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Situation analysis of ECCD-F1KD initiatives in selected UNICEF-KOICA provinces

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DISCUSSION PAPER SERIES NO. 2019-31

Situation Analysis of ECCD-F1KD Initiatives in Selected UNICEF-KOICA Provinces

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Abstract

Despite the Philippines' sustained economic growth, persistently high malnutrition remains to be a significant issue in the country, especially in a number of subnational regions. This clearly illustrates the urgent need to examine the formulation and delivery of health and nutrition initiatives particularly for children in their first 1000 days at the local level. This integrative report draws together the key findings from the situation analyses concerning early childhood care and development (ECCD) for the first 1000 days (F1KD) of children in three UNICEF-KOICA areas namely Northern Samar, Western Samar and Zamboanga del Norte. The key objective is to examine the contextual factors that influence the delivery of ECCD-F1KD efforts in these areas. The discussion is partitioned into three key themes: policy and governance, the delivery ECCD-F1KD programs and services, and the nurturing care practices of parents and caregivers. The analyses implemented qualitative analysis of primary data gathered through interviews and focus group discussions with key stakeholders such as local chief executives, local planners and budgeting officers, program managers, frontline workers and parents/caregivers. This is supplemented by other documents that include data on health budgets and key nutrition indicators. The study found that access to and delivery of ECCD-F1KD programs and services is greatly affected by the following factors - lack of economic development/opportunities for most of the LGUs leading to low tax revenue base and poor capacity of many households to access such interventions; lack of integrated planning at the LGU level; lack of coordination in planning and budgeting; the absence of proper monitoring and evaluation; questionable quality of data coming from the OPT; lack of capacity of volunteer health workers; overburdened midwives; difficulty of reaching GIDAs due to security concerns and geographical barriers; and lack of awareness in some parents and even in local government leaders/officials, among others.

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

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1. Introduction

Evidence shows that the quality of care and nurturing that is given to children during their first 1000 days of life has a profound effect on their future. When children are protected from disease, are well-nourished, and live in stimulating and protective environments, they develop and reach their full potential. Many children, however, are not able to get adequate nurturing care and live in favorable environments. In the Philippines, one in three children under five years old is considered stunted based on 2015 estimates. The stunting problem is even worse in some regions. In other health indicators like infant and under-five mortality and immunization coverage, the country's performance also reflects the urgent need for more effective and targeted efforts.

The limited access to quality, preventive and curative services is mainly due to financial and geographical barriers, the 2017 situation analysis of children in the Philippines noted. Parents and caregivers face economic constraints and such contributed to the malnutrition among women, infant and young children in five UNICEF partner municipalities.¹ Many of the gaps that have been identified concern program implementation at the local level. One of the key operational gaps in addressing stunting at the local level, the NNC noted, is the lack of local mobilization at the LGU level and a coherent mobilization strategy in the part of the NNC (Herrin, Abrigo, Tam and Ortiz, 2018). 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.² 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.).

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. 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. Furthermore, 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 councils. Lastly, there is lack of clarity in terms of roles and leadership in integrating the program. But amidst the challenges faced by LGUs, it is found that there is interest in the LGUs with respect

¹ See Integrative Competitive Intelligence Asia (n.d.) and De la Salle University – Social Development Research (n.d.)

² UNICEF 2018 Country Report

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.).

Aside from the economic, governance, and human resource constraints, external factors like natural calamities, safety and security issues, and inaccessibility of areas also affect service delivery. Typhoon Haiyan, for instance, has raised the urgency of having standardized national protocols for combatting malnutrition (Garg et al. 2016).

To address the abovementioned gaps, the Government of the Philippines is implementing an integrated programming and delivery of services for early childhood care and development (ECCD) during the first 1000 days of life (ECCD-F1KD). Such effort seeks to intensify the delivery of a package of services that are necessary to improve child development outcomes. For its part, UNICEF is supporting the government of the Philippines in improving outcomes for children focusing on the First 1000 Days of life. Specifically, it seeks to bring in its global expertise and provide technical support to the government in creating enabling environments for ECCD-First 1000 Days, strengthen service delivery and systems, and help address social and behavioral issues. Under the upcoming Country Programme for children 8 (CPC 8), UNICEF will work closely with provincial governments and help to strengthen their capacity to enable municipalities/cities in addressing relevant issues. With funding from KOICA, UNICEF has committed to provide technical support on ECCD-First 1000 Days to the provinces of Samar, Northern Samar, and Zamboanga del Norte.

This situation analysis aims to inform the development of strategies for improving health and nutrition interventions particularly those related to the first 1000 days of children's lives using the cases of three UNICEF-KOICA areas - Samar, Northern Samar, and Zamboanga del Norte. Adopting the Continuum of Nurturing Care Framework, the study focuses on the 1) policy, leadership and governance, 2) program and service delivery, and 3) nurturing care practices among parents and caregivers of young children. Specifically, the analysis elaborates on the different input and processes surrounding ECCD-F1KD program implementation. It documents barriers and challenges, as well as promising and good/best practices. Ultimately, the goal is to draw insights and recommendations for improving the delivery of ECCD-F1KD programs and services.

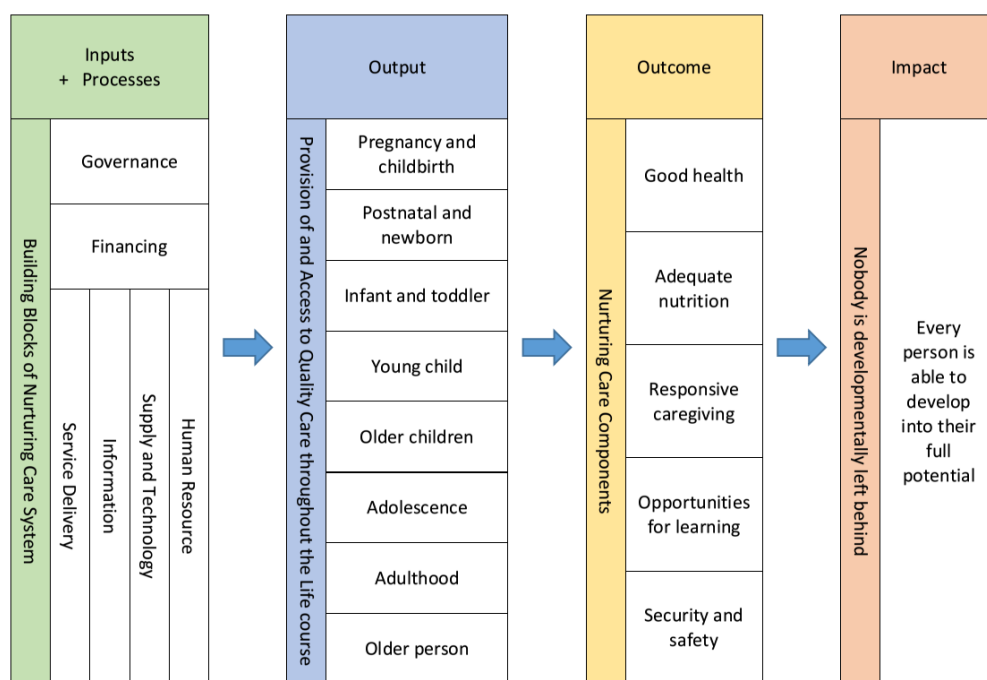
2. Objectives of the Study

This study aims to undertake a situation analysis that will inform the design of strategies for improving ECCD-First 1000 Days (F1KD) outcomes using selected cases in Northern Samar, Samar, and Zamboanga del Norte. Specifically, it seeks to understand the various factors surrounding local mobilization of ECCD-F1KD interventions focusing in the aspects of 1) policy, leadership 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) 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.

3. Methodology³

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 1.

Figure 1. Continuum of Nurturing Care Results Framework



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

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.

³ Section was lifted from the study's inception report

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

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 st)	Low (3.3%)
Lope de Vega	Low (4 th)	High (41.2%)
Samar (Western Samar)		
Calbayog City	High (1 st)	High (22.9%)
Catbalogan City	Low (5 th)	Low (10.6%)
Zamboanga del Norte		
Sindangan	High (1 st)	Low (4.3%)
Leon B. Postigo	Low (4 th)	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. Results

4.1. Policy, Leadership and Governance

The LGUs under study prioritize to some extent health and nutrition and allocate funds to its programs but these do not comprise the top priorities, which are usually infrastructure. It was found that the support of the LCE is very crucial in getting programs like ECCD-F1KD funded and implemented. A consistent finding of the study is that while the LGUs adhere to some extent to the prescribed processes of planning, in the exemption of some, the final decision rests on the local chief executive. Furthermore, perceptions and level of awareness of key officials on ECCD-F1KD issues are important in identifying priorities. 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.

In terms of planning, the local nutrition council is the key policymaking body for nutrition tasked to formulate the local nutrition action plan (LNAP). The study found that local government departments in the LGUs usually 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. What is usually done is for the nutrition action officer to consolidate programs from various agencies into the LNAP. The level of interaction among members of the nutrition council also varies across areas. There are those which have regular meetings. But there are also those which rarely, if at all, meet to discuss the LNAP. The inability to convene and jointly determine the plans is usually due to lack of time; in other cases, it is attributed to political transition.

The study found various quality of LNAPs. Some plans are of better quality than others. For instance, there are LNAPs with budgets specified, but there are those which do not reflect the budget allocated. In Zamboanga del Norte, the study found that many plans do not conform to the suggested format by National Nutrition Council. In this province, apart from the variation in the quality of plans, there is also wide variation in the availability of LNAPs. In some instance, there is a need to improve relevance of plans. In Northern Samar, there is a mismatch in some of the nutrition-sensitive programs with what the community needs.

On a positive note, the planning process can be roughly described as evidence-informed since OPT results and other sources like the FHSIS are used in drafting local needs and priorities. Another consistent finding in the study for all provinces is that the planning process is mired with delays which is a challenge in budget allocation. In Zamboanga del Norte, some FGD and KII participants mentioned the lack of transparency in the planning process.

In terms of financing, funds for ECCD-F1KD largely comes from national transfers, particularly the internal revenue allotments (IRA) although some richer LGUs have income generating projects. A consistent finding is the 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. In general, expanding local government incomes are critical in expanding local government programs.

Though LGUs particularly those in Samar are able to raise funds from other sources like non-government and private donors, the resources are not adequate to meet the targets. In Northern Samar, the expenditures of most municipalities are heavily concentrated on general public services. Furthermore, while IRA is released on time, funds are usually not enough to pursue development programs. For population, health, and nutrition (PHN) services in Zamboanga del Norte, local government spending per person per year averages to around Php120. In Samar, the bulk of health and nutrition funding in one case 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. Based on the cases examined in this province, it is a common practice for departments to base the current year's nutrition and health budget on the previous year's budget. This is probably the reason why there is not enough resources to implement the needed ECCD-F1KD interventions. Among ECCD-F1KD initiatives, one component that requires adequate budget allocation is

capacity building. In fact, in one LGU, the nutrition budget does not include an item for training of volunteers; the LGU merely relies on the provincial and regional levels for capacity building.

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. In Northern Samar, while LGUs independently decide on the projects, activities, and programs, the use of the fund follows the regular audit conducted by the COA.

If there is one single aspect of governance that requires greater prioritization aside from financing – it is the development or improvement of monitoring and evaluation in ECCD-F1KD. LGUs use various tools for monitoring health and nutrition outcomes. These are data from OPT, information from regular meetings with BNS, and accomplishment reports from frontline workers. However, the quality of some monitoring-related information sources may be suspect.

The conduct of the OPT, which is the main tool used by the local governments, is challenging. The measuring tools are not available for all barangays. During OPT operation, workers take turns in using the tools. Some of these tools are also not properly calibrated. Other workers use improvised tools. The lack of proper calibration and the use of improvised one can result to measurement errors or inconsistency in anthropometric measurements. The OPT process also suffers from delays which adversely affects LGU's ability to conduct timely monitoring. OPT in Samar also suffers from low coverage due partly to the inaccessibility of GIDAs. There are also issues with documentation that cast a doubt on the accuracy of data collected in the locality not only in OPT but in other data as well. There may be issues concerning coordination. In carrying out the OPT, particularly in Zamboanga del Norte, the BHW and BNS may or may not work together as this direction depends on the directives of their program managers. One can also speculate the same in one Samar case because BNS and BHWs have different program managers.

While the importance of research generation for policy formulation purposes was recognized and both the CNPC and CNAO of at least one LGU are trained in monitoring and evaluation, this is usually not carried out particularly for ECCD-F1KD efforts. One LGU in Samar admitted that it does not monitor its ECCD-F1KD initiatives. In another LGU, officials noted that the ECCD checklist, which is a prescribed monitoring tool, is quite new in health. The challenges in monitoring emanates from delays in getting the accomplishment reports from the different agencies doing nutrition-related programs. In addition, M&E is challenging for the CNAO, being merely a designation despite the heavy workload. Monitoring and evaluation are also not carried out in the barangay because the BNS are not computer literate.

Lastly, the organizational structures at the provincial level generally follows the devolved health system.

Personnel replacement depends on the association of the current executive power. In Samar, the study found varying structures (composition, number of members) of local nutrition councils with most changes occurring during political transition. Such frequent changes to organizational structures concerning nutrition or ECCD-F1KD may adversely affect the long-term trajectory and sustainability of ECCD F1KD programs.

4.2. Program and Service Delivery

ECCD-F1KD, in itself, is not yet formally institutionalized at the LGU level (in the cases examined) though many of the programs and services related to it are publicly provided in the community as part of separate programs on maternal and child health, family planning, early child care and development, and nutrition, among others. Nonetheless, looking into the checklist of the ECCD-F1KD components in the LGUs, there are still some that are yet to be provided. These findings are consistent for all provinces under study.

In Samar, most of the programs not provided are those that are meant to be implemented during pre-natal, immediate post-partum, postpartum and lactation. These include PHIC enrolment and linkages to community-based health workers and volunteers, nutrition counselling and provision of nutritious food and meals for mothers, counselling to parents/caregivers on responsive care and stimulation for infants/children, lactation breaks for women in the workplace, the provision of lactation stations in the workplace, and organization of breastfeeding support groups in workplace. For newborn, the interventions that are yet to be implemented are the early and continuous skin-to-skin contact and kangaroo mother care for babies in facilities with birthing services, and human milk pasteurizer with neonatal ICUs. The study also found the need to develop or improve programs for adolescent females. There is also a need for nutrition intervention and nutritional assessment for pregnant women as well as monitoring of teenage pregnancy. It is noteworthy that LGUs covered provide all the needed interventions for the first six months of infancy and for infants aged six months up to two years.

In Northern Samar, the bulk of nutrition programs are nutrition-specific. One of the issues identified, however, is the timing of these interventions. There are also some nutrition-specific programs that do not meet the number of target beneficiaries. Some LGUs give incentives to enhance the participation of people on nutrition-specific programs. Though some nutrition-sensitive programs are also implemented in Northern Samar, there is a need to improve on these interventions.

In implementing the numerous efforts for health and nutrition, in general, and ECCD-F1KD, in particular, LGUs must have adequate workforce. However, the human resource for health is limited. Due to this limited supply including the constraints in hiring them, public health workers often face heavy workload. This raises concerns about the sustainability of local services if the national health human resource program is discontinued. The human resource on the frontline, in particular, is not only inadequate but is also in need of capacity building. Midwives are overburdened with their multiple tasks. This is exacerbated by the unequal assignment in terms of population in the barangays assigned to many midwives particularly in the Samar cases. Amidst the heavy workload of midwives, the role of volunteer health workers (BNS, BHWs) is crucial as they support in the midwife's tasks in the communities. These volunteers, however, are in need of regular training due to high turn-over. Most of them also needs re-training during OPT season. The training needed are basic skills in obtaining children's age in months, weighing and height measurement. Because they directly engage with the population in the delivery of basic health and nutrition services, frontline workers' compensation must be improved.

While there is lack of volunteers in some areas, there are those which do not even have barangay nutrition scholars or assigned midwives. This finding is consistent for Samar and

Northern Samar. In a case in Samar, for instance, no midwives are assigned in GIDAs and while volunteers go there, they do not stay there. These areas, therefore, must be prioritized in the deployment of health personnel by the national government and in the local government agenda.

The local nutrition action officer's tasks of coordinating and facilitating nutrition programs are crucial. However, they are mere designated officers which may not be in the best interest of nutrition as it can become a mere second priority of the officer.

One of the crucial elements in the effective delivery of ECCD-F1KD is the accessibility of health facilities. A significant part of the provinces under study are difficult to access given the geographic features of these areas. Zamboanga del Norte's land feature is 97 percent strongly sloping to very steep hills and mountainous regions. Samar and Northern Samar has many geographically isolated and disadvantaged areas (GIDAs). There are also issues pertaining to adequacy of services. In Northern Samar, some services are not offered by the RHU; there are also some laboratory tests that some LGUs could not offer.

With regard to supplies, the delivery of health and nutrition services are hampered by bottlenecks in the logistics system and in the management of supplies at the LGU level. In Samar, the prevailing issue regarding supplies is the huge gap between requesting and receiving the necessary supplies from the regional office and the relatively short validity or shelf life of the supplies. In the case of Zamboanga del Norte, there is miscommunication between national government program implementers and local government program managers, regarding who will provide some of the key supplies for nutrition interventions.

On information and communication, LGUs usually course information to the communities through BNS/BHWs. They also conduct meetings and dissemination activities involving barangay captains. One LGU in Samar also conduct health summit for a selected set of barangays. Also in Samar, feedback from the ground is gathered through the frontline workers. Among themselves, the communication is through regular meetings and online chat platforms. In Northern Samar, communication between program managers and staff comprises mostly of verbal notifications which can result to inadequate actions among personnel. While several campaigns on health and nutrition are regularly done, some frontline workers recognize the need for training in communications that can help in reshaping mindsets of their target population. This is because of the need for more effective strategies to address 1) information fatigue among parents/caregivers, and 2) their indifference towards IEC materials. Many areas in the provinces examined are in need of improved internet and mobile phone connectivity and better infrastructure to improve access to locations.

In spite of the challenges in service delivery, there are good/best practices that are noteworthy. Calbayog's Nutrition Center is considered by one LGU official as a good practice. There are also municipalities in Samar that provincial officials noted as having exemplary service delivery networks (SDN) and referral systems such as the *duyan* and *habal-habal* systems. In Zamboanga del Norte, some of the best practices mentioned by the provincial government are their Ayuda Medical sa barangay, availability of halfway houses, birthing plan, rice monggo food processing plant, fresh milk dairy production for feeding the underweight from buffalos, and breastfeeding stations in the workplace and hospitals.

4.3. Nurturing Care Practices

In general, mothers are aware of the symptoms of pregnancy and the danger signs they need to look out for. One consistent finding is that there is generally trust in the information that parents/caregivers received from local government health workers including volunteers (i.e. BNS and BHWs). Hence, they avail of health services offered in the health center. In fact, there has been marked success in getting pregnant women, particularly in Samar, to attend checkups and give birth in the center, primarily because such services are free and incentives are offered. One problem that was observed in the cases studied in this province is the failure of some mothers in obtaining prenatal care during the first trimester. This is due to the irregular menstrual cycle of some women. Also, traditional beliefs and social norms still exert strong influence in pursuing specific actions towards health and nutrition. Moreover, social problems within the family such as engaging into gambling and vices, and parents' separation also affect the quality of care provided to young children.

Nonetheless, it is noteworthy that mothers are aware of and practice exclusive breastfeeding in the starting stages of their child's life, with the duration depending on several factors. They are also aware of signs of malnutrition and its impact on children and they exhibit their ability to care for their children. For instance, they administer first-aid medicines on sick infants and young children. As their children grow, they feed them with mashed vegetables and other semi-soluble, healthy concoctions. They are aware that there are foods/beverages/activities that expectant mothers and lactating mothers should and should not eat/drink/do. Mothers also ensure that their children receive deworming and micronutrient interventions and are vaccinated.

In Samar, mothers are identified as the primary caregivers in the household. After the mother, the next-in-line to be the primary caregiver of children vary per respondent. FGD participants believe that women are more equipped for providing care than men. They mostly ascribe to recommended care practices such touching/caressing/cradling. The general sentiment is that mothers push themselves to take care of their children, regardless of their own condition. In Zamboanga del Norte, households generally have good knowledge of nurturing care practices at home. Some of the activities mentioned were feeding, public service caravans, and visits by the BHWs/BNSs. In spite of this, statistics suggest that women and children in the province are not faring as others in the rest of Zamboanga Peninsula.

In terms of learning, some mothers/caregivers are aware of the importance of neurological stimulation. Some mothers have shared that they try to read to their children at night. They also try to play with them and cuddle with them when they can. In Zamboanga del Norte, some of the activities mentioned were playing with toys and reading materials. Also, Supervised Neighborhood Play is available for children below two years of age. In Samar, informal counselling is given to parents during their checkups. For 4Ps beneficiaries, lectures on responsive caregiving are inserted in their FDS.

Despite some success, the study found that there are still mothers who do not participate or cooperate in government efforts, and most of these come from relatively poorer families. Those from 4Ps families are generally active in participation because of the conditionality. The study found that components like Family Development Sessions can be an effective way to gather parents and families for information and education campaigns especially if extended

to all families, not just 4Ps beneficiaries.

4.4. Other Contextual Factors

Poverty among households and the lack of economic development are key barriers in people's access to health and nutrition as well as local government's ability to raise adequate amount of funds to finance all ECCD-F1KD program components. Some parents in poor families are unable to spend time in bringing their children to a health facility or barangay health center because they are either managing the household or at work. Parents recognize that their household income are often insufficient to provide the best quality of care for children. For local governments which are reliant on internal revenue allotment, the low level of economic development limits the amount of tax revenues generated which in turn limits the resources that can be allocated to ECCD-F1KD and even basic amenities like improving access to safe water. In Zamboanga del Norte, only one-fifth of households have their own piped water connection. The lack of economic opportunities in poorer areas results to a vicious cycle of poverty as families are unable to improve their well-being and contribute to local tax revenues.

Another key barrier is the presence of communities in geographically isolated areas. Such constrains the ability of resource-deprived local governments to reach these communities and provide basic health and nutrition interventions. This hurdle also limits LGU's capacity to gather data for establishing baseline information and monitoring performance. Clearly, the issue of poverty is magnified for people in geographically isolated areas.

A similarly important aspect that influences the delivery of health and nutrition programs including F1KD interventions is security. In Zamboanga del Norte, the existence of rebel groups is recognized. For this, the government tries to implement programs and services to the more remote communities. In Samar, the lack of ECCD-F1KD implementation in geographically isolated and disadvantaged areas even for LGUs with some resources is hampered by security issues.

In the three provinces examined, all these factors – poverty, geographic isolation, and security risks are present and affect service delivery. In addition, since GIDAs have low population density, they are not prioritized by LGUs which focus resources on areas with higher number of malnourished children such as the case of one LGU in Samar.

5. Recommendations

This situation analysis of ECCD-F1KD interventions in the three provinces provides some insights that can be used for crafting strategies of the government.

Efforts to enhance economic development in the provinces are urgently needed – a) to improve job opportunities so that families can enhance their livelihood sources and consequently improve their ability to access health and nutrition services and other basic amenities like water and sanitation that have direct implications on children's overall welfare during the first 1000 days of life; and b) for the LGUs to generate greater tax revenues so that it is better to able to finance development projects to spur more economic activities. For this, there is an urgent need

to improve the design and implementation of poverty reduction efforts, enhance people's livelihood skills, forge tie-ups with social enterprise, and effectively intensify convergence efforts.

In addition, people's access to information can be greatly enhanced by improving internet and mobile phone connectivity and better road infrastructure. With such improved access, the population in these areas can engage in productivity-enhancing activities. Similarly, service providers like the government and other stakeholders can easily reach the communities either physically or through more innovative approaches.

There is a need to further inform policymakers with regards to the malnutrition situation and its dire consequences. It was found that the level of awareness of officials are not sufficient to create the due sense of urgency and prioritization of the issue in the local government agenda. It is imperative that key decision-making officials gain a more nuanced appreciation of the necessity to spend a reasonable amount of resources in implementing and sustaining ECCD-F1KD initiatives.

Likewise, LGUs must place ample time and resources for integrative planning to more effectively synchronize determination of target outcomes. The current practice is that various departments separately craft initiatives supporting the same target beneficiaries. The implementation in some of the areas can be commended for its integrative approach. Such coordinative structure at the level of implementation is a promising practice. It clearly illustrates LGU's capacity to mobilize resources for F1KD efforts. Unfortunately, this mechanism lacks integrative planning where target outcomes are set by the group and thus lacking the clear delineation of roles necessary to promote efficacy and accountability.

The capacity of LGUs to effectively implement M&E is paramount in providing quality ECCD F1KD services. The studies highlight the vast room of improvement for LGUs when it comes to implementing M&E measures. This issue must be promptly addressed by the government, through investment in tools for effective needs assessment, monitoring and evaluation, as well the capacitation of officials and health staff with regards to proper monitoring. It is also integral to improve the quality of data that is being gathered to further enrich insights from evaluations.

In terms of program and service delivery, the development milestones of infants and children must be monitored more meticulously. That is, ECCD F1KD must not be implemented as separate programs, but rather, as an integrated and time-sensitive process, guided by the ECCD Checklist. Instrumental to this is ensuring adequate amount of resources are allocated to ECCD-F1KD initiatives. The government must find sustainable ways to tackle resource bottlenecks, whether it means to augment the limited financial base, or institutionalizing means to give the sufficient amount of resources to successfully implement ECCD F1KD programs.

LGUs must urgently capacitate its personnel, especially frontline workers and health volunteers. Many of volunteer health workers (i.e. BNS, BHWs) lack the basic anthropometric, documentation, nutritional assessment, communication, and IYCF skills while others need updating their skill set. Aside from knowledge building, LGUs with vast land area and dispersed populations including GIDAs must augment their frontline workers (i.e. midwives and volunteer health workers). LGUs need to rethink the matching of Barangay Health Stations to barangay clusters, keeping in mind the balancing of workload of health workers and providing access to isolated areas.

Furthermore, there should be greater focus placed on collaborative approaches between LGUs and stakeholders to facilitate higher participation and availing of services. Efforts must ensure the adequacy of supplies in government programs and services, especially in the grassroots. The need to increase awareness on how important it is to provide services to people in the GIDA must be further emphasized. This must be complemented with better and wider grassroots advocacy efforts regarding the importance of effective BNAP formulation and implementation in the barangays.

Knowledge and awareness of parents and members of the household with regards to proper nurturing care for children must be amplified through more rigorous dissemination of information and education campaigns. Findings from the study showed that child care extends to other members of the family aside from parents, with particular emphasis to female members. This necessitates that advocacy and IEC programs like mothers' classes and the 4Ps' Family Development Sessions (FDS) be made inclusive of all members of the households, as well as all families beyond just 4Ps beneficiaries. LGUs which are not implementing such initiatives must develop the IEC materials and strategies for implementation. There is also a need to expedite the organization of peer-to-peer structures in every barangay to serve as a support system for F1KD programs.

The government must implement effective strategies geared towards emphasizing the importance of early pregnancy detection, as well as proper pregnancy care for child development. This stems from findings that some pregnant women do not avail the necessary pre-natal care during the first trimester due to late pregnancy diagnosis. This must be addressed, as early detection is essential so that the pregnant woman can obtain the needed care during the crucial first three months.

It is essential to highlight the importance of practices such as playing, singing, reading and talking with children as foundations of early learning. Stimulation of a child's mind from a young age yield marked benefits for a child's intelligence and well-being. As such, parents and caregivers shall greatly benefit from knowledge of new techniques to perform said practices.

The LGUs should also endeavor to provide safe and secure environments for children. This is cognizant of the realities of parents' lack of access to health and nutrition services, as well as the inability to work due to the lack of an enabling support network to watch over children. The provision of safe spaces such as child-minding clusters or play groups are very crucial not only for children's growth and development but also the ability of the parents to perform other essential tasks such as work. Fostering voluntarism in local communities is very helpful in creating a child-friendly atmosphere.

The national and local governments must develop health and nutrition, with a particular focus on young girls and adolescents. This is in recognition of the positive relationship between the health of infants to that of their mothers. Thus, it is vital to identify the gaps and provide proper interventions to address health issues in this group.

The government must further strengthen its initiatives with regards to uphold environmental and economic security in the household and the community. Having a clean environment as well as financial security to secure proper health and nutrition supplies for the child such as food, vitamins, and medical checkups provide a strong enabling environment to the full development of children. Furthermore, the sense of holistic security such an environment affords also expands the capacity of parents to implement other nurturing care practices.

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