Republika ng Pilipinas
KAGAWARAN NG KALUSUGAN
PAMBANSANG PANGASIWAAN SA NUTRISYON
(NATIONAL NUTRITION COUNCIL)
Nutrition Building, 2332 Chino Roces Avenue Extension
Taguig City, Philippines

NNC Governing Board Resolution No. 1, Series of 2022

Adopting the National Policy on Nutrition in Emergencies, Tasking NNC Governing Board Member Agencies to Ensure the Efficient and Effective Implementation of the Policy, and Tasking the Nutrition Cluster to Formulate the Appropriate Advisories, Guidelines, and Other Materials to Disseminate and Implement the Policy

WHEREAS, emergencies and disasters disrupt the lives of populations affected, putting them at risk of developing various undesirable health and related conditions, including those that threaten the nutritional status of individuals especially the most vulnerable groups: infants, children, adolescents, pregnant women and breastfeeding mothers, older persons, persons with disabilities, people living with debilitating conditions, and indigenous peoples;

WHEREAS, the risk of deterioration in the nutritional status of the population likewise limits the achievement of the Philippine Plan of Action for Nutrition (PPAN) targets, Sustainable Development Goal (SDG) No. 2 (Zero Hunger) and other related SDGs;

WHEREAS, such a threat could be mitigated through the delivery of various nutrition-specific and nutrition-sensitive interventions, as well as related interventions, which are best identified and implemented through processes that allow the maximum participation of those affected;

WHEREAS, the delivery of quality nutrition-specific and related interventions could be facilitated through clear and practical quality standards;

WHEREAS, on 03 December 2009, the NNC Governing Board approved the Resolution No. 1 adopting the National Policy on Nutrition Management in Emergencies and Disasters;

WHEREAS, since the policy was adopted, the country has been adversely affected by emergencies, disasters, and worsening impacts of climate change, specifically, Typhoons Ondoy (2009), Sendong (2010), Pablo (2011), Yolanda (2013) and Odette (2021); Zamboanga Siege (2013); Bohol Earthquake (2013); Marawi City Siege (2017); Taal Volcano Eruption (2020); and the COVID-19 Pandemic (2020), through which more lessons have been learned along nutrition management in emergencies;

WHEREAS, the disaster risk reduction and management system in the Philippines has evolved significantly, which included the adoption of the National Disaster Response Plan that lays out the response protocols of all response clusters and the designation of National Nutrition Council as the Chair of the National Nutrition Cluster, a sub-cluster under the Health Quad Cluster, chaired by the Department of Health;

WHEREAS, in April 2018, the NNC Governing Board approved the Resolution No. 2 adopting the Strategic Plan on Nutrition in Emergencies (NiE) for 2017-2022;

WHEREAS, the Strategic Plan aims for a purposive action to address the gaps and enhance the benefit from positive lessons learned to contribute to the achievement of nutrition targets during emergencies and disasters;

WHEREAS, one of the activities for disaster preparedness of the National Nutrition Cluster in its Strategic Plan is the review and updating of policies on NiE, including the NNC GB Resolution No. 1, s. 2009;

WHEREAS, these changes and developments led to the review and updating of the National Policy on Nutrition Management in Emergencies and Disaster in 2019 to 2021 which considered the comments and recommendations of the National Nutrition Cluster, selected sub-national Nutrition Clusters, and the NNC Technical Committee;

NOW, THEREFORE, IN CONSIDERATION OF THE ABOVE PREMISES, BE IT RESOLVED AS IT IS HEREBY RESOLVED, the National Nutrition Council Governing Board hereby repeals the 2009 ***National Policy on Nutrition Management in Emergencies and Disaster*** and adopts the updated ***National Policy on Nutrition in Emergencies***.

RESOLVED FURTHER, that the National Nutrition Council Governing Board tasks its member agencies to issue appropriate agency policy instrument(s) to ensure the efficient and effective implementation of this policy.

RESOLVED FINALLY, that the National Nutrition Council Governing Board tasks the Nutrition Cluster to formulate appropriate advisories, guidelines, and other user-friendly materials to disseminate and implement the policy.

Approved this 28th day of January 2022.

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National Policy on Nutrition in Emergencies

January 2022

This *National Policy on Nutrition in Emergencies* replaces the *National Policy on Nutrition Management in Emergencies and Disaster,* which was adopted by the NNC Governing Board in December 2009. This updated policy was developed based on the results of the review and updating spearheaded by the Integrative Competitive Intelligence (ICI) Asia, Inc. in 2019-2020. The ICI Asia conducted desk review, focus group discussions, key informant interviews, and consultation workshop with members of the National Nutrition Cluster and selected Regional Nutrition Program Coordinators, DRRM-H Managers, Nutritionist-Dietitians, and Provincial/City Nutrition Action Officers from Luzon, Visayas, and Mindanao. This policy was further refined after its presentation to the National Nutrition Cluster in August 2020, NNC Technical Committee in August 2021, and NNC Governing Board in January 2022.

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1. INTRODUCTION

The occurrence of emergencies and disasters has risen dramatically in recent years, with a parallel growth in the numbers of stricken communities, refugees, and internally displaced persons. It threatens human lives and the general well-being of individuals and families, often resulting in food shortages, worsened nutritional status of a community, and even mortality in all age groups.

Thus, a primary concern during emergencies and disasters is to prevent death and malnutrition among the affected population, prioritizing the vulnerable groups: infants, young children, pregnant women and breastfeeding mothers, older persons, disabled persons, indigenous people, and those living with debilitating conditions. The resulting devastation is expected to aggravate the pre-existing health and nutrition situation. Therefore, nutrition is a key public health concern in disaster risk reduction and management.

Studies have shown that undernutrition, including micronutrient deficiencies worsen during emergency and disaster situations because livelihood and food crops are lost, food supplies are interrupted, diarrheal and infectious diseases break out, and the practice of optimum infant feeding practices are threatened and possibly impeded.

Furthermore, recent experiences of both natural and human-induced disasters, some of which were prolonged, highlight the need to develop nutrition management capacities, reduce vulnerability, and mitigate the consequences of a potential nutrition crisis. The health sector has a vital role in all these areas:

- provide education, advocacy, and technical expertise to ensure vulnerability reduction and preparedness for appropriate nutrition–related relief;
- treat and prevent malnutrition; and
- ultimately, promote nutrition in the context of broader health, community rehabilitation, and policy development.

At the same time, other sectors, e.g. agriculture, social welfare, etc., have crucial roles to play in nutritional management in times of emergencies and disasters. Preparedness for appropriate nutrition-related response is crucial to the community's survival and continuing development.

Almost all countries have developed or are developing national plans of action for nutrition, which include at varying levels, emergency and disaster preparedness and capacity-building for the management of nutrition in emergencies and disasters.

Therefore, nutrition management in emergencies and disasters shall be an integral part of the overall disaster management system of local government units (LGUs) within the structure of the disaster risk reduction and management plan and implemented by local disaster risk reduction and management councils (LDRRMCs).

This National Policy on Nutrition in Emergencies shall address the need for standards and guidelines on appropriate nutrition interventions and aid in identifying agency involvement; and shall serve as a motivation and basis for nutrition planning and evaluation.

2. SCOPE AND COVERAGE

The policy shall apply to all sectors, whether government, non-government or private institutions, and humanitarian organizations working with the government whose functions and activities contribute to the prevention of deterioration in the nutritional status of Filipinos, particularly the vulnerable groups: infants, young children, pregnant women and breastfeeding mothers, older persons, persons with disabilities, indigenous people, and those living with debilitating conditions during emergencies and disasters.

It shall also guide LGUs in preparing and managing the food and nutrition situation in times of emergencies and disasters at various phases: prevention and mitigation, preparedness, response (pre-impact, impact, and post-impact), as well as the recovery and rehabilitation.

This policy, in line with the current disaster risk reduction and management framework, provides the strategic directions for nutrition management in emergencies and disasters particularly on planning, nutritional assessment, implementation, monitoring and evaluation of nutrition interventions at various phases of the emergency and/or disaster.

3. DEFINITION OF TERMS

3.1. ***Acute Malnutrition***. Condition arising from a deprivation of food or bout of infection in the immediate past and is manifested by muscle wasting (another term for acute malnutrition is *wasting*). Acute malnutrition can be moderate or severe. Please see items 3.15 and 3.31 for the definition of moderate and severe acute malnutrition, respectively.

3.2 ***Child Growth Standards (CGS)***. A range of measurements for height and weight deemed to be within the healthy range of growth for children, especially those 60 months old and younger. It describes the pattern of growth for breastfed infants with no socioeconomic constraints, is suitable for all ethnic groups, and sets breastfeeding as the norm.

3.3 ***Complementary Feeding***. It refers to giving solid, semi-solid and soft foods (both locally prepared and commercially manufactured) to children between the ages of 6 and 23 months to complement breastmilk to meet the infant's nutritional requirements. It complements breastfeeding rather than replaces it.

3.4 ***Disaster***. A disaster is a serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources.

3.5 ***Disaster Risk Reduction and Management in Health (DRRM-H) Plan***. It is a three-year strategic health plan containing disaster risk reduction and management measures in the four thematic areas: Prevention and Mitigation, Preparedness, Response, and Recovery and Rehabilitation.

3.6 ***Diarrhea.*** Soft or watery stools occurring at least 3 episodes per day.

3.7 ***Emergency***. An actual threat to public health and/or public safety. It is a period characterized by chaos, death, injuries, damage to properties, displacement of families and to properties, and inadequate or lack of access to basic supplies.

3.8 ***Epidemic.*** It refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. It occurs when an agent (or pathogenic microorganism) and susceptible hosts are present in adequate numbers, and the agent can be effectively conveyed from a source to the susceptible hosts. Sometimes the term "outbreak" is used for "epidemic".

3.9 ***Food Security***. A condition that exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life.

3.10 ***Hazard***. any dangerous phenomenon, substance, human activity or condition that may cause loss of life, injury or other health impacts, and also loss of property, livelihood, and services, social and economic disruption, or environmental damage. These hazards are categorized as geological (i.e. earthquake, volcanic activity, landslide, liquefaction, tsunami); hydrometeorological (i.e. typhoons, storm surge, drought, flooding); biological (i.e. emerging and re-emerging diseases, zoonosis); and human-induced (i.e. armed conflict, terrorism, technological).

3.11 ***Information Management Officer (IMO)***. IMO is a core Nutrition Cluster member. An IMO is responsible for collecting and organizing data on nutrition cluster coverage and programming results and then producing and sharing information on response, showing results, gaps and trends with the Nutrition Cluster and its cluster partners to facilitate a timely and effective nutrition response and demonstrate whether results and impact are achieved or not.

3.12 ***Malnutrition***. A pathological state resulting from undernutrition or overnutrition or an absolute imbalance in nutrient intake. It results to impaired physical function to a point that the person cannot maintain adequate levels of performance at physical work, recover from the effects of disease, maintain adequate level of growth and processes of pregnancy and lactation.

3.13 ***Mass Feeding***. Refers to the distribution of food rations to all those affected by an emergency or disaster regardless of nutritional status or risk to undernutrition.

3.14 ***Microtoise***. A tool used to take height measurement of children over 2 years old.

3.15 ***Moderate Acute Malnutrition (MAM)***. A state characterized by a low weight-for-height/length (between -3 and -2 z-scores of the WHO Child Growth Standards). MAM is also indicated if mid-upper arm circumference (MUAC) is less than 125 mm (<12.5 cm) but greater than or equal to 115 mm (≥11.5cm).

3.16 ***Multiple Micronutrient Powder (MNP)***. Powder composed of vitamins and minerals in specified amounts added to foods after preparation of the food and just before consumption.

3.17 ***Nutrition Advocacy***. Advocacy in the context of nutrition involves convincing or persuading individuals, groups, and organizations to act or influence decisions on specific nutrition concerns. Advocacy aims to catalyze processes to achieve nutrition goals and objectives. It is geared towards drawing support and building commitments in terms of developing new or changing existing policies, programs,

and projects with direct or indirect impact on nutrition, as well as in increased resource allocation for nutrition programs and activities.

3.18 ***Nutrition Cluster***. Refers to a group composed of government, non-government and international humanitarian agencies that take the lead in nutrition management during emergencies and disasters.

3.19 ***Nutrition in Emergencies (NiE)***. This refers to the essential nutrition services that are part of emergency or disaster prevention and mitigation, preparedness, response, and recovery and rehabilitation to prevent deterioration of nutritional status and death. The nutrition services can include nutritional assessment; infant and young child feeding promotion, protection and support; management of acute malnutrition, micronutrient supplementation, dietary supplementation, and other interventions which can be food or non-food-based interventions.

3.20 ***Nutrition Promotion***. Promotion in the context of nutrition is the process of enabling people to increase control over, and to improve, their nutritional status. It helps people change their behaviors and health and nutrition practices through a combination of awareness and education campaigns, behavior change strategies, and creation of environments that support good health and nutrition practices.

3.21 ***Nutrition Surveillance System***. A mechanism to transfer food and nutrition data into action through formulation, modification and application of the food and nutrition policy of a country. This mechanism provides regular and updated information on the nutritional conditions of a population and the influencing factors. This information will provide a basis for decisions made by those responsible for policy planning and the management of programs relating to improvement of food consumption patterns and nutritional status.

3.22 ***Pandemic***. It refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.

3.23 ***Preparedness Phase***. A period which focuses on key strategic actions that give importance to activities revolving around community awareness and understanding; contingency planning; conduct of local drills and the development of national and local disaster risk reduction and management plans[1]. The target in this phase is to strengthen capacities of communities to anticipate, cope, and ensure early recovery from the negative health impacts of emergencies and disasters.

3.24 ***Prevention and Mitigation Phase***. Avoiding hazards and limiting their potential health impacts by reducing exposure to the hazards and the existing vulnerabilities of the community, through strengthening day-to-day operations of different health programs, assessing, and reducing risks in structural resilience or integrity of health infrastructure facilities through regular engineering and maintenance checks.

3.25 ***Rapid Nutrition Assessment***. Refers to the assessment of nutritional status based on anthropometric data (weight, length/height, MUAC, sex, age, and presence of bilateral pitting edema) and limited to children 6-59 months, who serve to represent the general population. This is done through the Nutrition Initial Needs

[1] The local Disaster Risk Reduction and Management (DRRM) plans, particularly of barangays, shall be developed following the provisions of NDRRMC Memorandum Circular No. 3, S. 2022: "Adoption and Utilization of the Enhanced Quality Assessment System for Barangay Disaster Risk Reduction and Management Plan and Committee (QAS for BDRRMP/C)".

Assessment (NINA), which is conducted within 24-72 hours after the onset of an emergency or disaster.

3.26 ***Ready-to-Use Supplementary Food (RUSF)***. It is a highly fortified, nutrient dense paste specifically designed for prevention and treatment of moderate acute malnutrition (MAM) among children over 6 months. The formulation delivers all the nutrients to reduce or eliminate the shortfall in local diets and helps meet daily requirements. Unlike fortified blended foods that require further preparation at home, RUSFs are ready for use.

3.27 ***Ready-to-Use Therapeutic Food (RUTF)***. It is an energy-dense, mineral and vitamin-enriched food specifically designed to treat severe acute malnutrition (SAM). This food delivers precise quantities of macro and micronutrients and is nutritionally equivalent to the F100 therapeutic milk used to treat SAM in hospital settings. RUTF comes in the form of oil-based paste with the texture of peanut butter. It has very low moisture content and thus does not spoil and can be stored in simple packaging in tropical climates for at least six months. As this can be eaten straight from the pack and do not require cooking or dilution with water, the labor and fuel demands on poor households are minimized.

3.28 ***Recovery and Rehabilitation Phase***. Characterized by the return to normal patterns of activity in an affected community; reintegration of displaced individuals and families; resumption of livelihood and economically productive activity in the area; restoring and improving health facilities, health conditions, and organizational capacity of affected communities; and reduce disaster risks. In this phase, food supplies for the community are transitioned back to agriculture and local sources.

3.29 ***Response Phase***. It gives importance to actions taken directly before, during or immediately after a disaster from preserving lives, search and rescue, reducing health impacts, ensuring public safety, needs assessment, meeting basic nutrition needs, relief operations, and to early recovery activities. The success and realization of this priority area rely heavily on the completion of the activities under both the prevention and mitigation and preparedness aspects, including among others the coordination and communication mechanisms to be developed.

3.30 ***Risk Communication***. It is an interactive process of exchange of information, advice and opinions between experts, community leaders, or officials and the people who are at risk. It informs the public, provide information about health risks and health effects, identify the hazard, and explain the situation and minimize outrage.

3.31 ***Severe Acute Malnutrition (SAM)***. A state characterized by a weight-for-height/length that is below -3 z-score of the WHO CGS. SAM is also indicated if MUAC is less than 115 mm (<11.5 cm), with or without bilateral edema.

3.32 ***Stunting***. It is the result of chronic or recurrent undernutrition, usually associated with poor socioeconomic conditions, poor maternal health and nutrition, frequent illness, and/or inappropriate infant and young child feeding and care in early life. Children are defined as stunted if their length/height-for-age is more than two standard deviations below the WHO CGS median.

3.33 ***Supplementary Feeding (or Dietary Supplementation)***. It is an intervention that involves the provision of nutritious rations to targeted individuals that supplement the energy and nutrients missing from the diet of those with higher nutritional

needs. The main objective of dietary supplementation is to prevent deterioration of the nutritional status of vulnerable groups and the increase in morbidity and mortality. The groups most at risk includes children under five years of age, pregnant and lactating women, older persons, and the unwell who are most prone to suffer from malnutrition and other illnesses. The foods include cereals, meat or fish, legumes, vegetables, and fruits.

3.33.1 ***Blanket Feeding Program***. A type of supplementary feeding program which aims to prevent widespread malnutrition and to reduce excess mortality by providing food and micronutrient supplement for all members of identified at-risk group (e.g., children under five or under three, pregnant women and lactating mothers, etc.), regardless of the nutritional status.

3.33.2 ***Targeted Feeding Program***. Another type of supplementary feeding program which refers to the rehabilitation of individuals with moderate acute malnutrition (MAM) to prevent them from becoming severely malnourished.

3.34 ***Therapeutic Feeding Program***. A feeding program that aims to rehabilitate severely acute malnourished (SAM) persons. The main aim is to reduce excess mortality especially during emergency or disaster situations.

3.35 ***Undernutrition***. It refers to consequence of consuming and/or absorbing insufficient nutrients or using or excreting them more rapidly than they can be replaced. It refers to a range of conditions, including acute malnutrition (wasting/thinness), chronic malnutrition (stunting/shortness), and micronutrient deficiencies (vitamin A deficiency, iron deficiency anemia, and iodine deficiency disorders). In times of emergencies and disasters, undernutrition is of greater concern.

3.36 ***Vulnerable Groups***. These refer to physically, mentally, or socially disadvantaged persons who may be unable to meet their basic needs and may therefore require specific assistance. In this policy, the groups considered as vulnerable are the infants (<6 months and 6-23 months), young children (24-59 months), school-age children (5-12 years old), adolescents, pregnant women and breastfeeding mothers, older persons, disabled persons, indigenous people, and those living with debilitating conditions. Persons exposed to and/or displaced by conflict or natural hazard may also be considered vulnerable. Vulnerable groups may experience a higher risk of poverty and/or social exclusion.

4. OBJECTIVE

This guide is intended to help health, nutrition, and other professionals involved in disaster prevention and mitigation, preparedness, response, and recovery and rehabilitation, as well as volunteers and other personnel to work together and coordinate with each other in nutrition management in emergencies and disasters whether at the local or national level. By improving understanding among the various sectors that are collectively responsible for ensuring adequate nutrition among emergency and disaster-affected population, this guide will promote coordinated and effective action.

This will then ensure that appropriate and quality package of nutrition interventions are delivered to prevent deterioration of the nutritional status of affected populations particularly vulnerable groups during emergencies and disasters.

5. POLICY STATEMENTS

Policy 1. ***Universal Declaration of Human Rights***. All victims of emergencies and disasters have the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food.

Policy 2. ***Priority Targets (Vulnerable Groups)***. Equitable delivery of nutrition interventions among vulnerable members of households including infants, young children, school-age children, adolescents, pregnant women and breastfeeding mothers, older persons, persons with disability, indigenous people, and those living with debilitating conditions. This policy recognizes that access to programs that are sensitive to differences in gender, age, disability, culture, and needs is a fundamental right of people being supported during an emergency or disaster and that they must be treated with respect and appropriate consideration throughout the emergency and disaster phases.

Policy 3. ***Multi-sectoral Collaboration***. The support and contributions of intra-agency and inter-agency collaborators from various clusters and sectors shall be harnessed to mount a systematic and comprehensive nutrition management of emergencies and disasters.

Policy 4. ***Capacity Development***. All stakeholders involved in nutrition management in emergencies and disasters shall be psychologically prepared; equipped with the necessary knowledge, attitude and skills; and supported with appropriate and adequate resources to carry out their tasks considering that equipment and tools necessary for nutritional assessment may or may not be available in times of emergencies and disasters. Apart from implementation as well as monitoring and evaluation of nutrition interventions, stakeholders especially those in LGUs must also develop the capacity for surveillance as part of disaster risk mitigation and preparedness, as well as early response.

Policy 5. ***Community Empowerment***. The affected community shall be made aware on what to do before, during and after an emergency and disaster. Likewise, they shall be empowered to gain control of their lives through continuing information and education, participation in decision-making and policy formulation, and planning for nutrition management in emergencies and disasters. They shall be equally and meaningfully involved in decision-making particularly on program design, implementation, and monitoring and evaluation.

Policy 6. ***Nutritional Assessment***. This refers to the assessment of the nutritional status of all nutritionally vulnerable population groups. During emergencies, special focus shall be given to monitor and protect the nutritional status of pregnant and lactating women and under 5-year-old children, particularly under 5-year-old children identified as stunted and wasted even before the onset of emergencies and disasters. They shall continue to receive relevant service package to prevent risk of morbidity and mortality. Anthropometric tools and protocols appropriate for rapid tests for emergencies should be given preference.

Policy 7. ***Minimum Service Package for Nutrition***. The nutritional requirements of the general population and vulnerable groups must be met primarily through infant and young child feeding, food assistance, management of acute malnutrition, and micronutrient supplementation. These must be supported with nutrition education as well as interventions related to food, health, psychosocial care, water, sanitation and hygiene (WASH), and livelihood.

Policy 8. ***Disaster Risk Reduction and Management in Health – Nutrition in Emergencies (DRRM-H-NiE)***. Planning for and managing nutrition during emergencies and disasters must be aligned with the national disaster risk reduction and management framework, which covers the following phases: prevention and mitigation, preparedness, response, and recovery and rehabilitation. All DRRM-H Plans at all levels shall incorporate NiE component with focus on the vulnerable groups. Reduction of risks and resilience-building of the general population to future disasters shall be achieved by the timely formulation of comprehensive risk assessment and management plan building on the available resources and structures and integrating them in the development plan of the agency or area. It requires coordination between and among agencies involved within and among the different clusters of the national or subnational risk reduction and management structures.

Policy 9. ***Research and Development***. Continuous research shall be conducted to update nutrition standards and generate new evidence for planning and policy development in nutrition management in emergencies and disasters.

Policy 10. ***Nutrition Advocacy for LGUs***. Local government units, from regional down to the barangay level, must engage in nutritional advocacy. This includes regular information dissemination to decision-maker, service providers and the general population, education on nutrition and NiE, and prioritization of nutrition service package for affected populations particularly the vulnerable groups.

Policy 11. ***Protection of Children's Health and Well-being***. Children's right to good health and well-being shall be protected before, during and after disasters. Part of NiE entails providing safe and adequate nutrition for infants through promotion of breastfeeding, as well as the proper use of breastmilk substitutes and breastmilk supplements. Donations of food and supplies for infants and young children must be in accordance with the Milk Code. Further, individuals below 18 years of age must be protected against violence, neglect, discrimination, and other acts detrimental to their health and well-being.

Policy 12. ***Focus on the First 1000 Days***. As part of ensuring good nutritional status for infants and young children, a package of health and nutrition services are focused on the pregnant mother and the newborn until 2 years old or the "First 1000 Days". Health and nutrition services shall operate in both normal and emergency situations to ensure good long-term nutrition outcomes.

Policy 13. ***Equitable Access to Quality and Affordable Health Care Goods and Services***. All Filipinos are entitled to access comprehensive health and nutrition services without incurring financial hardship. Populations who will experience difficulty accessing these services must be prioritized.

Policy 14. ***Protection and Support to the Nutrition Workers/Teams***. Nutrition workers/teams shall be mobilized following humanitarian, welfare, and psychosocial considerations, ensuring their safety and security at all times. Likewise, they should be mobilized based on their competence and expertise, with appropriate and adequate logistical support ensuring their self-sufficiency.

6. MANAGEMENT CONSIDERATIONS FOR NiE

The following processes should be integral to emergency and disaster risk reduction and management.

6.1 Coordination and Networking

This is a vital process in nutrition management in emergencies and disasters. It entails sharing relevant nutrition and other related-information, resources, services, and systems among agencies or individuals directly involved.

Coordinated actions result to better complementation and delivery of interventions, maximum utilization of resources, and wider service coverage.

6.1.1 The nutrition cluster on the national level shall function primarily for policy formulation, management, and coordination, including resource mobilization and service delivery. The nutrition committee at the regional, provincial, city/municipal, and barangay levels shall function as the local nutrition cluster in charge of service delivery, resource mobilization, and coordination. The local nutrition cluster should take charge of nutrition management in all phases of emergencies and disasters.

6.1.2 In the context of emergency management, the nutrition cluster is a sub-structure of the health quad cluster, and, as such, will be represented by the local health officer and/or the nutrition action officer in the local disaster risk reduction and management council. **The Regional and Local Nutrition Clusters shall include the Regional/Local Disaster Risk Reduction and Management (DRRM) Officer as one of its members to ensure alignment of the DRRM-H-NiE Plan with the national directives of the NDRRMC.** If this is not possible, the DRRM-H-NiE Plan, whether as a separate plan or integrated in the Nutrition Action Plan, should be reviewed by the DRRM Officer for inclusion in the DRRM-H Plan.

6.1.3 Efforts must be exerted to ensure that there are functional nutrition committees that will take on the role of nutrition cluster in the context of emergencies and disasters. Coordination may also utilize the province-wide and city-wide health systems (P/CWHS)[2] that link LGUs, especially in situations involving internal displacement of communities and

[2] The P/CWHS are integrated local health systems in which health care providers deliver continuous and integrated health services to individuals and/or communities in a well-defined catchment area. These health systems are forms of progressive cooperative undertakings among LGUs to complement the individual LGU's health operations. (Source: DOH AO No. 2020-0021 Guidelines on the Integration of the Local Health Systems into Province-wide and City-wide Health Systems (P/CWHS)

emergency situations requiring cooperation among multiple LGUs.

6.1.4 The local nutrition cluster shall ensure that its efforts and initiatives are linked with those of the other local clusters such as WASH, mental health and psychosocial support services, social protection, camp coordination and management, food and non-food items clusters. The local nutrition cluster should be represented in the local disaster risk reduction and management councils.

6.2 Planning

This is a decision-making process based on an analysis of the initial and comprehensive assessment of nutritional status, socio-economic, cultural, and other demographic factors predictive of the nutrition situation in a community. The thorough analysis of available information facilitates in identifying targets, prioritizing the type of support and assistance needed, in designing interventions to be implemented, and in deciding the monitoring and evaluation scheme to be used.

More specific concerns related to planning are as follows:

6.2.1 **Nutrition management in emergency and disaster situations should be a component of the local plans of action for nutrition and should be incorporated in the local DRRM-H plan.** Planning should consider both natural and human-induced emergencies or disasters that the area is susceptible to. The LGU should consider the latest risk assessment of the area coming from designated national or regional agencies.

6.2.2 Planning should consider available baseline data from available NiE information management (IM) tools, e.g. gap analysis, capacity map, data repository. These take into account the latest data from nutrition surveillance activities, including but not limited to, data from health providers, local census, and nutrition surveys.

6.2.3 The plans for nutrition management in emergency and disaster situations should define or identify:

6.2.3.1 Nutrition package and services to be delivered as per the Minimum Service Package, including estimated or forecasted requirements of the following:

6.2.3.1.1 Infant and young child feeding equipment, standards, and tools for nutritional assessment, and other IEC materials for counseling

6.2.3.1.2 Food rations for dietary supplementation (blanket, targeted)

6.2.3.1.3 Micronutrient supplementation

6.2.3.1.3.1 Vitamin A
6.2.3.1.3.2 Iron with Folic Acid
6.2.3.1.3.3 Zinc
6.2.3.1.3.4 Other forms of micronutrient supplements (powder, lipid-based paste, tablet/capsules)

6.2.3.1.4 Nutrition commodities for the management of acute malnutrition consistent with the guidelines of the Philippine Integrated Management of Acute Malnutrition (PIMAM) including RUTF and RUSF, therapeutic milk

6.2.3.2 Target groups

6.2.3.3 Logistics management (e.g. sources, delivery networks and warehousing)

6.2.3.4 Service providers (volunteers, health and nutrition staff, private practitioners, referral units)

6.2.3.5 Funding requirements and sources

6.2.3.6 Capacity building on nutrition management, nutritional assessment, and monitoring and evaluation schemes

6.2.3.7 Strategies for the disaster recovery and rehabilitation phase

6.2.4 These plans should be reviewed and updated according to the actual situation and unforeseen needs in emergencies and disasters. The plan, especially the response plan, must be regularly reviewed, updated, and tested with provisions for new information and relevant staffing. Plans should consider activities related to cluster coordination and information management from the prevention and mitigation phase, up to the recovery and rehabilitation phase of emergencies.

6.3 Funding

Local funds shall be used to fund for the DRRM-H-NiE Plan projects and activities, subject to applicable policies and guidelines governing utilization of such funds, and the usual accounting rules and regulations.

6.4 Capacity Building

This includes efforts to develop knowledge, attitudes, and skills to enhance performance of functions in nutrition management. It aims to develop understanding of basic concepts, standards, protocols, and procedures related to nutrition management in emergencies and disasters.

6.4.1 Training on nutrition in emergencies as well as information management shall cover the members of the nutrition cluster, service providers, volunteer workers, designated personnel for special assignments (warehouse, desk officers, etc.), and other personnel involved in nutrition management in emergencies and disasters.

6.4.2 The training course shall cover rapid nutrition assessment methodologies and tools (e.g. identifying presence of bilateral edema, measuring weight, height and MUAC and interpreting the results using standards tables), logistics management, nutrition service standards, nutrition advocacy, education and information, and personality traits of a nutrition responder. The focus of training shall match the competencies required for each of the

identified groups. Training shall also use the latest guidelines and tools for information management.

6.4.3 Staff training on psychosocial concerns to improve knowledge, understanding, and develop positive values and attitude towards disaster victims and their families shall likewise be considered.

6.4.4 All service providers shall be provided with the necessary physical, psychological and emotional support to accomplish their tasks especially during and post-emergencies.

6.4.5 Emergency and disaster-affected communities shall be given opportunities to develop their skills and coping mechanisms to enable them to adapt to the new environment and to make optimal use of the assistance provided.

6.5 Organizational Support

This is the provision of political, technological, financial resources, and information to build the capacity to cope with the immediate issues and institute long-term and developmental nutrition initiatives.

Members of the nutrition cluster, service providers, and other stakeholders shall be given appropriate organizational support. Specifically, the LGUs shall:

6.5.1 Adopt and pass local ordinances or resolutions to implement nutrition in emergencies interventions appropriate in their respective areas and considering national guidelines (e.g. micronutrient supplementation; use of fortified rice, flour, sugar, cooking oil, salt and processed foods; regulation of the marketing and donation of breastmilk substitutes under the Milk Code, zinc supplementation for diarrhea management).

6.5.2 Mobilize the existing calamity fund and allocate appropriate budget for the procurement of NiE commodities and other appropriate nutrition-related preparedness and response activities in emergencies and disasters.

6.5.3 Identify and mobilize additional resources.

6.5.4 Identify and dedicate an infrastructure with necessary transportation and communication facilities, and equipment which can serve as centers for nutrition management (e.g. evacuation/transit centers with provisions for breastfeeding rooms, community kitchen, feeding centers, and warehouse for stockpile).

6.5.5 Adopt local development plans and investment plans and DRRM plan which integrate provisions for NiE and other activities of the nutrition cluster/nutrition committee to ensure funding availability for critical capacity-building and response initiatives.

6.5.6 LGUs and NGOs shall provide benefits to service providers and responders. These shall also include protective equipment for use during response activities and other benefits to include but not limited to hazard, accident, and insurance benefits. Likewise, they shall ensure that all service providers and responders are self-sufficient and secured at all

times.

6.6 Social Mobilization

This is the process of bringing together all feasible and practical inter-sectoral social allies for the common goal of protecting the nutritional status of individuals and communities. Efforts for nutrition management shall foster self-governance, empowering community members to rely on themselves; strengthen community organization and involvement; and mobilize expertise and resources. The guiding principles are sustainability, participatory approach, gender equity, good governance, decentralization, and human rights.

Based on the plans for nutrition management in emergency and disaster situations, LGUs shall:

6.6.1 Map out potential allies (e.g. donors, NGOs including civic organizations, church groups, and private companies) within and outside the locality and identify their areas of expertise and potential contributions.

6.6.2 Establish rapport as early as possible and seek commitments for assistance.

6.6.3 Follow-up provision or delivery of committed support and assistance.

6.6.4 Establish regular communication with stakeholders to sustain partnership.

6.6.5 Capacitate the community in planning, response, rehabilitation, monitoring, evaluation, and provision of long-term interventions for sustainability.

6.7 Advocacy

This is the act of persuading on behalf of a particular issue, idea or person on the importance of nutrition management in emergencies and disasters. Members of nutrition clusters at all levels must have a common understanding of the key terminologies in nutrition management during emergencies and disasters. More specifically, cluster members shall:

6.7.1 Identify appropriate nutrition interventions based on an understanding of the general and specific effects of particular hazards occurring in specific communities, and their implications for immediate nutritional needs.

6.7.2 Encourage local implementation/execution of relevant policies and guidelines.

6.7.3 Develop locally inspired and culturally sensitive information, education and communication materials for training, education, and dissemination designed for decision-makers, service providers, and general public at the LGU level.

6.7.4 Promote resource generation, social mobilization, and engagement of communities where and to the extent possible. Families shall be considered as a primary resource especially during response.

6.7.5 Utilize a database of relevant nutrition and related information updated regularly by a trained LGU staff based on the recommended operationalization of information management system.

6.8 Logistics Management

This refers to ensuring that safe, adequate, and appropriate commodities are available for immediate distribution during emergencies and disasters. The logistics requirements for nutrition management during emergencies and disasters with corresponding budget and source of funds shall be integrated into the local plans. The LGU shall:

6.8.1 Ensure availability of essential supplies, drugs, tools, equipment (e.g. weighing scale, microtoise or height board/infantometer or MUAC tape for the rapid assessment), and materials for nutrition management during the pre-emergency period.

6.8.2 Identify potential donors and observe protocols in accepting local and foreign donations, particularly milk donations, during emergencies and disasters with due consideration of relevant existing DOH provisions.

6.8.3 Make special arrangements with selected donors and suppliers to have a credit set-up during emergency and disaster for immediate purchases.

6.8.4 Preposition items for supplementary and therapeutic feeding before the disaster season, including adequate supplies for micronutrient supplementation.

6.8.5 Prepare a monthly inventory report or maintain a database of supplies and materials including expiry dates which shall be circulated to all concerned offices.

6.8.6 Ensure that identified evacuation centers or transit centers have breastfeeding areas as well as provisions for the community kitchens.

6.8.7 Ensure establishment and maintenance of an effective supply chain system for inventory, procurement, storage and warehousing, transport, and distribution of food aid, supplies, and equipment in all LGUs.

6.9 Surveillance, Assessment, Monitoring and Evaluation

This involves the generation, analysis, dissemination, and use of timely, accurate and complete information to provide the basis for decision-making vis-à-vis targets and intervention designs. Appropriate surveillance methodologies and tools shall be put in place in all phases of emergency and disaster, thus:

6.9.1 At the disaster prevention and mitigation phase or "normal" times

6.9.1.1 LGUs shall conduct Operation *Timbang* (OPT) Plus according to the annual OPT schedule to identify and locate cases of under and overnutrition and determine overall prevalence per OPT Plus guidelines. Data will be recorded and reported using

the prescribed OPT Plus forms.

6.9.1.2 Individual child growth assessment shall be done facility- and home-based to catch possible growth faltering among children. This will be done monthly for children 0-23 months old and children 24-59 months old identified as wasted and stunted in the previous measurements; and then quarterly for all other children 24-59 months old. The Early Childhood Care and Development (ECCD) card shall be used in recording the results of the nutritional assessment.

6.9.1.3 OPT Plus results including the form "Masterlist of Stunted and Wasted Children" should be organized into a database and shared with all members of the local nutrition committee (with due consideration of Data Privacy Act provisions) for referral and intervention, and for planning and program monitoring and evaluation.

6.9.1.4 OPT Plus records must be maintained and updated by the Rural Health Midwife (RHM) and Barangay Nutrition Scholar (BNS), Barangay Health Worker (BHW) or the designated OPT Plus focal person or Information Management Officer in the LGU.

6.9.1.5 Information on the prevalence of each barangay/*sitio/purok* and ranking of barangays based on the proportion and number of underweight, stunting, and wasting among preschool children as well as the masterlist of children and families with underweight, stunted, and wasted preschool children must be ready at the city/municipal and barangay levels. Overweight and obese children must also be included in the surveillance.

6.9.1.6 Communication channels from the national to the local levels shall be set up, including the designation of nutrition information management officer at each level.

6.9.1.7 Continuous monitoring and evaluation of the performance of nutrition interventions shall be conducted using the gap analysis tool, one of the IM tools of the Nutrition Cluster.

6.9.1.8 Buffer stocks of supplies for emergencies and disasters should be procured and prepositioned.

6.9.1.9 LGUs should identify vulnerable groups through data from health providers, social welfare services, including active case finding.

6.9.1.10 Identified vulnerable individuals and their family members shall be given information on how they can be attended to and cared for when an emergency or disaster occurs and be given clear directions on what to do during emergencies.

6.9.1.11 LGUs adopting Local Nutrition Early Warning System for Food

and Nutrition Security (LNEWS-FNS)[3] may use indicators of food and nutrition security, alert levels and consecutive quarter summary findings to provide recommendations: on how to build the coping capacity and resilience of communities before a shock occurs, preparedness and possible disaster mitigation or emergency response programs, recovery or rehabilitation interventions that rebuild livelihoods and food security.

Other LGUs not adopting LNEWS-FNS may also use the InFoRM tool[4] developed by the Food and Agriculture Organization to facilitate the collection and reporting of data and other relevant information about food and nutrition security in their municipality. Integrated Food Security Phase Classification (IPC)[5] analysis/data may also be used as a tool prior to an emergency.

However, it is important to note that these tools are limited to local and provincial level. EWS-FNS or LNEWS-FNS is limited to municipal level and there are currently 78 city/municipality under LNEWS-FNS, while IPC is limited to provincial level.

6.9.2 In the first 24 hours of emergency or disaster, nutritional assessment may not be feasible or practical to conduct. Hence, the pre-disaster data can be initially utilized. Nutritional assessment, whether in evacuation centers or community-based, should be done within 24 to 72 hours after the onset of the disaster or emergency, since emergency or disaster, particularly the protracted ones, may have negative effects on the nutritional status especially among the vulnerable groups.

6.9.2.1 The nutritional assessment should aim to identify and locate preschool children with weights below the standard weight-for-height, which is indicative of wasting, a condition that requires a nutrition intervention. Weight and height/length are still the preferred assessments for children under 5 years of age since it can detect more accurately, and with more sensitivity and specificity the cases of wasting.

6.9.2.2 If measuring weight and height is not possible, the MUAC could be used as index for screening preschool children. MUAC can also be used for screening nutritionally-at-risk pregnant and lactating mothers.

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[3] The Local Nutrition Early Warning System for Food and Nutrition Security (LNEWS-FNS) is a tool and a process for the municipality to identify, discuss, and analyze any existing, emerging, or impending problems that threaten food and nutrition security. It enables the department heads and local chief executives to come together to identify, plan and allocate resources for actions and responses to address food security issues in their locality. It is the regular and periodic collection of relevant data (e.g. food production, climate, food prices, etc.) to determine status of food supply and food security in the city.

[4] InFoRM tool aims to make data and information about the community available on a regular basis, accessible for busy and workload- heavy community workers and leaders in a user-friendly format, and actionable for different stakeholders in the community. The types of data included in the information system are those relevant to key dimensions of food security: food availability, food access, and food utilization.

[5] IPC is a set of tools and procedures to classify the nature and severity of food insecurity. It classifies areas with acute food insecurity into five phases (minimal, stressed, crisis, emergency, famine) and with chronic food insecurity into four levels (low chronic, moderate chronic, high chronic, very high chronic). The IPC approach incorporates, and is strengthened by, specific analytical methods and mapping protocol. The IPC focuses on answering questions related to the situation analysis, e.g. where to allocate resources, to whom and to how many people, when and what should be done.

6.9.2.3 The presence of bilateral edema should also be watched out for as an indication of severe acute malnutrition.

6.9.2.4 The nutritional assessment should be complemented with the following:

6.9.2.4.1 A profiling of the population affected in terms of the number of pregnant women according to term of pregnancy, number of infants who are not exclusively breastfed, number of infants 6 months and older who are not receiving complementary foods, and extent of practice of proper complementary feeding

6.9.2.4.2 Determination of households' physical access to food

6.9.2.4.3 Determination of the magnitude of children under 5 years old with diarrhea

6.9.2.5 As part of the management of acute malnutrition, the weight-for-height/length assessment of preschool children should be done weekly for SAM and monthly for MAM and borderline MAM until "full normalcy" is achieved[6], to ensure provision of timely intervention and optimal support to the child. If necessary, prioritization of measurements shall be done by the BNS/BHW under the supervision of the midwife.

6.9.2.6 The nutrition cluster should spearhead the assessment and supervise its conduct to ensure that quality data is generated and disseminated.

6.9.3 There should also be efforts to monitor the extent of implementation of interventions at all stages of an emergency.

6.9.3.1 The monitoring should determine the extent to which:

6.9.3.1.1 The needy population, including cases of SAM and MAM, are receiving uninterrupted support and timely and quality intervention.

6.9.3.1.2 Interventions are reaching out to those who are not the intended targets.

6.9.3.1.3 Interventions are being implemented as designed, e.g. frequency, duration, level of supplementation, among others.

6.9.3.1.4 Post-incident surveillance and monitoring should also be included.

[6]National Guidelines on the Management of Severe Acute Malnutrition for Children under Five Years Manual of Operations, 2014

6.9.3.2 It should also determine reasons for observed trends to facilitate the identification of appropriate corrective actions.

6.9.3.3 To generate the aforementioned information, a reporting system should be set up and reported data analyzed.

6.9.3.4 A system for sharing the information among various stakeholders should also be set up, considering the provisions of Data Privacy Act.

6.9.3.5 Results of the monitoring should be used in making the needed adjustments in targeting, intervention design and implementation, and resource allocation.

7. SERVICE DELIVERY

7.1 Objectives

The delivery of nutrition services in normal, emergency and disaster situations aims to ensure the nutritional well-being of the population especially those considered nutritionally-at-risk.

7.1.1 However, in the response phase (impact or 0 to 48 hours from the onset of emergency or disaster), the objectives are to:

7.1.1.1 Mitigate hunger

7.1.1.2 Re-establish body reserves for micronutrients

7.1.1.3 Provide comfort, psychosocial support and improve morale

7.1.1.4 Help counteract shock

7.1.2 In the response (post-impact or >48 hours from the onset of emergency or disaster) and recovery and rehabilitation phases, the objectives are to:

7.1.2.1 Protect the nutritional status of the malnourished

7.1.2.2 Prevent deterioration of the nutritional status of the affected population

7.2 Priority (vulnerable) groups

While maintaining good nutrition among all those affected by an emergency and disaster is a general concern, special attention should be given to the vulnerable groups due to special nutrition concerns. (See Section 3 for the definition of "vulnerable groups".)

7.3 Key services that should be available in the emergency or disaster response phase

7.3.1 Minimum Service Package – The nutrition action officer, and personnel in charge of nutrition in emergencies must:

7.3.1.1 Conduct rapid assessment using MUAC, and subsequent assessments consistent with the Nutrition Cluster IM Tools during prolonged disasters.

7.3.1.2 Promote, protect, and support proper infant and young child feeding, and oversee proper implementation of the Milk Code, especially regarding milk and other donations covered by the Code.

7.3.1.3 Facilitate and coordinate with the social welfare department the following interventions: blanket feeding and supplementary feeding of the target population, distribution of food packs including its composition.

7.3.1.4 Ensure the tracking of the distribution of micronutrient powder and supplements, and follow up cases of MAM and SAM referred for management.

7.3.1.5 Coordinate with other clusters regarding the implementation of interventions for WASH and mental health and psychosocial support services intervention.

7.3.1.6 Coordinate with the local chief executive and other clusters regarding information management and documentation.

7.3.1.7 Prepare an exit strategy for nutrition interventions, with the aim of ensuring food security for the affected population.

7.3.2 Protection and reinforcement of breastfeeding in the general population and among females who are HIV positive

7.3.2.1 All efforts could be exerted to ensure that infants less than 6 months old are exclusively breastfed, and infants 6 months and older receive complementary foods with continued breastfeeding up to the second year of life or beyond. Such efforts could include:

7.3.2.1.1 Linking with evacuation center/camp managers to provide "Women/Mother and Child Friendly Spaces/Breastfeeding Room" for pregnant and lactating women in the response phase of an emergency. These spaces should be easily accessible areas where privacy, security and shelter are provided with access to clean and safe water and food for pregnant and lactating women.

7.3.2.1.2 Provision of peer-to-peer support in the form of mothers' support groups or similar initiatives for peer counseling.

7.3.2.1.3 Encouraging other mothers to breastfeed an infant who may have lost his/her mother, considering cultural beliefs or practices regarding this intervention.

7.3.2.1.4 Additional education and advocacy efforts to promote breastfeeding in cultural contexts that discourages or do not give importance to exclusive breastfeeding (EBF) for children under 6 months of age. Consultation with community leaders such as religious leaders and local chiefs should be done to devise culturally appropriate interventions to encourage EBF.

7.3.2.1.5 Discouraging the use of infant-feeding bottles and artificial teats during emergencies and disasters.

7.3.2.1.6 Providing counseling services for relactation and cup-feeding

7.3.2.2 In the very extreme and unlikely case of breastfeeding not being possible and after all other options were exhausted, including but not limited to milk expression, wet nursing or use of pasteurized donor breastmilk, breast milk substitutes may be used provided that it is given using cup and spoon and that those responsible for feeding breastmilk substitutes are adequately informed and equipped (i.e. availability of safe drinking water and adequate fuel to allow proper sterilization of the cup and spoon) to ensure its safe preparation and use.

7.3.2.3 All donations of breast milk substitutes shall have a permit from the Interagency Committee for screening in accordance with the provisions of the Milk Code (EO 51), DOH AO No. 2007-0017[7], and DOH Memorandum No. 2020-0231[8]. Violations of the Code will be subject to penalties as provided in the Code.

7.3.3 Promotion of desirable complementary feeding practices

7.3.3.1 The key characteristics of complementary foods, i.e. nutritionally adequate, safe and therefore hygienically prepared, easy-to-eat and digest, given to the infant in a caring manner, and introduced at the right time, i.e. 6th month of life onward, should be highlighted. Culturally appropriate complementary foods must be considered.

7.3.3.2 The preparation and giving of complementary foods should be the responsibility of the family even in evacuation centers or camps. However, caregivers should have a secure and uninterrupted access to appropriate ingredients with which to prepare and feed nutrient-dense complementary foods.

7.3.3.3 When available, food aid in the form of blended foods,

[7]Guidelines on the Acceptance and Processing of Foreign and Local Donations during Emergency and Disaster Situations
[8]Guidelines on the Standardized Regulation of Donations, Related to Executive Order 51, series of 1986 (The Philippine Milk Code), to Health Facilities and Workers, Local Government Units, Non-Government Organizations, and Private Groups and Individuals in Support to the Response to Emergencies, Disasters, and Situations Where Health and Nutrition of Mothers, Infants, and Young Children are Affected

especially if fortified with essential nutrients, may be used in emergencies and disasters provided the child's caregiver is informed on the proper use of these blended foods. However, the use of blended foods should not interfere with promoting the use of local ingredients and other donated commodities for preparing suitable complementary foods.

7.3.3.4 Multiple micronutrient powder shall be used to enhance the quality of food given to infants and young children as well as pregnant women. Multiple micronutrient powder should not be given to children with SAM or MAM who are already taking RUTF or RUSF.

7.3.4 Vitamin A supplementation

High-dose vitamin A supplements should be given to the following target groups:

7.3.4.1 6-11-month-old infants (100,000 IU), provided the infant did not receive a similar dose in the past four weeks

7.3.4.2 12-59-month-old preschoolers (200,000 IU), provided the child did not receive a similar dose in the past four weeks

7.3.4.3 Lactating mothers but only within one month of delivery (200,000 IU)

7.3.4.4 Children with measles, one dose upon diagnosis, another after 24 hours regardless of when the last dose of vitamin A supplement was given. One dose is defined as follows:

7.3.4.4.1 For infants 6-11 months old - 100,000 IU

7.3.4.4.2 For children 12-59 months old and 5-9 years - 200,000 IU

7.3.4.5 Children with severe pneumonia or persistent diarrhea, one dose except when the last supplementation was less than four weeks before diagnosis. One dose is defined as follows:

7.3.4.5.1 For infants 6-11 months old - 100,000 IU

7.3.4.5.2 For children 12-59 months old and 5-9 years old - 200,000 IU

7.3.4.6 Those diagnosed to have xerophthalmia, one dose upon diagnosis, another the next day, and another dose 2 weeks after. One dose is defined as follows:

7.3.4.6.1 For infants 6-11 months old - 100,000 IU

7.3.4.6.2 For children 12 months to 49 years old, post-partum and lactating women - 200,000 IU

7.3.4.7 Pregnant women with xerophthalmia should receive one capsule of 10,000 IU per day for 4 weeks upon diagnosis.

Do not give Vitamin A 10,000 IU if prenatal vitamins or multiple micronutrient tablets containing vitamin A are to be given. Vitamin A can be given regardless of age of gestation if a pregnant woman has night blindness, and under the strict supervision of a medical doctor.

7.3.4.8 Lactating women with xerophthalmia must receive one capsule of 200,000 IU only within 4 weeks upon diagnosis.

Do not give Vitamin A 200,000 IU if multiple micronutrient tablets containing vitamin A are to be given.

7.3.5 Iron supplementation

7.3.5.1 For infants with low birth weight, the recommended dosage is 0.3 ml of iron drops 15 mg elemental iron/0.6 ml starting at 2 months up to 6 months.

7.3.5.2 Non-pregnant women 10-49 years old may be given 1 tablet of 60 mg elemental iron and 2.8 mg folic acid weekly at menarche until one gets pregnant.

7.3.5.3 Non-pregnant women 10-49 years old and older persons in malaria-endemic areas, may be given a tablet of 60 mg elemental iron and 400 mcg folate daily for 2 months, provided the malaria is treated first and that a program to treat and control malaria is in place.

7.3.5.4 Non-pregnant women 10-49 years old in schistosomiasis-endemic areas may be given a tablet of 100 mg elemental iron/0.5 ml daily for 30 days. Administer iron supplement first before Praziquantel.

7.3.5.5 Pregnant women must be given a tablet of 60 mg elemental iron and 400 mcg folic acid daily for 180 days starting from the determination of pregnancy.

7.3.5.6 Lactating women should receive a tablet of 60 mg elemental iron with 2.8 mg folic acid once a week until one gets pregnant.

7.3.5.7 Older persons aged 60 years and above may receive the therapeutic dose of iron supplements to prevent the onset of anemia.

7.3.5.8 For those clinically diagnosed as anemic:

7.3.5.8.1 Individuals 10-49 years old may take a tablet of 60 mg elemental iron with 400 mcg folic acid daily until hemoglobin reaches normal level.

7.3.5.8.2 Children or those less than 10 years old may receive a therapeutic dose of iron supplement but assess for further management of anemia.

7.3.6 Iodine supplementation may be given to pregnant or lactating women at

250 ug/day or 400 mg/year provided the last iodine supplementation was a year ago. Adequately iodized salt must still be provided to the general population regardless of nutritional status.

7.3.7 Zinc supplementation may be given to children 6-59 months old with diarrhea at 20 mg elemental zinc per day for 10-14 days. Children with SAM or MAM who are already taking RUTF or RUSF may not receive zinc supplements.

7.3.8 Multiple micronutrient supplementation, with at least 15 essential vitamins and minerals: vitamin A, C, D, E, B1, B2, B3, B6, B12, folic acid, iron, zinc, copper, iodine, and selenium should be given daily until access to nutrient-rich foods have been re-established. This is in addition to the aforementioned micronutrient supplements for children.

If the child is receiving fortified food, multiple micronutrient supplements may be given less often. However, pregnant and lactating women should receive multiple micronutrient supplements daily in addition to fortified foods.

7.3.9 Supplementary feeding

7.3.9.1 Targeted supplementary feeding, usually targeting children 6-59 months as well as pregnant and lactating women, should be undertaken when the prevalence of wasting is 10-14 percent or when the prevalence of wasting is predicted to increase due to food insecurity or high level of disease.

7.3.9.2 On the other hand, a blanket approach or coverage of all in a particular group is indicated when the prevalence of wasting is more than 14 percent.

7.3.9.3 The supplementary food may be given in dry or wet (cooked food eaten in a centralized location) form.

7.3.10 Therapeutic treatment of preschool children who show wasting, with or without bilateral edema

7.3.10.1 Interventions for children in this group must be in accordance with the latest existing guidelines of PIMAM during extreme cases, or the most updated guidelines for management of SAM and MAM.

7.3.10.2 Those who show moderate acute malnutrition (MAM) but have no medical complications should be supported in a supplementary feeding program that provides cooked meals using locally available foods or dry take-home rations with the addition of RUSF, and standard medicines.

7.3.10.3 Individuals with severe acute malnutrition (SAM) with no medical complications may be treated in outpatient care sites, with RUTF or equivalent local foods and routine medicines. The child may attend the outpatient care site weekly or biweekly.

7.3.10.4 Individuals with SAM who have medical complications or infants with SAM need to be treated in an in-patient care facility until well enough to continue being treated in outpatient care. Referral must be facilitated by healthcare providers.

7.3.10.5 Adequate training and monitoring should be done to ensure the proper use of RUSF and RUTF and other nutrition commodities. Training should include healthcare providers as well as the primary caregivers of children with MAM or SAM.

7.3.10.6 Active case finding must be conducted in the evacuation sites to ensure that all children manifesting with MAM and SAM will be included in therapeutic feeding interventions.

7.3.10.7 Upon discharge of patients referred for in-patient management of MAM and SAM or their complications, follow up must be conducted regularly, with assessment of nutritional status as well as caregivers' feeding practices.

7.3.11 Provision of food rations[9] or mass feeding

7.3.11.1 All those affected should be targeted with special consideration of the nutritionally vulnerable groups. The nutrition cluster at the local level should ensure that the composition of the food pack meets the quality and quantity appropriate to the number and age of family members.

7.3.11.2 Use of fortified foods, in both dry rations and feeding programs, are encouraged at all times, including during emergencies.

7.3.11.3 Food rations must be appropriate for the religious, cultural and social values, and attitudes of the target population. Donated goods must be screened to ensure both adequacy and suitability.

7.3.11.4 Community leaders such as religious leaders and local chiefs must be consulted regarding the appropriateness and acceptability of food for general and supplementary feeding.

7.3.11.5 To the extent possible, food to be provided either in cooked or dry-ration form should be estimated based on 2,100 kcal per person per day, 10-12 percent of which will come from protein, and about 17 percent from fat. Adequacy of micronutrient intake should also be ensured through both fresh and fortified foods. Culture-sensitive food preference of families, particularly of indigenous people, should also be ensured.

[9]Food per se is not under the Nutrition Cluster, but of the Food and Non-Food Items (FNI) Cluster being led by the DSWD. The DSWD coordinates, allocates, orchestrates, and monitors the delivery of family food packs, ready-to-eat food and bottled drinking water, and also non-food item such as sleeping gears, family clothing packs, dignity kits, kitchen kits, and shelter kits to the affected families and communities. The FNI Cluster, in coordination with Nutrition Cluster as a part of Health Cluster, aims to regularly monitor the nutritional status of the affected population, identify gaps in the provision of food assistance, and formulate strategic interventions to address the gaps.

7.3.11.6 Other vulnerable groups with special diet needs have to be taken cared of. Calorie allowance should be adjusted based on the health status and presence of active infection.

7.3.11.7 For food rations, the choice of distribution site and its distance to affected households is important, particularly for child- and elderly-headed households, as carrying a large (monthly) ration can be difficult. Where feasible, smaller (2 week) rations should be considered to reduce the quantity to be carried.

7.3.11.8 In coordination with the Camp Coordination and Camp Management Cluster, which is being led by the DSWD, the distribution of food rations must be conducted in such a way that heads of households, caregivers, or individuals assigned to get food for their households will not face undue risk or discrimination while at the distribution site or while moving to and from this location. Gender sensitivity must be considered to ensure that women, adolescent girls, and LGBTIQA+ individuals are protected from gender-based abuse or violence.

7.3.12 Psychosocial care

Nutrition has extremely close links with care practices. Caring practices are the way community members, including the vulnerable such as children, the elderly and the sick, are fed, nurtured, taught, and guided which is the responsibility of the entire family and the community. The values of the society strongly influence the priority given to the care of children, women, and the elderly.

A child's nutritional status is often determined as much by feeding practices, home environment, and the attention received from the primary caretaker as by the food he/she eats. During interventions, nutrition and food services shall not impede or distract from existing care practices. Within emergency nutrition programs, different activities to support the psychosocial aspects of nutrition shall be put in place the soonest time possible, in close coordination with the local mental health and psychosocial support services (MHPSS) cluster.

These interventions can include:

7.3.12.1 Stimulating children and helping families to favor the child's development, including the psychological and emotional aspects.

7.3.12.2 Supporting play-sessions for mother and child by ensuring that a play area with toys is available to parents and staff to interact with malnourished children.

7.3.12.3 Offering social and psychological support to the families.

7.3.12.4 Offering breastfeeding corners/spaces for pregnant and breastfeeding women to provide mothers with a space to share

experiences, receive advice, and reinforce self-esteem.

7.3.12.5 Facilitating discussions between the families and the staff when a severely malnourished child has to be treated in an inpatient facility to clarify who will take care of the rest of the family and the household in the absence of the mother.

7.3.12.6 Educating and supporting caregivers to reduce caregiver burnout and fatigue.

7.4 Referral and follow-up

Cases with complications shall be referred to the appropriate in-patient facility for further medical and nutrition attention. These include complications from SAM and MAM, presence of acute illness, or exacerbation of chronic illness, including mental health concerns.

7.5 Information Management

Planning and implementation of nutrition interventions in emergencies and disasters must be based on the assessment of the affected communities' nutritional needs. Monitoring and evaluation should also be conducted to assess the impact of interventions and form basis for revision and implementation of plans during the response and recovery and rehabilitation phases. The Nutrition Cluster has developed the six (6) Information Management tools to assist nutrition clusters in assessing the situation, assessing its capacity for response and recovery and in planning for future emergencies. Please see **Annex A** for more details on the Operationalization of Information Management.

7.5.1 Baseline data from routine surveillance activities should be consolidated by the information management officer and disseminated to members of the local nutrition cluster to facilitate planning of nutrition interventions.

7.5.2 Results of rapid assessment and gap analysis during the response phase of an emergency or disaster should be collated, presented in a readily utilized format, and disseminated to LGU implementors as well as NGO partners for effective and efficient nutrition service delivery.

7.5.3 Lines of communication must be established to provide regular feedback from affected communities to other levels of the LGU as well as national agencies.

7.5.4 Nutrition interventions and service delivery should be monitored and evaluated in terms of impact and coverage of target population groups. The results of monitoring and evaluation should be consolidated by the information management officer for use in planning for recovery and rehabilitation, as well as the prevention and mitigation phases.

7.6 Risk Communication

Timely and appropriate risk communication is key to advocacy and social

mobilization prior to and during disaster response. Risk communication should involve government agencies, NGO partners, as well as vulnerable communities and groups.

7.6.1 During the prevention and mitigation phase, a risk communication strategy for nutrition must be included in planning for emergencies and disasters.

7.6.2 Upon raising of an alert or warning regarding an impending disaster, risk communication must target personnel at the forefront of disaster preparedness as well as communities most at risk of experiencing poor nutritional outcomes.

7.6.3 Risk communication should continue during the response phase all the way to the recovery and rehabilitation phase to address concerns regarding identified and emergent needs of affected communities with the goal of enabling families to build back better.

7.7 Nutrition Promotion

Promotion of nutrition programs and services during the prevention and mitigation phase helps reduce the risk of poor nutrition outcomes in the general population as well as vulnerable groups. Likewise, nutrition promotion during disasters and emergencies should be given importance in the DRRM plan of each LGU.

7.7.1 Each LGU's DRRM Plan/DRRM-H Plan/LNAP must have provisions for nutrition advocacy during emergency and disaster beginning from the prevention and mitigation phase and extending to the recovery and rehabilitation phase.

7.7.2 Regular advocacy activities should be conducted to keep communities abreast of updated nutrition information both prior to and after disasters. This may include practicable actions of families to protect themselves and their family members from the nutritional impact of the disaster.

7.7.3 Different sectors of civil society should be engaged in nutrition promotion, including religious leaders and other community leaders and mobilizers.

7.7.4 Nutrition in emergencies and disasters should be included in intra-and inter-cluster meetings and coordination.

7.8 Nutrition Services in Epidemics/Pandemics

During epidemics and pandemics, it is mandatory to attain and maintain optimal nutritional status to increase resilience against infectious or communicable diseases.

7.8.1 In case of national emergencies of similar magnitude and/or expected impact as that of COVID-19 and other biological hazards, delivery of essential health and nutrition services must continue, as far as practicable, following DOH or relevant agency's/ies' protocols, e.g. DOH DC No. 2020-0167[10], DOH DM No. 2020-0231, DOH DM No. 2020-0237[11].

[10]Continuous Provision of Essential Health Services During COVID-19 Epidemic

[11]Interim Guidelines for the Delivery of Nutrition Services in the Context of COVID 19 Pandemic

7.8.2 The nutrition interventions that shall be implemented in an epidemic or pandemic are micronutrient supplementation, promotion of infant and young child feeding, management of acute malnutrition, growth and development monitoring and promotion, promotion of hygiene and food safety, and promotion of healthy diet. These are existing programs that are to be continuously implemented during COVID-19 period and in similar and possible endemic or pandemic infectious diseases in the future.

7.8.3 Guidance to subnational partners and LGUs may be issued, as necessary, through Nutrition Cluster Advisories, e.g. Nutrition Cluster Advisory No. 1 s2020[12], Nutrition Cluster Advisory No. 2 s2020[13]. In addition, agencies/organizations may issue related guidelines in support of the Nutrition Cluster response plan and directions.

8. REGIONAL/LOCAL NUTRITION CLUSTER FUNCTIONS

Due to the devolved nature of the local government structure, it is the LGUs that shall take the lead in disaster risk reduction and mitigation in their respective areas, including the delivery of nutrition interventions. Consequently, LGUs should ensure local nutrition committees are active and functional during all phases of a disaster or emergency.

8.1 Regional/Local Nutrition Cluster – The Regional/Local Nutrition Cluster operates as a subset of the Health Cluster, which is under the Regional/Local Disaster Risk Reduction and Management, during times of emergency. This arrangement becomes effective during the preparedness phase, or when an alert or warning is raised for an imminent disaster. The Regional/Local Nutrition Cluster operates at the regional, provincial, city/municipal levels with interventions cascaded to the barangay level. The different agencies of the regional/local nutrition cluster must implement the specific local interventions of the Minimum Service Package (refer to Section 7 of this policy) to accordingly meet the needs of the community prior to, during and after the onset of an emergency or disaster.

The regional/local nutrition cluster must ensure that the following components of a functioning nutrition cluster are in place:

a. Designated Nutrition Action Officer
b. DRRM-H-NiE Plan linked to the DRRM-H Plan and Local Nutrition Action Plan of the LGU
c. Designated and trained Information Management Officer
d. Logistics (commodities, assessment tools, IEC materials, infrastructure, etc.) for NiE services and interventions

The following personnel and their local counterparts at different levels of the LGU shall be part of the Regional/Local Nutrition Cluster:

8.1.1 Regional Director (of a government agency identified as chair of the regional nutrition committee) / Governor / Mayor / *Punong Barangay* chairs the regional/local nutrition cluster.

[12]Guidelines on LGU Nutrition Actions Relative to COVID-19
[13]Recommendations on Healthful and Nutritious Family Food Packs and Sustainable Food Sources

8.1.1.1 Provides political, moral, and administrative leadership in the implementation of the DRRM-H-NiE Plan

8.1.1.2 Ensures the alignment, institutionalization, mainstreaming, and funding of the DRRM-H-NiE Plan

8.1.1.3 Plays a proactive role in the planning, implementation, and monitoring of related programs and activities

8.1.1.4 Works closely with the Local Nutrition Cluster members thru Nutrition Action Officers

8.1.2 Regional Nutrition Program Coordinator / Local (Provincial/City or Municipal/Barangay) Nutrition Action Officer coordinates nutrition in all phases of emergency or disaster management.

8.1.2.1 Coordinates the planning and implementation of nutrition programs indicated in the LGU's DRRM-H-NiE Plan, including but not limited to the Minimum Service Package and other appropriate nutrition-specific and nutrition-sensitive interventions

8.1.2.2 Ensures integration of NiE services and activities in the DRMM-H plan, the local nutrition plan and development plan with budgetary allocation during the regular LGU budget planning and during disaster operations

8.1.2.3 Coordinates with the healthcare providers for routine surveillance on the population's health and nutrition status, as well as identifying vulnerable groups especially during disasters

8.1.2.4 Coordinates with the local social welfare department to ensure the provision of and assist in developing cycle menus for blanket feeding to the planning and implementation of general feeding programs during disasters and the identification of affected households, especially among the most severely affected and marginalized

8.1.2.5 Ensures availability of complementary food for 6-23 months old children while continuing breastfeeding

8.1.2.6 Ensures availability and acceptable quality of goods and supplies for delivery of Minimum Service Package, which includes micronutrient supplements (vitamin A, iron with folic acid, zinc, and other micronutrient supplements in the form of powder, lipid-based pastes, and/or tablet/capsules) and nutrition commodities for the management of acute malnutrition (RUTF and RUSF, therapeutic milk)

8.1.2.7 Ensures the availability of infant and young child feeding equipment, standards, and tools for nutritional assessment, and other IEC materials for counseling

8.1.2.8 Oversees the rapid and subsequent nutrition needs assessment of

affected communities, including the means for further enhancing nutritional quality of food among the population, with the help of Barangay Nutrition Scholars (BNS), Barangay Health Workers (BHW), and other trained support groups

8.1.2.9 Facilitates prompt and complete reporting of data gathered from baseline and rapid assessment, as well as monitoring and evaluation results of NiE interventions

8.1.3 Regional / Local Information Management Officer

8.1.3.1 Supports development and maintenance of data repository and needs analysis, including filing and sharing of assessment reports pre-disaster

8.1.3.2 Supports gap analysis, capacity mapping, and development of monitoring and evaluation framework based on the local DRRM-H-NiE Plan

8.1.3.3 Collects information for geographic areas' prioritization, target and coverage calculations

8.1.3.4 Supports supplies estimation, financial tracking, and capacity building plan development

8.1.3.5 Organizes IM-related trainings to partners and coordinating teams

8.1.3.6 Updates data in data repository, capacity mapping, NC 4Ws, NC monitoring tool, and gap analysis tool

8.1.3.7 Supports tracking of EO 51 or milk code violations

8.1.3.8 Support production of nutrition cluster dashboard and reports, including production of infographics and maps

8.1.3.9 Ensures nutrition cluster's lines of communication is established and functional

8.1.4 Regional / Local Health Officer

8.1.4.1 Leads and ensures the planning and implementation of health including nutrition programs in the LGU during emergencies

8.1.4.2 Coordinates with the local nutrition action officer for the routine surveillance and rapid assessment of the population's health and nutrition status during emergencies

8.1.4.3 Facilitates the provision of therapeutic management and support to children assessed to have SAM and MAM, and refers to tertiary facilities for in-patient treatment, if necessary

8.1.4.4 Conducts surveillance for cases of communicable as well as water-borne and food-borne diseases in evacuation sites, and

facilitates the provision of treatment

8.1.4.5 Makes data available for use of the nutrition cluster and other clusters

8.1.4.6 Recommends other relevant interventions to protect and promote the nutrition of the affected population, consistent with applicable standards, protocols, rules, and regulations

8.1.4.7 Refers patients, as necessary, for further evaluation and management

8.1.5 Regional / Local Social Welfare Department Officer

8.1.5.1 Leads the planning, coordination, and delivery of food, non-food, and other social welfare needs of the community in all disaster phases

8.1.5.2 Coordinates with identified donors before and after disaster onset, oversees the receipt, conduct of inventory, quality control and distribution of donations

8.1.5.3 Oversees camp management during evacuation

8.1.5.4 Facilitates the procurement, stockpiling, prepositioning, transportation, and distribution of relief goods (both food and non-food)

8.1.5.5 Evaluates the emerging needs of evacuated populations until their return to their places of residence or permanent relocation

8.1.5.6 Coordinates with the local health officer and healthcare providers to provide psychosocial interventions to the affected community

8.1.5.7 Facilitates the reunion of internally displaced individuals with their families, especially children, persons with disabilities and other vulnerable persons

8.1.5.8 Ensures that there are no milk donations and other products covered by Milk Code in the evacuation centers and temporary shelters

8.1.5.9 Coordinates with NPC / NAO and/or BNS in setting-up mother-baby friendly spaces, breastfeeding areas, and community kitchen

8.1.5.10 Coordinates with NPC / NAO or ND on the nutrition adequacy of food prepared in the community kitchens

8.1.5.11 Makes data available for use of the nutrition cluster and other clusters

8.1.5.12 Coordinates with other department, partner agencies,

stakeholders to help provide livelihood programs during the recovery and rehabilitation phase of a disaster

8.1.5.13 Reviews and ensures inclusion of social welfare and protection concerns in the DRRM-H-NiE Plan and other local development plans

8.1.6 Regional / Local Agriculturist

8.1.6.1 Assesses the status of food supply and sources in the community, both prior to and after disasters

8.1.6.2 Makes data available for use of the nutrition cluster and other clusters

8.1.6.3 Engages in capacity building for food production in times of emergencies

8.1.6.4 Works with the local nutrition action officer to ensure food security of the population in evacuation centers as well as upon return to their residences or relocation to more suitable sites

8.1.6.5 Coordinates with other partner agencies and stakeholders to help provide livelihood programs during the recovery and rehabilitation phase of a disaster

8.1.6.6 Reviews and ensures inclusion of agriculture concerns in the DRRM-H-NiE Plan and other local development plans

8.1.7 Regional / Local Nutritionist-Dietitian

8.1.7.1 Formulates cycle menu for community kitchen in evacuation centers or for use by alternative modes of feeding

8.1.7.2 Coordinates with the local nutrition action officer and local social welfare and development officer for the provision of foods for supplementary feeding of persons belonging to the vulnerable groups

8.1.7.3 Monitors status and needs of community kitchens or other appropriate platforms to supply food to identified priority clients

8.1.7.4 Monitors the therapeutic management and support to children assessed to have SAM and MAM

8.1.7.5 Makes data available for use of the nutrition cluster and other clusters

8.1.8 Regional / Local DRRM-H Officer

8.1.8.1 Includes NiE in the LGU's DRRM planning

8.1.8.2 Facilitates coordination with partner agencies and other DRRM clusters for nutrition-sensitive interventions along WASH, education, agriculture, employment, etc.

8.1.8.3 Coordinates with all DRRM clusters in all phases of an emergency or disaster

8.1.8.4 Makes data available for use of the nutrition cluster and other clusters

8.1.8.5 Allocates funds as augmentation for nutrition interventions

8.1.9 Planning Development Coordinator/Local Statistician

8.1.9.1 Provides baseline data for the population: overall census with gender breakdown, number of children under the age of 5, pregnant and lactating mothers, and other data on vulnerable groups

8.1.9.2 Assists with the information management and documentation of assessments done during and after onset of disaster

8.1.9.3 Ensures the local development planning considers disaster risks of the LGU in the development of its policies and plans

8.1.10 Non-Government Organizations

8.1.10.1 Coordinate with the nutrition cluster to support the assessment, community mobilization, and logistics planning prior to disaster and provision of nutrition-related services

8.1.10.2 Augment food aid distributed to the general population as well as therapeutic interventions for vulnerable groups

8.1.10.3 Augment the LGU's logistical capacity to respond promptly to nutritional needs in coordination with the Local DRRM Officer especially when surge capacity is reached

8.2 Function of the Local Government Unit and Nutrition Cluster in the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) – The local government structure in BARMM differs significantly in composition and roles from the devolved structures in other LGUs. Functions of the BARMM LGU regarding NiE must be aligned with the structure under the Bangsamoro Organic Law. BARMM can adopt the provisions in this Policy that are applicable in their region.

8.2.1 The NNC in BARMM[14] is under the Office of the Chief Minister according to the Memorandum of Agreement signed and agreed by the NNC Central Office and BARMM. However, this can be amended as the situation improves.

[14]Once the issuance on creating NNC in BARMM is approved, the office of NNC in BARMM shall be called "Bangsamoro Nutrition Council".

8.2.2 The Rapid Emergency Action on Disaster Incidence (BARMM-READi) and other DRRM plans for BARMM should be aligned with the overall directives and plans of the NDRMMC. NNC-BARMM shall consult with BARMM READi to agree on the protocols and guidelines, synchronizing and aligning nutrition-related activities with their office.

8.2.3 Nutrition, including planning for NiE, should be prioritized by the Ministry of Health.

8.2.4 Planning and implementation of NiE can include the following other ministries:

8.2.4.1 Ministry of Basic, Higher and Technical Education
8.2.4.2 Ministry of Interior and Local Government
8.2.4.3 Ministry of Indigenous People's Affairs
8.2.4.4 Ministry of Finance, Budget and Management
8.2.4.5 Ministry of Human Settlements and Development
8.2.4.6 Ministry of Public Order and Safety
8.2.4.7 Ministry of Science and Technology
8.2.4.8 Ministry of Social Services and Development

8.3 Local Chief Executive – The local chief executive (governor, mayor, and *punong barangay*) of the LGU is key to ensuring the strengthening and activation of the local nutrition cluster.

8.3.1 The local chief executive shall take the lead in disaster risk reduction and mitigation in their respective areas and convene regular meetings (quarterly) with the local nutrition cluster to assess preparedness for emergencies, budget allocation, implementation and monitoring, and spearhead planning of programs for nutrition in emergencies.

8.3.2 The local chief executive shall facilitate opportunities for improving the capacity of the LGU to respond to emergencies and disasters.

8.3.3 The local chief executive serves as the point person during the disaster alert phase and must coordinate the local disaster risk reduction and management council for the rapid planning and deployment of services, including nutrition-specific and nutrition-sensitive programs.

8.3.4 At the most basic level of the LGU, the barangay, the local chief executive may delegate a councilor or staff to facilitate the cascading of nutrition interventions from the city/municipal level to the affected households.

9. FUNCTIONS OF NUTRITION CLUSTER MEMBER AGENCIES/ORGANIZATIONS

9.1 Government agencies

9.1.1 Department of Health – National Nutrition Council (DOH-NNC)

9.1.1.1 Serve as the lead of the Nutrition Cluster

9.1.1.2 Lead in the development of plans, policies, programs, standards and guidelines for nutrition during emergency prevention and management, preparedness, response, and recovery and rehabilitation

9.1.1.3 Coordinate with regional offices in disseminating policies, via memoranda, advisories to implementing agencies in the regional and local nutrition clusters on NiE

9.1.1.4 Provide technical assistance, consultative and advisory services to implementing agencies on NiE

9.1.1.5 Lead in organizing and coordinating efforts of agencies and organizations for emergency prevention and mitigation, preparedness, response, and recovery and rehabilitation

9.1.1.6 Include nutrition education as part of the protocol in disaster risk reduction and management

9.1.1.7 Lead in developing information systems and tools as well as building capacity for local nutrition assessment and surveillance systems that can be used for planning and decision making for nutrition in emergencies

9.1.1.8 Provide technical assistance along capacity building, and policy and program advisory services to implementing agencies of regional and local nutrition clusters in emergency prevention and mitigation, preparedness, response, and recovery and rehabilitation

9.1.1.9 Coordinate the development, reproduction, and dissemination of culturally sensitive information, education, and communication (IEC) materials for use by implementing agencies, general and target population

9.1.1.10 Ensure submission of nutrition cluster reports to DOH-HEMB Operation Center during emergencies and disasters

9.1.2 Department of Health – Health Emergency Management Bureau (DOH-HEMB)

9.1.2.1 Lead of the Health Cluster

9.1.2.2 Ensures in the integration of DRRM-H-NiE Plan in the Disaster Risk Reduction Management in Health (DRRM-H) plan, in coordination with NNC

9.1.2.3 Provide technical assistance along development of policies and guidelines and capacity building on NiE

9.1.2.4 Coordinate with other relevant departments, bureaus, offices, agencies, and other instrumentalities of the government for nutrition-related assistance in the form of human resource, operation center, and health emergency logistics (including human milk bank) during emergencies and disasters)

9.1.2.5 Collaborate in the planning system for health emergencies and addressing health and nutrition concerns during disasters and emergencies

9.1.2.6 Prepositioning of nutrition supplies for nutrition activities

9.1.2.7 Submit the HEARS report as part of assessment integrating relevant reports from relevant agencies

9.1.3 Department of Health – Disease Prevention and Control Bureau (DOH-DPCB)

9.1.3.1 Provide technical assistance in the development of policies and guidelines on nutrition management in emergencies and disasters

9.1.3.2 Issue relevant policies and protocols relevant to the delivery of quality health services, including nutrition interventions included in the minimum service package

9.1.3.3 Ensure the availability and access of nutrition commodities among priority groups

9.1.3.4 Support the provision of interventions for vulnerable groups, particularly pregnant women, lactating mothers, children 0-59 months, adolescents, and other nutritionally at-risk individuals

9.1.4 Department of Health – Food and Drug Administration (FDA)

9.1.4.1 Enforce guidelines and standard operating procedures on quality and safety of processed foods distributed during emergencies and disasters

9.1.4.2 Monitor and ensure quality of processed foods, drugs, and other related products through collection and analysis of samples from outlets and ports of entry

9.1.4.3 Monitor and validate compliance and violations of private companies, government agencies, non-government organizations, and international organizations on EO 51 (Milk Code)

9.1.4.4 Provide technical assistance in the development of policies and guidelines on nutrition management in emergencies and disasters

9.1.5 Department of Science and Technology – Food and Nutrition Research Institute (DOST-FNRI)

9.1.5.1 Provide relevant nutrition survey data for use as basis for policy recommendations during prevention and mitigation and preparedness phases

9.1.5.2 Develop cycle menus for disaster and emergency situations for use for children 6-23 months of age, 24-59 months of age, school-age children, adolescents, adults from 19-59 years old, and older persons aged 60 and over

9.1.5.3 Conduct food and nutrition researches in support to nutrition in emergencies and disasters (such as development of new food products)

9.1.6 Department of Trade and Industry (DTI)

9.1.6.1 Intensify monitoring of the prices of commodities/goods within the area/s affected by the disaster or emergency

9.1.6.2 Implement price stabilization policies and measures to ensure access to basic necessities and prime commodities during emergencies and disasters

9.1.6.3 Coordinate with private companies and business groups on information dissemination of disaster risk reduction management

9.1.7 Department of Social Welfare and Development (DSWD)

9.1.7.1 Lead of the Food and Non-Food Items Cluster during the response phase of disasters and emergencies

9.1.7.2 Coordinate with local field offices to comply with the implementation of the minimum standards of assistance to victims of emergencies and disasters

9.1.7.3 Provide the necessary logistics support for the procurement, storage, transport and distribution of relief goods and other food aid to affected communities

9.1.7.4 Augment the logistics for food aid at the different localities

9.1.7.5 Disseminate guidelines on the provision of family packs (with Halal foods, iron-fortified rice, proper labels, and nutritionally adequate) and breastmilk to affected families

9.1.7.6 Monitor and coordinate the distribution of relief foods or food donations, following prescribed international standards and guidelines for humanitarian aid

9.1.7.7 Lead of the Camp Coordination and Management Cluster; coordinate with local camp managers on the setting up of breastfeeding room in evacuation centers/camps; provision of safe spaces for mothers, women and children, and older persons

9.1.7.8 Provide guidelines on the standard data collection of affected population, with particular attention to the following groups: infants less than 6 months, 6 to 23 months, 24 to 59 months

children, pregnant women by term of pregnancy, lactating mothers, female adolescents

9.1.7.9 Disseminate guidelines for the adoption of WASH and community kitchen facilities during emergencies and disasters

9.1.7.10 Coordinate with the Department of Agriculture in maintaining food stocks in anticipation of emergencies and disasters

9.1.7.11 Ensure that Milk Code provisions and relevant DOH policies are strictly implemented

9.1.7.12 Conducts regular meetings with response cluster members

9.1.7.13 Coordinates with other members of response cluster on nutrition issues/ concerns

9.1.8 Department of Education (DepEd)

9.1.8.1 Contextualization of the National Policy on NiE to organize and train school health personnel as part of the disaster risk reduction and management teams in all DepEd Offices including schools

9.1.8.2 Continue the regular school feeding program and health programs in cooperation with NGOs and other government agencies involved in providing health and nutrition services to children

9.1.8.3 Ensure that learning continues during emergencies and disasters by following guidelines on re-establishing and continuing educational activities

9.1.8.4 Conduct information dissemination campaign on the importance of health and nutrition to learners, parents/guardians, and other caregivers

9.1.8.5 Establish and maintain a database on the nutritional status of school children

9.1.8.6 Forge partnership with government agencies, NGOs, and other stakeholders to support the emergency school feeding, delivery of health and nutrition services including mental health, ensure hygiene practices and to support other education continuity related activities

9.1.9 Department of the Interior and Local Government (DILG)

9.1.9.1 Lead the disaster risk reduction and management plan implementation

9.1.9.2 Issue directives to LGUs on strict implementation of the provisions of NiE and related policies

9.1.9.3 Ensure LGU compliance through monitoring activities

9.1.9.4 Assist in building the capacities of LGUs for nutrition management in emergencies and disasters

9.1.9.5 Ensure LGU provision of temporary livelihood during emergencies and disasters

9.1.10 Department of Agrarian Reform (DAR) through the Bureau of Agrarian Reform Beneficiaries Development (BARBD)

9.1.10.1 Participate under the principle of convergence in nutrition committees in the regional, provincial, and city/municipal levels

9.1.10.2 Through the facilitation of DAR, agrarian reform beneficiaries and organizations, composed of smallholder farmers and cooperatives nationwide, may enter into formal memoranda of agreement with the local government units for the supply of fresh vegetables, rice, meat, other major crops and processed foods in support of local nutrition programs and which can be distributed as part of food packs during emergencies and disasters.

9.1.10.3 Support LGUs, non-government organizations, barangays, and women groups in establishing sustainable vegetable production using available vacant/idle lands under the *Buhay sa Gulay* Project

9.1.10.4 DAR regional farm business schools to teach/demonstrate farmers and potential farmers to go into crop production that can contribute to the whole food supply chain

9.1.10.5 Agrarian reform beneficiaries and cooperatives to also help in information campaign concerning nutrition programs and activities at the local level

9.1.11 Office of Civil Defense (OCD)

9.1.11.1 Lead the overall disaster response plan to be followed by LGUs in its capacity as the secretariat of the NDRRMC

9.1.11.2 Coordinate with other national agencies as well as non-government entities involved in the different phases of disaster preparedness and response

9.1.11.3 Raise and disseminate alerts and updates for the general population to follow prior to and during emergencies

9.1.11.4 Cascade information and directives to local DRRM councils for implementation and further action

9.1.11.5 Maintain emergency operation center as repository of DRRM information

9.1.11.6 Lead in implementation of the incident command system during emergencies and disaster

9.1.11.7 Conduct capacity building on ICS of different NDRRM members

9.1.12 Other Government Organizations

9.1.12.1 Assist in the formulation of national food and nutrition policies and strategies in emergencies and disasters

9.1.12.2 Assist in the coordinated planning, monitoring, and evaluation of the national nutrition program in emergencies and disasters according to their respective mandates

9.1.12.3.1 Department of Budget and Management (DBM) – facilitate the release of funds, loans, and grants from government and NGOs and issue relevant memo circular providing guidelines on budgeting for emergencies

9.1.12.3.2 Philippine Statistics Authority (PSA) – provide relevant statistical data for analysis in aid of policy-making

9.1.12.3.3 Tertiary government hospitals

9.1.12.3.3.1 Serve as referral centers for in-patient management of cases of SAM and MAM with complications

9.1.12.3.3.2 Support IYCF with interventions to support lactation, re-establish lactation, and address health needs of mothers and children from 0-59 months of age

9.1.12.3.3.3 Provide further evaluation and management of other vulnerable individuals such as persons living with NCDs or debilitating conditions, older persons, and persons with disabilities

9.1.12.3.3.4 Coordinate with DOH to provide for the health and nutrition needs of affected population

9.1.12.3.3.5 Provide capacity building in the form of training of personnel involved in nutrition and NiE

9.1.12.3.4 Armed Forces of the Philippines (AFP)

9.1.12.3.4.1 Assist in the transport and distribution of goods and commodities

9.1.12.3.4.2 Ensure the security of workers involved in emergencies and disasters

9.1.12.3.5 Philippine National Police (PNP)

9.1.12.3.5.1 Ensure safety in evacuation centers, especially for mothers, children 0-59 months, adolescent females, older persons, indigenous peoples, and other groups assessed to be vulnerable

9.1.12.3.5.2 Ensure the security of personnel involved in emergencies and disasters

9.2 Non-government organizations (NGOs) / International Multilateral Organizations (IMOs)

NGOs/IMOs shall help the government work with other alliances such as civil society groups, people's organizations, church and international organizations in conceptualizing and implementing programs and projects in the fight against malnutrition specifically those resulting from emergencies and disasters. It shall complement and coordinate government efforts specifically along the following concerns:

9.2.1 Coordination and engagement via the appropriate channels with the LGU to augment nutrition services especially in surge capacity

9.2.2 Nutrition-related emergency and disaster preparedness activities

9.2.3 Organization and implementation of community-based health and nutrition programs in times of emergencies and disasters such as provision of RUTF and RUSF

9.2.4 Nutrition information, education, and communication

9.2.5 Intensifying food relief services

9.2.6 Establishment and operation of a systematic processing and marketing facility for a wide selection of food and other related products for feeding programs during emergencies and disasters

9.2.7 Capacity building for effective nutrition management in emergencies and disasters

9.2.8 Assisting in stress debriefing, counseling, transportation assistance, medical

or hospitalization support, burial assistance, among others

9.3 Private Individuals and Business Organizations

Civil society and business sector involvement in all phases of disasters and emergencies helps increase the community's resilience and capacity for response. Individuals, organizations, and private entities involved in NiE have the following roles:

9.3.1 Coordination and engagement via the appropriate channels with the LGU regarding participation in all phases of emergencies and disasters

9.3.2 Assist in the implementation of disaster risk mitigation and preparedness measures in homes, workplaces, and other private spheres of influence

9.3.3 Augmentation of food relief services consistent with existing rules on food and non-food donations

9.3.4 Increasing logistical capacity via provision of volunteer logistical services for nutrition

9.3.5 Disseminating verified and culturally sensitive information regarding nutrition in emergencies and disasters

10. SEPARABILITY CLAUSE

Should any of the provisions herein be declared invalid or unconstitutional by the appropriate authority or courts of laws respectively, the same shall not affect the validity of other provisions unless otherwise so specified.

Annex A. Operationalization of Information Management

I. Information Management Tools

The six Nutrition in Emergencies - Information Management (NiE-IM) tools shall be used by the Nutrition Cluster (NC) at different thematic areas or phases of disaster risk reduction and management.

Table 1. Summary of Nutrition Cluster Information Management Tools

Components	Data Repository	Capacity Map	NINA tool	NC 4Ws	NC Monitoring Tool	Gap Analysis Tool
Purpose	Extracts data or information from existing local databases and information system for pre-emergency nutrition situation analysis	Provides data on human resources and supplies available to conduct nutrition assessment and provide minimum service package for NiE	Provides immediate and initial needs assessment of the nutrition situation after an emergency	Provides a clearer picture of who is doing what, where, and until when; identifies potential partners and overlaps or gaps in nutrition response	Records data for monitoring of ongoing interventions for children under-five years old and pregnant & lactating women in evacuation center	Identifies gaps Between the expected or needed response and the actual state and determines corrective action needed to be taken
Frequency of data collection	Updated monthly, or as needed during preparatory and recovery phase based on availability of local data	Updated yearly during preparatory phase or as necessary during disaster response phase	Once only — ideally done within 24-72 hours after onset of a disaster	Prepared during pre-impact phase (Day 0 before disaster) Continuously Updated during response phase	Data is collected daily with Disaster Response Data Collection (DRDC) tool of DOH and updated as needed on a real-time basis	Data are obtained from the 5 IM tools
Frequency of submission to the next higher level	OPT Plus— every 2nd quarter of the year FHSIS— monthly at the municipal level	Every 2nd quarter of the year or as necessary when updated	Within 24 hours upon receipt of NINA data	Within 24 hours upon receipt of updated NC 4Ws	Dashboard is submitted daily to the health cluster counterpart and weekly to the next higher nutrition cluster level	Gap analysis is undertaken with nutrition cluster members. Results are shared within the nutrition cluster.

II. Assessment and Monitoring Team

A. Activation of Nutrition Assessment and Monitoring Team

During **disaster response** phase, the NAMT may be activated under the following circumstances:

1. Declaration of state of calamity by the Office of the President and/or declaration of state of calamity by the Local Chief Executive(s)
2. Upon recommendation of the National Nutrition Cluster and/or Regional Nutrition Cluster
3. Upon recommendation of the local Nutrition Cluster, e.g. due to high prevalence of undernutrition and/or track record of frequent disasters

The level of responding NAMT will be based on the magnitude of disaster and the capacity of assessment teams from barangay to national level. For efficiency in the conduct of assessments during disasters, the criteria on level of response will follow Section 15 of RA 10121.

Table 2. Criteria on the conduct of nutrition assessment and monitoring during emergencies by different administrative levels

Criteria	Level of Response
Scenario 1: One barangay is affected	Barangay Nutrition Assessment and Monitoring Team
Scenario 2: Two or more barangays are affected	City/Municipal Nutrition Assessment and Monitoring Team
Scenario 3: Two or more cities/municipalities are affected	Provincial Nutrition Assessment and Monitoring Team
Scenario 4: Two or more provinces are affected	Regional Nutrition Assessment and Monitoring Team
Scenario 5: Two or more regions are affected	National Nutrition Assessment and Monitoring Team (Assessment and Monitoring Working Group of the National Nutrition Cluster)

Notwithstanding the above criteria, the national or regional NAMT may opt to conduct assessment and monitoring in affected areas to complement assessment and monitoring being done at the local level or to build capacity for conducting needs assessment.

The national/regional NAMT can also augment local efforts by conducting nutrition initial needs assessment (NINA), if there is a major calamity that has transpired, and no information is received from the affected area within 24 hours post impact.

When settled and feasible, the local NAMT shall continue or sustain the initial efforts done by the national/regional NAMT. The national/regional NAMT shall endorse all data and information gathered during assessment and monitoring to the local NAMT.

B. Composition of Nutrition Assessment and Monitoring Team at Different Levels

The NAMT is composed of 4-5 members: focal point (or team coordinator), information management officer, and field assessment and monitoring team with 2-3 members. The designated functions of nutrition cluster members in the NAMT at different

administrative levels are presented below.

Table 4. Designated function of nutrition cluster members in nutrition assessment and monitoring team at different administrative levels

Level	**Focal Persons**	**Information Management Officer**	**Field Assessment & Monitoring Team**
National	Chair, National Nutrition Cluster Chair, Assessment and Monitoring Working Group	Technical Staff of Nutrition Surveillance Division and/or Nutrition Policy and Planning Division	Representatives from any of the member agencies of the Assessment and Monitoring Working Group of the National Nutrition Cluster
Regional	Chair, Regional Nutrition Cluster Regional Nutrition Program Coordinator of National Nutrition Council	Nutrition Officer III of NNC Regional Office	Representatives from any of the member agencies of Regional Nutrition Cluster
Province/ City/ Municipality/ Barangay	Chair, Local Nutrition Cluster Nutrition Action Officer/ District Nutrition Program Coordinator/ Midwife	To be designated by the chair of Local Nutrition Cluster	Representatives from any of the member agencies of Local Nutrition Cluster

C. Roles and Responsibilities

Nutrition response should be coordinated to ensure the rapid nutrition assessment and delivery of nutrition services. The roles and responsibilities of the nutrition assessment team members according to function are listed below.

Table 4. Roles and Responsibilities of Nutrition Assessment and Monitoring Team members

Responsibility Center	**Roles and Responsibilities**
Focal Persons	• Provide overall direction in conducting the NINA and monitoring activities in consultation with members of the nutrition cluster • Direct the organization of the field assessment and monitoring teams and planning for the conduct of NINA and monitoring activities • Lead the review of the findings of NINA and monitoring activities • Approve the NINA and monitoring report for submission to higher cluster level, i.e. local nutrition cluster to regional

Responsibility Center	Roles and Responsibilities
	nutrition cluster to national nutrition cluster, and for integration in Health Emergency Alert Reporting System (HEARS) report and Disaster Response Data Collection (DRDC) Tool of Quad Cluster • Endorse recommended nutrition interventions to nutrition cluster based on the findings of NINA and monitoring activities • Lead the updating of data repository and capacity map
Information Management Officer	• Follow-up submission of accomplished NINA forms, 4Ws and NC monitoring tool from the field assessment and monitoring team members • Encode and collate reports from field assessment and monitoring teams in the NINA consolidation tool, 4Ws, and NC monitoring tool • Analyze and interpret information generated from NINA, 4Ws and monitoring tool • Generate daily report based on the analyzed and interpreted information from IM tools • Submit the report within 24 hours after receiving data from Field Assessment and Monitoring Teams • Maintain the data repository for the six IM tools
Field Assessment and Monitoring Team	• Conduct nutrition initial needs assessment and monitoring activities in the assigned area • Ensure data quality is checked • Submit accomplished NINA, 4Ws and NC monitoring tool within 24 hours to the Information and Data Manager • Provide technical inputs and feedback on nutrition situation of affected area to the nutrition cluster during meetings, in support to the report provided by Information and Data Manager

The field assessment and monitoring team will appoint a team leader to be assisted by the rest of the member/s. The team leader will be responsible for ensuring that the NINA and monitoring activities are conducted according to their schedule and plan of activities.

III. Lines of Communication and Reporting Process

The importance of promptly generating the report is to provide planners and decision-makers actionable information. After the NINA and monitoring activities are conducted in the affected areas, the primary goal of the field assessment and monitoring team is to promptly transmit the data/report to the information management officer. The field assessment and monitoring team will use whichever communication channel is available to be able to transmit the data/report to the information management officer within 24 hours after data collection. The figure below shows the different information channels that can be used.

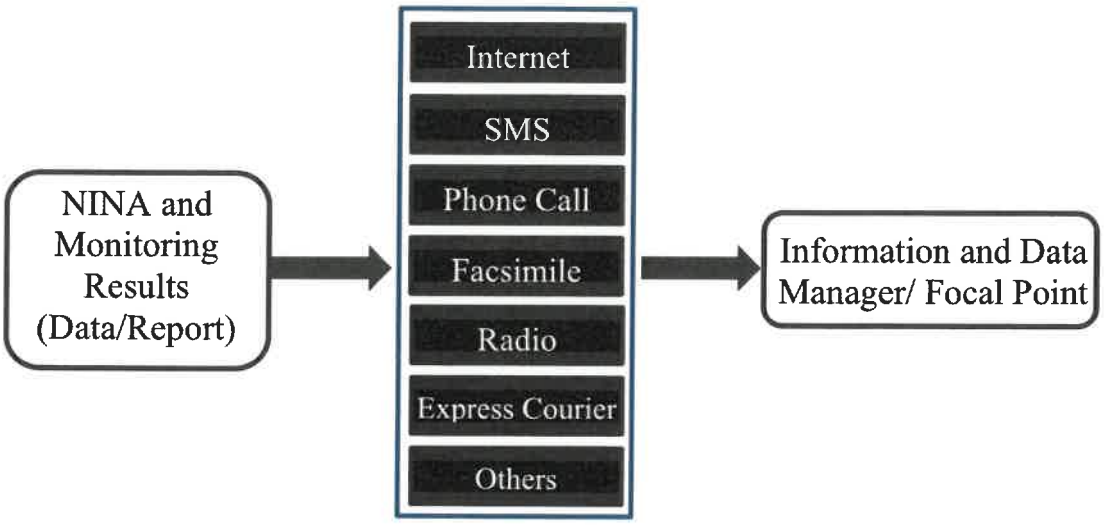

Figure 1. Different Information channels on reporting

For an effective submission of the reports and communication, the provincial/city/ municipal focal persons shall communicate and submit the report directly to the regional nutrition cluster while furnishing a copy to the provincial nutrition cluster to facilitate the sharing of information. The regional nutrition cluster IMO shall then consolidate the reports from relevant LGUs, and the focal person shall submit the report to the Regional Health Emergency Management Staff (HEMS) through the Disaster Risk Reduction and Management for Health Manager (DRRM-H Manager) copy furnished the National Nutrition Cluster. The IMOs at different levels shall share the consolidated reports to the relevant development partners.

Reports should be consolidated and submitted to the next higher level within 24 hours after receiving data from the concerned cluster level. The schematic flow of reports and feedback from the barangay to the national level and vice versa is shown in figure 2. As part of cluster approach, the results of the assessment and monitoring will be discussed in nutrition cluster meeting at all levels as basis for planning and implementation of response, recovery and rehabilitation activities.

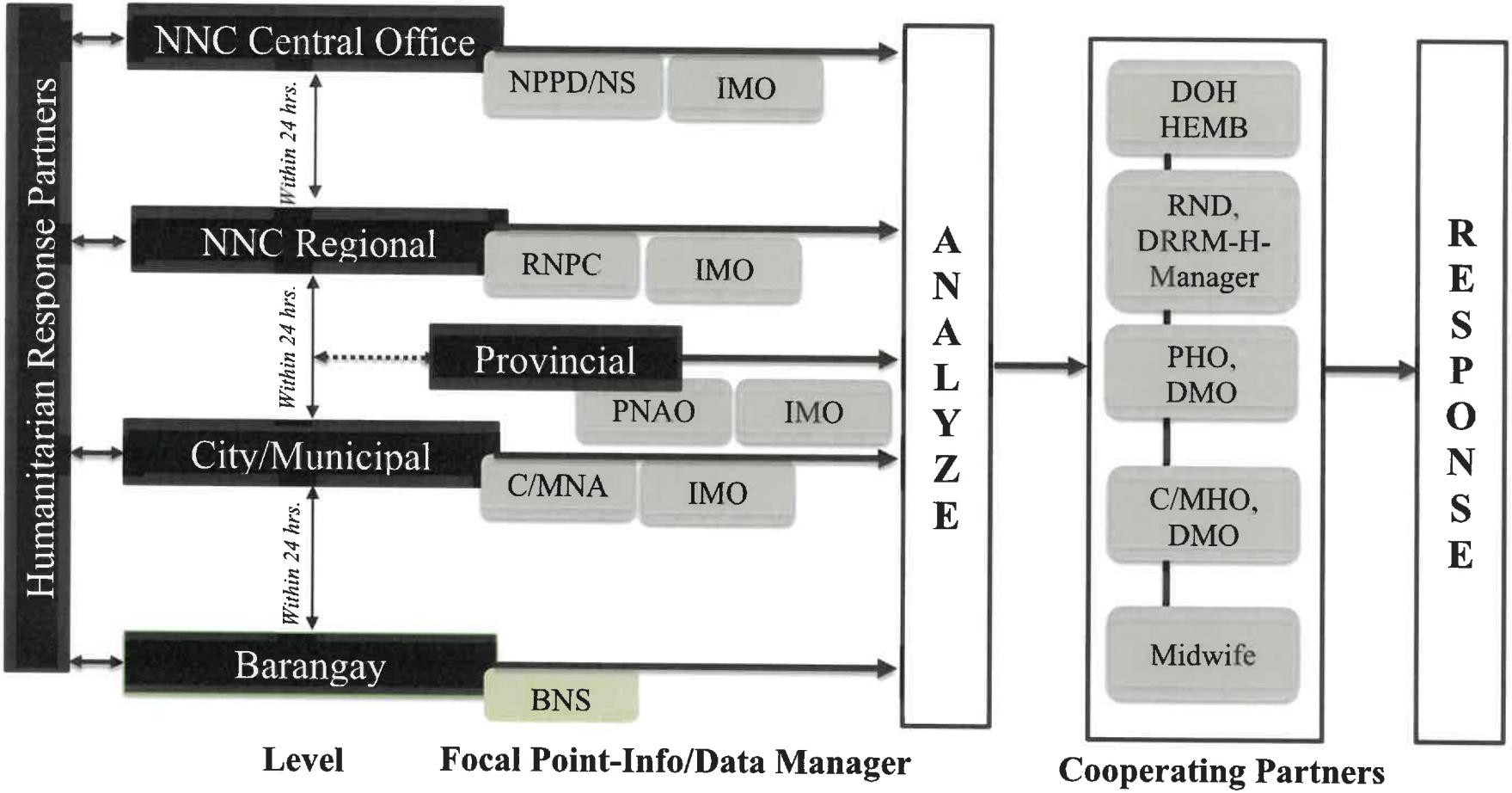

Figure 2. Flow of Reporting*

*Subject to changes depending on the updates of other relevant assessment tools and systems during emergency.