



Accelerate the reduction of malnutrition among pregnant and lactating women and children 0-2 years old

Malnutrition burden in the Philippines remains high

Protein calorie malnutrition

The proportion of Filipinos whose calorie intake is below minimum has significantly declined from 1993 to 2003 (see Figure 1). However, over half of Filipinos still do not meet daily caloric requirement. To reduce this to 34.1% by 2015 (MDG 1), the rate of reduction must be accelerated.

Stunting, wasting, and underweight

The proportions of stunted, wasted, and underweight children-under-five (CU5) have also not significantly reduced since the 90s (see Figure 2).

Micronutrient deficiency

This remains a serious concern. Prevalence of vitamin A deficiency (VAD) continues to increase among vulnerable age groups—children 5 years and

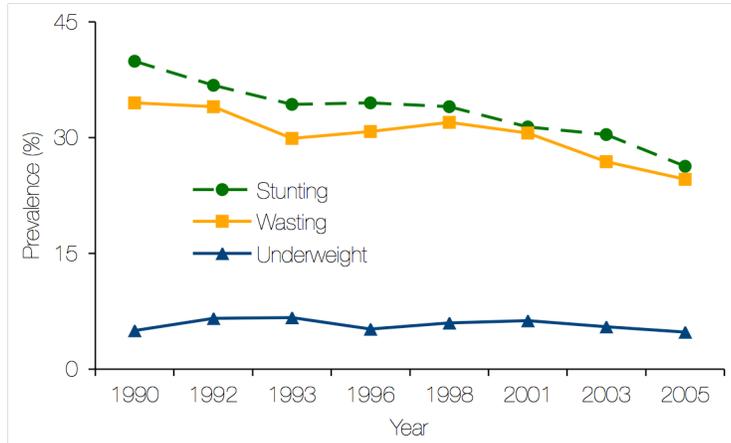


Figure 2. Prevalence of stunting, wasting and underweight among children, Philippines, 1990–2005

Source: DOST-FNRI, 2003; also in NNC, 2008.

below and pregnant and lactating women (see Figure 3 on next page). Prevalence of iron deficiency anemia (IDA) has not improved as well (see Figure 4 on next page).

Energy and micronutrient deficiencies, especially among both CU5 and pregnant and lactating women, are a serious public health concern as they may impair physical and mental development as well as increase the risk of dying (Bongga and Acuin, 2008).

Existing frameworks of the health sector in addressing malnutrition lack a common strategic focus

Malnutrition is a multi-sectoral concern. It needs to be addressed with both provision and access to adequate nutrition. The Accelerated Hunger Mitigation Program (AHMP) serves as one framework for nutrition interventions in the Philippines. Eighty-six percent (86%) of the National Nutrition Council’s budget for 2008 is allotted for the coordination and implementation of AHMP, which involves other sectors such as agriculture and education.

Interventions through the health sector spelled out in the AHMP include the conduct of social marketing and promotion of exclusive breastfeeding, appropriate complementary feeding, and increased consumption of vegetables. The health sector is also responsible for managing the population in order to protect access to adequate food and nutrition.



Figure 1. Proportion of Filipinos consuming below-minimum dietary energy requirement, 1993, 2003 and 2015

Source: DOST-FNRI, 2003; also in NNC, 2008.

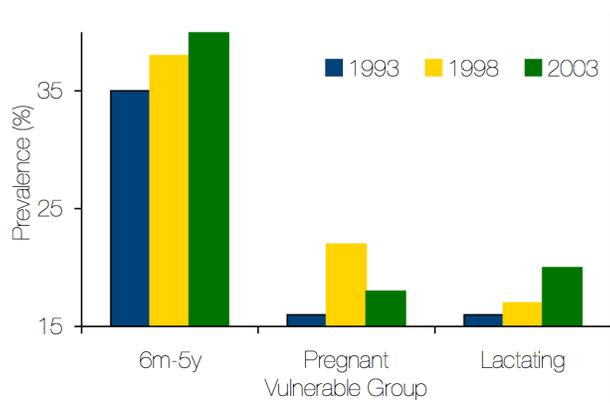


Figure 3. Vitamin A deficiency among pre-school, pregnant and lactating women, Philippines, 1993, 1998 and 2003

Source of data: DOST-FNRI, 2003

The Philippine Plan of Action for Nutrition (PPAN) also guides nutrition actions. It encourages the establishment of kitchen gardens and voluntary fortification of processed foods. It established mandatory fortification of salt with iodine, rice with iron, flour with iron and vitamin A, and sugar and cooking oil with vitamin A.

Based on PPAN, vitamin A and iron supplements are distributed to targeted population groups. School feeding programs and information, education, and communication (IEC) are used to promote good nutrition. PPAN employs a “life-cycle approach with strategic attention to adolescent females, pregnant/lactating women and children 0-3 years” (NNC website, 2008).

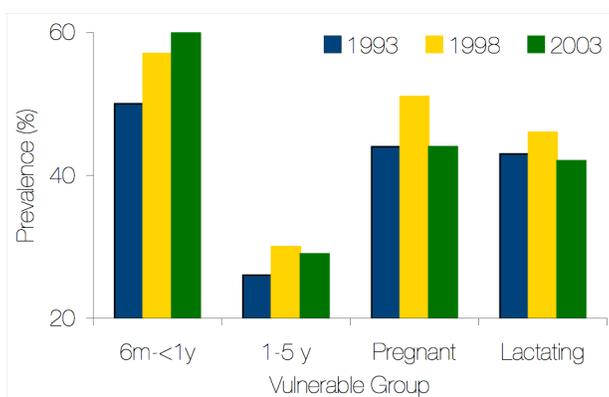


Figure 4. Trends in the prevalence of iron deficiency anemia, Philippines, 1993, 1998 and 2003

Source of data: DOST-FNRI, 2003.

Cross-country evidence shows that in order to maximize gains, nutrition interventions must focus on the window of opportunity, i.e., pregnancy through the first two years of life (World Bank, 2006; Bryce *et al.*, 2008). Any investments after this critical period are much less likely to improve nutrition (see Box 1). In order to take advantage of this window of

opportunity, most nutrition efforts should be directed to pregnant and lactating women and children below two years old. This will prove strategic in improving the nutrition status of Filipinos eight years into the MDG deadline.

Box 1. Gains from focusing nutrition interventions among pregnant and lactating women and children 0-2 years old

Nutrition interventions must focus on the “window of opportunity” because:

1. There is consensus that the damage to physical growth, brain development, and human capital formation that occurs during this period is extensive and largely irreversible.
2. There is also clear evidence that the major damage caused by malnutrition takes place in the womb and during the first two years of life; that this damage is irreversible; that it causes lower intelligence and reduced physical capacity, which in turn reduce productivity, slow economic growth, and perpetuate poverty.
3. There is clear evidence that malnutrition passes from generation to generation because stunted mothers are more likely to have underweight children. To break this cycle, the focus must be on preventing and treating malnutrition among pregnant women and children aged zero to two years.

Source: World Bank, 2006.

Some nutrition interventions in the country are found to be ineffective

Recent global studies also suggest that some of the country’s nutrition interventions are not effective in terms of addressing malnutrition. Preschool and school-age supplementary feeding programs are deemed inadvisable (Bhutta *et al.*, 2008) since stunting is especially difficult to reverse after 36 months of age. Moreover, rapid weight gain in later childhood is associated with adverse long-term outcomes.

Evidence suggests that behavior-change communication (BCC) and food supplements for children aged 6-23 months are more effective than food-support strategies that focus on underweight children under 5 years (Bhutta *et al.*, 2008). Thus, the use of resources could be maximized if these are to be shifted away from feeding programs targeting CU5 into IEC and food supplements for children below two years of age.

Available evidence on growth monitoring was not sufficient to support its use alone as an essential nutrition support (Bhutta, *et al.*, 2008). *Operation Timbang* should be accompanied with adequate nutrition counselling and referrals (see Box 2).

Box 2. Effective and ineffective nutrition interventions

Bryce *et al.* (2008) identified the following interventions as ineffective in terms of nutritional impact. All three are being implemented in the Philippines:

1. growth monitoring (ineffective unless linked to adequate nutrition counseling and referrals);
2. pre-school feeding programs targeting children over 24 months of age; and
3. school feeding programs targeting children older than 5 years of age.

Bryce *et al.* (2008) also identified the following selected interventions with proven efficacy in reducing under-nutrition, based on global studies:

1. maternal balanced energy-protein supplementation;
2. iron-folate supplementation;
3. universal salt iodization;
4. intermittent preventive treatment for malaria;
5. insecticide-treated bednets;
6. promotion of breastfeeding (individual and group counseling);
7. vitamin A supplementation, 6-59 months;
8. zinc supplementation;
9. zinc in management of diarrhea;
10. iron fortification;
11. iron supplementation;
12. treatment of severe acute malnutrition in children under 5 years in hospital consistent with WHO guidelines;
13. behavior change communication for improved complementary feeding;
14. conditional cash transfer programs (with nutritional education); and
15. interventions to improve hygiene.

Lessons emerging from international experience indicate that oversight agencies should not be given implementation responsibilities but there should be a clear division of responsibilities among implementing institutions (World Bank, 2006). NNC should make sure that nutrition efforts of the different agencies are aligned towards a coherent national strategy.

Securing commitment from these agencies is also crucial for the advancement of the nutrition situation in the country. To facilitate this, NNC should be able to influence inter-sectoral resource allocation “so it can give implementing agencies an incentive to perform” (World Bank, 2006).

As the chair of the NNC Governing Board, the Department of Health should exercise its technical leadership and authority in (1) clarifying the roles of NCDPC and NNC in reducing the burden of malnutrition; (2) defining and aligning the key nutrition priorities and programs of the two offices; and (3) ensuring that national nutrition policies and priorities are focused and effective.

Decision-making in the NNC Governing Board should be highly participative to ensure that its policy directions and strategic thrusts are congruent with those of its member agencies, and vice versa. If strategies were coherent and each member agency has a clear understanding of what it is expected to do vis-à-vis the other agencies, nutrition efforts in the country will not only be efficient but rationalized as well.

Nutrition interventions should be communicated to the LGUs as part of a coherent national strategy, regardless of ownership by NNC or NCDPC. Ambiguities should be settled at the national level so that implementation could push through effectively.

To scale up gains from nutrition programs, priorities and key interventions must focus on the window of opportunity

The health sector’s strategic nutrition policies and programs must be focused on reducing energy and micronutrient deficiency on the period from pregnancy through the first two years of life. To further the gains, nutrition interventions should be part of an integrated maternal-newborn-child health package.

Prevent early child and maternal malnutrition by promoting early and regular prenatal care. Include key nutrition services in prenatal care—nutrition counselling, iron with folate supplementation,

Coordination of national nutrition programs is not separate from implementation

The choice of existing nutrition interventions is a product of the current management system of nutrition programs in the country. Various line agencies are responsible in the national effort at addressing malnutrition, with oversight from the National Nutrition Council (NNC).

NNC does not only coordinate the different line agencies, it goes out of its way to develop and implement nutrition policies. Duplications arise between the roles of NNC and implementing agencies such as the National Center for Disease Prevention and Control (NCDPC). Ambiguity in role delineations could result to inefficient use, if not waste, of both human and physical resources. At the LGU level, this could cause confusion among implementers as to the chain of command.

de-worming the mother during the second trimester, and supplemental feeding.

Promote desirable infant and young child feeding and positive caring practices anchored on exclusive breastfeeding and proper complementary feeding.

Intensify the promotion of exclusive breastfeeding of infants up to at least 6 months after birth. Promotion efforts should be expanded to ensure that lactating mothers themselves are properly nourished.

Intensify the promotion of complementary feeding for infants at 6 months and the continuation of breastfeeding up to two years.

Keep the distribution of vitamin A supplements focused on infants, pregnant and lactating women.

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