Republic of the Philippines
Department of Health
NATIONAL NUTRITION COUNCIL

# PHILIPPINE PLAN OF ACTION FOR NUTRITION 2017-2022
## A call to urgent action for Filipinos and its leadership

## Executive Summary

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1. The Philippine Plan of Action for Nutrition (PPAN) 2017-2022 is an integral part of the Philippine Development Plan 2017-2022. It is consistent with the Duterte Administration 10-point Economic Agenda, the Philippine Health Agenda, and the development pillars of *malasakit (*protective concern)*, pagbabago* (change or transformation)*,* and *kaunlaran* (development), and the vision of *Ambisyon 2040.* It factors in and considers country commitments to the global community as embodied in the 2030 Sustainable Development Goals, the 2025 Global Targets for Maternal, Infant and Young Child Nutrition, and the 2014 International Conference on Nutrition.

2. It is a results-based plan with SMART results at different levels designed in a results framework.

3. It consists of 8 nutrition-specific programs, and initial list of 10 nutrition-sensitive programs, and 3 enabling programs. Member agencies of the National Nutrition Council (NNC), namely, Department of Health, Department of Agriculture, Department of Social Welfare and Development, Department of Education, Department of Budget and Management, Department of Labor and Employment, Department of Trade and Industry, National Economic Development Authority, Department of Interior and Local Government, and the Department of Science and Technology, other national government agencies, local government units (LGUs), non-government organizations (NGOs), academic institutions, and development partners can undertake one or more of these programs. For better accountability, a member agency of the NNC Governing Board has been designated as lead for these programs. For some programs, the designated lead is the NNC Secretariat.

4. The PPAN 2017-2022 comes with a budget estimate for the entire period of six years. The plan has a monitoring and evaluation framework showing the plan for progress monitoring and evaluation through the six-year period.

5. The National Nutrition Council Secretariat led and coordinated the plan formulation. Plan formulation started with the conduct of a nutrition landscape analysis commissioned by NNC with support from Micronutrient Initiative, now Nutrition International, and the United Nations Children's Fund (UNICEF). A team of Filipino

consultants conducted the assessment from August to October 2016 using landscape analysis based on document reviews, focus group discussions (FGDs), key informant interviews, inter-sectoral consultations and validation meetings with a wide range of stakeholders. The results of the analysis are contained in a separate document, *"Situation Analysis of Nutrition in the Philippines"*. However, its key findings are in the first part of the plan document.

6. Plan formulation was participatory, inter-sectoral, and multi-level. It engaged the participation of the NNC member agencies and their department senior officials at the national and regional levels as well as members of provincial and municipal nutrition committees of LGUs where the FGDs were held, i.e. 6 regions, 5 provinces, and 22 cities and municipalities.

7. Two consultation meetings, prior to the drafting of the plan and after the plan was drafted, were convened to ensure a wide participation in plan formulation.

8. The first round of consultation with an inter-sectoral group of 16 agencies joined by development partners and the academe was held in Tagaytay City on 12-16 September 2016. During the consultation, the national nutrition situation was reviewed together with issues related to policy and program formulation and implementation. The overall strategy and programs for PPAN 2017-2022 was agreed on during this consultation.

9. The second round of consultation was held in Cebu on 17-18 November 2016. During this consultation, more specific directions for the programs identified in the Tagaytay workshop were discussed and refined.

10. This was followed by two more meetings of the NNC Technical Committee on 23 November 2016, and 12 January 2017 before the final approval of the NNC Governing Board on 21 February 2017.

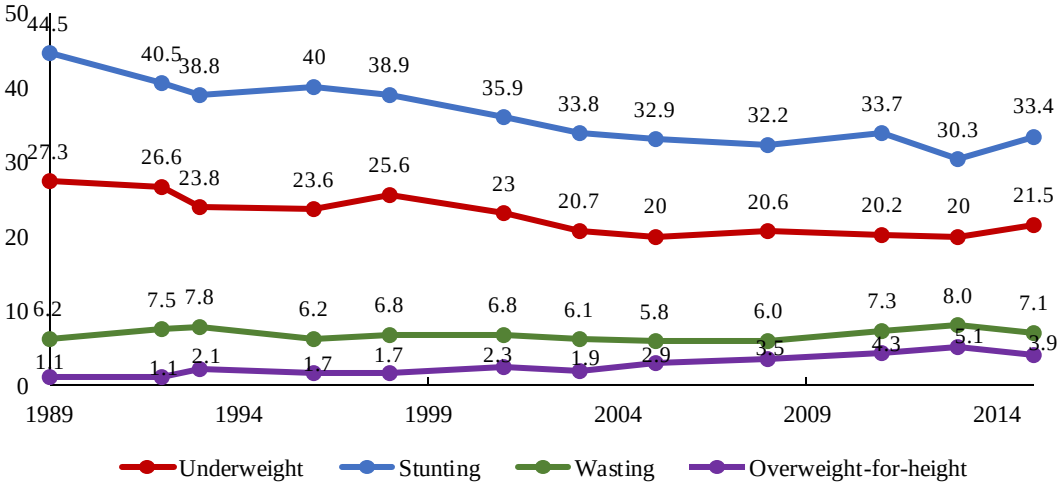
11. Even as the PPAN 2017-2022 was being formulated, related concerns were brought into discussions of relevant sectors of the Philippine Development Plan, e.g. agriculture, fisheries and forestry.

12. The PPAN 2017-2022 is divided into two parts: Part 1 consists of a summary of the situation analysis of nutrition in the country in 2016; and Part 2 presents the plan.

**Nutrition problems to be addressed**

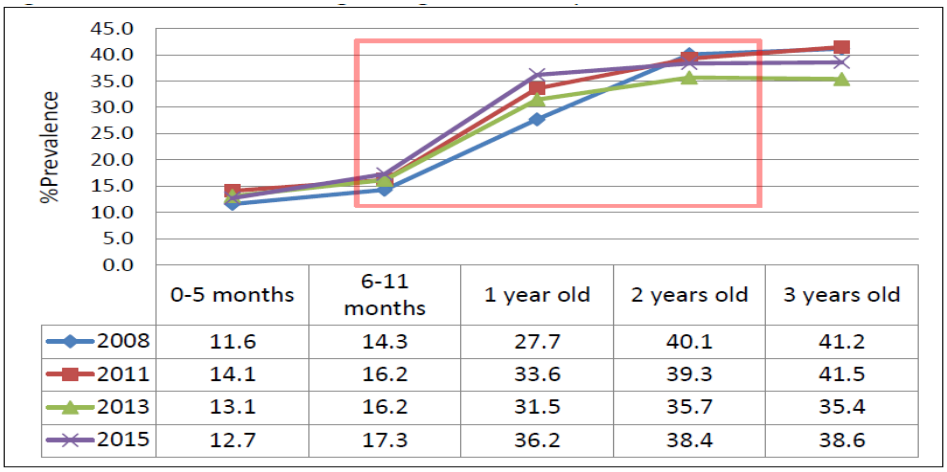
13. High levels of stunting and wasting among children under-five years of age, with levels that have remained unchanged over the years (Figure 1). Also stunting is relatively low among infants 0-11 months old, but is significantly higher among one-year olds (Figure 2). The prevalence of stunting remains high for the older children.

**Figure 1.** Trends in the Prevalence of Malnutrition among Children Under Five Years Old: National Nutrition Surveys (NNS), 1989-2015




Source: FNRI-DOST. 1989-2015 NNS

**Figure 2.** Trends in the Prevalence of Stunting in Children from Birth to Three Years: NNS, 2008 to 2015




| | 0-5 months | 6-11 months | 1 year old | 2 years old | 3 years old |
|---|---|---|---|---|---|
| 2008 | 11.6 | 14.3 | 27.7 | 40.1 | 41.2 |
| 2011 | 14.1 | 16.2 | 33.6 | 39.3 | 41.5 |
| 2013 | 13.1 | 16.2 | 31.5 | 35.7 | 35.4 |
| 2015 | 12.7 | 17.3 | 36.2 | 38.4 | 38.6 |

Source: FNRI-DOST. 2008, 2011, 2013 and 2015 National Nutrition Surveys.

14. Deficiencies in vitamin A, iron, and iodine particularly among groups for which the problem is of public health significance (Table 1)

**Table 1.** Prevalence rate of micronutrient malnutrition

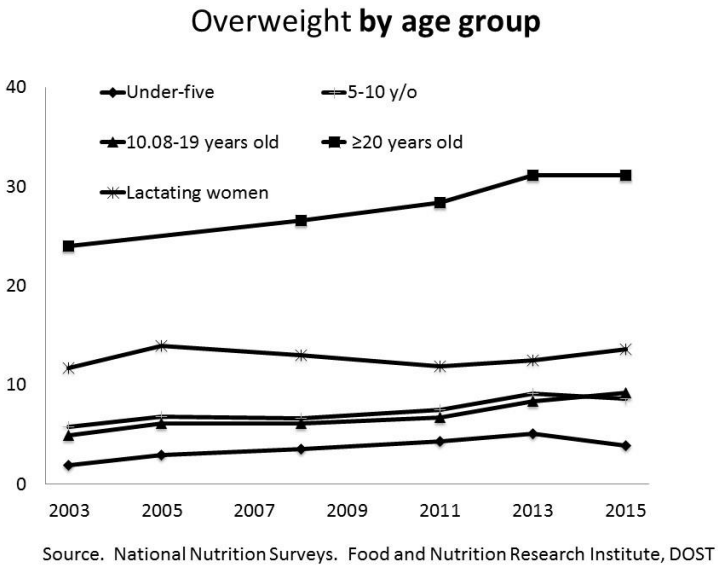
| Micronutrient deficiency/Population group affected | Prevalence rate | | |
|---|---|---|---|
| | *2008* | *2011* | *2013* |
| **Vitamin A deficiency:** % of children 6 mos-6 years old with low to deficiency serum retinol | 15.2 | No data | 20.4 |
| **Anemia**: % of anemic women of reproductive age (20-39 years old) | 18.6 | No data | 11.7 |
| **Iodine deficiency:** | | | |
| - Median urinary iodine concentration ug/L (Should be 100 ug/L for children 6-12 years old, and lactating women, and 150 ug/L for pregnant women) | | | |
| o Children, 6-12 years old | 132 | No data | 168 |
| o Pregnant women | 105 | No data | 105 |
| o Lactating women | 81 | No data | 77 |
| - Percent with iodine excretion concentration <50 mcg/L (should be less than 20%) | | | |
| o Children, 6-12 years old | 19.7 | | 16.4 |
| o Lactating women | 34.0 | | 34.3 |

Source: FNRI-DOST. 2008-2015 NNS

15. Hunger and food insecurity with 68.3% of Filipino households not meeting their caloric requirements. While this level is lower than that recorded in 1989 (74.1%) it is higher than the level reported in 1998 (57%) and 2008 (67%).

16. At the same time, overweight and obesity among various population groups should be addressed, especially among adults (Figure 3).

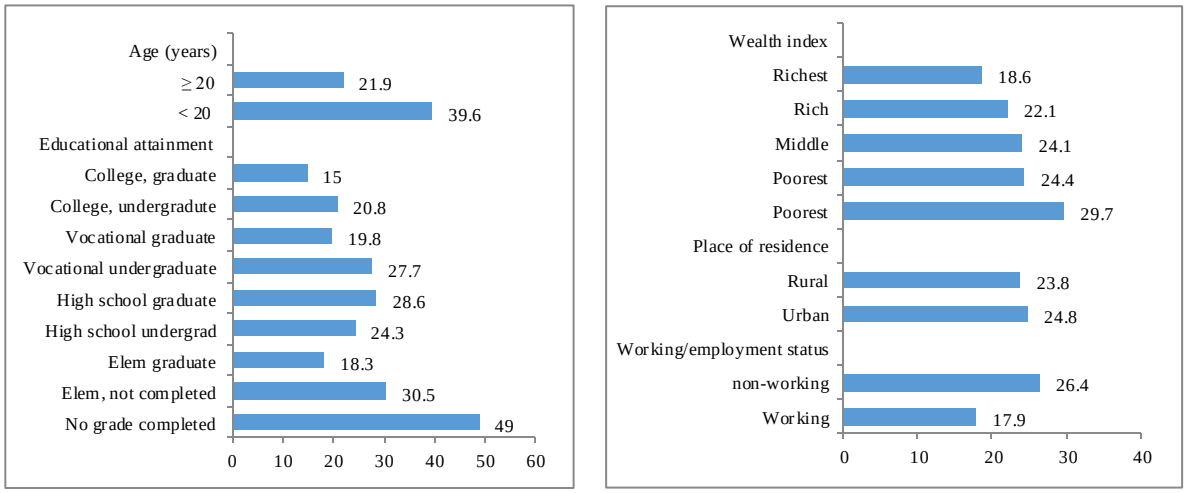
**Figure 3.** Overweight and obesity among various population groups




Source. National Nutrition Surveys. Food and Nutrition Research Institute, DOST

17. Maternal nutrition should also be addressed as survey results have shown that the prevalence of nutritionally-at-risk women has not improved over the years, with a prevalence rate between 24-26% since 2008. Furthermore, adolescent pregnant women, those of poor educational attainment, coming from the poorest wealth quintile, and are employed have relatively higher levels of undernutrition (Figure 4). Maternal nutrition could also affect the nutrition of the growing fetus.

**Figure 4.** Prevalence of Nutritionally At-Risk Pregnant Women by Age, Educational Attainment, Place of Residence and Wealth Index




Source: FNRI-DOST. 2015 National Nutrition Survey

18. Poor infant and young child feeding in the first two years of life coupled with bouts of infection can explain the high levels of stunting.

19. Exclusive breastfeeding (EBF) in the first six months of life continues to be a challenge. EBF increased from 48.9% in 2011 to 52.3% in 2013 but went back to

48.8% in 2015. However, a look at EBF rates by single age group within the 0-5 months-old band would show declining EBF with the lowest rate among the 5-month olds (Table 2). The low rate of EBF together with the rate of never breastfed represent sub-optimal breastfeeding practice. These low rates deprive the infant of needed nutrients for optimum growth at the time when his or her growth is most rapid.

**Table 2**. Proportion of exclusive breastfeeding among infants 0-5 months old, by single age. Philippines, 2011 – 2015

| Age in months | Exclusive breastfeeding, in % | | |
|---|---|---|---|
| | ***2011*** | ***2013*** | ***2015*** |
| All (0-5) | 48.9 | 52.3 | 48.8 |
| 0 | 69.1 | 65.5 | 68.0 |
| 1 | 55.6 | 64.3 | 58.3 |
| 2 | 51.9 | 54.4 | 53.7 |
| 3 | 55.0 | 58.8 | 45.1 |
| 4 | 39.8 | 44.2 | 43.5 |
| 5 | 23.8 | 28.3 | 24.7 |

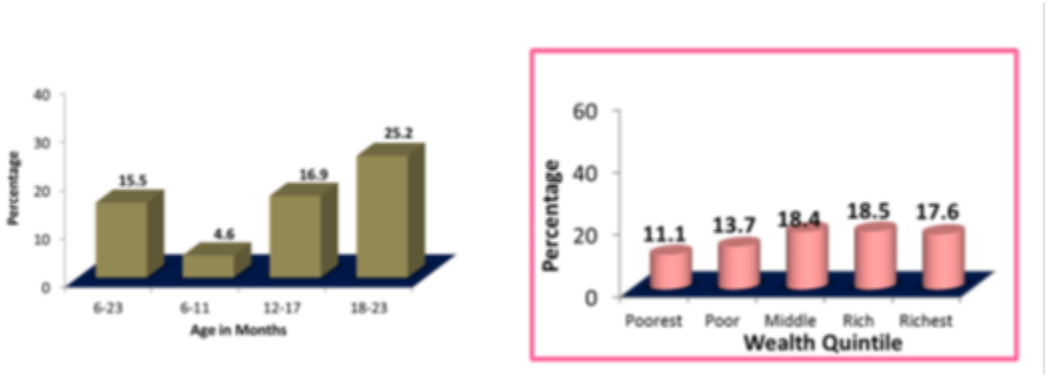
Source: NNS 2011. 2013, and 2015, DOST-FNRI.
Note: CV of estimates are ≤10% for all the age groups, except for the 5-month old group for which the CV is 10.5 in 2011, 13.2 in 2013 and 12.8 in 2015 and are considered acceptable.

20. By the sixth month of life, the infant should receive nourishment from solid and semi-solid food, in addition to breastmilk. However, only 15.5% of infants 6-23 months old receive the minimum acceptable diet[1].

21. As shown in Figure 5, the age group 6-11 months old are the worst off for this indicator. Furthermore, while the highest wealth quintile has higher proportion of children 6-23 months old with minimum acceptable diet, the level is still low at less than 20%. Thus, the problem for achieving optimum complementary feeding is not simply rooted on income.

[1]Minimum acceptable diet is based on the minimum frequency of feeds and diet diversity or consumption of foods from four groups of a group of seven groups that include grains, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, cheese); flesh foods (meat, fish, poultry and liver/organ meats); eggs; vitamin-A rich fruits and vegetables; and other fruits and vegetables.

**Figure 5.** Percent of children consuming minimum acceptable diet, Philippines 2013




Source: NNS 2013, DOST-FNRI

**Causality of malnutrition**

22. Figure 6 shows a framework for the causality of child and maternal undernutrition. The framework notes undernutrition to arise from the immediate causes of inadequate dietary intake and disease. These immediate causes are, in turn, linked with underlying causes at the household and communitylevels that include food insecurity, poor caring and feeding practices, and poor home environmental conditions and inadequate health services. However, these immediate and underlying causes are further linked to basic causes at the society level that covers among others, low access and control of resources.

23. While the framework in Figure 6 is a globally accepted, and used framework, a framework that integrates under- and overnutrition in one framework has been developed for use in the ASEAN region (Figure 7).

24. Thus, addressing both under- and overnutrition should involve actions to eliminate or reduce the negative impact of the identified causal factors.

**Figure 6.** Causal framework of child and maternal undernutrition

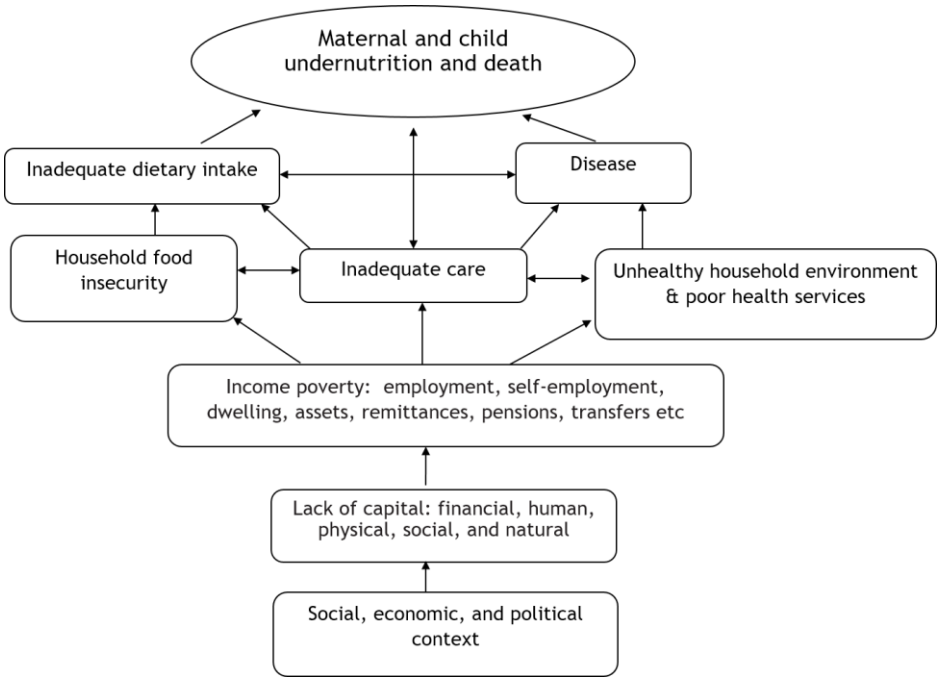
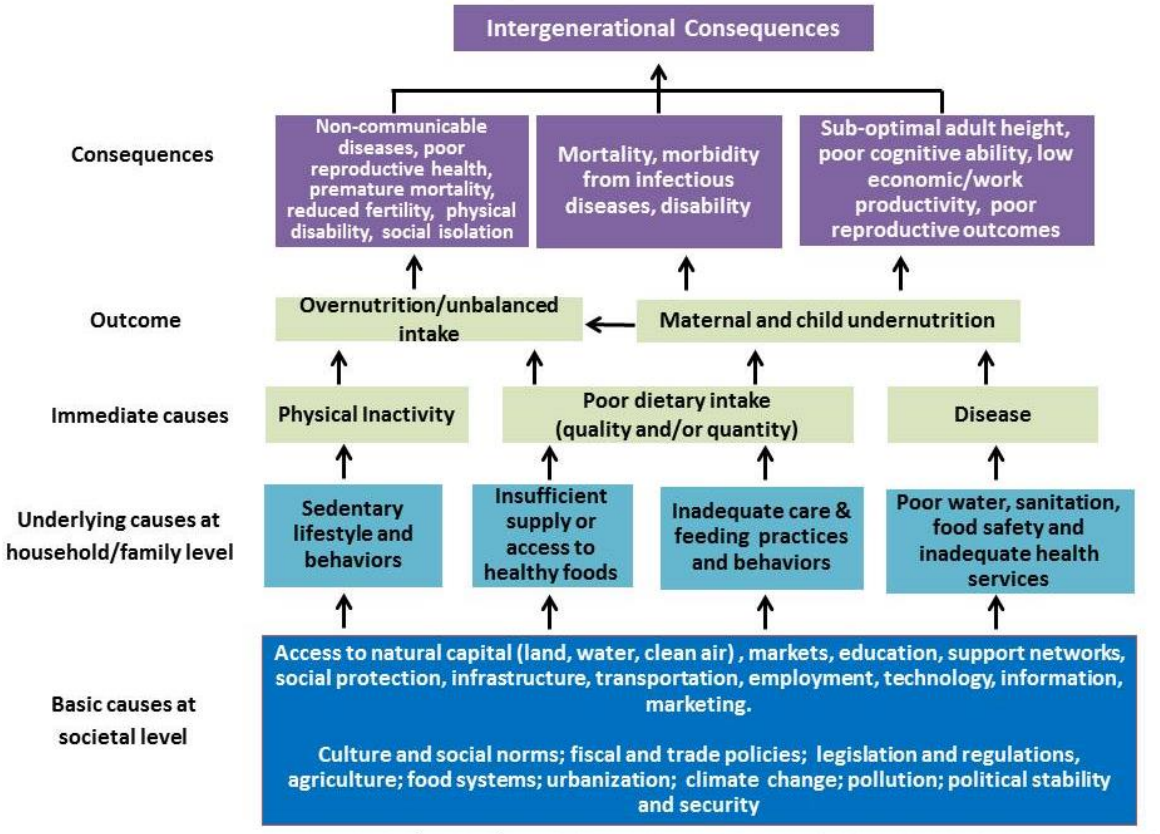



**Figure 7.** Conceptual framework of malnutrition




*Source: ASEAN/UNICEF/WHO (2016) Regional Report on Nutrition Security in ASEAN Volume 2*

**Goal**

25. To improve the nutrition situation of the country as a contribution to:

    a. The achievement of Ambisyon 2040[2] by improving the quality of the human resource base of the country

    b. Reducing inequality in human development outcomes

    c. Reducing child and maternal mortality

**Objectives**

26. PPAN 2017-2022 has two layers of outcome objectives, the outcome targets and the sub-outcome or intermediate targets. The former refers to final outcomes against which plan success will be measured. The latter refers to outcomes that will contribute to the achievement of the final outcomes.

***Outcome targets***

a. To reduce levels of child stunting and wasting

| **Indicator[1]** | **Baseline** | **2022 Target** |
|---|---|---|
| • Prevalence (in percent) of stunted children under five years old | 33.4 | 21.4 |
| • Prevalence (in percent) of wasted children | | |
| • Under five years old | 7.1 | <5 |
| • 6 – 10 years old | 8.6 | <5 |

[1]Baseline based on 2015 updating national nutrition survey conducted by the Food and Nutrition Research Institute.

b. To reduce micronutrient deficiencies to levels below public health significance

| **Indicator[1]** | **Baseline** | **2022 Target** |
|---|---|---|
| Vitamin A deficiency | | |
| • Prevalence (in percent) of children 6 months to 5 years old with vitamin A deficiency (low to deficient serum retinol) | 20.4 | <15 |
| Anemia | | |
| • Prevalence (in percent) of anemia among | 11.7 | 6.0 |

[2] Ambisyon 2040 is the Philippines' long-term vision, i.e. "By 2040, the Philippines shall be a prosperous, predominantly middle-class society where no one is poor, our people shall live long and healthy lives, be smart and innovative, and shall live in a high-trust society. The Philippine hereby aims to triple real per capita income, and eradicate hunger and poverty by 2040, if not sooner" (Executive Order 05, October 2017).

| Indicator[1] | Baseline | 2022 Target |
|---|---|---|
| women of reproductive age | | |
| Iodine deficiency disorders | | |
| • Median urinary iodine concentration, mcg/L | | |
| - Children 6-12 years old | 168 | ≥100 |
| - Pregnant women | 105 | ≥150 |
| - Lactating women | 77 | ≥100 |
| • Percent with urinary iodine concentration <50 mcg/L | | |
| - Children 6-12 years old | 16.4 | <20 |
| - Lactating women | 33.4 | <20 |

[1]Baseline based on 2013 national nutrition survey conducted by the Food and Nutrition Research Institute

c. No increase in overweight among children

| Indicator | Baseline | 2022 Target |
|---|---|---|
| • Prevalence (in percent) of overweight | | |
| • Under five years old[1] | 3.8 | <3.8 |
| • 6 – 10 years old[2] | 8.6 | <8.6 |

[1]Baseline based on 2015 national nutrition survey conducted by the Food and Nutrition Research Institute
[2]Baseline based on 2013 national nutrition survey conducted by the Food and Nutrition Research Institute

d. To reduce overweight among adolescents and adults

| Indicator | Baseline[1] | 2022 Target |
|---|---|---|
| Adolescents | 8.3 | <5 |
| Adults | 31.1 | 28.0 |

[1]Baseline based on the 2013 national nutrition survey conducted by the Food and Nutrition Research Institute

***Sub-outcome or intermediate outcome targets***

| Indicator | Baseline | Target, 2022 |
|---|---|---|
| Reduce the proportion of nutritionally-at-risk pregnant women[1] | 24.8 | 20.0 |
| Reduce the prevalence of low birthweight[2] | 21.4 | 16.6 |
| Increase the percentage of infants 5 mos old who are exclusively breastfed[1] | 24.7 | 33.3 |
| Increase the percentage of children 6-23 months old meeting the minimum acceptable diet[1] | 18.6 | 22.5 |
| Increase the percentage of households with diets that meet the energy requirements[3] | 31.7 | 37.1 |

[1]Baseline based on 2015 updating national nutrition survey conducted by the Food and Nutrition Research Institute
[2]Baseline based on 2013 National Demographic and Health Survey
[3]Baseline based on 2013 national nutrition survey conducted by the Food and Nutrition Research Institute

**Guiding Principles**

27. Attainment of nutritional well-being is a main responsibility of families but government and other stakeholders have the duty to assist those who are unable to enjoy the right to good nutrition

28. Priority will be given to the nutritionally vulnerable (pregnant women, lactating women, infants and young children 0-23 months old), and nutritionally-affected (those who are already malnourished) from poor families and communities that have less access to resources and services

29. Participation of various stakeholders, including members of the community, in policy and plan formulation, implementation, monitoring and evaluation

30. Gender sensitivity

31. Efficiency and effectiveness in resource allocation and implementation of programs and projects

32. Adherence to the principles of engagement of the Scaling Up Nutrition Movement as follows

    a. Transparency about intentions and impact
    b. Inclusiveness
    c. Being rights-based
    d. Willingness to negotiate
    e. Predictability and mutual accountability

f. Cost-effectiveness

g. Continuous communicativeness

h. Acting with integrity and in an ethical manner

i. Mutual respectfulness

j. Doing no harm

**Strategic Thrusts**

33. **Focus on the first 1000 days of life.** The first 1000 days of life refer to the period of pregnancy up to the first two years of the child. This is the period during which key health, nutrition, early education and related services should be delivered to ensure the optimum physical and mental development of the child. This is also the period during which poor nutrition can have irreversible effects on the physical and mental development of the child, consequences of which are felt way into adulthood.

34. **Complementation of nutrition-specific and nutrition-sensitive programs.** This strategic thrust recognizes that malnutrition has immediate, underlying, and basic causes, which should be addressed to achieve targeted nutritional outcomes. Thus, there is a need to implement and deliver nutrition-specific interventions. These interventions "address the immediate determinants of fetal and child nutrition and development, i.e. adequate food intake and nutrient intake, caregiving and parenting practices, and low burden of infectious diseases.

35. **Intensified mobilization of local government units.** To ensure that PPAN 2017-2022 delivers the planned outcomes, 36 areas with the highest prevalence of stunting based on the 2015 Updating National Nutrition Survey will be prioritized for mobilization of LGUs (Table 3). Mobilization will aim to transform low-intensity nutrition programs to those that will deliver targeted outcomes. It will involve capacity building and mentoring of LGUs on nutrition program management to transform them to self-propelling LGUs able to plan, implement, coordinate, and monitor and evaluate effective nutrition programs. This strategy is also expected to complement the interventions in the first 1000 days.

**Table 3.** PPAN 2017-2022 Focus Areas Based on Stunting Prevalence

| No. | Areas/ Provinces | No. | Areas/ Provinces |
|---|---|---|---|
| 1. | Abra | 19. | Maguindanao |
| 2. | Agusan del Sur | 20. | Masbate |
| 3. | Aklan | 21. | Mountain Province |
| 4. | Albay | 22. | Negros Occidental |
| 5. | Antique | 23. | Negros Oriental |
| 6. | Aurora | 24. | Northern Samar |
| 7. | Biliran | 25. | Occidental Mindoro |
| 8. | Bohol | 26. | Palawan |
| 9. | Bukidnon | 27. | Quirino |
| 10. | Camarines Norte | 28. | Romblon |
| 11. | Camarines Sur | 29. | Samar |
| 12. | Capiz | 30. | Sarangani |
| 13. | Catanduanes | 31. | South Cotabato |
| 14. | Cotabato | 32. | Sultan Kudarat |
| 15. | Eastern Samar | 33. | Sulu |
| 16. | Ifugao | 34. | Tawi-Tawi |
| 17. | Lanao del Norte | 35. | Zamboanga del Norte |
| 18. | Lanao del Sur | 36. | Zamboanga Sibugay |

36. **Reaching geographically isolated and disadvantaged areas (GIDAs), communities of indigenous peoples, the urban poor especially those in resettlement areas.** Efforts to ensure that PPAN 2017-2022 programs are designed and implemented to reach out to GIDAs and communities of indigenous peoples will be pursued. The community of NGOs and development partners' resources will be engaged for this purpose.

    There will also be efforts to reach the urban poor, especially those in resettlement areas.

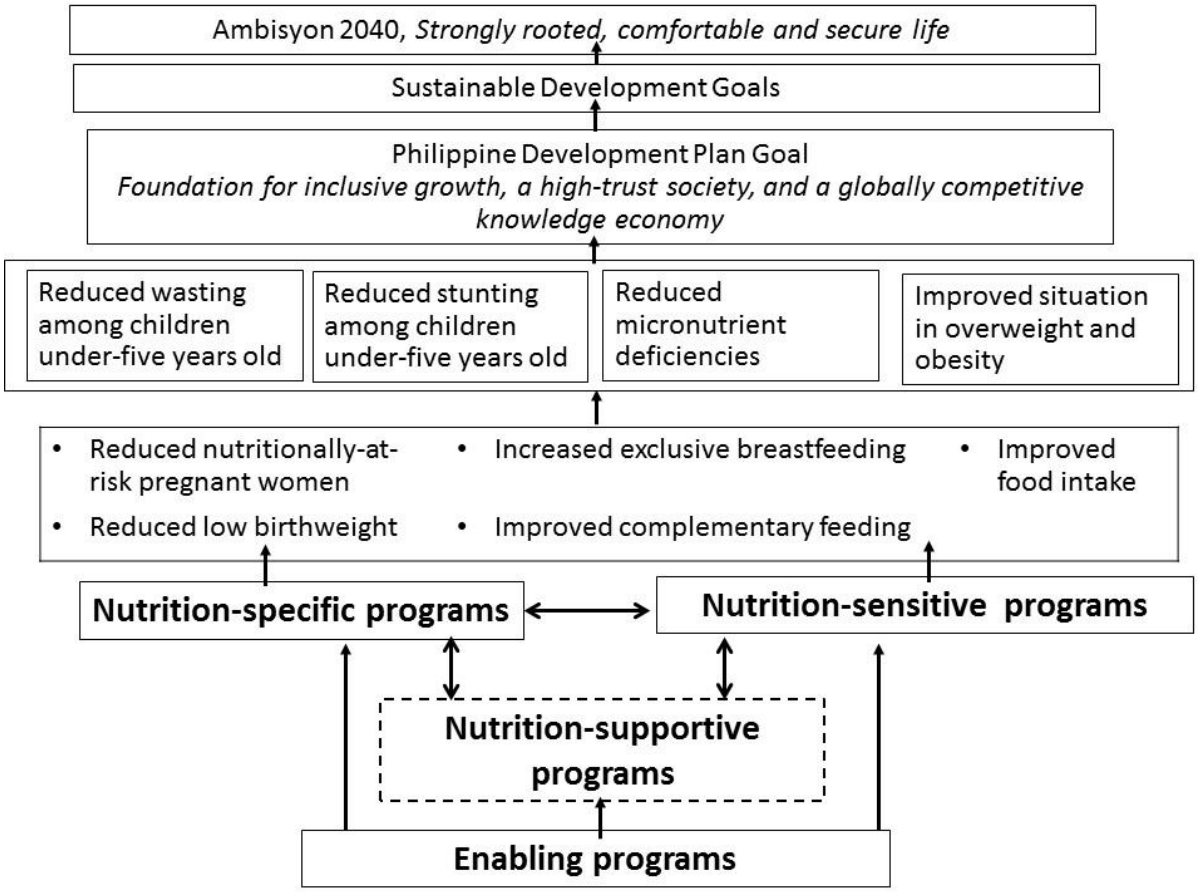
37. **Complementation of actions of national and local governments.** As LGUs are charged with the delivery of services, including those related to nutrition, the national government is charged with creating an enabling environment through appropriate policies and continuous capacity building of various stakeholders.

    The combined impact of the programs from the national and local level is needed to ensure the achievement of the desired outcomes. In this, there will be two reinforcing strategies complementing one another, the implementation of NGA programs and the delivery of nutrition services at the LGU level. This twinning of various reinforcing projects will provide cushion for securing outcomes in case of a shortfall/gaps in the implementation of one of the programs.

**Program Framework**

38. Consistent with the recommendations from the Lancet Series on Maternal and Child Health and Nutrition in 2008 and 2013[3], the PPAN 2017-2022 will involve the implementation of nutrition-specific and nutrition-sensitive programs (Figure 8). The former addresses the immediate causes of malnutrition, while the latter, the underlying and basic causes.

**Figure 8.** PPAN 2017-2022 Program Framework




***Nutrition-specific programs***

39. Nutrition-specific programs are those that were planned and designed to produce nutritional outcomes (Table 4). The selection of these nutrition-specific programs was inspired by global guidance like the WHO Essential Nutrition Actions, the recommendations of the Lancet Maternal and Child Nutrition Series, the International Conference for Nutrition 2 Framework for Action, among others.

[3] The Lancet Series on Maternal and Child Health Nutrition is a collection of papers on evidence on maternal and child undernutrition – its nature, causality and needed action to address the problem. Two such series have been published, the first in 2008 and a follow-up publication in 2013.

**Table 4.** Nutrition-specific programs

| Program | Project/Component | Agencies involved |
|---|---|---|
| 1. Infant and young child feeding | 1. Health systems support | DOH, LGUs |
| | 2. Community-based health and nutrition support | DOH, NGOs, LGUs, Development Partners (DPs) |
| | 3. Maternity Protection and Improving Capacities of Workplaces on Breastfeeding | DOLE, Employers, Employees' Unions, NGOs, LGUs, DPs |
| | 4. Establishment of breastfeeding places in non-health establishments | All agencies, NGOs, LGUs, DPs, CSC |
| | 5. Enforcement of the Milk Code | DOH, LGUs |
| 2. Integrated Management of Acute Malnutrition | 6. Enhancement of Facilities (Including RUTF and RUSF) and provision of services | DOH, NGOs, LGUs, DP |
| | 7. Building of Capacity of Local Implementers | DOH, NGOs, LGUs, DP |
| 3. National Dietary Supplementation Program | 8. Supplementary feeding of pregnant women | DOH, NGOs, LGUs, DPs |
| | 9. Supplementary feeding of children 6-23 months old | DOH, NGOs, LGUs, DPs,NNC |
| | 10. Supplementary feeding of children 24-59 months old | DSWD, NGOs, LGUs, DPs, NNC |
| | 11. Supplementary feeding of school children | DepEd, NGOs, LGUs, DPs |
| | 12. Food plants for producing supplementary foods | FNRI, LGUs, SUCs, NGOs |
| 4. National Nutrition Promotion Program for Behavior Change | 13. In schools | DepEd, NGOs, LGUs, DPs |
| | 14. In communities | DOH, DSWD, NGOs, LGUs, DPs |
| | 15. In the workplace | DOH, DOLE, NGOs, LGUs, DPs |
| | 16. Resource center | NNC (coordinator) |
| 5. Micronutrient supplementation (vitamin A, iron-folic acid, multiple micronutrient | 17. In health unit | DOH, NGOs, LGUs |
| | 18. In schools | DepEd, NGOs, LGUs |
| | 19. Communication support | DOH, NGOs, LGUs |

| Program | Project/Component | Agencies involved |
|---|---|---|
| powder, zinc) | | |
| 6. Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion) | 20. Rice fortification with iron | DOH, NNC, DSWD, DepED, NGOs, LGUs, industry |
| | 21. Flour fortification with iron and vitamin A | DOH, NNC, DSWD, DepED, NGOs, LGUs, industry |
| | 22. Cooking oil fortification with vitamin A | DOH, NNC, DSWD, DepED, NGOs, LGUs, industry |
| | 23. Sugar fortification with vitamin A | DOH, NNC, DSWD, DepED, NGOs, LGUs, industry |
| | 24. Salt iodization | DOH, NNC, DSWD, DepED, NGOs, LGUs, industry |
| 7. Nutrition in emergencies | 25. Capacity building for mainstreaming nutrition protection in emergencies | DOH, DSWD, National/Local Nutrition Cluster, National/Local DRRMC, NGOs, LGUs, DPs |
| 8. Overweight and Obesity Management and Prevention Program | 26. Healthy Food Environment | DOH, DSWD, DOLE, NGOs, LGUs, industry, CSC, DPs |
| | 27. Promotion of healthy lifestyle | DOH, DSWD, DOLE, NGOs, LGUs, industry, CSC, DPs |
| | 28. Weight Management Intervention (for Overweight and Obese Individuals) | DOH, DSWD, DOLE, NGOs, LGUs, industry, CSC, DPs |

***Nutrition-sensitive programs***

40. Complementing these nutrition-specific interventions are nutrition-sensitive programs. These are development programs and projects that will be tweaked to produce nutritional outcomes. Tweaking can be done by targeting households with undernourished children or nutritionally-vulnerable groups, or targeting areas with high levels of malnutrition, or being a channel for delivering nutrition-specific interventions. Table 5 shows an initial list of development programs and projects that will be tweaked to produce nutritional outcomes in addition to their original objectives. The list will be updated in the course of plan implementation.

**Table 5.** Nutrition-sensitive program

| Project | Agency involved |
|---|---|
| 1. Farm-to-market roads and child nutrition | DA, LGUs |
| 2. Target Actions to Reduce Poverty and Generate Economic Transformation (TARGET) and child nutrition | DA, LGUs |
| 3. Coconut Rehabilitation Program | PCA |
| 4. *Gulayan sa Paaralan* | BPI, DepED |
| 5. *Diskwento* caravans in depressed areas | DTI, LGUs |
| 6. Family development sessions for child and family nutrition project | DSWD, LGUs |
| 7. Mainstreaming nutrition in sustainable livelihood | DSWD, LGUs |
| 8. Public works infrastructure and child nutrition | DPWH, LGUs |
| 9. Adolescent Health and Nutrition Development | DOH, LGUs |
| 10. *Sagana at Ligtas na Tubig sa Lahat* (SALINTUBIG) and other programs on water, sanitation and hygiene | DOH, DILG, LWUA |

***Enabling programs***

41. **Mobilization of local government units for nutrition outcomes** - This program aims to deliver 36 provinces and the majority of its LGUs (total of 708 municipalities and cities), converting them from LGUs with low-intensity nutrition programs to ones that deliver nutritional outcomes during the six-year period of the PPAN. It is one of the cornerstones of the PPAN 2017-2022.

42. It is an essential part of the set of programs ensuring two contributions to the PPAN planned outcomes. One is by ensuring that the 36 focus provinces and their 708 cities and municipalities deliver nutritional outcomes. Two, by inspiring and providing models and practices that other provinces, cities, and municipalities can adapt.

43. LGU mobilization is expected to facilitate convergence of services, that among others will involve national government agencies working in tandem with the demands of the LGUs being mobilized.

    a. Mobilization of Local Government Units for Delivery of Nutritional Outcomes through the NNC Regional Network that will start with the formulation or updating the local nutrition action plan. Efforts will also ensure its integration in the annual investment program of the LGUs, and its full implementation. To catalyze related processes, inter-agency mobilization teams at the national and local levels will be organized and provide technical assistance to focus LGUs.

b. Enabling Policy and Legal Framework for LGU Mobilization that will involve the formulation of national issuances that will assist LGUs in managing their local nutrition action plans.

c. Development of Continuing Opportunities for LGU Excellence in Nutrition Programming that will generate success stories and good practices that LGUs can adapt.

d. Mobilization of Rural Improvement Clubs and other community-based organizations for nutrition action to ensure the close link with the families in the community.

44. **Policy development for food and nutrition** - The ultimate goal in the current period of the PPAN 2017-2022 is to secure important pieces of legislative, policy and budgetary support that will enable the NGAs and the LGUs to implement the PPAN more robustly. Project 2 (Public Advocacy for Improved Support to Nutrition in the Philippines) will expand and deepen the understanding and appreciation of nutrition in the public mind not just for the benefit of the PPAN 2017 -2022 but for generations beyond the current plan period.

a. Securing policy support for improving nutrition, specifically along the priority legislative measures, that include the following:

1) Regulation of the Marketing of Foods of Poor Nutritional Quality for Children

2) Amendment of PD 1569 Barangay Nutrition Scholar

3) Program Strengthening and Institutionalization of the First 1000 Days Program

4) Amendment of RA 8976 or the Food Fortification Act

5) Adoption of Maternity Protection Policy (Extended Maternity Leave)

6) Mandatory Plantilla Position for NAOs

7) Creating a system of food distribution addressing the nutritional needs of the people

8) Taxation of sugar-sweetened beverages

b. Public advocacy for improved support to nutrition will apply various strategies to influence actions of national and local leaders.

45. **Strengthened management support to the PPAN 2017-2022** – by improving the efficiency and effectiveness in the planning, implementation, and overall management of the nutrition specific and nutrition sensitive programs.

a. Securing resource requirements (human, financial, and organizational, for PPAN

b. Strengthening coordination, monitoring, evaluation and management of PPAN across NNC including member agencies and NNC Secretariat

**Service targets**

46. As a rule, 90% of the target population group of relevant nutrition-specific interventions will be targeted. This is based on estimates of the Lancet Series on Maternal and Child Malnutrition that a 90% coverage of key services can result to reduced mortality and stunting at significant levels. An exception though is the program on obesity for which the target has been set to 50% of the target population.

**Implementation and Management Mechanism**

47. Operationalizing the PPAN 2017-2022 will involve the formulation of the National PPAN Implementation Plan also for the same time. This implementation plan will cover specific activities to be undertaken for each program for each year. It will be updated annually to respond to the evolving situation. The implementation plan will include a resource framework with explicit estimates of funded and unfunded budgets and a resource mobilization strategy. This strategy will endeavor to ensure that needed resources will eventually be available within the plan period.

48. At the regional level, a Regional Plan of Action for Nutrition (RPAN) will be formulated to capture initiatives of regional offices of member agencies of the Regional Nutrition Committee along the PPAN programs for 2017-2022. Like the National PPAN Implementation Plan, the RPAN will be updated annually.

49. At the local level, local nutrition committees will formulate or reformulate their respective nutrition action plans (LNAPs). These plans, while formulated along the PPAN programs, will consider the locality's nutrition problems and causes. Per guidelines these LNAPs should cover the three-year term of the local chief executive, and relevant items integrated in the annual investment plan of the local government unit.

50. The National Nutrition Council Governing Board will continue to be the policy-making body for PPAN 2017-2022. It will be assisted by the NNC Technical Committee and technical working groups that will be established or re-organized for each program.

51. Monitoring will involve the generation of reports on physical and financial accomplishments from various stakeholders.