



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

May 23, 2005

ADMINISTRATIVE ORDER
No. 2005-0014

SUBJECT: National Policies on Infant and Young Child Feeding

I. BACKGROUND AND RATIONALE

Under-five mortality has declined from 54 to 48 to 40 percent as reported in the 1993, NDHS, the 1998 NDHS and the 2003 NDHS respectively. Yet, malnutrition remains a challenge in the Philippines, directly or indirectly responsible for around 60 percent of deaths among children under five years old. Only 68 percent of children 0-5 years old are normal in weight — for-age using the NCHS/ WHO standards (1998 NDHS, FNRI). On the other hand, based on the 2003 National Nutrition Survey, 27.6 percent of the same age is underweight and 30 percent are stunted. Low birth babies were about 13 percent (2003 NDHS).

As of the latest NDHS (2003), report shows that early initiation of breastfeeding within an hour after birth occurred in 54 percent of newborns. Thirteen percent of children born five years before the survey were never breastfed. Only 33.5 percent of infants less than 6 months old are exclusively breastfed but exclusive breastfeeding is very low for 4-5 months at 16 percent. The median duration of exclusive breastfeeding in the Philippines is very short for only less than a month.

The median duration of breastfeeding is fourteen months and children in the rural areas are breastfed longer by ten months than those in the urban areas. Children whose mothers have no or little education are breastfed three times longer than those whose mothers have college education. Mothers whose deliveries are attended by traditional birth attendants are more likely to breastfeed and breastfed longer than those mothers whose deliveries are assisted by medically trained personnel (83 percent compared with 93 percent). Similarly, children delivered in a health facility are less likely to be breastfed than those who were born at home (81 and 90 percent respectively).

Complementary feeding starts very early in the Philippines as shown by the 2003 NDHS report. Among breastfeeding infants under two months of age, 14 percent are given infant formula, 5 percent are given other milk/cheese/yogurt, and 6 percent each received other liquids and solid or semisolid food. The same report shows that 87 percent of 6-7 months old infants were given any solid or semisolid food.

The decline of breastfeeding, compounded by inappropriate complementary feeding practices, is a cause for alarm because of the consequent undernutrition and risk for childhood mortality and morbidity.

The Global Strategy for Infant and Young Child Feeding jointly developed by the World Health Organization and UNICEF is the result of a comprehensive two-year participatory process and grounded on the best available scientific and epidemiological evidence. The Strategy emphasized the need for comprehensive national policies on infant and young child feeding.

The Philippines adopted this strategy to revitalize our attention and commitment to infant and young child nutrition and its impact on survival and development of children.

This policy will serve as a guide for health workers and other concerned parties on infant and young child (1-3 yrs.) feeding including appropriate feeding practices in exceptionally difficult circumstances and ensuring the protection, promotion and support of exclusive breastfeeding and timely and adequate complementary feeding with continued breastfeeding.

II. Guiding Principles

This policy framework is guided by the following principles:

1. The 1987 Philippine Constitution mandates through Article XV Section 3, that “The State shall defend the right of children to assistance including proper care and nutrition, special protection from all forms of neglect, abuse, cruelty, exploitation, and other conditions prejudicial to their development.
2. This framework is a way of renewing the country’s commitment to the UN Convention on the Rights of the Child, and a response to the Executive Order 310 dated November 3, 2000, which mandates the adoption and implementation of the National Strategic Framework for Plan Development for Children, 2000-2025 (Child 21).
3. The policy framework will build on gains and achievements of the implementation of existing laws, policies and initiatives specifically: Executive Order 51 — Philippine Code of Marketing of Breast-milk Substitutes (1986); Republic Act 7600 — “ The Rooming —In and Breastfeeding Act of 1992” - February 5, 1992; Republic Act No. 8172 — An Act Promoting Salt Iodization Nationwide and For Related Purposes (ASIN Law); Republic Act 8976 — An Act Establishing the Philippine Food Fortification Program and for Other Purposes- Food Fortification Law; Republic Act No. 8980 — An Act Promulgating a Comprehensive Policy and A National System for Early Childhood and Development (ECCD) Providing Funds Therefore and For Other Purposes or ECCD Act; and the Philippine Plan of Action for Nutrition 1999-2004.
4. The policy framework is a response to Executive Order 286 issued by the President of the Philippines on February 23, 2004, directing national government agencies and other concerned agencies to actively support and implement programs on the “Bright Child”. All members of the

Council for the Welfare of Children / National ECCD Coordinating Council in partnership with the local governments, communities and families shall promote the Bright Child by pursuing the delivery of integrated services at home and facility

III. PROGRAM GOALS AND OBJECTIVES

General Objective:

The overall objective is to improve the survival of infants and young children by improving their nutritional status, growth and development through optimal feeding.

Specific objectives:

- All newborns are initiated to breastfeeding within one hour after birth
- All infants are exclusively breastfed for 6 months
- All infants are given timely, adequate and safe complementary foods
- Breastfeeding is continued up to two years and beyond

IV. COVERAGE AND SCOPE

This policy shall cover the whole health sector, whether government or private, including professional groups, private sector, LGUs, and other stakeholders at all levels nationwide.

V. POLICY GUIDELINES

A. Target Beneficiaries

- Infants, 0-11 months
- Young children, 1 year up to 3 years old

B. Breastfeeding Practices

1. Early Initiation of Breastfeeding.

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants. It is also an integral part of the reproductive process with important implications for the health of mothers. Infants shall be initiated to breastfeeding within one hour after birth. This will stimulate early onset of full milk production and promote bonding of mother and child. All medically trained personnel including doctors, nurses, and midwives and other birth attendants shall ensure that newborns are supported to their early initiation to breastfeeding. The health care delivery system in all facilities shall ensure that all newborns are initiated to breastfeeding within an hour after delivery.

2. Exclusive Breastfeeding for the first six months.

Infants shall be exclusively breastfed for the first six months of life to achieve optimum growth and development. Exclusive breastfeeding means giving breastmilk alone and no other foods or drinks, not even water, with the exception of vitamins and medicine drops. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production. The conclusion of experts in their systematic review of the optimal duration of breastfeeding that there was no observable deficits in growth for infants exclusively breastfed for 6 or more months. In addition, this also reduces morbidity due to gastrointestinal infections and their mothers are more likely to remain amenorrheic for six months postpartum.

3. Extended breastfeeding up to two years and beyond.

Breastfeeding shall be continued as frequent and on demand for up to two years of age and beyond. Although volume of breast-milk consumed declines as complementary foods are added, breast-milk contribute significantly as it provides one third to two thirds of average total energy intake towards the end of first year (Prentice, 1991, Heining et al, 1992a).

B. Complementary Feeding Practices

1. Appropriate complementary feeding.

Infants shall be given appropriate complementary foods at age six months in order to meet their evolving nutritional requirements. Appropriate complementary feeding means:

- a. timely — meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding;
- b. adequate — — meaning that they provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs;
- c. safe — meaning that they are hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats or artificial nipples;
- d. properly fed — meaning that they are given consistent with a child's signals of appetite and satiety, and that meal frequency and feeding method — actively encouraging the child, even during illness, to consume sufficient food using fingers, spoon or self-feeding — are suitable for age.

2. Ensure access to appropriate complementary foods.

Appropriate complementary feeding interventions shall encourage diversified approaches to ensure access to foods that will adequately meet energy and nutrient needs of growing children, such as use of home— and community-based technologies to enhance nutrient density, bio-availability and the micronutrient content of local foods.

3. Use of locally available and culturally acceptable foods.

Appropriate complementary food shall include locally available and culturally acceptable foods that meet the energy and nutrient need of young children. Mothers, particularly of infants and young children, shall be provided with sound and culture-specific nutrition counselling and recommendations of a widest array of indigenous foodstuffs. The agriculture sector has a particularly important role to play in ensuring that suitable foods for use in complementary feeding are produced, readily available and affordable.

4. Low-cost complementary foods / industrially processed foods.

In addition, low—cost complementary foods, prepared with locally available ingredients using suitable small-scale production technologies in community settings, shall be encouraged to meet the nutritional needs of older infants and young children. Industrially processed complementary foods also provide an option for some mothers who have the means to buy them and the knowledge and facilities to prepare and feed them safely. Processed—food products for infants and young children shall, when sold or otherwise distributed, meet applicable standards recommended by the Codex Alimentarius Commission and also the Codex Code of Hygienic Practice for Foods for Infants and children.

D. Micronutrient supplementation

Based on DOH Administrative Order 119 s. 2003 dated December 2, 2003 issued by the Secretary of Health - Updated Guidelines on Micronutrient supplementation, the following are the priority targets for micronutrient supplementation:

- Universal Vitamin A supplementation shall continue to be provided to infants and children 6-71 months of age. Vitamin A supplementation shall be given to children at risk, particularly those with measles, persistent diarrhea, severe pneumonia and malnutrition to help re-establish body reserves of Vitamin A and protect against severity of subsequent infections and or prevent complications. Postpartum women shall be given Vitamin A capsule within one month after delivery to increase Vitamin A concentration of her breastmilk as well as Vitamin A status of their breastfed children. Children with xerophthalmia, although rare, shall be treated. Children during emergencies shall be a priority for Vitamin A supplementation following schedule for universal supplementation and for high-risk children.
- Iron supplementation shall be provided to pregnant and lactating women and low birth weight babies and children 6-11 months of age. In addition, anemic and underweight children 1-5 years of age shall also be provided with iron supplements.
- Iodine supplementation shall be provided to women of reproductive age group, school age children and adult males in areas when the urinary iodine excretion of less than 50ug/L in more than 20% of the population, goiter prevalence among school children is greater than 5% and high

prevalence of goiter among males.

E. Universal salt iodization (USI).

Families shall be encouraged and educated to use iodized salt in the preparation of food for older infants and young children.

F. Food Fortification.

Food fortification of staple foods will help ensure that older infants and young children receive adequate amounts of micronutrients. The Department of Health as mandated by law shall also continue to encourage manufacturers to fortify processed foods and food products based on the BFAD standards.

G. Exercising other feeding options

- Most mothers can and should breastfeed, just as most infants can and should be breastfed.
- For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative — expressed breast milk from an infant's own mother, breast milk from a healthy wet—nurse or a human - milk bank, or a breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat - depends on individual circumstances.
- Only under exceptional circumstances can a mother's milk be considered unsuitable for her infant. There are three metabolic disorders that may interfere with breastfeeding, namely galactosemia, phenylketonuria and maple syrup urine disease.
 - a) Galactosemia - infants suffering from this disease cannot be fed either breastmilk or other infant or milk formula since lactose must be eliminated from the diet of these infants. Specially formulated milk-based, but lactose-free preparations or soya—based formula are required.
 - b) Phenylketonuria — infants suffering from phenylketonuria may be breastfed while their phenylalanine blood levels are monitored. Breastmilk should be supplemented with or replaced by a special low-phenylalanine formula if concentrations reach dangerous levels
 - c) Maple syrup urine disease — as in the case of phenylketonuria, breastmilk can be combined with special synthetic formulas low in the non-tolerated amino acids.
- Feeding with a suitable breastmilk substitute
 - In limited cases, for infants who do not receive breast milk, feeding with a suitable breast-milk substitute — for example an infant formula or other specially prepared formula that conform with applicable Codex Alimentarius standards, or a home-prepared formula with micronutrient supplements — — shall be demonstrated only by health workers, or other community workers if

necessary, and only to the mothers and other family members who need to use it; and the information given shall include adequate instructions for appropriate preparation and the health hazards of inappropriate preparation and use. Infants who are not breastfed, for whatever reason, shall receive special attention from the health and social welfare system since they constitute a risk group.

F. Feeding in exceptionally difficult circumstances

1. As a general rule, the following is the range of feeding options for infants and young children in certain circumstances and during times of crisis:

- a) Breastfeeding is the first and best feeding option for infants
- b) Expressed breastmilk, fed by cup
- c) Breastfeeding from healthy wet nurse
- d) Human milk from milk bank, fed by cup
- e) Infant formula, (preferably generically labelled), fed by cup

2. Families in difficult situations including but not limited to natural or human—induced calamities, shall require special attention and practical support to be able to feed their children adequately. Wherever possible, mothers and babies shall remain together and be provided the support they need to exercise the most appropriate feeding option under the circumstances.

3. Health workers shall ensure the protection, promotion and support on breastfeeding and timely, safe and appropriate complementary feeding. In exceptional cases, when a small number of infants have to be fed on breast-milk substitutes and milk supplements, ensure that substitutes/supplements, such as infant formula is safe, suitable and prepared in accordance with applicable Codex Alimentarius standards, or a home—prepared formula with micronutrient supplements.

4. Artificial feeding is difficult in these situations because the basic needs for artificial feeding such as clean water, fuel and utensils are scarce. Transport and adequate storage conditions of breastmilk substitutes cause additional problems. To minimize the risks of artificial feeding and avoid commercial exploitation of crises, the following procedures are recommended:

a) donations of breastmilk substitutes, feeding bottles, teats and commercial baby foods should be limited, if not refused

b) if needed, breastmilk substitutes should never be part of a general distribution. Distribution should only be to infants with a clear need, and for as long as the infant need them (until a maximum of 1 year or until breastfeeding is re-established).

c) Bottles and teats should never be distributed, and their use should be discouraged. Cup feeding should be encouraged instead.

d) Information on adequate preparation and the hazards of inappropriate preparation of breastmilk

substitutes or milk supplements should be given.

e) Uncontrolled distribution of infant formula or milk supplements during difficult situations can lead to early and unnecessary cessation of breastfeeding. More detailed guidelines shall be developed in collaboration with the national disaster coordinating body and health teams and provided to local government units and others concerned.

5. Infants and young children who are malnourished are most often found in environments where improving the quality and quantity of food intake is particularly problematic. To prevent a recurrence and to overcome the effects of chronic malnutrition, these children need extra attention both during the early rehabilitation phase and over the longer term. Nutritionally adequate and safe complementary foods may be particularly difficult to obtain and dietary supplements may be required for these children. Continued frequent breastfeeding and, when necessary, relactation are important preventive steps since malnutrition often has its origin in inadequate or disrupted breastfeeding.

6. The proportion of infants with low birth weight is about 13%. Most are born at or near term and can breastfeed within the first hour after birth. Breast milk is particularly important for preterm infants and the small proportion of term infants with very low birth weight; they are at increased risk of infection, long-term ill health and death.

Feeding options for HIV positive mothers.

Despite that HIV infection is reported to be slow and low in the Philippines, there is a need to address concern on the absolute risk of HIV transmission through breastfeeding for more than one year, which is globally between 10-20%. On the other hand, there is a need to balance the concern of HIV transmission through breastfeeding with the increased risk of morbidity and mortality when infants are not breastfed. All HIV-infected mothers shall receive counselling, which includes provision of general information about meeting their own nutritional requirements and about the risks and benefits of various feeding options, and specific guidance in selecting the option most likely to be suitable for their situation. Feeding options for HIV positive mothers include exclusive breastfeeding, wet-nursing, expressing and heat-treating breastmilk, breastmilk from banks, commercial infant formula and home modified animal milk. Mothers shall be supported in their feeding options.

Children living in special circumstances.

Children living in special circumstances also require extra attention — for example, orphans and children in foster care, and children born to adolescent mothers, mothers suffering from physical or mental disabilities, drug— or alcohol-dependence, or mothers who are imprisoned or part of disadvantaged or otherwise marginalized populations.

G. SUPPORT SYSTEMS

1. Mothers, fathers and other caregivers shall have access to objective, consistent and complete information about appropriate feeding practices, free from commercial influence. In particular, they need to know about the recommended period of early initiation, exclusive and continued breastfeeding; the timing of the introduction of complementary foods; what types of food to give, the quantity, frequency; and how to feed these foods safely. Where fathers are concerned, research shows that breast-feeding is enhanced by the support and companionship they provide as family providers and caregivers.

2. Mothers shall have access to skilled support to help them initiate and sustain appropriate feeding practices, and to prevent difficulties and overcome them when they occur. Knowledgeable health workers are well placed to provide this support, which shall be a routine part not only of regular prenatal, delivery and postnatal care but also of services provided for the well baby and sick child

3. "Infant and Young Child Feeding Specialist" to respond to common problems of mothers to initiate and sustain exclusive and continued breastfeeding practices and other feeding difficulties shall be accessible to mothers. The most common reasons for never breastfeeding and those who stop breastfeeding include insufficient milk, breast and nipple problem, weaning age and child refusal can be corrected through objective, consistent, accurate and complete information. Some of these problems need an expert to assist mothers to breastfeed. This specialist can be a doctor, nurse, midwife or an effective community health volunteer who have undergone an appropriate training.

4. Community-based networks offering mother-to-mother support, and trained breastfeeding counsellors working within, or closely with, the health care system, also have an important role to play in this regard.

5. A communication and marketing plan shall be developed to generate high political support at all levels including communities and families.

6. The Mother Baby Friendly Hospital Initiatives (MBFHI) shall be reviewed, accelerated and sustained. Efforts shall focus on the sustenance of certified MBF hospitals in the country to comply with the 10 steps to Successful Breastfeeding. Expansion of the initiatives to other hospitals, health centers and clinics shall be part of the acceleration strategy.

7. The Rooming In and Breastfeeding Act (RA. 7600) shall be strictly enforced in all the hospitals of the country to ensure the fulfilment of the right of mothers to breastfeed and right of children to be breastfed. Rooming - In facilitates mother and child bonding and early full milk production since breastfeeding is on demand.

8. All health facilities, public or private, in the health care system in the Philippines shall provide a supportive environment to Infant and Young Feeding practices through compliance to the Philippine Code of Marketing of Breast-milk Substitutes. The facility shall not display any breastmilk substitutes or any poster or sampling of such but instead provide an enabling environment to improve and promote breastfeeding and appropriate complementary feeding practices for infants and health and nutrition of mothers.

9. Hospitals shall support and provide an enabling environment for mothers to ensure continued breastfeeding and adequate complementary feeding to their hospitalised sick children. Whenever feasible, mothers shall be allowed their breastfed children to stay with their hospitalised sick mother.

10. Continuing training programs for promoting, protecting, support and improving Infant and Young Feeding shall be institutionalised for pre-service and in-service health providers. Knowledgeable health workers with the right attitude and practice can make a difference in the growth and development of children.

11. Work places Shall provide an enabling environment for breastfeeding mothers who return to work. This can include breastfeeding rooms, refrigerators for storage of breastmilk, creches, and breaks for breastfeeding or expressing milk among others. Ten steps shall also be defined to facilitate systematic implementation.

12. Mothers shall also be able to continue breastfeeding and caring for their children after they return to paid employment. This can be accomplished by implementing maternity protection legislation and related measures consistent with ILO Maternity Protection Convention, 2000 No. 183 and Maternity Protection Recommendation, 2000 No. 191. Maternity leave, day-care facilities and paid breastfeeding breaks shall be available for all women employed outside the home.

13. The Department of Health as the lead agency shall ensure the fulfillment of the rights of children to the highest attainable standard of health care and nutrition. It shall enjoin all partners from both the government and non-government and private sector and from the international organizations to form a strong alliance for the fulfilment of the IYCF Strategy's aims and objectives.

14. Consistent with the accepted principles for avoiding conflict of interest, The Department shall not forge partnerships with manufacturers and distributors of infant formula, milk supplements, complementary foods, feeding bottles and teats and other related products.

VI. IMPLEMENTING MECHANISM

A. Management

1. At the national level, the over-all management of the IYCF shall be the responsibility of a Management Committee of the Department of Health. The chair of this Committee shall be the Undersecretary for Health Operations, co-chaired by the Undersecretary for External Affairs. The Directors, or their alternates of the following offices shall make up the members of the Management Committee:

- National Center for Disease Prevention and Control (NCDPC)
- National Center for Health Facility Development (NCHFD)

- Bureau of Food and Drugs (BFAD)
- Bureau of Health Facility Services (BHFS)
- National Center for Health Promotion (NCHP)
- Bureau of Local Health Development (BLHD)
- Dr. Jose Fabella Memorial Medical Center (also designated IYCF National Training Institution)

The NCDPC staff shall act as the Secretariat and convenor of the Committee.

2. National IYCF Coordinators or focal persons from concerned offices shall be designated for the major components of the program:

- Mother and Baby Friendly Hospital Initiatives — NCHFD
- Enforcement of E.O. 51 (Milk Code) and R.A. 7600 — BFAD
- Public Health Initiatives - NCDPC

3. An IYCF Interagency Group shall be created to provide technical assistance to the DOH in planning, coordination, monitoring, evaluation and research. It shall recommend policies, guidelines and standards on IYCF. This interagency group shall be composed of representatives from government and nongovernment organizations, international organizations, health professionals and private sector.

4. Designation of coordinators at different levels at regional / provincial / city shall also be pursued to accelerate IYCF and sustain the gains in MBFHI in the nineties.

5. Existing multi-sectoral functional committees at regional / provincial / city / municipalities shall be mobilized to perform similar functions with that of the national interagency group

B. Supervision, Monitoring and Evaluation

1. Periodic monitoring and evaluation of the progress of the implementation of the IYCF Strategy shall be established, institutionalized and integrated with other MCH reviews. Indicators shall be defined and agreed upon by major stakeholders. Monitoring of the different indicators shall be integrated into the DOH Monitoring Coaching Team and the regular hospital assessment system.

2. National as well as regional monitoring teams shall be strengthened to ensure strict compliance to the laws in support of IYCF.

3. Incentive and Award system shall be planned to sustain efforts on promoting, protecting and improving infant and young child feeding. The National Nutrition Council gives regular awards for local government units. Indicators for IYCF shall be integrated into this award system.

4. Models of good practice shall be documented and disseminated to stakeholders including local government units.

C. Research and Development

Continuing clinical and population-based research and investigation of behavioural concerns are essential ingredients for improving feeding practices. Crucial areas include improving access to breastfeeding support, programmatic approaches and community—based interventions for improving breastfeeding and complementary feeding practices, improving maternal nutritional status and pregnancy outcome, and interventions for preventing mother—to—child transmission of HIV in relation to infant feeding.

VII. REPEALING CLAUSE

Any existing provisions of DC 76-A s. 1992 (Guidelines on Rooming—in, BF & Breastmilk Feeding), or issuances found inconsistent with this Order shall be repealed

VIII. EFFECTIVITY

This Order shall take effect immediately

MANUEL M. DAYRIT, MD, MSc
Secretary of Health