

## **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 Health for All Agenda of the Department of Health (DOH), 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, 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 12 programs and 46 projects serving as a framework for actions that could be undertaken by member agencies of the National Nutrition Council (NNC), other national government agencies, local government units, non-government organizations, academic institutions, and development partners. For better accountability, a member agency of the NNC Governing Board has been designated as lead for one or more of these programs.
4. Of these 12 programs, 8 are nutrition-specific, one is nutrition-sensitive and three are enabling support programs. A program for local government mobilization is among the three enabling programs to ensure their wider participation in delivering nutritional outcomes.
5. 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.
6. 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 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, 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*

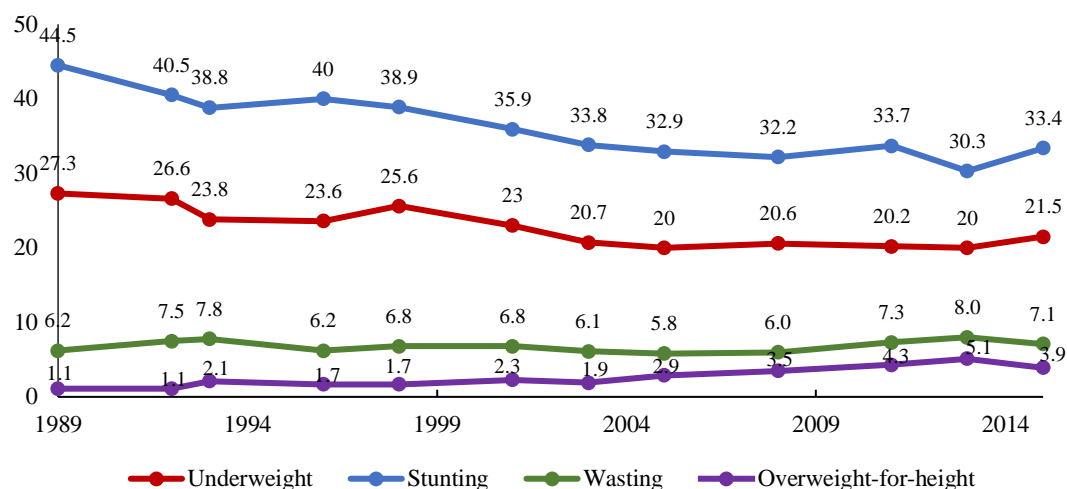
*in the Philippines*". However, its key findings are in the first part of the plan document.

7. 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. Please see Attachment 1 for the list of LGUs and persons covered by the FGDs.
8. Two consultation meetings, prior to the drafting of the plan and after the plan was drafted, were convened to ensure a wide participation in the plan formulation. The first round of consultation with an inter-sectoral group of 16 agencies joined by development partners and the academe was held in Tagaytay on 12-16 September. 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 national round of consultation was held in Cebu on 17-18 November. 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, related concerns were brought into discussions of relevant sectors of the Philippine Development Plan.
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.
13. Part 2 is divided into section describing the rationale for the PPAN, followed by a brief description of the PPAN, a description of the 11 programs and their classification, the projects included in each program, the program structure and results framework, PPAN strategy, the organization for its overall management and coordination, the monitoring and evaluation framework, and the plan's budget estimates section including a resource framework and resource mobilization strategy.

### **Nutrition problems to be addressed**

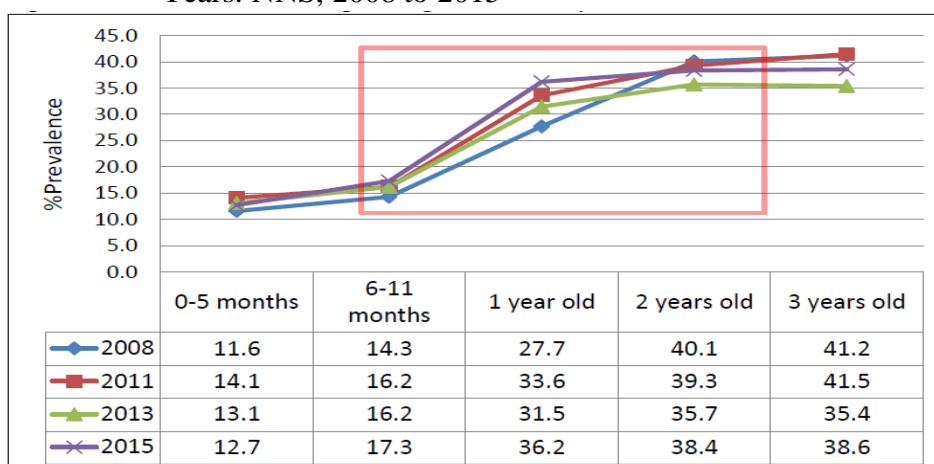
14. High levels of stunting and wasting among children under-five years of age, with levels that have remained unchanged over the years (Figure 1). Also stunting is relatively low among infants 0-11 months old, but is significantly higher among one-year olds (Figure 2). The prevalence of stunting remains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

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



Source: NNS 1989-2015, FNRI-DOST

**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.

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

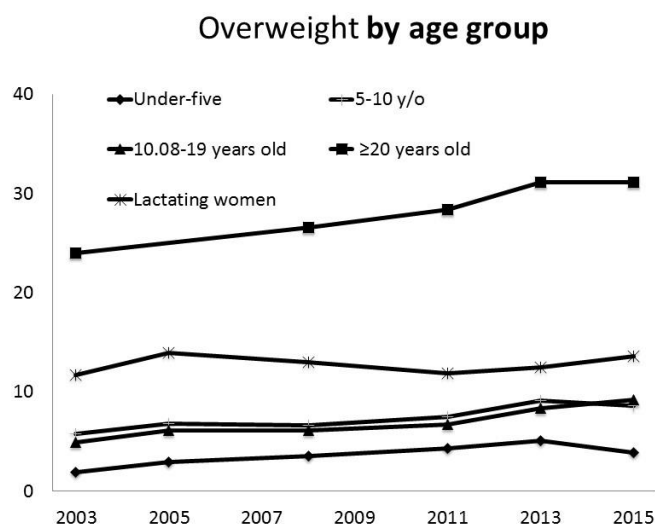
**Table 1.** Prevalence rate of micronutrient malnutrition

Micronutrient deficiency/Population group affected	Prevalence rate		
	2008	2011	2013
<b>Vitamin A deficiency:</b> % of children 6 mos-6 years old with low to deficiency serum retinol	15.2	No data	20.4
<b>Anemia:</b> % of anemic women of reproductive age (20-39 years old)	18.6	No data	11.7

Micronutrient deficiency/Population group affected	Prevalence rate		
	2008	2011	2013
<b>Iodine deficiency:</b>			
- 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

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

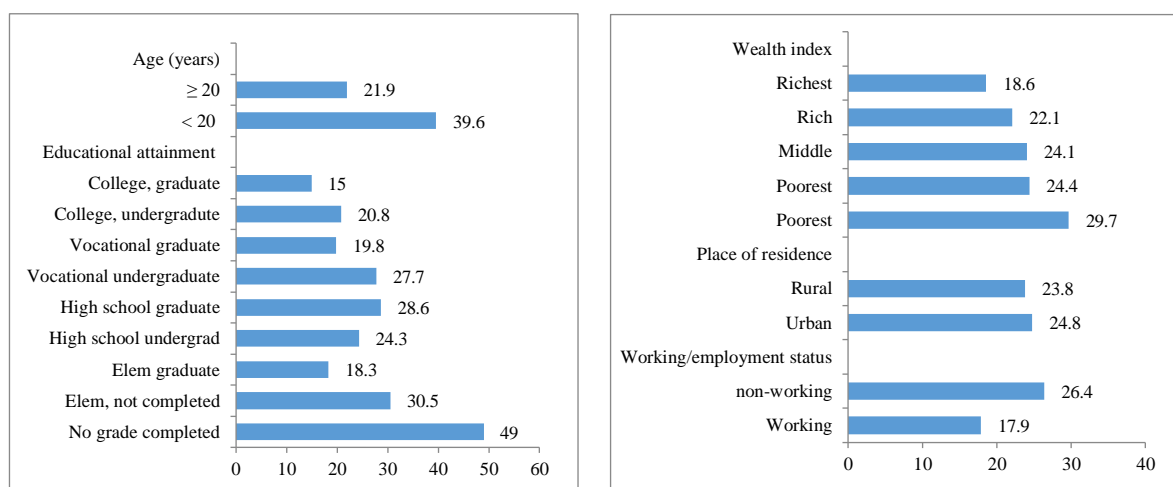
**Figure 3.** Overweight and obesity among various population groups



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

18. 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: NNS 2015, DOST-FNRI

19. 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.
20. 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 3). 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

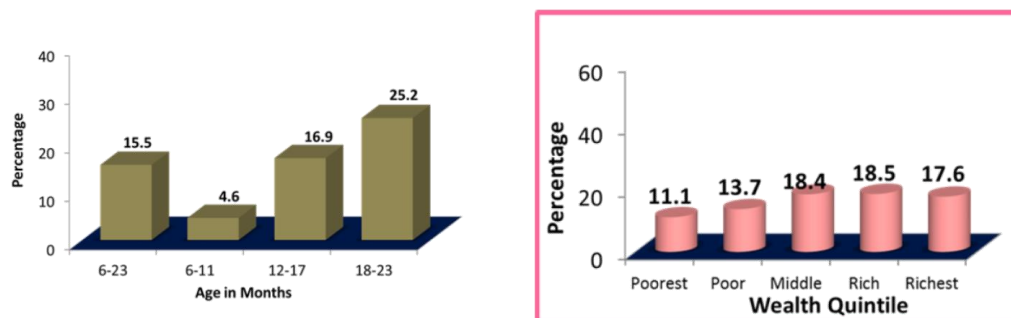
Age in months	Exclusive breastfeeding, in %		
	2011	2013	2015
All (0-5)	48.9	52.3	48.8
0	69.1	65.5	68.0
1	55.6	64.3	58.3
2	51.9	54.4	53.7
3	55.0	58.8	45.1
4	39.8	44.2	43.5
5	23.8	28.3	24.7

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.

21. 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<sup>1</sup>.
22. As shown in Figure 11, 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.

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



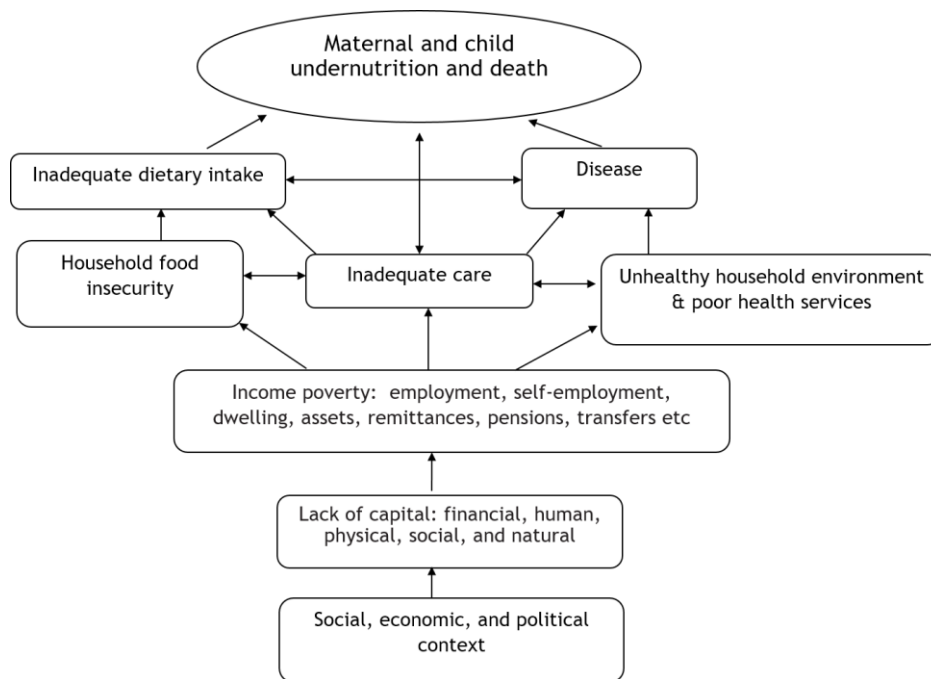
Source: NNS 2013, DOST-FNRI

### Causality of malnutrition

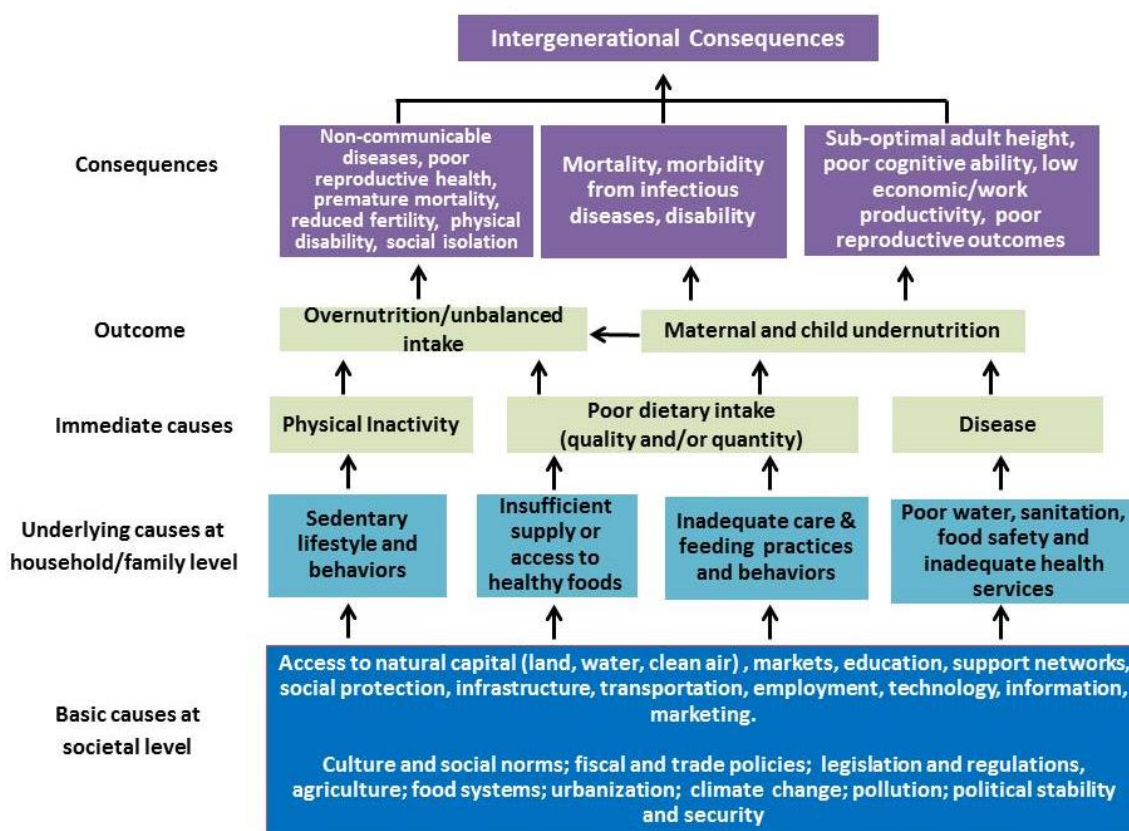
23. Figure 6 shows a framework for the causality of child and maternal undernutrition. The framework notes undernutrition to arise from the immediate causes of inadequate dietary intake and disease. These immediate causes are, in turn, linked with underlying causes that include food insecurity, poor 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.
24. 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).
25. Thus, addressing both under- and overnutrition should involve actions to eliminate or reduce the negative impact of the identified causal factors.

<sup>1</sup>Minimum acceptable diet is based on the minimum reQUENCY 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 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

26. To improve the nutrition situation of the country as a contribution to:
- The achievement of Ambisyon 2040<sup>2</sup> by improving the quality of the human resource base of the country
  - Reducing inequality in human development outcomes
  - Reducing child and maternal mortality

## Objectives

27. 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

28. To reduce levels of child stunting and wasting

Indicator	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

\* Consistent with the 2025 Global Targets for Maternal, Infant and Young Child Nutrition

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

Indicator	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
<u>Iodine deficiency disorders</u>		
• Median urinary iodine concentration, mcg/L		
- Children 6-12 years old	168	≥100
- Pregnant women	105	≥150
- Lactating women	70	≥100

<sup>2</sup> 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	Baseline	2022 Target
• Percent with urinary iodine concentration <50 mcg/L		
- Children 6-12 years old	16.4	<20
- Lactating women	33.4	<20

\* Consistent with the 2025 Global Targets for Maternal, Infant and Young Child Nutrition

30. No increase in overweight among children

Indicator	Baseline	2022 Target
• Prevalence (in percent) of overweight		
○ Under five years old*	3.9	<3.9
○ 6 – 10 years old	4.9	<4.9

\* Consistent with the 2025 Global Targets for Maternal, Infant and Young Child Nutrition

31. To reduce overweight among adolescents (from 8.3% to <5%) and adults (from 31.1% to 28%)

### *Sub-outcome or intermediate outcome targets<sup>3</sup>*

32. To reduce the proportion of nutritionally-at-risk pregnant women from 24.8% to 20% by 2022
33. To reduce the prevalence of low birthweight from 21.4% in 2013 to 16.6% by 2022
34. To increase the prevalence of exclusive breastfeeding among infants 5 months old from 24.7% in 2015 to 33.3 by 2022
35. To increase the percentage of children 6-23 months old meeting the minimum acceptable diet from 18.6% in 2015 to 22.5% by 2022
36. To increase the proportion of households with diets that meet the energy requirements from 31.7% in 2013 to 37.1 by 2022

### **Strategic Thrusts**

37. **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.
38. **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,

<sup>3</sup>Sub outcome 1 is a 20% reduction level, Sub outcome 2 is consistent with the 2025 Global Targets for Maternal, Infant, and Young Child Nutrition, i.e. 30% reduction by 2025, Sub outcome 3 represents an arbitrarily set 50% increase by 2025; Sub outcome 4 represents an arbitrarily set 30% increase by 2025; while Sub outcome 5 is based on a 15% increase by 2030 for the Sustainable Development Goals, and is based on a doubling of observed decrease between 1993 and 2013.

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.

39. **Intensified mobilization of local government units.** To ensure that PPAN 2017-2022 delivers the planned outcomes, 38 areas with greater magnitude of the stunting and wasting will be prioritized for mobilization of local government units. 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 compliment the interventions in the First 1000 Days.

**Table 3.** PPAN 2017-2022 Priority Areas

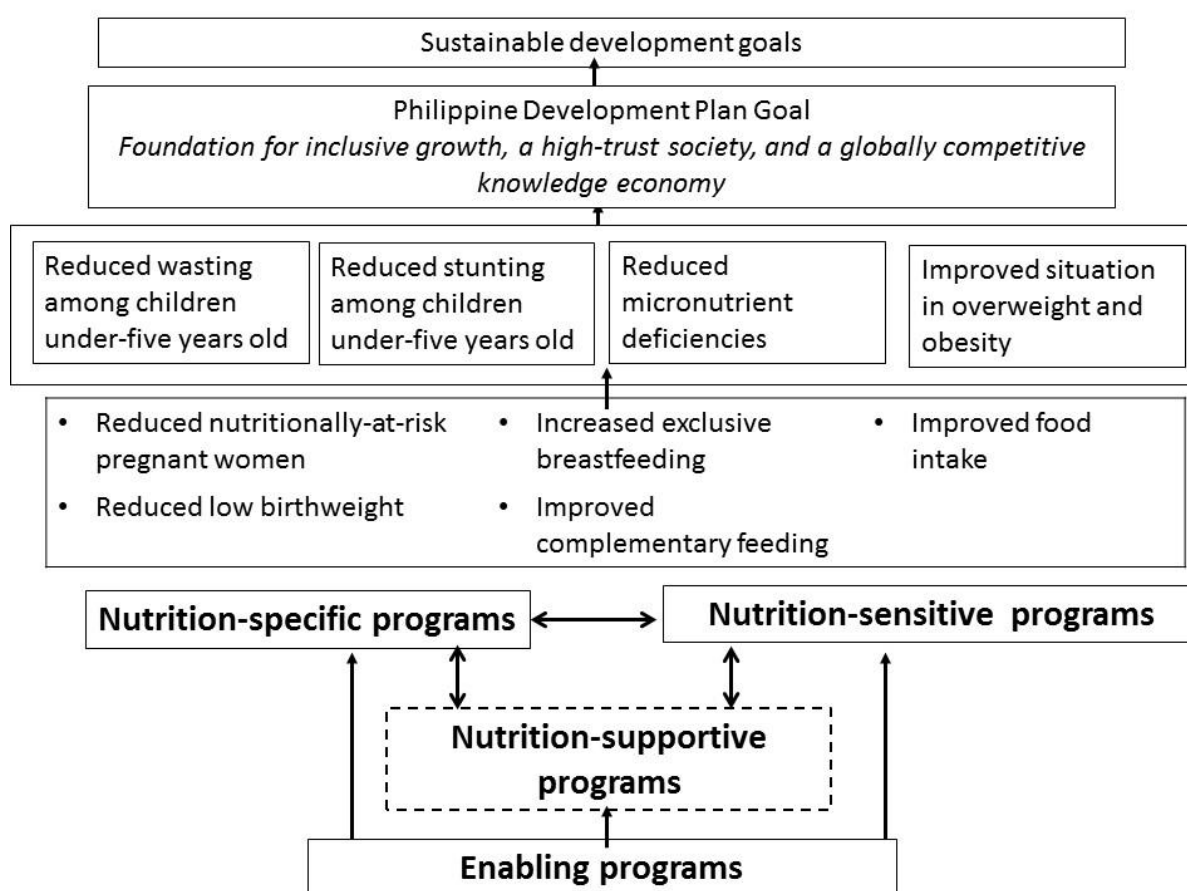
<b>REGION</b>	<b>PROVINCE</b>	<b>REGION</b>	<b>PROVINCE</b>
<b>CAR</b>	1. Abra	<b>VII</b>	20. Bohol
	2. Apayao		21. Cebu
<b>I</b>	3. Pangasinan		22. Negros Oriental
<b>II</b>	4. Isabela	<b>VIII</b>	23. Biliran
<b>III</b>	5. Aurora		24. Leyte
	6. Bataan	25. Northern Samar	
	7. Bulacan	<b>IX</b>	26. Zamboanga del Norte
	8. Nueva Ecija		27. Zamboanga del Sur
<b>IV - A</b>	9. Quezon	<b>X</b>	28. Bukidnon
<b>IV - B</b>	10. Palawan		29. Lanao del Norte
	11. Marinduque		30. Misamis Oriental
<b>V</b>	12. Albay	<b>XI</b>	31. Davao del Norte
	13. Camarines Norte		32. Davao del Sur
	14. Camarines Sur	<b>XII</b>	33. North Cotabato
	15. Catanduanes		34. South Cotabato
	16. Masbate		35. Sulu
<b>VI</b>	17. Aklan		36. Tawi-tawi
	18. Antique	<b>CARAGA</b>	37. Agusan del Sur
	19. Iloilo		<b>NCR</b>

40. **Reaching geographically isolated and disadvantaged areas (GIDAs) and communities of indigenous peoples.** 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.
41. **Complementation of actions of national and local governments**

## Program Framework

42. Consistent with the recommendations from the Lancet Series on Maternal and Child Health and Nutrition in 2008<sup>4</sup>, the PPAN 2017-2022 adopts the Nutrition Specific and Nutrition Sensitive Programs as essential interventions to address the underlying causes of malnutrition along the life cycle. Thus, PPAN 2017-2022 consists of 12 programs and 45 projects to be implemented by member agencies of the National Nutrition Council (NNC) in cooperation with local government units. Of these 12 programs, 8 are nutrition-specific, one is nutrition-sensitive and three are enabling support programs (Figure 8).

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



### *Nutrition-specific programs*

43. Nutrition-specific programs are those that were planned and designed to produce nutritional outcomes (Table 4). The selection of nutrition-specific programs to include was inspired by already-existing programs, 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.

**Table 4.** Nutrition-specific programs

<sup>4</sup> The Lancet Series on Maternal and Child Health Nutrition, 2008

<b>Program</b>	<b>Project/Component</b>	<b>Agencies involved</b>
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
	10. Supplementary feeding of children 24-59 months old	DSWD, NGOs, LGUs, DPs
	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	20. Rice fortification with iron	DOH, DSWD,

<b>Program</b>	<b>Project/Component</b>	<b>Agencies involved</b>
fortification (technology development, capacity building, regulation and monitoring, promotion)		DepED, NGOs, LGUs, industry
	21. Flour fortification with iron and vitamin A	DOH, DSWD, DepED, NGOs, LGUs, industry
	22. Cooking oil fortification with vitamin A	DOH, DSWD, DepED, NGOs, LGUs, industry
	23. Sugar fortification with vitamin A	DOH, DSWD, DepED, NGOs, LGUs, industry
	24. Salt iodization	DOH, 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 program***

44. Complementing these nutrition-specific interventions are nutrition-sensitive projects. These are development projects that were 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 a list of development programs and projects that will be tweaked to produce nutritional outcomes in addition to their original objectives. This list in this program is an initial one and will be updated in the course of plan implementation.

**Table 5.** Nutrition-sensitive program

<b>Project</b>	<b>Agency involved</b>
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
10. <i>Sagana at Ligtas na Tubig sa Lahat</i> (SALINTUBIG) and other programs on water, sanitation and hygiene	DOH, DILG, LWUA

### ***Enabling programs***

45. Mobilization of local government units for nutrition outcomes
  - a. Mobilization of Local Government Units for Delivery of Nutritional Outcomes through the NNC Sub-Regional Network
  - b. Enabling Policy and Legal Framework for LGU Mobilization
  - c. Development of Continuing Opportunities for LGU Excellence in Nutrition Programming
  - d. Mobilization of Rural Improvement Clubs and other community-based organizations for nutrition action
46. Policy development for food and nutrition
  - a. Securing policy support for improving nutrition, specifically along the priority legislative measures
  - b. Public advocacy for improved support to nutrition
47. Strengthened management support to the PPAN 2017-2022
  - a. Securing vital nutrition infrastructure and resource requirements for PPAN
  - b. Strengthening coordination, monitoring, evaluation and management of PPAN across NNC including member agencies and NNC Secretariat

## **Service targets**

As a rule, service targets or the percent of the target group that should be reached by a service, are being targeted at about 90% of the population group. 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**

48. 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.
49. At the regional level, a Regional Nutrition Action Plan (RNAP) 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 RNAP will be updated annually.
50. 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.
51. 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.
52. Monitoring will involve the generation of reports on physical and financial accomplishments from various stakeholders.