Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

December 18, 2015

ADMINISTRATIVE ORDER
No. 2015 - 055

Subject: National Guidelines on the Management of Acute Malnutrition for Children under 5 years

I. BACKGROUND AND RATIONALE

Despite the many gains in improving nutritional status of children under-5 in the Philippines, there remain persistent nutrition issues which impact their survival and long-term development. To address these issues, the Philippines in 2013 signed up to be part of the global Scaling-Up Nutrition (SUN) Movement, which unites governments, civil society, businesses and citizens in a worldwide effort to end under—nutrition.

One pressing issue is acute malnutrition or “wasting". According to the 2013 National Nutrition Survey of the Food and Nutrition Research Institute, wasting for children under five years has gradually increased from 6.9% in 2009 to 7.9% in 2013, which, as per World Health Organization’s public health problem threshold for global acute malnutrition, is considered poor.

Wasting is the life-threatening form of malnutrition. If not properly treated with evidence-based interventions, children with severe acute malnutrition are 9.4 times more likely to die compared to normal children. Nutrition situation is threatened to worsen during times of emergencies when the risk of developing wasting is high. In recognition of this, SUN countries, including the Philippines, have identified the reduction of wasting in children as a key nutrition target for reduced child mortality and long-term development. The increasing national trend of wasting and the life-threatening nature of the condition make it a public health nutrition issue that needs to be urgently addressed in both development and emergency scenarios.

Globally, acute malnutrition has been effectively managed in the last decade through an intervention called Integrated Management of Acute Malnutrition (IMAM). Death rates have been significantly reduced to less than 10% (from as high as 30—50%) through a largely community-based programme using standardized medical and therapeutic care protocols. The intervention is recognized by UNICEF and WHO as the only established, evidence-based intervention which successfully addresses the problem of acute malnutrition and saves children’ s lives. It also falls

into the category of “highly cost-effective" intervention in terms of Disability- Adjusted Life Years (DALYS) averted, a key measure of the cost-effectiveness of a public health intervention used by WHO.

In the Philippines, IMAM has already been demonstrated for the past 5 years both in the emergency and non—emergency programs. A draft protocol has been contextualized and adopted by the IMAM Technical Working Group and aptly named it as the Philippine Integrated Management of Acute Malnutrition (PIMAM). It has used successfully in response to major emergencies such as Tropical Storm Sendong, Typhoons Pablo and Yolanda, Bohol earthquake, Zamboanga City Siege, and the prolonged armed conflict in Central Mindanao. In 2014 alone, almost 3,500 children with severe acute malnutrition (SAM) have received life-saving care in all emergency areas. Several municipalities and cities with high burdens of severe acute malnutrition have adopted this protocol through their rural health units. In particular, Davao City has included PIMAM into its regular nutrition programs and the city’s health workers are already I accustomed to the protocol, integrating it in the routine Integrated Management of Childhood Illnesses (IMCI) and Operation Timbang (OPT) Plus.

This Order provides the policies and strategic framework to guide a multi-sectoral approach in the adoption and implementation of PIMAM.

II. GOAL AND OBJECTIVES

A. Goal

To improve the survival of children under 5 years by ensuring access to evidence-based, effective, and life-saving interventions to prevent and treat acute malnutrition.

B. General Objective

To provide the policy, strategy, and standards to health, nutrition, "and social service providers, including government partners, civil society organizations, and donors involved in the effective and efficient implementation of the Philippine Integrated Management of Acute Malnutrition.

C. Specific Objectives

1. To provide implementing units at all levels of the health and nutrition sector an evidence- based and standardized protocol to prevent, identify, refer, and manage children under 5 years old with acute malnutrition in communities, especially during emergencies and disasters.

2. To ensure that the health and nutrition sector will have the capacities, essential supplies and commodities, and logistics required that will enable implementing units to effectively deliver quality services.

3. To standardize and integrate indicators, reporting and monitoring tools and systems, and "evaluation mechanisms into existing information systems that will help in planning and sustainable programming at all levels especially for emergencies and disasters.

4. To define roles and functions of DOH Offices and its Attached Agencies, Local

Government Units, and partner agencies in the implementation and monitoring of PIMAM.

III. SCOPE AND COVERAGE

This Order is issued for the guidance of the health, nutrition, education, social welfare, food security and agriculture sectors, both public and private, involving DOH offices, its attached agencies, hospitals, other healthcare facilities, Local Government Units, other National and Local Government Agencies, Civil Society, Professional Societies, donors, and other stakeholders involved in nutrition.

IV. DECLARATION OF POLICIES

This order is guided by the following issuances:

1. Sphere 2011, The Sphere Project: Humanitarian Charter and Minimum Standards in Humanitarian Response 2011

2. Republic Act 7160, or the “Local Government Code of 1991"

3. Republic Act 10121 and its Implementing Rules and Regulations or the “Philippine Disaster Risk ReduCtion and Management Act of 2010"

4. Republic Act 10028 and its Implementing Rules and Regulations or the “Expanded Breastfeeding Promotion Act of 2009"

5. National Objectives for Health 2011-2016 which identified as one of the strategies in attaining better health outcomes is to “Adopt and implement appropriate guidelines for the community-based management of acute malnutrition"

6. Philippine Plan of Action for Nutrition 2011-2016 which aims for the integration of the management of severe and moderate acute malnutrition as a vital service in the community and health facility.

7. Integrated Management of Childhood Illness Chart Booklet which integrates the identification and management of acute malnutrition together with common childhood illnesses at the community level.

8. NNC Governing Board No. 1 82009, the National Policy for Nutrition Management in

Emergencies and Disasters, which indicates that PIMAM is a key service that shall be available in emergency and disaster situations.

V. DEFINITION OF TERMS

1. Acute malnutrition (or Wasting and/or edema) — occurs when an individual suffers from current, severe nutritional restrictions, a recent bout of illness, inappropriate childcare practices or their combination resulting to sudden weight loss or the development of bilateral pitting edema. This can be reversed with appropriate treatment.

a. Severe Acute Malnutrition (SAM) or Severe Wasting Very low weight-for—height defined as less than 3 standard deviations below the median (< -3SD) of the WHO growth standards, characterized by visible severe wasting, or by the presence of bipedal. pitting edema (WHO), or a Mid-Upper Arm Circumference (MUAC) measurement of < 115 millimeters (< 11.50m).

b. Moderate Acute Malnutrition (MAM) or Wasting Low weight-for—length/height defined as between 2 and 3 SD below the median (<-2 and >= SD) of the WHO growth standards or a MUAC measurement of < 125mm and 2 115mm (< 12.50m and >= 11.50m).

2. Appetite test — The most important criterion to decide if a patient shall be sent for in- or out-patient management. SAM cases 'with poor appetite indicates the presence of severe infection or major metabolic abnormality even in the absence of other signs, and shall be admitted for Inpatient Therapeutic Care.

3. Mid-Upper Arm Circumference (MUAC) — MUAC is a measure of muscle wasting and has been shown to have the highest correlation with risk of mortality of any anthropometric indicator. It is also a simple and transparent measure and therefore the most appropriate for use in decentralized services.

4. Ready—to-Use Food (RUF) — WHO recommended energy-dense, mineral and vitamin-enriched foods that deliver both macro and micronutrients and are ideally suited to the treatment of acute malnutrition in the community and at home.

a. Ready-to-Use Therapeutic Food (RUTF) - an energy and nutrition-dense paste, containing 520-550 kcal/100g recommended by the WHO for the home-treatment of severe acute malnutrition. While RUTF must be consumed along with clean drinking water, no other foods besides breast milk are necessary for the rehabilitation of the severely malnourished child.

b. Ready-to-Use Supplementary Food (RUSF) ——- types of RUF that are specifically designed either for the treatment-or prevention of MAM in children 6—59 months of age. It is eaten by the child in addition to breast milk and other family foods for about 3 months. It contains 534-543 kilocalories/ 100grams.

5. Therapeutic Milk — a low protein formulation that delivers the right balance of macro and micronutrients recommended by the WHO for the treatment of severe acute malnutlition with complications in a health facility/hospital. Therapeutic milk is specifically formulatedfor management of SAM and is not equivalent to any commercial milk formula. _

a. F—75 Therapeutic Milk —— a type of therapeutic milk suited to stabilize the condition and restore normal metabolic function and nutrition-electrolyte balance of patients suffering from severe acute malnutrition while their medical complications are being I treated during phase 1 of treatment.

b. F-100 Therapeutic Milk — a therapeutic milk formulation similar to RUTF for the recovery of patients suffering from severe acute malnutrition in- the nutritional rehabilitation phase of treatment (transition phase and phase 2).

VI. GENERAL GUIDELINES

1. Mothers and caregivers of children under 5 years shall have access to information and PIMAM health services including the prevention, diagnosis, management, and referral of acute malnutrition, especially during emergencies and disasters.

2. All public health and nutrition programs including but not limited to' IMCI, EPI, IYCF, micronutrient supplementation, and growth monitoring shall integrate PIMAM principles and strategies to provide clear policy guidanCe for alloCating and mobilizing needed resources to ensure the continuity of and access to evidence-based and life-saving nutrition interventions.

3. PIMAM services in development and emergency settings shall be available and accessible at all communities and health facilities. Intermediary LGUs, Regional Offices for Health, and DOH-Central Office shall provide technical support and assume augmentation and surrogate roles in times of disasters.

4. All Local Government Units, through their Local Health Offices, shall be responsible in enhancing the capacities of their communities to identify, refer, and manage cases of acute malnutrition.

5. Competent PIMAM service providers shall be developed and established at all levels with the capacities to deliver quality services both under routine health program and during emergencies. '

6. All implementing agencies (LGUs, Hospitals, NGOs) shall establish and implement mechanisms, tools, and systems for supplies management and monitoring and evaluation of service delivery during routine health programs and emergencies.

7. All implementing agencies shall develop, implement, and sustain information management systems and strategies to ensure that appropriate, timely and evidence-based information are available at all times and levels. Systems shall be put in place for making the information available

and accessible in the case of disasters and emergencies.

8. Coordinating, advocacy, networking, and partnership mechanisms shall be established and/or strengthened at all levels for effective and efficient PIMAM service delivery during routine health programs and emergencies.

9. The components of PIMAM shall be Community mobilization, Inpatient Therapeutic Care (ITC), Outpatient Therapeutic Care (OTC), and Targeted Supplementary Feeding (TSFP). These components shall sit within a multi-sectoral range of health and nutrition interventions and services which focus on tackling the determinants of undernutrition in the 'critical 1000 day window'

VII. SPECIFIC GUIDELINES

The components of PIMAM, and the guidelines, processes, and procedures are outlined in Figure 1 and described in detail in the Manual of Operations for the Management of SAM (http://www.doh.gov.ph/non-serials.html)

A. Community Mobilization

Community mobilization shall involve engaging the community to understand their needs and ensure that the service is accessible, available and appropriate; sensitizing the community to make them aware of acute malnutrition, its effects, and that treatment is available; and, finding cases of acute malnutrition, referring them for treatment and following up at-risk cases when needed.

B. Assessment and Diagnosis

1. Acute malnutrition shall be diagnosed by assessing the child to be of inadequate weight relative to height based on the WHO Child Growth Standards and/or by identifying muscle wasting using Mid Upper Arm circumference (MUAC) and for bilateral pitting edema;

2. Acute malnutrition shall be classified as moderate or severe according to the degree of wasting in comparison to specific cut-off points or reference standards. Children with bilateral pitting edema are always classified as having severe acute malnutrition.

3. Assessment shall be made in the CPD of an Inpatient Therapeutic Care (ITC) facility or in an Outpatient Therapeutic Care (OTC) facility (BHS, BHC, or RHU). Other venues such as daycare centers shall also be used as the need arises.

4. Once a child has been diagnosed with SAM, it is important to make sure that he or she shall be correctly assigned to outpatient or inpatient care based on his or her condition. This is based on whether the child has appetite (conduct Appetite Test using RUTF) and/or any medical complication based on IMCI criteria.

a. Identification of Acute Malnutrition in infants < 6 months of age

i. Severe Acute Malnutrition (any of the following)
1. Presence of bilateral pitting edema
2. W/L < -3 SD

ii. Moderate Acute Malnutrition 1
. W/L < -2 SD and >= -3 SD

b. Identification of Acute Malnutrition in children aged 6-59 months

i. Severe Acute Malnutrition (any of the following)

1. MUAC < 115 mm (or < 11.50m)
2. Presence of bilateral pitting edema
3. Weight-for-Height (W/H) or Weight-for—Length (W/L) < -3 SD

ii. Moderate Acute Malnutrition (any of the following)

1. MUAC < 125mm (< 12.5cm) and >= 115 mm (>= 11.50m)
2. W/H or W/L < —2 SD and >= -3 SD

c. Categorizing severity of pitting edema

i. Mild (+) — both feet
ii. Moderate (++) — both feet plus lower legs, hands and lower arms
iii. Severe (+++) — both feet, legs, hands, arms and face (generalized)

d. Categorizing results of the Appetite test using RUTF

i. Pass — The child takes at least 3-4 mouthfuls of RUTF.

ii. Fail -— The child does not take at least 3-4 mouthfuls of RUTF and is considered to lack sufficient appetite for outpatient treatment and shall be admitted for inpatient care.

C. Criteria for Admission

1. Infants < 6 months

a. Inpatient Therapeutic Care — all infants who meet the following shall be admitted for ITC:

Bilateral pitting edema or W/L < -3 SD AND one of the below

-Recent weight loss/inability to gain weight Any of the medical complications outlined for children

6—59m (see below)
-Any medical issue needing more detailed assessment or intensive support (e.g. disability)
-Ineffective feeding (attachment, positioning and suckling) directly observed Infant is lethargic and unable to suckle
-No possibility of breastfeeding (e.g. death of mother)
-Depression of the mother/caregiver or other social circumstances

b. Outpatient Breastfeeding Support — all mothers with infants who meet the following shall be provided with intensive outpatient breastfeeding support and counselling: -

i. W/L < -2 SD and none of the complications requiring inpatient care, or

ii. Mother is malnourished or ill

2. Children 6-59 months: a. Inpatient Therapeutic Care 4 all children who meet ANY ONE of the following criteria shall be admitted for ITC:

i. Have Grade 3 (+++) Bilateral pitting edema OR

ii. MUAC < 115 mm or W/H or W/L < —3 SD AND any grade of edema) OR

iii. MUAC < 115mm or W/ H or W/L < -3 SD plus ANY ONE of the following:

-Failed appetite test with RUTF
-Intractable (empties contents of stomach)
-Fever > 38.5°C axillary or 39.0°C rectal
-Hypothermia < 35°C axillary or < 35.5°C rectal
->= 50 breaths/min from 6 to 12 months
->= 40 breaths/min from 1 to 5 years
->= 30 breaths/min for over 5 year olds
-Any chest in—drawing (for children > 6 months)
-Very pale (palms, palate, nailbeds, eye palpebrae)
-Extensive skin infection requiring Intra-Muscular antibiotics
-Very weak, apathetic, or unconscious
-Any recent fits or convulsion
-Recent history of diarrhea/vomiting with of sunken eyes

b. Outpatient Therapeutic Care — all children who meet ALL of the following shall be admitted for OTC:

i. Have Grade 1 or 2 (+ and ++) Bilateral pitting edema or MUAC < 115mm or W/H or W/L< —3SD
ii. Passed the appetite test

iii. Do not have medical complications

c. Targeted Supplementary Feeding — all children aged 6-59 months who meet ANY ONE of the following criteria shall be admitted for TSFP

i. Have MUAC 2 115mm and < 125mm or W/H or W/L >= -3SD and < -2 SD
ii. No bilateral pitting edema
iii. All children with SAM discharged as cured

D. Criteria for Discharge

1. Infants < 6 months

a. Infants with SAM shall be considered cured if ALL of the following are met:

i. Breastfeeding effectively (based on assessment)

ii. Has adequate weight gain (5g/kg/d)

iii. W/L 2 -2 SD for 2 consecutive visits (where capacity exists to measure)

iv. Once the infant reaches 6 months of age, MUAC shall be taken at this point to assess whether the infant qualifies for enrolment in OTC as a child and to receive RUTF

2. Children 6-59 months with either SAM or MAM

a. For those admitted on MUAC, edema, or both MUAC and W/H SD, ALL of the following shall be met:

i. MUAC >= 125mm (>= 12.50m) for 2 consecutive visits
ii. No edema for 14 days
ii. Clinically well

b. For those admitted on W/H SD, ALL of the following shall be met:

i. W/H or W/L >= -2 SD for 2 consecutive visits
ii. No edema for 14 days
iii. Clinically well

E. Referral and Management

1. Inpatient Therapeutic Care (ITC) for infants and children shall focus primarily on the nutritional stabilization of the child and appropriate management of medical complications. Inpatient care shall be provided in order to:

a. Recover infants < 6 months with SAM who require intensive treatment.

b. Stabilize children with SAM aged 6 to 59 months who also have medical complications or a lack of demonstrated appetite sufficiently to allow them to continue their nutritional rehabilitation with OTC.

c. Provide complete nutritional rehabilitation in inpatient care for children with SAM where there is no access to OTC.

d. Children in outpatient care may also be referred to inpatient care for a period of more intensive treatment/monitoring when they are not responding appropriately to treatment as an outpatient.

ITC has 3 distinct phases described below. Children aged less than 6 months shall be treated using specific protocols for this age group.

a. Phase 1/Stabilization: Patients with an inadequate appetite and/or an acute major medical complication shall be initially admitted for stabilization treatment. F75 shall be used during this phase to stabilize and reverse physiological and metabolic abnormalities and correct electrolyte imbalances. There is no expectation for wasted children to gain weight during Phase 1.

b. Transition Phase: This phase marks the transition from stabilization to OTC where these facilities exist, or to Phase 2 inpatient care when it is not possible to refer to OTC. Clinically, the return of appetite, and/or the improvement of clinical signs and symptoms related to the medical complication shall indicate entry into this phase. In this phase, the diet shall be transitioned from F75 to RUTF (or to therapeutic milk _ F100 for Phase 2 inpatient care). Wasted children start to gain weight, while children with edema may continue to lose weight until the edema is resolved. Once the child is taking the prescribed amount of RUTF and complications are adequately resolved they shall be referred to OTC to continue their treatment at home.

c. Phase 2: Where it is not possible to refer to OTC,'children shall remain as inpatients until cured of acute malnutrition. This phase shall continue treatment with F100 therapeutic milk or RUTF, increasing the intake so as to promote rapid weight gain. The child shall remain under treatment until the criteria for discharge are reached.

2. Outpatient Therapeutic Care (OTC) provides treatment for children with SAM who have appetite and no medical complications. These children can be treated at home with simple routine medicines and RUTF. All cases admitted to OTC shall be provided with oral antibiotics in line with IMCI guidelines.

3. Targeted Supplementary Feeding Program (TSFP) provides treatment for children with MAM. These children can be treated at home with RUSF or locally available supplementary food (fortified with micronutrient poWders) and intensive nutrition counselling plus routine health care (consistent with IMCI guidelines, outpatient treatment of infections or referral to hospitals), in line with

national Supplementary Feeding Guidelines

F. Recovery and Links with Existing Programs

The child being treated for acute malnutrition suffers from some combination of nutritional deficit and infection and often may come from the poorest families in the community.

In order to continue healthy growth and prevent relapse, follow up care shall be sought. Depending on services available locally, the following shall be considered by health and nutrition community workers and hospital staff:

1. Referral to a supplementary feeding program.

2. Strengthen on— going IYCF support coupled with intensive nutrition counselling (e. g. IYCF Peer counselling, Family Development Sessions, Pabasa sa Nutrisyon) with referral to milk bank facilities or provision for wet/ cross nursing options.

3. Micronutrient supplementation in line with national guidelines.

4. Referral to Mother support groups and activities on Promotion of Good Nutrition.

5. Enrollment in routine growth monitoring program Operation Timbang Plus (if not yet enrolled).

6. Referral to a food security and livelihood program.

7. Social welfare services available and referral to any relevant programs.

8. Ensure enrolment and coverage of the child and mother in Phil Health or other social safety nets, as required by the family.

G. Supplies and Logistics

1. The overall management of all drugs, supplies, therapeutic and supplementary commodities, and diagnostic I tools for PIMAM, and the development and dissemination of corresponding guidelines and protocols shall be the responsibility of the DOH and the local government units.

2. The local governmentunits shall ensure that policies and guidelines for SAM treatment supplies management are implemented properly at their level. They shall also actively participate in the monitoring and evaluation of the implementation of these policies and guidelines.

3. Quantification and ordering shall be based on utilization rate, projected 1ncrease of cases due to strengthened case finding and provision of buffer stocks for emergencies. Buffer stocks shall be

maintained at 20% to be lodged at the DOH Regional Offices or Provincial Health Offices as needed.

4. Medicines and nutrition supplies shall be stored under appropriate conditions and accounted for through proper recording and reporting. Stock status shall be reflected in the National Online Stock Inventory Reporting System (N OSIRS)

5. The DOH Regional Offices, PHOs, and CHOs shall ensure that drugs and diagnostic supplies are promptly distributed to the next level. The DOH Central Office shall deliver the commodities to the DOH Regional Offices. DOH Regional Offices shall deliver the commodities to the PHOs/CHOs. PHOs and CHOs shall ensure the prompt delivery of the commodities to RHUs/Hospitals which shall serve as the Point of Care under the Service Delivery Network.

6. Disposal of expired and damaged medicines and nutritional supplies shall follow government rules and regulations.

7. The DOH Regional Offices shall be responsible for the reproduction of all forms used 1n the treatment of SAM to be distributed to PHOs/CHOs, RHUs, and hospitals.

8. LGUs shall set aside funds for the emergency procurement of sufficient quantities of drugs and nutrition supplies in times of impending shortage to ensure continuous availability of SAM treatment commodities at their service delivery points.

Figure 1. Flowchart for Inpatient and Outpatient Therapeutic Care and TSFP.

H. Monitoring and Evaluation of PIMAM

1. Monitoring and data collection in order to report on PIMAM indicators shall be performed through meetings, registration and reporting from community and health facility level, and through specific assessments conducted at municipality level of coverage.

2. Monthly collation and analysis shall be performed at the health facilities. Quarterly and annual consolidated and analyzed reports shall be submitted to the next higher level using the prescribed schedules, forms and templates in line with the Manual of Operations.

3. Among the many indicators to be monitored in PIMAM, there are core indicators that can facilitate efficient monitoring and evaluation and even bottleneck analysis. The following SAM indicators shall be measured both at the community and the facility level disaggregated by age and

gender:

a. Number of admissions — total number of SAM children admitted into the program during the reporting month.

b. SAM Cure Rate — number of admitted SAM children < 5 years successfully discharged cured as a percentage of all discharged SAM cases during the reporting month; Discharge is the sum of children cured, died, defaulted, and non-cured (Target: >75% cured).

c. SAM Default Rate — number of admitted SAM children < 5 years who defaulted (recorded as absent for 3 consecutive sessions - 3 visits in OTC or 3 days in ITC) as a percentage of all discharges during the reporting month (Target: < 15% defaulted).

d. SAM Death Rate -— number of admitted SAM children < 5 years who died during treatment as a percentage of all discharges during the reporting month (Target: < 10% died).

e. SAM Non-Cured Rate w number of admitted SAM children < 5 years discharged as non-cured as a percentage of all discharged SAM cases during the reporting month; non-cured is defined as not reaching discharge criteria after 4 months in the program as long as all possible interventions and follow-up have been attempted.

f. RUTF or F75 Stock-out Rate — number of health facilities with stock-outs of RUTF or F75 in the last 3 months as a percentage of all health facilities managing these commodities.

g. SAM Human Resources Rate —- number of health workers who have been trained on SAM management as a percentage of all health workers in SAM implementation/target areas.

h. Geographical Access — number of health facilities offering SAM treatment as a percentage of all health facilities 1n SAM implementation/target areas.

i. Utilization Rate —~ number of children < 5 with SAM who were admitted for SAM treatment as a percentage of identified SAM cases in implementation/target areas).

The following MAM indicators shall be measured by all PIMAM implementers and program managers:

a. MAM Cure Rate — proportion of children 6-59 months with MAM discharged as cured out of total number of discharged MAM cases; Discharge is the sum of children cured, died, defaulted, transferred (children who transferred from one SFP to another), and non-responder (Target: > 75%).

b. MAM Default Rate — proportion of children 6-59 months with MAM recorded as ' absent for 3 consecutive sessions out of total number of discharged MAM cases (Target: < 15%).

c. MAM Death Rate — proportion of children 6- 59 months with MAM who died while in treatment out of total discharged MAM cases (Target: < 3%).

d. MAM Non-Responder Rate - proportion of children 6-59 months with MAM who had been referred for medical investigation and are discharged non-responder according to discharge criteria after 4 months of treatment out of total discharged MAM cases (Target: < 15%).

I. PIMAM in Emergencies and Disasters

a. Where PIMAM is implemented, a support for BNS / BHW in screening for cases of SAM in the community, aiming to augment rather than replace current services; volunteers / assistants may provide ancillary help at the BHS / RHU.

- Provision of mobile OTC teams for communities unable to access health care and/or the establishment of temporary OTC sites in camps where health centers and / or health staff are affected by disaster.
- Provision of additional resources such as medicines and RUTF — based on calculated post-emergency caseload; buffer stocks from regular program may be used to ensure that children who need. it are provided the service immediately.
- Implementation of IYCF in emergencies services.
- Temporary ITC sites if hospital services for cases of SAM with complications where hospital services become inaccessible.
- If TSFP is available, ensure proper screening and referral of children with MAM.

b. Where no SAM treatment service is currently implemented, the implementation will likely require the assistance of neighboring local government units or local or international NGOs with previous experience on PIMAM. Coordination of programming for the treatment of SAM shall be done through the relevant local authorities and the Nutrition Cluster.

-The focus is on achieving high treatment coverage and early admission to treatment before complications can develop. As such, community mobilization and OTC services shall always be prioritized over ITC.
-Before implementation, the emergency program must have a well-defined and sustainable 'transition strategy'.

VIII. IMPLEMENTING MECHANISMS A. Roles and Responsibilities

1. Department of Health Central Office: The Heads of the Technical Services and Health Operations Clusters, shall oversee that these guidelines are implemented in the different offices of the Department.

DOH-Central Office shall:

a. Create the National Program Management Team (NPMT) and serve as the policy- making body

and leader in promoting the importance of standardized PIMAM services both during development and times of emergencies and disasters among the government and private sector including planners, decision makers, policy makers and-the general public.

b. Formulate, in coordination with members of the Health Sector, and implement policies, guidelines, protocols and standards and service packages and integrate all related programs to allow a holistic approach, not just focusing on malnutrition.

c. Provide assistance and guidance to all implementing agencies in strengthening and financing service delivery.

d. Provide training on the guidelines/protocol to "relevant stakeholders; conduct dialogues with relevant Stakeholders and review the implementation of the program

e. Spearhead the conduct of studies, management of information, and documentation of best practices to support and initiate evidence-based reforms.

Disease Prevention and Control Bureau (DPCB) shall:

a. As the NPMT lead, ensure that all of the functions set by the NPMT shall be carried out effectively and efficiently.

b. Regularly convene the NPMT to plan and address issues and other concerns that may arise during the course of the scale—up and program implementation and provide members with the program technical and administrative updates.

c. Generate additional membership of potential partners for an enhanced program implementation. '

d. Lead in the integration, standardization, and dissemination of indicators, tools, and recording and reporting forms. -

e. Facilitate the report (number and status of cases, interventions done, utilization of logistics) generation and analysis per facility and generate evidences and studies based on programming data and coordinate with relevant DOH Bureaus/Offices for integration.

f. Ensure that storage facilities have at least a 20% buffer stock of therapeutic products and routine medicines for the treatment of SAM and other materials and tools to last for 3 months.

g. Address possible issues and concerns on procurement or production of logistical. needs (RUTF/RUSF, MUAC tapes, weighing scales, height boards, standard weights for calibration-2kg).

h. Facilitate the development of system for inventory, transport and tracking of necessary logistics to the end—user.

National Nutrition Council (NNC) shall:

a. As NPMT co-lead, provide assistance to the DPCB in the fulfillment of the functions set for PIMAM implementation in the country.

b. Provide both Technical / Management support.

c. Utilize the existing Philippine Plan of Action for Nutrition (PPAN) strategy for enhancing the effective PIMAM program implementation, specifically it shall incorporate the program's screening activity in the conduct of the regular Operation Timbang (OPT) and annual Monitoring and Evaluation of Local Level Program Implementation (MELLPI).

d. Generate support from the council members to facilitate the effective and efficient PIMAM program implementation.

Health Emergency Management Bureau (HEMB) shall:

a. Serve as the lead coordinating office for the Quad cluster during times of emergencies and disasters and provide support to the National Nutrition Cluster.

b. Facilitate the coordination of response activities and information sharing among DOH Offices and Bureaus and cluster partners during emergencies.

c. Coordinate the augmentation of human resource and logistics in emergencies when assistance from the national government is needed.

d. Ensure the integration of PIMAM indicators in the SPEED and HEARS reporting systems for emergencies and disasters.

Health Promotion and Communication Service (HPCS) shall:

a. Lead in the advocacy and promotion activities.

b. Develop and produce appropriate advocacy and communication strategies, IEC materials and collaterals.

c. Support the NPMT 1n the dissemination of the IEC materials and collaterals.

d. Provide technical assistance in the local version translation of the IEC materials.

Epidemiology Bureau (EB) shall:

a. With the NPMT, facilitate the integration and consequent updating of PIMAM indicators under

the F SHIS and regular reporting systems of the department.

b. Support enhancement of surveillance systems and facilitate information sharing among DOH Bureaus and Units and cluster partners especially on cases of communicable diseases.

Bureau of Local Health Systems and Development (BLHSD) shall:

a. Support the advocacy for the implementation of PIMAM program in all LGUs.

b. Spearhead the integration of PIMAM program performance indicators in the LGU scorecard and to provide technical assistance in the conduct of M&E.

Health Facility Development Bureau (HFDB) shall:

a. Facilitate the setting up and/ or dedication of ITC areas in all hospitals with due priority for DOH Hospitals.

b. Provide technical support to ITCs through the dietary department in all hospitals.

c. Facilitate the organization and conduct of the capacity development for ITC.

Health Facilities and Services Regulatory Bureau (HFSRB) shall identify specific PIMAM requirements that will be incorporated in the checklist for routine licensing applications (new and renewal of license) of health facilities and PHILHEALTH I accreditation.

Knowledge Management Information Technology Service (KMITS) shall provide technical assistance to the NPMT in ensuring the functionality, maintenance, and integration of PIMAM into existing health information management systems (iClinicsys, PHIE, FHSIS, PIDSR, disease registries, and others).

Pharmaceutical Division shall expedite the registration of PIMAM commodities in the PNDF and issuance of clearance for commodities, drugs and medicines as needed.

Food and Drug Administration (FDA) shall:

a. Provide technical assistance in the acceptance of international and local donations, especially food and drugs.

b. Facilitate the acceptance and clearance of food, drugs and supplies which are necessary for PIMAM program implementation. '

Health Human Resource Development Bureau (HHRDB) shall:

a. In coordination with other NPMT members, standardize the training of trainers (PIMAM, active

screening, Essential Nutrition Action, Breast feeding community Initiative, mother-to-mother network group).

b. Develop or conduct other related learning and educational development activities.

Bureau of International Health Cooperation (BIHC) shall:

a. Facilitate the processing of international donations of commodities or grants,

b. Facilitate the acceptance of international donations of foods, drugs and supplies, and administer such in accordance with the terms of the grant or donation.

Health Policy Development and Planning Bureau (HPDPB) shall, in coordination with other NPMT members, review and provide technical assistance in the development of the PIMAM protocol.

2. DOH Regional Offices and National Nutrition Council Regional Offices

The DOH Regional Directors shall directly oversee the implementation and adoption of these policies within their Regions, create Regional PIMAM management teams, and provide feedback, suggestions, and policy recommendations to the Secretary of Health.

The Regional PIMAM Management Teams, led by the Family Health Medical Officer, shall be responsible for the implementation and adoption of these guidelines in their respective regions.

The Regional Offices for Health, being the lead of the PIMAM Regional Management Team, and Regional National Nutrition Councils, as co-lead, shall:

a. Formulate plans, procedures and protocols to implement this policy and guidelines.

b. Provide and implement a mechanism of coordination and collaboration with hospitals (both government and private), LGUs, partners, and other stakeholders, to ensure the timely and effective service delivery.

c. Support monitoring and evaluation activities.

d. Provide technical assistance and logistics support to implementing agencies and regions. Design, update, and conduct necessary training to enhance capabilities of PIMAM implementers.

e. Conduct studies and facilitate technical resource development that will contribute to improving service delivery.

f. Identify, develop and enhance capacity of the members of the health and nutrition sector.

g. Plan for and manage supplies efficiently and effectively.

h. Develop/improve and sustain a safe and efficient referral system of children with acute malnutrition.

i. Through the respective Development Management Officers, ensure the supportive supervision, monitoring, and coordination of PIMAM implementation at the LGU level including logistics coordination.

3. Local Government Units

"The Provincial/Municipal/City Chief Executives shall directly oversee the implementation and adoption of these policies within their locality, create Local PIMAM

Management Teams, and provide feedback, suggestions, and policy recommendations to the Regional Offices for Health.

The Local PIMAM Management Team, led by the Provincial/City/Municipal Health Officer, shall be responsible for the implementation and adoption of these guidelines in their respective locality. They shall report to the Provincial/City/Municipal Chief Executive.

The LGUs shall:

a. Institutionalize (structure, organization and policies, people, resources, systems, partners) health emergency management in their responsible areas.

b. Formulate plans, procedures and protocols to implement their policy and guidelines

c. Enforce existing local policies and guidelines.

d. Consider the principles set in this policy in their respective health and nutrition plans and systems.

e. Identify, develop and enhance capacity of the members of the health and nutrition sector.

f. Plan for and manage supplies efficiently and effectively.

g. With support from the Regional Offices for Health, develop/improve and sustain a safe and efficient referral system of children with acute malnutrition in their respective LGUs.

4. Hospitals

The Medical Center Chiefs/Chief of Hospitals shall administer these-regulations and- support all the policies and guidelines mentioned in this Order. He/she shall lead in the dissemination of these

guidelines, their integration of the same in the hospital and the creation of Hospital PIMAM Management Teams. He/ she shall ensure the availability of personnel and funds to suppert all the needed training and responses. He/ she shall submit reports to the respective Regional Office, LGU, or DOH-CO.

The Hospital PIMAM Management Team, led by the Chief of Clinics, shall directly oversee the implementation of these guidelines in their respective hospitals. He/ she shall report to the Chief of Hospital/Medical Center Chief.

Hospitals shall:

a. Formulate plans, procedures and protocols to implement this policy and guidelines.

b. Implement all policies, and adhere to all standards, requirements and systems.

c. Provide and implement a mechanism of coordination and collaboration with hospitals (both government and private), LGUs, partners, and other stakeholders, to ensure the timely and effective service delivery.

d. Support monitoring and evaluation activities.

5. Philippine Health Insurance Corporation shall develop strategies to ensure coverage for children requiring treatment of severe acute malnutrition including, but not limited to: out—patient treatment with routine medicines and therapeutic food provided in capacitated health facilities, in—patient treatment of severe acute malnutrition with medical complications, reimbursements, point-of-care service delivery in non-PhilHealth accredited institutions/health service providers during emergencies and disasters.

6. Other Government Agencies shall

a. Adopt these guidelines in their offices, as appropriate, and provide feedback and report sensitive interventions with the DOH.

b. Adhere to and observe all requirements and standards on PIMAM especially those needed to respond to emergencies and disasters in accordance to the thrust of the Department of Health.

c. Coordinate and participate in inter-agency activities with the Department of Health on Health Emergency Management.

d. Support the DOH/LGUs/Hospitals in providing technical assistance (through the conduct of assessment or trainings) and logistics support, as appropriate.

7. Academe and Professional Societies shall:

a. Adopt these guidelines in their institutiononrganizations as appropriate and provide feedback and report to DOH nutrition sensitive interventions.

b. Adhere to and observe all requirements and standards on public health especially those needed to respond to emergencies and disasters 1n accordance to the thrust of meDOH. ' ' '

c. Coordinate and participate in inter-agency activities with the DOH.

d. Support the DOH/LGUs/Hospitals in providing technical assistance through the conduct of assessment or trainings.

e. Ensure that all curricula relevant to PIMAM are updated and implemented and that bodies of evidence on PIMAM are generated and disseminated.

8. Non-Government Organizations/Agencies, Development Partners Private Sector and Civil Society Groups shall:

a. Adopt these guidelines in their locality, as appropriate, and provide feedback and report to DOH.

b. Participate in information dissemination, advocacy activities and training.

c. Adhere to and observe all requirements and standards needed to respond to emergencies and disasters in accordance to the thrust of the Department of Health.

d. Provide development/technical assistance to strengthen capacities and systems during scale-up and implementation of the program consistent with the above principles.

e. Coordinate with appropriate DOH Offices for assistance in the implementation of this policy and services during development and emergencies.

IX. REPEALING Clause

All orders, rules and regulations or any provisions thereof inconsistent with this Order are hereby repealed and modified accordingly.

X. EFFECTIVITY

This Order shall take effect immediately.

JANETTE P. LORETO-GARIN, M.D., MBA-H
Secretary of Health