turns in using the limited equipment they have. This prolongs the process of basic weight and height measurement. Parents have validated this inadequacy that prolongs their waiting time even in the Barangay Health Center. The lack of equipment causes volunteers to use different kinds of equipment which raises question on the accuracy/consistency of data being collected. In the absence of weighing scale, some use bathroom scale. Those without height board use meter sticks. Long-time volunteers improvise their own weighing scale<sup>12</sup> or use the mother and baby weighing method. It is notable that the regional office provided all 23 BHS with Detecto weighing scale some three years ago. And recently, the City Mayor is said to have funded the purchase of such equipment prioritizing those which did not have equipment. Barangays are also expected to incorporate in their BNAP the budget for purchasing the abovementioned equipment with the funds coming from the Internal Revenue Allotment. Nonetheless, the current situation reflecting the inadequacy is evident. It is important to undertake an assessment with regard to the actual implementation of current plans to properly equip the facilities.

**Aside from lack of anthropometric equipment, the LGU also lacks documentation equipment (i.e. laptop or desktop computer).** LGU staff would often share such equipment for OPT and non-OPT activities thereby prolonging the process of encoding which delays the LGU's ability to monitor its performance in a timely manner. Because of this lack of equipment and medical facilities, barangay health centers are mere buildings manned by volunteers.<sup>13</sup> At the level of the LGU main health facility, there is also some lack of equipment like CT-Scan. It was proposed that such equipment be made available at the city level so that people do not need to go to the provincial and even regional level facilities.

**Delays in the supplies coming from the regional office is another issue that LGUs confront in the implementation of F1KD programs.** Last year, the LGU of Calbayog was not able to implement their nutrition activities because they ran out of RUTF supplies,<sup>14</sup> a peanut-based food, used to treat severely acute malnourished (SAM) children without complications. The study also found that there are instances where supplies received are nearly expired (sometimes with only a 6-month allowance into expiration). Since the LGU cannot distribute these right away due to various constraints, some are already expired when these get to the barangay health

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<sup>12</sup> They use the so-called "panty" style weighing scale made of durable *katya* or denim (*maong*) fabric.

<sup>13</sup> Some (non-health) officials became aware of this because of the dengue outbreak in their locality.

<sup>14</sup> As for other supplies for the reduction of malnutrition, the LGU through the Office of the Mayor procures the antibiotics for the management of severely acute malnutrition, and this does not have the same challenges that the supplies from DOH have.

centers. The micronutrient powder (MNP) is an example of nutrition supplies which got expired because of delays. The ready-to-use therapeutic food (RUTF), which comes from the central office (DOH) and distributed by the regional office, has a remaining shelf life of less than one year when it is received by the LGU. To cite an example, some supplies which will expire in March 2020 were received in May to June 2019. This leaves the local implementers up to nine months for coordination and implementation assuming the planning and budgeting processes for corollary services are already finished.

### *Information and Communication*

**The manner by which information and data circulate and get discussed among department managers/decision-makers and staff is through regular and emergency meetings.** The City Nutrition Council conducts quarterly meetings although they are expected to meet monthly. Health volunteers (i.e. BNS, BHWs) also conduct regular meetings among themselves and with their direct supervisors, the midwives, CNAO and CNPC. At the CHO in Calbayog, meetings are held per district. Districts which have fewer BNS are combined in one meeting.

**Aside from these meetings, the LGU officials and staff also use other methods like online chat and radio.** Midwives in Calbayog use online platforms for discussion and information dissemination. BNS also have their own online platform (i.e. chatrooms) used to inquire about reports among other things. Other agencies with nutrition-related programs hold their meetings at the discretion of the head of the office. Urgent matters that require decision are directly discussed with the City Mayor. In areas which do not have access to the internet, health staff and volunteers use radio for accessing information. The BNS also use the *habal-habal* to gain access and send information to remote areas.

**Program managers gather inputs from the ground by monitoring and soliciting information from the Nutrition Center staff (in the case of Calbayog) during meetings held every week.** In these meetings, basic indicators like attendance rate in feeding, and the change in weight of target beneficiaries are discussed. For other problematic cases like when recipients do not attend feeding sessions, the program manager meets with the BNS (whose office is also located at the Nutrition Center) and probes or examines the reasons.

**Owing to the volunteers' direct role in implementation of FIKD programs and in disseminating information on the ground, it was proposed that these be provided with adequate training on how to communicate more effectively and properly.** Volunteers in the LGUs of study have diverse educational background with most of them having limited educational attainment.

**Most participants of IEC activities and other programs conducted by the LGU are 4Ps beneficiaries.** This group usually attend for fear of the consequence of not attending to such invitations. Unfortunately, there are not many non-4Ps families who participate in lectures concerning health and nutrition. This is an area that requires more innovative and effective approaches. The 4Ps, some officials noted, is a good program which FIKD program can 'latch on' for purposes of improving people's participation in government programs. Ensuring that 4Ps include all the poorest families is likely to result in a greater number, if not all, of these families participating in government programs and services.

### 5.3. Nurturing Care Practices

Understanding how parents and caregivers nurture infants and young children is essential to this situation analysis concerning FIKD interventions. Recognizing their awareness, knowledge and beliefs in child-rearing and examining their circumstances more deeply enables one to ascertain the contextual factors that influence the well-being of children in their first 1000 days.

#### 5.3.1. *Practices, knowledge, beliefs, and preferences*

**A consistent but expected finding of the study is that the mother is the primary caregiver of the child. Duties of the caregiver included assistance in educational activities, playing with the child, bathing and cleaning, feeding and putting the child to sleep.** The replacement of the mother as the primary caregiver when she is unavailable varies amongst participants. Parents from Calbayog stated that this duty falls to the child's father, grandparents and close relatives because the child is familiar with them. Catbalogan parents were a bit more specific, stating that next to the father, their basis for who should take care of the baby is gender – that is, they rely more on female than male kin. This is because they feel that a woman is more equipped than a man in looking after the baby. They also stated, however, that this replacement does not happen often, as it is common that mothers push themselves to care for their children even if they are unwell which is based on the notion that the quality of care that a mother gives is invaluable. In terms of priorities in caring for the children, parents from Catbalogan mentioned that maintaining a clean environment, providing proper nutrition, breastfeeding and immunization are their priorities. This was also reiterated by parents in Calbayog city, alongside regular pre-natal and baby checkups and proper care with vitamins. Interestingly they also noted that the doctor recommended that babies be made to cry every morning to purportedly strengthen their heart.

**The study found that parents have a profound understanding and definition of malnutrition.** They pointed out signs of malnutrition as thinness, being underweight and having big bellies despite small stature. Other signs they provided are paleness, darkness of feces, being lethargic (“*matamlay*”) and sickly. When asked about the long-term effects of malnutrition, participants from Calbayog emphasized the loss of appetite and drive to make friends, as well as an early death. In comparison, Catbalogan parents focused on low performance in school due to lower IQ and level of understanding, physical disability, constant sleepiness and inability to partake in physical activities.

**With regards to pregnancy-related practices, it was found that some women do not immediately consult with health professionals; they tend to wait a bit longer after their monthly period has stopped before going for a check-up at the health center.** As such, pregnant mothers have their first check up two to three months into their pregnancy. LGU health officers even noted that many mothers fail to get first trimester care because of such practice. Nevertheless, FGD participants from both LGUs confirmed that they were able to meet the minimum recommendation of visiting a health center four times during the pregnancy period. In Catbalogan specifically, mothers are able to have check-ups once a month for the first eight months of pregnancy before switching to a weekly checkup schedule during the ninth month. They attribute this to the accessibility of health centers, the willingness of health workers to visit pregnant mothers who could not go to centers for check-up, as well as 4Ps requiring mandatory monthly checkups as a condition for the cash transfers. When about asked whether they were made to take vitamin supplements, both sets of respondents mentioned that

they took ferrous sulfate, as this was recommended by the personnel to prevent lowering of blood levels during childbirth. However, parents noted that they were not able to ingest this routinely due to its rusty taste. They also showed awareness of symptoms that may affect their pregnancy such as varicose veins, severe bleeding, loss of breath and anemia. These risks were mitigated through constant check-ups in the health centers. Interestingly, it was found that women in Calbayog also relied on the “*hilot*” to fix the position of the baby through massage and stretches.

**In terms of childbirth, there has been an active attempt by LGUs to encourage mothers to give birth to their babies in hospitals or health centers.** In line with this, PhP1000-incentive is offered to mothers provided that they give birth in health centers. Aside from this, both LGUs have also began offering monetary incentives to the “*hilots*” on the condition that they refer pregnant women to health facilities instead of encouraging them to deliver in places other than a health facility. This policy has shown positive results, allowing better provision of healthcare services and more convenient registration of infants for birth certificates. This is said to be a marked improvement from before, where some participants shared that they were not able to register their children since their mothers gave birth to them at home.

**Regarding exclusive breastfeeding, interviews revealed that it is a widely accepted and performed practice in both LGUs based on responses of FGD participants. The timeframe when children were breastfed varied from six months to three years, with one mother having to breastfeed her child up to six years.** During the first six months of the baby, parents from Calbayog stated that they relied solely on breastfeeding to nourish their child. In contrast, mothers from Catbalogan did some mixed-feeding so that their children would be nourished even while the mothers had to go to work. By the time babies are able to eat semi-solid food, it is the mother who supervises the feeding of meals such as *malunggay* soup, Cerelac, rice with soup, biscuits and mashed vegetables. Their way to ensure food safety is sterilization of the utensils and providing utensils for the exclusive use of the child. As the child learns to eat solid foods, mothers begin to integrate the baby’s feeding with the family’s dining time so as to introduce regularity in their meal time and to provide bonding time with the family. Parents gave small bits of non-baby food, complemented by soup and Gerber. Commercial food is also an option, but participants tend to avoid this as they do usually do not have enough money to afford purchasing it regularly.

**With regard to immunization, the study shows that parents/caregivers in the LGUs approve of immunization for their children and they adhere to the immunization schedules prescribed to their children by the midwives.** They also showed some, albeit limited, awareness of various vaccines and the diseases they prevent.

**Parents under the study claimed that they had enough knowledge and skills to provide quality care for their babies, though caveats were made that they are not perfect parents and may need the advice of family and medical personnel from time to time.** Though the respondents claim that they adhere to the advice of health professionals like the midwives, it was observed there are still some prevailing norms and superstitions that parents adhere to. For example, some mothers refrain to eat certain foods out of bad luck (“*bawal kumain ng saging na nakadikit*”). Others believe that their children will also taste whatever they eat (through their breastmilk). Concerning the capability of mothers in managing unruly/crying children, it was noted that though parents are aware of various strategies to calm their child (carrying, singing, breastfeeding, cuddling them, etc.), there are times when they succumb to their frustration and fail to do such practices to calm their children.

**In some instance, however, there are also social and behavioral problems within the family.** Some parents are into gambling and vices which can affect the nutrition and well-being of the children. FGD participants noted that children of broken families are also not being adequately taken care of.

### *5.3.2. Awareness and health-seeking behavior*

**Parents tend to seek knowledge and advice about taking care of their children from a diverse pool of people.** Participants in Calbayog noted that they asked for help from medical practitioners such as midwives, and alternative sources like the “albularyo” for their herbal medicine needs whereas those from Catbalogan showed preference towards persons close to them like their parents. Others stated that they do not seek advice from anyone, and instead rely on their own experience when it comes to raising their child. Parents from both cities also cited getting insights on childcare from media outfits, particularly radio, social media (Facebook) and television.

**Parents also receive guidance from both formal and informal institutions.** Parent participants from Calbayog city cited the barangay assembly conducted by their officials as a conducive avenue to learn more about proper parenting, where they get instruction on topics such as health education, livelihood training, family planning and disaster prevention. They are given a venue to participate in these sessions through the open forum, and they showed enthusiasm to continue receiving these trainings even on a weekly basis. Aside from their barangay assemblies, parents also receive support in the form of workshops on proper childcare from NGOs like the Western Samar Development Foundation (WESADEF) and Compassion International, and the government’s 4Ps program.

**Parents from Catbalogan City mentioned the Family Development Session (FDS) of the 4Ps program as another means of gaining knowledge about proper parenting.** In this forum, teaching sessions are held covering topics such as immunization, child education, exclusive breastfeeding and health monitoring. The lectures are also meant to improve the participants’ skills in gardening, recycling and singing. Parents also recalled that they received information about ECCD-FIKD programs and services from the BHWs that both monitor the growth of their children, and encourage the parents to have check-ups in the center. Instruments such as the “bandilyo” or megaphone are also used to disseminate information on such initiatives. In contrast, some parents emphasized that while these formal methods are used, they sometimes fail to reach all of the households. In such instances it is the social networks within neighborhoods that disseminate information regarding programs and projects (“chika-chikahan”), thus highlighting the need for better coordination with the volunteers and the barangays.

**In contrast to the reception of the parents from Calbayog City of efforts like the FDS, parents from Catbalogan articulated a sense of tentativeness (“hiya”) to participate in the FDS, despite being participants for several years.** They attribute this to shyness in talking amidst large groups of people, and the fear of being treated maliciously by other participants in the forum. Aside from the FDS, parents claim to also receive occasional learning sessions from Church groups through school visits, as well as the Parent Effectivization Service which is a two-day seminar held by the CSWD where parents are taught skills in family life and parenting. This is usually catered towards 4Ps beneficiaries.

**Parents, however, shared that they are not familiar with the ECCD growth monitoring checklist although the LGUs do monitor the growth of children in their locale.** BHWs and BNS record the height and weight of children when they visit the health centers, or when home visits are conducted. This is especially true for parents who are also beneficiaries of the Pantawid Pamilyang Pilipino program, who must have their children checked regularly as a requisite of the conditional cash transfer. Such monitoring lists are also provided in schools and daycares.

**The high stunting prevalence may be attributed to the inability of some mothers to obtain proper healthcare and nutrition during the first trimester.** One official noted that these mothers did not have health check-up during the first three months because of their assumption that their monthly period is just delayed. Most of those who have this belief noted that they have irregular menstrual cycle. This is one reason why mothers do not get the proper care during the crucial first trimester.

**One of the key hurdles in accessing good health and nutrition is people's attitude towards such services. Frontline workers noted that some parents are lazy and do not seem to understand the importance of having good health and nutritional status.** People don't quite think about what to eat, its adequacy and nutritional content, as long as there is food to eat. One official noted that they usually secure the contact details of mothers during pre-natal check-up so that they can contact them if the latter forget or are not interested to visit the health center. This seemingly lack of interest has been observed in both pregnant and lactating mothers. In Catbalogan, this problem concerns only mainly mothers in poor households, who comprise a small percentage and does not include those who are working and are able to afford private healthcare. Poor people in the remote areas have very limited exposure to information sources, hence it is more difficult to motivate them of the merits of good health practices like immunization. These problems in parents' attitudes and superstitious beliefs and lack of awareness on the value of nutrition and cleanliness are also echoed by other officials.

**In addition, some mothers find it difficult to find time for health and nutrition as they are often busy with their day to day household works including caring for their small children.** An official noted that since the midwife visits the area, mothers do not spend a lot of time away from their home. They only need to go to the barangay health center or the equivalent area where they can meet the midwife and volunteers.

**Parents revealed that they are satisfied with the services provided and the manner of implementation in the barangay health centers.** It helps that personnel and parents already know each other as this allows for more affable and respectful communication from both sides. In Calbayog City, in particular, BHWs approach mothers personally in their households whenever they fail to go to the barangay health centers. Despite their satisfactory evaluation, however, some issues were raised. In Calbayog, it was mentioned that some health personnel sometimes do not seem to provide the attention sought out by parents. The appropriate health service was provided nonetheless. In Catbalogan City, the issues raised had to do more with the resources of the center rather than the attitude of the personnel. Though personnel were capable and willing to provide their needs, there are times when the health center lacks the necessary medicines and equipment.



### 5.3.3. Access

**In terms of access, parents and caregivers interviewed from both Catbalogan and Calbayog City did not find any difficulty in accessing health stations and rural health units in their locale.** Further, they noted that often the barangay health workers and nutritional scholars go house-to-house making it more convenient for them to receive health services. Nonetheless, reception and utilization of ECCD-F1KD programs offered by the local government among parents vary. Whereas most parents avail of services like antenatal and post-natal care, immunization, and growth-monitoring, others tend to not avail because they do not feel that they or their children are facing any health or wellness issues. This is slightly mitigated in the case of 4Ps beneficiaries, as they are required to have their children examined by health personnel regardless of health status.

**Catbalogan city, specifically, has health centers situated in the areas of the city with the densest populations, thus ensuring that there is an accessible facility for majority of the people.** Services for pregnant mothers are given for free in Catbalogan and it maintains a referral-first system through the barangay health workers so that residents are given priority in the provision of maternal services. Difficulties are encountered only when there are no physicians in the main health center, though the parents interviewed ascertained that this happened rarely. These facilities are always open and there are always BHWs available to assist patients, while midwives are on call when they are not on their rounds in that particular barangay. Aside from accessibility, mothers are also enticed to go to health centers through the implementation of incentives that provide monetary compensation for giving birth in health centers. Such incentive is also provided in Calbayog City.

### 5.4. Other contextual factors

There are contextual factors that affect not only people's ability to access health services but also local government's capacity to deliver services.

**Poverty is a key barrier in people's ability to obtain health and nutrition services.** It was noted that parents from poorer families are more passive and appear less interested in participating in various local interventions. Others simply do not have the financial resources to cover even transport cost. Sometimes frontline workers shoulder the transportation expenses of the patients just so the latter can reach the health facility. Some of the parents of malnourished children have very limited means and usually work as household workers or tricycle drivers. Taking a leave from work for even a day may be costly for them, making them unable to participate or sustain their participation in feeding sessions or other interventions.

**The geographic characteristics of the study areas pose significant challenges in the accessibility of programs and services. The population densities also play a role in the LGU's ability to reach people.** The challenges vary between the cities under study largely due to variation in land size and concentration of population. The population of Calbayog city is nearly twice that of Catbalogan. It is comprised of 157 barangays, 24 of which are considered GIDAs. The huge city also has several pockets of high population barangays dispersed from one another. It also has a number of far-flung, upland GIDAs which do not have viable barangay health stations. The roads to these GIDAs are not concrete and travel time going there on foot is estimated at 6 hours for the most difficult to reach areas. Conducting a visit to these areas is therefore expensive. Moreover, these remote barangays do not have access to Internet. Their usual means of getting information are radios. Because of accessibility problem, there

are no regular services in these areas and are rarely visited by midwives. In fact, no midwives are assigned in these areas. Although there are community volunteers (e.g. BNS), they don't stay long in these areas. Health and nutrition services are provided in GIDA either quarterly or twice each year. The LGU is unable to monitor what is happening in these areas.

In contrast, a great percentage of Catbalogan's population is located in a few barangays making the delivery of local interventions easier to conduct. Its GIDAs are in island barangays which can easily be reached by boats. As a result, these areas have either a functional barangay health center or a barangay health station which cater to the needs of the residents. It was also noted that these barangays have their own motorboat for use during emergency. People in the upland usually calls in during emergency then the health facility sends an ambulance to the nearest pick-up point to bring to patient to the hospital. For the routine check-up, midwives have schedules for going to the upland areas, hence, people do not have reasons not to visit. In some instances, people are asked to come down to the main health facility and some obliged.

**The lack of focus in GIDA in Calbayog is attributed not only on the high cost of doing interventions in these areas but also because population-wise these do not comprise a significant proportion of the city's population.** As shown earlier, the 24 GIDA barangays represent only 5.5 percent of the total inhabitants, unlike in Catbalogan where the GIDA barangays comprise 13 percent of its population. To make their efforts able to cover more children, the LGU in Calbayog focused its attention on the highly populated areas where there are large number of malnourished infants and young children. Furthermore, some of the people in GIDAs are said to be working in the city as they are fleeing these areas for safety concerns. One official suspects that some of these people are already getting the support they need in terms of healthcare if these workers bring their families with them in the lowlands. There is no data however on these movements. If indeed true, such mobility may also present some constraint in reaching people who are at times moving to other places.

**The issues of security in Calbayog also pose threat in the health and nutrition program implementation.**

In fact, a key consideration as to why no midwives are assigned in GIDA barangays is the safety of the health workers. The presence of private armies in these areas tend to discourage midwives from going to the areas to provide services. It was noted that one midwife did not go back to one area because there was an incident of beheading. The conflict was visible even during the period of data collection wherein the encounter between the government forces and a private armed group led to the death of four individuals in Calbayog City. It was also noted that people in GIDA are not organized. Hence, 90 percent of GIDA barangays do not have community volunteers. This adds to the difficulty and complexity of delivering services to such areas.

**Other factors that the study found which can adversely influence young children's health and nutrition are lack of decent shelter, pollution including second-hand smoke, and lack of sanitation.** Children are said to be more vulnerable to risks if they are living in subpar shelters. For this, Calbayog City is planning to create urban housing projects that prioritize local, informal settlers. Pollution in the environment including second-hand smoke also adversely affects children's health. The lack of proper garbage disposal by households is also a problem that hampers proper sanitation.

## 6. Recommendations

### 6.1. Policy, Leadership and Governance

**There is a need to take stock of local government initiatives that advance the welfare of infants and young children using clear and objective metrics.** This case study found that, as far as Calbayog and Catbalogan are concerned, there is focus on health and nutrition and the willingness of top officials in supporting ECCD-F1KD programs is evident. Likewise, they are implementing a great majority of the components of ECCD-F1KD. However, it is difficult to objectively ascertain how high a priority ECCD-F1KD is to the LGUs because of the difficulty to separate the resources that go to the different initiatives related to it. The government therefore must explore mechanisms how to effectively account for the resources spent on ECCD-F1KD initiatives.

**LGUs must allocate time and resources for integrative planning to ensure that target outcomes are jointly determined.** Currently, local government departments contribute to the effort of supporting the families of similar sets of target beneficiaries. This coordinative structure at the level of implementation is a promising practice. It is also evident of the LGU's ability to mobilize resources for improving the welfare of children in the first 1000 days. Unfortunately, this mechanism lacks integrative planning where target outcomes are jointly set and roles are clearly delineated for purposes of improving accountability. At present, targets are usually determined at the level of inputs, activities and outputs where every department conduct their own planning and targeting. Furthermore, the role of non-health departments appears ad-hoc because their contributions are often determined during regular meetings and may not be pre-determined for long-term planning and monitoring. The inability to conduct joint planning among departments implementing ECCD F1KD-related programs is said to be due to lack of time. The departments therefore must learn the value of joint planning and how crucial it is for implementing sustained efforts to effectively achieve desired outcomes. They must pursue to effectively develop and commit to the calendar of the planning process. Timeliness is crucial as lags in the planning process led to less time to scrutinize programs for budgeting purposes. In addition, there is a need to improve the capacity of people directly involved in crafting the LNAP.

**ECCD-F1KD program and service delivery will benefit from a better delineation of roles and enhancement of relations within departments that directly implement these programs.** The study found that the policy framework varies depending on individual LGU political or administrative dynamics. While a relatively dispersed organizational structure in one LGU may have resulted to a greater focus on nutrition, it may present some limitations in overall program design and service delivery. On the other hand, a less autonomous set-up for nutrition can have its own setback including but not limited to lack of discretion in resource allocation and in determination of priorities by those directly implementing the interventions. Achieving the right balance in the power dynamics within the LGU is, therefore, essential.

**There is a need to improve awareness of the policymakers on the current state of malnutrition problem and its serious consequences.** While there is some awareness on the extent of malnutrition problem, the perception gathered is not to the level that merits urgency and high priority in the local government agenda. It is important for officials that have a key role in the decision-making and budgeting processes to have a deeper appreciation of why it is necessary to spend a reasonable amount of resources in ECCD-F1KD initiatives. Some of the

key (non-health) officials who were interviewed lack awareness of the F1KD programs that the LGU needs to implement though they are aware of the general health concerns of the population. In discussions about children, they seem to be more familiar with ECCD programs that the CSWDO implements than those that concern infants and young children (aged 6 to 23 months). Awareness-raising campaign must be done through better generation, management and dissemination of data.

**There is an urgent need to carry out M&E and improve capacity of LGUs on M&E.** The lack of efforts and capacity for M&E is evident. The government, therefore, must invest in tools for effective needs assessment and for monitoring and evaluating various efforts and in capacitating officials and staff. The common tool for monitoring outcomes, which is the OPT, suffers from low coverage, delays in the information gathering process, and potential inconsistency in measurement. These pose challenges in its reliability and timeliness for policymaking. Improving the coverage of OPT and other monitoring tools is therefore essential. The government must also explore easier ways to document OPT and other data to reduce the chance of human error in recording, computation, and aggregation. New and innovative ways for documentation is therefore highly commended. For example, the OPT system may consider allowing the BNS to input only raw individual data and a computing system can do the aggregation and determination of those who are underweight for age, etc. at the barangay and higher levels. Furthermore, while measuring health and nutrition outcomes and improving the coverage and measurement are essential, monitoring inputs, activities and outputs (e.g. calculating total number of volunteers, trained volunteers by barangay, volunteers in need of training and re-training; population per volunteer, population per midwife, population per facility), which is relatively more feasible, must also be carried out while the outcome monitoring system is being enhanced. Installing a centralized database of target, inputs, activities, outputs, and outcomes is crucial for this.

**In relation to the abovementioned recommendations, objective metrics must be utilized in all aspects of policymaking – agenda-setting or planning, formulation including budgeting, decision-making, implementation and evaluation, in all relevant levels.** OPT results and other data are mostly used for targeting, advocacy and awareness raising campaigns, but not so in the key aspects. Capacity for utilizing evidence must therefore be enhanced. The effective and efficient allocation of resources is crucial. The current practice of gauging the current year's budget to the previous year's may not allow adjustments to changing circumstances and needs. Although, other funding sources can augment the available funds, it is important to institutionalize evidence-based approaches and not rely on ad-hoc augmentation. Institutionalization of long-term plans and budgets ensures that there are adequate resources so that efforts are sustained.

**Poverty reduction programs and economic development efforts that uplift the dire situation of the poor must be the top priority.** Poverty limits household's ability to access even the free health services provided by the government. The rising poverty incidence in Samar is a huge hurdle in government efforts to arrest the malnutrition problem. The current government programs like the 4Ps and livelihood programs must therefore prioritize such areas. The study also found that the 4Ps can be a good program for other programs in health and nutrition to latch on since it is relatively easier to convince 4Ps beneficiaries to cooperate in government efforts than non-4Ps. The targeting approach of the 4Ps program must therefore be improved to ensure that the poorest are not excluded so that all of these can gain support from the government for them to better provide the health and nutrition needs of their young children.

## 6.2. Program and Service Delivery

**Greater efforts are needed in tracking development milestones for all infants and young children.** At present, programs related to ECCD-F1KD are carried out sparsely and as separate programs. Such must be integrated where the focus is on the individual child and not in a programmatic manner which means that interventions are taken as packages rather than separate interventions. This can be further emphasized through the production and dissemination of the ECCD milestone checklist so that mothers may be able to keep track of the nurturing care needs of their children within specific timeframes of their youth.

**LGUs must ensure that there is adequate amount of resources allocated to ECCD-F1KD programs.** There is lack of resources that go into the implementation of ECCD-F1KD, whether this is due to lack of financial base or lack of funds going to ECCD-F1KD from the resource base. One reason why policymakers must be made more aware of the importance of ECCD-F1KD programs is for them to understand the need for allocating adequate resources. The funds for implementing nutrition programs alone do not meet the required amount to 1) conduct sustained feeding programs for identified malnourished children in the locality, and 2) to provide all necessary equipment for use in OPT, despite the support obtained from higher government levels and active non-government partners. The allocation of resources must be based on evidence.

**There is an unmet need for technical assistance that local governments must attend to.** It is an opportunity that more volunteer health workers are added to the pool each year. However, many of them lack the basic anthropometric, documentation, nutritional assessment, communication, and IYCF skills while others are in need of updating their skill set. LGUs that do not have on-site trainers rely on the provincial and regional offices for technical training. Volunteer health workers play a crucial role in program and service delivery and it is paramount that they are capacitated. Therefore, there is a need to ensure adequate allocation for technical assistance. Provincial and regional government bodies must assess and monitor the number of volunteers in need of basic training and incorporate this information in their policy processes to ensure that all demands for capacity building are met.

**The government must address bottlenecks in the public procurement process.** LGUs also face constraints in service delivery due to delays in the procurement process. These constraints include the difficulty of securing suppliers and in obtaining numerous signatures. Hence, though systems must be in place to ensure efficient and effective use of public funds, it is equally important to expedite processes that are meant to provide basic health and nutrition services for young children and pregnant women. In addition, accessing funds must be simplified. At the provincial level, although the lack of funds was not highlighted, the presence of an extra layer of bureaucracy in accessing provincial government funding by the PHO presents a hurdle in the financing aspect as opposed to when there is more direct channel between the provincial government funding and the PHO Technical Division.

**LGUs with vast land area and dispersed populations including GIDAs must augment their frontline workers (i.e. midwives and volunteer health workers).** Given the difficulty of attracting medical officers into public health facilities as well as the limited number of *plantilla* positions for public sector workers, expanding the pool of volunteers can improve on advocacy work and information dissemination especially in areas where many people are impoverished. It is also essential to evaluate how programs like the Deployment of Human

Resource for Health (formerly known as Nurse Deployment Program) is able to fill the shortage of medical staff in unserved and underserved areas. Such evaluation can show 1) whether the program is indeed delivering on its objectives, and 2) if there are aspects in need of improvement.

**LGUs must re-examine their deployment strategies so that midwives can have more equal workload.** Midwives are found to be overburdened as they make rounds in a number of barangay health centers. LGUs need to reduce the workload of those who are having difficulties serving in their assigned areas so that their services can be improved. The study found that there is wide variation with respect to the population assigned to the health stations manned by midwives; some can have 10 times the population in others. The clustering of the barangays must therefore be re-examined so that access by population to the health facilities can be improved. The LGUs need to rethink the clustering of barangays assigned to the Barangay Health Stations to make the workload of midwives more balanced and to improve access of those in most remote areas. In future efforts of building BHS, LGUs must ensure strategic positioning of BHS to cover underserved areas and those with both high stunting and high population densities. This must be done with the twofold purpose of reaching GIDA areas, as well as evening out the load on other BHS and personnel.

**LGUs must improve on their collaborative approaches to lure more people to participate in programs and avail of government services.** The poor and those living in remote areas must find greater reasons to actively partake in government interventions. Providing programs and services to cater to the needs of as many members of the household as possible during barangay visits (such as during feeding activities or immunization) is a promising approach that LGUs can develop and enhance. Such can entice people to improve their health-seeking behavior. The benefit-cost ratio of travelling to where the services are provided and/or of taking absence from their work/livelihood to avail of the services increases if more members can benefit as opposed to only one member (such as when the infant needs to be vaccinated).

**Efforts must ensure the adequacy of supplies in government programs and services.** Both LGUs in this paper have experienced shortage in supplies for the treatment of malnourished young children. Sometimes when supplies arrive, these have very short shelf life left and are at risk of getting expired prior to distribution to the target beneficiaries. As already mentioned, they also lack anthropometric equipment necessary in monitoring weight and growth of the target group (e.g. pregnant women, infants and young children). In OPT, they also lack computer for a more expedited process of recording and submitting OPT results.

**There is a need to increase awareness of how important it is to provide services to people in the GIDA.** A key thrust in the achievement of the Sustainable Development Goals is leaving no one behind. While people in the GIDA may not be prioritized due to the high cost of providing interventions in such areas and concerns involving security, governments must find more viable solutions so that they can gain access to basic health and nutrition programs and services in a regular manner. Installing properly manned health stations in GIDA or coming up with equally effective strategy for their inclusion is paramount.

**There is an urgent need for better and wider advocacy efforts about the importance of effective BNAP formulation and implementation in the barangays.** The barangay councils and committees are the government bodies closest to the people. It is important that the nutritional action plans in this level are well-formulated, provided reasonable funding, and

implemented. Also, given that frontline health workers (i.e. midwives, BNS and BHW) have the most grassroots engagement with the barangay population, efforts must ensure that they participate and are given a clear role in the formulation of the BNAP.

### *6.3. Nurturing Care Practices*

**Information and education campaigns must be intensified and be made available for all to improve the awareness of parents and other members of the households of the importance of properly nurturing children especially during the crucial first 1000 days.** The provision of childcare, the study found, is not exclusive to parents of young children. Rather, it extends to female kin and other members of the households. It is therefore essential that advocacy and IEC programs like mothers' classes and the 4Ps' Family Development Sessions (FDS) be made inclusive of all members of the households and the community, not just for 4Ps families. LGUs which are not implementing yet such program must develop the IEC materials and strategies for implementation. LGUs with existing similar interventions must continue to improve on coverage and content. There is also a need to expedite the organization of peer councilors in every barangay to serve as a support system for FIKD components like breastfeeding

**The government must implement effective strategies aimed at enhancing the knowledge of adolescents on the importance of early pregnancy detection and obtaining proper pregnancy care in the development of the child.** The study found that some pregnant women fail to gain the necessary pre-natal care during the first trimester because of late pregnancy diagnosis. These women do not go for pre-natal check up until their monthly period is three to five month's delayed because of irregular menstrual cycle. However, early detection is essential so that the pregnant woman can obtain the needed care during the crucial first three months.

**Parents must be made more aware of the importance of practices such as playing, singing, reading and talking with their children as a means of early learning.** Stimulation of a child's mind from a young age increases positive outcomes with regards to a child's intellect and mental well-being. Awareness and new techniques must be taught to parents to capitalize on this facet of nurturing care. Mothers' classes conducted by Calbayog City and the *Buntis* Congress carried out by Catbalogan must be expanded, intensified and improved to include modules on stimulation and early learning.

**The LGUs including the barangays must also carry out all initiatives necessary for young children to have a safe and secure environment.** Some parents are unable to access health and nutrition services for their younger children and often unable to work to earn a living because of lack of support network to look after their other children when they leave their dwelling. Providing safe spaces for young children to roam around and creating child-minding clusters or play groups are very crucial not only for children's growth and development but also so that parents can safely carry out other important tasks. Encouraging voluntarism among residents is also very helpful in creating a child-friendly community.

**The national and local governments must develop or intensify health and nutrition programs for adolescents especially young girls.** The health of the infant heavily relies on the general health condition of the mother. Therefore, there is a need for stock-taking of programs for adolescent girls to identify the gaps and challenges for the formulation of effective approaches.

**The government must further strengthen its initiatives with regards to mitigating violence, maintaining a clean environment, and providing economic security to households.** This is cognizant of the idea that maintaining a holistically secure environment both inside and outside the household is most conducive for the early development of the child. Such an environment provides a solid foundation for their development.



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