



PHILIPPINE PLAN OF ACTION FOR NUTRITION 2017-2022

**A call for urgent action
for Filipinos and its leadership**

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Republic of the Philippines
NATIONAL NUTRITION COUNCIL

NNC GOVERNING BOARD RESOLUTION
Resolution No. 1, Series of 2017

Approving and Adopting the Philippine Plan of Action for Nutrition 2017-2022

Whereas, maternal and child undernutrition continue to be of alarming levels in the Philippines as reported by the National Nutrition Surveys conducted by the Food and Nutrition Research Institute;

Whereas, these nutritional problems have economic and social costs to the country;

Whereas, these nutritional problems deprive Filipino of their right to food and good nutrition;

Whereas, the country has committed to pursue the 2030 Agenda for Sustainable Development and the Sustainable Development Goals, particularly the goal on ending hunger, achieving food security, and improving nutrition; and the Global Targets 2025 for Maternal, Infant and Young Child Nutrition;

Whereas, global evidence has established the need for nutrition-specific and nutrition-sensitive interventions, the former referring to interventions that address the immediate causes of undernutrition most of which are in the health sector and the latter to interventions that have other objectives but have been tweaked to contribute to nutritional outcomes and enabling strategies;

Whereas, the attainment of nutritional well-being is a main responsibility of families but duty bearers like government organizations and nongovernment organizations should help the families especially the marginalized, to be able to provide for their own nutritional needs;

NOW, THEREFORE, BE IT RESOLVED AS IT IS HEREBY RESOLVED, in consideration of the foregoing, we the National Nutrition Council Governing Board as the country's highest policy-making body on nutrition do hereby approve and adopt the PPAN 2017-2022;

RESOLVED FURTHER, that we commit our departments or agencies or organizations to:

1. Pursue the programs and projects herein specified and continue to identify new ones in the course of the plan's implementation


2. Ensure the availability of needed resources, by, among others, including related budgetary requirements in the agency budget proposal
3. Ensure reporting of related physical and financial accomplishments
4. Advocate for nutrition to be a perspective and component of our policies, plans and programs

RESOLVED FURTHER, for the National Nutrition Council Secretariat to ensure that the plan is disseminated as widely as possible to enable stakeholders to align their efforts along the priority concerns;

RESOLVED FURTHER, for the National Nutrition Council Secretariat in coordination with relevant agencies, to complete the implementation plan by 21 April 2017 and to facilitate the formulation of annual program plans thereafter;

RESOLVED FURTHER, for the National Nutrition Council Secretariat to monitor and to ensure the full implementation of this resolution.

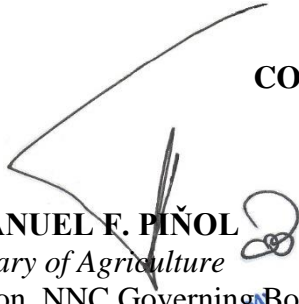
Approved this 21st day of February 2017.



PAULYN JEAN B. ROSELL-UBIAL, MD, MPH, CESO II
Secretary of Health and Chairperson
National Nutrition Council Governing Board


Attested:


Assistant Secretary of Health Maria-Bernardita T. Flores, CESO II
Council Secretary and Executive Director IV
National Nutrition Council


CONFORME:

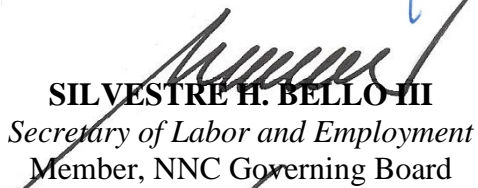

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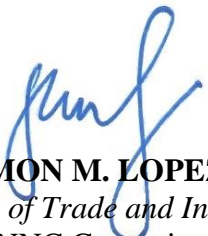

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PHILIPPINE PLAN OF ACTION FOR NUTRITION 2017-2022 **A call to urgent action for Filipinos and its leadership**

Executive Summary

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 an initial list of 11 nutrition-sensitive programs, and 3 enabling programs. Member agencies of the National Nutrition Council (NNC), namely, Department of Health, Department of Agriculture, Department of the Interior and Local Government, Department of Budget and Management, Department of Education, Department of Labor and Employment, Department of Science and Technology, Department of Social Welfare and Development, Department of Trade and Industry, National Economic Development Authority, and the 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 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

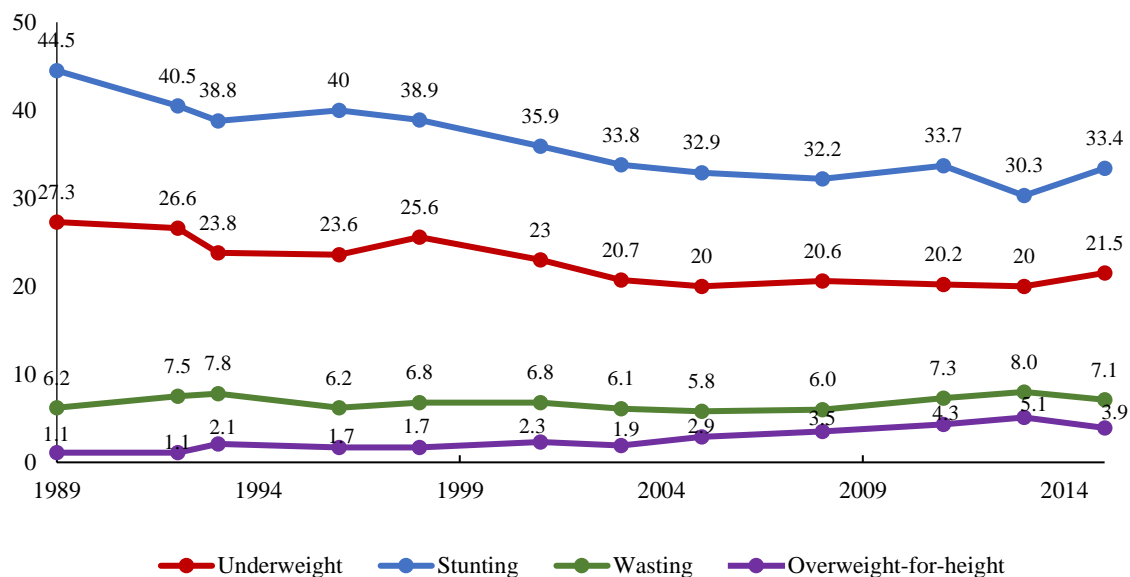
consultants conducted the assessment from August to October 2016 using landscape analysis based on document reviews, focus group discussions (FGDs), key informant interviews, inter-sectoral consultations and validation meetings with a wide range of stakeholders. The results of the analysis are contained 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 were agreed on during this consultation.
9. The second round of consultation was held in Cebu City 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

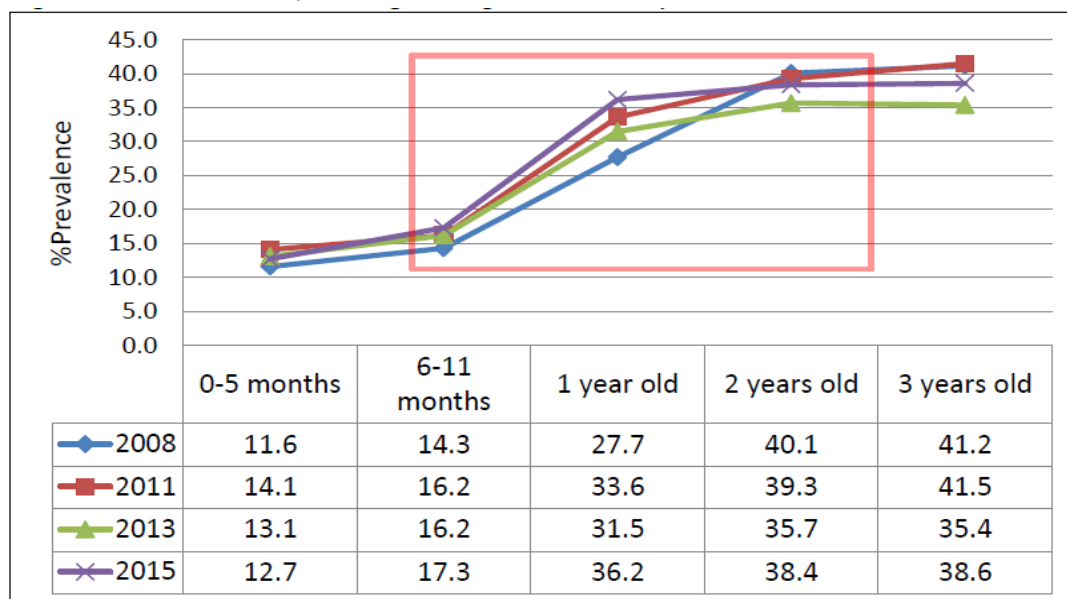
13. High levels of stunting and wasting among children under-five years of age, with levels that have remained unchanged over the years (Figure 1). Also, stunting is relatively low among infants 0-11 months old, but is significantly higher among one-year olds (Figure 2). The prevalence of stunting remains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



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)

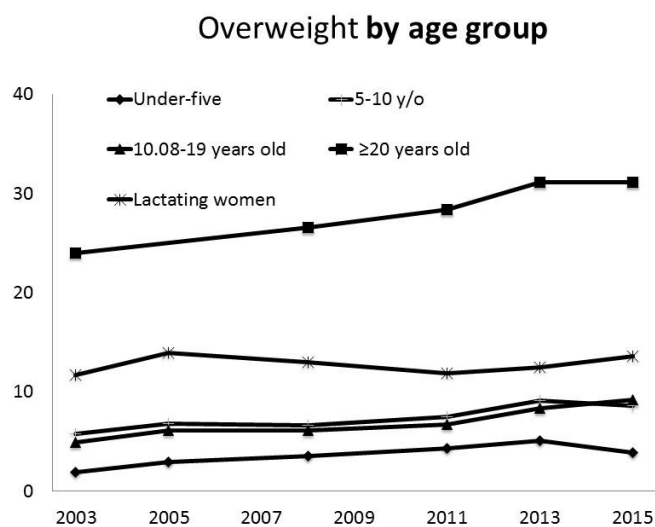
Table 1. Prevalence rate of micronutrient malnutrition

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).

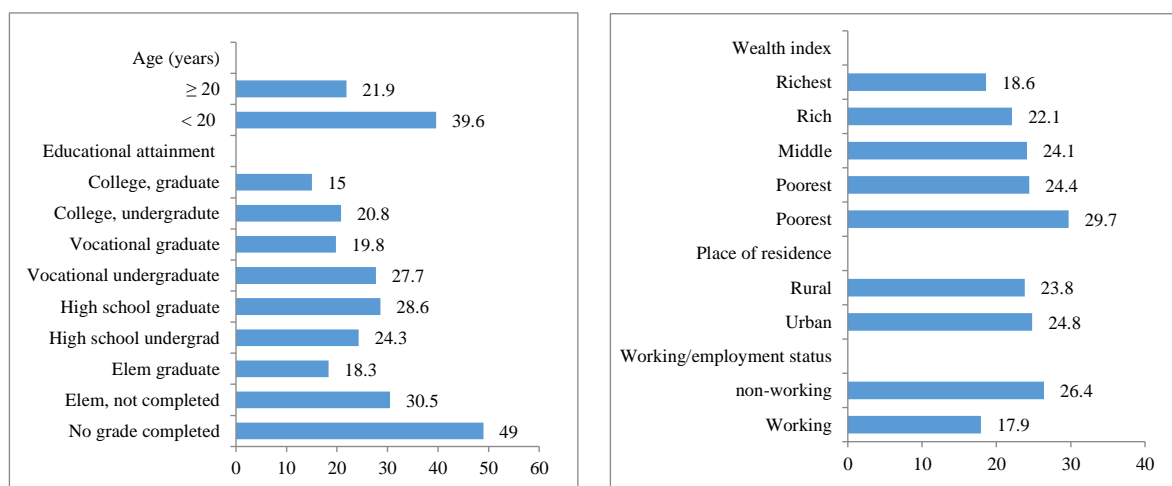
Figure 3. Overweight and Obesity among Various Population Groups



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

- 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 not working 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

- 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.
- 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

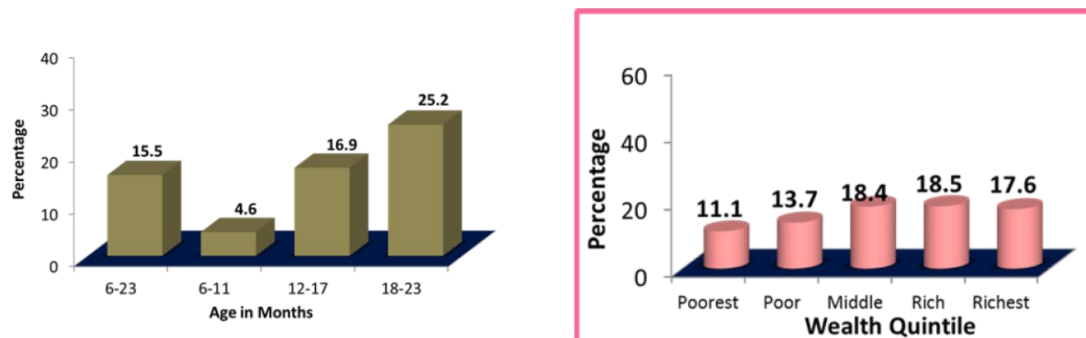
Source: NNS 2011, 2013, and 2015, DOST-FNRI.

Note: CV of estimates are $\leq 10\%$ 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 received the minimum acceptable diet¹.
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.

¹Minimum 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 community levels 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

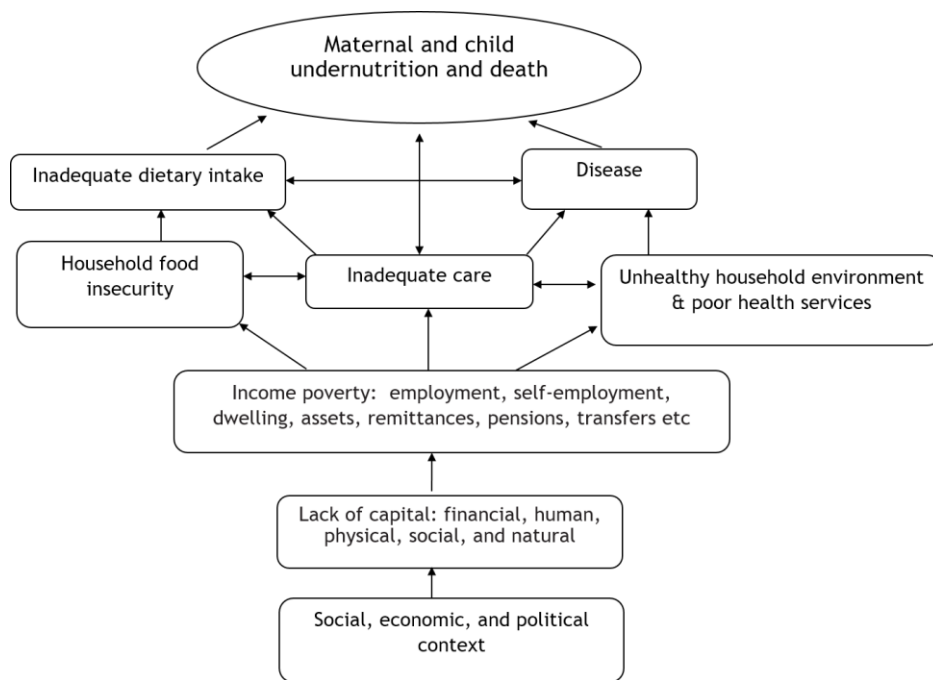
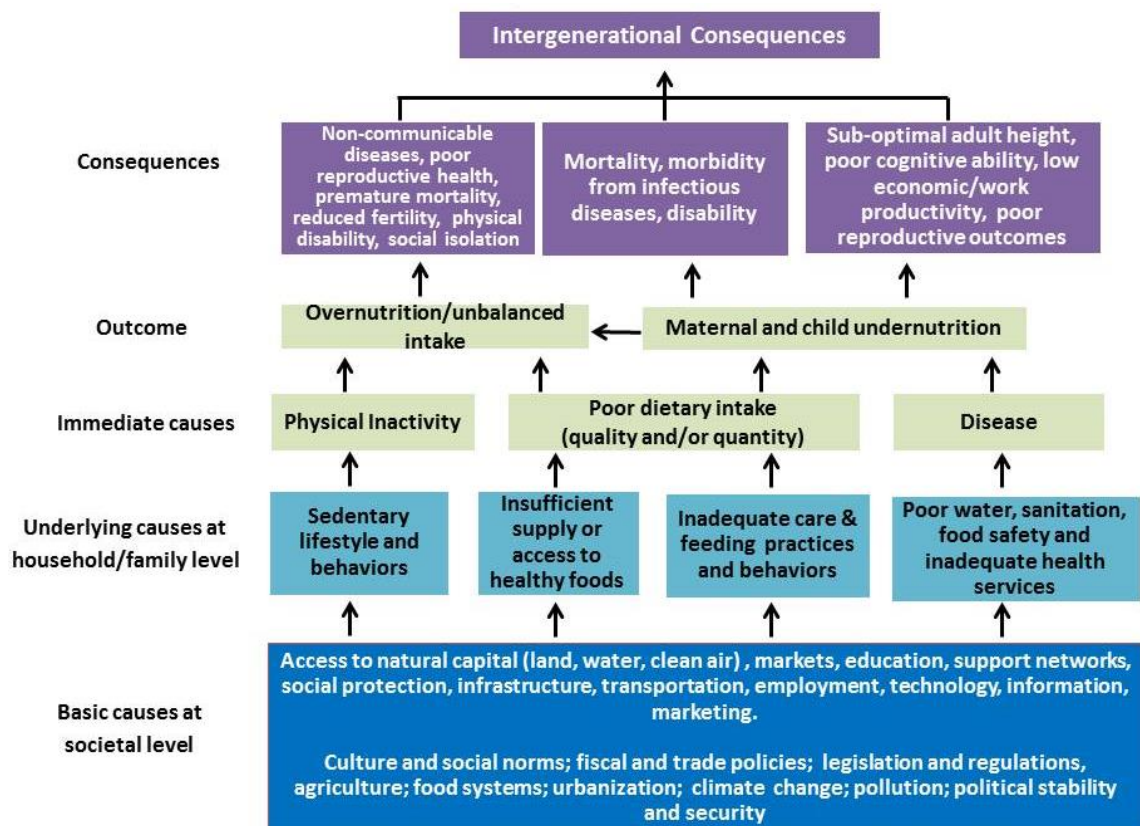


Figure 7. Causal framework of malnutrition



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:
- The achievement of AmBisyon 2040² by improving the quality of the human resource base of the country
 - Reducing inequality in human development outcomes
 - 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

¹Baseline based on 2015 Updating National Nutrition Survey conducted by the Food and Nutrition Research Institute (FNRI)

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

Indicator ¹	Baseline	2022 Target
<u>Vitamin A deficiency</u>		
• Prevalence (in percent) of children 6 months to 5 years old with vitamin A deficiency (low to deficient serum retinol)	20.4	<15
<u>Anemia</u>		
• Prevalence (in percent) of anemia among women of reproductive age	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).

Indicator¹	Baseline	2022 Target
<u>Iodine deficiency disorders</u>		
• 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

¹Baseline based on 2013 National Nutrition Survey conducted by the FNRI

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

¹Baseline based on 2015 Updating National Nutrition Survey conducted by the FNRI

²Baseline based on 2013 National Nutrition Survey conducted by the FNRI

d. **To reduce overweight among adolescents and adults**

Indicator	Baseline¹	2022 Target
Adolescents	8.3	<5
Adults	31.1	28.0

¹Baseline based on the 2013 National Nutrition Survey conducted by the FNRI

Sub-outcome or intermediate outcome targets

Indicator	Baseline	2022 Target
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

¹Baseline based on 2015 Updating National Nutrition Survey conducted by the FNRI

²Baseline based on 2013 National Demographic and Health Survey

³Baseline based on 2013 National Nutrition Survey conducted by the FNRI

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 provinces 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 national government programs and the delivery of nutrition services at the local 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 2013³, 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.

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.

Figure 8. PPAN 2017-2022 Program Framework

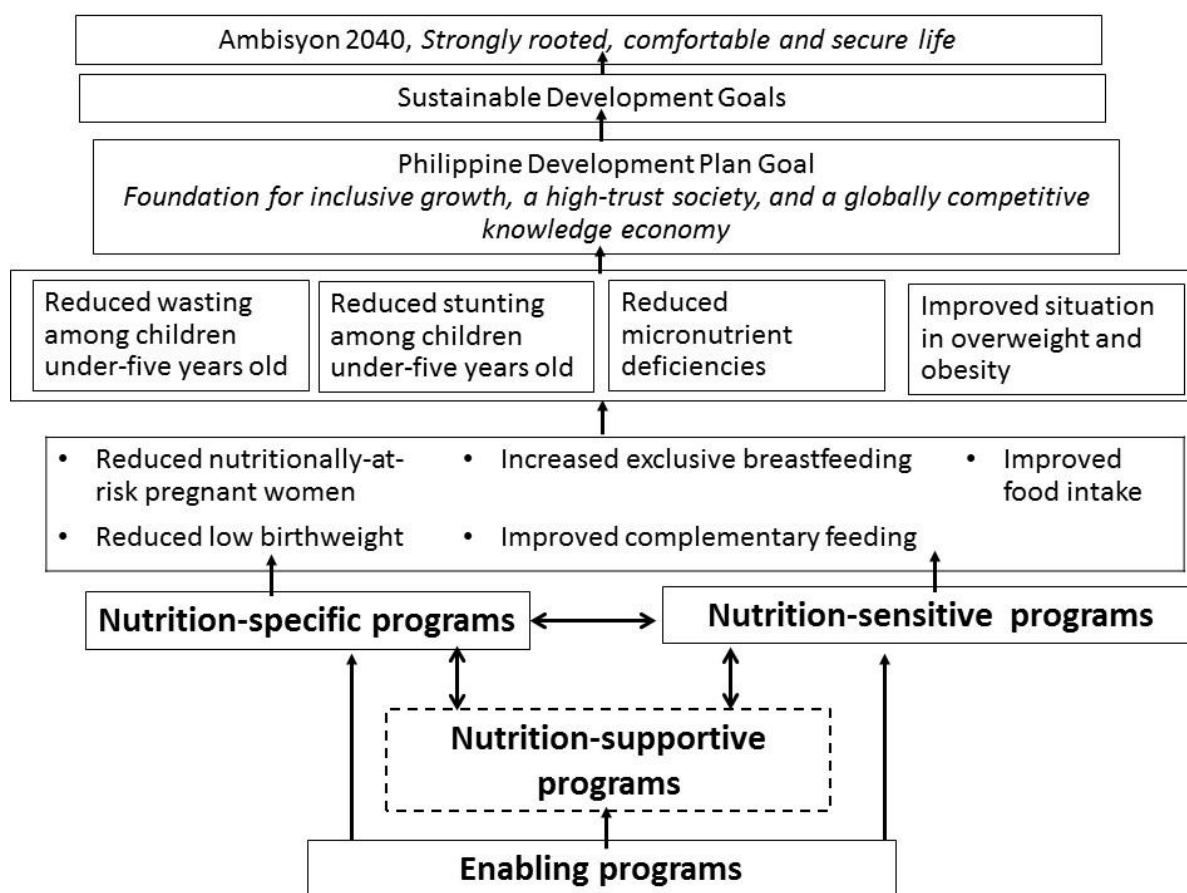


Table 4. Nutrition-specific programs

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

Program	Project/Component	Agencies involved
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 powder, zinc)	17. In health unit	DOH, NGOs, LGUs
	18. In schools	DepEd, NGOs, LGUs
	19. Communication support	DOH, NGOs, LGUs
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

Program	Project/Component	Agencies involved
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 programs

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. <i>Gulayan sa Paaralan</i>	BPI, DepED
5. <i>Diskwento</i> 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

Project	Agency involved
10. <i>Sagana at Ligtas na Tubig sa Lahat (SALINTUBIG)</i> and other programs on water, sanitation and hygiene	DOH, DILG, LWUA
11. Reproductive Health/Responsible Parenthood	DOH, DepEd, DSWD, DOLE, other government agencies, NGOs, LGUs, DPs

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 the plan’s 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 to 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** – The objective of this enabling program is to ensure effective management, coordination and implementation of PPAN programs that are currently lodged with the National Nutrition Council Secretariat. Consistent with the mandate of the NNC, the immediate contribution of this program is to increase efficiency and effectiveness in the planning, implementation, and overall management of the nutrition specific and nutrition sensitive programs.

- a. Securing resource requirements 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 period. 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 program 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.