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Identifying and Addressing the Determinants of Stunting in the First 1000 Days: Review of Nutrition Governance Strategies and Implementation of the Philippine Plan of Action for Nutrition (PPAN) 2017–2022

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Abstract

To examine whether current strategies and investment are directed towards cost-effective interventions, we reviewed public expenditures on nutrition (Annual Investment Plans [AIPs] and Gender and Development [GAD)] budgets) and evaluated implementation of the Philippine Plan of Action for Nutrition (PPAN 2017–2022) at regional to barangay levels. The delivery and management of mostly nutrition sensitive programs and interventions by looking at the three dimensions of awareness, adoption, and accountability. Qualitative data collection through KIIs was undertaken for Objective 3a (LGU nutrition governance) and Objective 3b (PPAN assessment) in an integrated manner. Eight (8) KIIs were conducted at regional, 9 at provincial, and 26 at city/municipality levels and 104 interviews were conducted at the barangay level from January to March 2021.

Higher levels of governance (regional to city/municipality levels are cognizant of the PPAN (2017–2022) as the national strategy to improve nutrition. Integral to the Philippine Development Plan; considered as a roadmap for operationalizing programs, projects, and activities. At these levels, the PPAN framework is integrated in local nutrition action and investment plans. However, there is a general lack of awareness on the PPAN at the barangay level which is the locus of implementation. Budget allocation and implementation are found to be inconsistent and highly fragmented across different governance levels. At lower LGU levels financing nutrition programs are perceived to be highly dependent on the priority of and buy-in from local chief executives, particularly mayors. This disparity in funding across LGUs is highly indicative of a lack of specific guidance for budget allocation. Local nutrition committees need to prioritize programs and target beneficiaries given the already limited budget. A deficit in human resources especially at the city/municipality and barangay levels remains to be a major bottleneck in implementation. Regional NNC Offices serve as a conduit for accountability and reporting between national level and LGUs. They are also responsible for advocating resource generation and mobilization, as well as building linkages. The MELPPI is done to track program implementation. Provinces function as intermediaries between LGUs and different stakeholders through advocacy, strategy development, and overall knowledge brokering. Cities and municipalities, on the other hand, are the primary drivers of implementation. They craft and develop the local nutrition action plans and provide support to barangays which are at the forefront of implementation. At their level, they perform program implementation review (PIR) to assess accomplishment of targets, and programmatic performance based on nutrition outcomes evidenced by OPT results - the main data for reporting prevalence of different forms of malnutrition and overall nutritional status. Results helped inform a proposed evidence-based framework for the comprehensive and sustainable implementation of the First 1000 Days Strategy and Nurturing Care framework for Early Child Care and Development.

Keywords: nutrition governance, plan of action for nutrition, awareness, adoption, accountability, First 1000 Days, Nurturing Care

Acknowledgments

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Review of Nutrition Governance Strategies and Implementation of the Philippine Plan of Action for Nutrition (PPAN) 2017–2022

Maria Asuncion A. Silvestre, Christian Edward L. Nuevo, Alfredo Jose C. Ballesteros, Joy Bagas, Valerie Gilbert T. Ulep[1]

1. Introduction

To examine whether current strategies and investment are directed towards cost-effective interventions, we reviewed public expenditures on nutrition and evaluated implementation of the PPAN at various governance levels. We reviewed Annual Investment Plans and interviewed key informants from national government agencies, program coordinators at regional, provincial, city/municipality and barangay levels, nutrition action officers and program/project/activity officers and also beneficiaries on the delivery and management of mostly nutrition sensitive programs and interventions. Results will inform an evidence-based framework for the comprehensive and sustainable implementation of the First 1000 Days Strategy.

2. Objectives

The overall objective of the study is to determine the drivers of stunting and examine whether current strategies and investments are directed towards cost-effective interventions. The Department of Health (DOH), National Nutrition Council with support from UNICEF identified three major objectives of this study. This last of three (3) reports, includes content for Specific Objective 3 that will be integrated with the reports already submitted for SO1 and SO2:

SO 3a Public Expenditure Review on Nutrition Spending

a. Analyze the level of public spending on nutrition of selected local government units (LGUs)
b. Analyze patterns of allocation of spending on nutrition across sectors and within sector and determine the allocative and distributional efficiency of these interventions
c. Analyze the input mix of public spending on nutrition.
d. Analyze the distributive equity of key nutrition programs
e. Analyze the transparency of budgetary formulation allocation.

SO 3b PPAN evaluation, LGU nutrition-program, and framework development

a. Review governance strategies of selected local governments in the delivery and management of programs and interventions.
b. Review the implementation of the PPAN vis-à-vis the results of the study and formulate the needed recommendations.
c. Develop an evidence-based framework for the comprehensive and sustainable implementation of the First 1,000 Days Strategy.

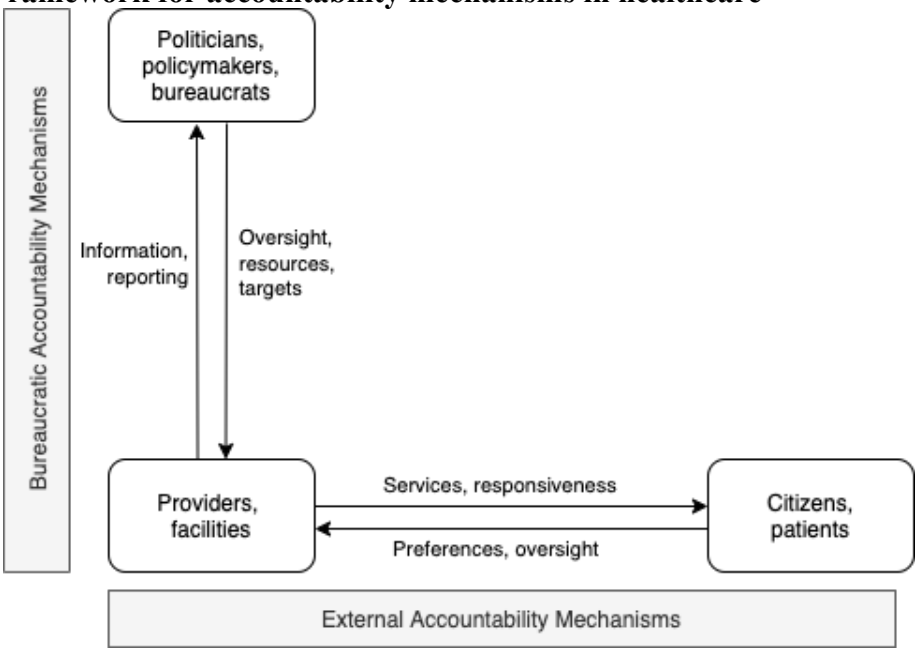
[1] MAS and CEN are consultants for Philippine Institute for Development Studies (PIDS). MAS worked on the PPAN Evaluation and CEN worked on the LGU Nutrition Program and Financing. JB and AJB are Research Assistants for the project. VGU is the Project Director and a Senior Research Fellow at the Philippine Institute for Development Studies.

3. Methodology

Governance is one of the softer components of the health system compared to others such as human resources for health, medicines, and infrastructure. A guiding framework is thus important in order to examine governance dynamics influencing the provision of nutrition-related and nutrition-sensitive services at the local government level. While there are several frameworks available in literature specific to nutrition, these are typically more general and macro in nature. Their static natures do not capture well power and decision-making dynamics that are crucial for this study.

In order to facilitate the objectives of the study, the Framework of Accountability Mechanisms in Health Care shall be used as conceptual framework (**Figure 1**).

Figure 1. Framework for accountability mechanisms in healthcare



Source: Cleary et al. 2013

This framework has strong roots in primary health care, to which nutrition is a crucial part of. By emphasizing both bureaucratic (institutions, powers) and external (stakeholders, citizens) accountabilities, it places well the dynamics of a wide range of factors that affect governance. This framework also puts primary focus on district / local level health systems, recognizing the situation of local governments in-between a central government, and its constituencies.

Analysis of the qualitative (primary) and financial (secondary) data gathered was anchored on the above framework and supported by other health system governance principles in published literature, to further enrich the insights.

3.1 LGU Nutrition Program

To examine how LGUs typically manage and implement nutrition programs, we focused on three domains: **financing, delivery,** and **governance.** Delivery is key in the dynamics between the provider/facility and the citizens/patients, while financing and governance are key to the relationship between provider/facility and the politicians and bureaucrats. The framework helped facilitate the organization and analysis of these domains to produce a comprehensive view of governance at the LGU level.

An earlier PIDS Discussion Paper Series No. 2019-28 to 31 engaged LGUs as well to assess financing, delivery, and governance in KOICA-UNICEF sites (i.e., Samar, Northern Samar, Zamboanga del Norte). Comprehensive reports have been put together and published, covering insights down to the level of beneficiaries and barangays. However, it was observed that a huge proportion of the data as reported in these discussion papers are on nutrition-specific programs. Recognizing the information already available for fairly current nutrition-specific programs, this study focused more on nutrition-sensitive programs. Through this, understanding on financing, delivery, and governance at the local level in relation with nutrition was more complementary and complete. This did not mean that data collection completely disregarded the former. However, probing was pursued more for nutrition-sensitive programs. Review of documents (i.e., investment plans, operating plans, budget, and expenditures, etc.) covered both nutrition-specific and nutrition-sensitive programs to the extent possible and available.
The table below presents the specific areas examined under each domain:

Table 1. Nutrition program data/information examined per domain

Domain	Areas	Data/information
LGU Financing	1. Level, type, and sources of public spending on nutrition 2. Allocation/prioritization practices and modalities of LGUs towards health/nutrition	Financial data of municipalities (e.g., Annual Investment Plan, Gender, and Development Fund) Key informant interviews of key officials. Document reviews
LGU service delivery (health facilities; human resources - e.g., staff, program Officers e.g., WASH workers; and beneficiaries)	1. Implementation and management of nutrition programs, including issues of different actors (e.g., LGU chief, health chief, health workers, other LGU agencies) 2. Availability, quality, and roles and functions of health workers (including backend workforce such as strategic planners/managers) in the delivery of nutrition programs 3. Role of the private sector	Key informant interviews and Operational plans and strategies of provinces, municipalities, and barangays

LGU Governance	1. Institutional arrangements and dynamics of units involved in the implementation of nutrition programs in LGUs 2. Strategic direction/policy development of LGU nutrition programs 3. Accountability mechanisms in implementing nutrition programs 4. Leadership in LGUs	Key informant interviews; document review

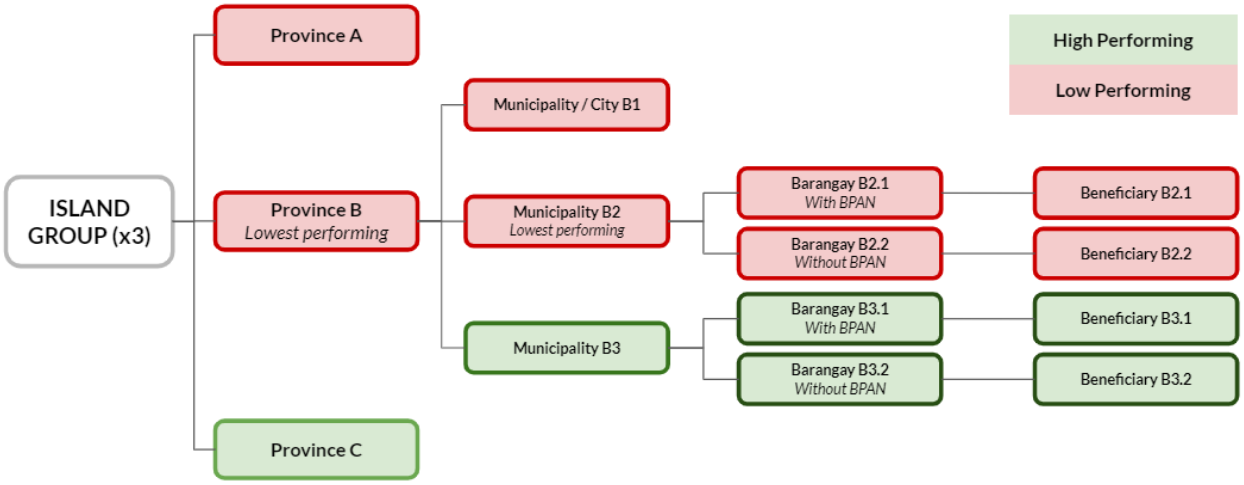
Source: Authors' interpretation

We performed quantitative and qualitative methods to answer issues under each domain. For the quantitative assessment, we examined the level, type and source of nutrition expenditures and the level of prioritization using financial and budgetary data of selected LGUs.

As part of the pre-interview phase with the targeted LGUs, financial documents were requested, particularly their Annual Investment Plan (AIP) from 2017 to 2019. Historically, it is known that the Gender and Development (GAD) funds of LGUs also function as a major source of funds for nutrition-specific and nutrition-sensitive programs and were requested as well. However, time constraints and actual document collection as expressed by field enumerators led to difficulties in obtaining the full set of financial data across all LGUs from 2017 to 2019. To address this, the team decided to focus and deep drive on financial data collected for 2019. According to an interview with Regional NNC, the Regional Level (RPAN) 2017-2022 which cascades down to local governments actually started in 2019 since workshops were conducted in 2018. This makes 2019 a good reference year to check expenditure patterns. Furthermore, this is also the most complete. Analysis was also done at the provincial level.

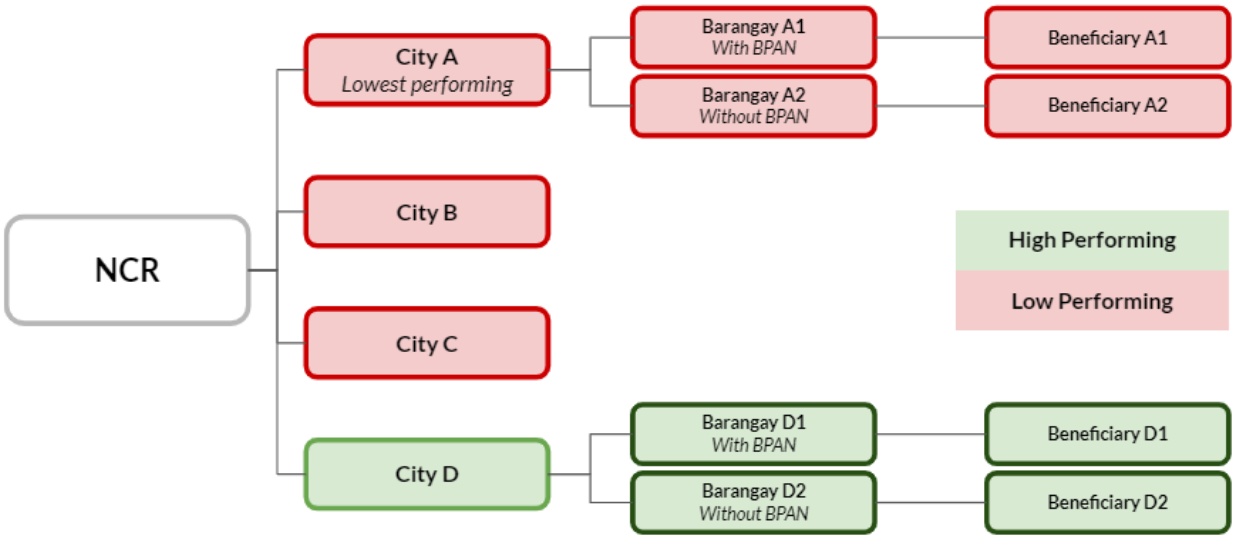
For the qualitative assessment, we identified and reviewed existing LGU strategies and plans (e.g., local investment plan, plans of action for nutrition), and policies to understand the implementation of nutrition interventions. We also supplemented quantitative data and documented review with qualitative assessment. Nutrition Action Officers of provinces, Barangay Captains, Nutrition program officers and barangay nutrition scholars (BNS), as well as beneficiaries from selected barangays were engaged in key informant interviews (KIIs).

Figure 2. Qualitative Site (Provinces) Sample Selection



Source: Author's illustration

Figure 3. Qualitative Site (NCR) Sample Selection



Source: Author's illustration

From each major island – Luzon, Visayas, Mindanao – three (3) provinces were selected. One (1) province with low stunting prevalence, while two (2) other provinces with high stunting prevalence based on the 2019 OPT Results were included in the sampling. This totaled to 9 provinces.

The National Capital Region (NCR) was treated separately on top of the three (3) selected provinces per island group. Three (3) NCR cities with the highest estimated stunting **numbers**, and the city with the lowest stunting numbers were selected. This totaled to 4 cities.

KIIs were done for each of the 9 provinces and 4 NCR cities. Target informants were their health and nutrition officers.

In selecting the municipalities from the three low-performing (high stunting prevalence) provinces, we selected two municipalities or cities in each using the following criteria:

- Fifth class municipalities (or cities) with high stunting or numbers
- First class municipalities (or cities) with high stunting or numbers
- Topography: Coastal, farmland, and mountainous municipalities

Similar to NCR, the municipality or city within the province with the lowest stunting numbers was also selected.

The selection of a mix of high-performing and low-performing areas across the different levels of government was done in order to capture both good and bad practices in relation to the governance, financing, and delivery of nutrition interventions.

Given that the *barangay* should be the locus of delivery of nutrition-specific and nutrition-sensitive services, as articulated in RA 11148 (Kalusugan at Nutrisyon ng Mag-Nanay Act of 2018), data was also collected at the *barangay* and beneficiary levels. One municipality or city representing each of the island groups and NCR was purposely selected, with priority for the different topographies. A *barangay* pair from each of these municipalities or cities was selected - One (1) **with a *Barangay* Plan of Action for Nutrition (BPAN),** and an adjacent one without a BPAN. In the selected municipalities, should there be no barangay with a BPAN, the plan was to purposively select a replacement while still preserving representation in the major island groups and topography. Should no barangay pair be identified, the plan was to do random selection. Official endorsement was secured from the municipality or city.

Enumerators interviewed two (2) to four (4) beneficiaries of nutrition-sensitive programs from the chosen barangays. Random selection from a master list of beneficiaries available in the barangay was performed. The number of target areas for data collection are listed in **Table 2**.

Table 2. Number of Target Areas for Data Collection

Per Island Group	9 Provinces
	9 Municipalities / Cities
	12 Barangays
NCR	4 Cities
	4 Barangays

Source: Authors' interpretation

From the target areas, key informants based on their function in nutrition governance and implementation were selected for the KIIs. The profile of key informants is outlined in **Table 3**.

Table 3. Profile of Key Informants at each level of governance.

Region and Province	**Municipality / City**
• Provincial Nutrition Action Officer (PNAO) • Regional NNC Program Coordinator	• Municipal / City Nutrition Action Officer (M/CNAO)
Barangay	**Beneficiaries**

• Barangay Captains
• PPA Officers and Barangay Nutrition Scholars (BNSs)
  • Two (2) in w/ BPAN
  • One (1) in w/o BPAN*
**May be other influential / significant individual since officer may not be available due to lack of a BPAN*
	• Two (2) to four (4) Beneficiaries* of Nutrition-sensitive PPAs
	
	** To be identified in partnership with local CSOs; if none, random selection from beneficiary list, or opportunistic interview in service delivery sites (ex. RHU, fish ports, markets, church, etc.)*

Source: Authors' interpretation

Results of the KIIs were transcribed and translated before analyzing thematically. We employed the following stages in thematic analysis:

- **Coding.** This stage involves generating labels that identify important features of the data that might be relevant to the research question.
- **Generating initial themes.** This stage involves examining the codes and collated data to identify significant broader patterns of meaning.
- **Defining and naming themes.** This stage involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the story of each.
- **Writing up.** This stage involves weaving together the analytic narrative and data extracts and contextualizing the analysis.

3.2 PPAN Assessment

The Philippine Plan of Action for Nutrition 2017-2022 is an integral part of the Philippine Development Plan. It outlines the country's strategy to improve nutritional status. It also articulates the investment requirements to implement these strategies. In this study, we examined the implementation of PPAN among relevant national government agencies (NGA) and local government units (LGUs) by looking at the following dimensions:

1. **Awareness** included questions that capture the knowledge and perception of the top leadership and backend workforce of NGAs and LGUs about PPAN and its core strategies.
2. **Adoption** included questions that capture how PPAN strategies are implemented (i.e., innovative delivery models) and how they are reflected in the work and financial plans of NGAs and LGUs.
3. **Accountability** included questions that capture governance dynamics and structures of NGOs and LGUs to adopt PPAN and its core strategies.

We conducted:

1. Desk review: We will examine previous assessment and evaluation, review of government documents, policies, and strategies including the PPAN mid-term review.
2. Primary data collection: We used qualitative methods to capture information about these three domains, i.e., key informant interviews with NGAs (See Table 3) and LGUs implementing the nutrition and health programs. The KIIs for LGUs were dove-tailed with the LGU Nutrition Program component (See Figure 3).

Qualitative data collection through KIIs was undertaken for Objective 3a (LGU nutrition governance) and Objective 3b (PPAN assessment) in an **integrated manner** (See Figures 3 and 4 above). Eight (8) KIIs were conducted at the regional level; 9 for the provincial level; and 26 including both pre-interview and KII for city/municipality level. A total of 104 interviews were conducted at the barangay level including both pre-interviews and KIIs.

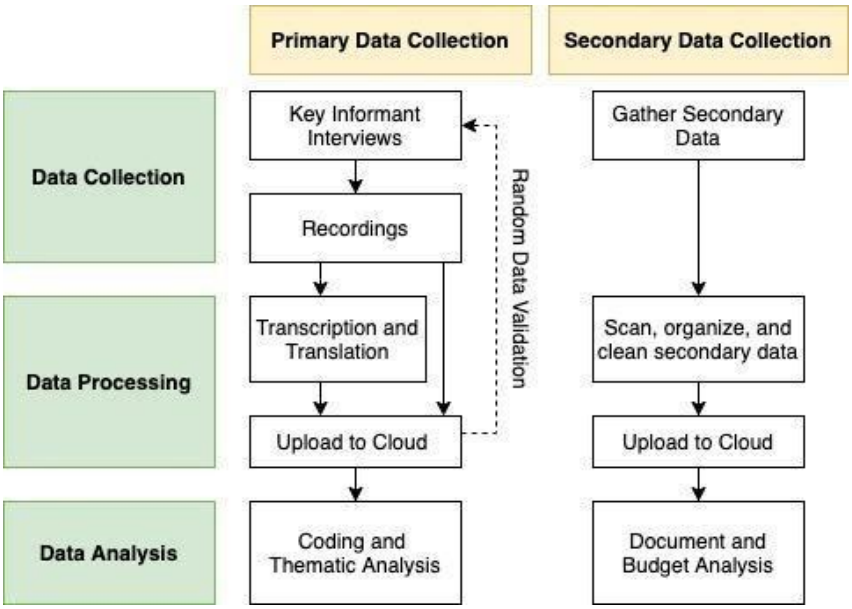
3.2.1 Selection of Key Informants

Key informants interviewed were Health/nutrition, and budget officer at the provincial and municipal levels, i.e., provincial/municipal health and NNC officials and municipal nutrition action officers where MHOs were not available for interview; and local chief executives at the village (*barangay)* level, i.e., *barangay* captains. From these interviewees a "snowball" sampling methodology was utilized to recruit *barangay* PPA officers and beneficiaries. Priority nutrition sensitive PPAs probed into were those relating to livelihood and economic initiatives, WASH and Adolescent Health.

An evidence-based framework was developed for the comprehensive and sustainable implementation of the First 1,000 Days Strategy. Within this framework, we included various scenarios, and formulated intermediate and long-term indicators.

Our integrated data collection and analysis workflow for both the LGU Nutrition Program and PPAN Evaluation is illustrated in **Figure 4**.

Figure 4. Data Collection Workflow



Source: Authors' illustration

3.2.2 Coding and Thematic Analysis

The recordings from the KIIs were transcribed and translated to English. We used MAXQDA software to code our qualitative data from the various levels of informants and analyzed the findings along the following three (3) dimensions and five (5) themes, the latter adapted from the SUN checklist for assessment of *national* nutrition plans (SUN 2016).

For Awareness

- Situation analysis and policy and programming review
- Stakeholders' engagement and political commitment process

For Adoption

- Costs and budgetary arrangements
- Implementation and management arrangements

For Accountability

- Monitoring, evaluation, operational research, and review arrangements

4. Results and Discussion

4.1 Regional Implementation

4.1.1 Dimension 1. Awareness

At Regional levels, there is a high awareness of the Philippine Plan of Action for Nutrition or the PPAN (2017-2022) as an integral part of the Philippine Development Plan, which outlines the national strategy to improve the status of nutrition and articulates the investments required for its implementation. It is considered a roadmap that directs stakeholders to navigate the urgent and serious challenges of malnutrition in our country. It lists programs, projects, and activities, big and small for every participant agency to push.

The PPAN is appreciated to be a directional plan to guide on what the country wants to do visibly for LGUs. The other plans like the Ambition 2040 and the like, are the DOH plan, but it actually wants to ensure a better quality of nutrition for all Filipinos.

Regional Nutrition Committees (RNCs), chaired by regional DOH Directors, together with the National Nutrition Council and members of other government agencies convene to discuss current nutrition situations in the Region including nutrition outcome trends. The RNCs analyze both routine local Operation Timbang and DOH FHSIS data, and data from national surveys, i.e., FNRI National Nutrition Survey and the PSA and also data from local social welfare development and other local offices represented in the Nutrition Committee. The RNCs formulate their Regional Plans of Action (RPANs) which include these situational analyses of nutrition, prioritizing nutrition problems and vulnerable groups. Human rights perspective is incorporated in these plans as it recognizes optimal nutrition as a basic human right. Hence, Filipino families are also considered accountable for ensuring the family's nutritional wellness.

RPAN formulation considers international targets to which we committed to. These include the 2030 Agenda for the Sustainable Development Goals, particularly SDG2 on ending hunger, achieving food security, and improving nutrition: and the Global Targets 2025 for Maternal, Infant and Young Child Nutrition. The key characteristics of the RPANs are these

plans being 1) anchored on Ambisyon 2040 as overall framework; 2) integral to the Philippine Development Plan 2017-2022; 3) integral to the All for Health towards Health for All agenda; and 4) contributes to Sustainable Development Goals; and 5) results-based, with clear agency accountabilities.

The PPAN and RPANs aim to address the nutrition situation, providing a guide for all who want to be involved in nutrition action. It sets all the targets, directions, and priority actions to address nutritional problems and achieve the targets that will be bound in several guiding principles.

> *"The goals, objectives, and outcome targets of the RPANs are identical to those indicated in PPAN: to improve nutrition situation of the country as a contribution to the achievement of the Ambisyon 2040 by improving the quality of human resource base of the country; reducing inequality in human development outcomes; reducing child and maternal mortality as the main goals of the PPAN. The objectives of the PPAN, we have our outcomes objective or targets: to reduce the levels of child stunting and wasting, to reduce the micronutrient deficiencies to levels below the public health significance; no increase in overweight and among children; we want also to address problems on overnutrition; to reduce the overweight among the adolescents. There are sub-outcomes or intermediate outcome targets in the PPAN: to reduce the proportion of nutritionally at-risk pregnant women; to reduce prevalence of low birth weight; to increase the prevalence of exclusive breastfeeding among infants 5 months old; to increase the percentage of children 6-23 months old meeting the minimum acceptable diet to increase the proportion of households with diet that meets the energy requirements."*

RNCs compare their regional data to the benchmark national indicators and perform gap analysis for e.g., service coverage, inventories. The RNCs then set their outcome targets as a contribution to achievement of national targets and develop problem tree analyses and corresponding programs, projects, and activities, anchored in the PPAN framework. This will constitute their Local Nutrition Action Plans or LNAPs with multisectoral partners. For example, reduction of stunting - our target for the prevalence is 15.9 percent by 2022. That is based on the baseline of 24.9 percent in 2015.

The RNCs base their RPANs on the PPAN, formulating nutrition-specific and nutrition-sensitive programs and projects and their enabling mechanisms and implemented by multiple sectors. The process of formulating PANs, at the regional level is considered difficult because of the need for series of meetings among multisectoral stakeholders. Each member agency of the RNC has its own mandates and allocated budget for nutrition and nutrition related PPAs.

Various regions have innovated on mobilization strategies and approaches to implementation. One example cited was shepherding, a mentoring and supportive supervision approach wherein problems are pinpointed and prioritized for action. These shepherding visits are a response to the sentiment that annual MELPPI processes of monitoring and evaluation are not frequent enough. In the same region, various component cities have innovative nutrition -sensitive programs, e.g., urban gardening in one city, direct purchase of vegetables from rural farmers (eliminating middlemen) in another city. In other regions, learning exchanges are facilitated through Lakbay-Aral program or Program Coordinators and BNSs. They are supported to visit high performing cities or municipalities that are Awardees in the National Nutrition Awarding Ceremonies (NNAC) where they learn good practices, receive positive reinforcement, and become more motivated.

The Philippines is one of the most natural hazard-prone countries in the world. Social and economic costs of disasters, both natural and man-made are increasing due to population growth, armed conflicts, environmental degradation change, unplanned urbanization and land-use patterns, migration, and global climate change. One mitigation strategy is the nutrition-specific Nutrition in Emergencies programs which is jointly implemented by the Departments of Health, Social Welfare and Development, and the National Disaster Risk and Reduction Management Council. The NIE Program includes approaches and actions to address emergency needs (e.g., climate-driven natural disasters, emerging/ re-emerging diseases, socio-economic shocks) in line with Sphere Standards on the Humanitarian Charter and Minimum Standards in Humanitarian Responses. The current COVID-19 pandemic is exacting unprecedented tolls on the provision of essential health and nutrition services and surveillance. The risks to nutrition programs in pandemics can be antithetical to the risks posed by natural disasters or armed conflicts. In preemptive and post disaster strategies, families are evacuated and are housed or seek shelter in commonly congested, sometimes makeshift, evacuation centers, with poor WASH conditions. In the current and possibly, in future pandemics, families are quarantined into their homes, where the message of "dirty water" and the lack of facilities for washing feeding bottles to convince them of the dangers of formula feeding, are not necessarily convincing educational messages to push breastfeeding There is a felt need for better defined and innovative mitigation strategies in the face of protracted or future pandemics.

The RPANs describe multi-sectoral and multi-stakeholder governance arrangements at both national and sub-national levels that specifies management, oversight, coordination, consultation, and reporting mechanisms. These refer to and integrate national policies relating to governance, accountability, oversight, enforcement and reporting mechanisms within the relevant departments and agencies. It demonstrates how past accountability and governance issues will be overcome to fully comply with the national regulations and international good practice.

The RNC's function and role is that of a coordinating body at the regional level, continuously coordinating with different government agencies as well as the other stakeholders, e.g., non-government organizations, civil society organizations and others and so on.

Regional NNC expressed the need for clearer directives from national agencies to their regional counterparts, through legal instruments such as circulars, memorandums etc. that will serve as their reference for implementation. These directives for nutrition could be similar to the issuance of the DBM to their regional offices for cascading to local counterparts.

RPANs should outline accountability mechanisms accessible to rights holders or their representatives where they can claim their nutrition-related entitlements and report on violators. Such an institutional framework should be in place to allow identification and management of Conflicts of Interest (CoIs).

Regional NNC Coordinators are very cognizant of the role of NNC as the highest policymaking and coordinating body on nutrition whether at the central office or regional NNC office where NNC has its own people. The NNC does not have staff at the provincial, municipal city or barangay levels, but the sphere of influence is until down to the barangay level.

Regional Nutrition Committees are composed of representatives of the Departments of Agriculture, Education, Social Welfare and Development, Public Works and Highways,

Energy and Natural Resources, Labor and Employment, Science and Technology and includes the President of the regional Municipal Nutrition Action Officers. The RNC drafts the RPAN and annual Program Implementation Reviews.

In the BARMM, the members of the RNC are five (5) different ministries of the Bangsamoro region - health, education, local government, trade as the ministry of agriculture, fisheries, and agrarian reform or MAFAR. These five constitute the main agencies, i.e., specific clusters within the RNC of BARMM. The BARMM RPAN is consistent with but not identical to the PPAN, as it has been adapted to the BARMM context. BARMM has the highest stunting prevalence (45.2%) but alarmingly also rising obesity and overweight numbers. The RNC of BARMM issues recommendations through the Ministry of Interior and Local Government. The mandate or memorandum is cascaded to BARMM LGUs for compliance. Most of the BARMM RPAN directives are trickling down to the LGUs and serve as guides for the LGU to follow in drafting their RPAN-aligned local nutrition action plans.

At the Regional level, the NNC advocates for support, resource generation, mobilization to build the all-important linkages and partnerships, including those with NGOs, CSOs and academe, to generate support for PPAN. Multisectoral stakeholdership can create a huge impact. Advocacy forums are conducted to engage the other members of the Local Nutrition Committee. and to push and lobby for nutrition funds. In these forums, planning and budget officers explain what PPAN is and what the DBM issuances say.

One of the challenges encountered in terms of coordination in RNCs is the direct participation of the regional directors in RNET meetings. Although it is difficult for regional directors to be physically present in all the meetings of the RNC, the agency representatives sent (usually middle management) should be deputized/empowered to make decisions while at the meetings to expedite consensus.

Local chief executives can make or break LPANs. Regional Nutrition Committees lament how they are still grappling with how to find nutrition champions amongst city and municipal mayors and barangay captains, one year short of the end of the current PPAN. Despite their being the policy and coordinating body, the key to the achievement of nutrition targets really depends on high level political commitment to the PPAN and RPANs.

RPANs should provide a clear reference to existing codes of conduct and legal obligations applicable to each stakeholder for the prevention and management Conflict of Interests (COIs) during the development, endorsement, and implementation of the plan.

4.1.2 Dimension 2. Adoption

On 21 February 2017, the NNC Governing Board approved the successor plan, Philippine Plan of Action for Nutrition 2017-2022 during the 1st Governing Board Meeting, series 2017 through GB Resolution No. 1, s. 2017 "Approving and Adopting the PPAN 2017-2022. The plan enumerated nutrition-specific, or the interventions that address the immediate drivers of malnutrition, and nutrition sensitive interventions, or the interventions adapted to contribute and enable the specific interventions. A multi-sectoral approach was used in formulating the plan, with subsequent desk reviews and consultations with various agencies and stakeholders.

At the regional level, RNCs drafted resolutions in support of the PPAN, enjoining LGUs to adopt the PPAN. The current implementation period is 2018 to 2020. Current RPANs were drafted in 2019.

The RNC drafts a Local Nutrition Action Plan or LNAP. Approval of the Annual Implementation Plan is contingent upon this LNAP among others, per DBM Local Budget Memo No. 80. This financial framework should include a comprehensive budget/ costing of planned actions and demonstrate efficiency and effectiveness of included PPAs. This framework will ensure the availability of funds for programs which are included in the plan. The basis for budgeting emanates from this plan - how programs allocate resources based on target recipients and planned activities. Estimates include a description of the costing methodology and assumptions and how these align with existing budget frameworks of the sectors concerned and recurrent and investment costs to implement planned actions, including (but not limited to) costs for staff, equipment, supply, direct costs, such as utilities, and indirect costs, such as training and supervision. Some Regional NNC staff report difficulty in assessing whether coverage targets are reached or budgets adequate, even pre-COVID but more so now during the pandemic. At the local level, with LNAPs, the budget does not come solely from the LGU but also from other sources - member agencies, NGOs or even CSOs. Budgeting is facilitated if the PPA Officer is a nutritionist, but this is not always the case. Conversely no matter how hardworking the NAO, or the BHW or the BNS are, an inadequate budget from the LGU constraints implementation.

Enabling mechanisms for implementation of the nutrition programs include capacity development, trainings. Funds have to be allotted to capacity building. At the regional level, it is always training of trainers who eventually cascade the training to city and municipal. Local Nutrition Committees should be active, functional, and able to plan for their Nutrition Action Plan so that it will be funded. The plan will be based on their identified problems and possible solutions based on their situational analysis. They will identify their activities, recipients and compute the budgetary requirements which they will propose. This Nutrition Action Plan will be included in the Annual Investment Program of the city or municipality so that they will get funding. There will be hearings and lobbying levels. If they are not able to plan, they will be left behind. If the Nutrition Committee is not active, they will not be able to plan the Nutrition Action Plan, and there will be no presentation to request. Unfortunately, at the local level, the lamentation is that the basis for funding becomes political.

From the regional perspective, the observation is that funding is driven largely by politics at the local level which determine how much resources nutrition gets, and which nutrition programs are allotted these resources. Integration of the PPAN to programs of the local chief executive is an effective mechanism to ensure funding for nutrition programs. Aside from this, local bodies such as the Local Nutrition Committee play a crucial role in making sure that this

decision-making follows through to actual budget allocation in line with problems and needs of the local community. Since security in the budget is not ensured, active participation in key steps such as budget hearings and development of Annual Investment Programs (AIPs) cannot be underestimated.

Regions participate in this entire ecosystem not as direct process owners of budget processes and systems but create influence by ensuring local officers are capacitated. Training on the RPAN, program management, as well as innovative approaches are provided by the region. The goal of these activities is to heighten appreciation for nutrition, and consequently direct more and consistent funding towards the right interventions. Each year, the available resource for nutrition is not guaranteed and will be subject to some deliberation and decision-making. A continuous process of capacity building then becomes important especially in order to keep up with annual cycles of resource allocation and opportunity.

In line with Republic Act 11223, the Universal Health Care Act mandating clinical practice guideline (CPG) development and health technology assessment (HTA), priorities for spending can be better spelled out based on cost-benefit analysis and demonstrated efficiency and effectiveness of the included nutrition programs and interventions.

At the Regional level, the operational framework describes detailed roles and responsibilities of the Government and partners in implementing, managing, and ensuring accountability of planned actions, including in governance and the organization of service delivery. The operational framework is developed according to existing delivery workforce and related capacities, based on the stakeholder mapping. The mechanisms for ensuring that sub-sectoral operational plans, e.g., sub-national plans, nutrition-relevant sector program plans and plans for agencies and autonomous institutions – are related and linked to the strategic priorities in the PPAN and integrate mutual accountability mechanisms. There should be a clear timeline that provides for the development of specific guidelines and annual operational planning.

At the regional level, RNC member agencies, based on their agency mandates, identify what programs and projects to commit to that are aligned with PPAN, the framework. The RPANs include these and provide for sound implementation pathways for joint targeting and efficient use of resources to address the food and nutrition security situation, based on updated information and consultation with local actors.

> *"For the regional level, we are still waiting for directives from the Central Office ... Only the DILG issued directives, but I am not sure with DA. DA leads in the nutrition-sensitive, but they were not able to issue policies supporting the programs of PPAN. DOH has a joint memorandum circular with DILG and NNC. We were hoping that the national offices will disseminate directives supporting PPAN and RPAN interventions and funding to their respective regional offices. With that, the regional offices can identify their beneficiaries in LGUs. But during PIR, they can provide us reports and accomplishments."*

The Regional NNC has a role in advocating for resource generation and mobilization by building linkages and establishing partnerships to generate support for PPAN. NGOs, CSOs, academe are mobilized in collaborative efforts at the national, regional, and local levels to achieve targets of reduction in stunting and wasting and prevention of increase in

overweight, obesity and other forms of malnutrition. LGUs have to be mentored and provided with technical assistance with regards to PPAN implementation.

The lack of manpower is a pervasive capacity gap in the regional offices. In all NNC Regional Offices there are only four (4) permanent positions: Regional Nutrition Program Coordinator, Nutrition Officer III (only technical staff of RNTC, Administrative Aide VI (clerk) and Administrative Aide IV (driver). To fill this manpower gap, some offices are able to hire job order (JO) staff, but there is no assurance that this JO hiring can be continued. There are likewise not enough nutritionists being hired. In one Region, it was reported that there were only three (3) nutritionists. Target is to have one BNS per barangay.'

NNC staff hold positions only at the regional offices. There are no NNC staff for provinces down to cities/municipalities, down to barangay levels. At provincial and city/municipality levels, Nutrition Action Officers are designated by LCEs. The designation or appointment to this position is variable. Some PNAOs, CNAOs and MNAOs are health professionals. In other areas, these are social workers, or members from the PPAN partner agencies. As such, the skill sets for LNAPs, more so implementation and monitoring of PPAN nutrition-specific and nutrition-sensitive PPAs are commonly inadequate.

At the community level, many LGUs lack Barangay Nutrition Scholars and where available, these Barangay Nutrition Scholars do not have plantilla positions. They are hired as casuals, job order staff or occasionally hold permanent positions. In many barangays, they are co-terminus with the barangay captain. This results in problems of retention of trained BNSs, necessitating repeated re-training. For example, saturation IYCF training of BNSs was done in 2008-2012 by regional staff in one region. Ten years hence these trained BNSs are no longer working in the barangays.

For nutrition specific program activities, Regional NNC staff rely heavily on health professionals (doctors. midwives and nurses) who themselves are tied up with patient care and their practices. Municipal health officers (MHOs) have both clinical and administrative functions and are thus also overstretched. Nutrition programs commonly have to take the backseat.

4.1.3 Dimension 3. Accountability

The barangays are evaluated by the municipalities/cities who in turn are evaluated by the provinces through their Provincial Nutrition Evaluation Team (PNET), and the provinces are rated by the Region. At the Regional level, the nutrition evaluation team is the Regional Nutrition Evaluation Team or the RNET.

The RNET is composed of the NNC Technical Working Group and members from other agencies, i.e., the DOH, DSWD, DILG, DA, DepEd, NEDA, a member from the PopCom or now called Community Development Population, and the National Food Authority, During the annual face-to-face (*en banc*) MELLPI, other agencies like the DPWH are also involved aside from NNC in the monitoring and evaluation of the PPAs and its implementation. This MELLPI is conducted yearly face-to-face such that evaluators visit the site to assess and check the status of program implementation. Data for monitoring and evaluation is sourced from Operation Timbang, and the FNRI National Nutrition Survey at the regional level and used in the annual MELPPI reviews. In 2019, review of quarterly accomplishment reports submitted by cities and provinces were replaced by upgraded MELPPI processes using the more automated, quantitative MELLPI PRO tool wherein evaluators insert or encode their ratings, results are displayed and the status of the LGU *vis a vis* their LNAPs are demonstrated. This is the tool used to assess PPAN program implementation plus the enabling mechanisms and organization support given by LGUs to PPAN.

The BARMM MOH works closely with NNC BARMM for nutrition-specific programs; and the MILG for LGU implementation; the Ministry of Education for supplementary feeding programs and also the Ministry of Social Services and Development. OPT data is collected (with considerable difficulty), collated and analyzed. Even pre-COVID, the monitoring and evaluation processes are difficult considering the difficult access to barangays due to armed conflicts, remoteness, etc., and competing health activities like supplemental immunization activities. Per protocol, reports are submitted to the Chief Minister, but are shared with DOH and NNC Central Offices.

NNCs mandate is policymaking and coordination for nutrition with different government agencies as well as the other stakeholders just like non-government organizations, civil society organizations and others. Regional NNC office staff are accountable to the central office and the whole government to perform duties expected from a regional office. Regional NNC verbalize their accountability to the people as public servants, accountable to everyone. At the Regional level, through the RPAN, the NNC is not the implementing organization but are part of the NNC Secretariat, the whole organization.

Program Implementation Reviews (PIRs) by the whole RNET are conducted annually to assess the effectiveness of strategies used and to check accomplishments against the targets in the RPAN. Program activities and outputs are monitored. When targets are not achieved, by the agencies, reasons are probed. Funding and funding mechanisms are evaluated scarcity of funding, non-release of funding, change in agency mandates etc.

Based on the regional 2019 data, there was reduction in all forms of undernutrition (wasting, stunting) and overnutrition (overweight and obesity). Majority of our LGUs demonstrated improvements. Unfortunately, since there was no PIR in 2020 because of the pandemic, only coverage targets albeit also incomplete, not nutritional outcomes could be assessed.

Target beneficiaries are from the lower strata of our communities at the barangay level, where stunting, wasting, malnutrition cases abound. Regular quarterly meetings with regional networks are held to discuss issues and concerns, update community workers and beneficiaries with new strategies and policies in addressing nutrition-related problems. Nutrition action officers, PPA officers and community volunteers, i.e., BNSs and BHWs are provided copies of RA 11148 as their basis for allocating budget for their programs, projects, and activities through implementing the First 1000 Days or F1K program. Policies are provided to help them in lobbying to their LCEs for investments in nutrition.

At the national level, there is an awarding system:

> *"Nutrition National Awardee for best LGUs, best BNSs held at the Philippine International Convention Center. Multisectoral partners and dignitaries are invited to this Ceremony for high visibility. At Regional level, there is an annual contest for best NNC Facebook page. In Regional advocacy forums with Nutrition Committee Members, NOWSNAOs, NDs, and mayors, good practices are highlighted. On social media, Facebook is a well utilized platform. Local Nutrition Committees are encouraged to have their own Facebook page so that they can post their nutrition PPAs. They are able to communicate with a wide audience."*

RPANs should set out the processes to monitor the implementation of the Conflict of Interest (CoI) institutional framework and related processes for mutual accountability. Operational research (OR) for the rigorous documentation and dissemination of good practices and lessons learned (including both successes and failures) should be intensified. These translational or implementation research findings should be very helpful as interventions are rolled out for the First 1000 Days strategies.

4.2 Provincial Implementation

At the provincial level, one KII was conducted with a PNAO from one of the selected provinces. For the analysis of financial data, an inventory of the collected AIP 2019 and GAD 2019 from the provinces are as follows:

Table 4. Collection of 2019 AIP and GAD data sets from selected provinces and municipalities/cities

Province/Municipality/City	AIP 2019	GAD 2019
Camarines Sur	✓	✓
Camaligan	✓	X
Libmanan	X	✓
Naga City	✓	✓
Iloilo	✓	✓
Maguindanao	✓	✓
South Upi	✓	✓
Sultan Kudarat	✓	✓
Datu Odin Sinsuat	X	✓
Misamis Oriental	X	✓
National Capital Region	✓	✓
Valenzuela	✓	✓
Caloocan	✓	X
San Juan	X	✓
Manila	X	✓
Northern Samar (Catarman)	X	✓
Pampanga	X	✓
Samar	✓	✓
Catbalogan	✓	✓
Sta. Rita	✓	✓
Talalora	✓	✓
Zamboanga del Norte	X	✓

Source: Authors' compilation

The submitted 2019 AIP indicates the fund sources for the different programs and activities implemented. In most instances, multiple fund sources are indicated for each. However, actual amounts could not be attributed for each fund source because these are not disaggregated accordingly in the dataset. As a form of processing, a tally was done on the frequencies of tapping a particular fund source. While this does not provide insight on magnitude in terms of amounts, it shows which fund source is more frequently used by local governments in implementing nutrition programs. Funds sources were grouped as follows:

- Local general - indicated as general fund
- Local special - fund pools with special purposes (i.e., GAD, mitigation fund, trust fund, disaster/calamity fund, Local Development Fund, Special Education Fund, Special Purpose Allocation, Senior Citizens Affairs, LGU Corporate Powers Challenge Fund)
- Nutrition - indicated as nutrition fund
- National - NGAs, internal revenue allotment
- PhilHealth - income from the Philippine Health Insurance Corporation
- Non-government - public-private partnership
- Others - no specification; indicated as others

In terms of expenditures, data from the 2019 AIP and GAD were categorized into four main groups:

- Nutrition-sensitive - addresses immediate determinants of nutrition
- Nutrition-specific - addresses intergenerational, social causes, or broad issues that affect nutrition
- General enabling - not particular as nutrition-specific or -sensitive, and/or administrative
- Unknown - cannot be grouped due to lack of identifiable detail

For those grouped under nutrition-sensitive and nutrition-specific, further categorization was done as follow:

Table 5. List of nutrition-specific and nutrition-sensitive interventions and their respective scopes

Program Classification	Scope
Nutrition-sensitive	
Access to healthcare services	● Social health insurance ● Primary health care facilities ● Inpatient care facilities
Adolescent health and education	● Teenage pregnancies ● Education interventions
Agriculture (food security and availability) and	● Food production ● Poultry and fisheries

fisheries	• Crops and vegetables
Disease prevention and management	• Treatment for communicable/infectious diseases and non-communicable diseases, support for senior citizens and persons with disability • Vaccination and immunization • Neglected tropical diseases
Early childhood care and development (ECCD)	• Responsive caregiving - training parents and caregivers • Early childhood education and learning (0 to 3 years)
Family planning and responsible parenting	• Family planning commodities • Responsible parenthood
Gender, women's empowerment, and child protection	• Women's livelihood • Maternal education, maternity protection in the workplace • Reduced gender discrimination • Violence against women and children
Humanitarian relief and emergency fund	• Quick response and calamity fund • Health emergency response
Maternal and neonatal health	• Antenatal care, facility-based delivery, postnatal care • Newborn care
Oral health	• Oral and dental health
Social welfare and peace and order	• Transfer (food or in-kind) • Poverty reduction • Peace and order
Water, sanitation (environment), and waste management	• Water systems • Handwashing and sanitation • Clean & green / environmental activities • Waste management
Nutrition-specific	
Infant and young child feeding	• Breastfeeding, appropriate complementary feeding • Dietary diversification in young children
Integrated management of acute malnutrition	• Malnourishment interventions • Malnourishment monitoring
Micronutrient supplementation	• Vitamin A, iron, folic acid, zinc • Multiple micronutrient powder
Nutrition specific support	• Nutrition personnel (i.e., BNS) • General nutrition programs (no identifiable specifics, but tagged as nutrition)
Overweight/obesity management and prevention	• Health lifestyle • Exercise and physical activities
Supplementary feeding	• Supplementary foods

General enabling	• **Administration, office functions** • **General LGU planning**
Unknown	***No identifiable detail for categorization**

Source: Authors' compilation

This data processing was done individually and in aggregate of all provinces and municipalities/cities.

4.2.1 Dimension 1. Awareness

PNAOs have good knowledge and understanding of PPAN and nutrition in general, which they use as their basis in engaging with other key stakeholders and units across governance levels. PNAOs operate with a technical lens in terms of approaching nutrition and the activities relating to it. They put great value in the PPAN and recognize that targets set within are linked with bigger national (Ambisyon 2040) and global (SDG) agendas. Thus, within their locality, they also benchmark these metrics both internally and externally. For example, there is recognition that while nutrition status may be improving across the years, a comparison with global (WHO) standards may prove that efforts still need to intensify, and that double (including overnutrition) and triple burdens of malnutrition exist.

> *"Yes. From the national level PPAN is the only framework for all nutrition interventions. It is our Bible."*

> *"So far, we have seen gains in our nutritional status in the province. Our stunting prevalence is decreasing although as of 2021 it is very high based on the WHO cut off point. For the wasting and underweight, our trend is going down. Unfortunately for the overweight/obesity we have doubled our prevalence as compared to the previous years."*

They use their knowledge when engaging with other governance units, particularly the municipalities with the goal of solidifying agreements and concurrence with local government units for proper implementation. Engagements do not just revolve around implementing entities such as MNAOs, but even LGU offices from other branches, as well as non-health entities. Part of their knowledge translation is ensuring that MNAOs also appreciate nutrition as something that goes beyond health, and thus should be approached and analyzed from a more sectoral perspective.

> *"For us to have a very strong implementation of this, we have to adopt and endorse support from Sanggunian to every solution. That would follow down to the municipal level."*

> *"I told MNAOs that it is difficult if you do not know the accomplishment of the health sector. They have to be involved because everything is monitored by the Nutrition*

Action Office including the totality of nutrition programs in the LGU. Do not leave it to the health sector and just take the data. It should not be sectoral; they have to understand and analyze."

"What I am insisting to the nutrition action officer is that if somebody is going to your office it is not good to tell them to go to health because the data is there. Because definitely when it comes to nutrition they will go to your office. So, it is shameful to tell them to go to RHU to get data for accomplishment of micronutrient supplementation."

4.2.2 Dimension 2. Adoption

The PPAN framework, as well as local numbers and statistics, are used by PNAOs to guide the development of LNAPs. Plans to operationalize these are done in partnership with different national and local bodies. The role of the PPAN is heavily emphasized in assembling the LNAP. While no explicit demand generation activities were mentioned, prioritization is done in recognition of local realities as informed by data. These are translated to actual plans involving national government agencies, as well as the local nutrition committee. Engagements with a wide array of stakeholders aims to ensure that nutrition is not just addressed from a health standpoint (nutrition-specific), but also including other determinants affecting it (nutrition-sensitive).

"We have involved the DSWDO, the Social Welfare Development Office, Provincial Agriculture, the Assessor's Management Office, PDO, PHO, and DILG. We are to start involving other organizations like the BNS Provincial Federation. Previously, we had the OPA, but the core team as for now includes the health, the social health worker office, DILG, and planning office who are always there during the planning stage."

Budget allocation and implementation for nutrition programs are unpredictable and unsecure, and often lack consistency. With prioritization and planning emanating from the PPAN and the LNAP, budget preparations also then become based on needs and population demographics. Budgeting also considers the need for continuous engagement with the various stakeholders involved in the planning and incorporates key enabling activities such as meetings.

> *"Those reflected in our plans are linked with other agencies who have the budget. The focused budget specifically are the ones that are on the enabling domain. If we conduct roll out training funded by the province, coordination and collaboration meetings, regular meetings of our MNAOs and PNC, those are under the enabling mechanisms."*

Methodically, this sound precise and well-inclusive. However, certain problems in the actual budget execution are caused by various factors.

Firstly, there is a natural competition with other LGU expenditures, and the lack of appreciation of local chief executives on nutrition puts its programs at a disadvantage. Budgets for nutrition often come in late. The Annual Investment Plan (AIP) also often reflects pared down allocations but are still seen as excessive by LCEs.

> *"The province will budget the activities. But in reality, when it comes for budget allocation, we do not meet the phase based on the plan. We understand that there are other sectors that also require a budget."*

> *"In terms of financing not so much. The budget allocation for nutrition is always late and when they see the AIP, they will comment that the budget is huge. I explained to them that what is reflected is the budget, but this is what is left. Then I will bargain 'Can you increase that at least 1 million?'"*

Secondly, funds for nutrition programs are inconsistent, and highly fragmented across varying levels of governance. Investments and resource allocation across nutrition programs are still very siloed, almost random, and indiscriminate. LGUs, given their complete autonomy over their finances and budget, have the liberty to exercise discretion on how and where they will spend their resources. Although there are certain nutrition-sensitive and -specific programs that tend to receive consistent and more funding than others, allocations tend to skew disproportionately to the disadvantage of other nutrition programs. While these may be brought by contextual needs of the different provinces, it is alarming that some nutrition programs receive very little funding allocation. This practically translates to non-implementation of the program, and absence of services and capacities related to them. This may also show that there is no actual harmonization of overall strategies for nutrition, and the potential synergistic and complementary effects of the different interventions are not optimized.

Table 6. Aggregate expenditures across nine (9) provinces on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

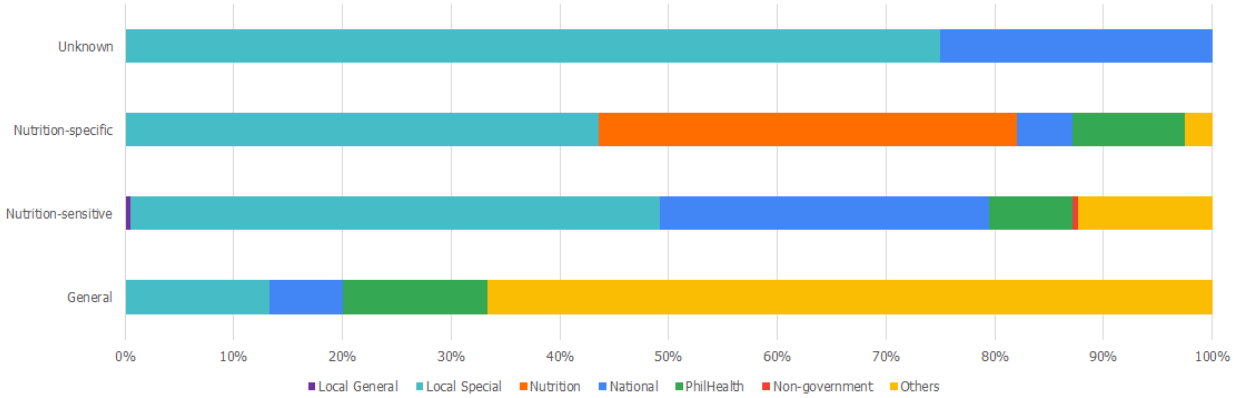
Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	584,840.99	1,202,769.36	1,787,250.35	88.65%
Access to healthcare services	45,627.66	113,411.11	159,038.77	8.67%
Adolescent health and education	41,962.53	54,116.18	96,078.70	5.24%
Agriculture (food security and availability) and fisheries	40,664.77	90,562.67	131,227.44	7.16%
Disease prevention and management	11,951.88	45,975.76	57,927.64	3.16%
Early childhood care and development (ECCD)	270.38	180,890.99	19,161.37	1.05%
Family planning and responsible parenting	2,364.00	17,095.04	19,495.04	1.06%
Gender, women's empowerment, and child protection	2,280.00	196,740.86	199,020.86	10.86%
Humanitarian relief and emergency fund	2,939.27	1,220.00	4,159.27	0.23%
Maternal and neonatal health	3,530.75	195,391.33	198,922.08	10.85%
Oral health	1,428.55	61,244.95	62,673.50	3.42%
Social welfare and peace and order	19,020.06	85,253.85	104,273.91	5.69%
Water, sanitation (environment), and waste management	412,461.14	160,865.72	573,326.86	31.27%
Nutrition-specific	70,410.57	40,524.82	110,935.39	6.05%
Infant and young child feeding	2,590.10	6,134.96	8,725.06	0.48%
Integrated management of acute malnutrition	1,209.00	9,744.73	10,953.73	0.60%
Micronutrient supplementation	559.83	3,197.80	3,757.64	0.20%
Nutrition specific support	65,911.14	20,923.27	86,834.41	4.74%
Overweight/obesity management and prevention	140.5	24.06	164.56	0.01%
Supplementary feeding	-	500	500	0.03%
General enabling	**95,698.43**		**95,698.43**	**5.22%**
Unknown	**610**	**882.4**	**1,492.40**	**0.08%**
Grand Total	**751,220.00**	**1,082,175.67**	**1,833,395.66**	**100%**

Source: Author's calculation

A considerable fund source for nutrition programs come from local special funds. Typically, special purpose funds such as these can be justified in terms of how and where they will be used. This further lends to the arbitrariness of investments on nutrition programs. Each cycle of funding allocation becomes unpredictable, and allocations become even more difficult to tie to an overall strategy. GAD funds, for example, often form a significant resource pool for nutrition, and should be planned for and facilitated deliberately with nutrition officers.

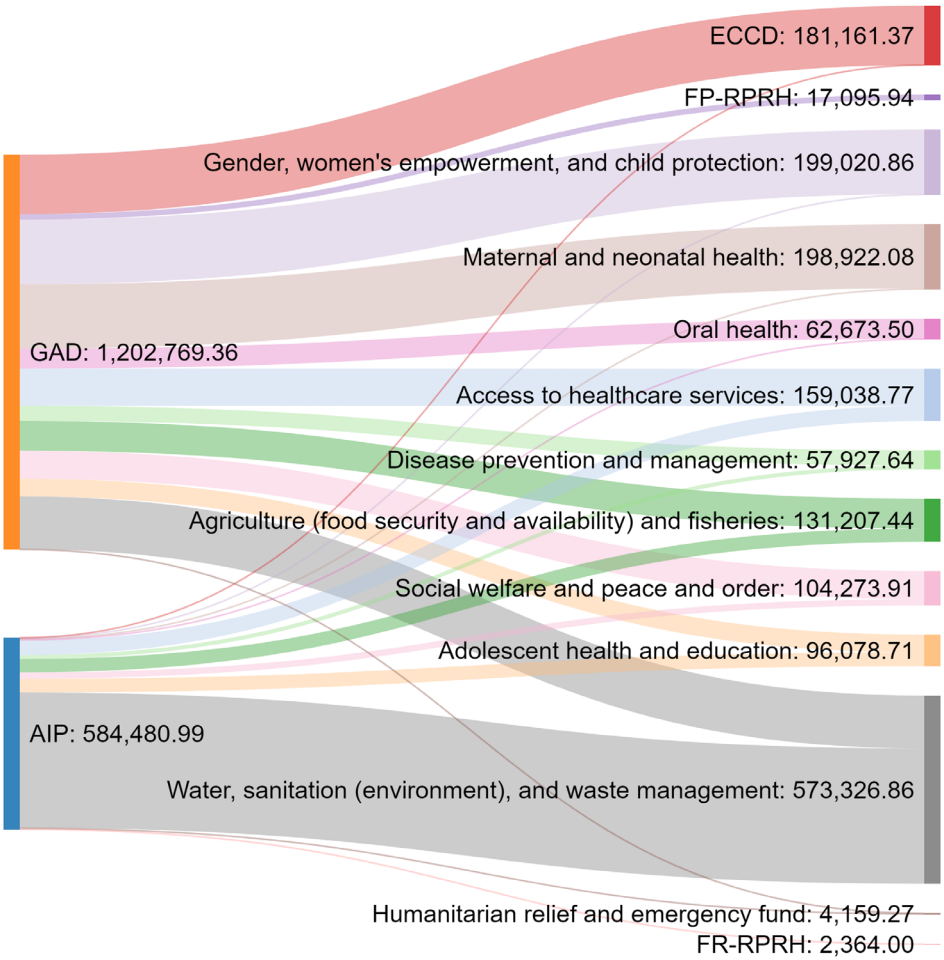
> *"To be honest, we are just starting because I was really insisting that Nutrition has to sit down on GAD planning."*

Figure 5. Fund sources of Nutrition Programs



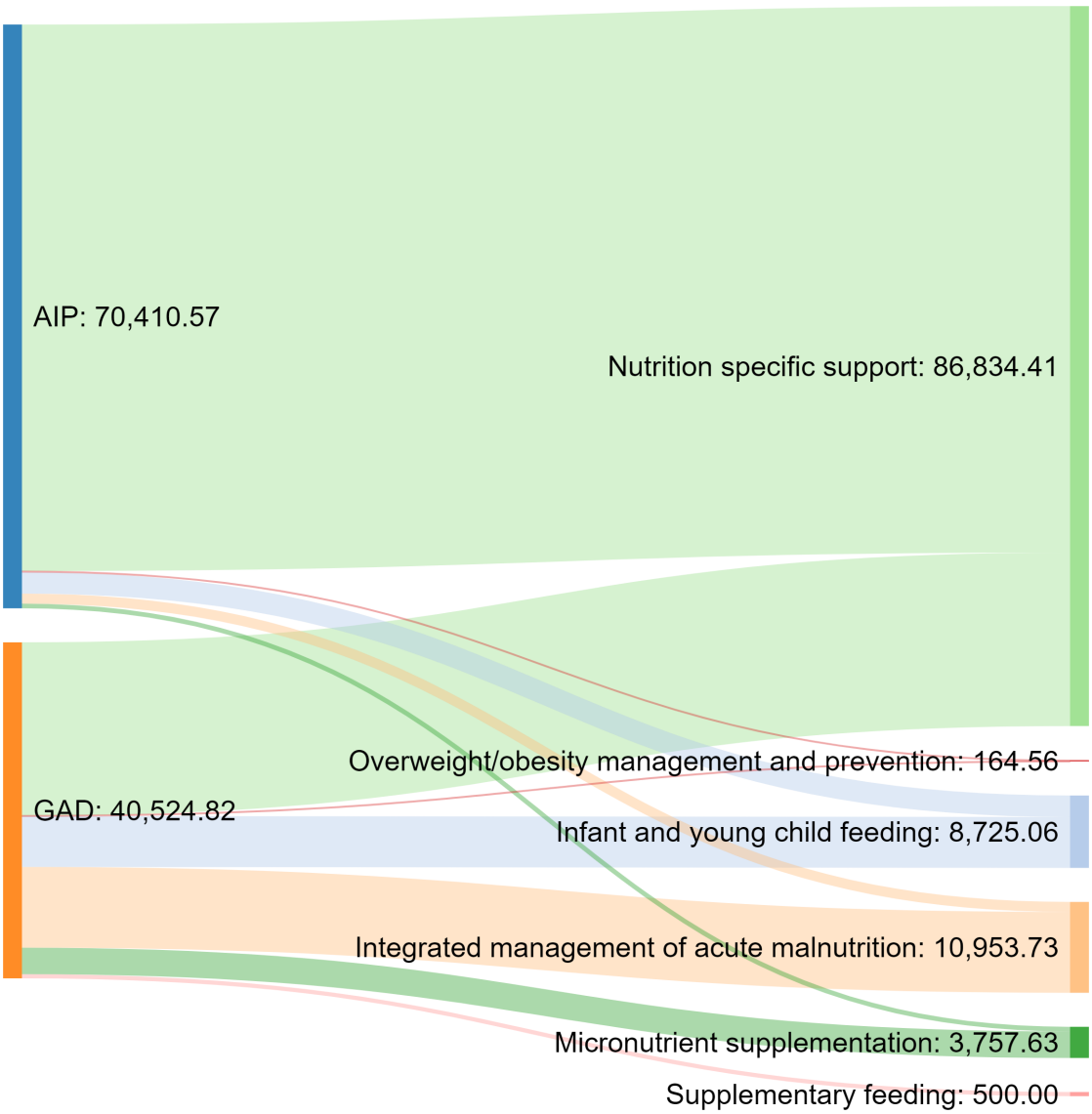
Source: Authors' illustration

Figure 6. Flow of AIP and GAD funds (in PhP thousands) to nutrition-sensitive interventions across 9 provinces



Source: Authors' illustration

Figure 7. Flow of AIP and GAD funds (in PhP thousands) to nutrition-specific interventions across nine (9) provinces



Source: Authors' illustration

Across the different provinces (see Annex C for expenditure tables per province) with available AIP and GAD funds, allocation tends to be skewed towards certain programs. In some cases, more than 50% of the total funds are poured in a single program. A greater proportion of funding for nutrition programs also still come from the GAD:

- Under nutrition-sensitive programs:
    - Access to healthcare services, agriculture, disease prevention and management, gender, women's empowerment, and child protection, maternal and neonatal health, as well as water, sanitation (environment), and waste management tend to get consistent funding.
    - Family planning and responsible parenthood, humanitarian relief and emergency fund, oral health, and social welfare and peace and order to receive less and more inconsistent funding.

- Under nutrition-specific programs:
    - Nutrition-specific support programs tend to get consistent funding.
    - Integrated management of acute malnutrition and infant and young child feeding are more or less funded across all provinces, but proportion of shares are low.
    - Micronutrient supplementation, overweight/obesity management and prevention, and supplementary feeding tend to get very low to no funds.

Aside from this, some funds are also lodged within the budgets of other local agencies. This leads to even further fragmentation of finances.

> *"In my AIP 2021 is 121 million overall but others are lodged on that amount. For the nutrition program per se to carry out the enabling part of the support of the province it is 14 million. Although I will lodge in other sectors like OPA and PSWDODSWD."*

Thirdly, there is some inherent dependency on the national government specifically from vertical programs. Programs that receive low allocation from local sources are those that have support from the national government in terms of commodities (i.e., family planning (FP), micronutrient supplementation, supplementary feeding).

> *"For the policies, I would mention specifically for micronutrient [supplementation], it is from the DOH. All commodities and supplements are 100% provided to the LGUS based on the computed beneficiaries.*

Table 7. Percent share in spending for nutrition programs

Program Classification	CamSur	Ilo	Mag	MisOr	NCR	NSam	Pam	Sam	Zam
Nutrition-sensitive	99	74.59	96	95.24	94.3	99.11	84.4	92.33	96.47
Access to healthcare services	2.11	17.52	22.71	48.54	6.56	0.33	0	1.52	0.37
Adolescent health and education	0.0001	6.94	2.03	2.5	0.48	0	1.24	14.67	0.51
Agriculture (food security and availability) and fisheries	1.07	14.84	1.69	0	0.004	0	63.29	4.3	9.59
Disease prevention and management	0.06	2.88	32.94	2.08	6.2	1.33	1.14	0.98	0
Early childhood care and development (ECCD)	0	0.06	1.77	18.15	1.63	0	0	2.31	2.76
Family planning and responsible parenting	0.04	0.6	0	0.63	4.43	0	2.04	0.29	1.83
Gender, women's empowerment, and child protection	9.66	3.64	26.73	16.94	14.3	97.45	2.79	14.03	0.11
Humanitarian relief and emergency fund	0	0.03	3.73	5.89	0.01	0	0	0.23	0
Maternal and neonatal health	0.0001	0.14	3.54	0.53	23.22	0	13.9	35.25	0.92
Oral health	0.06	10.5	0	0	0.005	0	0	0.03	0
Social welfare and peace and order	0.005	17.44	0	0	0.00002	0	0	0.21	0
Water, sanitation (environment), and waste management	85.99	0	0.87	0	37.46	0	0	18.51	80.38
Nutrition-specific	0.95	9.2	4	4.76	5.7	0.89	15.32	7.49	3.45
Infant and young child feeding	0.03	0.03	1.21	0	1.74	0	0	0.54	1.4
Integrated management of acute malnutrition	0.24	0	0	0	0.5	0	15.32	1.12	0.55
Micronutrient supplementation	0	0.08	0	0	0.81	0.89	0	0.01	1.14
Nutrition specific support	0.68	9.09	2.79	4.76	2.48	0	0	5.78	0.36
Overweight/obesity management and prevention	0.0001	0	0	0	0.01	0	0	0.04	0
Supplementary feeding	0	0	0	0	0.17	0	0	0	0
General enabling	**0.02**	**16.05**	**0**	**0**	**0**	**0**	**0**	**0.12**	**0**
Unknown	**0.05**	**0.16**	**0**	**0**	**0**	**0**	**0.27**	**0.06**	**0.08**
Grand Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Authors' illustration

While it can be argued that resources are in fact there, the lack of financial adoption of LGUs also diminishes their accountability to invest, mind and consequently deliver, for these programs.

Lastly, there is absence of specific guidance for allocation. There is currently no clear indication (e.g., percentages) on how much should be spent for nutrition. This leaves no check to the arbitrariness in budget allocations for nutrition programs.

"About the funding, although there are directives, still loopholes exist because there is not indicated how much percentage they have to make use as a fund from their IRA. Unlike GAD and disaster, they have specific percentages allocation. That is what we wanted to happen in nutrition. For now, the released directive is that the budget will not be improved unless we see that there is a plan for nutrition. Even the budget officer suggested to put percent allocation as well."

Key to ensuring translation and execution of plans, budgets, and programs is buy-in from local chief executives, particularly mayors. The main challenge is the lack of adequate understanding and appreciation of these LCEs (and even governors) on nutrition.

"The bottom line is if the mayor will not be that supportive our workers will have a hard time. So, our move for now is to buy-in the mayors in the implementation program. That they will have an in-depth understanding on how nutrition works."

"Yes. I would like to share and quote from the governor, "I was thinking that when someone reported to me a malnourished child, I would tell the Social Welfare office to prepare for the feeding." He thought it was that simple. Even other mayors thought it is that simple to feed a malnourished child for 120 days and that's all. They did not know you needed to mix the micronutrients supplements given by the RHU. It is very crucial to the health of the mother and child. So, for these 2021, we are intensifying and hopefully hit the target to buy-in all mayors. We are very lucky that the Governor is very supportive."

"From my point of view as I have assumed, LCEs have heard about PPAN but no in-depth understanding yet on how important it is. Based on my experience last year the mayors were shocked when I had one-on-one advocacy in presenting their prevalence and their status of their nutrition. I told them that the activities are existing in your locality, but somebody has to take responsibility in coordinating and collaborating all of these activities in your LGU and make it as one plan. There should be a focused target."

PNAOs recognize that the province does not specifically have implementing functions and/or mandates but have the responsibility to initiate action from their respective LGUs in accordance with plans. Advocacy activities with these key individuals and bodies are crucial. Successful experiences in the past have confirmed that without building this base with decision-makers, nutrition programs will not come into fruition.

"We are starting this one engagement where we activate Barangay Nutrition Committees. We are just starting this activity because in our province of _____, it is not yet highly organized and established."

We were able to convene our first PNC last year and before the year ends, we were able to have our second meeting. In those two meetings, we were able to endorse five nutrition policies for endorsement to Sangguniang Panlalawigan. That means we have 5 nutrition policies endorsed through PNC and SP.

Reporting is primarily challenged by lack of standardization, which makes consolidation difficult. Reports are regularly submitted as these are required from LGUs. However, these come in various formats and different levels of completeness. Some of the tools being used at the local level also seem outdated and no longer aligned with the PPAN. One case in point:

"Quarterly, the LGUs were required to submit PPAN reports to DILG. When I saw the reporting tool of the national level, it is lacking. We will harmonize everything in relation to what is included in the PPAN. This tool was used way back and not yet updated. I also noticed that the LGUs have their own format submitted. Some are using Excel, some are short, some pertinent data are not there. We presented their reporting tools during the PIR last year. They saw that we have to be detailed with the report and their progress should be in relation with the PPAN. Currently, they are using the fund utilization report designed for DILG. But we have to conceptualize for the enhancement of the report by incorporating what the DILG wants to see and the progress in relation to PPAN. We will have workshops by the end of February."

Ultimately, the whole thread of reporting, monitoring, and evaluation becomes ineffective. PNAOs have observed that what is reported may not necessarily be in line with what is actually happening.

4.2.3 Dimension 3. Accountability

Provinces and PNAOs take on a middleman role, liaising across different stakeholders in the form of advocacy, strategy development, and overall knowledge brokering. These efforts aim to enforce accountability in order to ensure right actions are made, as results also affect overall performance of the province.

Numbers and performance of each municipality effectively form the numbers and performance of the province. This creates a sense of accountability for PNAOs to ensure that municipalities are performing well and are implementing the right strategies. They gather data from the municipalities (e.g., through OPT and FHSIS), and use these to set targets and generate proposals based on needs and population demographics, as well as to submit reports to the governor.

Targets and proposals are often subject to budget constraints and leads to re-calibration. PNAOs provide much needed support in this process by identifying where limited resources can and should be allocated as part of their accountability. Oftentimes, PNAOs take the full responsibility to monitor targets even though these are set at the sectoral level. This is because

there is no singular team that takes on this role. This also helps ensure that they optimize the resources to still achieve high-impact good results.

> *"Actually, the FHSIS are taken from the PHO because they are the ones who have these data coming from the RHUs. We link our data from them; same with OPT it came from LGUs."*

> *"We submit them to the governor because the Nutrition Office is under the office of the Governor."*

PNAOs also help redirect activities and strategies specific to the context of each municipality during the course of implementation. Focus is directed towards municipalities who are most likely not going to meet their targets, and ways forward and options are discussed with the concerned LGU. For those who show good potential in meeting their targets, sustaining efforts and/or improving them is the main point of discussion.

> *"We as the implementers will think what our ways will be forward. If the municipality cannot meet the target, the province will also be affected. There are some municipalities that can meet the target. Thus, we focus ourselves on those who cannot reach and discuss what are their ways forward. Then we will agree on the ways forward that are common to all LGUs. For those who were able to reach, we will discuss how they can sustain or even make it better."*

The COVID-19 situation added another layer of constraint to PNAOs by making continued implementation of programs, execution of budgets, and delivery of services more difficult. However, PNAOs continue to take accountability and fulfill their roles by ensuring that responses to the pandemic are still in accordance with nutrition principles.

> *"During the pandemic, there are so many violations in which these people are really not aware that this is a violation. More so with our LCEs. They are not aware that they are violating it. When we called their attention, they were surprised that their practice is prohibited in relation to EO 51. That is where we realized we have to intensify the campaign of EO 51 especially during disasters. During lockdown there are many who donate milk products, but it is prohibited unless otherwise it is for 4 years or 3 years and above. But they still have to coordinate with our IATF to follow through to the intended age group and not that 2 and below."*

4.3 Implementation of Cities/Municipalities

4.3.1 Dimension 1. Awareness

At the City or Municipal levels, there is general awareness of the PPAN as the country's response in addressing malnutrition, and as the main framework to guide implementation of nutrition programs at the local level. PPAN has been discussed with cities and municipalities through orientations facilitated by regional NNC offices cascading nutrition programs stipulated under the PPAN.

The roles and responsibilities of C/MNAOs focus on planning, consolidation of reports, coordination with local partner agencies, and supervision of nutrition workers such as nutritionists-dietitians and barangay nutrition scholars (BNS). Central to their role, they also craft the Annual Investment Plan (AIP) and Annual Operational Plans that are required in the budget process for nutrition. These plans are then endorsed to the Office of the Mayor for review and budget approval.

> *"We are in-charge of collecting their reports, organizing the plans of the city, coordinating the different activities of the nutrition program here at city level. At the same time, we initiate meetings, assisting the City Nutrition Action Officer and the City Health Officer regarding the Nutrition Program. I am also in direct supervision of the different nutritionist-dietitians in the field and the barangay nutrition scholars who are implementing the nutrition program in the barangay or the community level. "*

> *"As a CNAO, it's more on consolidation of reports and coordination with other agencies like CSWD, DepEd, Agriculture and City Health Office."*

> *"I developed the plan... I do the Annual Investment Plan, Annual Operational Plan. All plans which shall be done or given, nutrition plan being submitted to budget, for us to have a budget, which will be endorsed to the Office of the Mayor to review. To give us enough budget for our program."*

4.3.2 Dimension 2. Adoption

In terms of the planning and prioritization processes, there is appreciation for evidence in terms of decision-making. Nutrition officers first consolidate reports that would make up the local situational analysis, wherein OPT data are used as the basis for nutrition outcome trends and the overall nutritional status per barangay and/or per district. Meetings are being held with local nutrition committees to present the results and identify priority areas and target sub-populations along with corresponding nutrition programs to address challenges in nutrition.

> *"First, we have the operation Timbang and survey on the first quarter, from there, you can see the result and the problems will come out not just in terms of nutritional status but also their profiles. The family profiles will be analyzed, there will be a situational analysis per barangay. This situational analysis will be presented to the Barangay Nutrition Committee, we have a Barangay Nutrition Committee here in _____ City, they are very active. So, in the first meeting of the Barangay Nutrition Committee, the*

situational analysis will be presented. From there, you will see the priority problems which should be addressed, then after that, you can produce a plan and they will fund it."

Cities/Municipalities adopt the PPAN in formulating their local nutrition action plans (LNAPs). According to priority, nutrition programs included in their plans are based on the list of nutrition-specific and -sensitive programs indicated in the PPAN. This is coupled with OPT data in mapping out priority beneficiaries to meet the targets in reduction of different forms of malnutrition prevalent in their locality.

"The PPAN is our basis in planning the programs and who are the beneficiaries. We also use the data from the OPT to identify who and where these children are. We look at the data, for example on immunization, breastfeeding accomplishment, complementary feeding accomplishment, immunization accomplishment. We look at those things."

"As a nutritionist, it is good for us to see or go to the children with nutrition problems because if we check them here at RHU, we can find ways to treat and stop [the problem], and if we can stop it. If we look at it that it is high, it may be bad for the image of the town however, personally, it has a good effect because we can see and identify who, when…"

Table 8 lists the available nutrition-specific programs in cities/municipalities sampled in the study.

Table 8. Available nutrition-specific programs reported by C/MNAOs

PPAN nutrition-specific programs	Frequency (N=12)
Infant and young child feeding	
1. Health systems support	11
2. Community-based health and nutrition support	10
3. Maternity Protection and Improving Capacities of Workplaces on Breastfeeding	10
4. Establishment of breastfeeding places in non-health establishments	8
5. Enforcement of the Milk Code	9
Integrated Management of Acute Malnutrition	
6. Enhancement of Facilities (Including RUTF and RUSF) and provision of services	9
7. Building of Capacity of Local Implementers	7
National Dietary Supplementation Program	

8. Supplementary feeding of pregnant women	6
9. Supplementary feeding of children 6-23 months old	11
10. Supplementary feeding of children 24-59 months old	11
11. Supplementary feeding of school children	11
12. Food plants for producing supplementary foods	7
National Nutrition Promotion Program for Behavior Change	
13. In schools	6
14. In communities	9
15. In the workplace	7
16. Resource center	4
Micronutrient supplementation (vitamin A, iron-folic acid, multiple micronutrient powder, zinc)	
17. In health unit	10
18. In schools	9
19. Communication support	10
Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion)	
20. Rice fortification with iron	8
21. Flour fortification with iron and vitamin A	8
22. Cooking oil fortification with vitamin A	7
23. Sugar fortification with vitamin A	6
24. Salt iodization	8
Nutrition in emergencies	
25. Capacity building for mainstreaming nutrition protection in emergencies	9
Overweight and Obesity Management and Prevention Program	
26. Healthy Food Environment	8
27. Promotion of healthy lifestyle	10
28. Weight Management Intervention (for Overweight and Obese Individuals)	8

Source: Authors' illustration

The following PPAN programs are the most available at the city/municipality level:

1. Health Systems Support

2. Supplementary feeding of children 6-23 months old
3. Supplementary feeding of children 24-59 months old
4. Supplementary feeding of school children
5. Community-based health and nutrition support
6. Maternity Protection and Improving Capacities of Workplaces on Breastfeeding
7. Micronutrient supplementation (vitamin A, iron-folic acid, multiple micronutrient powder, zinc) in health unit
8. Promotion of healthy lifestyle

On the other hand, programs for behavior change, capacity building for local implementers, food fortification and support for pregnant and lactating women seem to be the least available:

1. Nutrition Promotion Program for Behavior Change in resource center
2. Nutrition Promotion Program for Behavior Change in school
3. Supplementary feeding of pregnant women
4. Building of capacity of local implementers
5. Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion) sugar fortification with vitamin A
6. Food plants for producing supplementary foods
7. Nutrition Promotion Program for Behavior Change in workplace
8. Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion) cooking oil fortification with vitamin A)

In terms of the First 1000 Days (F1KD) programs, some cities/municipalities have increased priority in monitoring pregnant and lactating mothers, as well as adolescent children which includes programs on family planning and prenatal care.

> *"What we usually do is 'Operation Timbang' which is an assessment of children and adolescents. Our municipality has partner NGOs that help us in [supplemental] feeding programs. These programs are not just focused on [supplemental] feeding but also on child assessment. That is what is good here, it is assess, feed, and assess again. Immunization, baby-mother care, prenatal, and family planning are also included."*

> *"In the nutrition program, there is a specific target, 0-5, 6-11, in other words 0-59 months. Those are our priority – pregnant lactating mothers then school children. Who are being prioritized?* ***Those in the First 1000 days are being prioritized, those who are included – those who are pregnant and under 2 years old,*** *then those 24-59 mos."*

Table 9 lists available nutrition-sensitive programs in cities/municipalities sampled in the study.

Table 9. Available nutrition-sensitive program reported by C/MNAOs.

PPAN nutrition-sensitive programs	Frequency (N=12)
1. Farm-to-market roads and child nutrition	6
2. Target Actions to Reduce Poverty and Generate Economic Transformation (TARGET) and child nutrition	10
3. Coconut Rehabilitation Program	4
4. Gulayan sa Paaralan	12
5. Diskwento caravans in depressed areas	7
6. Family development sessions for child and family nutrition project	11
7. Mainstreaming nutrition in sustainable livelihood	11
8. Public works infrastructure and child nutrition	8
9. Adolescent Health and Nutrition	10
10. *Sagana at Ligtas na Tubig sa Lahat* (SALINTUBIG) and other programs on water, sanitation, and hygiene	9

Source: Authors' illustration

The most available (reported by 10-12 barangay out of the 12) nutrition sensitive program are as follows:

1. Gulayan sa Paaralan
2. Family development sessions for child and family nutrition project
3. Mainstreaming nutrition in sustainable livelihood
4. Target Actions to Reduce Poverty and Generate Economic Transformation (TARGET) and child nutrition
5. Adolescent Health and Nutrition

On the other hand, the least available nutrition-sensitive program (reported by only 1 to 5 city/municipality out of the 12) specific programs is the *Coconut Rehabilitation Program*.

Financing nutrition programs at the city/municipality level seem to be highly dependent on the priority of the local chief executives. This is where presentation of local nutritional status and nutrition outcome trends come into play in order to emphasize the urgency for allocating budget for nutrition. It also highlights the need to advocate the importance of nutrition and how increased investments in nutrition may lead to improving measures of human capital index (HCI) and economic productivity.

> *"Some LGUs do not prioritize nutrition programs. During workshops, they can produce promising plans, but mayors allotted only a certain amount for nutrition. Maybe because they do not understand the essence of nutrition programs which are more than just existing during nutrition month celebration. They thought feeding is only during nutrition month not knowing that the feeding program should be 120 days."*

"The one deciding is our chief, but we need to present good plans for them to see the goodness of the plan and the importance of the plan, right? Since sometimes the funds are not that huge, there is a need to prioritize"

"If there is not much support from the Local Chief Executive whether in the city or barangay level. If there is no support in the nutrition program, it is difficult for the nutritionist dietitians or the barangay nutrition scholars to integrate [programs]."

"Of course, here in the city level, those in the higher position including the budget office. They are the one who will budget. There will also be deliberation what programs can be funded. Of course, they have their own priorities, it is not just the nutrition program. Here in health, there are a lot of programs, so it depends on the urgency at necessities of the program, but I assure you that when it comes to nutrition, we always have a budget for."

The disparity in financing among LGUs are a clear indication of a lack of standardized allocation guidelines. Budget constraints are still evident at the city/municipality level. There are PPAs that have insufficient to no funding due to the lack of budget for nutrition. C/MNAOs recognize the need to diversify sources of budget to fund nutrition programs, which may be sourced from partner agencies, non-government organizations, gender, and development (GAD), and disaster risk reduction management, among others. In LGUs where nutrition is a priority of the mayor, sufficient funding is observed. However, this may not be the case for other LGUs with minimal support for nutrition from the LCEs.

"Then, in terms of funding, if the local government unit will be on their own, they should be able to provide funds for nutrition. But the nutrition program [coordinator] should be knowledgeable about what are the possible sources of funding and will not solely depend on one department. For example, we were able to get funds from the health department, but we can still get funds from the gender and development fund for other projects which will not be funded by our department. Then, we have funds in the local, the Children Local Council for the protection of children. We also have disaster risk reduction management. This means, there is a need for the coordinator to connect whether in the barangay or city level to share and discover the possible sources of funding for his/her planned program and activities to push through."

"Yes, there are activities there that need a budget because if we do not have that, we will not be able to act. The LGU will provide the budget; if it cannot provide one, we will ask the barangay. It is better if the barangay can provide the fund. There are some activities that we can do without the budget."

"As of now, we do not encounter problems in terms of nutrition programs since it is a priority of the mayor. During his first term, he has already been communicating with the governor since South Upi was 1st in number of malnourished children. When he took office, we talked about what needs to be done and told me to focus on nutrition. He hired barangay nutrition scholars which he supports. And after a year, he saw the changes. That is what inspired him, he ensured that there is enough budget for that and that the budget must be utilized by some which do not utilize theirs. For us, the budget is the number one priority."

"We have a budget hearing. In the budget hearing, before the budget hearing, we are gathered, what is your plan, how much budget do you need with the plans, what are your activities. If we have meetings with the budget, there will be budget hearings."

Across the different municipalities/cities that participated (see Annex for expenditure tables per municipality/city), the same observations can be inferred as in the province - allocation tends to be skewed towards certain programs. Similarly, there are cases where more than 50% of the total funds are poured in a single program.

Table 10. Percent share in spending for nutrition programs, municipality/city-level

Program	Camaligan	Libmanan	Naga City	South Upi	Skudarat	DOSinsuat	Valenzuela	Caloocan	San Juan	Manila	Catbalogan	Sta. Rita	Talalora	Catarman
Nutrition-sensitive	98.96%	78.10%	100.00 %	98.65%	93.49%	91.78%	95.13%	85.75%	86.70%	96.25%	97.79%	90.89%	82.88%	99.11%
Access to healthcare services	2.38%	0.00%	0.00%	38.51%	0.00%	6.85%	2.20%	55.75%	37.24%	0.00%	0.00%	0.00%	44.22%	0.33%
Adolescent health and education	0.00%	0.00%	0.00%	3.50%	0.38%	0.00%	0.00%	0.25%	1.91%	0.56%	1.24%	20.57%	1.35%	0.00%
Agriculture (food security and availability) and fisheries	1.20%	0.00%	0.06%	1.10%	4.43%	0.00%	0.00%	2.91%	0.00%	0.00%	13.43%	1.09%	2.21%	0.00%
Disease prevention and management	0.07%	0.00%	0.01%	50.77%	5.36%	17.36%	7.22%	6.07%	15.52%	1.10%	1.50%	0.21%	13.12%	1.33%
Early childhood care and development (ECCD)	0.00%	0.00%	0.00%	0.50%	0.00%	7.31%	2.83%	17.66%	1.52%	0.00%	6.93%	0.62%	2.80%	0.00%
Family planning and responsible parenting	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	2.23%	0.00%	8.11%	5.94%	0.83%	0.06%	0.88%	0.00%
Gender, women's empowerment, and child protection	0.09%	50.48%	85.44%	2.69%	55.70%	57.51%	5.25%	0.00%	18.90%	24.72%	3.93%	18.62%	2.02%	97.45%
Humanitarian relief and emergency fund	0.00%	0.00%	0.00%	0.00%	15.35%	0.00%	0.03%	0.00%	0.00%	0.00%	0.77%	0.04%	0.00%	0.00%
Maternal and neonatal health	0.00%	0.00%	0.00%	0.00%	12.26%	2.74%	0.04%	0.29%	0.00%	63.90%	1.49%	49.37%	15.45%	0.00%
Oral health	0.07%	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	2.55%	0.00%	0.00%	0.00%	0.00%	0.83%	0.00%
Social welfare and peace and order	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.31%	0.00%	0.00%
Water, sanitation (environment), and waste management	95.11%	27.62%	14.46%	1.58%	0.00%	0.00%	75.32%	0.28%	3.50%	0.02%	67.67%	0.00%	0.00%	0.00%
Nutrition-specific	1.04%	21.90%	0.00%	1.35%	6.51%	8.22%	4.87%	14.25%	13.30%	3.75%	2.21%	9.11%	17.12%	0.89%
Infant and young child feeding	0.00%	21.90%	0.00%	0.00%	4.98%	0.00%	0.56%	0.08%	0.81%	3.71%	0.50%	0.00%	12.12%	0.00%

Integrated management of acute malnutrition	0.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.33%	0.04%	0.22%	1.52%	0.08%	0.00%
Micronutrient supplementation	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.26%	13.80%	4.56%	0.00%	0.00%	0.00%	0.33%	0.89%
Nutrition specific support	0.77%	0.00%	0.00%	1.35%	1.53%	8.22%	4.03%	0.38%	3.43%	0.00%	1.49%	7.59%	3.42%	0.00%
Overweight/obesity management and prevention	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	1.17%	0.00%
Supplementary feeding	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.17%	0.00%	0.00%	0.00%	0.00%	0.00%
General enabling	0.00%	0.00%	0.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.22%	0.00%	1.82%	0.00%
Unknown	0.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.01%	1.22%	0.00%
Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Source: Authors' illustration

Human resources seem to be the resonating concern in implementation of nutrition programs. Firstly, there is a considerable deficit in nutrition workers to population ratio. While some progressive LGUs that have larger budget allocation for human resources for health, this is not the case for cities/municipalities with limited budgets. Furthermore, some cities/municipalities only have nutrition officers that are designated from other units or offices such as Health, Agriculture, or Center for Social Welfare and Development. This stretches the workload of nutrition officers, dividing their focus on nutrition which causes delays and impediments in fulfilling their roles as nutrition officers. Some LGUs also have unfilled plantilla positions which is also indicative of the importance they place on nutrition, or a lack of available manpower to match the necessary skill set. Lastly, there are instances when there is skills and knowledge mismatch in manpower particularly in the designation of C/MNAOs. In some cases, these roles are filled by midwives, or the wives of the mayor, in which case they may have a lack of understanding on nutrition.

> *"Most LGUs have plantilla positions for Nutrition Officer but sometimes they don't assign."*

> *"What I can share is... on my part, I am just new to nutrition, I don't know much yet. First of all, I am not a nutritionist, the midwife's job is different from a nutritionist."*

> *"There should be sufficient staff for nutrition programs to focus on nutrition programs because it is one of the reasons why implementation is not that successful, or priority actions were not clearly identified. The plans are promising yet the people assigned were just designated from Health, Agriculture, or DSWD. They have other responsibilities to attend thus it is hard to implement the Nutrition Program. There were no permanent Nutrition Officers."*

> *"In my opinion, PPAN is OK in the nutrition-sensitive program, they only need, if you will implement it alone, it is difficult. So, manpower is needed. That is the first thing they need to add, but in programs, everything is other is really lack of people."*

> *"Third, nutrition in emergencies. In nutrition in an emergency, yes, we have seminars. We have a health plan for who should be there if there is an emergency. But that time, there is no [one] or we lack manpower. But now, what happens is, our barangay health workers, they are 390, it should be 400 so that when something happens, if there is an emergency, it shall be separated for us. There should be a separation for nutrition, those 6 to 23, pregnant, senior citizens and adolescents."*

> *"For me, I wanted to implement the PPAN. However due to manpower constraints, non-cooperative chairman, it seems difficult to do. The laws are needed, the guidelines and laws, the DILG. Although the DILG helps to cascade…"*

"No, that is the problem, when there is no RND and the DOH no longer provides nutritionists, Doctor and I are the only partners, so that is where we have problems. For example, we hold trainings, just the two of us. Of course, I do everything…"

"In terms of human resources, we need to have additional particularly, the nutritionist."

Barangays are at the forefront of implementation. C/MNAOs communicate the programs to the barangays through communication letters, planning workshops, or pocket meetings which are also held with the participation of various focal persons such as barangay captains, BNSs, barangay secretariat, kagawad for health, or in some cases, barangay nutrition action officers.

"First, since we are here at the city level, for example the operation timbang, first, we communicate to them, or we call them in a meeting through the BNS or through the help of the Barangay Secretariat which is a member of the Philippine Nutrition Member Committee or league of barangays. We send letters to them if there are meetings or activities which will be conducted in their barangay. This is being planned, as part of preparation in the upcoming other programs to be conducted in their barangay."

"We have planning workshops wherein we invite the barangay officials, usually this is the barangay captain, the councilor for health and assigned barangay nutrition action officer or their BNS, we request them to have their own BNS. That is aside from the BNS which is city paid, so that it will be easier for us to coordinate to them and to inform them of the programs, projects and activities which will be done in their community. How do we do it? Planning workshop, meetings, communication letter, which is how we invite them to inform them about the dates."

4.3.3 Dimension 3. Accountability

The main data source for programmatic evaluation is the OPT data. The main practice in cities/municipalities is the consistent and sustained weighing and re-weighing of children to track and assess the prevalence of different forms of malnutrition. Almost all children are weighed quarterly but depending on the severity of malnutrition and age group, they also re-weigh on a monthly basis. However, in 2020, OPT has been hampered due to the restrictions in physical assemblies.

> *"The monitoring is monthly since it is re-weighing, it depends how severe, if severe malnourished, monthly. Because almost all children are weighed quarterly, there is monthly depending on their situation and age group."*

Reports are then submitted by nutrition workers and analyzed by nutritionists to track and monitor changes in nutritional status, check whether the programs and activities are being implemented, and goals and targets met. In some LGUs, nutrition workers have a monthly submission of reports and meetings to discuss trends in nutrition outcomes.

> *"There are 7 nutritionists who analyze the report and check their reports. We check if those malnourished are reduced, we check if the supposedly activities are being implemented and whether our goal to reduce is reached. We will be able to see that as our basis for nutrition if the children being affected by malnutrition is reduced."*

> *"For our nutrition workers, we have monthly meeting, monthly submission of reports. We have what we called BNS Summit, or we have the program implementation review. The BNS summit which is once a month or once a year. The program implementation review once a year. But the meetings and submission report are monthly. The monitoring is done by the nutritionist in the area. This monitoring is at least once a month or twice a month."*

> *"We compare at the end of the year if there is still a lot to be given of this kind of service, if they really need it. We still compare that. We still do the comparison. How many are provided with services, how many recovered, how many did we help. That is the assessment we conducted."*

To monitor and evaluate programmatic performance, cities/municipalities hold an annual program implementation review (PIR). Through this, they are able to assess whether targets are being met, and report accomplishments and outcomes of nutrition programs based on the local nutrition plans. This is also an avenue to re-strategize and recalibrate programs when targets are not met and identify both enabling and constraining factors and devise means of addressing them. Local partner agencies that are members of the local nutrition committee also participate to realign priority programs based on nutrition outcomes.

"Yes, we are able to do that through the program implementation review, PIR, what is the performance of each agency which member of the City Nutrition Committee implements or conducts nutrition projects. Through checking, if performed or not, how many percent is accomplished, we discovered and identified what are the facilitating and hindering factors contributing or high accomplishment."

"Before, we conducted that twice a year for all the programs. But last year, we were not able to do so, even just for one time, because we have this what you call diffuse for all the programs, in nutrition, in EPI so last year we were not able to do data quality check. But that is our routine, at the end of the year or at the first quarter of the following year, there is an evaluation for all programs."

However, in terms of community engagement, there is no evidence of transparency and dissemination of programmatic outcomes to the beneficiaries. Although, community engagement mostly involves lectures and assemblies to inform beneficiaries of programs that will be cascaded down to them and inform the beneficiaries of their nutritional status.

4.4 Barangay Implementation

4.4.1 Dimension 1: Awareness

There is a lack of awareness on the PPAN as a national plan and framework for addressing problems in nutrition at the barangay level. This includes barangay captains, PPA officers, and even barangay nutrition scholars, for some. While there is no mention of PPAN as a specific framework in their level of implementation, they do have a list of PPAs as basis for execution of nutrition programs. This may be indicative of how nutrition action plans are translated and cascaded from higher levels of governance to their level.

Implementers at the barangay level have varying roles. Barangays, which are headed by barangay captains, serve as a conduit for data collection and transmission. Some barangays work hand-in-hand with health centers in mapping out areas of concern in terms of nutrition and prioritize and fund programs specific to addressing prevalent forms of malnutrition and, broadly, pressing problems revolving nutrition.

"The barangay and the health center have a relationship when it comes to the nutrition and health of our citizens which is within the scope of my barangay. Whatever problem of my community about nutrition and health should be known by the barangay and reported to the health center so that there will be action if there are children who are malnourished or over nourished. Further, the barangay will be able to do something and include in the projects and be given with appropriate budget, through the help of our councilors."

Barangay nutrition scholars (BNSs), on the other hand, are at the forefront of service delivery. According to the P.D. No. 1569 (Section 2), they are "barangay-based volunteer workers responsible for delivering nutrition services, and other related activities such as community health, backyard food production, environmental sanitation, family planning, and health promotion, among others". They are also specifically tasked to conduct monitoring of children aged 0 to 59 months, including the pregnant and lactating women (PLW). They also perform

operation timbang (OPT), which is the anthropometric measurements and screening for under- and overnutrition, i.e., weighing, measurement of height/length and mid upper arm circumference (MUAC) of children to track prevalence of malnutrition.

> *"When the Chairman has a plan, he asks a question, we need that and this, he requests data from me. Similar to those children who [is] lack[ing] in weight, who are those children, give me the list. They develop a feeding for that, coordination is important and needed to have communication between the worker and barangay. That is when the program develops."*

> *"As a barangay nutrition scholar, one of my tasks is to monitor those 0 to 59 aged in months in our barangay. Included here are the pregnant and lactating mothers. Also, our daycare preschoolers of Brgy. Balong-Bato. Of course, there are other nutrition programs, micronutrients, iron supplementation, intervention in urban gardening."*

> *"Probably, one of the things I have seen since I am a Brgy. Nutrition Scholar, educate the mothers how to prepare the proper food on their dining table. Also, the proper hygiene. In the First 1000 Days, we take care of the pregnant mothers."*

PPA Officers, while not a set position title or item in the organizational structure, are mostly designated based on their function with respect to the PPAs they handle. For programs lodged under the 4Ps such as the Family Development Sessions (FDS), the role of PPA officer is filled by a Social Welfare Officer. For *Gulayan sa Paaralan*, principals assume this particular role. In some cases, Barangay Health Councilor or the BNSs themselves serve as PPA officers. Their functions are mainly attributed to the specific PPAs that are assigned to them providing oversight and overall direction.

> *"Our work is to conduct Family Development Session and give case management. We are the responsible person that helps whatever it is needed by our beneficiaries and the necessary intervention that should be given to them. That is one part of our case management."*

> *"Our councilor for health, he/she is the one who focuses on that."*

4.4.2 Dimension 2: Adoption

There is no specific mention of a PPAN-related framework used by barangays in planning and prioritizing nutrition programs. However, they do use a list of PPAs cascaded from the local nutrition action plan by the city/municipality as the basis for nutrition programs to be implemented at their level. In some situations, understanding of the guidelines to follow in implementation vary from one LGU to another. They mainly refer to directives from the C/MNAOs based on the nutrition action plans of cities/municipalities. Part of this mainly includes instructions or notices on specific programs that will be rolled out in barangays.

> *"We, the LGUs, follow something from the DOH that it should be the process which shall be used by each barangay. The DILG also helps, they will give the paper, we have guidelines which we should follow... We should follow the protocol of governance which will come from the higher ups."*

"BNS report to C/MNAOs, their focus on implementation is mainly on the nutrition action plan of the city or municipality."

"It is from the RHU in our MNAO, suggested to the LGU then discussed with the mayor. Our MNAO calls us and sometimes informs me personally that there would be a feeding program and our MNAO provides us with equipment such as containers, ladle, and pans – a complete set."

"It is from the RHU in our MNAO, suggested to the LGU then discussed with the mayor."

Situational analysis still remains to be a practice in prioritization given the very limited budget at the barangay level. Priority areas and sub-populations are identified through the OPT data. BNSs primarily serve as the main focal person for nutrition in the barangay, as they monitor and collect data through the OPT. The barangay councils, who are the main decision-makers and the recommendatory group at the barangay, tap them for any data needs in prioritization.

"We start first by looking at which sitios have the highest concentration of malnourished children, we prioritize them and educate."

"When the Chairman has a plan, he asks a question, we need that and this; he requests data from me. Similar to those children who are lacking [in] weight, who are those children, give me the list. They develop a feeding [program] for that. Coordination is important and needs to have communication between the worker and barangay. That is when the program develops."

"It is not just me who plans for the Barangay. We value transparency and it is not good if only the Brgy. Officials who will decide as the decision of the majority really matter."

"Of course, since the health center is there, we have our BNS and nurses there. So, they have records, from there we can get our data of who are malnourished, who are pregnant, who do breast feed, we are able to get the data."

"The council is there helping each other on the problem of our barangay about nutrition. I am not the only one who plans but the council."

"In our barangay council, we develop plans so that we have a budget for the people since we know that the population is getting bigger, and the budget should be like this to support the nutrition needs. We should give a budget to health in our barangay for it to be continuous and to give the needs of our residents in our barangay."

Municipal Links, who are employed under the local Social Welfare and Development offices, also play a direct role in ensuring participation of beneficiaries to both nutrition-specific and -sensitive activities. They mainly coordinate across implementers and beneficiaries through the 4Ps program and the family development sessions.

"Our part is to make sure the participation of the people and for the specific activity to be successful. Whatever program and activities of the LGU or RHU that is to be implemented, they coordinate directly to us… We have health grants, checkups - they

receive Php750, in total of Php1500, rice subsidy, feeding program x 21 days (weekly) with good outcomes, eating better, less undernutrition. Our FDS is no longer about lecturing only but encouraging them to practice, e.g., vegetable gardening, mangrove planting."

"After 9 years of implementing the "Pantawid", grantees or the households are already aware of their roles as beneficiaries, which is to obey the conditionalities. They need to cooperate because they are the ones who benefit. We do not terminate the beneficiary [if they default]. We just suspend them. We have to reprimand their actions and inform them that the program is not about dole-out. There is a corresponding consequence once you violate the rules of the program… Now at barangay level, not only RHU… results of mortality of giving birth in their houses has decreased too, but that is also because of our FDS activities. LGU is responsible for the activity. Whatever program and activities of the LGU or RHU that is to be implemented, they coordinate directly to us. Every quarter we regularly submit our report on good practice in Health."

There were also good local practices in terms of planning and prioritization in areas where nutrition is championed and is a high priority. There was one barangay that instituted a tri-sectoral council for development which comprises three (3) major committees: education and information, livelihood, and health nutrition, where the latter is led by the FNRI. Each of the committees have their own designated work under the umbrella council where programs are prioritized based on the situational analysis. In terms of nutrition, this specific barangay incorporates a three-pronged strategy called the EEI (Education, Enforcement, and Infrastructure). Firstly, education about nutrition is implemented in the community. Secondly, Enforcement is the establishment of local finance or local resolutions to support implementation. Lastly, Infrastructure, such as facilities, needs to be in place to aid in implementation.

"So, temporarily, we form a tri-sectoral council for the development of [barangay]. This tri-sectoral council has three major committees: education and information, livelihood and health and nutrition. In the Health and Nutrition, the lead agency is the FNRI."

"We have workshops, all the councilors, the whole council, each has their committee work then we have reporting, then we give comments before it will be formed."

"Actually, that EEI is for all. When you have a plan, there are three components, the EEI. The first 'E' is Education, about nutrition, you will educate the people. The second 'E' is Enforcement, you might need a local finance or local resolution to support your teaching. Next is 'I' which is Infra[structure] or it can be technology since how you will do it, do you have mechanisms. Do you have a place, something like that. We ensure that in each issue, we need to address that, we need to see the education, the enforcement since the barangay has that, the other agencies."

The lack of budget for nutrition programs is a recurrent concern among barangays. Funds sourced from their internal revenue allotment (IRA) is deemed insufficient to sustain programs, which in some cases, compels barangay councils to only prioritize which beneficiaries get to benefit from the programs. One instance cited below:

> *"The lack of funds is really the problem since our IRA is not enough to sustain it. But there are some who could benefit from it since an estimated 80 percent of the people in the barangay are 4Ps beneficiary where they have benefits such as health and education. We only prioritize those who are not 4Ps members but if we only have enough funds, we could accommodate them."*

> *"Mostly the support from the national government are the policies, but when it comes to budget, there is no funding."*

Additionally, barangay-driven nutrition programs are very scarce and un-sustained owing to the lack of budget. Case in point below, where the barangay is only able to conduct supplemental feeding once a year, whereas it should be sustained preferably daily for a period of 120 days.

> *"There are actually improvements since before, our allocated budget is only one thousand pesos but, in my term, it became five thousand pesos. I added funds to it since there are still excess funds and the supplemental feeding is only conducted once a year but sometimes still not enough and I even lend money only to suffice."*

While programs are mostly financed at the city/municipality level, much attention should be devoted to barangays which are the locus of implementation of nutrition programs. There are cases when health workers in barangays are forced to shell out money to provide for their expenses in conducting these programs.

> *"To be honest, it is difficult to become a health worker because our knowledge is limited, limited also in terms of budget. There are programs which need a budget. We need to spend money to support that program. We sacrificed since we get shy to ask from the doctor, nurses and who shouldered that, it is us."*

Barangays observe a straightforward process in budget allocation. Officers in-charge of health nutrition such as the Councilor for Health and BNSs, among others proposed programs with corresponding budgetary requirements. The *Sangguniang Barangay,* membered by the councilors, then deliberates on all proposed programs and decides on the amount of budget to be allocated based on the AIP, for the approval of the barangay chairman.

> *"The Barangay actually conducts its budget preparation during September up until the review. The suggestions of the Brgy. Officials are being heard not only by my decision in terms of budgeting, but it is done through agreement. I also ask the Brgy, Kagawad if they have something to prioritize for the budget and by October, we will submit it to the Sangguniang Bayan for review."*

> *"As councilors, we are the one developing the budget of each program of the barangay. Of course, it will all pass through us, through the approval of our chairperson, then application."*

"Through budget deliberation since as councilor, we develop it. We allocate budget per community based on the Annual Investment Plan."

Some nutrition sensitive PPAs are financed by local partner agencies such as DepEd, particularly for Feeding Programs in schools. However, the budget is not also standardized or consistent in and among barangays, an example below.

"We are provided by the DepEd with a fund of P16.00 per pupil for our Feeding Program. Sometimes, it is inadequate but because of our Gulayan sa Paaralan program, we manage to provide sufficient supply for the children."

Given the limited budget availability in barangays, there are some who source out funds from external stakeholders such as NGOs, private sector, and calls for development funding by agencies. This highlights the struggle of barangay implementers in compensating for the lack of budget and support by looking at other sources, external to the LGUs.

"We have barangay health workers who are barangay paid and employed here in the health center, but I was given the chance to do a project proposal to DILG. This is called resettlement governance assistance fund because we are a community which accepts 970 families from the riverbanks, we qualify from them. As a beneficiary, I was able to add 20 more barangay health workers who are paid with that project for 1 year."

"Previously, we had a 120-day program through the help of the NGO. We are able to finish that and those affected by the program were able to become normal. Their bodies were able to get better through the help of the health center."

"We improved since it widened. Since there are NGOs helping us. It is not through local only, there is also national so they can help in the needs of our barangay."

Table 11 lists all available nutrition-specific programs from barangays sampled in the study.

Table 11. Available nutrition-specific programs reported by Barangay Captains.

PPAN nutrition-specific programs	Frequency (N=16)
Infant and young child feeding	
1. Health systems support	9
2. Community-based health and nutrition support	12
3. Maternity Protection and Improving Capacities of Workplaces on Breastfeeding	12
4. Establishment of breastfeeding places in non-health establishments	9
5. Enforcement of the Milk Code	5
Integrated Management of Acute Malnutrition	
6. Enhancement of Facilities (Including RUTF and RUSF) and provision of services	11
7. Building of Capacity of Local Implementers	7
National Dietary Supplementation Program	
8. Supplementary feeding of pregnant women	9
9. Supplementary feeding of children 6-23 months old	11
10. Supplementary feeding of children 24-59 months old	11
11. Supplementary feeding of school children	12
12. Food plants for producing supplementary foods	8
National Nutrition Promotion Program for Behavior Change	
13. In schools	5
14. In communities	6
15. In the workplace	3
16. Resource center	4
Micronutrient supplementation (vitamin A, iron-folic acid, multiple micronutrient powder, zinc)	
17. In health unit	12
18. In schools	9
19. Communication support	8
Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion)	

20. Rice fortification with iron	3
21. Flour fortification with iron and vitamin A	6
22. Cooking oil fortification with vitamin A	5
23. Sugar fortification with vitamin A	5
24. Salt iodization	7
Nutrition in emergencies	
25. Capacity building for mainstreaming nutrition protection in emergencies	10
Overweight and Obesity Management and Prevention Program	
26. Healthy Food Environment	7
27. Promotion of healthy lifestyle	9
28. Weight Management Intervention (for Overweight and Obese Individuals)	7

Source: Authors' illustration

The most available (reported by 12-16 barangays out of the 16) nutrition specific programs are as follows:

1. Community-based health and nutrition support
2. Maternity Protection and Improving Capacities of Workplaces on Breastfeeding
3. Supplementary feeding of school children

On the other hand, the least available (reported by only 1 to 5 barangays out the 16) nutrition specific programs are as follows:

1. Rice fortification with iron
2. Nutrition Promotion Program for Behavior Change in the workplace
3. Nutrition Promotion Program for Behavior Change in the resource center
4. Enforcement of the Milk Code
5. Nutrition Promotion Program for Behavior Change in the resource center
6. National Nutrition Promotion Program for Behavior Change
7. Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion) cooking oil fortification with vitamin A
8. Mandatory food fortification (technology development, capacity building, regulation and monitoring, promotion) sugar fortification with vitamin A

The Table 12 lists all available nutrition-specific programs from barangays sampled in the study.

Table 12. Available nutrition-sensitive programs reported by barangay captains.

PPAN nutrition-sensitive programs	Frequency (N=16)
1. Farm-to-market roads and child nutrition	3
2. Target Actions to Reduce Poverty and Generate Economic Transformation (TARGET) and child nutrition	8
3. Coconut Rehabilitation Program	3
4. Gulayan sa Paaralan	11
5. Diskwento caravans in depressed areas	4
6. Family development sessions for child and family nutrition project	12
7. Mainstreaming nutrition in sustainable livelihood	4
8. Public works infrastructure and child nutrition	3
9. Adolescent Health and Nutrition	5
10. *Sagana at Ligtas na Tubig sa Lahat* (SALINTUBIG) and other programs on water, sanitation, and hygiene	11

Source: Authors' illustration

The most available (reported by 12-16 barangays out of the 16) nutrition sensitive program is *Family Development Sessions (FDS*) for child and family nutrition. On the other hand, the least available (reported by only 1 to 7 barangays out the 16) nutrition specific programs are as follows:

1. Public works infrastructure and child nutrition
2. Farm-to-market roads and child nutrition
3. Diskwento caravans in depressed areas
4. Mainstreaming nutrition in sustainable livelihood
5. Adolescent Health and Nutrition

Insights on sufficiency of human resources at the barangay level varies according to key informants. For barangay officials and staff, there is no perceived lack of manpower as all roles needed for the function of the barangay office are adequately filled. On the other hand, volunteer health workers such as barangay health workers (BHWs) and BNSs, who are the beneficiary-facing implementers, remain to be lacking given the health worker to population ratio.

> *"Yes, it is not enough since the barangay health workers have a [limited] ratio. In one barangay health worker, you should manage at least 120 families. If that is the case, each building here is 120 units [room] so if we have 30 buildings, at least 30 barangay health workers for it to be solved. Each building if they have barangay health workers, it will be good. But now, it is only three. They are overloaded."*

4.4.3 Dimension 3. Accountability

Much like the higher levels of implementation, barangays also refer to the OPT results as a main basis for monitoring and evaluation. Upon completion of OPT, the BNSs provide monthly reports that are submitted to the city/municipality. This also serves as guidance for prioritization of barangay nutrition programs. However, in some instances, it was found that there are multiple information systems for nutrition at their level that run in parallel causing duplication in data collection, albeit not harmonized in terms of reporting. In terms of monitoring and evaluation, there is no mention regarding the standard MELPPI tool used by higher LGU levels.

> *"We have monthly reports on that. We have OPT reports…"*

> *"We utilize it especially for those which we called new detect. Those 0 to 59 aged in months, [even] who are the lactating, and pregnant women."*

> *"However, in terms of data, the barangay has their own, for the baby, the NHA has data, the barangay health center has data, the DILG has data. When you cross check it, they are not the same."*

> *"Through our records and database. We have reports submitted to the LGUs. They make a database on that."*

4.5 Beneficiaries

Beneficiaries of nutrition-sensitive programs were also interviewed in order to get their experiences as recipients of the program services. Insights on their perception and outlooks on the programs were also probed.

Nutrition is largely perceived as food- or feeding-related and directed towards children. This is seen to stem from three main things. First, most of the respondents are parents that see the interventions as something for their children. Furthermore, most of the interventions they have experienced and/or participated in are related to food and feeding, mostly done in schools. They recognize that good food is important in ensuring that their children have good nutrition status.

> *"This nutrition program is a great help especially if the government will aid us by feeding the children every month, just like that. As you can see, it really helped since the children are not that malnourished ever since the nutrition was implemented, with healthy foods and the like. That is all I can think of."*

> *"It is the body's status if you are healthy. For me, if you are indigent, your situation would of course be difficult especially in provision of daily food and if ever you may have the chance to eat, it will not be three times a day. If your nutrition is good, then you can eat well three times a day."*

> *"I think of those children who lack food and care from their parents but here in our place, malnourished children are decreasing. It is better now because children are already fed and schooled well."*

"Nutrition is eating of healthy foods and taking of vitamins. These are the important needs that should be granted for the children's nutrition and most especially, the way parents take care of their children."

Nutrition-sensitive programs are viewed as an opportunity towards productivity, skills development, and self-sustenance. The barangays are recognized as key to providing much needed inputs and capital for individuals to achieve these for themselves. Beneficiaries appreciate the learning and skills they have developed by participating in the different programs. In the examples of Gulayan sa Paaralan, backyard gardening, and supplemental feeding, they acknowledge that learning how to plant, take care, and harvest their own food can help them be more self-sustaining. Because these foods are nutritious (i.e., crops, vegetables), it also becomes a good way for them to ensure nutritious food for the children. Aside from this, the programs also provide opportunity even for those who have less resources because necessary inputs (i.e., land space in the schools, seeds for backyard gardening, ingredients for feeding) are provided by the barangays. Those without their own land still get the opportunity to be productive and be motivated to be part of activities they see as fruitful.

"We had agreements to plant vegetables in school, this is the Gulayan sa Paaralan. So that whenever we conduct Supplemental Feeding, we will get the vegetables that we will be cooking from there."

"In Gulayan sa Paaralan since it is clear to us, that program is sustainable year-in, year-out, that is there. That is a permanent program."

"I learned so much from it, first we learned how to plant, and we feel motivated. We visit the garden every Saturday and use the harvest so that it would be of help to us, and we would not have to buy from others."

"In the past, the LGU encouraged us to plant in our backyard. I even won in backyard gardening."

"In our barangay, every time there is an assembly, the barangay officials promote backyard gardening and give vegetable seeds to the people."

"I just hope there will be seeds given to us, because all we have is mostly okra, sitaw, unfortunately the sigarilyas is not there now. Sometimes we are not able to plant gaway and many others."

"In a sense, especially for those who do not own a land, we were delighted with this program because instead of just lying around, just passively waiting for what comes next, we productively go to the garden. Second, it also serves as an exercise for our body since we go there at the break of dawn to cut the weeds. It is also a happy task especially if we are doing it together."

The 4Ps (Pantawid Pamilyang Pilipino Program) as an intervention is seen as crucial in the implementation of nutrition-sensitive programs. The Family Development Sessions (FDS) conducted through the 4Ps were seen as one of the best avenues to learn new skills. It also helps ensure the participation in key programs, mostly those relating to mother and child health.

"We have mothers' class, weighing of the children, those are requirements in the 4Ps and cooking of food. We cook nutritious and cheaper food."

"There are FDS because most of them are 4Ps beneficiaries. It is the MLs who teach during nutrition and family development sessions."

"Here in FDS, we learn how to communicate well with other people and with those who are higher-ranking than us. We see our co-beneficiaries here. We also learn how to live better. And since we are in 4Ps, we get the chance to buy good clothes for our children, good healthy foods, medicines and also the needs and expenses for school like uniforms. That is the huge help that we receive from joining FDS and 4Ps."

Private sector players are also acknowledged as key players in the implementation of these programs. Some have experienced feeding programs supported by UNICEF and the World Food Programme. Others, beneficiaries of Nestle Philippines, for example, specifically mentioned particular brands, e.g., Bear Brand (™) with the implementation of their Pinggang Pinoy Program in schools. These were appreciated as good support by the beneficiaries.

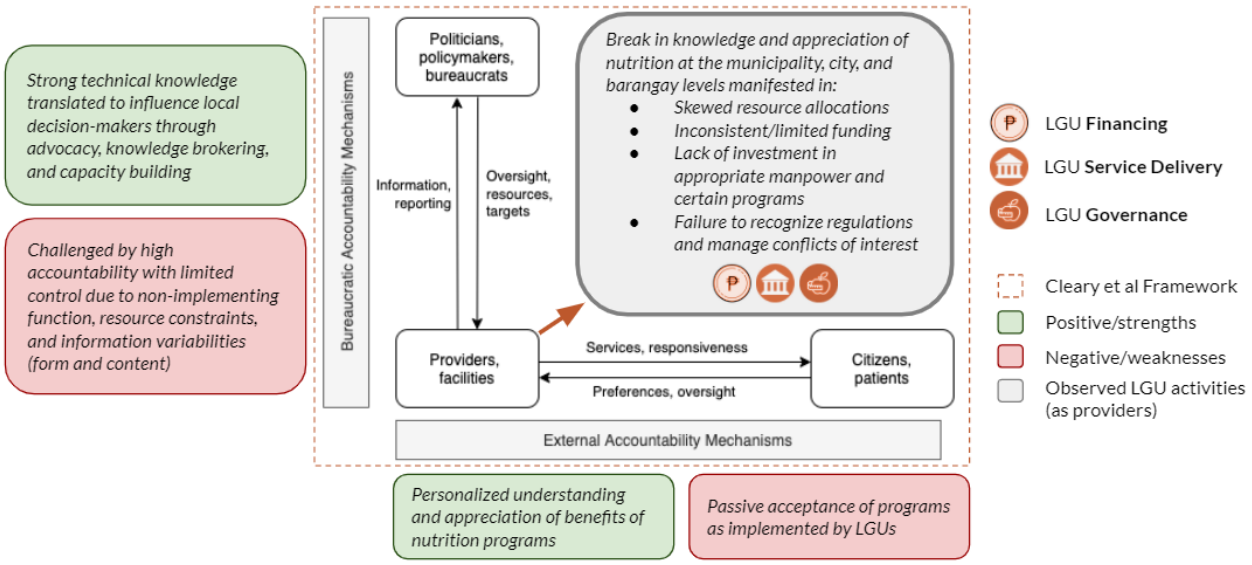
"UNICEF and World Food Programme. They are the ones which provide the rice and ingredients for viands while we cook the food."

"Well, now, we have wellness, but it is a private institution, Nestle actually. The school partnered with Nestle Philippines, the Pinggang Pinoy is there about our health program, what we know as go, grow, and glow foods. Nestle has wellness program, they presented this Pinggang Pinoy, it is coupled with activities also. There should be wellness and exercise."

4.6 Framework Synthesis

These results are further synthesized using the Cleary et al 2013 Framework for Accountability Mechanisms in Health Care. This is to identify how the bureaucratic (national, region, province) and external (beneficiaries) accountability mechanisms translate to nutrition program implementation/service delivery at the provider level (municipalities/cities and barangays).

Figure 8. Framework Synthesis of Results



Source: Authors' illustration

Note: Items in colored rounded rectangles are insights generated from the study. It should be noted that due to the nature of the study, these insights are not being directly correlated, but are being described within the parameters of the framework.

<u>Bureaucratic accountability mechanisms</u>

Defined as the national, regional, and provincial levels

Technical features surrounding nutrition, its strategies, as well as related programs form the core of all oversight functions and target setting. The PPAN is uniformly regarded by entities across this level as a crucial instrument to effective nutrition intervention. Its rationale, strategies, and targets are well-understood. This manifests in several ways such as: (1) recognition of the role of nutrition and PPAN in bigger national and global agendas, (2) knowledge of relevant policies and regulations, (3) confidence in extending technical support at the local level. From national, to regional, and provincial, this thread remains consistent. These higher-level entities use their knowledge of PPAN and its related policies when cascading and explaining nutrition programs at the local level.

Influence is exacted through capacity building and technical assistance that aim to shift paradigms for favorable local decision-making towards nutrition and the implementation of its programs. Much of the interventions revolve around advocacy, knowledge brokering, and information dissemination. They also make sure to transfer technical information to guide strategy development, and even discovery of innovations and alternative implementation approaches as needed. Given their lack of implementing function, these mechanisms are seen as the best ways to fulfill their mandate.

Aside from this, regions and provinces also facilitate inter-agency and multi-sectoral meetings. This emanates the recognition of nutrition as an agenda that goes beyond health. Other key stakeholders and offices are assembled to operationalize plans for both nutrition-specific and nutrition-sensitive programs. This also becomes the opportunity to engage local chief executives and decision-making bodies towards supporting these programs, both through resource mobilization and program prioritization. Budget allocation and policy development that are aligned with the PPAN and supportive of nutrition intervention are generally regarded as the wins.

The governance predicament centers around high accountability over matters with limited control. The performance of regions and provinces are based on the performance of localities within their respective jurisdictions. This drives their incentive to continue their capacity building and technical support activities. Still, these still remain limited since they mostly function influence, and not to directly enforce.

Implementation of this restricted position is further challenged by lack of resources, particularly manpower, as not all regions and/or provinces have adequate nutrition officers. Harvesting of data also proves inconsistent, which hampers monitoring and evaluation. Currently, mechanisms exist that mandate local governments to submit regular reports. However, several implementation challenges persist. For one, these are usually submitted in various formats which make consolidation difficult. Reports are also submitted to different agencies, naturally so because nutrition-specific and -sensitive programs are varied and cut across different sectors. Lastly, some reporting tools are outdated and lack details called for by the PPAN. Overall, this lack of unification in reporting continues to undermine the information collected, and eventually translation to relevant actions.

External accountability mechanisms

Defined as the communities / beneficiaries

Beneficiaries have personalized understanding and appreciation of advantages brought by programs. However, behavior points towards more passive acceptance of programs and the commodities thereof. Nutrition is seen as a key component to good health, especially for children. The expectation of dole-outs of commodities in feeding programs can be counterproductive to interventions to promote, support and protect breastfeeding whether under normal (IYCF) or disaster (NIE) contexts. This stems largely from the fact that most programs experienced and attributed to nutrition are on feeding, food, and agriculture.

Recipients have personalized understanding of the benefits of good nutrition for their children and households. There is recognition that programs can complement and reinforce each other (i.e., gardening nutritious foods for meals). They also see their participation as productive, especially since capital and materials are provided by the local government as part of the program (ex. land for gardening, seedlings, ingredients for cooking, etc.). These are welcome opportunities particularly for low-resource households to gain new skills, ensure health of their families, and potentially become self-sustaining.

Some beneficiaries recall their experience from nutrition-sensitive programs that are in fact no longer implemented in their communities (ex. supplemental feeding). While they express interest for these programs to be revived, these are nuanced more as wishful. Furthermore, experiences of inadequacies in program implementation were not translated to direct clamor towards their local governments and were only taken as a reality.

Provider / facilities

Defined as the municipal/city and barangay levels

Implementation of nutrition programs are ultimately within full control of local chief executives (LCEs) and local committees. The devolved set-up of the health system allows these LGUs and LCEs full autonomy on decision-making particularly in terms of program prioritization and resource allocation. These are also the two key factors identified by the higher governance levels as key to defining wins. Barangays become extensions of the decisions made at the municipal/city level in the form of implementation.

However, there is an evident break in the thread of understanding and appreciation of nutrition at the point between provinces and municipalities, cities, and barangays. Accountability mechanisms prove not strong enough. These manifest in skewed resource allocations, inconsistent and/or limited funding, and lack of investment in appropriate manpower and certain programs, among others. This is crucial because implementation, and consequently translation to results, happen within these levels. Beneficiaries that are on the other end of the accountability stream also tend to be yielding to whatever is provided and are not empowered and equipped to demand their own preferences.

Furthermore, there is failure to recognize important regulation and management of conflicts of interest as they relate to nutrition. National legislation that supports appropriate nutrition interventions and stakeholder engagement are being breached. These are: Executive Order 51 or the Milk Code [2] with its Implementing Rules and Regulations (IRR) which regulates advertising of breastmilk substitutes, including infant formula, other milk products, foods and beverages, feeding bottles and teats; DILG MC 2008-0055, or the "Guidelines on the acceptance and processing of foreign and local donations during emergency and disaster situations [3]; RA 11148 or the "Kalusugan at Nutrisyon ng Mag-Nanay Act" [4] which provides for consideration of World Health Assembly Resolution 69.9 [5] that recommends against cross-promotion and DOH Memorandum No. 2020-0231 or the "Guidelines on the Standardized Regulation of Donations, Related to EO 51 ..." which provides guidelines on how LGUs can help provide nutrition for non-breastfeeding children under 3 years of age. While solicitation and donations are banned as stipulated in various laws and orders, LGUs can procure formula for use by identified families in need, e.g., those with orphaned infants. Any lack of knowledge of these issuances and IRRs is a further indication of lack of attention to nutrition. The allowed interjection of private entities and even NGOs with conflicts of interest in the agenda of nutrition also shows unchecked conflicts of interest, improper policy implementation, and lack of knowledge at the level of beneficiaries.

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[2] Government of the Philippines. Executive Order 51 s. 1986. Adopting a National Code of Marketing of Breastmilk Substitutes, Breastmilk supplements and related products, Penalizing Violations Thereof, and for other purposes. Available at: https://www.officialgazette.gov.ph/1986/10/20/executive-order-no-51-s-1986-2/

[3] Department of the Interior and Local Governments. Memorandum Circular 2008-0055. Available at: https://dilg.gov.ph/issuances/mc/GUIDELINES-ON-THE-ACCEPTANCE-AND-PROCESSING-OF-FOREIGN-AND-LOCAL-DONATIONS-DURING-EMERGENCY-AND-DISASTER-SITUATIONS/1163

[4] National Nutrition Council. Republic Act 11148. Kalusugan at Nutrisyon ng Mag-Nanay Act. Available at: https://nnc.gov.ph/index.php/regional-offices/luzon/region-ii-cagayan-valley/3679-ra-11148-kalusugan-at-nutrisyon-ng-magnanay-act.html

[5] World Health Assembly Resolution WHA 69.9. Ending inappropriate promotion of foods for infants and young children. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf?ua=1

5. Limitations

Qualitative data collection through key informant interviews was undertaken entirely during this protracted COVID19 pandemic. Questionnaires were not designed to be self-administered and thus entailed face-to-face interviews by our trained enumerators.

The difficulties encountered were slow paced of securing appointments, what with the very tight key informants' work schedules; occasional impolite reception of enumerators' requests for interviews; short interview times. Considering these constraints, and as quarantine measures were tightened over the course of pandemic lockdowns, the need to cut interview time to 30 mins, precluded substantive exchanges between key informant and enumerators. After establishing rapport, instead of truly open-ended questions with sufficient probing, enumerators were compelled to ask yes/no questions especially when confirming issues about implementation and monitoring of nutrition programs. At the barangay level, potentially sensitive issues on transparency, accountability and reporting were not captured as well as at municipal/city, province, and regional levels).

6. Evidence-based framework

Evidence-based framework for the comprehensive and sustainable implementation of the First 1,000 Days and Nurturing Care Strategy

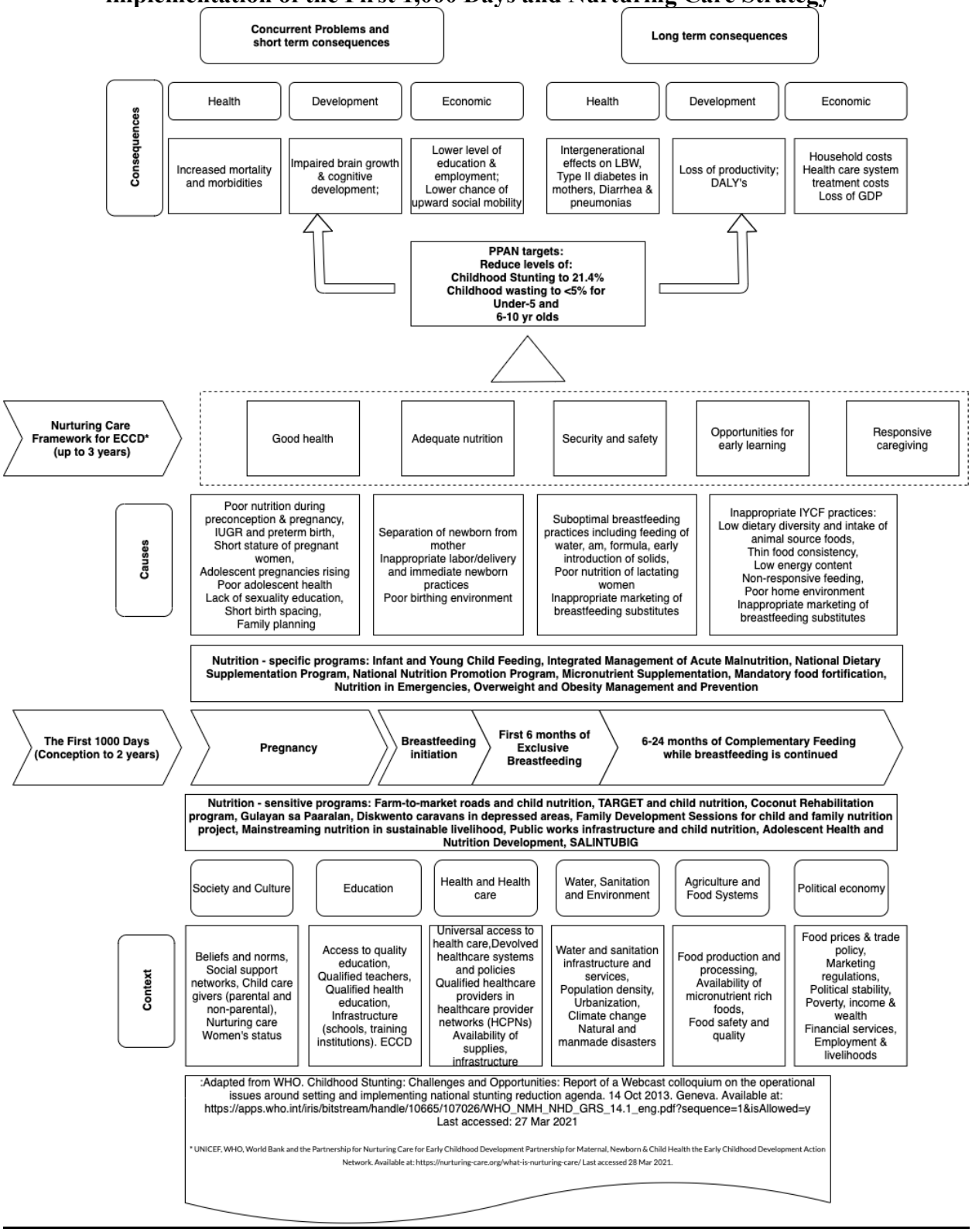
The first one thousand (1000) days of a child start at conception and end when the child reaches her or his second year of life. The first 1,000 days of life is a unique period of opportunity, when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established. This crucial period, "a moment of truth" in every child's life constitutes a period of rapid physical growth and brain development, which if compromised, will result in irreversible injuries that are very difficult to compensate for later in childhood.

Sadly, in low resource settings, poverty and its attendant condition, malnutrition, compromise this foundation, leading to poor overall health, and substantial loss of neurodevelopmental potential. Both undernutrition manifesting acutely as wasting, and chronically as stunting; and overnutrition, manifesting as overweight and obesity are forms of "malnutrition" in the true sense of its etymology - "bad" nutrition. Both types of malnutrition together with micronutrient deficiency have been shown to potentially reduce brain development.

It is imperative that preventive, population level interventions are implemented throughout the first 1000 days of each child's life. This means that from preconception, spanning pregnancy, to labor/delivery (270 days), over the first 6 months of exclusive breastfeeding (180 days) and thereafter until the child's second birthday (550 days), her/his nutrition should be ensured through evidence-based interventions that are both preventive and therapeutic, medical and, as our findings highlighted, developmental in nature. **The Nurturing Care framework for early childcare and development (ECCD) builds on current evidence**

of how child development unfolds and of the effective policies and interventions that can improve early childhood development. The Nurturing Care framework was developed by UNICEF, WHO, and the World Bank Group, in collaboration with the Partnership for Maternal, Newborn & Child Health the Early Childhood Development Action Network. It emphasizes helping children survive and thrive to transform health and human potential. Children require the five components of nurturing care namely: good health, adequate nutrition, safety and security, responsive caregiving, and opportunities for leaning to reach their maximum potential (UNICEF et al. 2021). **The majority of these interventions can be delivered at the primary care setting.** The framework outlines: "**why efforts to improve health and wellbeing must begin in the earliest years, from pregnancy to age 3; the major threats to early childhood development; how nurturing care protects young children from the worst effects of adversity and promotes physical, emotional and cognitive development and; what families and caregivers need to provide nurturing care for young children"** (UNICEF et al. 2020, p. 8)**.**

Figure 9. Evidence-based Framework for the comprehensive and sustainable implementation of the First 1,000 Days and Nurturing Care Strategy



Source: Authors' illustration based on related literature

7. Conclusions

We examined the implementation of PPAN at regional, provincial, city/municipality and barangay levels by looking at the following dimensions:
Dimension 1 Awareness

Higher levels of governance at the regional, provincial, and city/municipality levels are cognizant of the Philippine Plan of Action for Nutrition or the PPAN (2017-2022) as the national strategy to improve nutrition in the country. Integral to the Philippine Development Plan, the PPAN is considered as a roadmap for directing stakeholders and key implementers in operationalizing programs, projects, and activities across different levels of governance. At the regional, provincial, and municipal level, the PPAN framework is integrated in their local nutrition action and investment plans. However, there is a general lack of awareness on the PPAN at the barangay level which is the locus of implementation.

Dimension 2 Adoption

Budget allocation and implementation for nutrition programs are found to be inconsistent and highly fragmented across different levels of governance. At lower LGU levels financing nutrition programs are perceived to be highly dependent on the priority of and buy-in from local chief executives, particularly mayors. This disparity in funding across LGUs is highly indicative of a lack of specific guidance for budget allocation in nutrition.

Prioritization of nutrition programs, by practice, refer to local situational analyses on nutritional status and outcome trends across all levels of governance. Local nutrition committees need to prioritize programs and target beneficiaries given the already limited budget. Deficits in human resources especially at the city/municipality and barangay levels remains to be a major bottleneck in implementation.

Dimension 3 Accountability

Accountability is exacted across governance levels on different means and aspects. Regional NNC Offices serve as a conduit for accountability and reporting between the national level and the LGUs. They are also responsible for advocating resource generation and mobilization, as well as building linkages to support PPAN implementation. In terms of monitoring and evaluation in the region, they perform the MELPPI to assess and track program implementation. Provinces function as intermediaries between LGUs and partner agencies to liaise across different stakeholders through advocacy, strategy development, and overall knowledge brokering. Cities and municipalities, on the other hand, are the primary drivers of implementation. They craft and develop the local nutrition action plans and provide support to barangays which are at the forefront of implementation. At their level, they perform program implementation review (PIR) to assess accomplishment of targets, and programmatic performance based on nutrition outcomes evidenced by OPT results - the main data for reporting prevalence of different forms of malnutrition and overall nutritional status.

Beneficiaries

Beneficiaries largely perceived nutrition as food- or feeding-related and directed towards children. Insights on their perception and outlooks on the programs were also probed. Nutrition-sensitive programs are viewed as an opportunity towards productivity, skills development, and self-sustenance.

The barangays are recognized as key to providing much needed inputs and capital for individuals to achieve these for themselves. The 4Ps (Pantawid Pamilyang Pilipino Program) as an intervention is seen as crucial in the implementation of nutrition-sensitive programs. Private sector players are also acknowledged as key players in the implementation of these programs.

8. Recommendations

Align with reform directions of the Universal Health Care (UHC) Act to drive financing, service delivery, and governance of nutrition programs. This recently passed piece of legislation aims to introduce systematic changes that can improve overall efficiency and capacity of the health system. Two major reforms in this Act present opportunities to improve delivery of nutrition interventions. In particular:

- **Leverage reforms in health financing by tapping into upcoming mechanisms that can link payments with actual performance and service delivery.** One of the key reforms of the UHC Act is transforming PhilHealth to be a national purchaser of individual-based health services - or those services that can be definitively traced distinct, individual recipients (RP 2019). This effectively shifts financing of these services to PhilHealth, some of which are currently still being financed by DOH vertical programs. Nutrition, particularly components of nutrition-specific programs such as supplies, commodities, IYCF counseling (breastfeeding and complementary feeding), micronutrients, vitamins, supplements, and the like, are classified as individual-based (DOH 2020).

  One major advantage of PhilHealth financing is that it is specific to health, with the UHC Act further ensuring that it can and should only be spent for health purposes. This greatly secures resources as it diminishes the existing competition of nutrition, and health in general, with other LGU programs in need of financing. PhilHealth is also moving more towards performance-based payments, calibrated to the specific context of localities and/or providers being contracted. This presents an even bigger opportunity to link key nutrition targets and interventions specific to financing to optimize resources.

  A second major advantage of this shift in financing scheme is it helps ensure consolidation of financing to a defined financial source. As DOH vertical programs eventually move out of financing these items, the financial stake together with the necessary fiscal space shifts more towards local governments. This can help exact accountability on fund allocation and utilization towards nutrition.

However, another key policy directive that seems to present interference is the Mandanas ruling. This ruling enlarges the tax base subject for re-distribution to LGUs through the Internal Revenue Allocation (IRA) (RPCR 2020), effectively expanding their fiscal space. Still, the IRA remains to be an unconditional block grant annually downloaded to local governments, computed through a fixed formula. It will still be subject to budget allocation competition, and ultimately budgetary discretion (Canare 2019; Cuenca 2018), which have been shown to not favor nutrition in particular. Expecting funding for nutrition-specific programs from this may not be ideal. These can instead be the source of funds for nutrition-sensitive interventions, a lot of which are expensive (i.e., farm to market roads, establishment of irrigation and water systems, infrastructure for agriculture), and cannot be paid for by PhilHealth being not a direct delivery of health services. Recommendations on setting fixed percentages can be enforced within this fund. This still works in line with ensuring financing for nutrition programs, while decreasing potential for low allocation.

- **Position and integrate nutrition as part of primary care.** Shift towards a more primary care-oriented system is one of the major cornerstones of the UHC Act. This is emphasized through the development of a comprehensive primary care benefit (COBP) and ensuring primary care gatekeeping within healthcare provider networks (HCPNs). This direction will push the system to reorient service delivery and financing priorities towards primary, preventive, and promotive health care (RP 2019; DOH 2020), to which good nutrition is an essential component. Strategically positioning nutrition-specific interventions as part of these shifts towards primary care helps put nutrition within the same footing of prioritization, financing, integration, and ultimately equal delivery and access across all populations and areas.

- **Determine nutrition-specific interventions for financing and inclusion to primary care based on objective, evidence-based practices.** The UHC Act similarly establishes processes to help identify which services should be prioritized and invested on by the government. These include mandated clinical practice guideline (CPG) development and health technology assessment (HTA) especially for new interventions. Nutrition-specific interventions should be subjected to these institutionalized mechanisms in order to assure good quality and value.

Prioritize to nutrition programs with interventions in pregnancy to the first three years of life. An evidence-based framework based on both the First 1000 Days Strategy (from periconception to 2 years of age) and the Nurturing Care framework for Early Childhood Care and Development (up to 3 years of age) to guide direction and strategies for nutrition interventions should be developed and adequately cascaded. This should cover both the science of nutrition to ensure technical soundness, as well as implementation factors to ensure implementability and feasibility. This can be further operationalized through principles grounded on the key dimensions of awareness, adoption, and accountability.

- Strong and comprehensive **awareness** and appreciation of nutrition across various levels of governance towards security in program support
    - Issue clear directives from national agencies to regional counterparts with discrete legal instruments, circulars
    - Enable the leadership and strengthen nutrition governance among local chief executives
    - Intensify advocacy for the PPAN, by NNC and DOH, with health as lead sector

    - Start to draft the PPAN (2023-2028) as early as now to include mitigation strategies for pandemic readiness under the Nutrition in Emergencies program of the DOH, DSWD and Disaster Risk Reduction Council.
- Adequate knowledge, resources, and organizational capacity to enable consistent **adoption** of and investment on programs from national to barangay
    - Strengthen human resources for nutrition integrated with health
    - Provide technical assistance to provincial, city/municipality action officers and especially barangay level nutrition workers to draft action plans and implementing mechanisms
    - Upgrade information and technology systems
    - Translate current and updated evidence to practice
    - Move towards more streamlined consolidation of finances for nutrition programs
    - Integrate nutrition as part of the primary care agenda to improve alignment, consistency, and prioritizations
    - Sharpen the focus of nutrition programs at the barangay level to target priority populations, e.g., sexuality education for adolescents in and out-of-school, targeted rather than blanket feeding programs for pregnant pre-teens and teenagers, preschool age children, farm-to-market roads from farming and fisheries communities with high stunting prevalence etc.
- Consistent and consolidated mechanisms of **accountability** that is shared with multi-sectoral players to harmonize efforts
    - LPANs should set out the processes to monitor and manage Conflicts of Interest (CoI) and related processes for mutual accountability.
    - RPANs should set out the processes for institutional frameworks on Conflicts of Interest (CoI) considering current national legislation and DOH/DILG issuances
    - Intensify gaining commitments for public private partnerships, with development partners and NGOs providing technical assistance at the LGU level, but without partners with competing interests in the formula and baby food industry
    - Conduct operational research for more rigorous documentation and dissemination of good practices and lessons learners

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10. List of Acronyms

4Ps	Pantawid Pamilyang Pilipino Program
AIP	Annual Investment Plan
ANC	Ante-natal care
BMI	Body Mass Index
COI	Conflict of interest
COBP	Comprehensive Primary Care Benefit Package
CSWD	Center for Social Welfare and Development
DA	Department of Agriculture
DepEd	Department of Education
DILG	Department of Interior and Local Governance
DOH	Department of Health
DOST	Department of Science and Technology
DPWH	Department of Public Works and Highways
ECCD	Early Childhood Care and Development
EO 51	Executive Order 51 The Philippine Milk Code
FDS	Family Development Sessions
FAO	Food and Agriculture Organization
FHSIS	Field Health Services Information System
FNRI	Food and Nutrition Research Institute
IFYC	Infant and Young Child Feeding
IMCI	Integrated Management of Childhood Illness
IRA	Internal Revenue Allotment
HCI	Human Capital Index
HPDRC	Human Development and Poverty Reduction Center
KII	Key informant interview
LGU	Local government unit
LNAP	Local Nutrition Action Plan
MDG	Millennium Development Goals
MELPPI	Pro Monitoring and Evaluation of Local Level Plan Implementation Protocol
MNC	Municipal Nutrition Committee
MPDC	Municipal Planning and Development Coordinator
NCR	National Capital Region
NDHS	National Demographic Health Survey
NEDA	National Economic and Development Authority
NGA	National Government Agency
NNC	National Nutrition Council
NNS	National Nutrition Survey
OPA	Office of the Provincial Agriculturist
OPT	Operation Timbang

PCA	Principal Component Analysis
PhilHealth	Philippine Health Insurance Corporation
PIDS	Philippine Institute for Development Studies
PIMAM	Philippine Integrated Management of Acute Malnutrition
PIR	Program Implementation Review
PNC	Provincial Nutrition Committee
PPAN	Philippine Plan of Action for Nutrition
PM	Predictive Model
RAOD	Registry of Allotment, Obligation and Disbursements
RNC	Regional Nutrition Committee
SALINTUBIG	Sagana at Ligtas na Tubig Para sa Lahat
SAOB	Statement of Allotment, Obligation and Balances
SDG	Sustainable Development Goals
SUN	Scaling Up for Nutrition
TARGET	Target Actions to Reduce Poverty and Generate Economic Transformation
UHC	Universal Health Care
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organization

Annex A. Coding System for Thematic Analysis

Code System	Frequency
Code System	787
awareness	0
local nutritional status	13
challenges in nutrition	11
improvements in nutrition	17
awareness_ppan	14
role_nutrition action officer	7
role_importance	5
role_nnc	15
difficulties_ppan roles	15
advocacy	7
coordination and governance	7
adoption	0
prioritization, planning and financing	5
prioritization	0
LGU support	7
adoption_ppan framework	17
local nutrition action plan	12
regional plan of action for nutrition	7
PPA	1
nutrition-specific	0
nutrition sensitive	1
demand-side determination	15
community engagement	3
planning	1
enganging implementers	4
local nutrition committee	4
community engagement	1
national government	1
partner agencies	5
local government units	11
barangay nutrition committee	5

local chief executives	3
regional nutrition committee	11
decision-makers	10
financing	6
disbursement	1
determining / estimating allocation	9
translation and execution of ppan	6
PPAs	1
national agency support	0
DILG	1
DOLE	0
DPWH	0
DepEd	2
DA	0
DSWD	2
DOST	2
LGU Support	3
NGO/CSO Support	1
PPA officers	5
nutrition-specific	5
nutrition-sensitive	13
advocacy	9
nutrition promotion and education	24
breastfeeding	5
capacity building	9
engagement with LGUs	15
community engagement	10
monitoring and evaluation	12
process	10
tools and instruments	5
regulation of milk donation	10
resources	0
human resources	35
skills and knowledge	2
organizational structure	6

financing	18
process	16
budget allocation	10
plans and policies	10
NGO/CSO support	11
private sector support	1
accountability	0
transparency and accountability of office	7
external feedback mechanisms	0
tools and approaches	1
reporting channels	4
progress in meeting roles	3
targets and goals	13
target setting	11
gathering data	17
corrective actions	11
enabling factors	4
compliance of beneficiaries	1
manpower	1
LGU support	2
constraining factors	2
changes in leadership	1
LGU support	17
nutrition education	3
manpower	8
COVID-19	4
compliance of beneficiaries	2
other resources	5
recommendations	21
good practices	13
beneficiaries	0
awareness	1
nutrition	16
programs in the community	27
access to and participation in nutrition sensitive programs	38

NGO/CSO Support	1
private sector support	1
engagement with LGU implementers	6
satisfactory rating	22
recommendations	14

Annex B. Province level Expenditures for Nutrition Programs

Table 14. Camarines Sur province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	361,425.16	46,204.59	497,629.75	99.00%
Access to healthcare services	8,700.50	-	8,700.50	2.11%
Adolescent health and education	0.5	-	0.5	0.00%
Agriculture (food security and availability) and fisheries	4,404.57	-	4,404.57	1.07%
Disease prevention and management	256.2	-	256.2	0.06%
Early childhood care and development (ECCD)	-	-	-	0.00%
Family planning and responsible parenting	150	-	150	0.04%
Gender, women's empowerment, and child protection	330	39,435.10	39,765.10	9.66%
Humanitarian relief and emergency fund	-	-	-	0.00%
Maternal and neonatal health	0.05	-	-	0.00%
Oral health	257.89	-	257.89	0.06%
Social welfare and peace and order	20	-	20	0.01%
Water, sanitation (environment), and waste management	347,305.00	6,769.49	354,974.59	85.99%
Nutrition-specific	3,800	115	3,915.50	0.95%
Infant and young child feeding	-	115	115	0.03%
Integrated management of acute malnutrition	1,000.00	-	1,000.00	0.24%
Micronutrient supplementation	-	-	-	0.00%
Nutrition specific support	2,800.00	-	2,800.00	0.68%
Overweight/obesity management and prevention	0.5	-	0.5	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**7.78**	**-**	**-**	**0.02%**
Unknown	**200**	**-**	**200**	**0.05%**
Grand Total	**365,433.44**	**46,319.59**	**411,753.02**	**100.00%**

Source: Authors' calculations

Table 15. Iloilo province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	122,086.65	320,581.16	442,667.81	74.59%
Access to healthcare services	30,455.00	73,492.12	103,947.12	17.52%
Adolescent health and education	40,275.00	917.77	41,192.77	6.94%
Agriculture (food security and availability) and fisheries	20,650.00	67,400.57	88,050.57	14.84%
Disease prevention and management	8,092.65	9,027.70	17,120.35	2.88%
Early childhood care and development (ECCD)	-	367.15	367.15	0.06%
Family planning and responsible parenting	1,619.00	1,940.24	3,559.24	0.60%
Gender, women's empowerment, and child protection	-	21,578.81	21,578.81	3.64%
Humanitarian relief and emergency fund	200	-	200	0.03%
Maternal and neonatal health	739	108	847	0.14%
Oral health	1,056.00	61,244.95	62,300.95	10.50%
Social welfare and peace and order	19,000.00	84,503.85	103,503.85	17.44%
Water, sanitation (environment), and waste management	-	-	-	0.00%
Nutrition-specific	52,944.00	1,631.25	54,575.25	9.20%
Infant and young child feeding	-	173.5	173.5	0.03%
Integrated management of acute malnutrition	-	-	-	0.00%
Micronutrient supplementation	463	-	463	0.08%
Nutrition specific support	52,481.00	1,457.75	53,938.75	9.09%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**95,269.17**	**-**	**95,269.17**	**16.05%**
Unknown	**380**	**578.5**	**958.5**	**0.16%**
Grand Total	**270,679.82**	**322,790.91**	**593,470.73**	**100.00%**

Source: Authors' calculations

Table 16. Maguindanao province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	7,202.12	44,379.86	51,581.98	96.00%
Access to healthcare services	950	11,250.00	12,200.00	22.71%
Adolescent health and education	1,030.00	60/00	1,090.00	2.03%
Agriculture (food security and availability) and fisheries	578.62	327.78	906.4	1.69%
Disease prevention and management	700	16,997.34	17,697.34	32.94%
Early childhood care and development (ECCD)	-	950	950	1.77%
Family planning and responsible parenting	-	-	-	0.00%
Gender, women's empowerment, and child protection	1,570.00	12,794.00	14,364.00	26.73%
Humanitarian relief and emergency fund	2,003.50	-	2003.5	3.73%
Maternal and neonatal health	-	-	-	3.54%
Oral health	-	-	-	0.00%
Social welfare and peace and order	-	-	-	0.00%
Water, sanitation (environment), and waste management	370	100	470	0.87%
Nutrition-specific	1,250.00	900	2,150.00	4.00%
Infant and young child feeding	650	-	-	1.21%
Integrated management of acute malnutrition	-	-	-	0.00%
Micronutrient supplementation	-	-	-	0.00%
Nutrition specific support	600	900	1,500.00	2.79%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**-**	**-**	**-**	**0.00%**
Unknown	**-**	**-**	**-**	**0.00%**
Grand Total	**8,452.12**	**45,279.86**	**53,731.98**	**100.00%**

Source: Authors' calculations

Table 17. Misamis Oriental province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	-	18,124.73	18,124.73	95.24%
Access to healthcare services	-	9,237.24	9,237.24	48.54%
Adolescent health and education	-	475	475	2.50%
Agriculture (food security and availability) and fisheries	-	-	-	0.00%
Disease prevention and management	-	396.28	396.28	2.08%
Early childhood care and development (ECCD)	-	3,453.01	3,453.01	18.15%
Family planning and responsible parenting	-	119	119	0.63%
Gender, women's empowerment, and child protection	-	3,224.21	3,224.21	16.94%
Humanitarian relief and emergency fund	-	1,120.00	1,120.00	5.89%
Maternal and neonatal health	-	100	100	0.53%
Oral health	-	-	-	0.00%
Social welfare and peace and order	-	-	-	0.00%
Water, sanitation (environment), and waste management	-	-	-	0.00%
Nutrition-specific		905	905	4.76%
Infant and young child feeding	-	-	-	0.00%
Integrated management of acute malnutrition	-	-	-	0.00%
Micronutrient supplementation	-	-	-	0.00%
Nutrition specific support	-	905	905	4.76%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**-**	**-**	**-**	**0.00%**
Unknown	**-**	**-**	**-**	**0.00%**
Grand Total	**-**	**19,029.73**	**-**	**100.00%**

Source: Authors' calculations

Table 18. NCR expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	470.57	277,733.47	278,204.04	94.30%
Access to healthcare services	222.16	19,137.38	19,359.54	6.56%
Adolescent health and education	1.03	1,417.40	1,418.43	0.48%
Agriculture (food security and availability) and fisheries	11.58	-	11.58	0.00%
Disease prevention and management	44.04	18,249.85	18,293.89	6.20%
Early childhood care and development (ECCD)	70.38	4,742.32	4,812.69	1.63%
Family planning and responsible parenting	-	13,069.50	13,069.50	4.43%
Gender, women's empowerment and child protection	-	42,173.91	42,173.91	14.30%
Humanitarian relief and emergency fund	39.31	-	39.31	0.01%
Maternal and neonatal health	66.25	68,441.77	68,508.02	23.22%
Oral health	14.66	-	14.66	0.01%
Social welfare and peace and order	0.06	-	0.06	0.00%
Water, sanitation (environment), and waste management	1.1	110,501.35	-	37.46%
Nutrition-specific	96.11	16,719.39	16,815.50	5.70%
Infant and young child feeding	38.28	5,088.71	5,127.00	1.74%
Integrated management of acute malnutrition	-	1,473.30	1,473.30	0.50%
Micronutrient supplementation	56.3	2,325.50	2,381.80	0.81%
Nutrition specific support	1.52	7,307.83	7,309.34	2.48%
Overweight/obesity management and prevention	-	24.96	24.06	0.01%
Supplementary feeding	-	500	500	0.17%
General enabling	-	-	-	**0.00%**
Unknown	-	-	-	**0.00%**
Grand Total	**566.67**	**294,452.86**	**295,019.53**	**100.00%**

Source: Authors' calculations

Table 19. Northern Samar province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	-	28,513.22	28,513.22	99.11%
Access to healthcare services	-	94.38	94.38	0.33%
Adolescent health and education	-	-	-	0.00%
Agriculture (food security and availability) and fisheries	-	-	-	0.00%
Disease prevention and management	-	382.31	-	1.33%
Early childhood care and development (ECCD)	-	-	-	0.00%
Family planning and responsible parenting	-	-	-	0.00%
Gender, women's empowerment, and child protection	-	28,036.53	28,036.53	97.45%
Humanitarian relief and emergency fund	-	-	-	0.00%
Maternal and neonatal health	-	-	-	0.00%
Oral health	-	-	-	0.00%
Social welfare and peace and order	-	-	-	0.00%
Water, sanitation (environment), and waste management	-	-	-	0.00%
Nutrition-specific	-	256.9	256.9	0.89%
Infant and young child feeding	-	-	-	0.00%
Integrated management of acute malnutrition	-	-	-	0.00%
Micronutrient supplementation	-	256.9	-	0.89%
Nutrition specific support	-	-	-	0.00%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**-**	**-**	**-**	**0.00%**
Unknown	**-**	**-**	**-**	**0.00%**
Grand Total	**-**	**28,770.12**	**28,770.12**	**100.00%**

Source: Authors' calculations

Table 20. Pampanga expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	-	23,531.70	23,531.70	84.40%
Access to healthcare services	-	-	-	0.00%
Adolescent health and education	-	347.02	347.02	1.24%
Agriculture (food security and availability) and fisheries	-	17,645.00	17,645.00	63.29%
Disease prevention and management	-	318.63	318.63	1.14%
Early childhood care and development (ECCD)	-	-	-	0.00%
Family planning and responsible parenting	-	567.83	567.83	2.04%
Gender, women's empowerment, and child protection	-	778.43	778.43	2.79%
Humanitarian relief and emergency fund	-	-	-	0.00%
Maternal and neonatal health	-	3,874.79	3,874.79	13.90%
Oral health	-	-	-	0.00%
Social welfare and peace and order	-	-	-	0.00%
Water, sanitation (environment), and waste management	-	-	-	0.00%
Nutrition-specific	-	4,272.00	4,272.00	15.32%
Infant and young child feeding	-	-	-	0.00%
Integrated management of acute malnutrition	-	4,272.00	4,272.00	15.32%
Micronutrient supplementation	-	-	-	0.00%
Nutrition specific support	-	-	-	0.00%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**-**	**-**	**-**	**0.00%**
Unknown	**-**	**76**	**-**	**0.27%**
Grand Total	**-**	**27,879.70**	**27,879.70**	**100.00%**

Source: Authors' calculations

Table 21. Samar expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	93,168.30	229,496.55	322,664.85	92.33%
Access to healthcare services	5,300.00	0	5,300.00	1.52%
Adolescent health and education	656	50,624.99	50,624.99	14.67%
Agriculture (food security and availability) and fisheries	15,020.00	-	15,020.00	4.30%
Disease prevention and management	2,817.84	603.66	3,421.51	0.985
Early childhood care and development (ECCD)	200	7,882.42	8,082.42	2.31%
Family planning and responsible parenting	595	408.47	1,003.47	0.29%
Gender, women's empowerment, and child protection	380	48,659.87	49,039.87	14.03%
Humanitarian relief and emergency fund	696.46	100	796.46	0.23%
Maternal and neonatal health	2,725.00	120,467.15	123,192.14	35.25%
Oral health	100	-	100	0.03%
Social welfare and peace and order	-	750	750	0.21%
Water, sanitation (environment), and waste management	64,678.00	-	-	18.51%
Nutrition-specific	12,319.44	13,858.75	26,178.19	7.49%
Infant and young child feeding	1,901.81	-	1,901.81	0.54%
Integrated management of acute malnutrition	209	3,700.00	3,909.00	1.12%
Micronutrient supplementation	40	-	40	0.01%
Nutrition specific support	10,028.63	10,158.75	20,187.38	5.78%
Overweight/obesity management and prevention	140	-	140	0.04%
Supplementary feeding	-	-	-	0.00%
General enabling	**417.99**	**-**	**417.99**	**0.12%**
Unknown	**30**	**185.9**	**215.9**	**0.06%**
Grand Total	**105,935.73**	**241,541.20**	**349,476.93**	**100.00%**

Source: Authors' calculations

Table 22. Zamboanga del Norte province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Program Classification	AIP	GAD	Total	% share
Nutrition-sensitive	-	52,203.18	52,203.18	96.47%
Access to healthcare services	-	200	200	0.37%
Adolescent health and education	-	274	274	0.51%
Agriculture (food security and availability) and fisheries	-	5,189.32	5,189.32	9.59%
Disease prevention and management	-	-	-	0.00%
Early childhood care and development (ECCD)	-	1,496.10	1,496.10	2.76%
Family planning and responsible parenting	-	990	990	1.83%
Gender, women's empowerment, and child protection	-	60	60	0.11%
Humanitarian relief and emergency fund	-	-	-	0.00%
Maternal and neonatal health	-	498.88	498.88	0.92%
Oral health	-	-	-	0.00%
Social welfare and peace and order	-	-	-	0.00%
Water, sanitation (environment), and waste management	-	43,494.89	43,494.89	80.38%
Nutrition-specific	-	1,866.52	1,866.52	3.45%
Infant and young child feeding	-	757.75	757.75	1.40%
Integrated management of acute malnutrition	-	299.43	299.43	0.55%
Micronutrient supplementation	-	615.4	615.4	1.14%
Nutrition specific support	-	193.94	193.94	0.36%
Overweight/obesity management and prevention	-	-	-	0.00%
Supplementary feeding	-	-	-	0.00%
General enabling	**-**	**-**	**-**	**0.00%**
Unknown	**-**	**42**	**42**	**0.08%**
Grand Total	**-**	**54,111.70**	**54,111.70**	**100%**

Source: Authors' calculations

Annex C. Municipality / City Level Expenditures for Nutrition Programs

Table 23. Municipality of Camaligan, Camarines Sur province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Camaligan						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	361,375.00	₱	-	₱ 361,375.00	98.96%
Access to healthcare services	₱	8,700.00			₱ 8,700.00	2.38%
Adolescent health and education					₱ -	0.00%
Agriculture (food security and availability) and fisheries	₱	4,375.00			₱ 4,375.00	1.20%
Disease prevention and management	₱	250.00			₱ 250.00	0.07%
Early childhood care and development (ECCD)					₱ -	0.00%
Family planning and responsible parenting	₱	150.00			₱ 150.00	0.04%
Gender, women's empowerment, and child protection	₱	330.00			₱ 330.00	0.09%
Humanitarian relief and emergency fund					₱ -	0.00%
Maternal and neonatal health					₱ -	0.00%
Oral health	₱	250.00			₱ 250.00	0.07%
Social welfare and peace and order	₱	20.00			₱ 20.00	0.01%
Water, sanitation (environment), and waste management	₱	347,300.00			₱ 347,300.00	95.11%
Nutrition-specific	₱	3,800.00	₱	-	₱ 3,800.00	1.04%
Infant and young child feeding					₱ -	0.00%
Integrated management of acute malnutrition	₱	1,000.00			₱ 1,000.00	0.27%
Micronutrient supplementation					₱ -	0.00%
Nutrition specific support	₱	2,800.00			₱ 2,800.00	0.77%
Overweight/obesity management and prevention					₱ -	0.00%
Supplementary feeding					₱ -	0.00%
General enabling					₱ -	0.00%
Unknown	₱	200.00			₱ 200.00	0.05%
Grand Total	₱	365,175.00	₱	-	₱ 365,175.00	100.00%

Source: Authors' calculations

Table 24. Municipality of Libmanan, Camarines Sur province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Libmanan			
Program	**AIP**	**GAD**	**Total**	**% share**
Nutrition-sensitive	₱ -	₱ 410.00	₱ 410.00	78.10%
Access to healthcare services			₱ -	0.00%
Adolescent health and education			₱ -	0.00%
Agriculture (food security and availability) and fisheries			₱ -	0.00%
Disease prevention and management			₱ -	0.00%
Early childhood care and development (ECCD)			₱ -	0.00%
Family planning and responsible parenting			₱ -	0.00%
Gender, women's empowerment, and child protection		₱ 265.00	₱ 265.00	50.48%
Humanitarian relief and emergency fund			₱ -	0.00%
Maternal and neonatal health			₱ -	0.00%
Oral health			₱ -	0.00%
Social welfare and peace and order			₱ -	0.00%
Water, sanitation (environment), and waste management		₱ 145.00	₱ 145.00	27.62%
Nutrition-specific	₱ -	₱ 115.00	₱ 115.00	21.90%
Infant and young child feeding		₱ 115.00	₱ 115.00	21.90%
Integrated management of acute malnutrition			₱ -	0.00%
Micronutrient supplementation			₱ -	0.00%
Nutrition specific support			₱ -	0.00%
Overweight/obesity management and prevention			₱ -	0.00%
Supplementary feeding			₱ -	0.00%
General enabling			₱ -	0.00%
Unknown			₱ -	0.00%
Grand Total	₱ -	₱ 525.00	₱ 525.00	100.00%

Source: Authors' calculations

Table 25. City of Naga, Camarines Sur province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Naga City						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	50.16	₱	45,793.00	₱ 45,843.16	100.00%
Access to healthcare services	₱	0.50			₱ 0.50	0.00%
Adolescent health and education	₱	0.50			₱ 0.50	0.00%
Agriculture (food security and availability) and fisheries	₱	29.57			₱ 29.57	0.06%
Disease prevention and management	₱	6.20			₱ 6.20	0.01%
Early childhood care and development (ECCD)					₱ -	0.00%
Family planning and responsible parenting					₱ -	0.00%
Gender, women's empowerment, and child protection			₱	39,170.00	₱ 39,170.00	85.44%
Humanitarian relief and emergency fund					₱ -	0.00%
Maternal and neonatal health	₱	0.50			₱ 0.50	0.00%
Oral health	₱	7.89			₱ 7.89	0.02%
Social welfare and peace and order					₱ -	0.00%
Water, sanitation (environment), and waste management	₱	5.00	₱	6,623.00	₱ 6,628.00	14.46%
Nutrition-specific	₱	0.50	₱	-	₱ 0.50	0.00%
Infant and young child feeding					₱ -	0.00%
Integrated management of acute malnutrition					₱ -	0.00%
Micronutrient supplementation					₱ -	0.00%
Nutrition specific support					₱ -	0.00%
Overweight/obesity management and prevention	₱	0.50			₱ 0.50	0.00%
Supplementary feeding					₱ -	0.00%
General enabling	₱	7.77			₱ 7.77	0.02%
Unknown					₱ -	0.00%
Grand Total	₱	50.66	₱	45,793.00	₱ 45,843.66	100.00%

Source: Authors' calculations

Table 26. Municipality of South Upi, Maguindanao province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

South Upi						
Program	**AIP**	**GAD**	**Total**	**% share**
Nutrition-sensitive	₱ 2,300.00	₱ 27,034.77	₱ 29,334.77	98.65%
Access to healthcare services	₱ 950.00	₱ 10,500.00	₱ 11,450.00	38.51%
Adolescent health and education	₱ 980.00	₱ 60.00	₱ 1,040.00	3.50%
Agriculture (food security and availability) and fisheries		₱ 327.77	₱ 327.77	1.10%
Disease prevention and management		₱ 15,097.00	₱ 15,097.00	50.77%
Early childhood care and development (ECCD)		₱ 150.00	₱ 150.00	0.50%
Family planning and responsible parenting			₱ -	0.00%
Gender, women's empowerment, and child protection		₱ 800.00	₱ 800.00	2.69%
Humanitarian relief and emergency fund			₱ -	0.00%
Maternal and neonatal health			₱ -	0.00%
Oral health			₱ -	0.00%
Social welfare and peace and order			₱ -	0.00%
Water, sanitation (environment), and waste management	₱ 370.00	₱ 100.00	₱ 470.00	1.58%
Nutrition-specific	₱ 400.00	₱ -	₱ 400.00	1.35%
Infant and young child feeding			₱ -	0.00%
Integrated management of acute malnutrition			₱ -	0.00%
Micronutrient supplementation			₱ -	0.00%
Nutrition specific support	₱ 400.00		₱ 400.00	1.35%
Overweight/obesity management and prevention			₱ -	0.00%
Supplementary feeding			₱ -	0.00%
General enabling			₱ -	0.00%
Unknown			₱ -	0.00%
Grand Total	₱ 2,700.00	₱ 27,034.77	₱ 29,734.77	100.00%

Source: Authors' calculations

Table 27. Municipality of Sultan Kudarat, Maguindanao province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Sultan Kudarat						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	4,902.12	₱	7,300.00	₱ 12,202.12	93.49%
Access to healthcare services					₱ -	0.00%
Adolescent health and education	₱	50.00			₱ 50.00	0.38%
Agriculture (food security and availability) and fisheries	₱	578.62			₱ 578.62	4.43%
Disease prevention and management	₱	700.00			₱ 700.00	5.36%
Early childhood care and development (ECCD)					₱ -	0.00%
Family planning and responsible parenting					₱ -	0.00%
Gender, women's empowerment, and child protection	₱	1,570.00	₱	5,700.00	₱ 7,270.00	55.70%
Humanitarian relief and emergency fund	₱	2,003.50			₱ 2,003.50	15.35%
Maternal and neonatal health			₱	1,600.00	₱ 1,600.00	12.26%
Oral health					₱ -	0.00%
Social welfare and peace and order					₱ -	0.00%
Water, sanitation (environment), and waste management					₱ -	0.00%
Nutrition-specific	₱	850.00	₱	-	₱ 850.00	6.51%
Infant and young child feeding	₱	650.00			₱ 650.00	4.98%
Integrated management of acute malnutrition					₱ -	0.00%
Micronutrient supplementation					₱ -	0.00%
Nutrition specific support	₱	200.00			₱ 200.00	1.53%
Overweight/obesity management and prevention					₱ -	0.00%
Supplementary feeding					₱ -	0.00%
General enabling					₱ -	0.00%
Unknown					₱ -	0.00%
Grand Total	₱	5,752.12	₱	7,300.00	₱ 13,052.12	100.00%

Source: Authors' calculations

Table 28. Municipality of Datur Odin Sinsuat, Maguindanao province expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

Datur Odin Sinsuat					
Program	**AIP**	**GAD**	**Total**	**% share**
Nutrition-sensitive	₱ -	₱ 10,044.00	₱ 10,044.00	91.78%
Access to healthcare services		₱ 750.00	₱ 750.00	6.85%
Adolescent health and education			₱ -	0.00%
Agriculture (food security and availability) and fisheries			₱ -	0.00%
Disease prevention and management		₱ 1,900.00	₱ 1,900.00	17.36%
Early childhood care and development (ECCD)		₱ 800.00	₱ 800.00	7.31%
Family planning and responsible parenting			₱ -	0.00%
Gender, women's empowerment, and child protection		₱ 6,294.00	₱ 6,294.00	57.51%
Humanitarian relief and emergency fund			₱ -	0.00%
Maternal and neonatal health		₱ 300.00	₱ 300.00	2.74%
Oral health			₱ -	0.00%
Social welfare and peace and order			₱ -	0.00%
Water, sanitation (environment), and waste management			₱ -	0.00%
Nutrition-specific	₱ -	₱ 900.00	₱ 900.00	8.22%
Infant and young child feeding			₱ -	0.00%
Integrated management of acute malnutrition			₱ -	0.00%
Micronutrient supplementation			₱ -	0.00%
Nutrition specific support		₱ 900.00	₱ 900.00	8.22%
Overweight/obesity management and prevention			₱ -	0.00%
Supplementary feeding			₱ -	0.00%
General enabling			₱ -	0.00%
Unknown			₱ -	0.00%
Grand Total	₱ -	₱ 10,944.00	₱ 10,944.00	100.00%

Source: Authors' calculations

Table 29. City of Valenzuela, NCR expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

VALENZUELA						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	128.84	₱	137,512.01	₱ 137,640.85	95.13%
Access to healthcare services			₱	3,186.27	₱ 3,186.27	2.20%
Adolescent health and education	₱	0.03			₱ 0.03	0.00%
Agriculture (food security and availability) and fisheries					₱ -	0.00%
Disease prevention and management	₱	19.86	₱	10,428.22	₱ 10,448.08	7.22%
Early childhood care and development (ECCD)			₱	4,090.00	₱ 4,090.00	2.83%
Family planning and responsible parenting			₱	3,232.41	₱ 3,232.41	2.23%
Gender, women's empowerment, and child protection			₱	7,596.45	₱ 7,596.45	5.25%
Humanitarian relief and emergency fund	₱	39.31			₱ 39.31	0.03%
Maternal and neonatal health	₱	65.10			₱ 65.10	0.04%
Oral health	₱	4.49			₱ 4.49	0.00%
Social welfare and peace and order	₱	0.06			₱ 0.06	0.00%
Water, sanitation (environment), and waste management			₱	108,978.66	₱ 108,978.66	75.32%
Nutrition-specific	₱	39.28	₱	7,003.11	₱ 7,042.39	4.87%
Infant and young child feeding	₱	37.98	₱	768.20	₱ 806.18	0.56%
Integrated management of acute malnutrition					₱ -	0.00%
Micronutrient supplementation	₱	1.30	₱	373.50	₱ 374.80	0.26%
Nutrition specific support			₱	5,837.35	₱ 5,837.35	4.03%
Overweight/obesity management and prevention			₱	24.06	₱ 24.06	0.02%
Supplementary feeding					₱ -	0.00%
General enabling					₱ -	0.00%
Unknown					₱ -	0.00%
Grand Total	₱	168.12	₱	144,515.11	₱ 144,683.24	100.00%

Source: Authors' calculations

Table 30. City of Caloocan, NCR expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

CALOOCAN						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	341.72	₱	-	₱ 341.72	85.75%
Access to healthcare services	₱	222.16			₱ 222.16	55.75%
Adolescent health and education	₱	1.00			₱ 1.00	0.25%
Agriculture (food security and availability) and fisheries	₱	11.58			₱ 11.58	2.91%
Disease prevention and management	₱	24.18			₱ 24.18	6.07%
Early childhood care and development (ECCD)	₱	70.38			₱ 70.38	17.66%
Family planning and responsible parenting					₱ -	0.00%
Gender, women's empowerment, and child protection					₱ -	0.00%
Humanitarian relief and emergency fund					₱ -	0.00%
Maternal and neonatal health	₱	1.15			₱ 1.15	0.29%
Oral health	₱	10.17			₱ 10.17	2.55%
Social welfare and peace and order					₱ -	0.00%
Water, sanitation (environment), and waste management	₱	1.10			₱ 1.10	0.28%
Nutrition-specific	₱	56.80	₱	-	₱ 56.80	14.25%
Infant and young child feeding	₱	0.30			₱ 0.30	0.08%
Integrated management of acute malnutrition					₱ -	0.00%
Micronutrient supplementation	₱	55.00			₱ 55.00	13.80%
Nutrition specific support	₱	1.50			₱ 1.50	0.38%
Overweight/obesity management and prevention					₱ -	0.00%
Supplementary feeding					₱ -	0.00%
General enabling					₱ -	0.00%
Unknown					₱ -	0.00%
Grand Total	₱	398.52	₱	-	₱ 398.52	100.00%

Source: Authors' calculations

Table 31. City of San Juan, NCR expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

SAN JUAN					
Program	**AIP**	**GAD**	**Total**	**% share**
Nutrition-sensitive	₱ -	₱ 37,132.34	₱ 37,132.34	86.70%
Access to healthcare services		₱ 15,951.11	₱ 15,951.11	37.24%
Adolescent health and education		₱ 817.40	₱ 817.40	1.91%
Agriculture (food security and availability) and fisheries			₱ -	0.00%
Disease prevention and management		₱ 6,644.88	₱ 6,644.88	15.52%
Early childhood care and development (ECCD)		₱ 652.00	₱ 652.00	1.52%
Family planning and responsible parenting		₱ 3,471.33	₱ 3,471.33	8.11%
Gender, women's empowerment, and child protection		₱ 8,096.19	₱ 8,096.19	18.90%
Humanitarian relief and emergency fund			₱ -	0.00%
Maternal and neonatal health			₱ -	0.00%
Oral health			₱ -	0.00%
Social welfare and peace and order			₱ -	0.00%
Water, sanitation (environment), and waste management		₱ 1,499.44	₱ 1,499.44	3.50%
Nutrition-specific	₱ -	₱ 5,696.37	₱ 5,696.37	13.30%
Infant and young child feeding		₱ 346.60	₱ 346.60	0.81%
Integrated management of acute malnutrition		₱ 1,427.30	₱ 1,427.30	3.33%
Micronutrient supplementation		₱ 1,952.00	₱ 1,952.00	4.56%
Nutrition specific support		₱ 1,470.47	₱ 1,470.47	3.43%
Overweight/obesity management and prevention			₱ -	0.00%
Supplementary feeding		₱ 500.00	₱ 500.00	1.17%
General enabling			₱ -	0.00%
Unknown			₱ -	0.00%
Grand Total	₱ -	₱ 42,828.71	₱ 42,828.71	100.00%

Source: Authors' calculations

Table 32. City of Manila, NCR expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

MANILA					
Program	**AIP**	**GAD**	**Total**		**% share**
Nutrition-sensitive	₱ -	₱ 103,088.80	₱ 103,088.80		96.25%
Access to healthcare services			₱	-	0.00%
Adolescent health and education		₱ 600.00	₱	600.00	0.56%
Agriculture (food security and availability) and fisheries			₱	-	0.00%
Disease prevention and management		₱ 1,176.76	₱	1,176.76	1.10%
Early childhood care and development (ECCD)			₱	-	0.00%
Family planning and responsible parenting		₱ 6,365.77	₱	6,365.77	5.94%
Gender, women's empowerment, and child protection		₱ 26,481.27	₱	26,481.27	24.72%
Humanitarian relief and emergency fund			₱	-	0.00%
Maternal and neonatal health		₱ 68,441.77	₱	68,441.77	63.90%
Oral health			₱	-	0.00%
Social welfare and peace and order			₱	-	0.00%
Water, sanitation (environment), and waste management		₱ 23.24	₱	23.24	0.02%
Nutrition-specific	₱ -	₱ 4,019.91	₱ 4,019.91		3.75%
Infant and young child feeding		₱ 3,973.91	₱	3,973.91	3.71%
Integrated management of acute malnutrition		₱ 46.00	₱	46.00	0.04%
Micronutrient supplementation			₱	-	0.00%
Nutrition specific support			₱	-	0.00%
Overweight/obesity management and prevention			₱	-	0.00%
Supplementary feeding			₱	-	0.00%
General enabling			₱	-	0.00%
Unknown			₱	-	0.00%
Grand Total	₱ -	₱ 107,108.72	₱ 107,108.72		100.00%

Source: Authors' calculations

Table 33. Municipality of Catbalogan, Samar expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

CATBALOGAN						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	77,536.30	₱	10,612.20	₱ 88,148.50	97.79%
Access to healthcare services					₱ -	0.00%
Adolescent health and education	₱	550.00	₱	568.99	₱ 1,118.99	1.24%
Agriculture (food security and availability) and fisheries	₱	12,105.00			₱ 12,105.00	13.43%
Disease prevention and management	₱	1,244.84	₱	103.66	₱ 1,348.51	1.50%
Early childhood care and development (ECCD)	₱	200.00	₱	6,046.98	₱ 6,246.98	6.93%
Family planning and responsible parenting	₱	490.00	₱	258.47	₱ 748.47	0.83%
Gender, women's empowerment, and child protection	₱	350.00	₱	3,194.04	₱ 3,544.04	3.93%
Humanitarian relief and emergency fund	₱	696.46			₱ 696.46	0.77%
Maternal and neonatal health	₱	900.00	₱	440.07	₱ 1,340.07	1.49%
Oral health					₱ -	0.00%
Social welfare and peace and order					₱ -	0.00%
Water, sanitation (environment), and waste management	₱	61,000.00			₱ 61,000.00	67.67%
Nutrition-specific	₱	1,990.05	₱	-	₱ 1,990.05	2.21%
Infant and young child feeding	₱	449.25			₱ 449.25	0.50%
Integrated management of acute malnutrition	₱	200.00			₱ 200.00	0.22%
Micronutrient supplementation					₱ -	0.00%
Nutrition specific support	₱	1,340.80			₱ 1,340.80	1.49%
Overweight/obesity management and prevention					₱ -	0.00%
Supplementary feeding					₱ -	0.00%
General enabling	₱	200.00			₱ 200.00	0.22%
Unknown			₱	39.50	₱ 39.50	0.04%
Grand Total	₱	79,526.35	₱	10,612.20	₱ 90,138.55	100.00%

Source: Authors' calculations

Table 34. Municipality of Sta. Rita, Samar expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

STA. RITA						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	2,650.00	₱	218,253.73	₱ 220,903.73	90.89%
Access to healthcare services					₱ -	0.00%
Adolescent health and education			₱	50,000.00	₱ 50,000.00	20.57%
Agriculture (food security and availability) and fisheries	₱	2,650.00			₱ 2,650.00	1.09%
Disease prevention and management			₱	500.00	₱ 500.00	0.21%
Early childhood care and development (ECCD)			₱	1,500.00	₱ 1,500.00	0.62%
Family planning and responsible parenting			₱	150.00	₱ 150.00	0.06%
Gender, women's empowerment, and child protection			₱	45,253.73	₱ 45,253.73	18.62%
Humanitarian relief and emergency fund			₱	100.00	₱ 100.00	0.04%
Maternal and neonatal health			₱	120,000.00	₱ 120,000.00	49.37%
Oral health					₱ -	0.00%
Social welfare and peace and order			₱	750.00	₱ 750.00	0.31%
Water, sanitation (environment), and waste management					₱ -	0.00%
Nutrition-specific	₱	8,343.83	₱	13,792.75	₱ 22,136.58	9.11%
Infant and young child feeding					₱ -	0.00%
Integrated management of acute malnutrition			₱	3,700.00	₱ 3,700.00	1.52%
Micronutrient supplementation					₱ -	0.00%
Nutrition specific support	₱	8,343.83	₱	10,092.75	₱ 18,436.58	7.59%
Overweight/obesity management and prevention					₱ -	0.00%
Supplementary feeding					₱ -	0.00%
General enabling					₱ -	0.00%
Unknown	₱	20.00			₱ 20.00	0.01%
Grand Total	₱	10,993.83	₱	232,046.48	₱ 243,040.31	100.00%

Source: Authors' calculations

Table 35. Municipality of Talalora, Samar expenditures on nutrition-sensitive and nutrition-specific interventions, subdivided to AIP and GAD (in thousands PHP)

TALALORA						
Program	**AIP**		**GAD**		**Total**	**% share**
Nutrition-sensitive	₱	9,304.00	₱	630.58	₱ 9,934.58	82.88%
Access to healthcare services	₱	5,300.00			₱ 5,300.00	44.22%
Adolescent health and education	₱	106.00	₱	56.00	₱ 162.00	1.35%
Agriculture (food security and availability) and fisheries	₱	265.00			₱ 265.00	2.21%
Disease prevention and management	₱	1,573.00			₱ 1,573.00	13.12%
Early childhood care and development (ECCD)			₱	335.40	₱ 335.40	2.80%
Family planning and responsible parenting	₱	105.00			₱ 105.00	0.88%
Gender, women's empowerment, and child protection	₱	30.00	₱	212.10	₱ 242.10	2.02%
Humanitarian relief and emergency fund					₱ -	0.00%
Maternal and neonatal health	₱	1,825.00	₱	27.08	₱ 1,852.08	15.45%
Oral health	₱	100.00			₱ 100.00	0.83%
Social welfare and peace and order					₱ -	0.00%
Water, sanitation (environment), and waste management					₱ -	0.00%
Nutrition-specific	₱	1,985.56	₱	66.00	₱ 2,051.56	17.12%
Infant and young child feeding	₱	1,452.56			₱ 1,452.56	12.12%
Integrated management of acute malnutrition	₱	9.00			₱ 9.00	0.08%
Micronutrient supplementation	₱	40.00			₱ 40.00	0.33%
Nutrition specific support	₱	344.00	₱	66.00	₱ 410.00	3.42%
Overweight/obesity management and prevention	₱	140.00			₱ 140.00	1.17%
Supplementary feeding					₱ -	0.00%
General enabling	₱	217.99			₱ 217.99	1.82%
Unknown			₱	146.40	₱ 146.40	1.22%
Grand Total	₱	11,289.56	₱	696.58	₱ 11,986.14	100.00%

Source: Authors' calculations