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Department of Health
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ADMINISTRATIVE ORDER
No. 3-A s. 2000

SUBJECT: Guidelines on Vitamin A and Iron Supplementation

I. INTRODUCTION

Micronutrient malnutrition, particularly vitamin A deficiency, iron deficiency anemia and iodine deficiency disorders continue to persist in the country as a public health problem. Studies reveal that the above deficiencies result in learning disabilities, mental retardation, poor health, low work capacity, blindness and premature death among the population, especially children.

Cognizant of the problem, the Philippine Government has voluntarily signed the World Declaration on Nutrition and the Global Plan of Action for Nutrition adopted during the 1992 International Conference on Nutrition. The Philippine government has committed to virtually eliminate vitamin A deficiency and iodine deficiency disorders as well as significantly reduce iron deficiency anemia in the country by the year 2000. This commitment has been operationalized in the Medium-Term Philippine Food and Nutrition Plan 1993-1998, otherwise called the Philippine Plan of Action for Nutrition (PPAN) coordinated by the National Nutrition Council in collaboration with other government and non-government agencies.

In line with this commitment, the Department of Health (DOH) through its Nutrition Service has implemented programs geared towards the elimination or reduction of these deficiencies. In 1993, the DOH initiated the Universal Micronutrient Supplementation Program. This program primarily works in the provision of nutritional supplements to specific target population groups: Vitamin A capsules for 12-59 months old preschoolers, iron tablets for pregnant women and iodized oil capsules for child bearing age women. The Department

of Health will continue to implement this program until 2004 when the effect of the Food Fortification project is expected to cause an impact on the Philippine population. Micronutrient supplementation has been proven to be one of the most cost-beneficial and cost-efficient strategies. It is considered a short-term intervention measure to immediately correct the existing deficiencies and prevent adverse consequences attributed with each micronutrient deficiency. Vitamin A deficiency, iron deficiency anemia and iodine deficiency disorders could waste as much as 5 percent of gross domestic product, but addressing them comprehensively would cost less than 0.3 percent of the Gross Domestic Product. (Enriching Lives, Overcoming Vitamin and Mineral Malnutrition in Developing Countries, 1994).

In line with the continuing efforts to provide clear policy direction in the prevention and control of micronutrient deficiencies, these policies and guidelines are being presented to provide a standard and uniform basis for implementation.

II. POLICY

The Philippine government is committed to virtually eliminate Vitamin A Deficiency and Iodine Deficiency Disorders, and markedly reduce Iron Deficiency Anemia. Adopting this goal means improving the survival, growth, well being and development of children and their families. Hence, the Department of Health shall specifically seek to reduce morbidity and mortality associated with these micronutrient deficiencies. Preventive and control measures will be adopted including micronutrient supplementation program with supporting interventions such as food fortification and dietary improvement through nutrition education.

Micronutrient supplementation shall be given during regular or routine services at the health facilities and during national campaigns such as the Garantisadong Pambata Week when universal supplementation is done. It shall likewise be provided in evacuation centers during emergencies, disasters and calamities.

III. IMPLEMENTATION GUIDELINES

1. VITAMIN A DEFICIENCY

1.1 RATIONALE

The Philippines is considered an endemic region for VAD. The 1993 National Nutrition Survey reveals that sub-clinical VAD (i.e. serum retinol level < 0.7 umol/liter) continuous to be present in up to 35% of our pre-school children. The 1998 National Nutrition survey initial result reveals an even more alarming condition wherein the prevalence of maternal night blindness is 10.5% compared with the WHO cut-off point for public health significance of 1%

Vitamin A is one of the most essential vitamins in child and maternal survival programs. It has an unquestionable role in vision and eye health as well as in the immune system & also bone growth.

Vitamin A Deficiency (VAD) is a condition in which the body stores are depleted to the extent that physiological functions are impaired. Depletion of stored vitamin A occurs over time when the diet contains too little to replace the amount used by tissues. Improving the vitamin A status of deficient children has been shown to improve resistance to diseases thus reducing chances of childhood mortality. With vitamin A supplementation, the risk from mortality from measles is reduced by about 50%, diarrhea by about 40% and over-all mortality of pre-school children by 23-35%.

Importance/Uses of Vitamin A

- Maintenance of Normal Vision
- Promotes the differentiation of the epithelial cells of the body's skin and linings of all tissues from invasive microorganisms and other harmful particles
- Promotes growth
- Promotes immunity by maintaining the integrity of the epithelial tissues
- Influences the expression of over 300 genes

1.2 CLINICAL MANIFESTATION

Xeropthalmia constitute the principal clinical sign of Vitamin A deficiency and is the most widely employed definitive criterion for assessing whether Vitamin A poses a significant public health problem. Xeropthalmia includes all ocular manifestations of VAD, which are as follows:

- Nightblindness (XN): It is described as having difficulty in seeing in the dark and refuses to play after dusk; stumbles on furniture, gropes for food, ask questions at dusk like: is it already dark? Where is the door?

- Conjunctival Xerosis (X1A): The conjunctiva losses its natural luster due to hyposecretion of the goblet cells which is variably conducive to dryness of the epithelium.

- Bitot's Spots (X1B): these are foamy, soapy whitish patches seen in the white part of the eye (Scleral conjunctiva). Frequently associated with nightblindness. It can be removed but may re-accumulate later. This is a result of longstanding lack of vitamin A

- Corneal Xerosis (X2): cornea is cloudy and dry with an orange-peel appearance. Some people call this fish scale over the eyes. Child's vision is diminished even at daytime.

- Corneal Ulcer/Keratomalacia (X3A): cornea becomes soft, bulges with large perforations or holes in the surface. Most severe manifestation of VAD. Can lead to permanent blindness. Children with prolonged diarrhea and measles frequently develop this stage

- Corneal scar (XS): inactive VAD or healed corneal damage. Minimal scar slightly impairs vision but extensive scars at the pupil may cause total blindness.

1.3 PRIORITY TARGETS

First Priority:

- All active VAD cases
- 6-59 month old high-risk groups (1st, 2nd, 3rd degree underweight children with measles, ARI, diarrhea)
- post-partum/lactating mothers within one month after delivery

Second Priority:

- 60-72 month old high-risk pre-schoolers
- pregnant women

Third Priority:

- 3rd, 2nd, 1st degree underweight school children (above 6-12 years old)

1.4 MECHANICS OF SUPPLEMENTATION

1.4.1 Vitamin A Preparations and Targets

The prescribed vitamin A supplements to be used in the Vitamin A program is shown below:

PREPARATION/DESCRIPTION	TARGETS
100,000 I.U. Blue opaque soft-gelatin capsule with nipple	Infants 6-11 months
200,000 I.U. Red opaque or clear golden yellow soft gelatin capsule with nipple	Children 12 mos. and above, lactating women and adult VAD cases except pregnant women
10,000 I.U. White compressed powder tablets	Pregnant women

1.4.2. SCHEDULE OF SUPPLEMENTATION

1.4.2.1. THERAPEUTIC SUPPLEMENTATION

Strategies	Target	Dose	Remarks
1. Regular or Routine Supplementation of diagnosed cases of VAD during routine clinic services.	All cases of VAD with ocular signs/symptoms like nightblindness, Bitot's spots, corneal xerosis, & corneal ulcer/ keratomalacia except for pregnant women	➢ For 12 months old and above: 1 cap of 200,000 I.U. upon diagnosis, 1 cap. on the next day, 1 cap. after 2 weeks and 1 cap after 6 months ➢ For infants 6-11 mos. old, give 1 cap. of 100,000 I.U. upon diagnosis, 1 cap. on the next day and 1 cap after 2 weeks and 1 cap after 6 months. ➢ If after 6 months, any signs and/or symptoms of VAD still exist, the above therapeutic regimen is repeated.	Presence of eye signs or symptoms diagnostic of Vitamin A deficiency is a MEDICAL EMERGENCY. The therapeutic dose must be administered immediately as described. A different therapeutic regimen is recommended for pregnant women (pls. see row on pregnant women (200,000 I.U. is a red opaque or golden yellow soft gelatin capsule with nipple) (100,000 I.U. is a blue opaque soft gelatin capsule with nipple)
	All cases with corneal scar	➢ Give dose as above if associated with XN, X1A, X1B, X2, or X3A. ➢ Give 1 capsule only if not associated with any of the above symptoms.	
	Pregnant women with maternal nightblindness	➢ 1 cap. of 10,000 I.U. daily for at least 4 weeks	CAUTION: NEVER USE 100,000 I.U. or 200,000 I.U. for pregnant women 10,000 I.U. is a white compressed powder tablet

1.4.2.2 PREVENTIVE SUPPLEMENTATION

Strategies	Target	Dose	Remarks
1. Universal Supplementation Vitamin A is distributed nationwide during 2 occasions at 6 months interval, i.e. Garantisadong Pambata (GP) Week I & II	➢ All children 6-11 months old ➢ All children 12-59 months old	➢ 1 cap. of 100,000 I.U. single dose (once during the age of 6-11 mos. period) ➢ 1 cap. 200,000 I.U. 2x a year (every 6 months)	All targets should be given Vitamin A supplement only if they did not receive any Mega dose (100,000 I.U. or 200,000 I.U.) within the immediate past 4 weeks except for measles cases whose supplementation must be done regardless of the date of the last dose.
2. Regular or routine clinical supplementation	➢ Pregnant women with no signs of xerophthalmia	1 cap. of 10,000 I.U. 2x a week to start from 4th month of pregnancy until delivery.	**CAUTION: NEVER USE** capsules containing 200,000 I.U. or 100,000 I.U. of Vitamin A
	➢ Lactating women with no signs of xerophthalmia ➢ High-risk pre-schoolers 6-71 months with: • Severe pneumonia or very severe disease • Measles • Chronic diarrhea • Severely and moderate underweight ➢ Severe anemia ➢ Severely underweight school children 6 – 12 years old	➢ 1 cap. of 200,000 I.U. to be given within one month after delivery ➢ 12 mos. & over = 1 cap. of 200, 000 I.U. single dose ➢ 6-11 mos. = 1 cap. of 100,000 I.U. single dose ➢ 1 cap. of 200,000 I.U.	All targets should be given Vitamin A supplement only if they did not receive any Mega dose (100,000 I.U. or 200,000 I.U.) within the immediate past 4 weeks except for measles cases whose supplementation must be done regardless of the date of the last dose.
3. Supplementation during emergencies	➢ Severely under-weight school children 6-12 years old ➢ All children 6-11 months old ➢ All children 12-59 months old	➢ 1 cap. of 200,000 I.U. ➢ 1 cap. of 100,000 I.U. single dose (once during the 6-11 mos. period) ➢ 1 cap. 200,000 I.U. 2x a year (every 6 months)	

1.4.3. SAFETY

Vitamin A is known to be safe and effective even for persons who do not exhibit vitamin A deficiency. Some side effects may occur such as headache, nausea and vomiting. These are, however mild and transitory (disappear within 24 hours) and do not require specific treatment.

Mothers of children who receive 200,000 I.U. Vitamin A should be especially advised on possible side reactions.

1.4.4. DISTRIBUTION AND ADMINISTRATION

The distribution of vitamin A supplements from the region to the barangay level is the responsibility of the Nutritionist-Dietitians and RHU/BHS health workers.

Administration of Vitamin A

Administration of Vitamin A is the responsibility of the RHU/BHS personnel. Trained hilots or other health workers/volunteers may administer vitamin A supplements as long as he/she has been trained and are closely supervised by a midwife or other health personnel. Hospitals, health centers, clinics, weighing posts, Sangkap/patak centers or even home visits shall be used as distribution points of the supplements.

Vitamin A capsule is administered to children by cutting the capsule's nipple or by pricking and then squeezing the content into their mouth. For bigger children and adults, the capsule may be taken as is.

Acceptance is expected to be high if health workers adequately advise mothers regarding benefits of supplementation versus the minimal side effects of a properly implemented high dose supplementation schedule.

1.4.5. HANDLING AND STORAGE OF VITAMIN A CAPSULES

Vitamin A should be stored in dark colored bottles and kept in a cool, dry place, away from heat and direct sunlight to maintain its maximum potency. The container should also be labeled to include the name of the drug, dosage and its expiry date.

1.4.6. MONITORING

A monitoring system should be developed and integrated into the existing health system to cover the following indicators.

- Masterlist of vitamin A capsule recipients by health workers
- Information on the vitamin A compliance
- Information on observed signs and symptoms of vitamin A deficiency among recipients
- Information on dose reactions and response

SUPPLEMENTATION WITH VITAMIN A SHOULD BE RECORDED IN THE TARGET CLIENT LIST AND ON THE GROWTH CHART FOR ALL PRE-SCHOOLERS, IN THE HOME-BASED MATERNAL RECORD (HBMR) FOR PREGNANT AND LACTATING WOMEN, AND IN THE PATIENTS' RECORDS FOR OTHER TARGETS.

1.4.7 SUPPLY ESTIMATION PER TARGET

Strategy	Target group	Estimated Prevalence in Target group	Proportion of target group in total population	No. of VAC per year per target	Total no. of VAC per 1,000 population
For Routine targeted supplement ation	Children 0 - 83 mos. with Xerophthalmia (XN and/or X1b)	0.50%	20%	4	4
	Measles Cases	0.0001%	100%	1	0
	Severely underweight children (6-71 mos.)	1.50%	15.90%	1	2
	Children 6-71 months with chronic diarrhea, severe pneumonia or very severe disease	5.90%	15.90%	1	9
	Children 6 – 71 months with Anemia	5%	15.90%	1	8
	Severely underweight school age children 6-12 years old	0.30%	14%	1	1
	Pregnant women with no signs of Xeropthalmia	89.5%	3.5%	28	877
	Pregnant women with night blindness	10.5%	3.5%	48	176
	Lactating women	85%	3.0%	1	25
Sub-total for routine targeted supplementation per 1,000 population					
	* **200,000 I.U. caps**				**48**
	** **100,000 I.U. caps** (2% of req. for 200,000 caps)				1
	*** **10,000 I.U. tabs**				**1,033**
For Universal supplement ation	Children 12-59 mos.	100%	11.20%	2	224
	Infants 6-11 mos.	100%	3.0%	1	30
Sub-total for Universal supplementation per 1,000 population					**254**
	* **200,000 I.U. caps**				**224**
	** **100,000 I.U. caps**				**30**

Local government units should see to it that adequate vitamin A supplements is made available all the time for the target groups. They can procure any available local preparations provided the recommended dosage is strictly followed.

1.4.8. EMERGENCIES, DISASTERS, CALAMITIES, AND OTHER CONDITIONS

During Calamities and other emergencies, when the risk of epidemic of infectious diseases is high especially when people are housed in evacuation centers, Universal Vitamin A Supplementation should be done among RISK GROUPS as described above.

2. IRON DEFICIENCY ANEMIA

2.1. RATIONALE

Iron deficiency anemia is a problem of serious public health significance, given its impact on psychological and physical development, behavior, and work performance.

In the Philippines, the prevalence rate of anemia for all age groups is 30.6%. The most greatly affected groups are the infants (56.6%), pregnant women (50.3%), lactating women (45.7%), and the elderly (M-49.1%, F-39.2%) (FNRI-NNS 1998)

Iron deficiency is by far the commonest nutritional cause of anemia. An iron deficiency occurs when an insufficient amount of iron is absorbed to meet the body's requirements. This insufficiency may be due to inadequate iron intake, reduced bioavailability of dietary iron, increased needs for iron, or chronic blood loss. When prolonged, iron deficiency leads to anemia.

Anemia is caused by a deficiency of iron (or less often, of other nutrients) and other conditions. Malaria, hookworm disease (whether ancylostomiasis or necaturiasis), schistosomiasis and other infections play important role.

Infants, preschool children, adolescents and women of childbearing age, particularly pregnant women, are at greatest risk of developing iron deficiency anemia. However, adult males are also at risk, especially where there is inadequate food intake or frequent parasitic infestation.

The consequences of iron deficiency, and especially iron deficiency anemia, are many. They include the following:

In infants and children:

- Impaired motor development and coordination;
- Impaired language development and scholastic achievement;
- Psychological and behavioral effects (inattention, fatigue, insecurity, etc.);
- Decreased physical activity

In adults of both sexes:

- Decreased physical work and earning capacity;
- Decreased resistance to fatigue

In preguant women:

- Increased maternal morbidity and mortality
- Increased fetal morbidity and mortality;
- Increased risk of low birth weight

A number of interventions exist that may be used to prevent and correct iron deficiency anemia. These include dietary improvement, fortification of foods with iron, iron supplementation and other public health measures like parasitic control. However, iron supplementation will always be a part of anemia control programs in almost all contexts, and should be viewed as one of several tools in the battle against iron deficiency anemia.

2.2. PRIORITY TARGETS

First Priority:	- Pregnant women - Low birth weight infants - 6-23 month old infants
Second Priority:	- Lactating women - 1-4 year old moderately and severely underweight
Third Priority:	- 6-11 year old anemic, moderate and severely underweight children - adolescent girls - older and other adults

2.3. MECHANICS OF SUPPLEMENTATION

2.3.1. Iron Preparation and Targets

The prescribed iron supplements to be used in the Iron supplementation program is shown below:

PREPA-RATION	DESCRIPTION	TARGETS
Tablets	60 mg. elemental iron with 400 mcg. Folic acid	Pregnant and lactating women/adolescents, elderly
Syrup	30 mg. elemental iron/5 ml 120 ml. per bottle	Children 2-5 yrs. old 6-11 yrs. old
Drops	15 mg. elemental iron/0.6 ml. 30 ml. per bottle	Infants 2-23 mos.

2.3.2. Schedule of Supplementation

Strategies	Target	Dose	Remarks
1. Universal Supplementation (GP)	Pregnant Women	One (1) tablet once a day	A starter pack of Ferrous sulfate with folate tablets is given during this campaign. Replenishment of supplies is made thru the routine implementation to complete the 6 months supplementation period.
	Low birth weight infants (pre-term babies)	0.3 ml. or 2 mg/kg. Birth weight per day	Start at two mos. of age to consume one 30 ml. bottle of ferrous sulfate drops
	Infants 6-23 mos.	0.6 ml. or 2 mg./kg. Birth weight per day	To consume one 30 ml. bottle

Strategies	Target	Dose	Remarks
2. Routine supplementation	Pregnant women	One (1) tablet once a day	Start upon diagnosis of pregnancy. Minimum of 180 iron folate tablets is needed to complete 6 mos. supplementation period.
	LBW infants	0.3 ml. or 2 mg/kg. B.W. per day	start at two mos. of age to consume one 30 ml. bottle of ferrous sulfate drops
	Infants 6-24 mos.	0.6 ml. or 2 mg./kg. B.W. per day	To consume one 30 ml. bottle of ferrous sulfate drops
	Lactating women	One tablet once a day	Start immediately after delivery to consume 90 iron folate tablets for 3 mos. period of
	Children 2-5 yrs.	1 tsp. (5 ml.) once a day	To consume two 120 ml. bottles of ferrous sulfate syrup
	Children 6-11 yrs . anemic, moderately and severely underweight	2 tsp. (10 ml.) or 1 tablet once a day	If a child is able to swallow, iron should be given in tablet form, the preferred supplement form for this age group
	Adolescent girls/Older persons (elderly)	One tablet once a day	To complete three months of supplementation
	Schistosiamia sis endemic areas: Children 5-15 yrs. old	2 tsp. (10 ml.) once a day OR 1 tab once a day	Supplementation will be limited to endemic areas only and should be given for 2 months. Ferrous sulfate syrup for children 5 -9 years old and iron folate tablets for children 10 - 15 years old
	Malaria Endemic areas: Children Adults	2 tsp. (10 ml.) once a day OR 1 tab once a day 1 tab. once a day	Cases of malaria will only be specifically supplemented for 2 months Ferrous sulfate syrup for young children and iron folate tablets for older children Iron folate tablets for adults
3. Supplementation during emergencies, disasters and calamities	Low birth weight infants	0.3 ml. or 2 mg./ kg BW per day	Start at two mos. of age to consume one 30 ml. bottle of ferrous sulfate drops
	Infants 6-23 months	0.6 ml. Or 2 mg/kg. BW per day	To consume one 30 ml. bottle of ferrous sulfate drops
	Pregnant women	1 tab. once a day	180 iron folate tablets are needed to complete the 6 mos. period
	Lactating women	1 tab. once a day	Start immediately after delivery to consume 90 iron folate tablets for 3 mos. period
	Children 2-5 yrs. anemic, moderately & severely underweight	1 tsp. (5 ml.) once a day	To consume four 120 ml. bottles of ferrous sulfate syrup
	Children 6-11 yrs. anemic, moderate & severely underweight	1 tsp. (5 ml.) once a day	To consume four 120 ml. bottles of ferrous sulfate syrup

2.3.3. Safety

It should be stressed that there is no risk of toxicity to iron/folate supplementation when taken at prescribed dose. Present evidence indicates only minor undesirable gastrointestinal side effects in some individuals such as epigastric discomfort, nausea, vomiting, constipation, and diarrhea. The frequency of these side-effects is directly related to the dose of iron.

In cases of gastrointestinal intolerance, it is vital not to discontinue therapy and risk treatment failure. Rather, the dose of iron should be reduced and then gradually increased again until the full dose is reached and is well tolerated.

Iron supplement is ideally taken with empty stomach for optimal absorption. However, the frequency of side-effects can be reduced if the patient takes them with meals.

2.3.4 Distribution and Administration

The distribution of iron supplements is the responsibility of trained local health workers, i.e. midwives, other trained health or nutrition workers, including BHWs and BNS.

2.3.5. Handling and Storage

Iron supplements, particularly the iron folate tablet should be placed in dark colored containers and stored in a cool, dry place away from direct heat and sunlight. When transferring from its original container, make sure that the fingers do not touch the tablets to prevent the growth of molds. The container should also be labeled to include the name of the drug, and its expiry date.

2.3.6. Monitoring

A monitoring system should be developed and integrated into the existing health system to cover the following indicators.

- Master list of recipients of iron folate tablet/ferrous sulfate drops and syrup by health workers
- Information on compliance to supplementation

- Information on observed signs and symptoms of Iron Deficiency Anemia among recipients
- Information on dose reactions and response

RECEIPT OF IRON SUPPLEMENTS SHOULD BE RECORDED ON THE GROWTH CHART OF ALL PRESCHOOLERS GIVEN THE SUPPLEMENTS AND IN THE HOME BASED MATERNAL RECORD (HBMR) FOR PREGNANT AND LACTATING WOMEN.

2.3.7. Supply Estimation Per Target

Target Group	Estimated Prevalence of Condition in Target Group (FNRI-NNS 1998 %)	Proportion of Target Group in Total Population (%)	No. of Iron Tabs./btl. per year per target	Total No. of Iron tabs./btl. per 1000 population
Pregnant Women	N/A	3.5	180 tabs.	6,300
Lactating women	N/A	3.5	90 tabs.	3,150
Low Birth Weight infants	N/A	1.5	1 bottle. (30 ml)	15
Infants 6-23 months	N/A	4.5	1 bottle (30 ml)	45
Children 2-5 yrs. old moderately and severely underweight	29.6	11	4 bottles (120 ml)	130
Children 6-11 yrs. moderate and severely underweight	35.6	15	90 tabs.	4,806
Female Adolescents	33.3	17	90 tabs.	5,095
Older Persons	44.2	3	90 tabs.	1,193.4

Local government units should see to it that adequate supply of iron folate tablets/syrup and drops should be available at all level for the target population. They can procure any available local preparations provided the recommended dosage is strictly followed.

2.3.8 Emergencies, Disasters, Calamities and other Conditions

During calamities and other emergencies, when the risk of nutritional deficiencies is higher, iron supplementation may be given to all HIGH RISK GROUPS according to the prescribed dosage. High risk groups include pregnant women, low birth weight infants and infants 6 – 23 months.

IV. ROLES AND RESPONSIBILITIES

The following services/units shall be responsible in program implementation.

A. *DOH Central Office*

1. Provide policy directions and management guidelines in the implementation of micronutrient supplementation
2. Advocate to LGU to allocate funds for routine supplementation.
3. Assists LGUs in resource generation
4. Formulate/develop IEC materials on micronutrient.
5. Monitor coverage of micronutrient supplementation/assess accomplishment and provide feedback to DOH management.

B. *Regional Health Office/Local Government Unit*

1. Provide budgetary allocations for the purchase of micronutrients especially Vitamin A, iron and iodine to make the micronutrients available at all times.
2. Provide micronutrient in the delivery of routine health services at the health facilities, i.e. post partum supplementation with Vitamin A Capsule (200,000 I.U.); low dose Vitamin A tablets (10,000 I.U.) for pregnant women 2x a week.
3. Conduct of proper orientation of personnel on the micronutrient supplementation program and its policies for appropriate compliance and dissemination;
4. Conduct integrated nutrition education activities (use of IEC materials, lecturettes, and cassettes in wards/OPD).
5. Report, record and assess accomplishments particularly coverage and impact in the long run.

C. *Hospitals*

1. Provide budgetary allocations for the purchase of micronutrients especially Vitamin A, Iron and Iodine to make the micronutrients available at all times.
2. Integration of this Administrative Order in their treatment protocols.
3. Provide the micronutrients in the delivery of routine health services be it in the out patient department or in-hospital wards, i.e. post partum supplementation with Vitamin A Capsule (200,000 I.U.); low dose Vitamin A tablets (10,000 I.U.) for pregnant women 2x a week, etc .
4. Participate in nationwide programs for micronutrient supplementation like the Garantisadong Pambata Week.
5. Conduct of proper orientation of personnel on the micronutrient supplementation program and its policies for appropriate compliance and dissemination.
6. Conduct integrated nutrition education activities (use of IEC materials, lecturettes, and cassettes in wards/OPD).
7. Report, record and assess accomplishments particularly coverage and impact in the long run.

V. REPEALING CLAUSE

This order shall supercede and repeal all previous policies, guidelines and other related orders on micronutrient supplementation inconsistent herewith.

VI. EFFECTIVITY

This Order shall take effect immediately.

ALBERTO G. ROMUALDEZ, JR., M.D.
Secretary of Health