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 2009

Adopting the National Policy on Nutrition Management in Emergencies and Disasters

WHEREAS, the country continues to be affected by natural and human-induced emergencies;

WHEREAS, these emergencies 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, pregnant women and breastfeeding mothers, older persons, people with disabilities, and people living with debilitating conditions;

WHEREAS, the risk of a deterioration in the nutritional status of the population likewise threatens the gains achieved in improving the nutrition situation, which could reverse the high likelihood of achieving nutrition-related targets of Goal 1 of the Millennium Development Goals (MDGs) directly and the targets of the other MDGs indirectly;

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

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

NOW THEREFORE, BE IT RESOLVED AS IT IS HEREBY RESOLVED, in consideration of the above premises, we the National Nutrition Council Governing Board hereby adopt the **National Policy on Nutritional Management in Emergencies and Disasters**, as per attached**.**

RESOLVED FURTHER, for member agencies of the National Nutrition Council Governing Board to issue the appropriate agency policy instrument on the adoption of this policy.

RESOLVED FURTHER, for the Nutrition Cluster to formulate the appropriate guidelines, manual of operations, and other user-friendly materials to implement the policy.

Approved this 3rd day of December 2009.

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Attested by:

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National Policy on Nutrition Management in Emergencies and Disasters

I. 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, 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 most vulnerable groups: infants, children, pregnant women and breastfeeding mothers, older persons, disabled people and people 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 emergency and disaster management.

Studies have shown that under nutrition and 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 threatened and possibly impeded.

Furthermore, recent experiences of frequent emergencies and disasters, some of which have become prolonged, highlight the need to develop nutrition management capacities hence, reducing vulnerability of the population and mitigating the consequences of a potential nutrition crisis. The health sector has a precise role in all these areas: providing education, advocacy, and technical expertise to ensure vulnerability reduction and preparedness for appropriate nutrition–related relief, treatment and prevention of malnutrition, and ultimately promotion of 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 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 and are developing national plans of action for nutrition, which should include concerns on emergency and disaster preparedness and capacity-building for management of nutrition in emergencies and disasters.

Therefore, nutrition management in emergencies and disasters shall be an integral part of the entire disaster management system of local government units (LGUs) through local disaster coordinating councils (LDCCs).

This National Policy and Guide on Nutrition Management in Emergencies and Disasters 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.

II. SCOPE AND COVERAGE

The policy shall apply to all sectors, whether government, non-government or private institutions whose functions and activities contribute to the prevention of a deterioration in the nutritional status of Filipinos particularly the most vulnerable groups: infants, children, pregnant women and breastfeeding mothers, older persons, people with disabilities, and people 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 stages: early, intermediate and extended emergency.

This policy covers directions on strategies for nutrition management in emergencies and disasters particularly on planning, surveillance, rapid nutritional assessment, and implementation of nutrition interventions at various stages.

III. DEFINITION OF TERMS

A. ***Acute Malnutrition.*** Condition arising from a deprivation of food or bout of infection in the immediate past and is manifested by muscle wasting. Acute malnutrition can be moderate or severe. Please see item K and T for definition of moderate and severe acute malnutrition, respectively.

B. ***Complementary Feeding***. Provision of additional foods and liquids in addition to breast milk for infants from 6 months of age onwards. It complements breastfeeding rather than replaces it.

C. ***Disaster***. An event causing great distress or ruin, in which local emergency management measures are insufficient to cope with a hazard, whether due to lack of time, capacity or resources, resulting in unacceptable levels of damage or number of casualties.

D. ***Emergency***. A sudden and unexpected turn of event that creates actual threat to public safety. It is the period characterized by chaos, death, injuries, damage to properties, displacement of families, and inadequate or lack of basic supplies.

E. ***Early Emergency***. It is the period immediately following a disaster, lasting from one to two days, or even for just a few hours depending on the nature of the disaster. The period is characterized by stress, anxiety and in some cases, shock where food supply is cut-off; no productive labor is possible and people are hungry but not starving.

F. ***Intermediate Emergency***. It is the transition period from initial onset of disaster to rehabilitation. Conditions are still far from normal but the initial shock is over. Provision of food is part of the relief package.

G. ***Extended Emergency***. It is the period after the worst is over. Rehabilitation to near-normal conditions takes place. At this phase, families start to go back to their homes to continue their everyday life. The affected community is encouraged to start anew so they do not become dependent on the subsistence given. The entire feeding should last not longer than two weeks. However, in devastated areas, the crisis may still be far from over after this time such that emergency mass feeding must be extended.

H. ***Food Security***. A condition that exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food for a healthy and active life

I. ***Malnutrition***. A pathological state resulting from a relative lack of nutrients (under nutrition) or excess of nutrients (over nutrition) 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, recovering from effects of disease, maintaining adequate level of growth and processes of pregnancy and lactation.

J. ***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.

K. ***Moderate Acute Malnutrition (MAM).*** Characterized by a low weight-for-height (between minus 3 and minus 2 z-scores of the median growth standards). In the Philippine context, these are those classified as "moderately wasted", based on the revised tables on weight and height measurements using the WHO Child Growth Standards (CGS). MAM is also indicated if mid-upper arm circumference (MUAC) is less than 125 mm (12.5 cm. or 4.9 in) but greater than or equal to 115 mm.

L. ***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. Some known brands are Mix Me™ and Sprinkles™.

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

N. ***Nutrition Surveillance System***. It refers to watching over nutrition in order to make decisions leading to improvements on nutrition of the population by providing regular information about nutrition.

O. ***Persistent Diarrhea.*** An episode of soft to watery stools lasting for more than 14 days but without signs of dehydration.

P. ***Planning for Nutrition Management in Emergencies***. Includes all aspects of planning for a nutrition response in emergencies. It refers to the management of nutritional risks and consequences of emergencies and disasters, including measures of prevention and preparedness in anticipation of possible hazards.

Q. ***Rapid Nutrition Assessment***. Refers to the assessment of nutritional status based on anthropometric data (weight, height, mid-upper arm circumference or MUAC, sex, age and presence of edema) and limited to children of preschool age, who serve to represent the general population. The data is limited to protein-energy malnutrition without attempting to assess other nutritional deficiencies as further variables can add workload and cause unnecessary delay.

R. ***Recommended Energy and Nutrient Intakes (RENI).*** Refers to the levels of intakes of energy and nutrients, which on the basis of current scientific knowledge, are considered adequate for the maintenance of health and well-being of nearly all healthy persons in the population.

S. ***Ready-to-Use Therapeutic Food (RUTF).*** Energy-dense, mineral and vitamin-enriched foods that deliver precise quantities of macro and micronutrients and are nutritionally equivalent to the F100 therapeutic milk used in hospital wards. These foods come in the form of oil-based pastes with the texture of peanut butter. They have very low moisture content and thus do not spoil and can be stored in simple packaging in tropical climates for at least six months. As they 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.

T. ***Severe Acute Malnutrition (SAM)***. Characterized by a weight that is below minus 3 z-scores of the median growth standards. In the Philippine context, these are those classified as "severely wasted", based on the revised tables on weight and height measurements using the WHO Child Growth Standards (CGS). SAM is also indicated if mid-upper arm circumference (MUAC) is less than 115 mm (11.5 cm. or 4.5 in); and when bilateral edema is present.

U. ***Supplementary Feeding*****.** Refers to the provision of food to the undernourished or nutritionally vulnerable, equivalent to about 1/3 of the RENI for energy and protein. It also refers to the giving of foods in addition to what is available at evacuation centers; usually given to the nutritionally vulnerable such as young children, pregnant, and lactating women and older persons who are most prone to suffer from malnutrition and other illnesses. These foods include cereals, milk, meat or fish, vegetables, and fruits.

V. ***Undernutrition*****.** 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.

IV. OBJECTIVE

This guide is intended to help health, nutrition, and other professionals to work together and coordinate with each other in nutrition management in emergencies and disasters whether at the local and national level. By improving understanding among the various sectors who 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 the affected population particularly women, infants, children, older persons, persons with disabilities, and the minority groups in emergencies and disasters.

V. 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 women, infants, children, older persons, disabled, marginalized, indigenous people, and compromised groups shall be observed. Gender-sensitive, age-sensitive, disability-sensitive, culture-sensitive and need-sensitive programming is a fundamental right of people being supported during an emergency and they shall be treated with respect and appropriate consideration throughout the emergency and disaster response.

Policy 3. ***Multi-sectoral Collaboration***. The support and contributions of all clusters and sectors shall be harnessed to mount a systematic and comprehensive nutrition management in 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 are more likely not available in times of emergencies and disasters.

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 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***. Nutritional assessment shall be conducted for extended emergencies and disasters in affected areas at the soonest possible time at the local level.

Policy 7. ***Nutrition Intervention Package***. The nutritional requirements of the general population and vulnerable groups must be met primarily through infant feeding; food assistance; supplementary and therapeutic feeding; 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. ***Nutrition Management Planning during Disasters***. All Emergency and Disaster Management Plans at all levels shall incorporate a nutrition management component with focus on vulnerable, marginalized, and compromised groups.

Policy 9. ***Research and Development***. Continuous research shall be conducted to update nutrition standards, develop ideal foods for emergency feeding and generate new evidences for planning and policy development in nutrition management in emergencies and disasters.

VI. IMPLEMENTING MECHANISMS

The following processes should be integral to emergency and disaster preparedness.

A. 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.

1. The nutrition committee of each LGU shall function as the local nutrition cluster and in the context of emergency management shall be considered a sub-structure of the local disaster coordinating council. The local nutrition cluster should take charge of nutrition management in emergencies and disasters

2. In the absence of a functional nutrition committee, efforts must be exerted to reactivate said committee to include but not be limited to the local health office, nutrition office, social welfare and development, public elementary school system, academic institutions, other government agencies and non-governmental organizations (NGOs).

3. The local nutrition cluster shall ensure that its efforts and initiatives are linked with those of the other local clusters such as WASH, psychosocial, social protection, food and non-food clusters all of which are also under the local disaster coordinating councils.

B. Planning

This is a decision-making process based on an analysis of the initial and comprehensive assessment of nutritional status and 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, 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:

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 disaster preparedness plan.

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

    a. Nutrition package and services to be delivered, including estimated or forecasted requirements of the following:

        1) Food rations for mass and supplementary feeding

        2) Multiple micronutrient powder

        3) Vitamin and mineral supplements

            a) Vitamin A

            b) Iron

c) Zinc

d) Multiple micronutrient supplements

4) Equipment and tools for nutritional assessment

b. Target groups

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

d. Service providers (volunteers, health staff, private practitioners, referral units)

e. Funding requirements and sources

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

g. Rehabilitation strategies for the post-disaster phase or extended emergency.

3. These plans should be reviewed and updated according to the actual situation and unforeseen needs in emergencies and disasters. The plan must be regularly updated with provisions for new information and relevant staffing.

C. 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.

1. Training on nutrition 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.

2. The training course shall cover rapid nutrition assessment methodologies and tools (e.g. identifying bilateral edema, measuring weight, height and MUAC and interpreting the results using growth charts and 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.

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 implemented.

4. All service providers shall be provided with the necessary physical, psychological and emotional support to accomplish their tasks.

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.

D. 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 adequate and appropriate organizational support. Specifically, LGUs shall:

1. Adopt and pass local ordinances or resolutions to support compliance to national laws and policies related to nutrition management (e.g. micronutrient supplementation; mandatory fortification of rice, flour, sugar, cooking oil, and salt; regulation of the marketing of breastmilk substitutes, zinc supplementation for diarrhea management).

2. Mobilize the existing calamity fund and lobby for increased budgetary allocation for appropriate nutrition-related responses in emergencies and disasters.

3. Identify and mobilize additional resources.

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).

E. 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, a participatory approach, gender equity, good governance, decentralization and human rights.

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

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.

2. Establish rapport as early as possible and seek commitments for assistance.
3. Follow-up provision or delivery of committed support and assistance.

4. Establish regular communication with stakeholders to sustain partnership.

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

F. 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 key terminologies in nutrition management during emergencies and disasters. More specifically, cluster members shall:

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.

2. Encourage local adoption, adaptation, or execution of policies and guidelines.

3. Develop and disseminate information, education and communication materials for training and education.

4. Promote resource generation and social mobilization.

5. Utilize a central database of relevant nutrition and related information.

G. 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 overall contingency and emergency plan of the area. The LGU shall:

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

2. Identify potential donors and observe protocols in accepting local and foreign donations during emergencies and disasters with due consideration of the provisions of DOH Administrative Order 2007-0017.

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

4. Pre-position items for supplementary feeding before the disaster season, including adequate supplies of multiple micronutrient powder

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. Ensure that identified evacuation centers or transit centers have breastfeeding areas as well as provisions for the preparation of food for supplementary feeding.

H. Surveillance, 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 before, during, and after the emergency and disaster period, thus:

1. At the pre-emergency stage or "normal" times

    a. LGUs shall conduct Operation Timbang (OPT) according to the prescribed frequency per OPT guidelines.

    b. To the extent possible, growth charts shall be used in recording the results of regular weighing.

    c. OPT results should be organized into a database that can be used for planning and program monitoring and evaluation.

d. OPT records must be maintained by the rural health midwife (RHM) and barangay nutrition scholar (BNS).

e. Information on the prevalence of underweight preschool children for each barangay as well as the ranking of barangays by prevalence of underweight preschool children must be ready at the municipal level.

f. Communication channels from the national to the local levels shall be set up.

g. Continuous monitoring and evaluation of the performance and effectiveness of nutrition interventions shall be conducted.

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

i. LGU should identify vulnerable groups.

j. Identified vulnerable groups shall be given information on how they can be easily attended and cared for when an emergency and disaster occurs and on clear directions on what to do during emergencies.

2. In the early stage of the emergency and disaster, rapid nutritional assessment may not be feasible or practical. However, a nutritional assessment should be done in the intermediate and extended phases since the disaster or emergency may have negative effects on the nutritional status especially of the nutritionally vulnerable.

a. 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

b. If measuring weight and height is not possible, the MUAC could be used as index for screening preschool children.

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

d. The nutritional assessment should be complemented with

1) A profiling of the population affected in terms of the number of pregnant women, 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

2) The determination of the presence of other risk factors

a) Child-headed households

b) Orphan-hosting households (substitute households)

c) Elderly-headed households (caring for grandchildren)

d) Households caring for chronically sick members

e) High prevalence of HIV further exacerbated by the foregoing risk situations.

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3) An assessment instrument for measuring food security and/or insecurity

4) Determination of the extent of diarrhea and acute respiratory tract infection among preschool children

5) Determination of child mortality

e. Weight and height measurements of preschool children should be done monthly until "full normalcy" is achieved, by which time the OPT system can be used for nutritional assessment.

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

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

a. The monitoring should determine the extent to which:

1) The needy population is receiving the intended intervention on time and of right quality

2) Interventions are reaching out to those who are not the intended targets

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

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

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

d. A system for sharing the information among various stakeholders should also be set up.

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

I. Service Delivery

1. Objectives

a. The delivery of nutrition services in normal, emergency and disaster situations aims to ensure the nutritional well-being of the population especially those who are nutritionally vulnerable.

b. However, in the early emergency stage, the objectives are to:

1) Mitigate hunger

2) Re-establish body reserves for micronutrients

3) Provide comfort and improve morale

4) Help counteract shock

c. In the intermediate and extended states, the objectives are to:

1) Improve the nutritional status of the malnourished

2) Prevent a deterioration in the nutritional status of the affected population

2. Priority groups

While maintaining good nutrition among all those affected by an emergency and disaster is a general concern, special attention should be given to specific groups due to certain vulnerabilities, as follows:

a. Pregnant women
b. Lactating women
c. Infants, 0-11 months old
d. Young children, 1-2 years old
e. Children below 6 years old
f. Children with low weight-for-height or low MUAC
g. Older persons
h. Sick and injured
i. Rescue workers
j. Cases of HIV-AIDS

3. Key services that should be available in the emergency (early, intermediate, and extended) phase

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

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

a) Linking with other sectors to provide 'safe havens' for pregnant and lactating women in the early phase of an emergency. These 'safe havens' should be easily accessible areas where privacy, security and shelter are provided with access to water and food for pregnant and lactating women. An alternative would be designating a special area in evacuation centers or camps for pregnant and lactating women.

b) Provision of peer-to-peer support

c) Encouraging other mothers to breastfeed an infant who may have lost his/her mother

d) Discouraging the use of infant-feeding bottles and artificial teats during emergencies and disasters

e) Providing counseling services for relactation

2) In the very extreme and unlikely case of breastfeeding not being possible, breast milk substitutes may be used provided that it is given using the 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.

b. Promotion of desirable complementary feeding practices

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.

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.

3) When available, food aid in the form of blended foods, 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.

4) When possible, multiple micronutrient powder shall be used to enhance the quality of food given to infants and young children as well as pregnant women.

c. Provision of food rations or mass feeding especially in the early stage of an emergency.

1) All those affected should be targeted. The nutrition cluster at the local level should also ensure quality of relief items to victims, especially rice.

2) 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.

3) For HIV or HIV-AIDS cases, calorie allowance should be increased by 10 percent for asymptomatic (without signs/symptoms) and 20-30% for symptomatic (with signs/symptoms) HIV-infected adults; and 50-100% for children with acute weight loss and infection

4) 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 in order to reduce the quantity to be carried.

d. Vitamin A supplementation

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

1) 6-11 months old infants (100,000 IU), provided the infant did not receive a similar dose in the past four weeks

2) 12-59 month-old preschoolers (200,000 IU), provided the child did not receive a similar dose in the past four weeks

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

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

   a) For infants 6-11 months old-100,000 IU

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

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:

   a) For infants 6-11 months old-100,000 IU

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

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:

   a) For infants 6-11 months old-100,000 IU

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

7) Pregnant women with xerophthalmia, 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 pregnant woman has nightblindness.

8) Lactating women with xerophthalmia, 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.

e. Iron supplementation

1) For infants with low birth weight, 0.3 ml of iron drops 15 mg elemental iron/0.6 ml starting at 2 months up to 6 months

2) For non-pregnant women 10-49 years old, 1 tablet of 60 mg elemental iron and 2.8 mg folic acid weekly at menarche until one gets pregnant

3) For non-pregnant women 10-49 years old and older persons in malaria-endemic areas, 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.

4) For non-pregnant women 10-49 years old in schistosomiasis-endemic areas, a tablet of 100 mg elemental iron/0.5 ml daily for 30 days. Administer iron supplement first before Prazinquantel.

5) For pregnant women, a tablet of 60 mg elemental iron and 400 mcg folic acid daily for 180 days starting from the determination of pregnancy

6) For lactating women, a tablet of 60 mg elemental iron with 2.8 mg folic acid once a week until one gets pregnant

7) For those clinically diagnosed as anemic

a) For those 10-49 years old, a tablet of 60 mg elemental iron with 400 mcg folic acid daily until hemoglobin reaches normal level

b) For children or those less than 10 years old, therapeutic dose of iron supplement but assess for further management of anemia

f. Iodine supplementation of pregnant or lactating women at 250 ug/day or 400 mg/year provided the last iodine supplementation was a year ago.

g. Zinc supplementation of children 6 -59 months old with diarrhea at 20 mg elemental zinc per day for 10-14 days.

h. 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.

i. Supplementary feeding

1) Targeted supplementary feeding, usually targeting preschool children 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.

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.

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

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

1) Those who show moderate acute malnutrition but have no medical complications should be supported in a supplementary feeding program that provides dry take-home rations, preferably of ready-to-use therapeutic food (RUTF), and standard medicines.

2) 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.

3) Individuals with SAM who have medical complications or infants with SAM need to be treated in an in0patient care facility until well enough to continue being treated in outpatient care.

4) Adequate training and monitoring should be done to ensure the proper use of RUTF.

k. 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 psychosocial cluster.

These can include:

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

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

3) Offering social and psychological support to the families.

4) Offering breastfeeding corners for pregnant and breastfeeding women to provide mothers with a space to share experiences, receive advice, and reinforce self-esteem.

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.

4. Referral and follow-up

Cases with complications shall be referred to the appropriate in-patient facility for further medical and nutrition attention.

VII. Institutional Management

A. Government agencies

1. Department of Health-Health Emergency Management Staff (DOH-HEMS)

a. Serve as the lead of the Nutrition Cluster

b. Lead in organizing and coordinating efforts of agencies and organizations for emergency preparedness and response.

c. Lead in the development of plans, policies, programs, standards and guidelines for the prevention and mitigation of nutrition and nutrition-related emergencies.

d. Provide technical assistance, capacity building, and consultative and advisory services to implementing agencies in

nutrition in preparation and response to emergencies and disasters.

e. Coordinate with other relevant departments, bureaus, offices, agencies, and other instrumentalities of the government for assistance in the form of personnel, facilities, and resources as the need arises.

f. Coordinate the development, reproduction, and dissemination of information, education, and communication (IEC) materials

g. Include nutrition education as part of the protocol in emergency and disaster management

h. Collaborate in the evaluation of the suitability and nutritional adequacy; and monitor and coordinate the distribution of relief foods.

i. Promote the conduct of studies and researches related to nutrition in emergencies and disasters.

2. Department of Health-National Nutrition Council (DOH-NNC)

a. Lead in developing policies on nutrition management in emergencies and disasters.

b. Coordinate with regional offices in disseminating the policy

c. Provide technical assistance, consultative and advisory services to implementing agencies on nutrition management in emergencies and disasters.

3. Department of Health-National Center for Disease Prevention and Control (DOH-NCDPC)

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

b. Monitor the implementation of micronutrient supplementation and infant and young child feeding

c. Augment logistics for micronutrient supplementation and advocacy activities.

4. Department of Health-Food and Drug Administration (FDA)

a. Enforce guidelines on quality & safety of processed foods distributed during emergencies and disasters.

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

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

5. Department of Science and Technology-Food and Nutrition Research Institute (DOST-FNRI)

   a. Provide essential nutrition data and recommendations for administrators, planners, and policy makers in both government and private sectors.

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

   c. Develop cycle menus for disaster and emergency situations.

   d. Conduct food and nutrition researches particularly on the development of food products suitable for emergencies and disasters.

6. Department of Trade and Industry. Intensify monitoring of the prices of commodities/goods within the area in times of disaster and emergencies.

7. Department of Social Welfare and Development (DSWD)

   a. Coordinate with local field offices to comply with the implementation of the minimum standard rates of assistance to victims of emergencies and disasters.

   b. Disseminate guidelines on the provision of family packs to affected families.

   c. Monitor and coordinate the distribution of relief foods or food donations.

   d. As lead of Camp Coordination and Management Cluster, coordinate with local camp managers on the setting up of breastfeeding room in evacuation centers/camps.

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

8. Department of Education (DepED)

   a. Make available school buildings for use as temporary shelters of affected families.

   b. Organize and train emergency and disaster control groups and reaction teams in all schools.

c. Continue and expand the school feeding and health program in cooperation with NGOs, and other government agencies involved in providing health and nutrition services to children.

d. Provide emergency feeding assistance in disaster areas.

e. Provide nutrition counseling to parents and children.

f. Ensure that learning continues during emergencies and disasters by improving the nutritional and health status of children.

g. Conduct information dissemination campaign on the importance of health and nutrition to the general public.

h. Establish and maintain a data base on the nutritional status of school children.

9. Commission on Higher Education (CHED)

Mainstream emergency and disaster risk reduction in the tertiary education system through the integration of appropriate concepts and learning experiences in the basic curricula in schools of health sciences.

10. Department of the Interior and Local Government (DILG)

a. Issue directives to LGUs on strict implementation of the provisions of this policy.

b. Ensure LGU compliance through monitoring and report to the NNC-GB accordingly.

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

11. Other Government Organizations

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

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

1) Department of Budget and Management - facilitate the release of funds, loans, and grants from government and NGOs

2) Armed Forces of the Philippines

a) Assist in the transport and distribution of goods and commodities

b) Ensure the security of workers involved in emergencies and disasters

3) Provide essential nutrition data and recommendations for administrators, planners, and policy makers in both government and private sectors.

4) Serve as training institutions for human resource development.

5) Participate in the development of nutrition manuals and guidelines.

6) Suggest innovative technologies for effective emergency and disaster management

B. 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:

1. Nutrition-related emergency and disaster preparedness activities
2. Organization and implementation of community-based health and nutrition programs in times of emergencies and disasters, including the provision of RUTF
3. Nutrition information, education and communication
4. Intensifying food relief services
5. 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,
6. Capacity building for effective nutrition management in emergencies and disasters,
7. Assisting in stress debriefing, counseling, transportation assistance, medical or hospitalization support, burial assistance, among others.

VIII. 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 other provisions' validity unless otherwise so specified.