MDG ACHIEVEMENT FUND

FINAL EVALUATION

Philippines

Thematic window
Children, Food Security and Nutrition

Programme Title:
Ensuring Food Security and Nutrition for Children 0-2 years old in the Philippines

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August 2013

Prologue

This final evaluation report has been coordinated by the MDG Achievement Fund joint programme in an effort to assess results at the completion point of the programme. As stipulated in the monitoring and evaluation strategy of the Fund, all 130 programmes, in 8 thematic windows, are required to commission and finance an independent final evaluation, in addition to the programme's mid-term evaluation.

Each final evaluation has been commissioned by the UN Resident Coordinator's Office (RCO) in the respective programme country. The MDG-F Secretariat has provided guidance and quality assurance to the country team in the evaluation process, including through the review of the TORs and the evaluation reports. All final evaluations are expected to be conducted in line with the OECD Development Assistant Committee (DAC) Evaluation Network "Quality Standards for Development Evaluation", and the United Nations Evaluation Group (UNEG) "Standards for Evaluation in the UN System".

Final evaluations are summative in nature and seek to measure to what extent the joint programme has fully implemented its activities, delivered outputs and attained outcomes. They also generate substantive evidence-based knowledge on each of the MDG-F thematic windows by identifying best practices and lessons learned to be carried forward to other development interventions and policy-making at local, national, and global levels.

We thank the UN Resident Coordinator and their respective coordination office, as well as the joint programme team for their efforts in undertaking this final evaluation.

MDG-F Secretariat

Final Evaluation of the Joint Programme:

"Ensuring Food Security and Nutrition for Children 0-24 Months in the Philippines"

(MDG-F 2030)

FINAL REPORT

19 July 2013

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A. EXECUTIVE SUMMARY

In accordance with the guidelines of the Millennium Development Goals Achievement Fund (MDG-F) M&E Strategy and Programme Implementation Guidelines, the United Nations joint programme partners in the Philippines commissioned the final evaluation of the Joint Programme - "Ensuring food security and nutrition for children 0-24 months in the Philippines, (MDG-F 2030)". The evaluation was undertaken from April 23 to July 5 by a two-member team of independent evaluators with an international team leader and national team member.

The unit of analysis was the JP MDG-F 2030, which in this context included the set of outcomes, outputs, activities and inputs that were detailed in the JP document and in associated modifications made during implementation. The overall purpose of this evaluation was to (a) Measure the extent to which the JP delivered its intended outputs and contribution to outcomes[1], and (b) Generate substantive evidence based knowledge, by identifying good practices and lessons learned that could be useful to other development interventions at national (scale up) and international level (replicability).

The JP intended to contribute to three outcomes; (1) increase breastfeeding in the JP areas by at least 20% annually, (2) reduce prevalence of under-nutrition in children 0-24 months by at least 3%, and (3) improve capacities of national and local governments and other stakeholders to formulate, promote and implement policies and programmes on Infant and Young Child Feeding (IYCF). Seven interventions were implemented.

(a) Promoting exclusive breastfeeding (EBF) through communication for behavioral impact (COMBI).
(b) Promotion of EBF for workers in the formal and informal sectors (EBF-W).
(c) Establishing a human milk bank.
(d) Monitoring the milk code.
(e) Supply and distribution of micro-nutrient powder (MNP).
(f) Recipe trials for complementary feeding using locally available cereals and vegetables.
(g) Establishing food security and nutrition early warning systems (FS-EWS).

Summary of key findings

Relevance

The JP was well aligned to the national nutrition policies and strategies, and particularly the Philippines Action Plan for Nutrition (PPAN, 2008 -10) and the Philippine Development Plan (PDP 2011-2016), both of which prioritised nutrition for children 0-24 months and provided the

[1] By definition, **outputs** are the products, capital goods and services which result from a development intervention; and **outcomes** are the likely or achieved short-term and medium term effects of an intervention's outputs.

strategies for reducing under-nutrition. The new PPAN 2011-16 identified six specific challenges and priorities, (1) high levels of hunger, (2) children under-nutrition (stunting and wasting), (3) vitamin A deficiency, (4) Anaemia, (5) Iodine deficiency, and (6) overweight and obesity.

The JP leveraged on existing national systems and structures; such as the Barangay Nutrition Scholars (BNS) and 'Promote Good Nutrition (PGN)' programme of the National Nutrition Council (NCC), which was focused on:

- Increasing the number of infants 0-6 months who are exclusively breastfed;
- Reducing the number of infants receiving food and drink other than breast milk;
- Increasing the number of infants 6-12 months old who are given calorie and nutrient-dense complementary foods.

Implementation

The JP experienced delays with implementing some of its critical activities, such as for example the baseline studies which were completed in April 2011, almost 15 months after the release of the first tranche of funds. The end line survey was started in October 2012, which effectively meant that available data on the JP's contribution to results only covers a timeframe of 18 months marked by these two surveys.

A Programme Management Committee (PMC) was established with appropriate representation by national and UN agency partners; and was co-chaired by the NNC and UNICEF. The PMC exercised overall management of the JP through the JP Manager who was located at the NNC offices. National Technical Working Groups (NTWG) was also established to coordinate activities under each component, while also local TWGs were established to coordinate activities in the JP areas. Since the NNC was the official national coordination agency for nutrition, the establishment of a PMC specifically for the joint programme duplicated already existing national structures.

While the JP interventions covered most of the essential components required to address the challenge of food insecurity and malnutrition for children 0-24 months in the Philippines, there was very little lateral convergence between the seven JP interventions, and none of them were collectively implemented in a single municipality. Zamboanga City had 6 interventions implemented, while Naga City and Iloilo City had 5 interventions. The rural municipalities had fewer interventions four each in Aurora and Ragay; and only 3 interventions implemented in Carles.

Effectiveness

The planned results to reduce under nutrition by 3%, and increase EBF for 0-6 months by 20% annually in the targeted JP areas were not achieved. There was no change in the prevalence of wasting during the life of the project and the prevalence of stunting even increased by almost three percentage points. The major contributing factors were (1) the 3-year planned

implementing time was not sufficient to effectively change behaviours, particularly on IYCF practices, (2) the interventions were not collectively implemented in the same municipalities, and (3) delayed implementation of the JP's critical activities.

Since the JP areas had received additional resources and targeted interventions, it would be reasonable to expect the nutrition indicators in the JP areas to be better compared to the national average. However, the NNC noted that there was a general national improvement on nutrition indicators, but there was no evidence that indicated higher improvement in the JP areas.

There were several factors that contributed to the status of results. First, the use of Peer Counselors to promote Exclusive Breastfeeding (EBF) was a very good strategy; the system was however based on volunteer counselors, which limited the programme's ability to exercise authority over their activities. About 20-30% of the trained volunteer Peer Counselors were not active. The JP design did not include Growth Monitoring and Promotion (GMP) as an output, although the GMP card would have been an excellent tool to tie up with the counseling sessions and other information dissemination in the community. With respect to EBF in the workplace, the enforcement of compliance for establishment of lactation stations was vested in the Department of Health (DOH), but labour regulations did not provide the DOH with the authority to access and inspect the companies. This authority was vested in the Department of Labour and Employment (DOLE), who could also award exemptions to the companies upon application.

The JP had weak follow-up mechanisms to monitor and evaluate effectiveness of its capacity building interventions. Based on questionnaires administered to the health workers, for example, there were gaps in their knowledge of the issues on EBF and IYCF. 20% of Peer Counselors said they had little or no knowledge on their roles and activities as volunteers or counselors; and 30% felt they had little or no knowledge on right message and information if the child was sick.

Efficiency

The JP had a total allocated budget of US$3,500,000. At the time of drafting, the JP had delivered 93% of the budget.

Although the evaluation team was unable to compute the JP efficiency in terms of cost of intervention per capita, based on the planned beneficiaries provided in the JP documents (Monitoring Reports) as 187,905 women, the assumed cost efficiency was $18.60 per individual beneficiary impacted by the JP interventions. In the context of the nutrition challenge in the Philippines, this seemed to be a reasonable price to pay for addressing the problems of child under-nutrition and infant mortality; which also has a wider impact on other MDGs.

With regards to governance and management efficiency, the JP established institutional mechanisms as required by the MDG-F, including the National Steering Committee (NSC),

Programme Management Committee (PMC), and National Technical Working Group (NTWG). However, the NNC was the official coordinating agency for nutrition, and the establishment of a dedicated PMC to coordinate joint programme activities could be regarded as not completely consistent with the principles of the Paris Declaration.

Sustainability

The close linkages of the JP interventions with ongoing government programmes provided a very solid basis for sustainability. For example, Peer Counseling for EBF was very likely to be continued because the activities were implemented through existing structures and systems of the government's localised health care delivery system consisting of BHWs and BNS. By complementing ongoing national programmes, the JP induced significant leveraging of resources both by the national and local governments. Counterpart resources were estimated at $3,016,141 or 86% of the MDG-F contribution.

The JP also developed exit strategies and sustainability plans for their respective municipalities. These plans had high potential of continuation because of the effective engagement and support of the local government at the highest levels. At the time of drafting, Some UN agencies had already started developing plans for upscaling the JP interventions, including more specifically the integration of JP components within the regional European Union (EU) funded project known as Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA).

Conclusions

The JP contributed to the government initiatives through development of policies on EBF, IYCF and initiated multi-sectoral participation specifically on the EBF in the workplace and local government involvement. The importance of children nutrition and its impact on social development and to the achievement of the MDGs cannot be overemphasized.

The actual contribution of the JP to expected results was however low to medium, as some of the JP areas actually experienced a worsening in their indicators. Given the delays in the JP inception phase in general and specific interventions in particular, the implementing timeframe whose results were actually captured by the baseline and endline surveys was actually only about 15-18 months. Clearly no significant results could be expected to be achieved over such a short timeframe. Secondly, the interventions did not have sufficient convergence. There was no single JP area in which all seven interventions were implemented,; Zamboanga City had 6 interventions and all the others had four or less interventions implemented.

It was also noteworthy that Ragay municipality had a better improvement in all its indicators compared to the other JP areas. Ragay municipality only had one JP intervention – the food security early warning system (FS-EWS). However, other interventions were

implemented in the municipality, albeit not by the JP. It seemed plausible to conclude that because of the FS-EWS intervention, the municipality undertook evidence-based decisions by providing food insecure households with supplementary feeding and seeds to supplement their food resources, thereby achieving better improvement in indicators. if this were indeed the case, then a major lesson would be on the need to complement nutrition interventions with more specific livelihood and poverty reduction interventions.

Endline survey data also showed illness profiles of the sampled children; 13% had diarrhea two weeks before the interview date. Although nothing in the endline survey report suggested that the diarrhea had anything to do with unsafe water, it would still be interesting to know whether or not results would have been different if complementary interventions such as access to safe drinking water were also implemented in the JP areas. This underscores the importance of addressing child malnutrition from a multi-sector perspective; as well as the importance for building synergies with other joint programmes.

Recommendations

The evaluation team recommends that the JP interventions and its components should be continued through the programmes of partner UN agencies, either individually or collectively; and makes five specific recommendations to inform future programming in the Philippines.

Recommendation 1: The UN should use existing national structures for programme management and coordination.

Since the NNC was the national coordination agency for nutrition in the Philippines; there was no real need to establish a parallel coordination mechanism specifically for the joint programme. UN agency staff should be coopted into the existing national structures as technical resource persons.

Recommendation 2: Programme interventions should be based on a clearly defined 'pathway to change model', which takes into account all dimensions and manifestations of the development challenge.

Core activities such as baseline surveys should be undertaken well in advance so that they constitute and inform the programme's impact pathway and logic model. For example, could different interventions and strategies been developed had information such as the growing prevalence of teenage pregnancies been known during planning and design; or if it was known well in advance that the prevalence of wasting (underweight for length) was highest among the 6-11 months old children.

Recommendation 3: Pilot interventions should be linked and implemented jointly in target areas so that their collective impact can be objectively determined.

In order to achieve more effective results, all JP interventions should be implemented in all target municipalities. In addition, other interventions such as for example, the Growth Monitoring and Promotion, should be factored into the design in order to optimize the impact of the programme.

Recommendation 4: Child nutrition should be addressed in the context of the broader household food security, including access to quality food, and livelihood opportunities.

Four of the JP areas had reduction in the proportions of children receiving adequately diverse diets - Zamboanga City (-15.2%), Iloilo City (-2.5%), Ragay (-2.3%) and Aurora (-1.1%). However, in Ragay municipality where some livelihood interventions were undertaken, the proportion of children that were fed the minimum acceptable diet was higher. This underscores the need to complement nutrition interventions with livelihood and poverty reduction interventions.

Recommendation 5: Strengthen follow-up mechanisms in monitoring and evaluation systems

There was no follow-up undertaken to evaluate whether the capacity building interventions were effective or whether the implementing partners were effectively passing on the knowledge that they had acquired from the training. For example many Peer Counselors indicated that they did not have sufficient knowledge about different aspects of their work.

B. CONTENTS

C. ACRONYMS

ARMM	Autonomous Region of Muslim Mindanao
BHW	Barangay Health Workers
BNS	Barangay Nutrition Scholar
CFSN	Children, Food Security and Nutrition
CHO	City Health office
COMBI	Communicating for Behavioral Impact
DILG	Department of Interior and Local Government
DOH	Department of Health
DOLE	Department of Labour and Employment
EBF	Exclusive Breastfeeding
ERG	Evaluation Reference Group
FDA	Food and Drug Administration
FGD(s)	Focus Group Discussion(s)
FNRI	Food and Nutrition Research Institute
FPC(s)	Field Programme Coordinator(s)
FS-EWS	Food Security Early Warning System
GAIN	Global Alliance for Improved Nutrition
ICMBS	International Code of Marketing of Breastmilk Substitutes
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IPNAP	Infant and Pediatric Nutrition Association of the Philippines
IRR	Implementing Rules and Regulations
IYCF	Infant and Young Child Feeding
JP	Joint Programme
LGU(s)	Local Government Unit(s)
LTWG(s)	Local Technical Working Group(s)
M&E	Monitoring and Evaluation
MDG(s)	Millennium Development Goal(s)
MDG-F	Millennium Development Goals Achievement Fund
MNP	Micro-nutrient Powder
MTE	Mid-Term Evaluation
MTPDP	Medium-Term Philippine Development Plan
MYCNSIA	Maternal and Young Child Nutrition Security Initiative in Asia
NAPC	National Anti-Poverty Commission
NCDPC	National center for Disease Prevention and Control
NCHP	National Center for Health Promotion
NDHS	National Demographic and Health Survey
NEDA	National Economic Development Authority
NNC	National Nutrition Council
NNS	National Nutrition Survey
NSC	National Steering Committee
NTWG	National Technical Working Group

PDP	Philippines Development Plan
PMC	Programme Management Committee
PPAN	Philippine Plan of Action for Nutrition
SOCCSKSA	South Cotabato, Cotabato (North), Sultan Kudarat, Sarangani, and
RGEN	General Santos City
TOR	Terms of Reference
U5MR	Under-five Mortality Rate
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
WHO	World Health Organisation

I. INTRODUCTION

1.1. Evaluation Context

1. In December 2006, the United Nations Development Programme (UNDP) and the Government of Spain signed a major partnership agreement for the amount of €528 million with the aim of contributing to progress on the Millennium Development Goals (MDGs) and other development goals through the United Nations system. The Fund used a joint programme mode of intervention and operated through the UN teams in each country, promoting increased coherence and effectiveness in development interventions through collaboration among UN agencies.

2. Under the Millennium Development Goals Achievement Fund (MDG-F) M&E Strategy and Programme Implementation Guidelines,[2] each programme team was responsible for designing an M&E system, establishing baselines for (quantitative and qualitative) indicators and conducting a final evaluation with a summative focus. In accordance with this guideline, evaluation unit of UNICEF Philippines commissioned the final evaluation of the Joint Programme - "Ensuring food security and nutrition for children 0-24 months in the Philippines, (MDG-F 2030)". The evaluation was undertaken from April 23 to July 5by a two-member team of independent evaluators with an international team leader and national team member.

3. The evaluation focused on the joint programme (JP) outcomes as set out in the JP document and its subsequent revisions. The unit of analysis was the JP MDG-F 2030, which in this context included the set of outcomes, outputs, activities and inputs that were detailed in the JP document and in associated modifications made during implementation. This report contains six chapters. Chapter 1 introduces the evaluation, including a discussion on the mandate, purpose, scope, objectives and methodology of the evaluation. Chapter 2 contains an overview of historical trends and development challenges of child nutrition in the Philippines. It includes an explanation and description of how the theme was addressed by government, and how it was reflected in national policies and strategies, as well as activities of development partners. Chapter 3 describes the JP's interventions in response to the development challenge. This chapter explains the overarching outcome model, the results frameworks and detailed explanation of the main JP components and activities. Chapter 4 contains the evaluation findings and provides an analysis of the ***evidence*** relating to the evaluation criteria. The analysis addresses the key evaluation questions as set out in the Terms of Reference on Relevance, Participation and Empowerment, Efficiency, Effectiveness, Sustainability and Impact. Chapters 5 contains the conclusions and lessons learned; while Chapter 6 provides the evaluators' recommendations respectively, based on the evidence contained in chapter four.

[2] MDG-F; Monitoring and Evaluation System, "Learning to Improve: Making Evidence work for Development".

1.2. Purpose, Scope and Objectives of the Evaluation

1.2.1. Purpose of the evaluation

4. In line with the instructions contained in the MDG-F M&E Strategy, a final evaluation seeks to track and measure the overall impact of the JP on the MDGs and in multilateralism. The overall purpose of this evaluation was to (a) Measure the extent to which the JP delivered its intended outputs and contribution to outcomes[3], and (b) Generate substantive evidence based knowledge, by identifying good practices and lessons learned that could be useful to other development interventions at national (scale up) and international level (replicability). The primary users of the evaluation include the JP partner UN agencies, national and local government partners, civil society organizations and beneficiary communities, the MDG Fund Secretariat as well as the wider UN development system organisations.

1.2.2. Scope of the evaluation

5. The scope of the evaluation was to ascertain how successful the JP components and interventions contributed to the achievement of outcomes based on the five criteria laid out in the Organization for Economic Cooperation and development – Development Assistance Committee (OECD-DAC) Principles for Evaluation of Development Assistance,[4] (Box 1).

Box 1: OECD-DAC Evaluation Criteria

Relevance: The extent to which the intervention is suited to the priorities and policies of the target group, recipient and donor.

Efficiency: An assessment of whether development aid uses the least costly resources possible in order to achieve the desired results.

Effectiveness: A measure of the extent to which a development intervention attains its objectives.

Impact: The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended.

Sustainability: The probability that the benefits of an intervention are likely to continue after the programme cycle.

1.2.3. Specific objectives of the evaluation

6. The specific objectives of the final evaluation were to:

[3] By definition, **outputs** are the products, capital goods and services which result from a development intervention; and **outcomes** are the likely or achieved short-term and medium term effects of an intervention's outputs.

[4] The *DAC Principles for the Evaluation of Development Assistance*, OECD (1991), Glossary of Terms Used in Evaluation, in 'Methods and Procedures in Aid Evaluation', OECD (1986), and the *Glossary of Evaluation and Results Based Management (RBM) Terms*, OECD (2000).

i) Measure to what extent the JP contributed to solve the needs of target beneficiaries, as well as the challenges and bottlenecks affecting nutrition for children 0-24 months.

a) Measure the JP's degree of implementation efficiency and quality of delivered outputs and outcomes, against what was originally planned or subsequently officially revised.

b) Measure to what extent the JP attained expected development results to the targeted population, beneficiaries and participants, whether individuals, communities, or institutions.

c) Measure the JP's contribution to the objectives set out for the thematic window on Children, Food Security and Nutrition (CFSN) as well as the overall MDG Fund objectives at local and national level.

d) Identify and document substantive lessons learned and good practices on the specific topics of the thematic window, MDGs, Paris Declaration on Aid Effectiveness, Accra Principles and UN reform with the aim to support the sustainability of the JP or some of its components.

e) Provide recommendations to inform future programming, upscaling and replication of the JP's interventions.

1.3. Evaluation Methodology

1.3.1. Overall approach

7. An initial desk review of official background documents and JP files and reports was conducted culminating with drafting of an Inception Report outlining the scope of work and evaluation design. The Evaluation Reference Group (ERG) and MDG-F Secretariat reviewed the Inception Report and provided comments resulting in the revised Inception Report. Based on the agreed plan and design, a country mission to the Philippines was carried out from May 13 to June 14, 2013. The mission included field visits to all the 6 JP areas in the three regions covered by the JP[5].

8. During the course of the country mission to the Philippines, individual interviews were carried out with the JP UN agency senior management and programme staff, officials and staff of participating national and provincial Government departments, officials and health workers of the target municipalities and community beneficiaries. Additional documents were also made available and reviewed during the in-country mission. The list of documents reviewed is at Annex 1 to this report. At the end of the country mission, a presentation of the evaluation findings, conclusions and recommendations was made to the Project Management Committee (PMC), and their comments were incorporated in the draft report.

[5] The JP targeted 6 areas in three regions: **Region 5** – Naga City and Ragay Municcipality; **Region 6** – Iloilo City and Carles Iloilo Municipality; and **Region 9** – Zambaonga City and Aurora Municipality.

1.3.2. Data Collection and Analysis

9. Main sources of data included both secondary (document review) and primary (interviews and focus group discussions). Individual interviews were conducted mainly in Manila with partner UN agency staff and officials of participating national Government departments. In the municipalities, focus group discussions (FGDs) were conducted with health workers as well as target beneficiaries, including lactating mothers and caregivers. The list of individuals interviewed is provided at Annex 2.

10. Quantitative analysis techniques were applied to assess JP performance related to quantitative targets and indicators; for example, decrease in malnutrition. However, mostly qualitative analysis was used to determine the JP's contribution to outcomes (Box 2).

Box 2: Data analysis criteria

Relevance:	Content analysis of JP interventions relative to national programmes, MDGs and United Nations Development Assistance Framework (UNDAF).
Efficiency:	Comparative and frame analysis[6].
Effectiveness:	Matrix/logical analysis (based on stated output/outcome indicators.
Sustainability:	Frame analysis based on triangulated information.

1.4. Limitations

11. At the time of writing this report, the official JP end line survey was still in draft and the data may be subject to revision. In the JP areas, specific disaggregated data was not readily available. Nutrition data was collected for the whole province and not disaggregated for the individual municipalities targeted by the JP area. In some provinces, nutrition data was available for the 0 – 71 months age group and not disaggregated for 0 -6 months, and 6 – 23 months groups, which were the JP's target groups.

II. THE DEVELOPMENT CHALLENGE

12. This chapter provides a general overview of historical trends and development challenges in child nutrition in the Philippines. It also examines how the theme is addressed by government, and how it is reflected in national policies and strategies. Information on the activities of other development partners is also provided, where available.

13. The design of the JP was based on data contained in the 2004-2010 Medium-Term Philippine Development Plan (MTPDP). The Philippines Development Plan (PDP), 2011 – 2016,

[6] **Frame analysis** is a method based on qualitative interpretation of how people understand situations and activities.

also used 2008 nutrition data as its baselines. Recent data from the Philippines Progress Report on the MDGs (2010) and the 2011 mid-term evaluation (MTE) of the JP were also used throughout this report as reference points. The JP also undertook baseline survey in June 2011, which provided specific data on the target JP areas.

2.1. Food Security and Child Nutrition in the Philippines

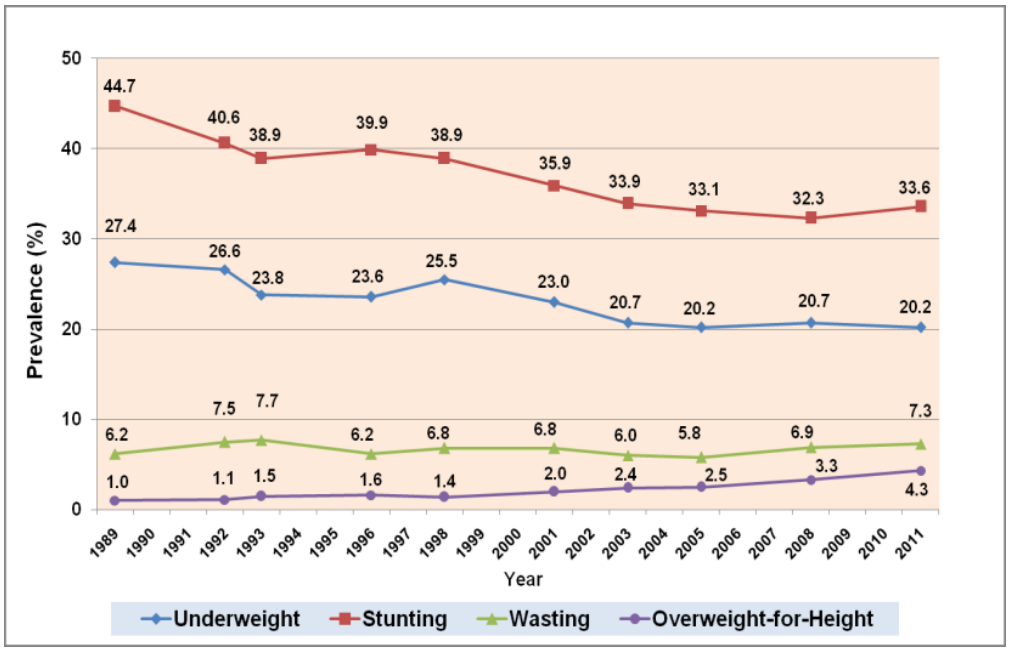
14. From 2005 to 2008, there was a significant increase in the proportion of underweight children aged 0-5 from 24.6 percent to 26.2 percent, according to the National Nutrition Survey (NNS) conducted by the FNRI (Figure 1).[7] A very high prevalence of underweight preschoolers was noted in Regions IV-B, V, VI, VIII, IX, and SOCCSKSARGEN, where data on the proportion of underweight-for-age children registered at greater than or equal to 30 percent. The report concluded that hunger and malnutrition had common underlying causes like poverty, rising food prices, poor dietary diversity, lack of access to potable drinking water and sanitation, and poor health status, among others. Micronutrient deficiency is another important indicator because increased immunity and adequate level of vitamins and minerals in the body can enhance nutritional status. Although the prevalence of iron and iodine deficiency was decreasing, it continued to be a public health concern because it was persistent among the most vulnerable groups like infants, children and pregnant women. FNRI data further showed that the trend of underweight children in the past ten years has not improved and stunting and wasting even increased (Figure 2).

Figure 1: Proportion of underweight children 0-5 years old (%), 1990-2008

Source: Philippine MDG Progress Report, 2010

[7] Philippines Progress Report on the Millennium Development Goals (2010), page 76.

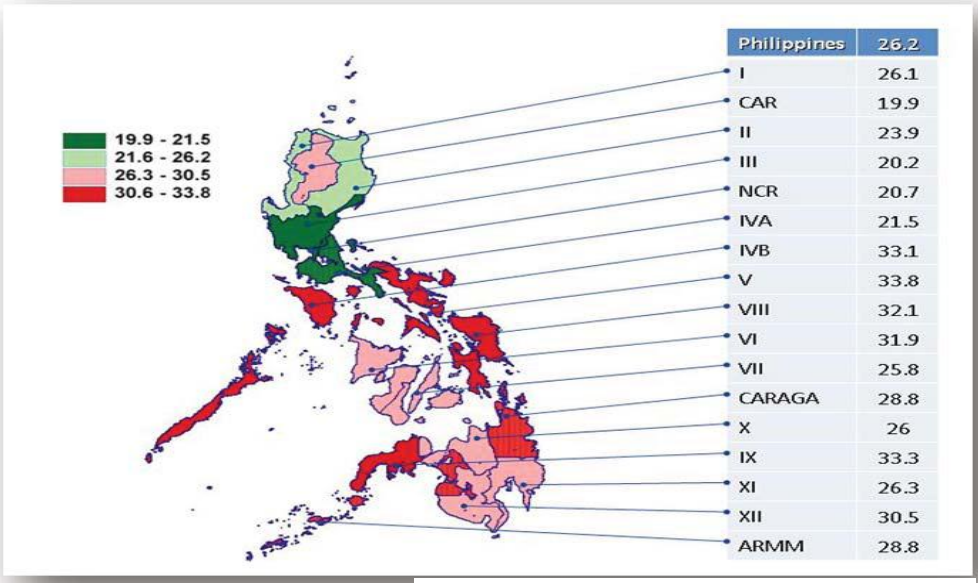
Figure 2: Trends for malnutrition among children 0-60 months, 1989-2011



Source: NNS-FNRI, 2008, 2011

15. The MDG Progress Report also indicated huge regional disparities on food insecurity and malnutrition among children. Regions 5, 6 and 9 had the highest proportion of underweight children in the 0 -5 year age groups over 30% (Figure 3).

Figure 3: Proportion of underweight children 0-5 years old (%), by region, 2008

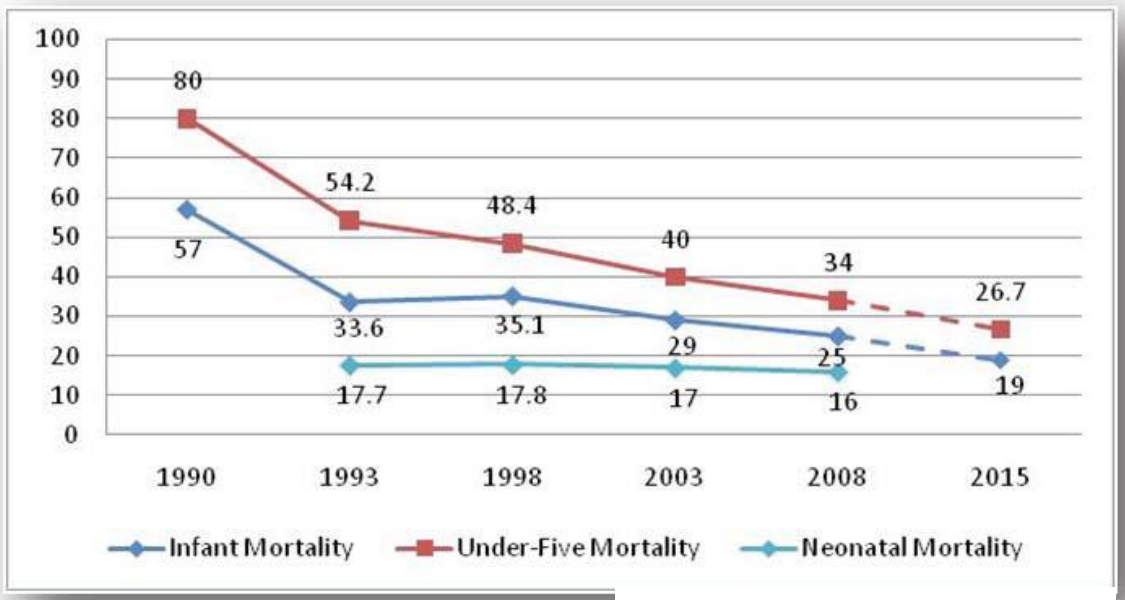


Source: Philippine MDG Progress Report,

2.2. Nutrition and Child Mortality

16. The MDG Progress Report (2010) showed that the Philippines was on track to achieve its MDG targets to reduce infant mortality to 19/1,000 live births, and under-five mortality to 26.7/1,000 live births by 2015. Infant mortality rate (IMR) declined from 29/1,000 in 2003, down to 25/1,000 in 2008. Under-five mortality rate (U5MR) also declined from 40/1,000 to 34/1,000 over the same period. However, the report also noted that the neonatal death rates were between 16-18 deaths for every 1,000 births; resulting mainly from prematurity (28%), sepsis (26%), and asphyxia (23%); all of which have implications on the quality of pre-natal care that pregnant women were receiving as well as the care of the newborn (Figure 4).

Figure 4: Infant, under-five and neo-natal mortality rates (1990-2008).



Source: MDG Progress Report, 2010

17. Urban and rural residency data varied with more rural dwellers experiencing more infantile and child deaths. In 2008, IMR was 35/1,000 in rural areas compared to only 20/1,000 in urban areas. U5MR was also higher in rural areas (46/1,000) compared to urban areas (28/1,000).

18. Baseline data collected in the 6 JP areas also corroborated the evidence. The overall prevalence of underweight-for-age among children 0-23 months in the JP areas was 16% while the corresponding figure among children 6-23 months in the Global Alliance for Improved Nutrition (GAIN)[8] sites was 21%. Both figures were far from the 2015 MDG target of 13.6% prevalence of underweight among 0-5 years old (FNRI, 2011). The prevalence of underlength-for-age (stunting) was also high 23% in the JP areas and 34% in the GAIN sites while underweight-for-length (wasting) (Box 3) was almost 3% and 7% in JP and GAIN areas, respectively. Table 1 shows the anthropometric measures for the 6 JP areas.

> ***Box 3: Important definitions***
>
> ***Stunting:*** *Reduced growth rate as manifestation of malnutrition during fetal development and/or in early childhood.*
>
> ***Wasting:*** *Low weight for height, where a child is thin for his/her height but not necessarily short. It is also known as Acute Malnutrition.*

Table 1: Percent of Children Underweight for Age; Underlength for Age, and Underweight for Length According to Age Group in JP Areas

Age Group	THE 6 JP AREAS						Average JP Areas
	Naga	Iloilo	Zamboanga	Ragay	Carles	Aurora	
UNDERWEIGHT FOR AGE							
<6	0.0	21.6	9.9	16.6	4.2	14.9	10.4
6-23	20.4	19.6	17.4	20.6	25.3	11.1	18.5
6-11	21.0	12.8	17.1	4.2	22.2	2.4	16.9
12-23	20.1	23.1	17.6	28.9	27.4	15.9	19.6
Overall	17.0	20.1	14.8	19.8	21.8	11.7	16.2
UNDERLENGTH FOR AGE - STUNTING							
<6	12.6	23.2	15.8	22.4	29.1	8.8	16.5
6-23	28.7	31.1	20.8	25.8	39.0	30.8	25.0
6-11	19.8	22.9	20.6	7.7	30.4	30.7	20.9
12-23	33.6	35.3	21.0	34.9	44.8	30.8	27.6
Overall	26.0	29.1	19.1	25.1	37.4	27.2	22.6
UNDERWEIGHT FOR LENGTH - WASTING							
<6	7.0	6.4	6.7	5.8	8.4	19.3	6.9
6-23	3.5	7.6	8.0	2.6	3.1	7.5	6.6
6-11	5.7	7.5	6.4	0.0	0.0	2.4	6.1
12-23	2.3	7.7	9.1	3.9	5.1	10.3	7.0
Overall	4.1	7.3	7.6	3.2	4.0	9.4	6.7
SEVERE UNDERNUTRITION							
Underweight	4.3	4.0	2.4	5.5	5.5	4.2	3.2
Stunting	9.6	11.3	4.9	14.5	13.9	10.3	7.3
Wasting	1.5	1.3	1.2	1.1	1.2	3.7	1.4

Source: JP Baseline Survey Report, 2011

[8] The Global Alliance for Improved Nutrition (GAIN) also provided funds for the conduct of Infant and Young Child Feeding (IYCF) baseline survey in the six MDGF sites plus two other non-MDGF cities.

19. The overall prevalence of anemia was 47% in the MDGF sites with the highest prevalence occurring in Zamboanga City at 51%. It is noteworthy that the highest prevalence of anemia occurred among infants and this figure (61.5%) is much higher than that of the national prevalence for the same age group (55.1%) (FNRI, 2009). The prevalence of iron deficiency among the JP areas was lower at 30.7% with the 12-23 months children being more affected than infants.

2.3. Infant and Young Child Feeding Practices in the Philippines

20. Data from the National Demographic and Health Survey (NDHS, 2003) showed that the incidence of breastfeeding exclusively for infants below 6 months had remained stagnant at 34% from 2003 to 2008. The data further showed that the most cited reason for not practicing breastfeeding was that 'mothers cannot produce enough milk' (31%), followed by 'mothers were working' and that 'mothers had nipple or breast problem' (tied at 17%). In the JP areas, 10.5% of children were never breastfed.[9] Exclusive breastfeeding was practiced in 28.5% - 30.2% during the first three months but steeply declined to half (14.8%) during the fourth month. At six months, only 3% of the children were exclusively breastfed. Among those who were not exclusively breastfed, plain water (22.8%) and other milk (35.2%) were given as early as the first month. Based on World Health Organisation (WHO) estimates, nine out of ten infant deaths less than 6 months of age are not exclusively breastfed.[10]

21. While a high proportion of children 6-23 months achieved the minimum number of frequency of feeding, only slightly over half (54.4%) of those that were ever breastfed achieved the minimum diet diversity. About a third (65.7%) of non-breastfed children achieved the minimum diet diversity. Compared with the national data, which is 78.7%, only Ragay (73.2%) and Aurora (85.6%) municipalities had a higher proportion of children 12-23 months who met the minimum diet diversity. The survey also noted that the 6-11 months age group had the least proportion of children who were given a variety of foods.

2.4. Government Response and Strategies.

22. The Philippines was one of the first countries to substantially adopt the International Code of Marketing of Breastmilk Substitutes (ICMBS).[11] Some of the relevant Philippine laws, rules and regulations on infant nutrition included:

[9] JP Baseline Survey, 2011
[10] Ibid (MDG Progress Report2010, page 113)
[11] Position Paper of the Infant and Pediatric Nutrition Association of the Philippines (IPNAP)

a) **Executive Order No. 51 (1986).** National Code of Marketing of Breastmilk Substitutes, Breastmilk Supplement and Other Related Products, more commonly known as the Philippine Milk Code. Requires approval of an Inter-Agency Committee (IAC) for advertising, promotion or marketing activities for infant formula (0-6 months), breast-milk substitutes, and complementary food within the scope of the Milk Code. The IAC is composed of the Department of Health, Department of Trade and Industry, Department of Justice and Department of Social Welfare and Development.

b) **Rooming-in and Breastfeeding Act (2010).** Adopts rooming-in as a national policy to encourage, protect and support the practice of breastfeeding and provides specific measures that would present opportunities for mothers to continue expressing their milk and/or breastfeeding their infant or young child. Provides tax incentives for private health and non-health establishments, where expenses incurred in complying with the Act shall be deductible expenses for income tax purposes up to twice the actual amount incurred. Provides continuing education and training of health workers and health institutions on lactation management and stipulates that information materials shall be given to all health workers involved in maternal and infant care health institutions. Provides for the integration of breastfeeding education in the curricula.

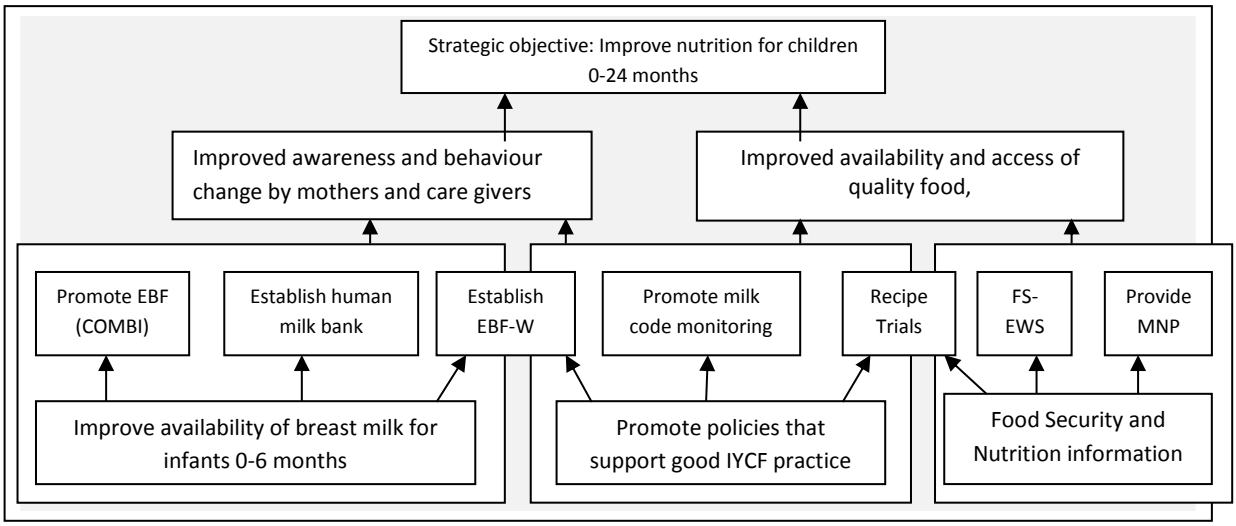
c) **Department of Health (DOH) Guidelines for Physicians on Breastfeeding (2010).** This was issued on May 14, 2010 by the DOH to guide physicians in promoting, protecting and supporting breastfeeding.

III. DESCRIPTION OF THE JOINT PROGRAMME

3.1. JP Logic Model

23. The JP logic and pathway to change was to improve availability of breast milk for infants 0-6 months, support policies that promote good IYCF practices and improve food security and nutrition information systems (Figure 5).

Figure 5: JP Logic Model



3.2. JP Results Framework

24. The JP planned to contribute to three outcomes; (1) increase breastfeeding in the JP areas by at least 20% annually, (2) reduce prevalence of under-nutrition in children 0-24 months by at least 3%, and (3) improve capacities of national and local governments and other stakeholders to formulate, promote and implement policies and programmes on IYCF. The JP intended to deliver 19 outputs in order to achieve these outcomes (Annex 3).

3.3. JP interventions

25. The JP worked at two levels: (1) "upstream" at national level to influence policy and programmes through lessons learnt from local implementation and evaluation using data from the nutrition information system; and (2) "downstream" at the local level to work through existing local nutrition structures (nutrition action committees) for programme coordination.

26. Five UN agencies partnered with government agencies at national and local level.[12] The key national implementing partners included, (i) the National Economic Development Agency (NEDA), (ii) Department of Health (DOH), (iii) Department of Interior and Local Government (DILG), (iv) Department of Labour and Employment (DOLE), (v) National Nutrition Council (NNC), (vi) National Anti-Poverty Commission (NAPC), (vii) National Centre for Disease Prevention and Control (NCDPC), (viii) National Centre for Health Promotion (NCHP), (ix) Food and Drug Administration (FDA), (x) Local Government Units (LGUs), (xi) Employers Organisations

[12] The participating UN agencies were FAO, ILO, UNICEF, WFP and WHO.

and Chambers of Commerce, (xii) Private Sector Organisations, and (xiii) Trade Unions, Formal and Informal Workers Organisations.

27. Seven interventions were implemented.

(h) Promoting exclusive breastfeeding (EBF) through communication for behavioral impact (COMBI).
(i) Promotion of EBF for workers in the formal and informal sectors (EBF-W).
(j) Establishing a human milk bank.
(k) Monitoring the milk code.
(l) Supply and distribution of micro-nutrient powder (MNP).
(m) Recipe trials for complementary feeding using locally available cereals and vegetables.
(n) Establishing food security and nutrition early warning systems (FS-EWS).

IV. EVALUATION FINDINGS

28. This Chapter 4 contains the evaluation findings and provides an analysis of the evidence relating to the evaluation criteria, and addresses the key evaluation questions as set out in the evaluation terms of reference (TOR).

4.1. Relevance

29. The JP was well aligned to the national nutrition policies and strategies. The NNC is the major national coordinating agency for nutrition. The NNC Action Plan (2008 -10)[13] provided the overall directions for action (Box 4).

Box 4: Directions for 2008 – 2010

1. Reduce disparities by prioritising population groups and geographic areas:
a) Focus on pregnant women, infants and children 1-2 years,
b) Focus on populations and areas highly affected or at risk to malnutrition.
2. Increase investments in interventions that could impact more significantly on under-nutrition:
a) Breastfeeding promotion,
b) Complementary feeding,
c) Supplementation with Vitamin A and Zinc,
3. Upscale in the implementation of nutrition and related interventions.

[13] Updated Medium Term Philippine Plan of Action for Nutrition, 2008 – 2010.

30. The Philippine Development Plan (PDP 2011-2016) also prioritised nutrition for children 0-24 months and provided the same strategies for reducing under-nutrition.[14] The Philippine Plan of Action for Nutrition (PPAN 2011 – 2016) identified six specific challenges, (1) high levels of hunger, (2) children under-nutrition (stunting and wasting), (3) vitamin A deficiency, (4) Anaemia, (5) Iodine deficiency, and (6) overweight and obesity.

31. The JP interventions were also very closely aligned to the programmes of the NNC, and in fact, at local level the joint programme used existing systems and structures established through the NNC programmes. The JP components complemented the government's efforts to improve IYCF practices by promoting exclusive breastfeeding in the first six months of life and introducing calorie- and nutrient-dense complementary food from six months onwards with continued breastfeeding. Moreover, the JP considered the decentralized set up of the government's delivery system to focus technical support and capacity building in the six LGUs; and JP advocacy and capacity building was designed appropriate to the needs of respective LGUs.

32. For example, the JP used the Barangay Nutrition Scholars (BNS) in several of its interventions (Box 5).

Box 5: Barangay Nutrition Scholars

The Barangay Nutrition Scholar Program is a human resource development strategy of the Philippine Plan of Action for Nutrition, which involves the recruitment, training, deployment and supervision of volunteer workers or barangay nutrition scholars (BNS). Presidential Decree No. 1569 mandated the deployment of one BNS in every barangay in the country to monitor the nutritional status of children and/or link communities with nutrition and related service providers.

33. The NNC also first undertook food insecurity assessments in 2004. The NNC developed and used indicators, which led to recognition that food insecurity did not exist in a single dimension but rather in a cross-section of dimensions that include economic, nutrition, health, and sanitation and education aspects. The results of these assessments led to the development of the 'Promote Good Nutrition (PGN)' programme to improve the nutrition knowledge, attitudes and practices of families to increase demand for adequate, nutritious and safe food. The PGN programme's key objectives were to:

- Increase the number of infants 0-6 months who are exclusively breastfed;
- Reduce the number of infants receiving food and drink other than breast milk;
- Increase the number of infants 6-12 months old who are given calorie and nutrient-dense complementary foods; and

[14] Philippine Development Plan 2011 – 2016, page 266.

- Increase the number of families who improved diets in terms of quality and quantity and involved in food production activities

34. The primary target groups for the PGN programme were the pregnant women and mothers of 0-2 year old children – to practice proper infant and young child feeding (IYCF). The primary messages were:

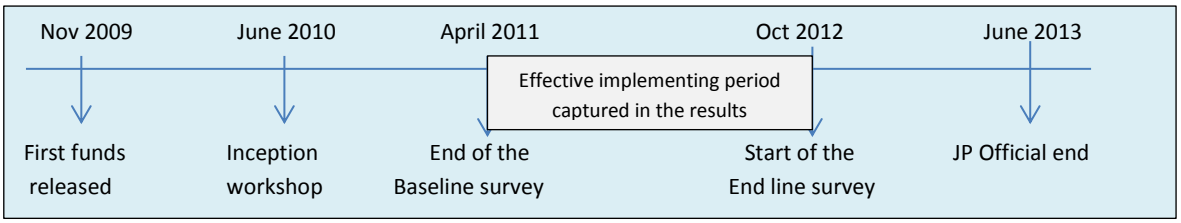
a. Initiate breastfeeding within 1 hour from birth,
b. Practice EBF for the first 6 months,
c. Introduce appropriate complementary foods not earlier than 6 months, and
d. Continue breastfeeding up to 2 years and beyond.

FGD with mothers in Aurora

4.2. JP Implementation

35. The JP was approved in the last quarter of 2008, and the official start date based on the release of the first tranche of funds by the MDG-F was November 2009. However, the inception workshop to launch the start of activity implementation was only held in June 2010. Due to these delays in the inception phase, the JP requested and got approval for a no-cost extension to June 2013. The JP also experienced delays with implementing some of its critical activities. For example, the baseline studies were completed in April 2011[15] and the end line survey was started in October 2012.[16] From the outset, a 3-year implementing timeframe was already too short to achieve the desired outcomes of attitude and behaviour change. However, in reality, although most planned activities were completed (Annex 3) the results that were measured through the baseline and end line surveys only included results for intervention implemented within an 18-month period (Figure 6).

Figure 6: Effective activity implementing period measured by results



[15] JP Baseline Survey Report, page 9.
[16] JP End line survey draft report, page 1.

36. A Programme Management Committee (PMC) was established with appropriate representation by national and UN agency partners; and was co-chaired by the NNC and UNICEF. The PMC exercised overall management of the JP through the JP Manager who was located at the NNC offices. A National Technical Working Group (NTWG) was also established to coordinate activities under each component. At the local level, local TWGs were also established to coordinate JP activities in the JP areas. The establishment of a PMC and NTWG that are specific for the joint programme appeared to duplicate already existing structures within the NNC. Moreover, the position of JP Manager was established specifically for the joint programme and the incumbent recruited from outside the NNC structures. This position would cease to exist after the JP life cycle.

37. The JP partners and government counterparts interviewed agreed that the conceptual framework of JP covered most of the essential components required to address the challenge of food insecurity and malnutrition for children 0-24 months in the Philippines. However, the initial stage and development of the tools needed for implementation was faced with various challenges, some of which were beyond the control of JP partners, but nonetheless affected field work. For example, individual JP partners had operational guidelines which caused contractual challenges in getting technical consultants. The JP partners noted that the implementation of the components lacked coherence and horizontal linkages that would be necessary to achieve collective synergy in order to effectively contribute to the overall objectives of the JP. Many of the respondents at the national level were in agreement that there was no lateral convergence of the components, which they recognized as a weakness in the concept. However, in terms of coordination and review of specific tools and modules, JP partners contributed their technical expertise through the NTWG meetings, which served as the clearing house of JP materials and activities. The components were implemented by the JP partners in the pilot sites vertically or independently (Table 2).

Table 2: Project Sites where JP Components Implemented

Project Site	EBF	EBF-W	Human Milk Bank	Milk Code	MNP	FS-EWS	IYCF	COMBI
Naga City	✓	✓		✓			✓	✓
Ragay Municipality	✓			✓		✓	✓	
Iloilo City	✓	✓		✓			✓	✓
Carles Municipality	✓			✓			✓	
Zamboanga City	✓	✓	✓	✓	✓		✓	✓
Aurora municipality	✓			✓	✓		✓	

38. The NNC observed that since the JP interventions complemented national nutrition programmes, which were implemented nationwide; it was quite feasible that improvement in some indicators could be observed in areas where not all JP interventions were implemented.

4.3. Joint Programme Effectiveness

4.3.1. JP Contribution to Expected Results

39. Based on data from the end line survey, the planned results in the targeted JP areas were not achieved. However, it is worth noting that the period of intense implementation/operationalization of the project components in the project sites covered only less than 18 months and the period to achieve behavior changes and impact on the nutritional status may require a longer period. The JP had planned to achieve 3-percent point reduction in anthropometric measures of nutritional status. However, for the prevalence of underweight-for-age, only a 1% point reduction was observed between the baseline and end line measurements. There was no change in the prevalence of wasting during the life of the project and the prevalence of stunting even increased by almost three percentage points.

40. Although the proportion of mothers who exclusively breastfed increased by almost 8%, the target for 20% annual increase was not achieved within the project life of three years. However, if we consider the period of one year period implementation (between the baseline and endline survey) the project indeed achieved more than 20% of EBF 0-<6months (at least for that one year period). Similarly the target to increase the proportion of mothers who initiated breastfeeding within an hour of delivery to 70% was not achieved; only 12% of mothers were able to initiate breastfeeding within the prescribed time. The end line survey noted however that difference between the baseline and the end line figures was, statistically significant (Table 3).

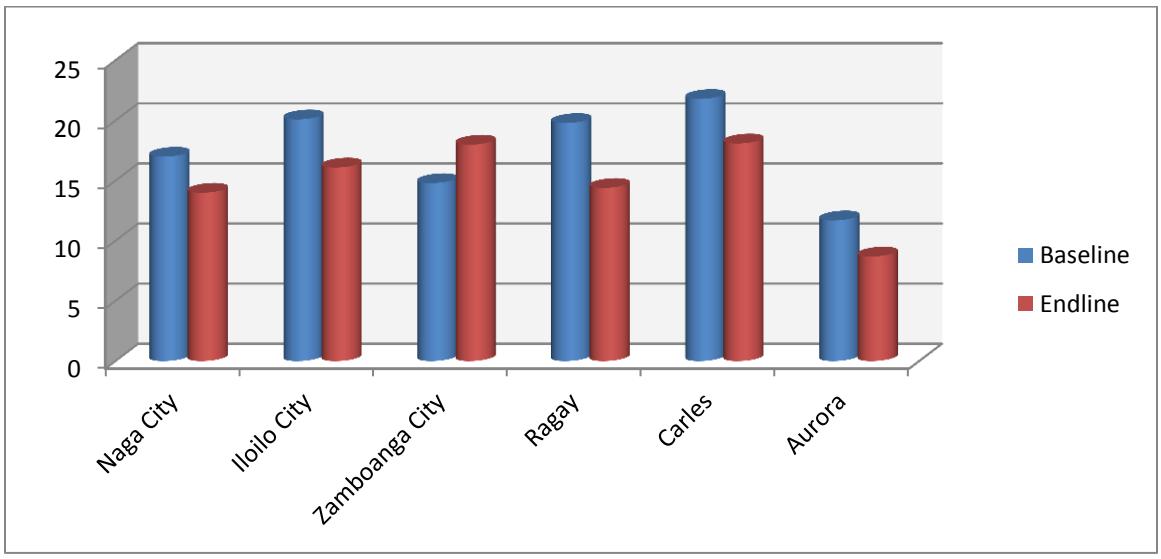
Table 3: Progress on JP indicators

INDICATORS	Target	Baseline	End line	Difference	p-value
Breastfeeding Practices					
EBF, <6 Months	20%a	22.1%	29.8%	7.7%	0.08
BF within an hour, Children 0-24 Months	70%	51.0%	62.8%	11.8%	<0.01
Complementary Feeding, Children 6-24 Months					
% Received CF, Children 6-8 Months	20%b	76.5%	92.6%	16.1%	<0.01
% Achieved Minimum Diet Diversity	20%b	59.6%	61.8%	2.2%	0.46
% Achieved Minimum Meal Frequency	20%b	75.2%	88.4%	13.2%	<0.01
% Received Iron-rich/fortified Foods	20%b	62.4%	85.1%	22.7%	<0.01
VNM Consumption, Children 6-24 Months c					
% Ever Consumed	90%	0.0%	59.4%	59.4%	-
Anthropometric Measures, Children 0-24 Months					
Underweight-for-age	3%d	16.2%	15.5%	-0.7%	0.62
Underlength-for-age (Stunting)	3%d	22.6%	25.3%	2.7%	0.09
Underweight-for-length (Wasting)	3%d	6.7%	6.6%	-0.1%	0.89
Hemoglobin Status, Children 6-24 Months					
Anemia Prevalence, 6-11 months	9.5%e	69.6%	55.8%	-13.8%	0.02
Anemia Prevalence, 12-24 months	8.2%e	38.6%	43.4%	4.8%	0.28

Source: JP Endline Survey

41. The data from the baseline and end line surveys did not provide conclusive evidence on the effectiveness of the JP interventions. For example, while early initiation of breastfeeding generally increased in all JP areas, the data showed that it actually declined in two of the target JP areas – Naga City (-17.4%) and Iloilo City (-3.1%). In addition, looking at Table 2 above, Zamboanga City was the only JP area where all the interventions were implemented (only the FS-EWS was not implemented in Zamboanga City. It would seem reasonable therefore to expect that Zamboanga City would show a greater improvement on the indicators. However, the end line survey actually showed Zamboanga City as the only one of the 6 JP areas to record an increase in the prevalence of under-weight for age for children 0-24 months (Figure 7). It would seem plausible therefore to conclude that the JP interventions had limited impact on the indicators (at least that would be true for Zamboanga City).[17]

Figure 7: Percent of Children under-weight for age in JP areas



Source: JP End line Survey: Progress Report, March 2013, page 43

42. Since the JP areas had received additional resources and targeted interventions, it would be reasonable to expect the nutrition indicators in the JP areas to be better compared to the national average. The NNC noted however that there was a general national improvement on nutrition indicators, and they did not have any evidence that it was any better in the JP areas (Annex 4).

[17] At the time of drafting this report, no specific studies had been made to determine why there was an increase in under-weight for age in Zamboanga City.

4.3.2. Factors That Affected Contribution to Results

A. Outcome 1. Increased exclusive breastfeeding (EBF) rate, in 6 JP areas, by at least 20% annually.

43. The JP planned to deliver 10 outputs to contribute towards Outcome 1. All planned activities were completed, but some of them experienced long delays. The most significant delay was on the development and reproduction of training modules for midwives and counseling tools for Peer Counselors. The delays had a ripple effect of delaying the organizing of the community peer support groups, and intensive training of the Peer Counselors started effectively in the last quarter of 2011.

44. While the use of Peer Counselors to promote EBF was a very good strategy, the system was based on volunteer counselors, which limited the programme's ability to exercise authority over their activities. In fact, in the JP areas, about 20-30% of the trained volunteer Peer Counselors were not active. Some of the Peer Counselors worked under the supervision of a BNS, who in turn coordinated with the midwife. The evaluation team observed that other than the Barangay Health Workers (BHWs) and BNS, the Peer Counselors were not trained or oriented on the use of the Growth Monitoring Card, which was either maintained at the health center or by the mother. The Growth Monitoring Card provided specific data on the growth of the child, and should have been used as the logical entry point for counseling. The evaluation team also noted that the JP design did not include Growth Monitoring Promotion (GMP) as an output. However the GMP card would have been an excellent tool to tie up with the counseling sessions and other information dissemination in the community.

45. All the JP cities had issued ordinances for companies to establish lactation stations but actual implementation was still very low. One of the reasons for this low level of implementing was that the implementing rules and regulations (IRR) only required companies with at least 200 employees to establish these centers. The evaluation team also noted that the enforcement of compliance was vested in the DOH, but labour regulations did not provide the DOH with the authority to access and inspect the companies. This authority was vested in the Department of Labour and Employment (DOLE), who could also award exemptions to the companies upon application. This could provide a scapegoat mechanism for companies not to comply with the policy. For example, in Zamboanga City, the City Health Office (CHO) had passed an ordinance making the issue of a sanitary license conditional upon establishing a lactation station. It was still to be seen how this would play out in a situation where the company obtained an exemption from DOLE.

46. With regards to the informal sector, lactation stations had been established in the public markets. However, on inspecting the usage log book maintained at the lactation station, the evaluation team noted that they were not extensively used. On average, the lactation stations at the public markets recorded intermittent daily visits of about 3-5 mothers every other day.

The BNS and Peer Counselors said this was because mothers usually left their children in the care of family caregivers and relatives when they went to the public markets.

47. The JP had weak follow-up mechanisms to monitor and evaluate effectiveness of its capacity building interventions. Based on questionnaires administered to the health workers, there were some significant gaps in their knowledge of the issues on EBF and IYCF. 20% of Peer Counselors said they had little or no knowledge on their roles and activities as volunteers or counselors; and 30% felt they had little or no knowledge on right message and information if the child was sick. With regards to the skills of Peer Counselors, 50% felt that they were able to discuss basic information about nutrition of pregnant women and infants 0-24 months and perform their task accurately and confidently most of the time. Only one-third of the Peer Counselors (most of them also BHWs or BNS) could use the weighing scales and growth charts most of the time.

B. Outcome 2: Reduced prevalence of under-nutrition by at least 3% among children 6-24 months old

48. The JP interventions under outcome 2 included counseling on complementary feeding, recipe trials and supply and distribution of MNP. Although most of the planned activities were completed, they also experienced a delayed start. At the time of drafting, some of the intended outputs were yet to be delivered. For example, the counseling materials on complementary feeding such as the complementary feeding guide, recipe trial booklet and the information, education and communication guide (IEC) were not distributed in all the JP areas.

49. The supply and distribution of MNP had also experienced various setbacks due to either lack of clarity or agreement among JP partners on dosages, packaging and other related issues. The evaluation team also heard that some of the procured MNP was either expired or nearing its expiry date, which affected its taste and coloration. During the focus group discussions (FGDs), some of the mothers noted that their children did not like the taste of MNP and that it had an unpleasant odour. The medical officers in the Zamboanga City and Aurora municipality where the MNP was distributed suggested that a syrup could be better than powder form in terms of preparation and feeding to the child. The evaluation team also observed that the monitoring mechanism for the use of MNP was lacking or ineffective. The MNP was distributed in sachets for 3-month supply. Some of the mothers noted that they did not use all of it because their children disliked the taste, but they still continued to receive subsequent supplies. The health workers however said they asked to see the empty sachets before additional supply was provided.

50. The JP commissioned a study to determine the appropriate frequency of MNP distribution to ensure high coverage, adherence and intake. This research compared the operational feasibility of two distribution models; (1) a one time delivery of 60 sachets of MNP every six months (Model 1); or (2) delivery of 30 sachets of MNP every three months (Model 2). While this study was conducted in a province outside the 6 JP pilot sites, it showed a significant improvement on hemoglobin

concentration and anemia among children. Underweight, stunting and wasting among children were slightly lower at post supplementation compared with the baseline. This improvement can be attributed to the systematic and thorough monitoring of the health workers, the quality of complementary foods fed to children improved after six months of the home fortification intervention and adherence of caretakers to the home fortification procedures. Lessons from this research will be used in further improvement of the delivery of MNP nationwide.

51. Out of the 40 Peer Counselors and BHWs who responded to the evaluation questionnaire, 75% Peer Counselors said they had enough knowledge on basic information and messages on complementary feeding; and less than 20% felt that their knowledge was enough, while about 10% said they had little knowledge on complementary feeding.

C. *Outcome 3:* Improved capacities of national and local government and stakeholders to formulate, promote, and implement policies and programs on IYCF

52. The JP planned to deliver three outputs through two interventions on recipe trials and the FS-EWS. The interventions were only implemented in Ragay municipality. The evaluation team noted that the recipe trials were not widely implemented. However, the food security and nutrition early warning system was quite successful in Ragay. The municipality had acquired the requisite skills and was consistently collecting quarterly data on food security and nutrition in the municipality. In addition, the data was used effectively to develop specific mitigating interventions such as supplementary feeding and distribution of seed for community gardens.

53. Although it could not be said conclusively that the JP intervention was responsible for the overall state of nutrition in Ragay municipality, it was noteworthy that out of all the six JP areas, Ragay municipality either had the best indicators, or had attained the greatest relative improvement on its indicators (Figure 8).

Figure 8: Changes in underweight by age in the JP areas (positive change means indicator worsened)

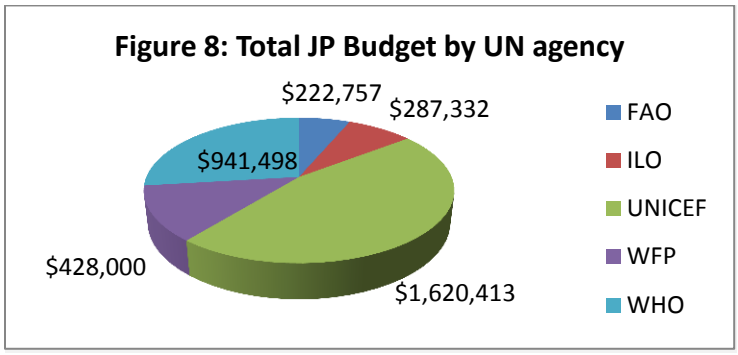
Age Group	CITIES			MUNICIPALITIES		
	Naga	Iloilo	Zamboanga	Ragay	Carles	Aurora
<6	4.1	-9.7	0.9	-11.2	5.3	4.6
6 - 23	-4.1	-1.8	2.4	-4.6	-5.1	-3.5
6 - 11	-10.6	3.7	0.5	6.2	-7.3	-2.4
12 - 23	-0.5	-4.4	3.7	-8.7	-3.7	-4.5
Overall	-3.0	-3.6	3.2	-5.5	-3.7	-2.2

Source: Extracts from the JP End line Survey Report, Table 7 page 13

54. The data seems to suggest nutrition interventions that are complemented by livelihood and other poverty reduction interventions are more effective.

4.4. Joint Programme Efficiency

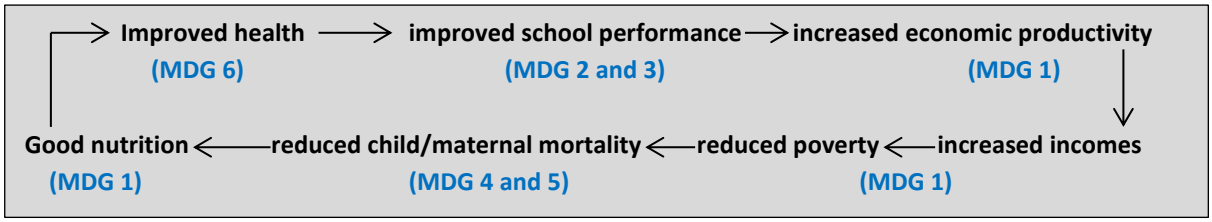
55. At the time of drafting, the JP had delivered 93% of the total US$3.5 million (Figure 9).



Source: JP Monitoring report, Feb 2013

56. The JP did not effectively implement its M&E framework. For example existing data was not leveraged to disaggregate data for children 0 - 24 months that were impacted by its interventions. The end line survey was based on sampling methodology which did not indicate the number of beneficiary children in absolute terms. The evaluation team was therefore unable to compute the JP efficiency in terms of cost of intervention per capita. However, based on the planned beneficiaries provided in the JP documents (Monitoring reports) as 187,905 women, the assumed cost efficiency was $18.60 per individual beneficiary impacted by the JP interventions. In the context of the nutrition challenge in the Philippines, this seemed to be a reasonable price to pay for addressing the problems of child under-nutrition and infant mortality. In addition, child nutrition has a wider impact on other development objectives and MDGs (Figure 10).

Figure 10: Development impact of investing in nutrition



4.4.1. Management efficiency

57. The joint programme established a management mechanism as recommended by the MDG-F Secretariat. The Program Management Committee (PMC) was co-chaired by UNICEF and the NNC, while the National Technical Working Group (NTWG) was chaired by NNC. The NTWG served as the venue to discuss project operations as well as the clearing house of materials and activities. JP partner reported on the status of their activities, outputs and fund utilization.

58. Overall strategic guidance and oversight was provided by the National Steering Committee (NSC), which included the UNCO, NEDA and the Spanish Embassy. The NSC effectively discharged its responsibilities, including making strategic decision, such as for example, authorizing the change of one of the JP areas when it became apparent that the targeted municipality was not fully supportive.

59. The establishment of a PMC and NTWG, which were in addition to the national structures already in existence within the NNC, could be regarded as not completely in line with the principles of the Paris Declaration. However, some of the stakeholders observed that the NNC structures were established by statute and therefore it was not easy to make amendments without going through lengthy legal processes. They also noted that continued expansion of the NNC working groups every time additional programmes were developed by different partners would ultimately render it ineffective, with lengthy agendas to cover the full spectrum of programmes for all the partners. While it may have been more effective to establish a dedicated TWG for the joint programme, the evaluation team did not see the need to establish an additional and parallel coordination mechanism with a separate reporting structure from running from the Programme Manager – PMC – NSC – MDG-F Secretariat.

60. The JP had Field Programme Coordinators (FPC) in each of the three regions. The FPCs were co-located with the local NNC offices and they provided field coordination for the JP in the framework of the Local Technical Working Groups (LTWG) established for the respective components. For example, the International Labour Organisation (ILO) component for EBF in the Workplace had a LTWG that mirrored the NTWG in Manila, with the local Chambers of Commerce as the Secretariat. The evaluation team had a sense that the FPCs were under-utilised. For example, the delay in the development of training modules for Peer Counselors was a consequence of the WHO procurement system which had a limit on the hiring of consultants. The FPCs noted that they could have developed the training modules as they collectively had the requisite technical capacities to do that.

4.5. Sustainability

61. The close linkages of the JP interventions with ongoing government programmes provided a very solid basis for sustainability. For example, Peer Counseling for EBF was very likely to be continued because the activities were implemented through existing structures and systems of the government's localised health care delivery system consisting of BHWs and BNS. In addition, almost all the intervention components had established local technical working groups, which were likely to continue the activities of the JP.

62. The LGUs had also developed exit strategies and sustainability plans for their respective municipalities. These plans had high potential of continuation because of the effective engagement and support of the local government at the highest levels. In Naga City for

example, the Mayor was involved in several JP activities, including the information and awareness activities. In all municipalities, several ordinances and resolutions were passed in support of, and as a result of the JP interventions.

63. At the time of drafting, Some UN agencies had already started developing plans for upscaling the JP interventions. Some of the components of the JP were integrated within the regional European Union (EU) funded project known as Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA). Through MYCNSIA some of the JP interventions will be continued in the six pilot areas, and also expanded to cover additional municipalities.

64. As noted earlier, the JP interventions mainly complemented ongoing national programmes; and as such there was quite significant leveraging of resources both by the national and local governments. For example, the national JP manager and the FPCs were all housed within the NNC facilities at national and local levels respectively. The LGUs supported the operations of the FPCs by providing them transport services and logistical support for training and other awareness raising information and communication activities. Counterpart resources provided were estimated at $3,016,141 or 86% of the MDG-F contribution (Table 4).

Table 4: Counterpart funding for MDG-F 2030

Type	Donor	Annual Contribution (US$)			Total (US$)
		2010	2011	2012	
Parallel	World Visions (Iloilo City)	7,327	12,028	12,023	31,378
Cost sharing	UNICEF- European Union (MYCNSIA)		917,591	1,320,715	2,238,306
	DSM		195,260		195,260
	GAIN		85,000		85,000
Counterpart	Zamboanga City	13,467	6,595		20,062
	DOH Region 9	16,744			16,744
	Aurora municipality	2,263	1,003		3,266
	Carles municipality	326	651	3,179	4,146
	Carles – Dept. of Education			238	238
	Iloilo City			2,440	2,440
	Naga City		7,952	71,095	79,047
	Ragay municipality		1,076	5,071	6,147
	NNC Regional offices	16,588	63,535	27,794	107,917
	NCHP	190,476		35,714	226,190

Parallel financing – complementary funding not channeled through UN agencies

Cost sharing – Funds channeled through UN agencies for execution of a specific programme.

Counterpart funds – contribution of national institutions in cash or kind for a specific programme.

V. LESSONS LEARNED AND CONCLUSIONS

65. As stated in the JP document the project was *aimed "to contribute to the improvement of nutritional status of 0-2 year old children and complement government's efforts through social*

marketing strategies to increase the percent of exclusive breastfeeding through nationwide efforts". The FE believed that the project indeed contributed to the government initiatives through development of policies on EBF, IYCF and initiated multi-sectoral participation specifically on the EBF in the workplace and local government involvement.

66. The actual contribution of the JP to expected results was however low to medium, as some of the JP areas actually experienced a worsening in their indicators. The final evaluation team noted two reasons that most probably contributed to the low achievement. First, the results analysis in this report was based on the data provided through the baseline and endline surveys. Given the delays in the JP inception phase in general, and specific interventions in particular, the timeframe measured by the baseline and endline was actually only about 15-18 months. Clearly no significant results could be expected to be achieved over such a short timeframe. This was more particularly significant given that the JP logic was based on changing behaviours and attitudes, something which cannot be achieved in a short period of time.

67. Secondly, the interventions did not have sufficient convergence. As noted earlier, the JP implemented the full array of its interventions in only one city - Zamboanga City; all the other JP areas had only two or three interventions. Quite significantly (and surprisingly) Zamboanga city itself had the worst results of all the JP areas.[18] The evaluation was unable to make conclusive opinions on why this was the case. However, one theory seemed to be quite plausible; there was a general trend of increased number of teenage pregnancies, particularly in urban areas; and from the observations of the evaluation team, such teenage mothers were not quite represented in the "peer system". By definition, a peer is "*a person of the same age, status, or ability as another specified person".* The evaluation team observed that most of the peer counselors were elderly women, who may not have had the desired 'peer effect' on teenage mothers.

68. It was also quite significant that Ragay municipality tended to have a better improvement in all its indicators compared to the other JP areas. Ragay municipality only had one JP intervention – the food security early warning system. However, all the other interventions were also implemented in that municipality, albeit not by the JP. However, through the FS-EWS intervention, the municipality undertook evidence-based decisions by providing food insecure households with supplementary feeding and seeds to supplement their food resources. More specifically, the municipal authorities noted that they had generated information about the cycle of food insecurity and vulnerable groups and they were thus able to target these groups more effectively and at the appropriate time. It would therefore also seem quite plausible to surmise that combination of the nutrition interventions such as exclusive breastfeeding and IYCF, were more effective if complemented with livelihood and poverty reduction interventions. This would most probably be the significance of the endline data which showed that in most of the JP areas, less than half of the target children were fed the minimum

[18] Some stakeholders also noted that Zambaonga peninsula was affected by conflict

acceptable diet; while also the 6-11 month old children had the poorest diet diversity (49%) and the worst minimum acceptable diet (37.6%).[19]

69. The data collection for the endline survey also studied the illness profiles of the sampled children. The survey reported that about one in three (37%) of the children in the sample reportedly had fever; one in four (26%) had acute respiratory infection and one in ten (13%) had diarrhea two weeks before the interview date. Although nothing in the endline survey report suggested that the diarrhea had anything to do with unsafe water, it would still be valid to question whether the JP results could have been different if they were supported with complementary interventions such as access to safe drinking water. This underscores the importance of addressing child malnutrition from a multi-sector perspective; as well as the importance for building synergies with other joint programmes.

70. In addition, it was also quite possible that the JP expectations were too high and the performance was not sufficiently supported by evidence. The evaluation team had observed that there was a general feeling in all municipalities that exclusive breastfeeding had increased. When asked why they felt that way, the most usual answer was that "*because the peer counselors had been trained and were undertaking house-to-house visits".* However, there were no specific monitoring mechanisms established to assess effectiveness of the peer counselors in delivering the message, or to monitor if indeed the mothers were consistently complying with practices that they were being advised to apply. For example, as noted earlier, the usage of public lactation stations was low because most mothers left their babies in the care of other household members. However, these 'other caregivers' were not being targeted with the messages for IYCF that were specifically designed for them.

VI. RECOMMENDATIONS

71. The importance of children nutrition and its impact on social development and to the achievement of the MDGs cannot be overemphasized. The evaluation team recommends that the JP interventions and its components should be continued through the programmes of partner UN agencies, either individually or collectively. The evaluation makes the following specific recommendations to inform future programming by UN agencies.

Recommendation 1: The UN should use existing national structures for programme management and coordination.

72. The NNC was the national coordination agency for nutrition in the Philippines; and in the exercise of its mandate, the NNC further established various national technical working groups to coordinate implementation of various activities. There was therefore no real need to

[19] Endline survey report, Table 13 page 28.

establish a PMC to provide a coordination mechanism specifically for the joint programme; instead, the UN agency staff could have been coopted into the existing structures (at least for the duration of the JP).

Recommendation 2: Programme interventions should be based on a clearly defined 'pathway to change model', which takes into account all dimensions and manifestations of the development challenge.

73. Core activities such as baseline surveys should be undertaken well in advance so that they constitute and inform the programme's impact pathway and logic model. Could some of the interventions have been done differently if the planning had benefited from the baseline survey prior to design and implementation? For example, would the modules for the training of Peer Counselors been different if it was known upfront that the highest incidence of stunting (underlength for age) was evident in the 12-23 months old children; or that the prevalence of wasting (underweight for length) was highest among the 6-11 months old children. Also, if the problem of teenage pregnancies had been considered, how would this have affected the selection of Peer Counselors? These questions remain unanswered, but they do underscore the need for enabling activities to precede the design and implementation of interventions.

Recommendation 3: Pilot interventions should be linked and implemented jointly in target areas so that their collective impact can be objectively determined.

74. The JP results in Carles and Aurora municipalities were not very different from each other (Figure 6), even if the one of the interventions (MNP) was not undertaken in Carles (Table 2). This raises the question – if the same results could be achieved with less interventions (and resources), then what was the added value of the extra intervention in Aurora municipality? In order to make an objective comparison and determine the effectiveness of the interventions, all target municipalities should have been subjected to the same interventions. In addition, all other existing interventions such as for example, the Growth Monitoring Promotion, should be factored into the design in order to optimize the impact of the programme.

Recommendation 4: Child nutrition should be addressed in the context of the broader household food security, including access to quality food, and livelihood opportunities.

75. As noted in the endline survey report, the proportion of children 6-23 months who were fed the minimum acceptable diet was low in all the sites. Although no specific qualitative data was provided to indicate why this was the case, it could be any number of reasons ranging from lack of information to lack of quality food at the family food table. However, in Ragay municipality where some livelihood interventions were undertaken, the proportion of children that were fed the minimum acceptable diet was higher. However, with respect to diet diversity,

four of the JP areas had reduction in the proportions of children receiving adequately diverse diets - Zamboanga City (-15.2%), Iloilo City (-2.5%), Ragay (-2.3%) and Aurora (-1.1%). This underscores the need to complement nutrition interventions with livelihood and poverty reduction interventions.

Recommendation 5: Strengthen follow-up mechanisms in monitoring and evaluation systems

76. Many of the JP components had a capacity development component which included training of various implementing partners. However, there was no follow-up undertaken to evaluate whether the training had been effective or whether the implementing partners were effectively passing on the knowledge that they had acquired from the training. This was particularly evident with regards to the training of Peer Counselors. Many of them indicated during the FGDs that they did not have sufficient knowledge about different aspects of their work. Monitoring and evaluation should be strengthened and designed appropriately to the specific needs of trainees; and should also include follow-on activities such as facilitative supervision.

ANNEX 1: DOCUMENTS REVIEWED

1. MDG-F 2030 (2011); Joint Programme Monitoring Report: July – December 2010.
2. Philippines – Nutrition Transmit Memo.
3. MDG-2030 (2011); Summary of Physical Accomplishments based on Color-coded Status Report as of 30 June 2011.
4. MDG-2030 (2011); Nutrition Month 2011 – Talking points.
5. MDG-2030 (2011); Coordinating Meeting: 7 July 2011.
6. MDG-2030 (2011); Activity Report: Regional Consultation on Interventions to Promote Exclusive Breastfeeding in the Workplace (Region 6).
7. MDG-2030 (2011); Joint Programme Monitoring and Evaluation Framework: Children, Food Security and Nutrition.

8. MDG-2030 (2011); Color coded progress report as of June 2011.
9. MDG-2030 (2011); Process Documentation: Regional .
10. MDG-F 2030 (2011); National Steering Committee Meeting and Field Visit: Caraga Region, July 2011.
11. MDG-2030 (2010); National Technical Working Group Meeting No. 4, Series of 2010.
12. Government of Philippines (2009); Republic Act No. 10028.
13. MDG-F 2030 (2010); Joint Programme Monitoring Report: July – December 2009.
14. MDG-F 2030 (2010); Mid-Year Programme Narrative Progress Report for period January-June 2010.
15. Government of Philippines (2010); Philippine IYCF Strategic Plan of Action for 2011-2016.
16. MDG-2030 (2009); Joint Programme Document Ensuring Food Security and Nutrition for Children 0-24 Months in the Philippines.
17. MDG-F (2009); Implementation Guidelines for MDG Achievement Fund Joint Programmes.
18. UNDG (2008); Revised Standard Joint Programme Document.
19. MDG-F Advocacy and Communication Strategy.
20. MDG-F Mission Report.
21. Advocacy and Partnerships: Guidance Note for Elaborating Advocacy Action Plans.
22. Generic Terms of Reference for the Mid-Term Evaluation of Children, Food Security and Nutrition Joint Programmes.
23. Monitoring and Evaluation System: "Learning to Improve," Making evidence work for development.
24. UNDP/Spain Millennium development Goals Achievement Fund Framework.
25. MDGF 2030 Bi-annual reports 2012.
26. JP Baseline Survey 2011.
27. JP Draft Endline Survey 2013.
28. JP Partners MDGF Documents.
29. LGU Resolutions on the JP Interventions.
30. Overall MDGF Evaluation Report.
31. Mid Term Evaluation Report.
32. Information, Education and Communications Materials i.e. IYCF Counseling Cards, COMBI/EBF-TSEK collateral materials.
33. COMBI Evaluation Report.
34. Draft Communications Plan.
35. MDG-2030; Minutes of National Technical Working Group Meetings 2011 and 2012.
36. Draft report on the Research on MNP Feasibility on Delivery Mechanism in Misamis Oriental.
37. IYCF Data Quality Workshop Proceedings.

38. Draft MDGF 2030 ESSP.
39. JP Partners MDGF Documents.
40. LGU Resolutions on the JP Interventions.

ANNEX 2: INDIVIDUALS INTERVIEWED

AGENCY/LGU	NAME	POSITION	FIELD
UNCO	Ms. Luiza Alicia Giminez Eden Luminan	Resident Coordinator Coordination Associate Coordination Specialist	
UNICEF	Tommo Hozumi Dr Henry Mdebwe	Country Representative Nutrition Specialist	
	Mr. Hammad	Planning, M&E Specialist	
Food Agriculture Organization (FAO)	Aristeo A. Portugal Maria Cecilia Pastores Dr. Demetria Bongga	Assitant FAO Representative Team Leader Consultant EWS	
International Labour	Concepcion Sardana	Project Manager	

Organization (ILO)	Annalisa Velencia	National Project Coordinator	
World Food Programme	Roselie Asis Susan Batutay Dr. Corazon Barba	Senior Program Assistant WFP Coordinator Reg 9 Consultant, WFP	
WHP	Marie Juliet Labitigan	COMBI Project Coordinator	
NEDA	Mr. Kevin Godoy	MDGF Program Support staff in NEDA	
Department of Health	Ms. Liberty Importa Ms. Vicente Borja	GP and GMP Program Coord IYCF Coordinator	
University of the Philippines-College of Public Health	Dr. Ophie Saniel May O. Lebanan Teddy Mondres Juan Paolo Gasgonia	Principal Investigator (PI) Co PI Research team Research team	
National Nutrition Council	Asec. Ms. Maria Bernardita T. Flores Ms. Rhoda Valenzuela	Asec and ED of NNC MDGF National Corrdinator	
CHD-NCR Paranaque City Health Office; NCR	Norhasim T. Ali Dr.Alma Corazon L. Ortillo Abelyn C. Bugayong Cleofe O. Goco Christine Maria Lara Benne Reida B. Sy	NCR COMBI Coordinator IYCF Coordinator Nutritionist Officer IV Nutritionist Officer V Nutritionist Officer III Nutritionist Officer I	
Sun Valley health Center- Paranaque City	Dr. Marie Fe Ricohermoso	Health center Physician	4 BHW-Peer Counselors
Region 5: CHD V	Dr. Napoleon Arevalo Ms Arlene Reario Regie Guillen	Asst. Regional Health Director Regional Nutrition Coord NNC MDGF Coord Region 5	
Naga City Nutrition Office and Health Office	Raquel Buere Baby del Castillo Rosemarie V. Zuniga Alvin V. Villacuez Jo Framel Dr. Borja Grace Guevarra	City Nutritionist City Nutrition Action Officer Staff City health Office “ “ Assistant City health Office HEPO-CHO	
Barangay Del Rosario, Naga City	Susan B. Ilagan	Midwife I	22 Members of the Community (BHWs, BNS, Peer Counselors, PHNs, RNHeals, Bgy Captain,SK, BSPO)
Breastfeeding in the Workplace, Naga City market	Nenita D. Bulahan	Secretary of the Verdas Association	
Barangay Caluag, Naga	Nona P. Olson	Midwife	7 Members of the

City			Community (BHWs, BNS, Peer Counselors, Kagawad, BSPO)
Region 6	Ms. Nona Tad-y Ms Marilyn Tumilba	Regional Nutrition Coordiantor-NNC Regional Nutritionist-DOH	
Iloilo City Health Office	Dr Baronda Ms Jean Calloso Ms. Theresa Garganera Ms. Jasmine Noble	City Health Office Nurse Nutritionist HEPO	
Barangay Huges, Iloilo City	Angelita Atilano Joenzo Mamigo Christine Macuro	Midwife Nurse Casual Midwife	1 BND-PC 2 BHW-PC 4 Mothers
Barangay East Timawa, Iloilo City			4 BHW/BNS PCs 2 Mothers
Carles, Municipality, Iloilo Province	Hon. Arnold Betita Dr Ronal Betita Paulo Bacinillo Bopeep Jacar	Mayor Municipal Health officer Nurse Nurse	
Barangay Bangkal, Carles	Lyna G. Minguez	Midwife	7 BHW-PCs
Barangay Tupaz, Carles			4 BHW-PCs
Ragay, Camarines Sur	Mr. Jojo Tipay Ms. Suset C. Muelio Dr. Virgin G. Ramirez	Municipal Planning Officer Municipal Nutrition Action Officer MHO	5 Nutrition Coordinators (Nurses)
Barangay Poblacion Ilaod, Ragay	Ms. Synette Llantos Ms. Fely Baloloy	Nurse Midwife	6 BHW-PCs
Barangay Binahan Proper, Ragay			9 BHWs-PCs-BNS
Region 9	Ms Evelyn Capistrano Ms Pamela Tarroza Ms Susan Batutay	Regional Nutritionist DOH Regional Nutrition Coordinator NNC WFP Coordinator	
Human Milk Bank			1 Nurse
Municipality of Aurora		Mayor of Aurora municipality	1 Doctor 2 Nurses 2 Midwifes
Barangay San Jose, Aurora			6 BHWs, BNS 4 PCs and 5 mothere
Barangay Sta. Catalina,Zamboanga City		City MHO 4 Nurses/Midwifes	4 BHW/BNS/PCs
Barangay Libertad, Aurora			10 BHW/BNS/PC
Barangay Lower,	Andrea Aliosway	Nurse	9 BHWs/BNS and PCs

Binahan, Aurora	Maribeth Gunda	Midwife	
ECOP	Ms. Dang Buenaventura Mr. Angelo Jon Aloglah	Manager CSR Support Staff	
NAPC	Ms Jessie Rebueno Ms. Joy Bacon	Technical Officer Focal Person for Workers in the Informal Sectors	
DOLE	Mr. RC Brillantes	Technical Officer, DOLE rep	
Food and Drug Administration	Atty, Christine Macaranas-De Guzman Ms Myrlin	Attorney III, Legal Info and Compliance Div Milk Code Monitoring Focal Person	

ANNEX 3: MATRIX FOR PLANNED VS ACCOMPLISHED ACTIVITIES BY OUTCOME AND YEAR

			Was the planned activity accomplished? When? Numbers/Quantity if applicable?				Remarks (Change in Output Indicator)
Outcome 1	**Output Indicator**	**Sub-activity**	**2010**	**2011**	**2012**	**2013**	
Increased exclusive breastfeeding rates in highly urbanized cities and JP municipalities by 20% annually **Revised to: Increased exclusive breastfeeding (EBF) rate, in 6 JP areas, by at least 20% annually (source Jan-June 2012 Bi-annual report)**	1.1 An evidence-based marketing and advocacy campaign developed and executed nationally and in JP areas Note: Revised to: 1.1 Increased number of pregnant & lactating women visited at home by a peer counselor (Source: Jan-June 2012 Bi-annual report.)	1.1.1 Development of a "marketing Brand" for EBF6 Revised to: 1.1.1 Development and execution of an evidence-based marketing and advocacy campaign on exclusive breastfeeding for the first six months of life (EB6), in highly urbanized cities, including 3 JP cities (Communication for Behavioral Impact or COMBI)	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q3 & Q4, 2010	Accom-plished Source: July-Dec 2011 Bi-annual report/ CFSN Q1, 2011			-Change in output indicator Source: CFSN Q4, 2010 -Contract out of "marketing brand" to a Branding agency, Camp Cebu Marketing brand developed was - Breastfeeding TSEK (Tama, Sapat, EKlusibo) for the EBF Campaign (Breastfeeding –Right/Appropriate-sufficient exclusive) Source: CFSN, Q1, 2011; MDGF Communication Plan
		1.1.2 Launching of a PR and media campaign in support of EB6	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q4, 2010	Accom-plished Source: July-Dec 2011 Bi-annual report/ CFSN Q1, 2011	33 events conduc-ted Source: July-Dec. 2012 Bi-annual report		Source: Jan-June 2012 Bi-annual report & July-Dec 2012 Bi-annual report Run for BF event- Feb. 4 at SM-MOA. Published in Manila Standard Today, Phil Star, Manila Bulletin, & Business Mirror. Aired at GMA's "Unang Hirit" & DZMM EBF brand materials reproduced & distributed: -200,000 three in one cards -7,000 vests -7,000 rubber stamps with logo -50,000 posters Source: July-Dec 2012, Bi-annual report
		1.1.2 Engaging DOH hierarchy and LGUs at all levels to actively participate in COMBI	Accom-plished Source:	Accom-plished Source:	Accom-plished Source:		Sec.Ona, DOH, sent letters to **6,363** DOH staff (CHDs & hospitals) as advocates of EBF on Sept. 11, 2011 & April 2012. Source: CFSN, Q1, 2012

		1.1. 2 Change to 1.1.1.1 in 2012	Jan-June 2010 Bi-annual report/ CFSN Q3 & 4 2010	CFSN Q1 2011	CC Report Q1 2012		
		1.1.4 Building partnerships with the private sector to mobilize resources for the COMBI Plan	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1 2011	Accom-plished Source: CC Report Q1 2012		Source: CFSN Q4, 2010 Protégé, business group will organize how to link companies to COMBI support groups. With Partnership Advocacy Kits approved by the National COMBI Committee Source: CFSN, Q1, 2012 662 (out of 631 target) community support groups established in COMBI areas Source: July- Dec. 2012 Bi-annual report
		1.1.5 Deployment of corps of trained peer counselors (PCs) to effect desired behavior change (EB6) among pregnant mothers	Accom-plished Source: CFSN Q4, 2010	Accom-plished 40% of target peer counse-lors Source: July-Dec. 2011 Bi-annual report/ CFSN Q1, 2011	**5,464** Peer counse-lors trained & deployed (target-8,835) Source: Jan-June 2012 Bi-annual report		Source: Jan-June 2012 Bi-annual report NOTE: The peer counselor (PC) was decided to be only ONE for both COMBI and IYCF. One PC for every 20-25 pregnant & infants 0-23 months Source: CFSN Q4, 2010 -Contract out of training of peer counselors to ARUGAAN. With training manual, materials, & kits. Source: CFSN, Q1, 2011 -Contract out hiring & deployment of city COMBI/peer counselors to NCP & PHILSSA - About **3,760** PCs trained in NCR and 2 joint programs areas of Naga, Iloilo, and Zamboanga. -COMMED trained PCs in Antipolo, Bacoor, Dasmariñas, Imus, Cebu

							City, Lapu-Lapu, Mandaue, Tacloban; -Health Devt Insititute trained PCs in Malolos, Marilao, Meycauayan and KPS Foundation, a member NGO for PHILSSA will train in General Santos City. - All **12** City COMBI/ BF TSEK Coordinators deployed in NCR, Cavite, Iloilo & Cebu. Source: July-Dec 2012 Bi-annual report
		1.1.2.2 Development and reproduction of training modules on enhanced skills of midwives on community mobilization and organizing community peer support groups, and on peer and group counseling tools for peer counselors	-	-	Accom-plished Source: CFSN Q1, 2012		Note: Additional sub-activity. This activity was delayed due to the training module. Draft is 70% done. Review, pretesting, and finalization are set on April and May. Source: CFSN, Q1, 2012
		1.1.6. Organizing and holding of COMBI launch	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Source: CFSN Q1, 2011 COMBI launch last 23 February 2011 with **300** guests. Press conference with DOH, UNICEF & WHO was also conducted.
		1.1.7 Promotion of EB6 in various points of service delivery	1 BF Photo exhibit & radio guestings Nov. 2010 Source:	Accom-plished Source: July-Dec 2011 Bi-annual report			

			July-Dec 2010 A.R.				
	1.2 Exclusive breastfeeding is strengthened as a key component of the National Family Welfare Programme (FWP)	1.2.1 Conduct (1) national (3) regional consultations to review the Family Welfare Programme (FWP) and existing practices in setting up lactation stations in the workplace	Accom-plished Source: CFSN Q4 2010	Accom-plished Source: CFSN Q1, 2011			Results of the consultations used as inputs in the development of IRR on RA 10028. Source: CFSN, Q1, 2011 For sustainability: In 2012- COMBI on EBF component will be scaled up by NCHP, DOH using gov't funds.
		1.2.2 Documentation and dissemination of good practices on workplace-based/ workplace-initiated support to working mothers, particularly through the promotion of exclusive breastfeeding	Accom-plished Source: CFSN Q4 2010	Accom-plished Source: CFSN Q1, 2011			Source: CFSN, Q4, 2010 Results presented to national consultation & final report submitted to ILO on December 2010 Final report submitted on March 31, 2011. Source: CFSN, Q1, 2011
		1.2.3 Formulation, review, issuance of a DOLE policy on integrating EBF-W in the National Welfare Program	Not accom-plished Source: CFSN Q4, 2010	Not accom-plished	Accom-plished Source: CC Report Q1, 2012		Through consultative meetings, the labour component will be able to consolidate issues among FWCs and stakeholders, generate recommendations and improve drafting of the DOLE policy advisory on Family Welfare Program. Source: CC Report, Q1, 2012
	1.3. Strengthened FWP piloted in 3 JP cities	1.3.1. Conduct orientations on RA10028 and its IRR for Family Welfare focal persons and Family Welfare Committees in 3 JP cities	Not accom-plished	Accom-plished Source: July-Dec 2011 Bi-Annual report	Accom-plished Source: Q1, 2012 report		
		1.3.2. Establish partnership/network of Family Welfare focal persons, FW	Accom-plished	Accom-plished			Sub-TWG on EBF in the workplace composed of DOLE, Trade Unions of the Philippines (TUP), ,National Anti-Poverty

		committees and JP local implementers, particularly health officers (PHO, CHO, MHO)	Source: CFSN Q4 2010	Source: CFSN Q1 2011			Commission (NAPC), and ILO. Source: CFSN, Q1, 2011 PHILSSA & E-networking tapped for other social developments programme + BF. In Reg 6, NGOs & academe were involved. Source: July-Dec. 2012 Bi-annual report
		1.3.3. Conduct of advocacy activities on EBF, IYCF, RA 10028 among employers/companies and trade unions	Accom-plished Source: July-Dec 2010 Bi-Annual report	Accom-plished Source: July-Dec 2011 Bi-Annual report	Accom-plished Source: Jan-June 2012 A.R.		In 2012-Advocacy conducted to prevent the passage of a proposed legislation to amend RA 10028 and the Milk Code. Advocacy efforts i.e. one-on-one meetings with key legislators, sending of position papers, and participation in deliberation meetings. Discussed RA 10028 with employ-ees & all workers fora Source: Jan-June 2012 Bi-annual report
		1.3.4. Advocacy and communication activities of EBF-W		Accom-plished Source: July-Dec 2011 Bi-Annual report	Accom-plished w/ SM Cares, BF Patrol of Mandaluyong City & LATCH re: BF Photo exhibits & EBF promo-tions Source: Jan-June		In 2012 other NGOs involved are PHILSSA & E-Networking tapped for other social development + BF. Regions 6 & 9 the NGOs & academe were involved in BF. Source: Jan-June 2012 Bi-annual report

					2012 Bi-annual report		
		1.3.5. Provision of technical assistance to companies piloting EBF		Accom-plished Source: July-Dec 2011 Bi-Annual report	Accom-plished Source: CC report Q1, 2012		Discussed with ECOP on the modules, M&E Tool for companies with EBFW.
	1.4. Models of informal sector workplace interventions for exclusive breastfeeding designed and demonstrated in 3 JP	1.4.1. Conduct of baseline study on informal sector practices to promote breastfeeding/EBF	Accom-plished Source: CFSN Q3 & Q4 2010	Accom-plished Source: CFSN Q1, 2011	Accom-plished Source: Jan-June 2012 Bi-annual report		Baseline study contract out to NAPC. Results will serve as reference for the development of modules, use of M&E tools, kits on PMT for LGUs, and Peer education training. Source: Jan-June 2012 Bi-annual report & CC report, Q1, 2012
		1.4.2. Conduct of consultations with informal sector stakeholders towards designing demonstration projects for EBF in the workplace	Accom-plished Source: CFSN Q4 2010	Accom-plished Source: CFSN Q1, 2011			Source: CFSN Q4, 2010 Conducted in Regions 5,6, and 9.
		1.4.3.Provision of support to pilot informal sector workplaces piloting EBF	Not accom-plished Source: CFSN Q4, 2010		Accom-plished Source: CC Report Q1, 2012		In, 2012 provision of refrigerator, comfortable seats, M&E tool for the LGUs, & guidelines on use of public lactation rooms. Source: CC report, Q1, 2012
		1.4.4. Monitoring and documentation of demonstration	Not accom-		Accom-plished		M& E tool for EBF in workplace programmes for the informal sector

		projects for informal sector workplaces in 3 JP Cities	plished Source: CFSN Q4, 2010		Source: CC Report Q1, 2012		developed and pre-tested in February 2012. Source: CC report, Q1, 2012
	1.5. Local peer counselors nominated and trained	1.5.1. Development and reproduction of training modules on enhanced skills of midwives, peer counseling tools, and module for group counseling on complementary feeding	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Source: CFSN Q4, 2010 Contract out to 2 contractors. Target for finalization of training Module is on June 2011. **986** midwives & healthworkers trained on IYCF **169** midwives & health workers trained on community mobilization Source: July-Dec Bi-annual report 2012
		1.5.2. Mobilization of opinion leaders and the community	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			
		1.5.3.Conduct of IYCF trainings	Accom-plished Source: CFSN Q4, 2010	-	-	-	5 days IYCF training for midwives in Regions 5, 6 & 9. Source: CFSN, Q4, 2010
		1.5.4.Distribution of equipment for the barangays and health offices for training	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Equipment distributed are: Salter WS, infant WS, height board, Detecto beam balance scale, & laptop. Source :CFSN, Q1, 2011
		1.5.5. Identification and training of peer counselors on IYCF	Accom-plished Source:	Accom-plished Source:	5,464 peer counse-lors		c/o LGUs with NNC at the barangay level. Source: CFSN Q4, 2010 Purchased 4,683 pcs. vests for the peer

			CFSN Q4, 2010	CFSN Q1, 2012	trained at NCR & JP areas/ **662** commu-nity support groups establish-ed Source: July-Dec. 2012 Bi-annual report		counselors Source: CFSN, Q1, 2011 In 2012- partner institutions have been selected to train the rest of the targeted 32 cities. Source: Jan-June 2012 Bi-annual report
	1.6. Home visits conducted by peer support counselors	1.6.1.Mapping and updating of list of households with target groups (pregnant, lactating women and/or Children 0-24 months)	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			JP areas updated list of target households Source: CFSN, Q1, 2011
		1.6.2. Conduct of home visits (c/o peer counselors) and counseling of targets on exclusive breastfeeding, breast feeding, and appropriate complementary feeding practices	Not Accom-plished	Not Accom-plished			Source: CFSN Q4, 2010 & CFSN Q1, 2011
		1.6.3. Conduct of monitoring visits in JP areas	Not accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Field Programme Coordinators and focal points of JP areas conducted regular monitoring visits Source: CFSN, Q1, 2011
	1.7. Communications for	1.7.1. Conduct of community	Not Accom-	Accom-plished			Communications Specialist from UNICEF has completed visits to the

	development on IYCF developed and implemented	events and promotional activities to produce an enabling and supportive environment for breastfeeding	plished Source: CFSN Q4, 2010	 Source: CFSN Q1, 2011			JP areas and surveyed the available IYCF communication activities and resources. Source: CFSN, Q1, 2011
	1.8. Pregnant and lactating women received adequate supply of iron-folic acid tablets	1.8.1. Procurement of iron folic acid tablets	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q3 2010	Accom-plished Source: CFSN Q1, 2011			Year 1 - FeFO procurement completed & Year 2 - FeFO procurement is being prepared Source: CFSN, Q1, 2011
		1.8.2. Repacking and distribution of iron folic acid (IFA) tablets	90% IFA distribu-ted to LGUs Source: July-Dec 2010 Bi-annual Report/ CFSN Q3 2010	Accom-plished Source: CFSN Q1, 2011			FeFo distribution guidelines have been drafted awaiting approval of NCDPC,DOH. Source: CFSN, Q4, 2010
	1.9. Human milk bank established in a tertiary hospitals Revised & transferred to 1.3) 1.3 Establishment of Human Milk Banks (HMB) in 1	1.9.1. Review of Human Milk Bank (HMB) Guidelines in the IRR of the Expanded Breastfeeding Promotions Act – RA 10028	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Public hearing on RA 10028's Implementing Rules and Regulations held, and guidelines drafted. Source: CFSN Q4, 2010
		1.9.2.Qualitative study on KAP and perception by health staff and community on use of HMB	Accom-plished Source:	Accom-plished Source:			Qualitative study c/o baseline & endline surveys. Source: CFSN Q4, 2010

	secondary or birthing facility in one of the JP areas		Jan-June 2010 Bi-annual report/ CFSN Q3 & Q4 2010	CFSN Q1, 2011			
		1.9.3.Technical training on HMB conducted	Not Accom-plished Source: CFSN Q3, 2010	Accom-plished Source: CFSN Q1, 2011	Accom-plished Source: July-Dec 2012 Bi-annual report		
		1.9.4.Development, orientation, and dissemination of advocacy information on HMB	Not accom-plished Source: CFSN Q4, 2010	Not accom-plished Source: CFSN Q1, 2011			2nd qtr.
		1.9.5. Identification and selection of hospital where Human Milk Banks (HMB) will be established	Not accom-plished Source: CFSN Q4, 2010	Not accom-plished Source: CFSN Q1, 2011	Accom-plished Source: July-Dec 2012 Bi-Annual report		Target: at least 1 HMB Source: July-Dec 2012 Bi-annual report Construction on-going at Zamboanga Medical Hospital
		1.9.6. Organization and maintenance of functional Human Milk Bank Committees and adoption of HMB by birthing facilities	Not Accom-plished Source: CFSN Q3 & Q4	Not Accom-plished Source: CFSN Q1, 2011	Not Accom-plished		Reason: construction is on-going as of 2012

			2010				
		1.9.7. Procurement of supplies needed to establish HMBs	Not Accom-plished Source: CFSN Q3 & Q4 2010	Not Accom-plished Source: CFSN Q1, 2011	Accom-plished Source: July-Dec 2012 Bi-annual report		Reason: construction is on-going as of 2012
	1.10. National standard module for monitoring the Milk Code developed	1.10.1. Orientation on the Milk Code (Year 2: DOH, DTI, DOJ, DSWD) , Private hospitals and birthing centers	5 orienta-tions conduc-ted Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Oriented were professionals, media & LGUs personnel Source: CFSN, Q4, 2010 Year 1 orientations-completed Year 2 orientations- for 2nd quarter. Source: CFSN, Q1, 2011
		1.10.2. Setting up of text hotlines to report violators	For Year 2 Source: CFSN Q3 & Q4 2010				FDA will be providing the mobile phone and prepaid load credits. Source: CFSN, Q1 , 2011
		1.10.3.Conduct of region-based advocacy activities on the Milk Code (Year 2: Tacloban, Tagaytay, Palawan, Carles, Zamboanga, Naga) Monitoring of MDG-F areas (Monitors trained on Milk Code monitoring) and monitoring of advertisements, sponsorships, donation	Accom-plished Source: CFSN Q3 & Q4 2010	Accom-plished Source: July-Dec 2011 Bi-annual report	Accom-plished Source: Jan-June 2012 Bi-annual report		Milk Code monitoring kit has been developed, and scheduled for printing and publication for Year 2. Source: CFSN Q4, 2010 Training of monitors on Milk Code monitoring was conducted in JP areas in regions 5, 6 and 9. Source: CFSN Q4, 2010
		1.10.5. Zonal Program	Not				

		Implementation Review (Manila, Cebu, Davao)	accom-plished				
Outcome 2	**Output Indicator**	**Sub-activity**	**2010**	**2011**	**2012**	**2013**	**Remarks (Quantity, Contracted out. Issues/Concerns, etc?)**
Reduced prevalence of undernutrition by at least 3% among children 6-24 months old by	2.1 Resources for counseling on age-appropriate complementary feeding produced	2.1.1 Conduct of formative research on KAP of child caregivers on complementary feeding (linked with JP 1)	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Linked with baseline study. Source: CFSN, Q4, 2010
		2.1.2 Designing and testing of learning resources for appropriate complementary feeding	Accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Linked with baseline study. Source: CFSN, Q4, 2010
	2.2 Recipes from homestead gardens and locally available foods for integration in community / nutrition education activities documented	2.2.1 Conduct of formative research and production of resource materials on group counseling for appropriate complementary feeding practices and recipes from locally available foods (UNICEF, FAO)	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q3 & Q4 2010	Accom-plished Source: CFSN Q1, 2011			Formative research contract out to UPLB and will be completed first quarter of 2011.
	2.3 Community/household nutrition education activities on improving the quality of diets for complementary foods from homestead gardens and locally available foods	2.3.2 Training of community health/ nutrition workers, and midwives on the preparation of nutritious and age-appropriate complementary foods made from homestead/community gardens and locally available foods	Not accom-plished Source: CFSN Q4, 2010	Not accom-plished Source: CFSN Q1, 2011	Accom-plished Source: Jan-June 2012 Bi-		Completed training on recipe trails using local foods. Source: Jan-June 2012 Bi-annual report Final report currently being reviewed for technical clearance. Source: CC report, Q1, 2012

	conducted	(training on recipe trials)			annual report		
	2.4 Improved micronutrient status of all children6-24 months old in the 2 JP areas, through micronutrient powder (MNP) supplementation and proper utilization, as indicated by significant increase in hemoglobin level among beneficiaries	2.4.1 Procurement of micronutrient powders (MNP)	Accom-plished Source: CFSN Q3, 2010	Accom-plished Source: CFSN Q1, 2011			7 million packets of MNP procured in March 2011, but awaiting final box design prior to delivery. Design of box had to be revised to be compliant with provisions of the Milk Code. Source: CFSN, Q4, 2010 & CFSN, Q1, 2011
		2.4.2 Development of MNP local packaging	Accom-plished Source: CFSN Q3, 2010	Accom-plished Source: CFSN Q1, 2011	Accom-plished Source: CC Report Q1, 2012		
		2.4.3 Distribution of MNP	Not accom-plished Source: CFSN Q3, 2010	Accom-plished Source: CFSN Q1, 2011	Conti-nued MNP distribu-tion in Zambo & Misamis Oriental Source: Jan-June 2012 Bi-annual		In 2012- MNP study, Misamis Oriental determined the distribution schemes to help DOH in firming up guidelines on the nationwide distribution. Activities to monitor the MNP distribution & roll out MNP IEC materials & activities were integrated in regular programming of the CHO, Zamboanga. The MNP will be distributed by 2011 of 2nd quarter using the simple temporary packaging.

					report		Source: CFSN, Q1, 2011
		2.4.4. Assessment of local companies for possible production/packaging of MNP in the country.	Not accom-plished Source: CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			Postponed in Year 1, due to pending approval of local company for the assessment process. Source: CFSN Q4, 2010
		2.4.5. Conduct of the MNP Effectiveness Study		Accom-plished Source: CFSN Q1, 2011	Comple-ted Source: July-Dec 2012 Bi-annual report		MNP study contracted out to HKI, Phils. by WFP.
	2.5 Increased awareness of LGU functionaries, health workers, households and communities on the need and importance of using MNP in improving the nutritional status of children 6-24 months old.	2.5.1 Design, production and printing of IEC and training materials	Accom-plished Source: Jan-June 2010 Bi-annual report/ CFSN Q4, 2010	Accom-plished Source: CFSN Q1, 2011			
		2.5.2 Organize community events, face-to-face communication and distribute promotional and IEC materials	Not accom-plished Source: CFSN Q3, 2010	Not accom-plished Source: CFSN Q1, 2011			In 2010, conduct of orientations to LGU officials in Zamboanga City and Aurora, Zamboanga del Sur. Source: CFSN, Q4, 2010
	2.6 Improved capacity of all BHWs and BNSs in 2 JP areas on advising and counseling mothers on the	2.6.1 Training and retraining of trainers, BHWs, BNSs and other MNP distributors in 2 JP (Zamboanga City & Aurora)	Not Accom-plished Source:	Accom-plished Source:	627 trained Source:		In 2010 - Implementation is dependent on availability of the MNP and MNP IEC materials Source: CFSN, Q4, 2010

	appropriate use of MNP to fortify home-prepared complementary foods for children 6-24 months old		CFSN Q3, 2010	CFSN Q2, 2011	July-Dec 2012 Bi-annual report		Training has been rescheduled to May 2011 due to DOH's anti-measles campaign Source: CFSN, Q1, 2011 Source: July-Dec 2012 Bi-annual report MNP usage w/in 2 months Target: 90% Accomp: 29,618 out of 26,100 kids Taking proper dosage of MNP w/in 1 year Target: 90% Accomp: 29,618 out of 26,100 kids (113.5%)
Outcome 3	**Output Indicator**	**Sub-activity**	**2010**	**2011**	**2012**	**2013**	**Remarks (Quantity, Contracted out.Issues/Concerns, etc?) Source document**
Improved capacities of national and local government and stakeholders to formulate, promote, and implement policies and programs on IYCF	3.1 Needs assessment on knowledge, attitude and practices on three policies conducted and used for formulating and adjusting policies, and program designs among others.	3.1.1 Conduct of IYCF-related policy scan and assessment (completed in 2010)	Accom-plished Source: July-Dec. 2010 Bi-annual report/ CFSN Q1, 2011	-	-	-	Preliminary results was presented to the national and regional TWG. Source: CFSN, Q4, 2010 Policy scan & assessment was integrated in the guidelines for the IYCF developed. Source: July-Dec. 2010 Bi-annual report Policy Scan completed, with final report submitted MDG-F Supplies on March 2011 Source: CFSN, Q1, 2011
		3.2.2 Development of LGU policies, plans, and programs to create an enabling environment for optimal IYCF including local ordinances and and incentives program	Not accom-plished Source: CFSN Q3 & Q4 2010	Accom-plished Source: CFSN Q1, 2011	Accom-plished Source: July-Dec. 2012 Bi-annual		5 PIPH/CIPH and 5 AOPs completed in 2012 Source: July-Dec. 2012 Bi-annual report

					report		
		3.2.3 Development of local policy, administrative ordinances, and local incentive systems supporting IYCF	Not Accom-plished Source: CFSN Q3, 2010	Not accom-plished Source: CFSN Q1, 2011	Accom-plished Source: July-Dec. 2012 Bi-annual report		Completed 9 out of the 6 target in 2012 Source: July- Dec Bi-annual report, 2012
	3.2 Early warning system (EWS) for food security and nutrition is piloted in one JP area	3.2.1 Review of existing data on household food security, nutrition and identify gaps/deficiency	Accom-plished Source: CFSN Q4 2010	Accom-plished Source: CFSN Q1, 2011	Comple-ted 4 quarters of data collec-tion. Source: Jan-June 2012 Bi-annual report		Revised output indicator
		3.2.2 Actual piloting of the EWS in Ragay, Camarines Sur	Not accom-plished Source: CFSN Q3, 2010	Not accom-plished Source: CFSN Q1, 2011	Ragay adopted EWS Source: Jan-June 2012		JP area of Pasacao has been proposed but changed to Ragay, Camarines Sur due to poor feasibility of pilot success given the low appreciation of the LGU of the technical assistance. Source: CFSN, Q4, 2010 Ragay completed 2 quarters using LGU funds. Expansion in 5 nearby municipalities using UNICEF-EU funds.
		3.2.3 Monitoring of activities of LGU officials in the actual piloting of EWS	Not accom-plished Source: CFSN Q3, 2010	Not accom-plished Source: CFSN Q1, 2011	Accom-plished Source: CC Report Q1, 2012		Regular quarterly meetings to present data gathered on EWS Source: CC Report Q1, 2012
	3.3 Nutrition information system evaluated	3.5.1 Assessment of nutrition information at LGU level	Not accom-	Accom-plished	Accom-plished		Implementation moved to Year 2.

			plished Source: CFSN Q3, 2010	 Source: CFSN Q1, 2011	(1) Target (1) Source: July-Dec 2012 Bi-annual report		Source: CFSN, Q4, 2010
		3.5.2 Formulation of recommended measures to improve the nutrition information system	Not accom-plished Source: CFSN Q3, 2010	Accom-plished Source: CFSN Q1, 2011	Accom-plished (1) Target (1) Source: July-Dec 2012 Bi-annual report		

ANNEX 4: RESULTS-BASED MATRIX FOR ASSESSING RESULTS ACHIEVEMENT AND CONTRIBUTION

<table>
<tr><th>Expected Results (Outcomes/Outputs)</th><th>Indicators</th><th>Results Accomplished (Change in Indicators)</th></tr>
<tr><td rowspan="2">Outcome 1: Increased exclusive breastfeeding rates in highly urbanized cities and JP municipalities by 20% annually

Revised to:
Increased exclusive breastfeeding (EBF) rate, in 6 JP areas, by at least 20% annually
(source Jan-June 2012 Bi-annual report)</td><td rowspan="2">Based on the interventions that were undertaken, there were two specific targets that were intended:
2) Early initiation on Breastmilk within an hour of delivery
3) Exclusive Breastmilk for infants 0-6 months (with no other liquids)</td><td>Early initiation:
Overall, early initiation to breastfeeding increased by 15.1% during the implementation period. However, the percent of infants initiated to breastfeeding within one-hour declined in Naga City and Iloilo City.
<table>
<tr><th rowspan="2">JP Area</th><th rowspan="2">Baseline</th><th rowspan="2">Endline</th><th colspan="2">Change in indicator</th></tr>
<tr><th>Expected</th><th>Actual</th></tr>
<tr><td>Naga city</td><td>77.0%</td><td>60.4%</td><td>100%</td><td>-17.4%</td></tr>
<tr><td>Iloilo city</td><td>59.5%</td><td>56.4%</td><td>100%</td><td>-3.1%</td></tr>
<tr><td>Zamboanga city</td><td>39.3</td><td>64.8%</td><td>62.8%</td><td>25.4%</td></tr>
<tr><td>Ragay</td><td>43.3%</td><td>64.2%</td><td>69.3%</td><td>20.9%</td></tr>
<tr><td>Carles</td><td>68.2%</td><td>90.0%</td><td>100%</td><td>20.8%</td></tr>
<tr><td>Aurora</td><td>46.6%</td><td>74.9%</td><td>74.6%</td><td>28.3%</td></tr>
<tr><td>Overall</td><td>51.0%</td><td>66.1%</td><td>88.1%</td><td>15.1%</td></tr>
</table>
Source: Baseline Table 9 page 18; Endline Table 8 page 15

The expected increase in early initiation should have grown to 61.2% (Year 1), 73.4% (Year 2) and 88.1% (Year 3). Only Ragay and Aurora municipalities actually achieved the expected targets.</td></tr>
<tr><td>Exclusive breastfeeding 0-6 months:
Overall EBF for 0-6 months increase by 12.2%, compared to expected increase of 13.3%. However, Naga, Iloilo and Aurora actually experience a decline in their EBF rates. Only Ragay municipality achieved the expected target.
<table>
<tr><th rowspan="2">JP Area</th><th rowspan="2">Baseline</th><th rowspan="2">Endline</th><th colspan="2">Change in indicator</th></tr>
<tr><th>Expected</th><th>Actual</th></tr>
<tr><td>Naga city</td><td>50.5%</td><td>24.4%</td><td>80.8%</td><td>-26.1%</td></tr>
<tr><td>Iloilo city</td><td>27.5%</td><td>20.9%</td><td>44.0%</td><td>-6.6%</td></tr>
<tr><td>Zamboanga city</td><td>16.1%</td><td>30.2%</td><td>25.8%</td><td>14.1%</td></tr>
<tr><td>Ragay</td><td>23.3%</td><td>36.0%</td><td>37.3%</td><td>12.7%</td></tr>
<tr><td>Carles</td><td>39.1%</td><td>83.2%</td><td>62.6%</td><td>44.1%</td></tr>
<tr><td>Aurora</td><td>56.5%</td><td>46.9%</td><td>90.4%</td><td>-9.6%</td></tr>
<tr><td>Overall</td><td>22.1%</td><td>34.3%</td><td>35.4%</td><td>12.2%</td></tr>
</table>
Source: Baseline Table 11 page 19; Endline Table 8 page 15</td></tr>
</table>

Outcome 2: Reduced prevalence of under-nutrition by at least 3% among children 6-24 months old by 2012

The JP aimed to contribute towards two specific indicators:

1) **Reduce under-weight for age among children 0-24 months,**
2) **Improve micronutrient status of children 6-24 months, and especially reduce prevalence of anaemia and iron deficiency.**

Anthropometric measures:

The 6 JP areas had mixed results in terms of anthropometric measures. The JP had specifically targeted under-weight for age, and achieved overall improvement of 2.1%, with Zamboanga city actually worsening.

JP Area	Underweight for age		Underlength for age		Underweight for length	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Naga city	17.0	14.0	26.0	18.4	4.1	7.6
Iloilo city	20.1	16.5	29.1	27.0	7.3	4.4
Zambo city	14.8	18.0	19.1	28.3	7.6	8.1
Ragay	19.8	14.4	25.1	17.4	3.2	11.4
Carles	21.8	18.1	37.4	40.1	4.0	3.9
Aurora	11.7	9.5	27.2	27.2	9.4	6.2
Overall	16.2	14.1	22.6	23.7	6.7	7.3

Although the Program did not specify targets for wasting and stunting, the endline survey report noted increases in the prevalence of stunting (1.1%) and wasting (0.6%) at the end of the JP.

Micronutrient status of children 6-23 months.

Although the JP had collected baseline data on anaemia, iron deficiency anaemia and vitamin A deficiency, which was appropriately disaggregated by age group, no similar data was collected for the endline survey. Thus it was not possible to ascertain the specific results in terms of biometric measures.

However, the endline survey noted that the prevalence of anaemia among children 6-24 months old decrease by 2.4% (from 50.9% at baseline to 48.5% at endline).

The endline report also noted that the proportion of children 6-23 months who were fed the minimum acceptable diet was low in all JP areas. The scores for the minimum acceptable diet were relatively higher only in Aurora (68%) and in Ragay (54%); while in the rest of the JP areas, less than half of the target children were fed the minimum acceptable diet. In Zamboanga City, only 29% of the target children were fed the minimum acceptable diet.

Outcome 3: Improved capacities of national and local government and stakeholders to formulate, promote, and implement policies and programs on IYCF	**The final evaluation assumed that the intended indicators for this outcome were:** **1) Enactment of appropriate national laws and policies** **2) passing of appropriate local ordinances**	The notable achievements for outcome 3 were the operationalization of the Milk Code through development and passing of the Implementing Rules and Regulations. The JP was instrumental in advocacy work to strengthen the government's policy work around the milk code and Breastmilk substitutes. At the local level, all JP areas had passed various ordinances to support exclusive breastfeeding and IYCF. In all three cities, ordinances for establishment of lactation stations in companies were passed, and the LGUs were actively supporting with resources, the work of health workers in promoting IYCF. In Ragay municipality, where food security early warning was piloted, the municipality had acquired sufficient capacity and was conducting food security assessment quarterly over the last 2 years of the JP. Recipe trials had also been initiated and were ongoing at the time of drafting, but early indications were that there was wide support for the initiative by local governments.

ANNEX 5: TERMS OF REFERENCE FOR THE FINAL EVALUATION OF MDG-F 2030

GENERAL CONTEXT: THE MDG-F

In December 2006, the UNDP and the Government of Spain signed a major partnership agreement for the amount of €528 million with the aim of contributing to progress on the MDGs and other development goals through the United Nations System. In addition, on 24 September 2008 Spain pledged €90 million towards the launch of a thematic window on Childhood and Nutrition. The MDG-F supports joint programmes that seek replication of successful pilot experiences and impact in shaping public policies and improving peoples' life in 49 countries by accelerating progress towards the Millennium Development Goals and other key development goals.

The MDG-F operates through the UN teams in each country, promoting increased coherence and effectiveness in development interventions through collaboration among UN agencies. The Fund uses a joint programme mode of intervention and has currently approved 128 joint programmes in 49 countries. These reflect eight thematic windows that contribute in various ways towards progress on the MDGs, National Ownership and UN reform.

The MDG-F M&E Strategy

A result oriented monitoring and evaluation strategy is under implementation in order to track and measure the overall impact of this historic contribution to the MDGs and to multilateralism. The MDG-F M&E strategy is based on the principles and standards of UNEG and OEDC/DAC regarding evaluation quality and independence. The strategy builds on the information needs and interests of the different stakeholders while pursuing a balance between their accountability and learning purposes.

The strategy's main objectives are:

1. To support joint programmes to attain development results;
2. To determine the worth and merit of joint programmes and measure their contribution to the 3 MDG-F objectives, MDGS, Paris Declaration and Delivering as one; and
3. To obtain and compile evidence based knowledge and lessons learned to scale up and replicate successful development interventions.

Under the MDG-F M&E strategy and Programme Implementation Guidelines, each programme team is responsible for designing an M&E system, establishing baselines for (quantitative and qualitative) indicators and conducting a final evaluation with a summative focus.

The MDG-F Secretariat also commissioned mid-term evaluations for all joint programmes with a formative focus. Additionally, a total of nine-focus country evaluations (Ethiopia, Mauritania, Morocco, Timor-Leste, Philippines, Bosnia-Herzegovina, Colombia, Honduras and Ecuador) are planned to study more in depth the effects of joint programmes in a country context.

MDG-F 2030 entitled, *Ensuring Food Security and Nutrition for Children 0-24 Months Old in the Philippines,* is a 3-year joint programme which contributes to the achievement of the Millennium Development Goals (MDG) target on halving the 1990 prevalence of underweight children under 5 years old by 2015 (MDG 1 eradicate extreme poverty and hunger), which will also contribute to a reduction in child mortality (MDG 4).

The Philippines battles the continued prevalence of undernutrition; decreasing child mortality rate but steady neonatal mortality rate; and poor infant and young child feeding (IYCF) practices.

- 2008 national nutrition survey conducted by the Food and Nutrition Research Institute reported that about 20.6 percent of Filipino children under 5 years old were underweight-for-age, 32.2 percent were stunted or short for their age, and 6.0 percent were wasted or thin for their height. The 2008 prevalence of underweight under-five children is lower than the 1990 prevalence (27.3 percent). This decline is equivalent to an annual average decrease of 0.37 percentage points per year, which is only about 68 percent of the targeted annual decline to reach the MDG of halving 1990 levels by 2015. This slow decline stresses the need to double efforts in implementing interventions that have been proven to be effective in addressing child undernutrition. Data on undernutrition by single age group shows that undernutrition (underweight-for-age and stunting) are relatively low among infants less than one year old, but significantly higher (at least about 50 percent higher) among one-year olds. Furthermore undernutrition continues to be high among older children. This suggests the need to intervene within the first year of life to prevent child undernutrition.
- The Philippines 4th Progress Report on the MDGs (2010) noted that the country is on track in reducing infant mortality and under-five mortality rates. However, the continued decline in infant and under-five mortality is threatened by the continued and non-changing level of neonatal mortality.
- The National Demographic and Health Surveys (NDHS) reported essentially no change in infant and young child feeding (IYCF) practices between 2003 and 2008. Exclusive breastfeeding prevalence for children <6 months of age was unchanged at 34%. Breastfeeding, with or without complementary food declined further among older infants, reaching an almost negligible level starting from the 8-9 month-old age group. The WHO estimates that the current poor breastfeeding practices in the Philippines result to an additional 1.2 million diarrhoea and pneumonia episodes. Nine out of every 10 deaths among infants below 6 months old occurred among those who were not breastfed. Among the under-fives, 13% of deaths could have been prevented through exclusive breastfeeding.

The joint programme aims to complement government efforts to improve IYCF practices anchored on exclusive breastfeeding in the first six months of life and introduction of complementary feeding from 6 months of age onward with continued breastfeeding. It endeavors to create an enabling environment where optimum IYCF is practiced, promoted, supported and protected by communities and the nation as a whole. It is designed to model IYCF-related initiatives in selected areas in the country for eventual replication nationwide.

The joint programme has 3 outcomes and 19 outputs over a period of 3 years (November 2009 - November 2012).

Outcome 1.	**Increased exclusive breastfeeding rate in the JP areas by 20% annually**
Output 1.1	An evidence-based marketing and advocacy campaign developed and executed nationally and in JP areas
Output 1.2	Exclusive breastfeeding is strengthened as a key component of the National Family Welfare Programme (FWP)
Output 1.3	Strengthened FWP piloted in 3 JP cities
Output 1.4	Models of informal sector workplace interventions for exclusive breastfeeding designed and demonstrated in 3 JP cities

Output 1.5	Local peer counselors nominated and trained
Output 1.6	Home visits conducted by peer support counselors
Output 1.7	Communications for development on IYCF developed and implemented
Output 1.8	Pregnant and lactating women received adequate supply of iron-folic acid tablets
Output 1.9	Human milk bank established in a tertiary hospital
Output 1.10	National standard module for monitoring the Milk Code developed
Outcome 2.	**Reduced prevalence of undernutrition by at least 3% among children 6-24 months old by 2012**
Output 2.1	Resources for counseling on age-appropriate complementary feeding produced
Output 2.2	Recipes from homestead gardens and locally available foods for integration in community / nutrition education activities documented
Output 2.3	Community/household nutrition education activities on improving the quality of diets for complementary foods from homestead gardens and locally available foods conducted
Output 2.4	Improved micronutrient status of all children6-24 months old in the 2 JP areas, through micronutrient powder (MNP) supplementation and proper utilization, as indicated by significant increase in hemoglobin level among beneficiaries
Output 2.5	Increased awareness of LGU functionaries, health workers, households and communities on the need and importance of using MNP in improving the nutritional status of children 6-24 months old.
Output 2.6	Improved capacity of all BHWs and BNSs in 2 JP areas on advising and counseling mothers on the appropriate use of MNP to fortify home-prepared complementary foods for children 6-24 months old
Outcome 3.	**Improved capacities of national and local government and stakeholders to formulate, promote, and implement policies and programs on IYCF**
Output 3.1	Needs assessment on knowledge, attitude and practices on three policies conducted and used for formulating and adjusting policies, and program designs among others.
Output 3.2	Early warning system (EWS) for food security and nutrition is piloted in one JP area
Output 3.3	Nutrition information system evaluated

The JP is implemented through partnership of UN agencies (*World Health Organization, United Nations Children's Fund, World Food Programme, International Labour Organization, Food and Agriculture Organization*); national government agencies *(Department of Health-National Nutrition Council, National Center for Disease Prevention and Control, National Center for Health Promotion, Bureau of International Health Cooperation, National Center for Health Facility Development, Center for Health Development of Regions 5, 6 and 9, Food and Drug Administration*, *Department of Labor and Employment, National Anti-Poverty Commission)*, and the local governments of Naga City, Ragay, Camarines Sur, Iloilo City, Carles, Iloilo, Zamboanga City, and Aurora, Zamboanga del Sur. One of the JP components (communication for behavioral impact or COMBI focuses on exclusive breastfeeding) will be implemented in key urban areas including the National Capital Region, Regions 3, 4A, 7, 8, and 12.

Providing overall leadership in the management of the program is the MDG-F 2030 Programme Management Committee (PMC) with support from the MDG-F 2030 National and Regional (Regions 5, 6, and 9) Technical Working Groups (TWG). The National Nutrition Council, as the country's highest policy-making and coordinating body on nutrition chairs both groups.

The commissioner of the evaluation is seeking high-qualified consultants to conduct the final evaluation, of this joint programme

A. OVERALL GOAL OF THE EVALUATION

One of the roles of the Secretariat is to monitor and evaluate the MDG-F. This role is fulfilled in line with the instructions contained in the Monitoring and Evaluation Strategy and the Implementation Guide for Joint Programmes under the Millennium Development Goals Achievement Fund. These documents stipulate that **all joint programmes will commission and finance a final independent evaluation**.

The final evaluations is **summative** in nature and seeks to:

1. Measure to what extent the joint programme has fully implemented its activities, delivered outputs and attained outcomes and specifically measuring development results.
2. Generate substantive evidence-based knowledge, on one or more of the MDG-F thematic windows by identifying good practices and lessons learned that could be useful to other development interventions at national (scale up) and international level (replicability).

The findings, conclusions and recommendations generated by the evaluation will be part of the thematic window meta evaluation that the Secretariat is undertaking to synthesize the overall impact of the fund at national and international levels.

B. SCOPE OF THE EVALUATION AND SPECIFIC OBJECTIVES

The final evaluation will focus on measuring development results and potential impacts generated by the **joint programme**, based on the scope and criteria included in this term of reference. This will enable conclusions and recommendations for the joint programme to be formed within a period between four and six months.

The unit of analysis or object of study for this evaluation is the joint programme, understood to be the set of components, outcomes, outputs, activities and inputs that were detailed in the joint programme document and in associated modifications made during implementation.

This final evaluation has the following **specific objectives**:

1. Measure to what extent the joint programme has contributed to solve the needs and problems identified in the design phase.
2. Measure joint programme's degree of implementation, efficiency and quality delivered on outputs and outcomes, against what was originally planned or subsequently officially revised.
3. Measure to what extent the joint programme has attained development results to the targeted population, beneficiaries, participants whether individuals, communities, institutions, etc.

4. Measure the joint programme's contribution to the objectives set in the thematic window on child food security and nutrition as well as the overall MDG fund objectives at local and national level. **(MDGs, Paris Declaration and Accra Principles and UN reform**).
5. Identify and document substantive lessons learned and good practices on the specific concerns of the thematic window on child food security and nutrition, MDGs, Paris Declaration, Accra Principles and UN reform to support the sustainability of the joint programme or some of its components.

C. EVALUATION QUESTIONS, LEVELS OF ANALYSIS AND EVALUATION CRITERIA

The evaluation questions define the information that must be generated as a result of the evaluation process. The questions are grouped according to the criteria to be used in assessing and answering them. These criteria are, in turn, grouped according to the three levels of the programme.

Design level

- **Relevance: The extent to which the objectives of the joint programme are consistent with the needs and interest of the people, the needs of the country and the Millennium Development Goals.**

1. To what extent was the design and strategy of the development intervention relevant (assess including link to MDGs, UNDAF and national priorities, stakeholder participation, national ownership design process)?
2. How much and in what ways did the joint programme contribute to solve the (socio-economical) needs and problems identified in the design phase?
3. To what extent was the programme designed, implemented, monitored and evaluated jointly? (see MDG-F joint programme guidelines.)
4. To what extent was joint programming the best option to respond to development challenges stated in the programme document?
5. To what extent did implementing partners participating in the joint programme have an added value to solve the development challenges stated in the programme document?
6. To what extent did the joint programme have a useful and reliable monitoring and evaluation strategy that contributed to measure development results?
7. To what extent did the joint programme have a useful and reliable communication and advocacy strategy?
8. If the programme was revised, did it reflect the changes that were needed? Did the JP follow the mid-term evaluation recommendations on the programme design?

Process level

- Efficiency: Extent to which resources/inputs (funds, time, human resources, etc.) have been turned into results

1. To what extent was the joint programme's management model (i.e. instruments; economic, human and technical resources; organizational structure; information flows; decision-making in management) efficient in comparison to the development results attained?

2. To what extent was the implementation of a joint programme intervention (group of agencies) more efficient in comparison to what could have been through a single agency's intervention?

3. To what extent did the governance of the fund at programme level (PMC) and at national level (NSC) contribute to the efficiency and effectiveness of the joint programme? To what extent were these

governance structures useful for development purposes, ownership, for working together as one? Did they enable management and delivery of outputs and results?
4. To what extent and in what ways did the joint programme increase or reduce efficiency in delivering outputs and attaining outcomes?
5. What type of work methodologies, financial instruments, and business practices have the implementing partners used to increase efficiency in delivering as one?
6. What was the progress of the JP in financial terms, indicating amounts committed and disbursed (total amounts & as percentage of total) by agency? Where there are large discrepancies between agencies, these should be analyzed.
7. What type of (administrative, financial and managerial) obstacles did the joint programme face and to what extent have this affected its efficiency?
8. To what extent and in what ways did the mid-term evaluation have an impact on the joint programme? Was it useful? Did the joint programme implement the improvement plan?
9. What was the progress of the JP in financial terms, indicating amounts committed and disbursed (total amounts & as percentage of total) by agency? Where there are large discrepancies between agencies, these should be analyzed.

- Ownership in the process: Effective exercise of leadership by the country's national/local partners in development interventions

1. To what extent did the targeted population, citizens, participants, local and national authorities make the programme their own, taking an active role in it? What modes of participation (leadership) have driven the process?
2. To what extent and in what ways has ownership or the lack of it, impacted in the efficiency and effectiveness of the joint programme?

Results level

- Effectiveness: Extent to which the objectives of the development intervention have been achieved.

1. To what extent did the joint programme contribute to the attainment of the development outputs and outcomes initially expected /stipulated in the programme document? (Detailed analysis of: 1) planned activities and outputs, 2) achievement of results).
2. To what extent and in what ways did the joint programme contribute:
   a. To the Millennium Development Goals at the local and national levels?
   b. To the goals set in the thematic window?
   c. To the Paris Declaration, in particular the principle of national ownership? (Consider JP's policy, budgets, design, and implementation)
   d. To the goals of delivering as one at country level?
3. To what extent were joint programme's outputs and outcomes synergistic and coherent to produce development results? `What kinds of results were reached?
4. To what extent did the joint programme have an impact on the targeted citizens?
5. Have any good practices, success stories, lessons learned or transferable examples been identified? Please describe and document them.
6. What types of differentiated effects are resulting from the joint programme in accordance with the sex, race, ethnic group, rural or urban setting of the beneficiary population, and to what extent?

7. To what extent has the joint programme contributed to the advancement and the progress of fostering national ownership processes and outcomes (the design and implementation of National Development Plans, Public Policies, UNDAF, etc)
8. To what extent did the joint programme help to increase stakeholder/citizen dialogue and or engagement on development issues and policies?
9. To what extent and in what ways did the mid-term evaluation recommendations contribute to the JPs achievement of development results?

Sustainability: Probability of the benefits of the intervention continuing in the long term.

1. To what extent did the joint programme decision making bodies and implementing partners undertake the necessary decisions and courses of action to ensure the sustainability of the effects of the joint programme?

At local and national level:

   a. To what extent did national and/or local institutions support the joint programme?
   b. Did these institutions show technical capacity and leadership commitment to keep working with the programme or to scale it up?
   c. Have operating capacities been created and/or reinforced in national partners?
   d. Did the partners have sufficient financial capacity to keep up the benefits produced by the programme?

2. To what extent will the joint programme be replicable or scaled up at national or local levels?
3. To what extent did the joint programme align itself with the National Development Strategies and/or the UNDAF?

D. METHODOLOGICAL APPROACH

This final evaluation will use methodologies and techniques as determined by the specific needs for information, the questions set out in the terms of reference and the availability of resources and the priorities of stakeholders. In all cases, consultants are expected to analyse all relevant information sources, such as reports, programme documents, internal review reports, programme files, strategic country development documents, mid-term evaluations and any other documents that may provide evidence on which to form judgements. Consultants are also expected to use interviews, surveys or any other relevant quantitative and/or qualitative tool as a means to collect relevant data for the final evaluation. The evaluation team will make sure that the voices, opinions and information of targeted citizens/participants of the joint programme are taken into account.

The methodology and techniques to be used in the evaluation should be described in detail in the desk study report and the final evaluation report, and should contain, at the minimum, information on the instruments used for data collection and analysis, whether these be documents, interviews, field visits, questionnaires or participatory techniques.

E. EVALUATION DELIVERABLES

The consultant is responsible for submitting the following deliverables to the commissioner and the manager of the evaluation:

1. **Inception Report** (to be submitted within 15 days of the submission of all programme documentation to the evaluation team)

This report will be 10 to 15 pages in length and will propose the methods, sources and procedures to be used for data collection. It will also include a proposed timeline of activities and submission of deliverables. The desk study report will propose initial lines of inquiry about the joint programme. This report will be used as an initial point of agreement and understanding between the consultant and the evaluation managers. The report will follow the outline stated in Annex 1.

2. **Draft Final Report** (to be submitted within 20 days after the completion of the field visit, please send also to MDG-F Secretariat)

The draft final report will contain the same sections as the final report (described in the next paragraph) and will be 20 to 30 pages in length. This report will be shared among the evaluation reference group. It will also contain an executive report of no more than 5 pages that includes a brief description of the joint programme, its context and current situation, the purpose of the evaluation, its methodology and its main findings, conclusions and recommendations. The draft final report will be shared with the evaluation reference group to seek their comments and suggestions. This report will contain the same sections as the final report, described below.

3. **Final Evaluation Report** (to be submitted within 10 days after receipt of the draft final report with comments, a copy of which should also be shared with the MDG-F Secretariat)

The final report will be 20 to 30 pages in length. It will also contain an executive summary of no more than 5 pages that includes a brief description of the joint programme, its context and current situation, the purpose of the evaluation, its methodology and its major findings, conclusions and recommendations. The final report will be sent to the evaluation reference group. This report will contain the sections established in Annex 2.

F. KEY ROLES AND RESPONSABILITIES IN THE EVALUATION PROCESS

There will be 2 main actors involved in the implementation of MDG-F final evaluations:

1. **UNICEF Philippines Evaluation Section** as **commissioner** of the final evaluation will have the following functions:
   a. Lead the evaluation process throughout the 3 main phases of a final evaluation (design, implementation and dissemination)
   b. Convene the evaluation reference group
   c. Lead the finalization of the evaluation terms of reference
   d. Coordinate the selection and recruitment of the evaluation team by making sure the lead agency undertakes the necessary procurement processes and contractual arrangements required to hire the evaluation team
   e. Ensure the evaluation products meet quality standards (in collaboration with the MDG-F Secretariat)
   f. Provide clear specific advice and support to the evaluation manager and the evaluation team throughout the whole evaluation process
   g. Connect the evaluation team with the wider programme unit, senior management and key evaluation stakeholders, and ensure a fully inclusive and transparent approach to the evaluation

h. Take responsibility for disseminating and learning across evaluations on the various joint programme areas as well as the liaison with the National Steering Committee
i. Safeguard the independence of the exercise, including the selection of the evaluation team

2. The **programme coordinator** MDG-F will have the following functions:
   a. Contribute to the finalization of the evaluation terms of reference
   b. Provide executive and coordination support to the reference group
   c. Provide the evaluators with administrative support and required data
   d. Liaise with and respond to the commissioners of evaluation
   e. Connect the evaluation team with the wider programme unit, senior management and key evaluation stakeholders, and ensure a fully inclusive and transparent approach to the evaluation
   f. Review the inception report and the draft evaluation report(s);
   g. Ensure that adequate funding and human resources are allocated for the evaluation

3. **The co-chairs of the Programme Management Committee and selected members of the NTWG and partners** that will function as the **evaluation reference group as follows (TBD):**

Name	Alternates	Agency
1. Asst. Secretary Maria Bernardita T. Flores		DOH-NNC (PMC Chair)
2. Mr. Tomoo Hozumi	Dr. Soe Nyut-U	UNICEF/WHO (PMC Co-chairs)
3. Ms. Maria Lourdes A. Vega		DOH-NNC (National TWG Chair)
4. Mr. Henry Mdebwe		UNICEF (National TWG Co-Chair)
5. Undersecretary Florencia Dorotan		NAPC
6. Ms. Maria Evelyn Lita P. Manangan	Mr. Romulo C. Brillantes	DOLE-BWSC
7. Ms. Juliet D.R. Labitigan		WHO
8. Ms. Ginger de Guzman-Caranto	Ms. Concepcion Sardana	ILO
9. Ms. Roselie E. Asis	Carleneth Valentin	WFP
10. Ms. Maria Cecilia F. Pastores	Aristeo Portugal	FAO
11. Dr. Ofelia Saniel		UP College of Public Health (Academe partner)
12. Ms. Iza Abeja	TBD	Beauty, Brains, and Breastfeeding/LATCH/ARUGAAN (CSO partner)
13. For id of WHO		
14. For id of ILO	TBD	ECOP/TUCP (CSO partners)
15. Ms. Roda B. Valenzuela	CFSN National JP Coordinator	DOH-NNC

This group will comprise the representatives of the major stakeholders in the joint programme

a. Review the draft evaluation report and ensure that the final draft meets the required quality standards.
b. Facilitate the participation of those involved in the evaluation design
c. Identify information needs, define objectives and delimit the scope of the evaluation.
d. Provide input and participate in finalizing the evaluation Terms of Reference
e. Facilitate the evaluation team's access to all information and documentation relevant to the intervention, as well as to key actors and informants who should participate in interviews, focus groups or other information-gathering methods
f. Oversee progress and conduct of the evaluation and ensure the quality of the process and the products
g. Disseminate the results of the evaluation

4. **The MDG-F Secretariat** that will also function as a **quality assurance member** of the evaluation in cooperation with the commissioner of the evaluation

- Review and provide advice on the quality the evaluation process as well as on the evaluation products (comments and suggestions on the adapted terms of reference, draft reports, final report of the evaluation) and options for improvement.

5. **The evaluation team** will conduct the evaluation study by:

Fulfilling the contractual arrangements in line with the terms of reference, UNEG/OECD norms and standards and ethical guidelines. This includes developing an evaluation matrix as part of the inception report, drafting reports, and briefing the commissioner and stakeholders on the progress and key findings and recommendations, as needed