Evaluation of the Philippine Multisectoral Nutrition Project (PMNP)

Midline Report | May 2026

Organisation commissioning the evaluation
Republic of the Philippines – Department of Health

Organisation conducting the evaluation
UNICEF

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Contents

Exhibits

List of acronyms

ACT	Area Coordinating Teams
AiD	Associates in Development
AIP	Annual Investment Plan
AIR	American Institutes for Research
BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
BCG	Bacillus Calmette–Guérin
BHW	Barangay Health Worker
BNAP	Barangay Nutrition Action Plans
BNC	Barangay Nutrition Committees
BNS	Barangay Nutrition Scholar
CDD	Community-Driven Development
CEAC	Community Empowerment Activity Cycle
CHD	Center for Health and Development
CNSPMC	Community Nutrition Sub-Project Management Committees
CSO	Civil Society Organisation
CV	Community Volunteers
DA	Department of Agriculture
DAC	Development Assistance Committee
DBM	Department of Budget Management
DEPDev	Department of Economy, Planning, and Development
DILG	Department of the Interior and Local Government
DMO	Development Management Officers
DOH	Department of Health
DOST	Department of Science and Technology
DQC	Data Quality Checks
DSWD	Department of Social Welfare and Development
EBF	Exclusive Breastfeeding
ECCD	Early Childhood Care and Development
EQ	Evaluation Questions
FDS	Family Development Sessions
FGD	Focus Group Discussions
FHSIS	Field Health Services Information System
FNRI	Food and Nutrition Research Institute
FPIC	Free, Prior and Informed Consent
GIDA	Geographically Isolated and Disadvantaged Areas
GTWA	Geotagging Web Application
HAZ	Height-for-age-Z-score
HCA	Human Capital Asia
HCSC	Household Convergence Scorecard
HPO	Health Provincial Officers
HSS	Health Sector Strategy

IATF-ZH	Inter-Agency Task Force on Zero Hunger
IEC	Information, Education, and Communication
IFA	Iron-Folic Acid
IPs	Indigenous peoples
IRB	Institutional Review Board
IYCF	Infant And Young Child Feeding
KALAHI-CIDSS	Kapit-Bisig Laban sa Kahirapan Comprehensive and Integrated Delivery of Social Services
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interviews
KMITS	Knowledge Management Information Technology Service
LANA	Landscape Analysis and Nutrition Situation Assessment
LCE	Local Chief Executives
LDI	Learning and Development Intervention
LDN	Lanao Del Norte
LGUs	Local Government Units
LNAP	Local Nutrition Action Plan
LNC	Local Nutrition Committees
M&E	Monitoring and Evaluation
MAD	Minimum Adequate Diet
MAM	Moderate Acute Malnutrition
MCHN	Maternal and Child Health and Nutrition
MELLPI	Monitoring and Evaluation of Local Level Plan Implementation
MGA	Municipal Grant Allocations
MIAC	Municipal Inter-Agency Committee
MMR	Measles, Mumps, and Rubella
MMS	Multiple Micronutrient Supplementation
MNAO	Municipal Nutrition Action Officer
MNAP	Municipal Nutrition Action Plans
MNC	Municipal Nutrition Committee
MPDO	Municipal Planning and Development Office
MUAC	Mid-Upper Arm Circumference
NC	Nutrition Committee
NCIP	National Commission on Indigenous Peoples
NEDA	National Economic and Development Authority
NGO	Non-Government Organisation
NIE	Nutrition in Emergencies
NLG	Nutrition Leadership and Governance
NNC	National Nutrition Committee
NPHC	Nutrition and Primary Health Care
NPMO	National Project Management Office
NTWG	National Technical Working Group

OECD	Organisation for Economic Co-operation and Development
OPT+	Operation Timbang Plus
OPV	Oral Polio Vaccine
OR	Odds Ratio
PBG	Performance-Based Grants
PCF	Primary Care Facility
PDOHO	Provincial Department of Health Officers
PHC	Primary Health Care
PIMAM	Philippine Integrated Management of Acute Malnutrition
PIMS	Project Information Management System
PMNP	Philippine Multisectoral Nutrition Project
PMO	Project Management Offices
POM	Project Operations Manual
PPAN	Philippine Plan of Action for Nutrition
PWD	People With Disabilities
RA	Republic Act
RHU	Rural Health Unit
RPMO	Regional Project Management Office
RTWG	Regional Technical Working Group
RUSF	Ready-to-use Supplementary Food
RUTF	Ready-to-use Therapeutic Food
SAM	Severe Acute Malnutrition
SBC	Social and Behaviour Change
SDG	Sustainable Development Goals
SJREB	Single Joint Research Ethics Board
ToC	Theory of Change
TOR	Terms of Reference
TOT	Training of Trainers
TPV	Third-Party Verification
TUPAD	Tulong Panghanapbuhay sa Ating Disadvantaged Workers
UHC	Universal Health Care
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UPLBFI	University of the Philippines – Los Banos Foundation Inc.
WASH	Water, Sanitation, and Hygiene
WFL/H	Weight-for-Length/Height
WHZ	Weight-for-Length/Height-Z-Score
ZDS	Zamboanga Del Sur
ZOD	Zero open defecation

Executive summary

National nutrition surveys in the Philippines show that malnutrition, stunting, wasting, micronutrient deficiencies – and, simultaneously, obesity – are key issues affecting Filipino children's health. Recently, the Government of the Philippines has taken executive action through a country loan from the World Bank to address these issues by launching the Philippine Multisectoral Nutrition Project (PMNP). PMNP is a multisectoral programme implemented by the Department of Health (DOH) and the Department of Social Welfare and Development (DSWD) that seeks to increase access to and utilization of a package of evidence-based nutrition-specific and nutrition-sensitive interventions designed to improve health and nutrition outcomes, particularly for pregnant women, women of reproductive age and children.

PMNP aims to improve key health behaviours and practices known to reduce stunting through a coordinated package of nutrition-specific and nutrition-sensitive interventions together with a Social and Behaviour Change (SBC) strategy. PMNP focuses on strengthening health service delivery, multisector nutrition convergence, and institutional strengthening to provide an enhanced and comprehensive approach to national nutrition goals.

DOH commissioned UNICEF Philippines to conduct a rigorous mixed methods impact and process evaluation of PMNP. This is the midline process evaluation of PMNP, conducted from September to October 2025, following the baseline assessment conducted from August to October 2024 as part of the broader impact evaluation, to assess the programme's relevance, coherence, effectiveness and efficiency, and to provide evidence on the up-to-date performance of its components—particularly regarding governance, service delivery, and financing. The evaluation reviews PMNP's implementation process (including barriers and facilitators to successful implementation) and overall performance at the programme's midpoint and offers preliminary insights on sustainability. Findings will guide adjustments to the current project to ensure the achievement of objectives by the end of the implementation period, will guide the conduct of the ongoing PMNP M&E activities including the endline evaluation, and will serve as input to scale up PMNP to other areas of the country. UNICEF partnered with institutional contractor, American Institutes for Research (AIR), to co-design and undertake the evaluation.

The Philippine Multisectoral Nutrition Project (PMNP)

Funded by a US $178 million loan from the World Bank and the Philippine Department of Finance, PMNP aims to deliver a coordinated package of

nutrition-specific and nutrition-sensitive interventions supported by a Social and Behaviour Change Strategy (SBC). PMNP implementation sites include 235 municipalities and 5,936 barangays in 12 regions and 26 provinces including 40 municipalities from three provinces in the Bangsamoro Autonomous Region in Muslim Mindanao, targeting Local Government Units (LGUs) with high levels of childhood stunting and poverty, among other criteria. The primary PMNP participants are households with pregnant women and children 0-23 months old, and additional participants include women of reproductive age, indigenous peoples (IPs), children with disabilities and low-income households. PMNP launched in 2021, and implementation is projected to last through 2026.

The end objective of PMNP is to improve key health behaviours and practices known to reduce stunting in the targeted LGUs through increasing the use of the package of interventions. With a focus on nutrition interventions at the point of pregnancy, birth, and the first years of a child's life, PMNP builds on the efforts of the First 1,000 Days Law (RA 11148) as well as community-driven development initiatives of the DSWD's Kapit-Bisig Laban sa Kahirapan Comprehensive and Integrated Delivery of Social Services (Kalahi-CIDSS) project.

The five core project indicators are:

1. Percentage of pregnant women who have received complete iron-folic supplements or Multiple Micronutrient supplementation
2. Percentage of pregnant women in project areas receiving prescribed antenatal care services from the first trimester of pregnancy
3. Percentage of households in participating barangays with convergence of priority nutrition-specific interventions nutrition-sensitive interventions
4. Percentage of children 6-23 months of age in project areas who meet the minimum age-appropriate diet
5. Percentage of households in project areas with access to improved toilets

PMNP comprises three main components: (a) strengthened delivery of nutrition and primary health services; (b) community-based nutrition service delivery and multisectoral nutrition convergence; and (c) institutional strengthening, monitoring and evaluation (M&E) and communication.

Evaluation purpose

The main purpose of this mixed-methods midline process evaluation is to provide relevant stakeholders with evidence to improve the implementation of PMNP and its effectiveness in addressing malnutrition and caregivers' behaviours that enable this change as well as to identify lessons learned for programmatic adjustments while the programme delivery is still underway. These insights will be crucial to shaping future multisectoral nutrition initiatives aimed at improving the country's nutrition outcomes.

Evaluation objectives

The specific objectives of this midline evaluation are:

- To assess PMNP implementation status and identify challenges faced during implementation that may have prevented the programme from meeting expectations so far
- To provide evidence for necessary adjustments to strategies, interventions or resource allocations by highlighting both strengths and weaknesses

Additionally, given the central role of capacity-building interventions within PMNP, UNICEF expanded the midline evaluation scope to include the following objectives:

- Examine whether capacity-building activities are sensitive to the needs of primary care facility (PCF) staff, local chief executives (LCEs), and Local Nutrition Committees (LNCs)
- Examine whether capacity-building activities have improved the Knowledge, Attitudes and Practices (KAP) of Primary Health Care (PHC) providers and governance capacity of LCEs and LNCs regarding nutrition programming
- Assess whether PMNP implementation is coherent with local plans, policies, and programming, and identified any duplication of efforts

Evaluation intended users

The primary audience for this midline evaluation consists of policymakers and the main implementing agencies within the Government of the Philippines (i.e., the duty bearers) including the DOH and the DSWD. Other key stakeholders in the country are UNICEF, the World Bank, the PMNP lender, and the Department of Finance who provides financial oversight on all foreign-assisted projects in

the Philippines. The secondary audience comprises other actors in the nutrition and health space including, the National Nutrition Council (NNC), the Food and Nutrition Research Institute (FNRI), the Department of Economy, Planning, and Development (DEPDev, formerly the National Economic and Development Authority (NEDA), academia, as well as non-governmental organizations. Additional secondary audiences include the Southeast Asia region and the global level. Lastly, PMNP targeted communities, their local government, their children, women, and families (i.e., the rightsholders or beneficiaries) are also stakeholders who stand to benefit from the evaluation's findings. The evidence generated through this evaluation will play a vital role in enhancing knowledge and raising awareness regarding the effectiveness of multisectoral nutritional programming.

Midline evaluation methodology

The research team used a mixed-methods design, emphasizing data triangulation to answer midline evaluation questions and understand both programme processes and outcomes. As part of the desk review, the research team examined PMNP documents, training curricula, competency frameworks, and PMNP monitoring data. Qualitative methods included key informant interviews with national and local officials, implementing partners and health providers to explore relevance, coherence, efficiency, and sustainability, focus group discussions with pregnant women, parents, and service providers to capture experiences and perceptions of PMNP interventions and case studies with training implementers and participants to assess alignment and impact of capacity-building activities. The quantitative methods used were embedded into case studies to assess the effectiveness of the capacity building on nutrition and PHC, and nutrition leadership and governance. The research team administered knowledge assessments to health providers to measure skills in nutrition and maternal and child health (including management of acute malnutrition), conducted direct observations of providers to examine their practices and skills during growth monitoring sessions, infant and young child feeding (IYCF) counselling and prenatal checkups, and assess the availability of equipment and resources influencing service quality through a health facility checklist.

Key midline findings

The mixed-methods evaluation assessed PMNP along five Organisation for Economic Co-Operation and Development – Development Assistance Committee (OECD-DAC) criteria. A summary of results for each criterion is presented below:

Relevance

- *POM revisions (Oct 2024) improved fit to LGU needs*—The revised PMNP Project Operations Manual (POM) strengthened implementation by expanding guidance on digital systems, monitoring and evaluation, procurement, and sustainability, while adding a new chapter on integrated information systems to improve nutrition data management.
- *Multisectoral design is appropriate at barangay/LGU level*—Stakeholders widely viewed the multisectoral approach—combining health, Water, Sanitation, and Hygiene (WASH), Early Childhood Care and Development (ECCD), and SBC—as essential for addressing nutrition challenges, with planning tools like Municipal Nutrition Action Plans (MNAPs) and Barangay Nutritional Action Plans (BNAPs) helping embed nutrition priorities into local governance and budgets.
- *Integrated National and Primary Healthcare (NPHC) training content aligns with provider needs*—The Integrated NPHC training was highly relevant to PHC staff, addressing gaps in child growth monitoring, maternal nutrition, and emergency response, though its condensed format limited mastery of practical skills and highlighted the need for refresher courses and additional structured supervision of PHC staff.
- *Nutrition Leadership & Governance (NLG)*— Capacity-building activities for local leaders, including the Executive Forum for Mayors, NLG training, and MNAP workshops, were effective in raising the prioritization of nutrition, strengthening evidence-based planning, and improving governance at municipal and barangay levels.

Coherence

- *Strong policy alignment*—PMNP programming mirrors RA 11148 (First 1,000 Days), Philippine Plan of Action for Nutrition (PPAN) 2023–2028, Universal Health Care/Health Sector Strategy (HSS), and DSWD Strategy Map; complements existing DOH/DSWD platforms (e.g., 4Ps, Kalahi CIDSS).
- *Vertical & horizontal coordination structures function but uneven*—National Technical Working Group (NTWG)/Regional Technical Working Group (RTWG)/Regional Project Management Office (RPMO) mechanisms enable cross sector coordination; yet regional/national fragmentation and overloaded DOH staff create gaps.
- *Systems compatibility is partial*—PMNP leverages the field health services information system (FHSIS), Operation Timbang Plus (OPT+), monitoring

and evaluation of local level plan implementation (MELLPI Pro), geotagging web application (GTWA), project information management system (PIMS), ECCD checklist, iClinicSys electronic medical record (EMR,) and introduces the Household Convergence Scorecard (HCSC); but adoption and integration are inconsistent, with manual data flows common.

- *Value-add without duplication*—PMNP expands and harmonizes existing initiatives (e.g., WASH/ECCD via Kalahi CIDSS, SBC through family development sessions (FDS), though misaligned timelines between Components 1 and 2 may have reduced synergy.

Effectiveness

- *Improved service delivery*—Evidence suggests that PMNP has improved service delivery as facilities are better equipped and have more trained staff.
- *Skills improved, practices lagged*—Knowledge gains (notably the Philippine Integrated Management of Acute Malnutrition (PIMAM) and Nutrition in Emergencies (NiE) are clear, but direct observations show persistent accuracy gaps in growth monitoring and counselling.
- *Service utilization is mixed*—Strong coverage for Vitamin A, ANC/PNC, and growth monitoring; SBC reach is modest.
- *Governance advanced but uneven*—MNAP/BNAP drafting and budgeting progressed; however, functional Nutrition Committees (NCs) are present in less than half of PMNP municipalities.
- *Regional heterogeneity*—Staffing, supplies, and SBC participation vary widely by region; targeted support is required to close gaps.

Efficiency

- *Initial signs of cost effectiveness*—PMNP demonstrated cost efficiencies by leveraging existing programmes, structures, and systems (Kalahi CIDSS, municipal nutrition committees (MNCs), MNAP cycles) and condensed trainings. MNCs coordinate and reduce duplication, though their existence and functionality notably vary by municipality. Selective resource sharing examples show potential efficiency gains when multisector ties are actively leveraged. These efficiency findings indicate how the PMNP model enables efficient use of resources, increasing its likelihood of demonstrating value-for-money. Endline cost-effectiveness findings will be necessary to confirm this.

- *Programme implementation experienced widespread delays*—Procurement and funding delays (e.g., Performance-Based Grant (PBG) tranche timing, Department of Budget Management (DBM) cycles) caused cascading schedule slippage and staff retention issues. Activities were differently affected, with several being delayed by up to 6 months.

Sustainability

- *Institutionalization advancing*—capacity building and the embedding of MNAPs/BNAPs suggest durability; stakeholders expressed intent to continue activities, though at a reduced scale without PMNP support.
- *Key risks*—LGU budget constraints, staffing shortages/turnover (Barangay Health Workers (BHW)/Barangay Nutrition Scholars (BNS)/Municipal Nutrition Action Officers (MNAO), lack of formal handover/transition plans, and partial digital integration (HCSC interoperability).
- *Scale up potential with conditions*—approach is scalable if funding, dedicated technical assistance and monitoring roles, and cross agency coordination are secured; alignment of training with DOH certification[1] and system interoperability are prerequisites.

Conclusions

The main finding section follows the order of the OECD-DAC evaluation criteria. However, upon request of the government, the research team collated the findings in this executive summary from the individual OECD-DAC criteria to generate the high-level midline findings along the three main PMNP implementation pathways: 1) governance, 2) service delivery, and 3) financing. Overall, PMNP has driven notable improvements in each of these areas, laying the foundation for multisectoral nutrition programming. However, sustaining these achievements will require continued investment, capacity building, and systemic alignment across all levels of government.

Governance

PMNP significantly strengthened nutrition governance through integrated health, WASH, ECCD and 4Ps, technical assistance, and Performance-Based Grants (PBGs). Key achievements include full MNAP compliance, 100% alignment of municipal budgets with PMNP standards, and PHP 1.07 billion in grants distributed to 235 municipalities. Nutrition committees, MNAPs, and

[1] Accreditation for PhilHealth SAM OTC Benefit Package

leadership training improved planning and accountability. However, challenges persist including fragmented coordination at national/regional levels, manual data systems, staff shortages, and political tensions. Sustainability risks include staff turnover, lack of dedicated monitoring roles, and limited local capacity for fund allocation.

Service delivery

Training improved health workers' skills in malnutrition diagnosis and culturally appropriate SBC, though shortened sessions reduced mastery and retention. PMNP addressed supply gaps and promoted facility-based deliveries, while convergence mechanisms enhanced multisectoral collaboration at local levels. Despite progress—such as the 4,884 WASH and ECCD completed subprojects and expanded access to essential medicines—regional disparities, resource constraints, and volunteer turnover, which has been consistently high, remain. Sustaining gains requires refresher training, digital integration, and targeted support for under-resourced areas.

Financing

Nutrition planning is increasingly being institutionalized at the municipal level, with 100% of PMNP municipalities producing enhanced MNAPs, which include budgeted nutrition-sensitive and nutrition-specific programs that are integrated into the LGU's Annual Investment Plans (AIPs). PBGs incentivized MNAP compliance and supported service delivery, complementing RA 11148. Yet sustainability is threatened by persistent LGU budget constraints, delayed staff payments, and reliance on external funding. Limited resources for WASH and ECCD and unsynchronized implementation resulting from funding delays at the national level hinder full integration. Without additional funding and stronger coordination, PMNP's financial gains may not endure beyond programme support.

Recommendations

The table below presents recommendations that were initially developed based on the midline findings and subsequently discussed, validated, and amended in consultation with key stakeholders and through formal written feedback.

#	PMNP COMPONENT(S)	RECOMMENDATION	RESPONSIBLE PARTY
1	1	Clarify how PMNP intends to target and meet the needs of people with disabilities. Train service providers including nurses, midwives, and BHWs	DOH and UNICEF

		and build their capacity to engage with PWD populations in the project's targeted municipalities.	
2	1	Provide additional structured supervision and support to ensure that improved PCF staff *knowledge* translates to improve *practices* as well. This could include additional hands-on training, formal mentoring, and structured supervision to ensure that enhanced knowledge is applied during health and nutrition service delivery.	DOH and UNICEF
3	1	Explore options to expand the training for PCF workers to better align with DOH's and potentially facilitate certification for trainees. While there are time and resource constraints to be mindful of, better alignment between PMNP trainings and existing DOH trainings would facilitate continuity and sustainability beyond PMNP.	DOH and UNICEF
4	1, 3	Support the establishment and proper functioning of Nutrition Committees (less than half of PMNP municipalities have them) and undertake a close examination of the main constraints preventing NCs from becoming fully functional according to DILG Memorandum Circular 2018-42.	DOH and NNC
5	1	Provide targeted support to regions and municipalities that have under-delivered on monitoring indicators. Monitoring data suggest wide variation in the execution of PMNP activities, and therefore a combination of monitoring and targeted technical assistance could be included as part of PMNP CONNECT. To facilitate proper monitoring, it is suggested bringing on a dedicated MEL partner to support continuous feedback loops or undergoing a high-quality process evaluation to identify bottlenecks in real time.	DOH, and DSWD
6	1,2,3	Related to Recommendation # 5, expand and centralize the existent PMNPs monitoring framework. For all project components, include three types of indicators: 1) resource use indicators, 2) process indicators, and 3) beneficiary utilization indicators. Set up a dashboard to track progress in real time and identify municipalities requiring targeted assistance. **Annex G** provides additional, detailed recommendations on the monitoring framework.	DOH and DSWD
7	1	Conduct a "postmortem" to identify the core procurement issues that delayed the distribution of PMNP supplies (including life-saving therapeutic commodities such as RUTF and RUSF) and grant funds so that future procurement and grants distribution run more smoothly. ○ At the national level, ensure adherence to the PBG timeline to prevent service disruptions,	DOH

		personnel issues, and eroded trust at the municipal level. ○ At the local level, invest in the administrative capacity of LGUs (particularly the ones lagging in terms of resource execution) to ensure timely procurement following PBG disbursement.	
8	1,3	Provide basic digital literacy training to PCF staff and community volunteers to ensure they are comfortable with digital data collection and can properly and safely record and transmit digital health information. This recommendation should also improve workload for service providers, many of whom complain about the extra work that PMNP entails.	DOH
9	3	Support the digitization of current manual data collection methods (for FHSIS, OPT+, MELLPI Pro, HCSC, ECCD checklist, and other systems currently reliant or partially reliant on manual data collection) to facilitate an integrated data ecosystem, including government systems such as KMITs. Prioritize basic digital literacy training for frontline workers to ensure they have the skills needed to operate tablets, computers, and other data collection tools.	DOH and DSWD
10	1,2,3	Formalize sustainability and handover plans, perhaps mimicking the Kalahi-CIDSS which requires a detailed MOA when leaving an LGU. Specifically, DOH and DSWD should formalize sustainability agreements with LGUs, similar to the Kalahi-CIDSS MOA, to ensure a clear transition of personnel and funding responsibilities before the current project closes in 2026.	DOH and DSWD
11	3	Strengthen the compatibility of the Convergence Score Card with existing systems, such as KMITS, and establish a clear handover plan for continuing the Convergence Score Card after PMNP concludes.	DOH
12	1	Consider ways to further culturally contextualize SBC messages during PMNP CONNECT, especially for IP communities, to address specific local resistance to vaccines and exclusive breastfeeding practices.	DOH and UNICEF
13	2	Consider expanding the menu of nutrition-sensitive Component 2 subproject available to communities to better respond to their actual needs. In addition, coordination between DOH and DSWD should be present at all levels to ensure efficiency and service convergence.	DSWD and DOH

1. Introduction

Despite considerable economic growth over the past decade, poverty rates and inequality remain persistent in the Philippines. Recent national nutrition surveys show that malnutrition, stunting, wasting, micronutrient deficiencies – and, simultaneously, obesity – are key issues affecting Filipino children's health. Stunting, in particular, is a high-priority public health problem in the country, with the stunting rate amongst children under 5 years old surpassing the Southeast Asia regional average (27.4%).[2] Average stunting rates place the Philippines amongst the top 10 countries in the world with the highest number of stunted children.[3]

The Government of the Philippines has taken action to address these issues through the PMNP, a multisectoral programme implemented by the DOH and the DSWD that seeks to increase access to and utilization of a package of evidence-based nutrition-specific and nutrition-sensitive interventions designed to improve health and nutrition outcomes, particularly for pregnant women, women of reproductive age and children.

DOH commissioned UNICEF Philippines to conduct a rigorous mixed methods impact and process evaluation of PMNP to answer a comprehensive set of questions around relevance, coherence, effectiveness, efficiency, impact and sustainability, based on the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) criteria (see Exhibit 2.4.1). UNICEF partnered with its institutional contractor, American Institutes for Research (AIR), to co-design and undertake the evaluation.

As part of this broader impact evaluation, a midline process evaluation, the focus of this report, was conducted to address the relevance, coherence and efficiency of PMNP's implementation to-date as well as to provide evidence to support the effectiveness of the intervention components particularly as they related to strengthened governance, service delivery and financing. In addition to describing the fidelity and success of the programme's implementation midway through the period of performance, this report also provides preliminary insights into questions around the sustainability of PMNP. Results from this midline evaluation will be used to inform any necessary programme implementation adjustments to facilitate the successful attainment of PMNP's

[2] Gaupholm, Josephine et al., 'Exploring the double burden of malnutrition at the household level in the Philippines: Analysis of National Nutrition Survey data', *PLoS One*, 18(7), 17 July 2023, <doi: 10.1371/journal.pone.0288402>

[3] Mbuya, Nkosinathi V.N., Piza, Sharon Faye A., Adona, Ann Jillian, V., 'Undernutrition in the Philippines: Scale, Scope, and Opportunities for Nutrition Policy and Programming', *International Development in Focus*, World Bank, 30 April 2021, <http://hdl.handle.net/10986/35530>

overarching objectives. The remainder of this report is structured to provide a high-level background on the nutritional status of women and children in the Philippines followed by a brief description of PMNP and its activities.

This report then describes the intended purpose of the midline evaluation including the evaluation objectives and scope, the theory of change (ToC) guiding the programme as well as the evaluation, the questions this evaluation sought to answer, and the intended users of the results. Next, this report describes the evaluation approach detailing both the quantitative and qualitative methodologies employed, specifics of the data collection process, and finally the findings organized by OECD-DAC criteria. This report concludes by collating the results across criteria and summarizing the key takeaways, lessons learned and recommendations group by implementation pathway—governance, service delivery, and financing—for ease of use by government and UNICEF partners.

1.1 Context

The Philippines faces a triple burden of malnutrition with persistently high levels of undernutrition and rapidly rising levels of overnutrition.[4] In the past 30 years, wasting and stunting rates have been nearly flat: the stunting and wasting rates amongst children under 5 in 2023 (23.6% and 5.6%, respectively) were statistically equivalent to their 2021 levels (26.7% and 5.5%, respectively).[5] Stunting, in particular, is a high-priority public health problem in the country. Average stunting rates place the Philippines amongst the top 10 countries in the world with the highest number of stunted children.[6]

Beyond visible measures of undernutrition, rates of micronutrient deficiency are also high in the Philippines, especially amongst pregnant or nursing women and children under the age of 5. An estimated 70 to 80% of adults fall short of the recommended nutrient intakes for many vital micronutrients, including iron, calcium and vitamin A.[7] Anaemia rates amongst pregnant women and

[4] CJ Peradilla, How communities in the Philippines are working to combat child malnutrition: Macalelon's commitment to nutrition for every child, UNICEF Philippines, [accessed January 2026] https://www.unicef.org/philippines/stories/how-communities-philippines-are-working-combat-child-malnutrition

[5] Food and Nutrition Research Institute (FNRI). 2024. National Nutrition Summit: Key Findings from the 2023 National Nutrition Survey. Monograph.

[6] Mbuya, Nkosinathi V.N., Piza, Sharon Faye A., Adona, Ann Jillian, V., 'Undernutrition in the Philippines: Scale, Scope, and Opportunities for Nutrition Policy and Programming', *International Development in Focus*, World Bank, 30 April 2021, <http://hdl.handle.net/10986/35530>

[7] Gaupholm, J., Dodd, W., Papadopoulos, A., & Little, M. (2023). Exploring the double burden of malnutrition at the household level in the Philippines: Analysis of National Nutrition Survey data. *PloS one*, *18*(7), e0288402.

children are also concerning. Estimates indicate that anaemia rates are 38% amongst infants 6 to 11 months old, 26% amongst children 12–23 months, and 45% for pregnant women.[8]

The Philippines has also witnessed a rapid rise in overnutrition rates (e.g., overweight, obesity) and associated chronic diseases (e.g., hypertension, diabetes) in the past 30 years. Recent data indicate a doubling of overweight and obesity rates amongst adults, from 17 to 36% between 1993 and 2021.[9] Likewise, data demonstrate more than a doubling of overweight and obesity rates amongst adolescents in the Philippines, from 5% in 2003 to 13% in 2021.[10] Nevertheless, overweight and obesity rates amongst children under 5 have declined slightly in recent years, from 5 to 3.9% between 2013 and 2021.[11] Children and adolescents in upper wealth quintiles have higher rates of overweight and obesity, with a 25.6% rate among adolescents in the richest quintile.[12]

The Philippine Plan of Action for Nutrition (PPAN) 2023-2028 identified three underlying determinants of poor nutrition outcomes in the country: food access and quality, feeding practices and behaviour, and nutrition services access and quality (see Exhibit 1.1.1).[13] As a result of these factors, Filipinos broadly experience suboptimal dietary intake, both in terms of quality and quantity, and suboptimal care due to inadequate services and poor care-seeking behaviours. The PPAN highlighted how access to resources, cultural norms and the policy environment can exacerbate the three underlying determinants of poor nutrition.

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[8] Mbuya, Piza, & Adona, 2021; Alem, A.Z., Efendi, F., McKenna, L. et al. Prevalence and factors associated with anemia in women of reproductive age across low- and middle-income countries based on national data. Sci Rep 13, 20335 (2023). https://doi.org/10.1038/s41598-023-46739-z

[9] DOST-FNRI, 2022; Hsu, Wan-Chen, de Juras, Aileen R., & Hu, Susan, C., 'Prevalence and Determinants of Multiple Forms of Malnutrition among Adults with Different Body Mass Index: A Population-Based Survey in the Philippines' BioMe*d research international*, 26 May 2023, <doi.org/10.1155/2023/3182289>

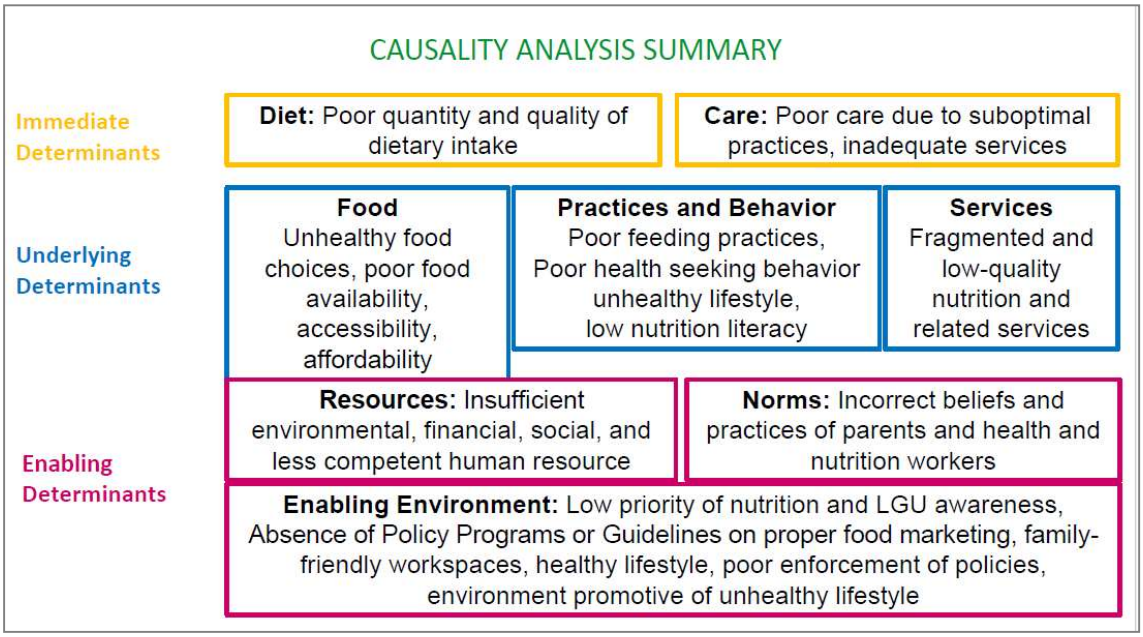
[10] DOST-FNRI, 2022; United Nations Children's Fund, 'Everybody Needs to Act to Curb Obesity: DOH and Development Partners Call for a Whole-of-Society Approach to Reduce Obesity in the Philippines', UNICEF, 4 March 2022, <www.unicef.org/philippines/press-releases/everybody-needs-act-curb-obesity>

[11] DOST-FNRI, 2022; Mbuya, Piza, & Adona, 2021

[12] DOST-FNRI, 2022; Mbuya, Piza, & Adona, 2021

[13] Philippines National Nutrition Council (NNC), 'Philippine Plan of Action for Nutrition 2023-2028', Presentation, 30 August 2023, <www.nnc.gov.ph/phocadownloadpap/userupload/Rocar-webpub1/2nd%20NAOs%20conference%20Powerpoints%2008.30.23.pdf>

Exhibit 1.1.1. Determinants of Malnutrition Outlined in the PPAN 2023-2028[14]



Indeed, factors such as poverty, disaster risk, rurality and indigeneity lead malnutrition rates to differ between regions in the Philippines. For example, in some regions the stunting rate exceeds 40% of the population of children under five years of age. Estimates indicate that stunting rates amongst children below 5 years are highest in Bangsamoro Autonomous Region in Muslim Mindanao (BARMM) (45%), MIMAROPA (41%), Bicol Region (40%), Western Visayas (40%) and in the SOCCSKSARGEN (40%).[15] The Visayas, Bicol and Mindanao areas of the Philippines are home to a greater number of Geographically Isolated and Disadvantaged Areas (GIDA) (see Exhibit 1.1.2). The GIDA classification by the Filipino government identifies "far flung areas and marginalized populations which includes islands, mountainous areas, conflict affected areas, internally displaced persons, and indigenous persons."[16]

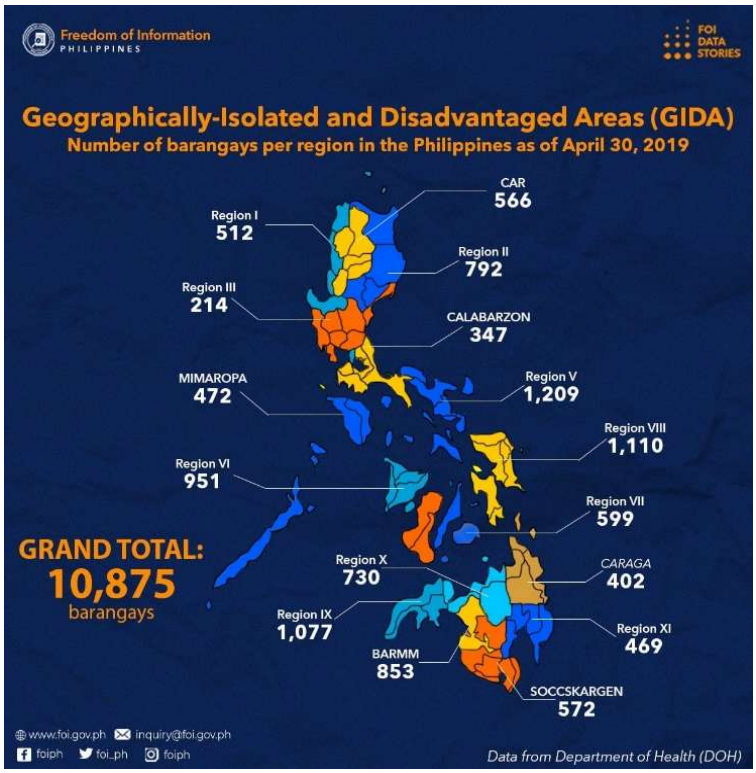
[14] UNICEF conceptual framework of Malnutrition 2020. https://www.unicef.org/media/113291/file/UNICEF%20Conceptual%20Framework.pdf

[15] Mbuya, Piza, & Adona, 2021

[16] Department of Social Welfare and Development, 'Guidance note on identifying geographically isolated and disadvantaged areas in Pantawid Pamilyang Pilipino Program', DSWD, 6 August 2021, p. 1., <pantawid.dswd.gov.ph/wp-content/uploads/2023/03/Guidance-Note-on-Identifying-Geographically-Isolated-Disadvantaged-Areas-GIDA-in-Pantawid-Pamilyang-Pilipino-Program.pdf>

BARMM, SOCCSKSARGEN and Western Visayas are also home to significant populations of indigenous groups such as the Maguindanao, Maranao, Tausog, Ati and Suludnon.[17] Indigenous peoples (IPs) face overlapping vulnerabilities including higher poverty rates and increased disaster risk due to their reliance on agriculture, providing them with additional barriers to optimal nutrition.[18] Estimates from the 2013 National Nutrition Survey and 2015 Updating Survey indicate a rising trend in the prevalence of stunting and underweight conditions in IP children. In 2013, 44% (IP households) versus 30% (non-IP households) of children below 5 were stunted compared to 47% (IP households) versus 33% (non-IP households) in 2015. Comparably, in 2013, 27% (IP households) versus 20 % (non-IP households) of children below 5 were underweight compared to 30% (IP households) versus 21% (non-IP households) in 2015. These percentages constitute the latest available nationally representative datasets with IP-disaggregated nutrition data. Subsequent national surveys have not reported nutrition outcomes specific to IPs, leaving a significant evidence gap after 2015. [19]

Exhibit 1.1.2. Map of the Number of GIDAs, by Region[1]



[17] ACAPS, 'Philippines Update: Impact of Typhoon Rai', ACAPS, Briefing note, 31 January 2022, <www.acaps.org/fileadmin/Data_Product/Main_media/20220131_acaps_briefing_note_philippines_typhoon_rai_update.pdf>; Philippines Statistics Authority, 'Ethnicity in the Philippines (2020 Census of Population and Housing)', PSA, 7 April 2023, <psa.gov.ph/content/ethnicity-philippines-2020-census-population-and-housing>

[18] ACAPS, 2022; Duante, Charmaine A., et al., 'Nutrition and Health Status of Indigenous Peoples (IPs) in the Philippines: Results of the 2013 National Nutrition Survey and 2015 Updating Survey', *Philippine Journal of Science*, 151 (1), January 2022, pp. 513-531, <www.researchgate.net/publication/367594183_Nutrition_and_Health_Status_of_Indigenous_Peoples_IPs_in_the_Philippines_Results_of_the_2013_National_Nutrition_Survey_and_2015_Updating_Survey>

[19] Duante, C. A., Austria, R. E. G., Ducay, A. J. D., Acuin, C. C. S., & Capanzana, M. V. (2022). Nutrition and health status of Indigenous Peoples (IPs) in the Philippines: Results of the 2013 National Nutrition Survey

In recent years, the threat that disasters and emergencies impose on food security and nutrition in the country has become increasingly salient. For example, the incidences of maternal and infant mortality climbed during the COVID-19 pandemic while the incidences of stunting stagnated during that time.[20] Meanwhile, natural disasters and armed conflict have a long history of undermining food security and nutrition outcomes in the country. The Philippines is ranked amongst the top five countries in the world in terms of its vulnerability to climate change and is particularly prone to typhoons, floods, drought, rain-induced landslides and other natural disasters.[21] Between 2015 and 2020, an average of 6.4 million Filipinos were affected each year by natural disasters, including volcanic activity, earthquakes, severe storms and floods.[22] In addition, the southern Philippines has a complex history of ethnic and armed conflict, which has imposed severe consequences on children (e.g., death, displacement). Climate and conflict factors serve to further disadvantage poor populations, undermine the readiness of key infrastructures necessary for good health and nutrition, and increase health risks more broadly.[23]

To support good nutrition for all families and communities, the Filipino government has enacted an extensive framework of sectoral and multi-sectoral policies which prioritise and mainstream nutrition. Within the health sector, nutrition programming is undergirded by three key laws which demonstrate the government's commitment to providing high quality health services (see Exhibit 1.1.3).[24]

Exhibit 1.1.3. Key Health Sector Laws in the Philippines.

REPUBLIC ACT NO.	NAME OF LAW	SUMMARY
11148	Kalusugan at Nutrisyon ng Mag-Nanay Act (The First 1,000 Days Law)	Outlines the Philippines' integrated strategy and funding for maternal, neonatal, child health and nutrition in the first 1,000 days of life.

and 2015 Updating Survey. Philippine Journal of Science, 151(1). https://www.academia.edu/download/97503699/nutrition_and_health_status_of_indigenous_people_in_the_Philippines_.pdf

[20] NNC, 2022

[21] World Bank, 'Philippines', Climate Change Knowledge Portal, World Bank Group, Database, 2021, <climateknowledgeportal.worldbank.org/country/philippines/vulnerability>

[22] World Bank, Disaster Risk Management in the Philippines [Background Paper PH-11], World Bank, 2023. < https://openknowledge.worldbank.org/server/api/core/bitstreams/a4a1c553-8974-4ae5-b4c9-2150d78a703f/content>

[23] World Bank, 2023.; DOST-PCHRD, National Health Research Agenda in Disaster Risk Reduction and Climate Change Adaptation 2023-2028, DOST, 2023.

[24] Additional laws of note include PD 491 (Nutrition Act of the Philippines), RA 8172 (Salt Iodization Law), RA 8976 (Food Fortification Act of 2000), and RA 11037 (Masustansyang Pagkain para sa Batang Pilipino Act).

10028	Expanded Breastfeeding Promotion Act of 2009	Aims to encourage, protect and support the practice of breastfeeding and rooming-in, which are seen as crucial practices for fulfilling the basic physical, emotional, and psychological needs of mothers and infants.
11223	The Universal Health Care law	Provides for a national health care model which provides all Filipinos to quality and cost-effective, promotive, preventive, curative, rehabilitative and palliative health services in an affordable manner, while prioritizing the needs of those who cannot afford such services.

Established in 2018, Republic Act (RA) 11148 particularly targets nutrition outcomes by outlining 76 services which should be provided by the DOH to support maternal and child nutrition during the crucial period between pregnancy and age two. It also includes targeted services for adolescent girls aged 10 to 18 and for mothers and children experiencing natural disasters.[25] Overall, these laws remain central to health programming and are actualized through strategy documents such as the Health Sector Strategy (HSS) 2023–2028.[26] For instance, Administrative Order (AO) 2023-0015 lays out the 8-Point Action Agenda as the Medium-Term Strategy of the Health Sector for 2023-2028, an agenda which prioritizes strengthening PHC to achieve a future where "Filipinos are among the healthiest people in Asia by 2040."[27]

Several multisectoral policies also comprise part of the enabling environment surrounding nutrition outcomes. Core among these is the PPAN 2023-2028, a comprehensive blueprint to guide stakeholders including the government, non-governmental organizations, academia, and the private sector, in a coordinated effort to address all forms of malnutrition (i.e., wasting, stunting, overweight, and obesity). The PPAN is aligned with the DSWD Strategy Map 2028 as well as broader development plans such as AmBisyon Natin 2040 and the Philippine Development Plan 2023-2028. The reverse is also true, with these broader development plans reflecting the importance of addressing malnutrition. For instance, the DSWD Strategy Map identifies its primary goal as, "a future where Filipinos are free from hunger and poverty."[28] In addition, the DSWD's cornerstone Pantawid Pamilyang Pilipino Programme (4Ps), a conditional cash

[25] Republic of the Philippines, *Republic Act No. 11148*, 2018, <lawphil.net/statutes/repacts/ra2018/ra_11148_2018.html>
[26] Department of Health, 'Health Sector Strategy 2023-2028', DOH, 2022.
[27] Department of Health Office of the Secretary, AO 2023-0015: Adoption of the 8-Point Action Agenda as the Medium-Term Strategy of the Health Sector for 2023-2028, DOH, 2023.
[28]Department of Social Welfare and Development, 'DSWD Refreshed Strategy Design', DSWD, 2022, <osm.dswd.gov.ph/dswd-strategy-2028>

transfer programme targeting the poorest of the poor, requires recipients to utilise key health and nutrition services to receive the cash grant.[29]

As mentioned above, the PPAN identified nutrition services' access and quality as underlying determinants of nutrition outcomes. In line with this assumption, the PPAN identified several gaps in nutrition programming:

- Weak nutrition programme leadership in some local government units (LGUs) due to lack of knowledge and insight into the nutrition problems.
- Reliance on volunteers and staff with other multiple functions; absence of fulltime/dedicated staff or nutrition office.
- Lack of capacity in local nutrition committees (LNCs) and non-functional LNCs.
- Too many programmes with few human resources.

These gaps particularly undermine the effectiveness of key nutrition-specific and nutrition-sensitive interventions and contribute to the country's "nutrition crisis".[30]

PMNP is heavily informed by the nutrition context and policy landscape described in this subsection. With a focus on marginalized communities, especially GIDA and IPs, PMNP aims to improve the quality and utilisation of key nutrition-specific and nutrition-sensitive services through supply-side and demand-side interventions. In the next section, this report unpacks key aspects of PMNP, highlighting how it addresses determinants of malnutrition while building on existing policies.

1.2 Object of Study: PMNP Programme Description

Funded by a US $178 million loan from the World Bank and the Philippine Department of Finance, PMNP aims to deliver a coordinated package of nutrition-specific and nutrition-sensitive interventions supported by an SBC strategy. The high-level objective of PMNP is to improve key health behaviours and practices known to reduce stunting in the targeted LGUs through increased use of the package of interventions.[31] With a focus on nutrition interventions at

[29] Republic of the Philippines Official Gazette, 'Pantawid Pamilyang Pilipino Program', n.d., <www.officialgazette.gov.ph/programs/conditional-cash-transfer/>
[30] Philippine Multisectoral Nutrition Programme Technical Working Group, 'Philippine Multisectoral Nutrition Project Operations Manual (POM)', Version 15, 4 October 2022, <1a - DRAFT PMNP POM Manual_4 October 2022.docx - Google Docs>
[31] PMNP TWG, Project Operations Manual, 2022.

the point of pregnancy, birth, and the first years of a child's life, PMNP builds on the efforts of the First 1,000 Days Law (RA 11148). The five core project indicators are:

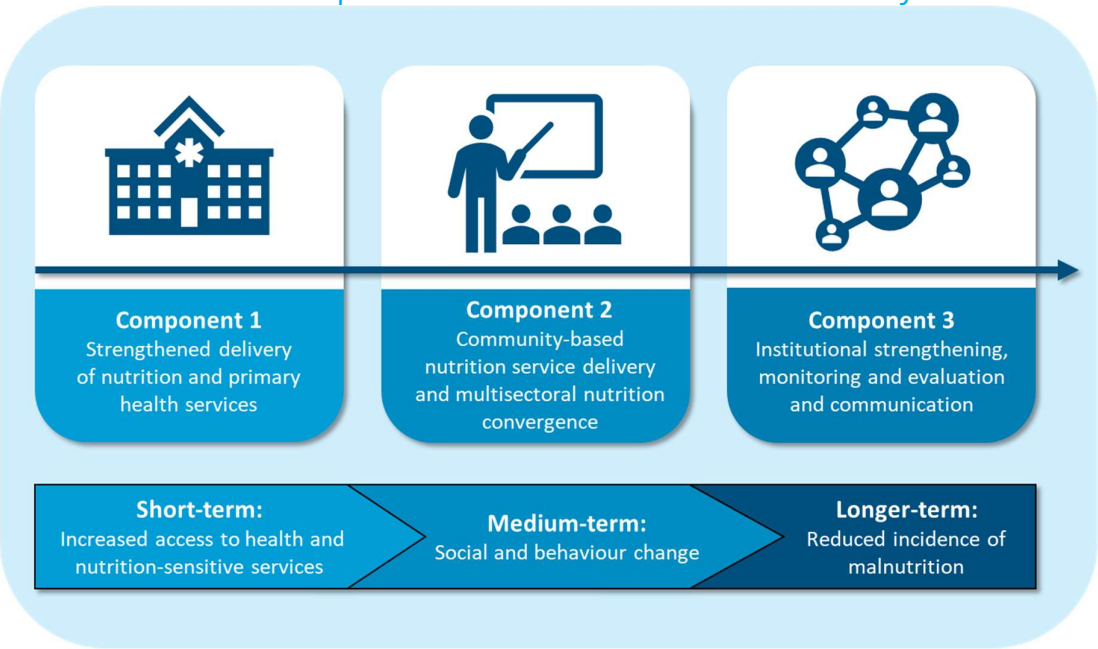
1. Percentage of pregnant women who have received complete iron-folic supplements or Multiple Micronutrient supplementation
2. Percentage of pregnant women in project areas receiving prescribed antenatal care services from the first trimester of pregnancy
3. Percentage of households in participating barangays with convergence of priority nutrition-specific interventions nutrition-sensitive interventions
4. Percentage of children 6-23 months of age in project areas who meet the minimum age-appropriate diet (MAD)
5. Percentage of households in project areas with access to improved toilets

Nutrition-Specific Interventions
These are programmes and actions that address the immediate causes of malnutrition by targeting specific nutrition deficiencies and aiming to improve nutrition and health outcomes. Examples of these programmes include micronutrient supplementation, breastfeeding promotion, complementary feeding, food fortification, treatment of severe and moderate acute malnutrition, and disease prevention.

Nutrition-Sensitive programmes
These are development programmes and policies that address the underlying determinants of nutrition by incorporating specific

PMNP comprises three main components (see Exhibit 1.2.1): (a) strengthened delivery of nutrition and primary health services, led by DOH; (b) community-based nutrition service delivery and multisectoral nutrition convergence, led by DSWD and DOH; and (c) institutional strengthening, monitoring and evaluation (M&E) and communication, led by DOH and DSWD. Each of PMNP's main components contain several subcomponents and activities.

Exhibit 1.2.1. PMNP Components and Potential Outcome Pathways



In this way, PMNP is a key effort in the Philippines' progress toward achieving the Sustainable Development Goals (SDG): The program supports SDG 2 (Zero Hunger) by working to end malnutrition (target 2.2). It also aligns with the efforts of SDG 3 (Good Health and Well-Being) of fighting communicable, especially waterborne, diseases (target 3.3), achieving universal health coverage (target 3.8), and it advances efforts to increase health financing and supporting the health workforce (target 3.C). In addition, it advances progress toward SDG 6 (Clean Water and Sanitation) by expanding access to safe drinking water (target 6.1) and working to end open defecation and provide access to sanitation and hygiene (target 6.2).

PMNP implementation sites include 235 municipalities and 5,936 barangays in 12 regions and 26 provinces,[32] targeting LGUs with "high childhood stunting rates (above 17.5% in 2019), high poverty incidence, Kapit-Bisig Laban sa Kahirapan Comprehensive and Integrated Delivery of Social Services (Kalahi-CIDSS) implementation experience, and the Human Development and Poverty Reduction Cabinet Cluster/PPAN focus areas."[33] Primary beneficiaries include households with pregnant women and children 0-23 months old (see Exhibit 1.2.2). Other participants include women of reproductive age (15-49 years old), IPs, 4Ps beneficiary households, children with disabilities and low-income households. Each group of participants receives a different type and amount of

[32] Although 40 municipalities from 3 provinces in the BARMM will receive technical assistance and capacity building on health and nutrition under PMNP, these areas were not considered in the sampling framework of this study as they are not part of the scope of work of this evaluation.
[33] PMNP TWG, Project Operations Manual, 2022.

PMNP programming and services, and the PMNP logical framework outlines several indicators to ensure the project activities reach vulnerable populations.

Exhibit 1.2.2. Identified PMNP Beneficiaries

All children below five years old (<5 years old), focus on stunted children	990,991
Pregnant women, focus on the nutritionally at risk (NAR)	175,468
Children aged 6 to 23 months old	286,050
Children aged 0 to 5.9 months old	110,381
TOTAL	**1,562,890**

Note. Beneficiary identification conducted in November 2021. Reported in the POM.

PMNP was approved by the Board and the Investment Coordination Committee of the former National Economic and Development Authority (NEDA)[34] in 2021, the loan was made effective in August 2022, and the project's formal launch occurred in March 2023. The implementation period was originally projected to last until December 2025, though a no-cost extension was granted, extending the programme through December 31, 2026, and the loan closing date was revised to June 30, 2027. The new closing date helps address implementation delays resulting from an initial fund disbursement holdup from the Government of the Philippines and setbacks in the performance of some implementation subcontractors.[35]

1.3 PMNP Stakeholders

The nutrition policy landscape in the Philippines engages multiple stakeholders, including national line ministries, LGUs, multisectoral coordination bodies, development partners, and communities themselves, each playing complementary roles in shaping, delivering, and sustaining nutrition-specific and nutrition-sensitive interventions.

Key coordination bodies include the Inter-Agency Task Force on Zero Hunger (IATF-ZH), which was a key facilitator in designing PMNP, and the project's NTWG. At the regional level, the RLGUMob-TAT groups provide multisectoral oversight of project implementation. DSWD and DOH have a primary role in the project as implementing agencies, but the National Nutrition Council, Department of Agriculture (DA), Department of Interior and Local Government, and the Food and Nutrition Research Institute also participate in the NTWG.

[34] As of April 2025, NEDA was succeeded by the Department of Economy, Planning, and Development (DEPDev)

[35] Subandoro, Ali Winoto. *Disclosable Restructuring Paper - The Philippines Multisectoral Nutrition Project - P175493.* Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099100725020029232

External stakeholders include third parties contracted (e.g., UNICEF) and the World Bank. Finally, the target community members and service providers constitute a crucial stakeholder group in PMNP. This includes primary care workers (e.g., doctors, nutritionists), local nutrition committee members, pregnant and lactating women, children under 5 years old, and their families.

2. Midline Evaluation Purpose

This section contains the evaluation purpose, objectives, and scope, as well as a detailed description of the programme's ToC and evaluation questions (EQs).

This mixed-methods midline evaluation has two primary purposes: 1) accountability to programme results; and 2) learning to inform improvement and scale up of the intervention package. The main purpose of the evaluation is to provide evidence to improve the implementation of PMNP and its effectiveness in addressing malnutrition and caregivers' behaviours that enable this change as well as to identify lessons learned for programmatic adjustments while the programme delivery is still underway. These lessons learned and recommendations should be feasible, actionable, and time-bound given the remaining implementation period. These insights will be crucial to shaping future multisectoral nutrition initiatives aimed at improving the country's nutrition outcomes.

2.1 Midline Evaluation Objectives

The overarching objectives of this midline evaluation are:

- To assess PMNP implementation status and identify challenges faced during implementation that may have prevented the programme from meeting expectations so far
- To provide evidence for necessary adjustments to strategies, interventions or resource allocations by highlighting both strengths and weaknesses

Additionally, the midline evaluation will:

- Examine whether capacity-building activities are sensitive to the needs of Primary Care Facility (PCF) staff, Local Chief Executives (LCEs), and LNCs
- Examine whether capacity-building activities have improved the KAP of
- PHC providers and governance capacity of LCEs and LNCs regarding nutrition programming

- Assess whether PMNP implementation is coherent with local plans, policies, and programming, and identified any duplication of efforts

2.2 Scope of the Midline Evaluation

Thematic scope: The midline evaluation assessed the implementation of PMNP encompassing all three components, their sub-components and activities, as well as intervention strategies. These components include: 1) Enhanced Delivery of Nutrition and Primary Health Services; 2) Community-Based Nutrition Service Delivery and Multisectoral Nutrition Convergence; and 3) Institutional Strengthening, Monitoring, Evaluation, and Communications. The midline evaluation also focused on the capacity strengthening activities for frontline workers and LCEs and LNCs.

Geographical scope: The midline evaluation included six purposively selected PMNP intervention sites and three purposively selected non-PMNP intervention municipalities across the three island clusters of Luzon, Visayas, and Mindanao. These nine municipalities are part of the broader impact evaluation sample of 150 municipalities to maximize the possibility of triangulating findings at endline.

Chronological scope: The midline evaluation examined PMNP implementation from baseline to mid-2025.

2.3 Intended Use and Audience

The primary audience for this midline evaluation consists of policymakers and the main implementing agencies within the Government of the Philippines (i.e., the duty bearers) including the DOH and the DSWD. Other key stakeholders in the country are UNICEF, and the World Bank, the PMNP lender. The secondary audience comprises other actors in the nutrition and health space including, the National Nutrition Council (NNC), the Food and Nutrition Research Institute (FNRI), the Department of Economy, Planning, and Development (DEPDev, formerly NEDA), academia, as well as non-governmental organizations. Additional secondary audiences include the Southeast Asia region and the global level. Lastly, PMNP targeted communities, their local government, their children, women, and families (i.e., the rightsholders or beneficiaries) are also stakeholders who stand to benefit from the evaluation's findings. The evidence generated through this evaluation will play a vital role in enhancing knowledge and raising awareness regarding the effectiveness of multisectoral nutritional programming.

2.4 Theory of Change

The ToC guides the evaluation by mapping out the way in which PMNP, if implemented with fidelity, can lead to an improvement in children's nutritional outcomes (see Exhibit 2.3.2). The ToC presents and links the initial conditions of the implementation context with the intervention and expected outputs, outcomes and impacts. This section discusses each of the ToC components in detail. It is theorized that the suite of PMNP inputs will improve the availability and quality of nutrition-specific and nutrition-sensitive services (Early Childhood Care and Development [ECCD] and water, sanitation, and hygiene [WASH]) for pregnant and lactating women, caregivers, and children, particularly those who are also beneficiaries of the 4Ps programme. Furthermore, more access to and better quality of health and nutrition services is expected to improve caregivers' knowledge of child nutrition and responsive care. In turn, improvements in the health environment and caregiver's knowledge would result in the consistent adoption of nutrition practices and behaviours known to reduce stunting. Importantly, the ToC highlights that the achievement of improved anthropometric measures (e.g., height and weight) is a long-term outcome – one that might not be captured within the project lifetime.

Initial conditions

The implementing agencies aim to reduce child malnutrition by strengthening the convergent provision of nutrition and health services for pregnant and lactating women, caregivers and children under five years of age. The limited availability of high-quality health and nutrition services in many parts of the country drives the need for a multisectoral approach that seeks to strengthen local structures and actors to implement demand-side and supply-side interventions. The current primary healthcare system faces many challenges including the lack of resources, tools and equipment, as well as limited and overworked PHC staff, many of whom lack the necessary skills and knowledge to deliver high-quality services. In addition, there is limited coordination between the PHC system and other nutrition-relevant programmes and actors at the local level. In addition to supply-side constraints, there are demand-side issues such as knowledge gaps and misconceptions about nutrition and health that prevent caregivers for accessing key healthcare services. Lastly, competing priorities for governments at the municipal and barangay levels, coupled with reduced leadership and governance around nutrition and health issues, often results in insufficient resources directed towards these services and projects.

Programme activities

The main activities for each of the PMNP components are listed below in Exhibit 2.3.1:

Exhibit 2.3.1. PMNP Components and Corresponding Activities

COMPONENT	ACTIVITIES/INPUTS
1	• Financing mechanism: Performance-Based Grants (PBG's) and Health Promotion Grants (HPG) to LGUs • Human resources: additional staff at different levels • Provision of equipment and supplies to PHC units • Capacity building to LGU and barangay officials to strengthen governance at local level and integrate nutrition into local development plans and budgets • Capacity training to PHC staff, community health and nutrition volunteers, and local leaders to deliver high-quality health and nutrition services • Strengthening and harmonization of existing information systems • Locally targeted nutrition and health-related SBC campaigns financed HPG
2	• Financing mechanism: Municipal Grant Allocations (MGAs) • Provision of municipal block grants for the implementation/construction of targeted community subproject on ECCD and/or WASH. • Financial resources for community planning activities related to health and nutrition (planning grants) • Community-Driven Development (CDD) Activities– such as Barangay Assemblies, Barangay Participatory Situational Analysis, expansion of the Barangay Nutrition Committees (BNCs) to include the Community Nutrition Sub-Project Management Committees (CNSPMCs) • Local capacity building to barangay and LGU officials on community-driven development tools and topics • For existing 4Ps women, identify and update information of new pregnancy/ newborn children so that they can also be monitored under 4Ps. • Support 4Ps beneficiaries to benefit from PMNP activities (especially WASH and ECCD Support interventions)
3	• Capacity building activities to DOH and DSWD as required by the technical and management needs of the project

	• Provision of additional staff to DOH and DWSD as needed for the successful implementation of the programme • Establish M&E framework • Harmonize information systems to allow for vertical (national - municipality) and horizontal (DSWD – DOH – municipality) coordination.

Outputs

Activities from the three PMNP components are expected to generate outputs at the institutional, community, household and individual levels. At the institutional level, capacity building under Components 1 and 2 will improve the knowledge of municipal and barangay officials on nutrition issues as well as their capacity to advocate for, plan, budget and implement nutrition policies and programmes that are relevant to local contexts. This should be materialized in the MNAPs and BNAPs. In addition, LGUs and barangays will have access to additional financial resources that will allow them to consistently execute nutrition and health services as well as nutrition-sensitive community-driven initiatives. Furthermore, the harmonization of information systems (Component 3) should result in improved coordination and convergence both vertically (national-LGU) and horizontally (DSWD-DOH-LGU).

At the community level, Component 1 activities are expected to increase the scope and improve the quality of nutrition and PHC services through superior and sufficient equipment, and more and better-qualified frontline health staff and nutrition volunteers. Simultaneously, through Component 2, communities are expected to benefit from WASH and ECCD subprojects. Additional support will be provided to 4Ps beneficiaries so they can benefit from PMNP activities. Households, in particular those with pregnant and lactating women as well as caregivers of children under 5 years, are expected to participate in different types of SBC activities, including above-the-line interventions (e.g., television and media campaigns) and below-the-line interventions (e.g., community dialogues, monthly conversations between mothers and nutrition volunteers). SBC will be contextualized to the local practices and realities.

Outcomes

At the institutional and community levels, the link between the activities and the project's key outcomes relies on the consistent discussion and prioritization of multisectoral nutrition and health issues by municipal and barangay officials. For instance, at the barangay level, nutrition committees should remain active and functional, identifying and advocating for nutrition priorities. MNAPs and

BNAPs should be periodically updated and serve as a basis to explicitly allocate funds to nutrition and health projects in the local budgets.
The link between activities and outcomes for households and individuals relies on the buy-in to the SBC messages and the consistent utilization of health and nutrition services. With buy-in, SBC is expected to change the nutrition knowledge, which in turn should improve caregiving practices and increase health-seeking behaviour among pregnant and lactating women and caregivers of children. The larger demand for health and nutrition services will be met by the boost in their supply and quality at the community level. Larger proportions of pregnant and lactating women, caregivers and children are then expected to consistently access and benefit from the convergence of an enhanced and extended supply of nutrition-specific and nutrition-sensitive services.

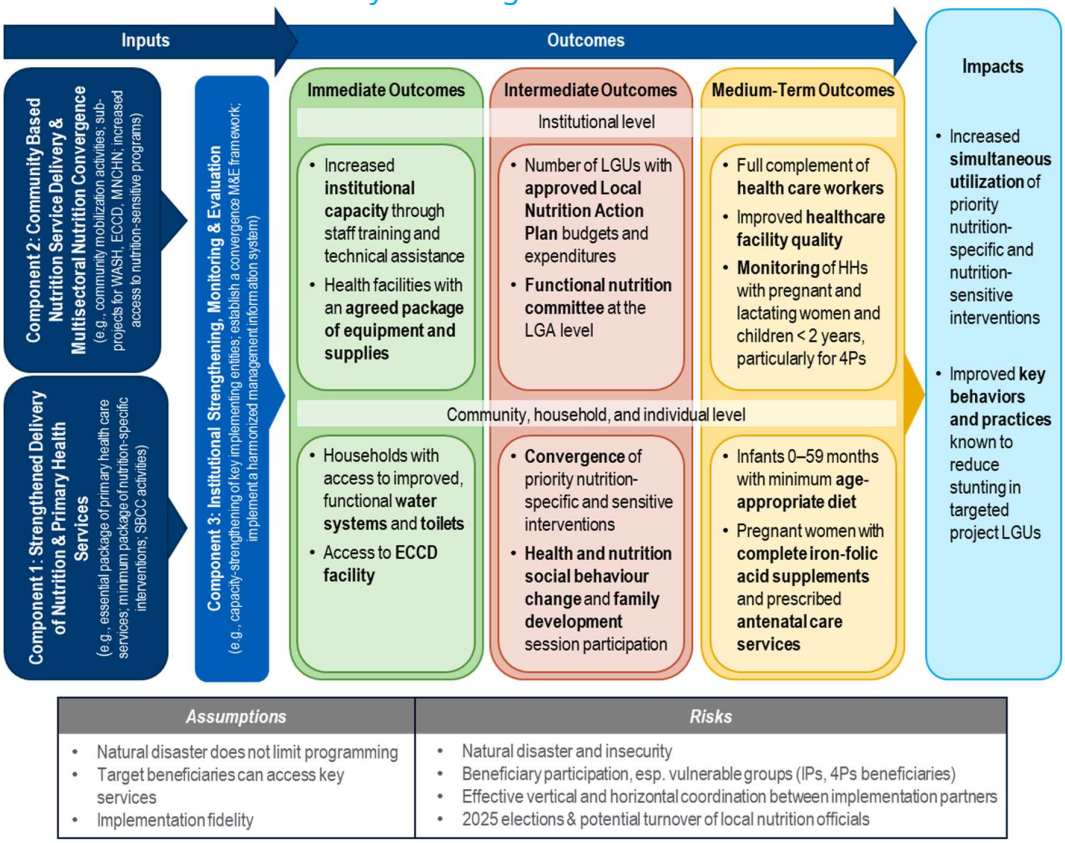
Impacts

Assuming demand-side interventions from Components 1 and 2 result in increased knowledge of optimal nutrition practices and responsive care, one would then expect pregnant and lactating women as well as caregivers to improve their caregiving practices and increase their access to and utilization of nutrition and health services. In time, larger proportions of pregnant women should receive appropriate iron-folic acid supplementation and attend all prescribed antenatal appointments. In addition, more knowledgeable caregivers are expected to ensure children have more diversified diets, comply with all age-appropriate vaccinations and engage in safe sanitation practices. In the long-term, changes in practices and health and nutrition services are expected to reduce malnutrition in young children, impacting stunting rates.

Assumptions and risks

Several assumptions underpin this ToC while there are also risks that may affect the programme's ability to achieve intended impacts. The mechanisms hypothesized in the ToC rest on the assumption that natural disaster does not significantly limit PMNP implementation; beneficiaries can access the nutrition-sensitive and nutrition-specific services supported by the programme (e.g., enabling social and cultural norms); and implementation is aligned with the plans outlined in the POM. Relatedly, key risks such as natural disasters and insecurity; the participation of vulnerable beneficiaries; the harmonization and coordination of PMNP components; and nutrition official turnover connected with 2025 elections are among the key obstacles affecting linkages in the ToC.

Exhibit 2.3.2. PMNP Theory of Change



2.5 Evaluation Criteria and Questions

2.4.1 Evaluation Criteria

For the full impact and process evaluation, this report will assess progress toward expected programme results, including the identification of PMNP implementation capacity and issues, in addition to crafting lessons learned for intervention improvement, sustainability and scaling. The evaluation questions (EQs) that guide this report's broader analysis reflect six OECD DAC criteria: relevance, coherence, effectiveness, efficiency, impact and sustainability. However, for this midline evaluation, the EQs focused on relevance, coherence, effectiveness, efficiency and sustainability. Across the OECD-DAC criteria, the evaluation prioritizes gender, equity and human rights as key cross-cutting analysis criteria. In other words, using a human rights and equity lens to respond to each OECD-DAC criterion enables us to shed light on the project's implications for human rights, gender equality, and the overall inclusiveness of PMNP programming across each domain being evaluated.[36] Addressing these

[36] OECD, 'Applying a human rights and gender equality lens to the OECD evaluation criteria', OECD, June 2023. < https://www.oecd.org/en/publications/applying-a-human-rights-and-gender-equality-lens-to-the-oecd-evaluation-criteria_9aaf2f98-en.html>

OECD-DAC and cross-cutting criteria allows us to evaluate the project design, implementation and effectiveness, while capturing nuances at the sub-group level and big-picture lessons on factors that foster long-term project success. The following paragraphs describe the EQs for each OECD-DAC criterion for this midline evaluation.

Relevance. Investigating the relevance of PMNP in this context means assessing the extent to which the project objectives, design and interventions address the core issues of target participants (e.g., households with pregnant women, children 0–2 years old, women of reproductive age, IPs, children with disabilities, low-income households) and respond to government policies and strategies. Such investigation also entails analysing how the project leverages existing DOH and DSWD government activities to achieve project objectives and analysing whether project objectives and strategies were formulated in a realistic, culturally appropriate and adaptive manner that can evolve with and effectively respond to changing circumstances. The EQs under this theme test assumptions about programme activities and implementation modalities, such as the appropriateness of implementation modalities for achieving desired results and relevance of interventions for indigenous groups' priority needs.

Coherence. Understanding PMNP coherence involves assessing project comparability with other relevant policies, programmes and interventions nationally and locally and its overall goodness-of-fit within the policy landscape. To address questions of coherence, the evaluation team compared PMNP implementation design and infrastructure with specific policies and interventions (e.g., the PPAN) to determine complementarity, harmonization, coordination and value-add of PMNP efforts.

Effectiveness. Analysing effectiveness means evaluating the extent to which project inputs and activities lead to outputs, such as increased provider knowledge in the provision of quality antenatal, intrapartum and postnatal care services. The evaluation team is measuring effectiveness of the project components by the extent to which they achieve their objectives relative to the results framework.

Efficiency. Analysing the efficiency of project implementation means assessing the extent to which PMNP resources are used most productively to achieve intended outputs, outcomes and impacts, such as minimum acceptable diets for children 0–23 months old. To address efficiency, the evaluation team is assessing the timeliness of outputs, overlap and coordination with other projects and barriers and bottlenecks to programme implementation.

Sustainability. Understanding programme sustainability entails assessing the extent to which the project creates opportunities for the adoption, enhancement and longevity of project benefits in the medium to long-term. This report will draw upon lessons learned from other components of the study (e.g., relevance, efficiency, effectiveness) to assess whether the project strengthens local and national ownership and capacity to facilitate the sustainability of project benefits.

In Exhibit 2.4.1 this report presents the evaluation criteria and their associated EQs along with the indicators, data collection methods, and analysis methods used to answer each EQ. Bolded rows indicate EQs that were added because of expanding the scope of the midline assessment. This report also denote which indicators will not be addressed until future rounds by putting “endline” in brackets after each relevant indicator in the table.

2.4.2 Evaluation Question

Exhibit 2.4.1. Evaluation Matrix

Evaluation Questions	**Illustrative Indicators**	**Data Collection Methods**	**Reporting**		
Exhibit 1: Evaluation Matrix			Baseline	Midline	Endline
Relevance: The extent to which PMNP's objectives, design, and interventions relate to or respond to participants' needs/priorities, and government policies and strategies, and continue to do so if circumstances change? Examine whether the capacity-building activities are sensitives to the needs of PCF staff, LCEs, and LNCs.					
1.1 How well do the programming strategies outlined in the POM appropriate for achieving the desired results?	• Perceived relevance of strategies and activities	Focus Group Discussions (FGDs), Key Informant Interviews (KIIs)	I	I	I
1.2 How well does PMNP meet the priority needs for multisectoral nutrition programming at the LGU level (and other levels – province, municipal, and barangay)?	• Perceived usefulness and responsiveness of PMNP for LGU (and other) officials	KIIs		I	I
1.3 How well is the Competency Framework for Integrated Nutrition and Primary Health Care (Integrated NPHC) aligned with the needs of Primary Health Care Facility Staff?	• Alignment between training content and service provider needs • Self-reported needs of primary care facility staff • NPHC knowledge scores • Proportion of PHC Facility Staff with appropriate NPHC training	Desk review, FGDs, KIIs, observations, knowledge survey, health facility checklist		I	

1.4 How well are the Nutrition Leadership and Governance (NLG) Capacity Building Activities aligned with the needs of LCEs and LNCs?	• Self-reported needs of LCE's and LNCs	FGDs, KIIs		I	I
Coherence: Compatibility of PMNP with other policies, programmes and interventions in the country, implementation areas, relevant to multisectoral nutrition programming. How well does the intervention package fit?					
2.1 How well is PMNP programming consistent with the First 1,000 Days Law (i.e., RA 11148)?	• Alignment between PMNP strategy/programming and the First 1,000 Days Law	Desk review, stakeholder consultations, KIIs	I	I	I
2.2 How well is PMNP programming consistent across sectors and multisectoral interventions delivered by the DOH and the DSWD, including health, nutrition, WASH, ECCD, and social protection? This includes complementarity, harmonization, and coordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort. Have synergies been created across different programme components, thus facilitating a system-wide approach to reducing malnutrition?	• Alignment, complementarity, and harmonization between PMNP and other complementary interventions at national, regional, and municipal levels • Extent of coordination between involved sectors and departments, including for targeting • Existence of linkages/synergies across programmes	Desk review, stakeholder consultations, KIIs, and financial case studies	I	I	I
2.3 How well is the PMNP strategic design and approach aligned with the PPAN 2023–2028, HSS (also in relation to Universal Health Care law), and DSWD Strategy Map 2028?	• Level of strategic alignment between PMNP and PPAN, HSS, Universal Health Care law, and DSWD Strategy Map 2028	Desk review, stakeholder consultations, KIIs	I	I	I
2.4 How well is PMNP at the local level coherent with the local plans, policies, interventions, and systems?	• Alignment between PMNP and local plans, policies, programmes, and systems (e.g., BNAPs)	Desk review, KIIs, FGDs	I	I	I

2.5 How compatible are PMNP systems, including information systems, with existing government and sector systems?	• Existence of shared platforms such as registries, monitoring information systems • Level of integration between PMNP and other government/sector systems (e.g., Field Health Services Information System [FHSIS])	Desk review, KIIs	I	I	I
2.6 How is PMNP adding value while avoiding duplication of effort? Have synergies been created across different government agencies with mandates related to the Nutrition programme components from the national to barangay level, thus facilitating a system-wide approach to reducing malnutrition?	• Perceived redundancy of PMNP activities • Perceived level of coordination between different PMNP components	Desk review, KIIs, FGDs		I	I
Effectiveness: The extent to which PMNP achieved, or is expected to achieve, its objectives and results, including any differential results across groups					
3.1 To what extent were the desired PMNP intermediate results for each of the three project components achieved?	• Number of staff trained, including frontline health workers, community health and nutrition volunteers, parents, and leaders. • Number of project areas with a functional nutrition committee **[Endline]** • Proportion of communities with executed ECCD and WASH project **[Endline]**	Results Framework, Monitoring data		I	I

3.2 To what extent have the integrated NPHC and PMNP capacity-building interventions contributed to improvements in the KAP of PCF staff and to overall healthcare delivery and quality?	• Perceived competency gains for PCF staff • Differences in KAP for PCF staff between treatment and comparison areas. • Perceptions of healthcare quality • Level of patient satisfaction with PCF staff	FGDs, KIIs, knowledge survey, observations, health facility checklist		I	I
3.3 To what extent have the nutrition leadership and governance (NLG) capacity-building interventions, including training and the NLG competency framework, contributed to improvements in the capacity of LCEs and LNCs to lead the development of multisectoral MNAPs, including as it pertains to budget planning and utilization and SBC activities?	• Perceived usefulness of NLG training and capacity building • LCE and LNC knowledge about nutrition action planning, budgeting, and SBC interventions • Existence and comprehensiveness of multisectoral MNAPs (vis a vis MNAP quality checklist and competency framework) **[Endline]** • Alignment between budget plans (e.g., AIPs), MNAPs and utilization reports **[Endline]** • Extent of budget tagging for nutrition-specific and nutrition-sensitive interventions **[Endline]** • Extent to which MNAP is costed **[Endline]** • Alignment between SBC guidance (e.g., national strategy) and LNC planning **[Endline]**	Desk review, FGDs, KIIs, financial case studies		I	I

3.4 How has the Performance-Based Grants (PBG) improved the capacity of LGUs to implement nutrition services in terms of human resources, supply chain, and governance systems?	• Perceived changes in the capacity of LGUs to implement nutrition services attributed to PBGs • Number of facilities equipped with technology to access information systems • Change in number of staff at LGU level attributed to PBGs **[Endline]** • Perceived adequacy of current human resources and skills in supply chain and governance systems in LGUs • Competency of MNAPs according to the NLG competency framework	KIIs, FGDs, facility checklist, financial case studies		I	I
3.5 To what extent have PMNP's interventions reached the most vulnerable and marginalized population groups including, women, children, geographically isolated and disadvantaged, 4Ps beneficiaries, Indigenous Populations (IPs), and people with disabilities?	• Perceived usefulness of PMNP interventions • Proportion of eligible households receiving PMNP activities **[Endline]** • Proportion of eligible households reporting satisfaction with PMNP programme activities **[Endline]** • Experiences and perceived level of access to PMNP interventions for vulnerable and marginalized groups • Existence of disability-friendly approaches within PMNP activities • Cultural appropriateness of interventions	HH survey, monitoring data, FGDs, KIIs		I	I

3.6 How successful was PMNP in implementing the full suite of planned interventions such that programme participants received all activities?	• Proportion of eligible households receiving all programme interventions **[Endline]** • Fidelity of implementation of programme activities **[Endline]**	HH survey, FGDs, KIIs			I
3.7 To what extent did PMNP achieve desired results in relation to: • PMNP convergence model/approach for delivery of nutrition-specific and nutrition-sensitive interventions for the first 1,000 days? • Nutrition and health systems strengthening in improving the delivery of high-impact nutrition interventions within primary health care? • Performance-based grants facilitating implementation of services and fostering multi-sectoral planning, budgeting, finance management, and action at the subnational level? • Kalahi-CIDSS community-driven development approach facilitating the implementation of community-based nutrition programming and multisectoral nutrition convergence? • Use of SBC communication strategies and approaches to change key behaviours and practices known to reduce stunting?	• Proportion of eligible households reporting improvement in outcomes of interest (e.g., receiving all PMNP nutrition-specific and nutrition-sensitive interventions) **[Endline]** • Participant awareness of and ease of access to the full set of PMNP interventions **[Endline]** • Uptake of PMNP activities **[Endline]** • Perceived extent of convergence between nutrition sensitive and nutrition specific interventions (e.g., targeting regular planning, touch points, and coordination; communication)	HH survey, monitoring data, FGDs, KIIs		I	I

• Institutional strengthening of DOH, DSWD, and LGUs to implement and manage nutrition interventions. To what extent were the approaches used effective (e.g., project management units at national and sub-national level; procurement and financial management; environmental and social management; information management; and M&E of the project, amongst others)?					
3.8 What were the major factors influencing the achievement or non-achievement of PMNP intermediate results?	• Perceived project facilitators and barriers	HH survey, FGDs, KIIs		I	I
3.9 Are there any unintended results of PMNP at the national, LGU, municipality, and household levels?	• Perceived unintended consequences (positive or negative) at different levels	FGDs, KIIs,		I	I
Efficiency: The extent to which PMNP resources (human, expertise, financial and materials) were sufficient and efficiently used to produce achieved results (impacts, outcomes, and outputs) in a timely way					
4.1 To what extent is PMNP efficient and cost-effective in the achievement of desired results in terms of resource utilization (human, technical, financial) and timely delivery? What is the cost-effectiveness of PMNP on the main outcomes of interest? Have there been any significant delays and deviations in programme implementation and achievement of results, and if so, why?	• Cost per beneficiary **[Endline]** • Perceived efficiency and timeliness of service delivery **[Endline]** • Resource utilization in LGUs	Cost data, monitoring data, KIIs, FGDs, financial case studies			I
4.2 How efficiently did PMNP stakeholders coordinate and use resources and capacities to achieve results? Did PMNP coordination and	• Perceived capacity of MNCs to coordinate, collaborate, and prevent duplication of efforts	KIIs, FGDs, financial case		I	I

collaboration structure avoid duplication and facilitate efficiency and effectiveness?	• Evidence of resource sharing • Perceived success of coordination and collaboration structures (e.g., MNCs) • Co-creation level using NLG competency framework	studies (MNAP assessment)			
Impact: The extent to which PMNP has generated or is expected to generate positive or negative intended or unintended changes					
5.1 To what extent has PMNP improved the following behaviours and practices sufficiently to contribute to stunting reduction? • Minimum acceptable diet amongst children 6–23 months • Exclusive breastfeeding amongst infants 0–6 months • Timely initiation of complementary feeding and continued breastfeeding amongst infants 6–8 months • Responsive caregiving practices • Maternal and child nutritional status (stunting measured by Height-for-age-Z-score (HAZ), wasting measured by weight-for-length/height-Z-score (WHZ) and mid-upper arm circumference (MUAC)	• Proportion of participants demonstrating improvement in desired practices/outcomes (e.g., exclusive breastfeeding amongst infants 0–6 months, HAZ improvements, supervision of children 0-59 months) **[Endline]** • Reported changes in knowledge and behaviours **[Endline]**	HH survey, FGDs, KIIs			I
5.2 To what extent has PMNP improved utilization of the following services sufficiently to contribute to stunting reduction: • Pregnant women receiving the complete dosage of iron-folic acid supplements	• Proportion of participants accessing vital services (e.g., pregnant women with complete dosage of iron and folic acid supplements) **[Endline]** • Proportion of participants practicing exclusive breastfeeding (EBF),	HH survey, FGDs, KIIs			I

• Pregnant women receiving prescribed antenatal care services from the first trimester of pregnancy • Households with access to and use of improved toilets • Households with access to a Level II water supply system • Households with access to and use of ECCD facility/services • Households with convergence of priority nutrition-specific and nutrition-sensitive interventions	continued breastfeeding (BF), and achieving MAD for both women and children. **[Endline]** • Participant awareness of and ease of access to the full set of PMNP interventions **[Endline]** • Uptake of PMNP activities **[Endline]**				
5.3 What are the enabling factors that contributed to the achievement of results, and what are the bottlenecks/barriers that led to non-accomplishment of the results?	• Perceived enabling factors and barriers • Proportion of households with improved outcomes (likely to facilitate positive spillovers) **[Endline]**	HH survey, FGDs, KIIs			I
5.4 What are the factors that influenced the achievement or non-achievement of the desired results?	• Impact of shocks (such as climate shocks or death of a household member) on household nutrition (differences across treatment and comparison) **[Endline]**	HH survey, FGDs, KIIs			I
Sustainability: The extent to which PMNP succeeded in creating opportunities for the government to adopt, enhance and support continuation of the intervention benefits for participants over the medium and long term					
6.1 How likely are the activities and results achieved likely to continue after PMNP has ended?	• Existence of stakeholder commitments (e.g., staffing, policy,	FGDs, KIIs		I	I

	budget) to continue/scale up PMNP interventions • Perceived sustainability of PMNP interventions • Perceived ability to sustain changes from PMNP interventions				
6.2 What are the major factors that influence the achievement or non-achievement of sustainability?	• Existence of stakeholder commitments to continue/scale up PMNP interventions • Perceived sustainability of PMNP interventions at all levels • Convergence approach **[Endline]**	FGDs, KIIs		I	I
6.3 Can the PMNP model or approach(es) as a whole or in part (best practices) be institutionalized in government or scaled up?	• Existence of stakeholder commitments (e.g., staffing, policy, budget) to continue/scale up PMNP interventions • Scalability and adaptability of PMNP interventions • Perceived sufficiency of financial and human resources	Stakeholder consultations, KIIs, financial case studies		I	I
6.4 To what extent has PMNP, through its interventions, led to a lasting change to children, women and communities that can be sustained after the project has ceased?	• Child stunting (which is a long-term nutrition outcome) **[Endline]** • Mothers' nutrition knowledge **[Endline]** • Perceived ability to sustain changes from PMNP interventions	HH survey, monitoring data, FGDs, KIIs			I
6.5 How does PMNP change budget allocation and investment in nutrition activities at the municipal level?	• Number and funding amount of non-PBG sources of funding in AIP to support nutrition activities **[Endline]**	KIIs, FGDs, financial case studies			I

	• Changes in budget allocation and utilization for nutrition activities **[Endline]** • Perceived ability of MNCs to fund the forthcoming MNAP • Perceived importance of nutrition activities by LCEs • Perceived sustainability of multisectoral nutrition funding after PBGs				

Note: Indicators marked with **[Endline]** will only be assessed at endline. Bolded questions were introduced as part of the expanded scope.

3. Methodology

3.1 Summary of Midline Evaluation Approach

The research team used a mixed-methods approach to answer the midline EQs. The study design included a desk review, knowledge surveys, direct observations, a facility checklist, Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). Taking a mixed-methods approach that prioritized data triangulation allowed us to investigate PMNP processes to understand the *why* and *how* of the programme and helped with the interpretation of other evaluation results.[37] Mixed-methods investigations of programme processes also help ascertain whether a programme is effective (or ineffective) because of its underlying design and ToC or because of its quality of delivery.[38] The research team triangulated findings from different data sources and methods to provide a comprehensive and nuanced response to the midline EQs.

3.2 Desk Review

Upon commencing midline research activities, the research team conducted a desk review to help shape this report's study design, inform the development of the data collection instruments, and identify data sources that could provide evidence on implementation progress and fidelity. The team reviewed and analysed documents such as the integrated competency framework on integrated NPHC developed by University of the Philippines – Los Banos Foundation Inc. (UPLBFI), the NLG training curriculum for Local Nutrition Committees (LNCs) developed by Human Capital Asia (HCA), documents from the Local Nutrition Action Plan (LNAP) 2026-2028 Formulation Workshop, among others. The research team also reviewed the Learning and Development Intervention (LDI) materials and mentoring and coaching tools to understand PMNP's approach to capacity building and ensure that the evaluation adhered to PMNP standards for service delivery and government planning. In addition, it collated secondary data sources including PMNP monitoring data. Annex B provides a list of all documents examined during the desk review process.

3.3 Qualitative and Quantitative Sampling Sites

The research team conducted quantitative and qualitative midline evaluation activities in nine purposefully sampled municipalities (six treatment and three

[37] Oakley, Ann, et al., 'Process evaluation in randomised controlled trials of complex interventions', *BMJ*, 332(7538), 2006, pp. 413–416, <doi.org/10.1136/bmj.332.7538.413>

[38] Rychetnik, Lucie, et al., 'Criteria for evaluating evidence on public health interventions. Journal of Epidemiology & Community Health', 56(2), 2002, pp. 119–127, <https://doi.org/10.1136/jech.56.2.119>

comparison) from six PMNP regions across the main three island groups (Exhibit 3.3.1). It sampled sites such that within each island cluster, there were two treatment municipalities and one comparison municipality, which corresponds to the impact evaluation randomization pair of one of the two selected treatment municipalities.[39] In addition, because one of the key objectives of the midline evaluation was to assess the PHC capacity building activities on NPHC and NLG, all treatment municipalities in the sample had received integrated NPHC trainings before midline data collection took place. This diverse sample enabled us to assess PMNP implementation in a variety of contexts, and to compare PHC services and nutrition governance across treatment and comparison municipalities. Moreover, these nine municipalities are part of the quantitative impact evaluation sample of 150 municipalities to maximize the possibility of triangulating findings at endline.

Exhibit 3.3.1 - Sampling Sites - Midline Assessment

REGION	PROVINCE	MUNICIPALITY	PMNP (TREATMENT=1; COMPARISON=0)
REGION X	LANAO DEL NORTE (LDN)	MAIGO	1
REGION X	LANAO DEL NORTE	SULTAN NAGA DIMAPORO	0
REGION VIII	LEYTE	CAPOOCAN	1
REGION VIII	LEYTE	SAN ISIDRO	0
REGION VII	ILOILO	BADIANGAN	1
REGION IV-A	QUEZON	CALAUAG	1
REGION IV-A	QUEZON	SAMPALOC	0
REGION IX	ZAMBOANGA DEL SUR (ZDS)	MIDSALIP	1
REGION V	CAMARINES SUR	BUHI (IP Municipality)	1

3.5 Qualitative Methodology

The midline implementation review involved rigorous qualitative data collection, spanning the breadth of actors and institutions who helped design, implement, evaluate, and benefit from the investments of PMNP. Qualitative participants were selected based on their roles, familiarity with, and levels of involvement in PMNP. To ensure a range of stakeholder perspectives were included in the midline analysis and thematic saturation was achieved, the research team spoke with project implementers at the national, regional, municipal, and barangay levels, PHC workers, WASH inspectors, ECCD workers,

[39] For details on the design of the impact evaluation, please refer to the PMNP Baseline Report (DOH, 2024).

and pregnant women, mothers, and fathers receiving local health and nutrition services, among others (further described below). The research team conducted KIIs and FGDs as described below to identify challenges that manifest when implementing PMNP and determined the extent to which the interventions were implemented with fidelity and reached their target population.

Exhibit 3.5.1 provides definitions of each type of qualitative data collection method along with intended uses of each methodology.

Exhibit 3.5.1 - Summary of Qualitative Methods

METHOD	DESCRIPTION	RESEARCH USE
FGDS	Semi-structured, facilitated discussions between 6 to 8 peers.	Ideal for understanding the experiences of a greater number of stakeholders in a short period of time, and in a group environment with their peers where researchers can observe interactions amongst participants.
KIIS	One-on-one interviews with people who possess expert knowledge.	Ideal for gathering insiders' perspectives about the design and purpose of a policy or programme and/or implementation experiences.

Midline process evaluation. The core process evaluation sampled respondents at the national, provincial, municipal, and barangay levels in *six* treatment municipalities across six regions. The research team conducted 88 KIIs, 48 FGDs and 6 group interviews as depicted in Exhibit 3.5.2.

Exhibit 3.5.2 - Midline Process Evaluation Sample

RESPONDENT	METHOD	NUMBER	LOCATION(S)
National level agencies (NNC, FNRI, DepDev, DOH DPCB, DSWD, DILG, National Commission On Indigenous Peoples (NCIP), PMNP National Project Management Office (NPMO)	KII	9	National level
World Bank Representative(s)	KII	1	National level

UNICEF representatives	KII	3	National level
PMNP MPMO focal points (Technical Manager/MHO)	KII	6 (1 per municipality – *treatment only*)	Municipal level
Municipal level DSWD staff (4Ps municipal link and KALAHI-CIDSS staff)	Group interview	6 (1 per MLGU – *treatment only*)	Municipal level
WASH providers (e.g., sanitation inspectors)	KII	6 (1 per municipality – *treatment only*)	Municipal level
Barangay captains	KII	6 (1 per barangay – *treatment only*)	Barangay level
Health committee counsellor	KII	1 (Maigo, LDN)	Barangay level
ECCD providers (e.g., child development workers)	KII	6 (1 per barangay - *treatment only*)	Barangay level
Pregnant women	FGD	12 (2 per barangay)	Barangay level
Mothers of children 0–23 months old	FGD	12 (2 per barangay)	Barangay level
Fathers of children 0–23 months old	FGD	6 (1 per barangay - *treatment only*)	Barangay level
TOTAL: 30 FGDS, 38 KIIS, AND 6 GROUP INTERVIEWS			

Process evaluation KIIs explored issues of *programme relevance, coherence, efficiency, effectiveness, and sustainability* as well as aspects of *gender equality, equity and inclusion* in nutrition strategy and programme implementation. Not all KIIs covered all these topics; the evaluation team carefully developed individualized KII protocols based on the initial desk review for each type of respondent. Developing individualized KII protocols ensured that respondents were asked about the topics they are most knowledgeable about and that topics were explored in sufficient detail during each interview. KIIs at the national level (national and regional) focused on the design and rollout of the programme, alignment with broader health and nutrition objectives, and the potential to learn from and scale up PMNP. KIIs with sub-national leaders, PHC workers, social welfare officers, and ECCD providers shed light on subnational-level (province, municipality, barangay) experiences with the programme, barriers and facilitators to implementing PMNP activities, and perceived impacts of different PMNP components. Midline KIIs also explored the issue of convergence (complementing the quantitative data on this topic), specifically whether and how the different multisectoral interventions were able to converge on the same participant households.

Process evaluation FGDs also explored PMNP's *relevance, coherence, efficiency, effectiveness, sustainability* and individual experiences of *gender equality*, *equity and inclusion* in PMNP. The research team asked pregnant women and parents about their access to and experience with different PMNP interventions (including whether they have benefited from multiple interventions, and the linkages between them), their appropriateness and usefulness, and perceived changes because of the interventions. The evaluation team prioritized diversity within the gender-segregated focus groups, including people with disabilities and a range of socioeconomic statuses, where possible.

Capacity building assessment case studies. In addition to the central process evaluation, the research team designed a case study approach to assess the effectiveness of the capacity building activities of PMNP. The team conducted KIIs and FGDs with the actors involved in implementing these activities, such as Regional Project Management Offices (RPMOs) and the implementing subcontractors, as well as with the training participants, such as PHC staff and LCEs. Qualitative data collection explored the design of the capacity building training, the alignment between the training and service provider needs, and the extent to which the training affected local nutrition service delivery and nutrition action planning. It sampled respondents across all *nine* municipalities (six treatment and three comparison) to enable a qualitative comparison of capacity outcomes.

To assess the integrated NPHC trainings package, the research team conducted 46 KIIs and 16 FGDs with the key stakeholders presented in Exhibit 5. In these interviews, the team asked UPLBFI, UNICEF, and DOH PMNP NPMO representatives about the training design considerations, expected results, and potential moderators to effects. In addition, the research team conducted nine FGDs with participants of the trainings (i.e., doctors, nurses, midwives, and nutritionist-dieticians) to understand the alignment of the training with the needs of service providers, identify perceived competency gains, and understand how these could cascade onto other providers, specifically barangay-based frontline workers. In these FGDs, the usefulness of the training LDIs, TOT, training roll out, and any observed or expected impacts of the roll out trainings were inquired. In control municipalities, the FGDs with service providers explored similar themes to examine provider knowledge, needs, and strengths in the absence of PMNP training. To assess the NLG capacity building activities**,** the research team conducted KIIs with representatives of the implementing organization and with a member of the PMNP NPMO (see Exhibit 5). In these interviews, the research team inquired about the training design considerations, expected results, and potential factors that may affect the

magnitude of the programme's impact. The research team also conducted KIIs with MNAO and municipal planning and development office (MPDO) officials to understand their experiences with local nutrition planning and the perceived capacity of local nutrition officials. In addition, the team conducted 9 FGDs with LNC and LCE members to understand the alignment of the training with their needs. For control municipalities, these FGDs unpacked their nutrition planning practices in the absence of PMNP training.

The research team also incorporated questions related to the capacity building assessment in the data collection described in the process evaluation. For instance, when speaking with caregivers and pregnant women, it inquired about their perspectives on the quality of nutrition services received and any SBC interventions they may have seen. When speaking with local officials such as PMNP focal points and sanitation inspectors, the research team asked if they have been consulted as part of MNAP planning.

For these capacity building assessment case studies, the research team triangulated the qualitative findings with quantitative survey results (see Exhibit 6 below), to more reliably report on whether the capacity building activities led to tangible outcomes in nutrition service delivery and nutrition planning. The goal was to gather suggestive evidence on how the capacity building activities enhanced the quality of service in a way that is conducive to improving health and nutrition outcomes for pregnant women and children 0-23 months old. In addition, the research team provided evidence-based recommendations on implementation challenges or programme design bottlenecks that may hinder the effects of the capacity building activities.

Exhibit 3.5.3 - Capacity Building Assessment Qualitative Sample

RESPONDENT	METHOD	NUMBER	ASSESSMENT	
			Services	Governance
Representative of DOH PMNP NPMO	KII	1	I	I
RPMOs	KII	6 (1 per region)	I	I
Representative of nutrition (HCA) and primary health care capacity building implementer (UPLBFI)	KII	1	I	
Regional technical working group representative(s)	KII	6 (1 per region)	I	I
Nurses, midwives and nutritionist-dieticians/participants in	FGD	9 (1 per case study)	I	

service provider capacity building training				
Barangay health workers (BHW), barangay nutrition scholars (BNS)	KII	18 (2 per case study)	I	
Members of MNCs/participants in nutrition governance capacity building training	FGD	9 (1 per case study)		I
MNAO	KII	9 (1 per case study)		I
Mayors	KII	9 (1 per case study)		I
TOTAL: 50 KIIS AND 18 FGDS				

3.7 Qualitative Analysis

The research team coded and analysed transcripts from KIIs and FGDs using the NVivo qualitative analysis software. The evaluation team created a preliminary coding structure based on the EQs, research protocols and memos of ideas that emerged during data collection. This coding outline was used to organize and subsequently analyse the information gathered through KIIs and FGDs. The outline was also modified during data analysis as new themes emerged from the data itself. The research team also included codes related to gender norms (e.g., caregiving roles) and disability inclusion (e.g., disability awareness), as part of the approach to examining the human rights and gender implications of PMNP programming. To ensure the consistency of coding between team members, the codebook included definitions for the different nodes, and the coders also selected a sample of interviews to double code to ensure inter-coder consistency. After organising the data in NVivo, researchers characterised the prevalence of responses, examined differences amongst groups and identified key findings related to the research questions, along with any interesting divergences. These findings were subsequently triangulated with the quantitative results through several meetings during which researchers compared results.

The qualitative evidence discussed throughout this evaluation report includes prevalent themes observed across multiple participant groups and localities, as well as less prevalent perspectives observed amongst select groups and localities to add nuance and transparency to the analysis and highlight any differences or challenges unique to particular stakeholders and barangays. Where appropriate, the research team specifies whether one, several, some, many, or most participant(s) reported a perspective during KIIs and FGDs to

indicate the dominance of a given finding. Illustrative quotes are used throughout to highlight recurring and contrasting themes.

3.8 Quantitative Methodology

To complement the desk review and qualitative data, the research team administered quantitative surveys and observations in nine municipalities as part of the capacity building assessment case studies. Within each municipality, the research team collected data from both facility-based PHC providers (i.e., doctors, nurses, midwives, nutritionist-dieticians), who typically provide services in the municipal health facilities (rural health units (RHUs) and birthing homes), and community-based providers (i.e., BHWs and BNSs), who are the frontline workers that interact on a day-to-day basis with mothers, caregivers, and children. Specifically, the research team selected one of each type of facility-based provider and two of each community-based providers for the knowledge survey based on the availability of each type of provider in the sampling sites. This approach allowed the research team to understand both the state of municipal-level service provision regarding maternal, child, and nutrition-related services, while also delving deeper into the capacity and quality of service at the community level.

As shown in Exhibits 3.8.1 and 3.8.2 below, the research team used three quantitative instruments to collect data for this study: a knowledge assessment, an observation protocol, and a health facility checklist. These exhibits present the sample according to the number of surveys in treatment (T) and comparison (C) municipalities.

Exhibit 3.8.1. Proposed Quantitative Sample and Associated Instruments

RESPONDENT TYPE	# PER MUNICIPALITY	TOTAL	DATA COLLECTION TOOL
DOCTORS, NURSES, MIDWIVES, NUTRITIONIST-DIETICIANS	4 (1 of each type)	24 T 12 C	• Knowledge survey
BNS, BHW	2 (1 of each type)	12 T 6 C	• Knowledge survey
BARANGAY HEALTH CENTER BIRTHING HOME RURAL HEALTH UNIT	3 (1 of each type)	18T 9 C	• Facility checklist

Through the knowledge assessment, the research team collected basic background information from each of the PHC providers to their knowledge of service provision for children under 24 months, lactating, and pregnant women. These services include proper methods for weighing and measuring the height and Mid-Upper Arm Circumference (MUAC) of an individual, when to provide referrals for services and who to refer to in specific instances of severe and moderate acute malnutrition, treatment of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM), recommending appropriate supplements and assessing dietary diversity and nutritional content, for example. The research team ensured the knowledge assessment aligned with the material provided through the integrated NPHC trainings and that the surveys utilized captured the same knowledge as the pre-tests administered during the training sessions while also adding questions indirectly related to the material to capture wider knowledge changes.

In addition, the research team performed direct observation of service provision for different types of services and providers. Exhibit 7 lists the types of services during which the team observed providers and illustrative examples of the practices that were evaluated during service provision. Based on WHO and DOH guidelines, the research team developed detailed observation protocols to evaluate the competencies and practices of PHC workers during service provision and thoroughly trained enumerators to perform these activities.

Exhibit 3.8.2. Direct Observation of Service Provision

SERVICE	PRACTICES TO BE OBSERVED (ILLUSTRATIVE)	PLACE	# PER MUNI.	TOTAL	DATA COLLECTION TOOL
Prenatal Check-ups	Nutritional assessment of pregnant women Administration of essential micronutrients Prenatal nutrition counselling referral to services as appropriate	Barangay Health Center or RHUs and birthing homes	3	6T 3C	Observation Protocol
Infant and young child feeding (IYCF) and Breastfeeding Counselling Sessions	IYCF and Breastfeeding counselling for parents	Barangay Health Center or RHUs and birthing homes	3	6T 3C	Observation Protocol

Growth Monitoring Check-ups	Assessment of Nutritional Status of Children under 24 months old. Referral for appropriate nutrition services.	Barangay Health Center or RHUs and birthing homes	3	6T 3C	Observation Protocol

Additionally, the research team administered a health facility checklist which gathered information on the current equipment and resources available at RHUs and barangay health units as the availability of resources may influence the quality of care provided. For this reason, the research team used this information to assist in identifying the determinants of care quality as well as potential moderating factors in PHC staff competency.

3.9 Quantitative Analysis

The research team used quantitative data collected through the above instruments to assess improvements in practitioners' KAP related to providing care to malnourished individuals, particularly children and pregnant women, and to the availability of equipment and resources in facilities. It conducted descriptive analysis, mainly indicator/variable mean comparisons between the treatment and the comparison group. While the team was unable to assess changes in KAP over time or to attribute changes in PHC staff's knowledge or behaviours, in quality of care provided, or in access to specific healthcare inputs specifically to the interventions, these analyses allow the research team to provide suggestive evidence of the effectiveness of PMNP, particularly when triangulated with other data sources.

3.10 Evaluation Limitations

As with any study, this midline evaluation has some limitations the reader should consider when interpreting results. The research team identifies and describes four limitations and how they attempted to mitigate their effects below:

- Much of the analysis relies on self-reported data, which can be subject to social desirability bias and recall bias. For example, respondents may be embarrassed to truthfully answer questions about instances of food insecurity, and households may not remember clearly all encounters with nutrition services in the past year. However, the research team designed the survey instrument using validated modules to mitigate bias, and

employed experienced enumerators to build rapport with respondents, so they feel comfortable answering any sensitive questions truthfully.

- The research team cannot attribute changes or differences in outcomes at midline to PMNP (i.e., cannot speak to causality). They were also unable to implement an experimental or quasi-experimental design to assess the effectiveness of the capacity building activities. Due to resource constraints as well as timing of activity delivery and evaluation roll-out, most capacity building activities were implemented prior to data collection for this midline evaluation such that the research team lacked baseline data for PHC worker KAP and LCE and LNC capacity building. Without baseline data, they were unable to definitively assess how individuals' knowledge and skills changed over time; to determine changes, the research team would need to know levels of providers' knowledge and capacities prior to receiving the trainings. However, the design allowed the research team to compare the knowledge and skills of providers across treatment groups at a single point in time after delivery of the capacity building activities. The research team is, thus, able to provide suggestive evidence of the effectiveness of the NPHC activities for providers.
- Not only were the analyses limited by the ability to attribute change to the project, the research team was also restricted in the number of providers and health facilities sampled due to resource constraints.[40] The midline quantitative sample was limited to a relatively small sample of 54 providers whose knowledge could be assessed, 27 of each type of counselling or growth monitoring sessions observed, and 27 total health facilities resulting in a very small sample size reducing the ability to detect small differences in outcomes between the two groups. Thus, while the research team found a few small differences in provider KAP between groups or resources and equipment in facilities, it is possible there were other observed differences for which they were not able to detect significance. Even so, the research team is confident that the data and results provide clear and suggestive evidence of the effectiveness of

[40] The research team worked closely with UNICEF and the DOH during the planning stage to determine the preferred study design and sampling approach in light of the available resources. The entities collaboratively opted for a descriptive study (i.e., not causal) with a sample spanning each of the three key island groups to enable as much representativeness as possible in the sample, though this was not a key consideration in the approach. Accordingly, the research team selected a sample which allowed them to assess differences between the treatment and comparison groups - focusing on nine municipalities (three from each major island group with a 2:1 split of treatment and comparison municipalities). The research team also identified the types of providers they wanted to target for the quantitative data collection activities (i.e., doctors, nurses, midwives, nutritionists, BNSs and BHWs) and included them in the sample as appropriate (e.g., one of each type of professional provider, two of each type of barangay-level provider).

the NPHC training on service provider KAP and on the resources available in health facilities. In addition, the research team triangulated these findings with those from qualitative methods to further assess the effectiveness of these capacity building activities.

Lastly, as with all research studies relying on self-reported data, the evaluation results could be affected by social desirability bias or recall bias. The former occurs when respondents provide answers they believe the interviewer wants to hear or that they feel are more socially acceptable answers even if these differ from their actual practices or beliefs resulting in unreliable data. Recall bias, on the other hand, occurs when respondents are unable to accurately remember their past experiences and are unable to reliably provide valid answers to questions referring to events in the past. To account for these potential biases, the research team implemented several common mitigation strategies. Firstly, during data collector training, the team trained on neutral, non-judgmental interview techniques for both quantitative and qualitative interviews such as regulating facial expressions and commentary on responses. Qualitative interviewers were further trained on neutral probing techniques when attempting to elicit further responses and more details from interviewees. This training also included tips on building rapport with respondents including how to reinforce the idea of confidentiality of responses to establish trust and ensuring data collection activities took place in a safe and secure location away from eavesdroppers, including family members. Further, the research team ensured all surveys and interview protocols were free from leading questions. While for recall bias, all protocols used recent and well-known reference points rather than specific dates to help respondents provide valid responses based on associating memories with key events such as a cyclone or holiday. Accordingly, the research team believes these techniques enabled collection of reliable data.

4. Data Collection

4.1 Training and Piloting

The research team partnered with Associates in Development (AiD), a Philippine data collection firm, for the evaluation of PMNP. The qualitative and quantitative teams were trained at the University of the Philippines, Los Baños, from August 26 to 29, 2025. Sixteen field team members were thoroughly trained by Dr. Normahitta Gordoncillo to conduct observations of service provision, namely prenatal check-ups, growth monitoring, and IYCF counselling. Quantitative and qualitative teams then piloted the full instruments on August 29 and debriefed from the pilot the same day.

4.2 Fieldwork Processes and Timeline

Prior to collecting data, the research teams conducted courtesy calls with regional and provincial DOH officials, municipal mayors, and barangay captains. During courtesy calls, the research team explained the planned research activities and requested approval to conduct the activities. Data collection began on September 22, 2025, and finalized on October 31, 2025.

4.3 Data Quality Controls and Cleaning

Throughout data collection, the research team conducted high frequency checks in Stata to assess incoming data quality and enumerator performance. Prior to data cleaning and analysis, the research team conducted a quality assessment of the complete survey data, which included various checks for data anomalies (e.g., duplicate responses, missing values, outlier values, other logic checks) in Stata.

Following the data quality assessment, the research team cleaned the data as needed (e.g., labelled variables, recoded and labelled missing values) and generated key outcome variables. In some cases, outcome variables were constructed with single survey questions, and in other cases, outcome variables were constructed by combining several survey questions (e.g., developed indices). Outcome variables were disaggregated by treatment status and tested statistical equivalence of each outcome between the two study groups.

The research team also reviewed qualitative transcripts for completeness and quality before imputing them into NVivo for analysis.

4.4 Ethical Protocol

The research team recognizes its responsibility for safeguarding and ensuring ethics at all stages of the evaluation cycle. This includes, but is not limited to, ensuring informed consent, protecting privacy, confidentiality and anonymity of participants, ensuring cultural sensitivity, respecting the autonomy of participants, ensuring fair recruitment of participants (including women and socially excluded groups) and ensuring that the evaluation results in no harm to participants or their communities.

The research team adheres to the 2020 United Nations Evaluation Group (UNEG) Ethical Guidelines, which require both a conflict- and gender-sensitive approach to research; adherence to the do-no-harm principle; and

transparency, confidentiality, accuracy, accountability, and reliability, among other key principles. Specifically, with regard to the protection of vulnerable individuals and communities, The research team respects and adheres to the United Nations Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Declaration on the Rights of Indigenous Peoples, as well as other human rights conventions and national legal codes that respect local customs and cultural traditions, religious beliefs and practices, personal interaction, gender roles, disability, age, and ethnicity.

Ethical Approval. This study was approved by the American Institute of Research (AIR) Institutional Review Board (IRB) as well as the Philippines Single Joint Research Ethics Board (SJERB).

The AIR IRB (IRB00000436) is registered with the U.S. Office of Human Research Protection as a research institution (IORG0000260) and conducts research under its own Federal-wide Assurance (FWA00003952). The IRB preapproves all research activities and protocols involving human subjects conducted by AIR researchers, as well as an information security plan to protect the confidentiality of data obtained from research participants. The AIR IRB follows the standards set forth by the American Evaluation Association Guidelines and the Joint Committee on Standards for Educational Evaluation. These standards can be distilled into three general principles: (1) Evaluators will conduct evaluations legally and ethically, taking into account the welfare of those involved in the evaluation, as well as the general public; (2) evaluators will conduct evaluations in a competent and efficient fashion that will lead to reliable and accurate results; and (3) evaluators will design evaluations and report the results in a manner that is useful to and appropriate for the intended audience. The midline evaluation research activities were approved by the AIR IRB in September 2025.

In addition, the research team submitted all necessary documents to renew ethics approval from the SJERB, which is under the purview of the DOH. The SJERB is the foremost body overseeing ethics in health research in the Philippines, and it serves to verify that all data collection tools and protocols adhere to the highest standards of participant protection in ethical health research. PMNP midline research and data collection activities were approved by the Single Joint Research Ethics Board (SJREB) on September 11, 2026.

The study further required ethical clearance from the National Commission on Indigenous Peoples (NCIP) to conduct research in IP communities. This process is referred to as Free, Prior and Informed Consent (FPIC), and it involves the

submission of an application to NCIP officials, meetings to seek the consent of the IP community leaders, and the creation of a memorandum of agreement for the agreed-upon research activities. After the research, FPIC also mandates a validation workshop and the issuance of a certificate of validation by the community. Prior to the launch of midline data collection, the research team obtained NCIP's approval to conduct data collection in the IP community of Buhi (Camarines Sur) through a Memorandum of Understanding between NCIP and DOH.

Data security and Confidentiality. To ensure that ethical standards were maintained throughout the research process, the research team trained all data collectors in research ethics and standards for the evaluations prior to baseline data collection. All potential study participants were asked to provide active, informed consent for their participation in the research, and they were permitted to withdraw from the research activity at any time.

AIR took several steps to secure all data collected in the field. As outlined in the project's data governance plan (which was approved by the AIR IRB), all data were deidentified by the enumerators, so that no names or other personal information were included on the transcripts or survey data. When transmitting files digitally, the research team encrypted and password-protected all files. Audio recordings of interviews and focus groups were deleted once the transcriptions were verified and translated into English (if necessary). During the data analysis phase, it stored the data on a secured, encrypted server and restricted access to the server to approved members of the research team. These steps helped ensure multiple levels of data protection and security to further protect research participants' confidentiality.

Approach to Inclusivity and Gender Sensitivity. The research team gender-responsive approach to evaluating the PMNP programme is designed to address gender, equity, and inclusion, from framing the research questions to designing the data collection and collecting the data, to analysing and disseminating the results. Such considerations are crucial to conducting research among vulnerable populations, such as those who participated in baseline data collection.

First, the research team considered the gender and equality implications at the level of the research tools and design. In terms of sampling, program beneficiaries who reflect the diversity of the PMNP implementation sites were included and participant security was ensured amid this approach. It further designed and pretested protocols to ensure they are not leading or biased; train facilitators in research techniques, including best practices with vulnerable

groups such as youth, Ips, and people with disabilities; and supported facilitators' recognition of researcher reflexivity, particularly as it relates to biases and preconceived notions of research participants.

The research team then collected data in a gender-responsive way, considering the risks that women and female youth may face when participating in the data collection processes. For instance, the research team ensured that focus groups with women and mothers were led by female facilitators. Similarly, to mitigate ethnic and linguistic power imbalances, the research team recruited all data enumerators from locations near the LGUs of qualitative and quantitative data collection. The research team also instructed enumerators to ensure that respondents are in a safe space, with no other family members nearby, before conducting the survey or interview. These considerations helped create a safe environment in which participants can openly and honestly respond to survey questions.

Finally, the research team adopted a gender-sensitive and equity-focused data analysis approach, including by disaggregating data according to characteristics of vulnerability where possible and by conducting thematic analyses of qualitative data to explore themes related to inclusivity and gender equality. These subgroup analyses helped ensure the nuance of findings and aid in the refinement of the programme according to goals of equity and inclusion.

5. Findings

This section presents the findings from the midline evaluation by evaluation criteria. Since this is a midline study, results do not provide answers to questions around impact and some questions around efficiency and sustainability require collecting information at the end of the programme to provide comprehensive answers. This report presents a summary of main findings at the beginning of each evaluation criterion section.

POM revisions (Oct 2024) improved fit to LGU needs—clearer guidance on digital systems, M&E, governance, grant disbursement, and procurement, and proactive communication of updates via departmental memoranda.

Multisectoral design is appropriate at barangay/LGU level—stakeholders emphasized the need to integrate nutrition, health, WASH, and ECCD; nutrition planning instruments (MNAPs/BNAPs) are now more multisectoral, responsive to local needs, and embedded in AIPs.

Integrated NPHC training content aligns with provider needs—strong content relevance; however, condensed delivery reduced mastery and practical retention; calls for refresher, mentoring, and role-tailored modules.

Nutrition Leadership & Governance (NLG)—Executive Forum for Mayors and NLG trainings meet LCE/LNC needs (planning, budgeting, supervision, SBC integration), strengthening evidence-based local leadership for nutrition.

5.1 Relevance

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Integrated NPHC training content aligns with provider needs—strong content relevance; however, condensed delivery reduced mastery and practical retention; calls for refresher, mentoring, and role tailored modules.
Nutrition Leadership & Governance (NLG)—Executive Forum for Mayors and NLG trainings meet LCE/LNC needs (planning, budgeting, supervision, SBC integration), strengthening evidence based local leadership for nutrition.

Q1.1 To what extent are the PMNP programming strategies outlined in the POM appropriate for achieving the desired results?

The PMNP Project Operations Manual (POM) is a complex document of over 500 pages which details PMNP design, guidance for implementing key activities, mechanisms of coordination, and administrative procedures related to procurement, grievances, environmental and social risk, and other topics.

POM Revision

The original POM was developed in 2022 but has been updated, expanded, and elaborated over the course of PMNP implementation. The current POM dates to October 2024, and it improved on the previous version by further developing the implementation guidance related to digital systems, monitoring and evaluation, governance, grant disbursement, procurement, and sustainability.

The revised 58ncludees an additional chapter focused on “information system development,” signalling more comprehensive efforts to support capacity development related to data and information management in LGUs. The chapter lays out efforts to integrate information systems under DOH, DSWD, and NNC to enable multisectoral nutrition monitoring and to support local officials in collecting, analysing, and reporting nutrition related data. The

chapter also outlines incentives for LGUs to adopt integrated systems for timely reporting, and it identifies the roles and responsibilities of specific actors (e.g., UNICEF, PMNP NPMO) in the information system development efforts. The push to integrate data and information systems is highly relevant in light of existing incompatibilities. (Information systems are further reported in Q2.5.)

Other notable changes between the 2022 and 2024 POM include more detailed guidance on the calculation of PBGs and MGAs; expansion of the results monitoring and evaluation framework with additional indicators; and a clarified role for UNOPS in project procurement and the information systems development activities. Overall, the POM revisions build on the lessons learned from PMNP implementation to strengthen coordination, clarify processes, and elaborate programming in areas of emerging need for LGUs and PCF providers.

To ensure the changes in the POM were understood and adopted across the various levels of implementation, PMNP proactively communicated project stakeholders. As noted by a regional level respondent, *"We are always updating our LGUs for these changes [to the POM] to at least make them aware,"* with updates frequently communicated through official departmental memorandums to relevant offices.

Perceived relevance of strategies and activities

As reported at baseline, the strategies and activities outlined in the POM are seen as appropriate for addressing gaps in multisectoral nutrition. The POM provides comprehensive guidance for implementing activities such as grants, capacity building, and project coordination, and is viewed as highly relevant by stakeholders for strengthening LGU-level nutrition services.

The collaboration with Kalahi-CIDSS was crucial for addressing critical infrastructure gaps undermining service delivery. As of January 2025, there were a total of 4,884 subprojects completed, primarily related to daycare facilities (4,201 subprojects) and WASH (684 subprojects).[41] Investments in day care centres including new rooms, kitchens, and upgraded equipment were cited by respondents as essential for improving the nutrition and learning environment of young children. ECCD was further described as critical, with supplementary feeding programmes targeting those who are malnourished.

Transportation to primary care facilities arose in the qualitative data as a challenge that families and young children face which is perhaps not fully

[41] Bukluran 2025 PREW_05 Feb 2025

accounted for in the POM. A number of beneficiaries and service providers cited transport as a key barrier to the uptake of the nutrition-specific services, including growth monitoring and antenatal care, targeted by PMNP. This is especially so in GIDA municipalities and IP communities, who are among the most vulnerable target beneficiaries of PMNP. The improvement of transport infrastructure is not supported under component two. Although transport infrastructure may be insufficiently linked to project objectives to qualify as an eligible subproject, the POM and PMNP more broadly may address transportation barriers through other approaches, such as coordination with cash assistance programs or investments in health facility construction and staffing in remote areas.

Exhibit 5.1.1. A PMNP-constructed Day Care Facility in Leyte

Q1.2 How well does PMNP meet the priority needs for multisectoral nutrition programming at the LGU level (and other levels – province, municipal, and barangay)?

Perceived usefulness and responsiveness of PMNP for LGU (and other) officials

Stakeholders repeatedly emphasized the usefulness of the project's integration of health, WASH, ECCD and SBC interventions. Respondents agreed that the multisectoral approach was a critical feature of PMNP's design, noting that no single component could address the multi-dimensional nature of nutrition challenges at the barangay level. As a municipal level respondent explained,

"Everything is important…it is really a multisectoral approach, the PMNP, so you should not only focus on one program. You should include everything - you should tackle everything because nutrition is about the whole well-being of a human. So, you should not do feeding only, what you need to do is a multisectoral approach."

Provincial level stakeholders viewed PMNP as a timely tool that filled gaps through the provision of additional funds to ensure resources withing health centres are continuously stocked to meet health needs. In line with allocation of funds, through HPGs, LGUs were able to develop information education campaigns and the implementation of SBC.

PMNP implementation was also associated with increased awareness among local officials regarding the range of services eligible for funding, particularly through the DSWD. Several participants reported that PMNP expanded their understanding of DSWD's role beyond infrastructure-focused interventions. For example, a WASH officer noted increased awareness that DSWD funding could complement DOH inputs, such as supporting construction costs for facilities where equipment had already been provided but remained unused due to funding constraints.

LGU officials reported that PMNP coverage prioritized municipalities that previously lacked MNAPs, many of which also experienced higher rates of stunting. According to respondents, PMNP support contributed to notable improvements in local nutrition planning, including the development and refinement of MNAPs and their cascading to the barangay level.

For LGUs with pre-existing MNAPs, PMNP introduced closer monitoring to ensure plans were implemented as intended. Participants emphasized that the programme strengthened LGU capacity to understand the importance of BNAPs and to systematically identify barangay-specific nutrition gaps, service delivery bottlenecks, and resource constraints. As one participant explained, *"BNAPs have been essential in ensuring that the most priority needs at each barangay get the attention and allocated budget they need."* Training and regular monitoring by MNAOs were reported to further enhance the relevance and practical use of BNAPs. Over time, barangay officials observed a notable institutional shift, with BNAPs becoming a prerequisite for budget approval, reinforcing accountability and closer alignment between planning and resource allocation.

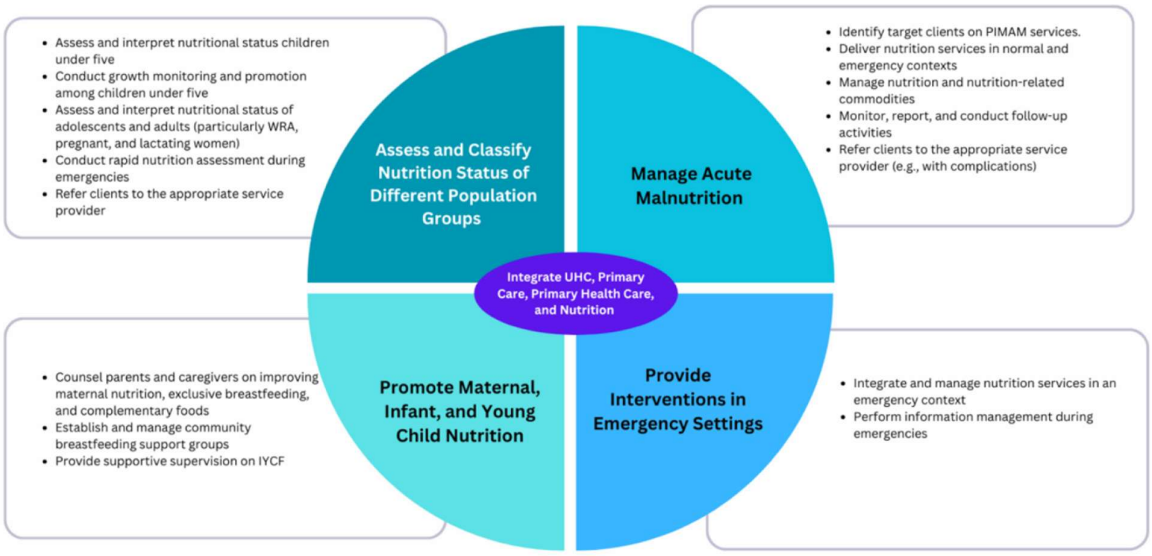
Beyond PMNP's multisectoral approach, respondents felt the combination of technical assistance, monitoring, and financing (i.e., PBGs, MGA, HPG) helped LGUs coordinate and prioritize nutrition more effectively. The establishment of nutrition committees and the requirement for LGUs to prepare MNAPs were described as timely responses to existing planning and resource mobilization gaps. Other municipal staff noted that MNAPs now integrate both nutrition-specific and nutrition-sensitive interventions, making them more responsive to the realities faced by municipalities. Municipal staff also clarified that PMNP

processes have helped ensure these interventions are reflected and budgeted for in the Annual Investment Plans (AIPs).

Q1.3 How well is the Competency Framework for Integrated Nutrition and Primary Health Care (Integrated NPHC) aligned with the needs of Primary Health Care Facility Staff?

The Integrated NPHC training was designed to improve the knowledge and skills of practitioners for delivering high-quality nutrition and PHC services. The integrated NPHC training content is split into four key areas: assessing and classifying the nutritional status of different target populations (e.g., pregnant women and children under 5), managing acute malnutrition, promoting IYCF and maternal nutrition, and providing nutrition services in emergencies (see Exhibit 5.1.2).[42]

Exhibit 5.1.2. Integrated NPHC Training Content



UPLBFI, in collaboration with DOH and UNICEF, developed training and reference materials for PHC workers covering these topics and more. The training was first provided to master-level trainers, which included officials at the province and region, and comprised seven modules: i) understanding universal health care, PHC, and nutrition; ii) child growth monitoring and nutrition assessment; iii) promoting IYCF; iv) management of acute

[42] UPLBFI. (2024). Integrated Nutrition and Primary Care – Capacity Building of Frontline Workers on Nutrition and Primary Care, Monitoring and Support on Social and Behaviour Change in 235 Philippine Multisectoral Nutrition Project (PMNP) Municipalities in Luzon, Visayas and Mindanao and 40 Municipalities in the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM): Inception Report. Manila: Philippines.

malnutrition; v) supporting NiE; vi) supportive supervision; and vii) mastering training delivery – the technical, content and administrative aspects.

Within this model, nutrition in emergencies was incorporated as a cross-cutting technical component, supporting the continuity and adaptation of PMNP nutrition interventions in emergency contexts. A national level DOH stakeholder, however, pointed out that a more comprehensive training to NiE— in line with the quad cluster approach— would require incorporating Mental Health and Psychosocial Support (MHPSS) and WASH in Emergencies training to the package.
Master trainers were then expected to train facility-based providers at the municipal level (e.g., doctors, nurses, midwives, nutritionists). As such, most facility-based providers receive rollout training from the master trainers.
In the remainder of this section, this report presents results from qualitative interviews and FGDs describing the perceived appropriateness and need for the content provided in these integrated NPHC training, followed by quantitative findings from the knowledge surveys highlighting the training received by surveyed respondents.

Alignment of training content to service provider needs

The October 2024 Landscape Analysis and Nutrition Situation Assessment (LANA) results identified key gaps in human resource capacity, including the need for refresher training on child growth monitoring and limited training for nutrition in emergencies in seven of the eight assessed regions. Qualitative data shows that the Integrated NPHC training content under PMNP addressed these gaps by providing a consolidated model aligned with the technical needs of PHC staff, covering maternal and child nutrition, growth monitoring, and emergency nutrition.

Respondents consistently highlighted the relevance of these topics to their daily work. A municipal level respondent in Maigo, Lanao del Norte (FGD) shared, "*The PMNP training is a huge help especially in our field of work because it enables us to review and refresh our knowledge regarding the proper weighing of children... and the proper MUAC measuring in a very detailed way*."

Specifically, the training was reported to be relevant for teaching PCF workers how to use MUAC to diagnose SAM and MAM. This hands-on skill was considered essential for accurate identification and management of malnourished children. As one Barangay representative noted, "*the training enables us to review and refresh our knowledge regarding the proper weighing*

of children, which made me realize there are small details about it that we tend to overlook but are very important in this field."

The training condensed several curricula (e.g., PIMAM, IYCF, and NiE), a decision which received mixed reviews by project stakeholders and service providers. On one hand, the training accommodated the busy schedules of many health service providers, providing extensive information in a shorter period of time. The intensive nature of the training was appreciated by some, with one training recipient noting, *"The trainings were really intensive and required a lot of interaction, unlike the previous ones that were usually finished in just a day"* (National representative). On the other hand, stakeholders felt that the shortened format reduced training quality and completeness and compromised mastery of practical skills such as case-based management, with several national level respondents observing that shortening the course from 15 to 5 days risks diluting key competencies. Similarly, staff reported that skills were sometimes forgotten when integrated packages are delivered too briefly, reducing their usefulness in daily practice.

While it was comprehensive, several respondents suggested that the training design could be better tailored to participants' roles and capacities rather than delivered as a uniform package. A regional level respondent explained, "*We cannot just present the training as apples to apples… we have to make it a little bit more personalised, or we will adjust to what their capabilities are… and also the learning curve of our municipality.*" A national level staff member also highlighted the need for clear policy guidance and operational tools, as the absence of officially adopted materials (i.e., the condensed training content) makes it difficult to introduce new practices in regions unfamiliar with the framework.[43] Beyond training content, PHC workers emphasized the need for adequate time, resources, and supervision to apply learning. For instance, a UPLBFI representative pointed out that competing tasks limit time for counselling, home visits, and monitoring, while a municipal level respondent stressed the importance of "*refresher courses in anthropometric measurement to ensure accurate service delivery*."

Although not incorporated into the training materials, respondents also noted that the NPHC training package covered the topic of culturally respectful engagement, including working with IP communities. Several respondents highlighted how the training equipped providers with practical skills to build trust and communicate more effectively with IP groups particularly in situations

[43] Note that DOH issued DM 2025-0200 on the Endorsement of the Final LDI Materials for the INPHC of the PMNP on May 8, 2025. More in-depth training on growth monitoring is typically rolled out through Operation Timbang (OPT) Plus Data Quality Check training.

where they previously felt less confident or had demonstrated unintentional bias or unfamiliarity.

In line with these self-reported needs, several subnational staff expressed that existing training sessions, while beneficial, were insufficient to keep pace with evolving programme requirements and community needs. For example, one BHW noted,

"We really hope, ma'am, that we could have seminars or training that all of us can attend to gain more knowledge. Many of us have low educational attainment... It would be really good to have additional training so we can improve our services and stay updated".

Others highlighted the challenge of relying on intermittent guidance from municipal health staff, stating that regular, accessible training would help them stay informed and confident in their roles. The need for training was not limited to technical skills; respondents also cited the importance of capacity building in areas such as mental health and psychosocial support, recognizing that their well-being directly affects service delivery.

Q1.4 How well are the NLG capacity building activities aligned with the needs of LCEs and LNCs?

To date, PMNP's activities on Nutrition Leadership and Governance (NLG) include the Executive Forum for Mayors, the Integrated NLG Training Curriculum for LNCs and LCEs, and the MNAPs Formulation Workshop. The section presents qualitative findings from each activity, highlighting participants' experiences, perceived relevance, and the ways in which these initiatives contributed to strengthening local leadership, multisectoral coordination, and evidence-based nutrition planning.

Executive Forum for Mayors. The Executive Forum for Mayors, which took place in Taguig City during July 16-17, 2025, was attended by over 400 participants, including 167 of the 235 PMNP mayors (about 71% of PMNP Mayors). The Forum included sessions to guide the recognition of the local nutrition situation including gaps, challenges, and leadership roles and apply effective leadership approaches and tools to strengthen governance of nutrition programmes and services at the local level.[44] Stakeholders consistently described it as a relevant and strategic platform for deepening Mayors' understanding of their responsibilities in nutrition governance. Qualitative

[44] DESIGN Mayors Forum VER3 05JUN2025

interviews indicated that the training addressed low prioritization of nutrition as a key challenge within leadership. A local-level respondent reported that the trainings improved departmental capacity for budget planning and strengthened coordination with the MSWDO and MPDO especially during implementation planning.

NLG NPM training for LNCs and LCEs. The objective of the NLG training is to build the competencies of LCEs and LNCs in supportive supervision, data-driven planning and decision-making, and effective implementation of MNAPs with SBC initiatives.[45] To date, three batches of NLG NPM trainings have been conducted. The content of the training was developed collaboratively by NNC, DOH, UNICEF, and Human Capital Asia to address critical governance gaps identified through baseline assessments. The curriculum focuses on strengthening evidence-based nutrition planning and budgeting, improving LNC functionality, and enhancing monitoring and evaluation systems at the LGU level. For LCEs, the training emphasizes leadership engagement, prioritisation of nutrition within local development agendas, and practical strategies for resource allocation and staffing to institutionalize nutrition governance. These efforts aim to build sustainable capacity for multisectoral nutrition programming and ensure that LGUs move beyond short-term feeding programmes towards comprehensive, nutrition-sensitive interventions. Implementation of this integrated NLG training is still in its early stages, with initial sessions and advocacy activities underway.

Training participants noted that while some topics were refreshers, the sessions provided deeper, structured guidance on planning, implementation, and the nutrition programme management cycle. Local-level respondents reported that the content was relevant, as it was informed by their understanding of participant needs and previously identified priority areas.

A regional participant also shared, the training "*enhanced and focused on how to plan, how to implement… they tackled [the topics] one by one*." There was also emphasis on the value of the leadership component, noting that the training "*harmonized the leadership skills as a leader*," and was delivered to the appropriate audience, LCEs and MNCs who are directly responsible for advocating, planning for, and supporting the execution of nutrition activities at the local level.

MNAP formulation workshop. The MNAP workshop was developed to ensure effective formulation, implementation, and monitoring of MNAPs, and to

[45] NLG-NPM Training for LNC Draft 14APR2025

ensure alignment with national policies and inclusion of marginalised sectors.[46] The workshop also updated provided guidance to local officials on how to incorporate PBGs into MNAPs. Local officials and national stakeholders alike found the training to be relevant, and that it clarified key processes such as key elements of an MNAP, fund management, and transparent budget utilisation. While these workshops were also viewed as refreshers, a municipal-level respondent noted that *"there have been many trainings, but each year there are changes in how MNAPs are formulated."*
For some national stakeholders, trainings such as the MNAP workshop are necessary to ensure that municipalities are submitting high quality MNAPs and not simply preparing them to be compliant with the PBG eligibility criteria.

Self-reported needs of LCEs and LNCs

Training-related feedback from LCEs and LNCs points less to gaps in training content and more to challenges in how training is targeted, reinforced, and translated into practice. It is important to note, however, that there were limited instances in which LCEs and LNCs explicitly articulated their own training needs. This may reflect limited awareness of the full scope of information and support that could be provided through the NLG training, rather than an absence of capacity gaps.

Instead, respondents described implementation challenges that have implications for capacity strengthening. Local respondents reported that while trainings are regularly conducted, they do not reach all relevant committee members or implementers. Participation is often restricted to a small number of designated representatives, with the expectation that learning will be informally cascaded to others. In practice, this approach does not consistently result in shared understanding or improved implementation at the local level. As one local level participant noted, "*PMNP always calls for training… I just hope… that everyone will participate and with attendance… They have target participants. When in fact, the local government knows who should be able to contribute to the implementation of the program."*

5.2 Coherence

Strong policy alignment—PMNP programming aligns with RA 11148 (First 1,000 Days), PPAN 2023–2028, UHC, HSS, and DSWD Strategy Map; it also complements and expands existing DOH and DSWD efforts (e.g., 4Ps, Kalahi-CIDSS, OPT+).
Vertical & horizontal coordination structures are in place and functioning —Technical working groups and project management offices enable cross-sector coordination, with challenges

[46] PROGRAMMEDESIGN STS – LNAP Formulation VER.6 (PresMat V.2) as of May 5

Systems compatibility is partial—PMNP leverages FHSIS, OPT+, MELLPI Pro, GTWA, PIMS, ECCD checklist, iClinicSys EMR, and introduces HCSC; adoption/integration is inconsistent, with manual data flows common.
Value-add without duplication—PMNP expands and harmonizes existing initiatives (e.g., WASH/ECCD via Kalahi-CIDSS, SBC through FDS), though misaligned timelines between Components 1 and 2 may have reduced synergy.

Q2.1 To what extent is PMNP programming consistent with the First 1,000 Days Law (i.e., RA 11148)?

PMNP's design reflects strong alignment with RA 11148, the First 1,000 Days Law. Planning documents consistently emphasize the critical window from conception to a child's second birthday and highlight the need for targeted nutrition interventions during this period. Under Component 1, the program also prioritizes a package of "*high-impact*" nutrition actions that form part of the 76 services mandated under RA 11148. In addition, both RA 11148 and PMNP identify GIDAs and adolescent mothers as priority populations for delivering essential nutrition-specific and nutrition-sensitive services. Respondents repeatedly highlighted that PMNP's focus mirrors the First 1,000 Days Law's mandated priority groups: pregnant and lactating women and children under two. This includes support for ANC, micronutrient supplementation (e.g., ferrous sulphate), IYCF, and community-level maternal-child health services.

Many LGU-level staff described PMNP as enhancing existing F1KD implementation, with 69% of PHC facilities equipped with F1KD supplies,[47] by filling gaps in supplies, equipment, and service delivery capacity. Health workers noted that PMNP helped address shortages of vitamins, ANC supplies, and basic anthropometric tools, making service delivery more consistent for first-1,000-days beneficiaries. A Department of Interior and Local Government (DILG) representative also emphasized that PMNP "*complements*" RA 11148 by providing LGUs with additional financial and logistical capacity to implement the law more effectively.

Similar to baseline findings, respondents consistently highlighted PMNP's alignment with provisions on ANC, lactation support, and child nutrition, but none mentioned programme components related to labour, delivery, or immediate postpartum services.

[47] See Effectiveness section.

Q2.2 To what extent is PMNP programming consistent across sectors and multisectoral interventions delivered by the DOH and the DSWD, including health, nutrition, WASH, ECCD and social protection?

PMNP implementation can be generally understood through its vertical and horizontal coordination structures. Vertically, the National Project Management Office (NPMO) transmits policies and guidelines to the Regional Project Management Office (RPMO) at the Center for Health and Development (CHD), then to Provincial Department of Health Offices (PDOHO) and Development Management Officers (DMOs) at the city/municipal level. DMOs coordinate with City/Municipal Health Officers (nurses or midwives) and Barangay Health Staff (BHW and BNS). On the DSWD side, the NPMO passes policies to RPMO and Area Coordinating Teams (ACTs), which guide Community Volunteers (CVs) and Barangay LGU leaders in implementing subprojects and the Community Empowerment Activity Cycle (CEAC).

Horizontally, the IATF-ZH coordinates project implementation among DOH, DSWD, other agencies, and LGUs, and serves as the PMNP steering committee in collaboration with the World Bank.[48] The National Technical Working Group (NTWG), co-chaired by DOH and DSWD, includes DepEd, DA, Department of Science and Technology (DOST), DILG, DEPDev, NNC, and FNRI, and oversees planning, implementation, and reporting. Similar multisectoral working groups exist in each region where PMNP operates (i.e., RTWGs). It should be noted that regional technical working committees existed before but are now enhanced with PMNP because of the conduct of regular meetings.

Alignment, complementarity, and harmonization between PMNP and other complementary interventions and sectors at national, regional, and municipal levels

At the national level, PMNP successfully complements and harmonizes with existing government programmes across sectors. Most NTWG members are active participants, though some noted that DA is less consistently present. The planning of NTWG largely prevents overlap and leverages established modalities from programmes like Kalahi-CIDSS and 4Ps. National level coordination also led to the DILG Memorandum Circular 2024-071 (Adoption and Implementation of PPAN 2023-2028) to all municipalities in the Philippines which aimed to "*encourage LGUs to create nutrition programs and put them in*

[48] World Bank, May 2022, Project Appraisal Document on a Proposed Loan in the Amount of US$178.1 Million to the Republic of the Philippines for the Philippines Multisectoral Nutrition Project [Report No. PAD4498]. <https://documents1.worldbank.org/curated/en/671151655916778864/pdf/Philippines-Multisectoral-Nutrition-Project.pdf>

their local plans" (National representative, KII). In addition to NTWG efforts and official memoranda, mechanisms like Kalahi-CIDSS mapping and negative lists (projects that cannot be funded as they are covered by another agency) and the household convergence scorecard operationalize multisectoral harmonization. Overall, national-level coordination is facilitated by regular communication, shared monitoring tools, and a focus on complementarity.

Compared to the national level, regional level harmonization is shouldered by RPMOs and involves adapting project guidance to the regional context, forging relationships with regional counterparts in other sectors, and overseeing the logistical aspects (e.g., scheduling) of coordination and harmonization. As one national representative pointed out, DA and DILG sometimes conduct infrastructure projects at the regional level, so the Kalahi-CIDSS activities of PMNP required close coordination with those departments. Overall, DSWD appeared to have more streamlined procedures for downloading project guidance from the national to the local level since 4Ps and Kalahi-CIDSS programmes predated PMNP. On the other hand, regional and provincial coordination seemed more challenging within DOH, with relationship building and consistent communications being necessary for RPMOs to facilitate project implementation.

Harmonization at municipal and barangay levels typically takes place through the work of MNCs to implement multisectoral nutrition interventions. While at baseline, harmonization and coordination structures were not evident at municipal levels, midline findings explored under EQ4.2 indicate that MNCs appear to be effectively engaging across sectors to prepare and carry out MNAPs. That evidence indicates how PMNP emphasis on local nutrition planning and MNC capacity building has improved coordination and harmonization since baseline.

Notably, with the rollout of the PuroKalusugan program in 2025, health service provision is also being provided at the purok level in prioritized barangays. This highlights that future PMNP efforts may consider how to implicate these service providers in coordination and capacity building efforts.

Existence of linkages and synergies across programmes

The strongest intersectoral linkages enabled by PMNP are between DOH and DSWD, but respondents raised a variety of other programs with which PMNP might coordinate.

PMNP coordination with DSWD programs like 4Ps, Kalahi-CIDSS, and supplemental feeding programs primarily takes place through shared targeting strategies, with the household convergence scorecard intended to support these efforts. Other linkages take the form of the listing of interventions eligible for Kalahi and PBG funding. For 4Ps specifically, requirements for antenatal visits, child growth monitoring, and family gardening work synergistically with PMNP efforts, while family development session (FDS) have proved a useful vehicle for SBC.

Beyond DSWD, synergies exist between DOH and DILG through PMNP through the Seal of Good Local Governance (SGLG). Outlined in the POM and cited by a few respondents, certain requirements for securing SGLG are supported by PMNP, including having and carrying out MNAPs.

A variety of additional, relevant programs were raised by qualitative respondents, both national level policymakers and local officials who witnessed these programs on the ground (see Exhibit 5.2.1). Several non-government organisations (NGOs) were also noted to be active on topics of nutrition and health in treatment areas, including Save the Children, Hellen Keller International, the Red Cross, and 4-H. The project may consider strengthening coordination with these implementers to reinforce PMNP efforts.

Exhibit 5.2.1. Programs complementary to PMNP, according to qualitative respondents

Program	Dept.	Description	Recommendation
Tulong Panghanapbuhay sa Ating Disadvantaged Workers (TUPAD)	DOLE	Provides employment for displaced workers, the underemployed and the unemployed poor.	Beneficiary convergence
Assistance to Individuals in Crisis Situation (AICS)	DSWD	Provides medical assistance, burial, transportation, education, food, or financial assistance for people experiencing crisis, victims of calamities, and those with inadequate resources.	Beneficiary convergence
Community Empowerment thru Science and Technology (CEST)	DOST & FNRI	Transfer of technology-based livelihood projects (including health and nutrition projects) to provide livelihood and alleviate poverty in remote communities.	Beneficiary convergence

Province-led agriculture and fisheries extension system (PAFES)	DA	Enhances local agricultural extension and strategic planning to increase household income and support household food security.	Local level coordination on SBC
Halina't Magtanim ng Prutas at Gulay, Kadiwa'y Yaman, Plants for Bountiful Barangays Movement (HAPAG Kay PBBM)	DA & DILG	Supports increased production and supply of fresh fruits and vegetables in participating communities to address hunger and ensure food security to diversify food sources.	Local level coordination on SBC
Alas Kwatro, Kontra Mosquito	DOH	Mosquito eradication campaign to address rising cases of Dengue fever. Mentioned by a qualitative respondent as a programme that reinforced local WASH sector coordination.	Local level coordination on SBC Beneficiary convergence
Walang Gutom Programme (WGP)	DSWD	A programme that provides food assistance for low-income households.	Beneficiary convergence
Tutok Kainan Dietary Supplementation Programme (TKDSP)	NNC	Dietary supplementation programme for pregnant teenage mothers.	Beneficiary convergence

Q2.3 To what extent is PMNP strategic design and approach aligned with the PPAN 2023–2028, HSS (also in relation to Universal Health Care law), and DSWD Strategy Map 2028?

PMNP is highly aligned with the PPAN 2023-2028, the HSS, Universal Health Care law, and the DSWD Strategy Map 2028. Its multisectoral approach mirrors PPAN's convergence principle by integrating nutrition-specific and nutrition-sensitive interventions during the first 1,000 days of life, addressing key determinants such as feeding practices, food access, and service quality. PMNP emphasizes institutional capacity building, monitoring, and local governance to address gaps identified in the PPAN. Similarly, PMNP reinforces HSS and UHC objectives by strengthening PHC systems and improving access to services particularly for pregnant women and young children to support the UHC's mandate for equitable and quality care. The programme leverages social protection platforms like 4Ps and Kalahi-CIDSS to complement DSWD's vision of reducing hunger and poverty through integrated welfare and development strategies. Overall, PMNP demonstrates strong policy coherence across these

frameworks, positioning itself as a key instrument for advancing national goals on nutrition, health, and social protection.

Q2.4 To what extent is PMNP at the local level coherent with the local plans, policies, interventions and systems?

PMNP is widely perceived by service providers and government stakeholders as strengthening existing plans, systems, and services. National, regional, and municipal level officials said that PMNP worked with existing offices and committees - including provincial nutrition offices and committees and municipal nutrition committees - to develop and implement MNAPs, thereby strengthening an already-existing system for nutrition programming at the LGU level. Regional stakeholders including RPMOs oversaw the PBG distribution process and provided technical support to municipalities to help them understand grant requirements. Provincial health offices also supported training and capacity building activities at the LGU level. Service providers perceived the PBGs to directly support their day-to-day work by helping ensure barangays have adequate resources to implement services including micronutrient supplementation, feeding programmes, and immunization. At the policy level, PMNP strengthens local guidelines by training healthcare workers to promote facility-based deliveries, encouraging pregnant mothers to give birth in hospitals rather than at home. Municipal level respondents also said that PMNP reinforces Executive Order 51 (Milk Code), a national policy and local mandate to promote exclusive breastfeeding by educating families on its nutritional benefits.

Q2.5 To what extent are PMNP systems, including information systems, compatible with existing government and sector systems?

PMNP is partially compatible with government and sector systems to monitor nutrition and health in the Philippines (Exhibit 5.2.2). It leverages multiple existing systems including the Field Health Services Information System (FHSIS), Operation Timbang Plus (OPT Plus), the Monitoring and Evaluation of Local Level Plan Implementation (MELLPI Pro), the Geotagging Web Application (GTWA), the Project Information Management System (PIMS), and the Early Childhood Care and Development (ECCD) checklist. The project also introduced the HCSC, which was designed to complement existing government and sector systems by filling household-level convergence data gaps. While these systems are intended to interoperate, data sharing remains mostly manual or via Excel due to resource constraints - including internet, technology, and staff- and digital literacy challenges, resulting in inconsistencies between digital and paper-based reporting. As a result, most systems not being fully-adopted by all

PMNP localities. The table below summarizes each system's ownership, purpose, and level of integration.

Exhibit 5.2.2. PMNP/Government Systems and Integration

System	Ownership	Purpose	Integration
FHSIS	DOH EB	Tracks key health indicators including immunization and breastfeeding.	Data is collected manually and electronically by midwives and nurses. Older healthcare workers struggle with digital tools. Many facilities lack adequate laptops or tablets and internet access.
OPT Plus	NNC	Monitors child nutrition status (malnourished, stunted, overweight).	Most BNS and BHWs collect data manually due to lack of tablets, computers, and training. In some municipalities, data is collected electronically.
MELLPI Pro	NNC	Evaluates regional-provincial-municipal-and-barangay-level nutrition programs.	RNCs/PNCs/MNCs primarily collect data manually via checklists and written reports. Some municipalities digitally encode results for reporting.
GTWA	DSWD	Maps locations of programme activities across the Philippines.	The GTWA is sporadically used by municipal offices. While PMNP encourages its use, many stakeholders are unaware of the tool or have not received training on it.
PIMS	DSWD	Tracks project implementation at the municipal level.	Usage and PMNP integration vary by municipality. Data is collected manually and digitally.
ECCD Checklist	ECCD Council	Tracks growth and development of children in daycare.	Daycare workers primarily use paper forms or logbooks to collect data. Access to tablets and computers varies across facilities.
iClinicSys EMR	DOH KMITS	Tracks individual patient data at the Rural Health Unit (RHU) level. Includes a module for FHSIS reporting.	The iClinicSys EMR is designed to digitalize patient records and support interoperability with other health system data, including the FHSIS. RHU and FHSIS data collection remain mostly manual, however.
HCSC	PMNP, DOH	Tracks service convergence (health, nutrition, WASH, ECCD) at the household level. Designed to	The HCSC is designed for digital data collection via tablets, but data is collected manually in many

	complement existing systems by filling household-level gaps in service monitoring. Used as PMNP's *Case* Management System to inform households of available health, nutrition, and social welfare services; direct them to appropriate departments/offices; and monitor use of services.	areas due to limited resources or internet connectivity.

As highlighted above, there is no standardized process for data collection; data is collected manually or digitally depending on municipal and barangay access to technology, the internet, and digitally literate staff. While manually collected data are later transferred to Excel or other digital systems, the process remains slow and inconsistent. The DOH Knowledge Management Information Technology Service (KMITS) specifically developed the iClinicSys EMR in an effort to digitalize and integrate patient health data across indicators and DOH health programs, but full integration remains a work in progress due to the aforementioned data collection challenges. As a result, the HCSC and other government and sector systems are not entirely compatible with each other. Equipment and capacity constraints and poorly integrated manual and digital systems also threaten the longer-term use and ownership of the HCSC to complement other systems after the project ends. It is important to note that the HCSC was only rolled out in the third quarter of 2025, however, and Phase II of the HCSC Information System is on-going. It specifically focuses on increasing interoperability with other systems.

Q2.6 How is PMNP adding value while avoiding duplication of effort? Have synergies been created across different government agencies with mandates related to the Nutrition programme components from the national to barangay level, thus facilitating a system-wide approach to reducing malnutrition?

PMNP is widely recognized for its role in *expanding* existing multisectoral nutrition initiatives rather than duplicating them. In qualitative data, national, regional, and municipal-level respondents said that PMNP helps government agencies and LGUs sustain and expand their nutrition and health programmes by providing additional resources and training. For example, national and municipal stakeholders said the project provides additional funding to the DSWD Kalahi-CIDDS project to implement nutrition-sensitive interventions including ECCD and WASH infrastructure updates under component two. It broadens the reach of supplemental feeding activities, building on those

already offered under the national Gender and Development programme to ensure that more vulnerable groups, such as young children and mothers, benefit from improved nutrition support. PMNP strengthens local SBC campaigns to promote nutrition and health education and behavioural change. While many LGUs already conduct similar SBC activities, municipal -level participants said PMNP funding enables local governments to deliver these activities more consistently and at a larger scale. Additionally, the project supports OTP+ by providing additional training and funding for equipment to measure children.

PMNP stakeholders have also coordinated to ensure fieldwork does not result in a duplication of efforts across agencies. For example, LGUs were required to submit certificates of non-overlapping activities before implementing PBG-funded projects to ensure DOH, DSWD, and other sector initiatives were not duplicated. To avoid parallel sanitation projects, sanitation inspectors were responsible for reporting households without toilets under component 2, while KALAHI-CIDDS was responsible for funding the distribution of toilet bowls. Instead of scheduling separate sessions and targeting the same families with similar information, DOH and MNAO provided key health and nutrition messages during existing 4Ps Family Development Sessions.

Qualitative data at the national and subnational levels suggest that PMNP has successfully fostered synergies at the national, regional, municipal, and barangay levels. Through project management mechanisms— including RPMOs, RTWGs and RLGUMobTATs—and collaborative planning workshops, the DOH, DSWD, DA, DILG, and local governments have aligned their efforts to jointly plan nutrition-specific and nutrition-sensitive interventions. This has facilitated multisectoral collaboration and integrated nutrition activities into municipal investment plans and MNAPs. A regional level respondent explained,

"We can indeed observe here and with our LGUs that we have nutrition-specific, and we have nutrition-sensitive indicators. And it cuts across not only DOH and NNC, but also DSWD. There are food security packs which can be provided by our DAs. We also have DILG, which is also part of the RTWG. So, among all, before, when you said nutrition, we'd only focus on those who are malnourished, and the food insecurities. But now, when we say nutrition, it really should be multi-sectoral. Especially in terms of our environmental and water safety. So, our LGU noticed that it is indeed very important that when we say nutrition programme, it cuts across all other agencies."

Bureaucratic delays and overworked and under-resourced personnel have hindered the implementation of a fully coordinated, multisectoral intervention and system-wide approach, however (further described under EQ 3.7 below).

5.3 Effectiveness

Improved service delivery: Evidence suggests that PMNP has improved service deliver as facilities are better equipped and have more trained staff.
Skills improved, practices lagged: Knowledge gains (notably **PIMAM** and **NiE**) are clear, but direct observations show persistent gaps in provider practices.
Service utilization is mixed: Strong coverage for Vitamin A, ANC/PNC, and growth monitoring; SBC reach is modest.
Governance advanced but unevenly: MNAP/BNAP drafting and budgeting progressed; however, functional Nutrition Committees are present in less than half of PMNP municipalities.
Regional heterogeneity: Staffing, supplies, and SBC participation vary widely by region; targeted support is required to close gaps.

Q3.1 To what extent were the desired PMNP intermediate results for each of the three project components achieved?

National-level monitoring data indicate strong overall progress across the three project components, though regional and municipal results reveal some implementation gaps. Component 1 shows improvements in service delivery, with increased staffing, training, and commodity distribution, but disparities persist—some regions remain under-staffed and under-supplied, and SBC participation varies widely. Governance has been strengthened, with full MNAP compliance in municipalities and most barangays meeting BNAP requirements, largely driven by PBG-linked incentives. Component 2 met its target by timely completing 4,884 WASH and ECCD subprojects providing critical nutrition-sensitive infrastructure to support the project's multisectoral approach. Nonetheless, subproject selection and implementation were not always community driven, as originally intended. Component 3 demonstrates strong household targeting through updated PMNP beneficiary master lists, despite data accuracy issues, but highlights weaknesses in governance: fewer than half of all project barangays and municipalities have functional Nutrition Committees, which are essential for planning, coordination, and sustainability. These findings underscore the need for targeted support to address regional disparities and strengthen governance structures while sustaining gains in infrastructure and provider knowledge.

Component 1

National-level PMNP monitoring data for indicators under Component 1 show improvements across all four intermediate result categories (Exhibit 5.3.1):

1. Service Delivery (Indicators 1.1–1.5)
2. Nutrition Outcomes (Indicators 1.6–1.11)
3. Governance and Advocacy (Indicators 1.12–1.14)
4. Social and Behaviour Change (Indicators 1.15–1.16)

The data suggest particularly strong progress in governance and advocacy, which measure municipal and barangay nutrition planning and budgeting—likely because drafting MNAPs is linked to the release of PBG funds. Advancements in healthcare capacity are also notable, especially in the provision of supplies and equipment for First 1,000 Days nutrition and health services. The delivery of these supplies to facilities has positively influenced overall performance on nutrition outcome indicators, particularly those related to providing Vitamin A to children under five. Lastly, while there has been some progress in implementing SBC activities, execution remains delayed. Fewer than one-third of caregivers have attended an SBC session[49] in the past three months.

Exhibit 5.3.1. National-level monitoring indicators for Component 1 (as of Quarter 3 – 2025)

Ind.	Indicator Description	Current	Baseline	Revised End Target*
1.1	Percentage of PHC facility staff trained IYCF and PIMAM	65%	49%	60%
1.2	Percentage of PHC facility staff trained on Nutrition in Emergencies	65%	49%	60%
1.3	Percentage of PHC facilities with appropriate First 1000 days supplies/equipment	69%	6%	50%
1.4	Percentage of PHC facilities with appropriate staffing for First 1000 days services	59%	0%	60%
1.5	Percentage of PHC facilities scoring at least 65% on the Quality Checklist	88%	0%	60%
1.6	Percentage of infants<6 months of age who are exclusively breastfed	92%	42%	65%
1.7	Percentage of infants<6 months of age who are exclusively breastfed (IPs)	94%	46%	65%

[49] SBC sessions include (a) community level Buntis Congress, (b) barangay nutrition assemblies or community meetings on health and nutrition, (c) mothers' classes/nutrition learning sessions/nutrition education sessions, (d) Idol ko si Nanay/Idol ko si Tatay attendance, (e) breastfeeding support groups, and (f) Family Development Sessions

1.8	Percentage of 6–59-month-old children who received Vitamin A within the past six month	94%	25%	75%
1.9	Percentage of 6–11-month-old children who received Vitamin A within the past six month	90%	25%	75%
1.10	Percentage of 12–59-month-old children who received Vitamin A within the past six month	94%	25%	70%
1.11	Percentage of 6–59-month-old children who received Vitamin A within the past six month (IPs)	94%	0%	70%
1.12	Number of municipalities with approved MNAPs budgets and expenditures in accordance with plans	100%	0%	100%
1.13	Number of barangays with approved BNAPs budgets and expenditures in accordance with plans	81%	0%	59%
1.14	Number of municipalities with at least one mass media nutrition campaign	93%	0%	90%
1.15	Percentage of households with parent/caregiver of children under 5 years old who attended at least one (1) SBC session on nutrition in the last three months	30%	0%	50%
1.16	Percentage of IP households with parent/caregiver of children under 5 years old who attended at least one (1) SBC session on nutrition in the last three months	104%	0%	50%

Source: PMNP Monitoring Data – PMNP Results Framework
*Revised End Target per Proposed Project Restructuring Paper[50]

Monitoring data indicate that PMNP has increased the proportion of PHC facilities equipped with essential supplies and equipment. For Indicator 1.3, nearly 70% of RHUs in PMNP areas have received a comprehensive supply package that includes anthropometric equipment, iron-folic acid (IFA), multiple micronutrient supplementation (MMS), Ready-to-use Therapeutic Food (RUTF), Ready-to-use Supplementary Food (RUSF), Vitamin A, deworming medication,

[50] Subandoro, Ali Winoto. *Disclosable Restructuring Paper - The Philippines Multisectoral Nutrition Project - P175493.* Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/099100725020029232

and Zinc, among other commodities. Findings from the Health Facility Checklist (Exhibit 5.3.2) partially confirm these results: over 70% of PMNP health facilities have MUAC tapes for children and adults, two-level height boards, and 25 kg Salter scales. Most facilities also stock Vitamin A, Zinc, and deworming medication (Albendazole or Mebendazole). However, availability of therapeutic foods remains limited, with only 39% of facilities having RUSF and 28% having RUTF in stock.

Interestingly, facilities in both PMNP and non-PMNP areas appear similarly equipped with F1K anthropometric tools, educational materials, and medications. However, these comparisons are assessed for a small sample size which is likely not sufficient to detect statistically moderate or small differences between treatment groups. Notably, PMNP health facilities are significantly more likely to have child vaccines—specifically Hepatitis B, Oral Polio Vaccine (OPV), and Measles, Mumps, and Rubella (MMR)—as well as a vaccine refrigerator. Although PMNP did not directly supply vaccines, municipalities can use PBG funds to procure them as these are nutrition-specific supplies and part of the PBG menu of expenditures[51]. In fact, the PBG Financial Utilization Report for Q1 2025 indicates that municipalities frequently allocated Tranche 1 resources to purchase vaccines for children under five and pregnant women (Tranche 1 – Q1 2025 FUR PMNP).

Exhibit 5.3.2. F1K Equipment and Supplies – Health Facility Checklist

	Treatment	Comparison	N
F1K Anthropometric Equipment (%)			
25kg hanging scale	78	67	27
MUAC tapes for children	83	89	27
MUAC tapes for adults	72	78	27
Two-level height board	89	78	27
250kg Weighing Mother-Baby Scale	56	56	27
F1K Education Materials (%)			
Breastfeeding flipchart	78	67	27
IYCF counselling cards	56	44	27
Complementary feeding materials	61	44	27
F1K Medications/Immunizations			
Vitamin A capsules or drops	89	100	27

[51] PMNP POM Chapter 5

Albendazole/Mebendazole tablets	83	100	27
Zinc tablets or syrup	56	33	27
Ready-to-use Therapeutic Food (RUTF)	28	11	27
Ready-to-use Supplementary Food (RUSF)	39	22	27
Therapeutic milk F75	17*	0	27
Bacillus Calmette–Guérin (BCG) vaccine	44	33	27
Hepatitis B vaccine	50*	33	27
Oral Polio Vaccine (OPV)	28***	0	27
Pentavalent vaccine	44	33	27
Measles, Mumps, and Rubella (MMR) vaccine	56*	33	27
Pneumococcal	28	33	27
Vaccine refrigerator	50*	22	27

Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Furthermore, qualitative respondents at all levels consistently reported an *increase in supplies* (including vaccines) over the past year. Barangay-level respondents said vitamins, medications, height boards, and scales had become more available over the past year. In Calauag, a female caregiver shared, "*There's an increase in the amount of medicines given*," while in Iloilo, another respondent reflected, *"...since the implementation of PMNP, we have received sufficient supplies, including vitamins, which we can readily utilize*." Both female and male caregivers largely agreed that vaccines had become more available over the past year as well.

Monitoring data for Indicators 1.1, 1.2, and 1.4 shows that PMNP has not only increased the number of PHC facility staff—such as doctors, nurses, midwives, and nutritionists-dieticians—but also provided training on IYCF, Growth Monitoring, PIMAM, and NiE through the integrated NPHC training package. However, more than one-third of PHC staff in PMNP areas still require initial training or retraining on these topics. Findings from the Knowledge Assessment further confirm that service providers in PMNP areas are significantly more likely to be trained in integrated NPHC content compared to their non-PMNP counterparts. As shown in Exhibit 5.3.3, 64% of services providers (i.e., Doctors, Midwives, Nurses, Nutritionist-Dietitians, BNS, BHWs) in PMNP municipalities

have been trained in IYCF, PIMAM, Growth Monitoring, and NiE in the last 12 months, compared to only a third in comparison areas.

Exhibit 5.3.3. F1K Trainings to Service Providers in the Last 12 Months – Knowledge Assessment

F1K Trainings	Treatment	Comparison	N
Infant & Young Child Feeding	64%*	33%	54
+ PIMAM			
+ Child Growth Monitoring			
+ Nutrition in Emergencies			

Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

These improvements in supplies, equipment, and trained human resources—documented in the project's monitoring data and partially validated by the Health Facility Checklist and Knowledge Assessment—are consistent with findings from the Tranche 2 Third-Party Verification (TPV) Report (UNICEF, 2025). The TPV results show that 97% of RHUs in the verification sample achieved a full score on the PMNP Health Facility Quality Checklist[52], demonstrating compliance with essential nutrition and health services, functional equipment, trained staff, organizational structure, policies, standards, and updated health service records.

In terms of nutrition outcome indicators (1.6-1.11) in Exhibit 5.3.1, monitoring data shows that Vitamin A coverage for children aged 6–59 months increased from 25% to 94% since baseline (Indicator 1.8), while exclusive breastfeeding (EBF) rose from 42% to 92% (Indicator 1.6). Improvements in Vitamin A coverage are credible and align with increased supply availability at healthcare facilities (see Indicator 1.3). Furthermore, they seem to be equally benefiting IP and non-IP children, which is positive from the equity perspective that guides the programme design.

However, the EBF results are less convincing. First, evidence from the literature suggests that interventions promoting EBF during the first six months typically improve rates by an average odds ratio (OR) of 3.15,[53] which in this context would correspond to an increase from 42% to about 70%—substantially lower

[52] Full score on the checklist for the PBG tranche 2 is achieve by getting at least 60% in the actual checklist.
[53] Sarah Dib, Frankie Joy Fair, Lucy Jane McCann, Antonia Nicholls, Anastasia Z. Kalea, Hora Soltani, Mary Fewtrell; Effects of Exclusive Breastfeeding Promotion Interventions on Child Outcomes: A Systematic Review and Meta-Analysis. *Ann Nutr Metab* 2 April 2024; 80 (2): 57–73. https://doi.org/10.1159/000535564

than the 94% reported. Second, EBF measurement requires systematic 24-hour dietary recall that asks about each liquid and food item individually, whereas the HCSC questionnaire[54] uses only a single question asking mothers to classify their feeding practice—which often leads to misreporting when mothers consider water or teas compatible with "exclusive breastfeeding." Field validations from the Tranche 2 TPV Report (UNICEF, 2025) also revealed inconsistencies affecting EBF data accuracy and continuity, potentially biasing this indicator. While PMNP may have contributed to increased EBF, the upcoming impact evaluation (endline scheduled for June 2026) will provide a more reliable measure of changes for this outcome.

Regarding governance and advocacy (Indicators 1.12–1.14), monitoring data indicate strong progress in municipal and barangay nutrition planning and budgeting, particularly in the development of MNAPs. The proportion of PMNP municipalities with MNAP budgets and expenditures aligned with PMNP standards increased from 0% to 100%. Likewise, 81% of PMNP barangays now have a budgeted BNAP that meet project requirements. Fieldwork findings support these results: the research team obtained copies of the 2023–2025 and 2026–2028 MNAPs from all six PMNP municipalities in the midline sample, whereas none of the three comparison municipalities had prepared their 2026–2028 MNAPs (see Exhibit 5.3.4).[55] This progress in MNAP drafting—likely driven by the requirement to draft MNAPs as a condition for releasing PBG funds— is a necessary input for improvement in long-term nutrition outcomes since planning ensures that interventions are targeted, coordinated, and adequately resourced.

Exhibit 5.3.4. Municipal Financial Documents

Municipality	MNAP (2023-2025)	MNAP (2026-2028)
Treatment		
MAIGO	Complete	Complete
CAPOOCAN	Complete	Complete
BADIANGAN	Complete	Complete
CALAUAG	Complete	Complete
MIDSALIP	Complete	Complete
BUHI (IP Municipality)	Complete	Complete
Control		
SAMPALOC	Complete	Missing
SAN ISIDRO	Complete	Missing
SULTAN NAGA DIMAPORO	Complete	Missing

[54] HCSC questionnaire – Question 501, Section V: Child Nutrition.

[55] These documents were gathered by the field team as an input to the financial case studies that will be conducted at endline.

Although national-level intermediate indicators for Component 1 show overall positive progress, regional and municipal-level monitoring data reveal notable implementation gaps, particularly in service delivery and SBC. For service delivery (Indicators 1.1–1.5), more than 75% of PMNP RHUs in Calabarzon, Mimaropa, and Eastern Visayas lack the full complement of PHC workers required under First 1,000 Days staffing norms, while 100% of RHUs in Central Luzon, Western Visayas, Zamboanga, and Northern Mindanao are fully staffed. Integrated NPHC training for facility-based service providers has been completed in seven PMNP regions but remains pending in others. Commodity distribution also varies: RHUs in Central Luzon, Davao, and Soccsksargen have achieved full coverage, whereas only 44% in Zamboanga and 36% in Mimaropa received supplies. For SBC, participation rates differ significantly by region: 63% of caregivers in Caraga attended a session in the past three months, compared to just 13% in Central Luzon. Overall, these findings underscore the need for targeted support to regions and municipalities experiencing delays in implementing Component 1 activities.

Component 2

Activities under Component 2, specifically the improvement or rehabilitation of nutrition-sensitive community WASH and ECCD subprojects, were successfully completed by the third quarter of 2024, well before those under Components 1 and 3. DSWD was able to execute activities under this component in a timely manner not only because they were fewer and simpler compared to those in the other two components, but also because DSWD leveraged the existing KALAHI-CIDDS structure and processes.

Originally, all the 5,936 PMNP barangays were eligible to benefit from WASH and ECCD subprojects under Component 2; however, due to limited budget allocation per municipality, some barangays were clustered to share benefits from subproject improvements. Therefore, the main target from Component 2 was adjusted from 5,936 to 4,895 subprojects. According to the national-level monitoring data (Exhibit 5.3.5), targets for all Component-2 indicators were achieved or surpassed. A total of 4,884 subprojects were completed, targeting 683 WASH and 4,201 ECCD facilities across the 235 PMNP municipalities. These subprojects covered 5,875 out of the 5,936 PMNP barangays and covered 591,000 households.

Although the progress shown by the monitoring data is highly commendable in terms of subproject completion and population coverage, none of the indicators sheds light on utilization by target beneficiaries. Indicators 2.2–2.9

are based on the number of households, women in reproductive age, and children living in areas where subprojects were constructed, rather than actual subproject utilization. To try to circumvent this gap, the research team requested DSWD information on ECCD enrolment or attendance, but this data is not kept by the department. Nonetheless, by January 2025, 93% of subprojects (4,570), had an Operations and Maintenance Group in place (2025 NTWG meeting), which suggests there is some local institutional capacity to ensure service delivery, build community trust, and encourage beneficiary utilization. In addition, the upcoming impact evaluation (endline scheduled for June 2026) will collect data from target beneficiaries to understand their access, utilization, and perception of the quality of the subprojects delivered by PMNP in their communities. This would help us better understand the effectiveness of Component 2.

Furthermore, qualitative data from FGDs conducted during the Mayor's Forum suggests that timely subproject completion may have come at the expense of community involvement and responsiveness to actual needs.[56] Although subprojects were supposed to be selected and executed through a community-driven development (CDD) approach, this was not always the case. As mentioned in the Documentation Report of the FGDs, many LGU representatives from Leyte expressed a lack of consultation and transparency from DSWD during project identification and implementation. Others complained about the limited menu of subprojects available to communities since only certain WASH systems and ECCD improvements were eligible for selection. This constraint, however, fell outside DSWD's authority, as the Investment Coordination Committee (ICC) established the permissible subproject types and scope during the PMNP design period. Lastly, the overrepresentation of ECCD vis-à-vis WASH activities was also discussed considering that access to potable water is a building critical for nutrition and health.

Exhibit 5.3.5. National-level monitoring indicators for Component 2 (as of Quarter 3 -2024)

Ind.	Indicator Description	Target	Current
2.0	Number of Subprojects	4,895	4,884 (99%)
2.1	% Community nutrition-sensitive sub-projects completed in accordance to plan, budget and schedule	85%	99%
2.2	% Target households with access to a functional Level II Water Supply System	80%	102%

[56] Documentation Report - KSS Small Group Documentation Report , July 2025.

2.3	% Target households with access to ECCD facility	80%	101%
2.4	# Households covered by project interventions	567,000	591,000 (104%)
2.5	# Women of reproductive age (including pregnant and lactating women) covered by project interventions	585,000	818,000 (140%)
2.6	# Children under 5 years old covered by project interventions	238,000	379,000 (160%)
2.7	# 4Ps female grantees with children under 5 years old covered by project interventions	70,700	95,700 (135%)
2.8	# 4Ps children under 5 years old covered by project interventions	79,400	109,200 (138%)
2.9	# IP households covered by project interventions	36,100	46,600 (129%)

Source: 2024 PMNP National Technical Working Group (NTWG) Meeting – February 5, 2025.

Component 3

National-level data show 100% compliance with maintaining updated master lists of households with pregnant and lactating women and children under five (Indicator 3.2, Exhibit 5.3.6.). These master lists are critical for ensuring the convergent delivery of PMNP activities at the household level. However, the Tranche 2 TPV report highlights issues with data accuracy. Specifically, LGU-level master lists—compiled from barangay data—often contain inconsistencies such as incorrect birthdates and names. Despite these challenges, the evidence suggests that most PMNP areas are actively tracking mothers and young children, an essential intermediate step to ensure services reach intended beneficiaries.

Conversely, indicators on nutritional governance and advocacy (Indicators 3.3 and 3.4) reveal significant gaps in establishing and supporting functional Nutrition Committees (NCs).[57] Fewer than half of PMNP barangays and municipalities meet this requirement. Functional NCs are critical because they provide strategic planning, advocacy, coordination, and community

[57] Fully Functional Barangay Nutrition Committees:
- Have a Barangay Nutrition Scholar (BNS) who has completed a training on Basic Course for BNS.
- Meet regularly (at least one every quarter) and keeps minutes of meetings documented and file
- OPT Plus and school weighing report updated AND nutrition situation report prepared
- LNAP is integrated into the local development plan with budget AND integrated in the Annual Investment Plan
- Funds allocated and expended for nutrition and related activities from annual budget
- Target groups provided with nutrition and related interventions
- Monitoring visits conducted and documented at least twice a year

engagement—ensuring interventions are relevant, funded, and sustainable. Understanding the barriers preventing NCs from becoming fully operational is therefore a priority for strengthening nutrition programming.

Exhibit 5.3.6. National-level monitoring indicators for Component 3 (as of Quarter 3 -2025)

Ind.	Indicator Description	Current	Baseline	Progress
3.1	Percentage of Registered grievances satisfactorily resolved in line with the Grievance Redress System	99% (3,469/3,472)	0	99%
3.2	Percentage Barangays with updated nutrition information on the status of HHs with pregnant and lactating women and children under 5 years old	100%	0	100%
3.3	Percentage of Project areas with functional nutrition committee (NC) at the municipal level	39%	0	39%
3.4	Percentage of Project areas with functional nutrition committee (NC) at the barangay level	46%	0	46%

Source: PMNP Monitoring Data – PMNP Results Framework

Lastly, monitoring data reports that the project has responded to and resolved grievances[58] at an almost perfect rate, having satisfactorily addressed 3,469 out of the 3,472 reported grievances to date.

Q3.2 To what extent have the integrated NPHC and PMNP capacity-building interventions contributed to improvements in the KAP of PCF staff and to overall healthcare delivery and quality?

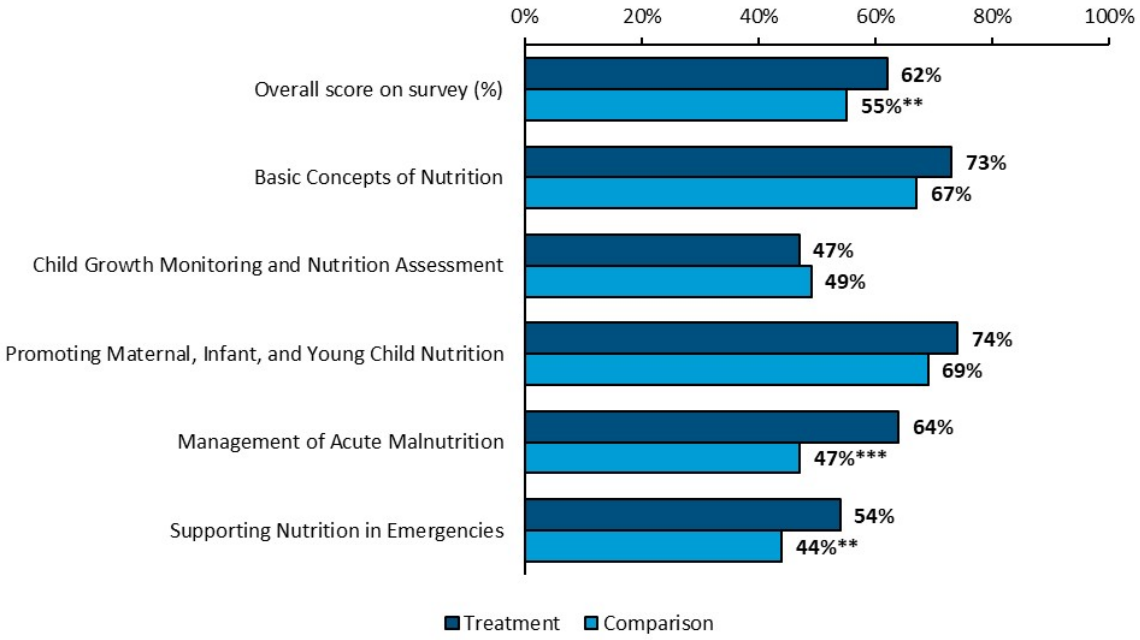
Differences in Knowledge for PCF Staff between Treatment and Comparison Areas

The research team examined the effectiveness of the integrated NPHC training package on providers' knowledge via an assessment containing 49 questions

[58] The Grievance Redress System (GRS) is a mechanism by which any complaint or grievance related to the PMNP implementation can be reported by any institution or individual at any time to the Implementing Agencies (DSWD and DOH) and to the World Bank, 8938 and in turn given attention for timely resolution. Any community or individual who believes that he/she has been adversely affected by the Project may submit complaint/s through the existing system.

about basic nutrition concepts (seven, questions), child growth monitoring (10 questions), IYCF promotion (11 questions), PIMAM (12 questions), and nutrition in emergencies (9 questions). The Knowledge Assessment (Annex C) was developed based on the contents of the integrated NPHC training materials. Findings from the assessment show that, overall, the treatment group outperforms the comparison group, scoring 62% versus 55%, with significant differences in the Management of Acute Malnutrition (64% vs. 47%; p-value < 0.01) and supporting Nutrition in Emergencies (54% vs. 44%; p-value <0.05) sections (Exhibit 5.3.7). Both groups show strong understanding of basic concepts of nutrition and promoting maternal, infant, and young child nutrition, where treatment scores reach 73% and 74%, respectively. The only category where the comparison group exhibited greater knowledge was child growth monitoring and nutrition assessment (49% vs. 47%), though this was not a statistically significant difference. These results suggest that the integrated NPHC training package improved knowledge in critical areas for PCF, particularly in the areas of NiE and PIMAM.

Exhibit 5.3.7. Overall Performance in the Knowledge Assessment



Note: N = 54 service providers. Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Provider Performance on the Basic Concepts of Nutrition Section

This section assesses providers' understanding of fundamental nutrition concepts, including the definition, causes of malnutrition, distinctions between primary and secondary forms, and the indicators of undernutrition. It evaluates

knowledge of essential nutrients and their categories, as well as the health consequences of specific micronutrient deficiencies. The questions also test awareness of vulnerable population groups and the increased micronutrient requirements during pregnancy, ensuring providers can recognize both general principles and critical nutritional needs across different life stages

Service providers demonstrated moderate knowledge in the basic concepts of nutrition, scoring 71% overall (on average) with no significant differences in performance between the treatment and comparison groups (Table A-2 in Annex). Most were able to correctly define malnutrition (96%), distinguish between primary and secondary malnutrition (81%), identify the six categories of nutrients (85%), and recognize the link between Vitamin A deficiency and night blindness (81%). However, fewer than half (43%) acknowledged that all population groups are equally vulnerable to malnutrition. Just over half of the providers (51%) accurately listed the characteristics of undernutrition, though a notable proportion incorrectly included micronutrient excess (41%) and overweight (46%) as responses. When asked about nutrients required in greater amounts during pregnancy, folic acid (94%) and iron (85%) were most frequently identified by service providers, while zinc was least selected (33%).

Performance in the Child Growth Monitoring and Nutritional Assessment Section

The child growth monitoring and nutritional assessment section tested providers' knowledge of what encompasses a nutritional assessment, including which and how often anthropometric measures should be collected from different target populations (i.e., healthy children, SAM, and MAM). The section also includes questions asking providers to classify the nutritional status of a child based on her z-scores for height/length-for-age, weight-for-age, and weight-for-height/length using the appropriate WHO growth tables.

Overall, service providers scored 48% in the child growth monitoring and nutrition assessment section, reflecting notable gaps in knowledge across both PMNP and non-PMNP areas. More than half (56%) incorrectly identified MUAC as suitable for assessing children under six months, and only 30% correctly recognized the frequency of anthropometric measurements for children with MAM, with poorer knowledge in treatment areas (19% vs 50% in comparison; p-value < 0.10). Notably, significantly more providers in the treatment areas (78% vs 50%; p-value < 0.01) correctly identified how to adjust a child's measured length to convert it to standing height. Overall, just 30% of the assessed providers could classify nutritional status using z-scores, and fewer treatment group providers selected the incorrect statement that MUAC and Weight-for-

Length/Height (WFL/H) can both identify acute malnutrition in children under five (31% vs 56%; p-value < 0.05) as detailed in results in (Results Table A-3 in Annex A).

Provider Performance in the Promoting Maternal, Infant, and Young Child Nutrition Section

This section assesses providers' knowledge of the impacts of poor maternal, infant, and young child nutrition practices, DOH recommended antenatal care visits, and appropriate supplementation during pregnancy. It evaluates their ability to identify interventions for undernourished pregnant women, as well as their familiarity with the topics covered in MIYCN counselling tools. It further tests their understanding of optimal breastfeeding practices, including initiation, frequency, and clarifying misconceptions about breastfeeding among mothers with certain health conditions (HIV, Hepatitis C). The section also examines knowledge of complementary feeding recommendations, guidance for infant feeding in emergencies, and special considerations for low-birth-weight infants who may require additional support.

Service providers achieved a score of 73% on the maternal, infant and young child nutrition section with no significant differences between the treatment and comparison arm. A majority (70%) were able to identify the negative outcomes of sub-optimal nutrition. For pregnant women in their first trimester with a MUAC < 21 cm, more treatment arm providers correctly selected RUSF for 90 days as the appropriate course of action (86% vs 56%, p-value<0.05), while counselling using Pinggang Pinoy was more frequently chosen in the comparison arm (83% vs 100%, p-value<0.05). Additionally, a slightly higher proportion of providers in the treatment arm correctly rejected the statement that women with Hepatitis C should not breastfeed their child (81% vs 56%, p-value <0.1). All service providers in the treatment arm accurately identified the DOH recommendation to begin complementary feeding at six months for healthy infants (Results Table A-4).

Provider Performance in the Management of Acute Malnutrition Section

The Management of Acute Malnutrition section evaluates providers' knowledge of acute malnutrition, including its definition, causes, and clinical forms such as kwashiorkor and marasmus. It tests understanding of age estimation practices, as well as the components and strategies of the PIMAM, particularly the roles of Outpatient Therapeutic Care (OTC) and Inpatient Therapeutic Care (ITC). The questions assess providers' ability to distinguish between true and false statements about OTC services, classify children's nutritional status using MUAC, WFH, and clinical signs, and determine appropriate next steps when

children fail appetite tests or present severe malnutrition. Overall, the module focuses on accurate diagnosis, correct classification, and proper referral or treatment pathways for children with moderate or SAM.
The overall score in the management of acute malnutrition section was 58%, with service providers in the treatment group performing significantly better than those in the comparison group (64% vs 47%, p-value <0.01). Service providers in treatment areas showed stronger knowledge in defining malnutrition (100% vs 61%, p-value <0.01), kwashiorkor (67% vs 33%, p-value <0.05) and marasmus (61% vs 39%, p-value <0.1) (Results Table A-5). They were also more likely to recognize community mobilization and outreach as a component of PIMAM (92% vs 83%, p-value <0.1) and performed better at classifying the nutritional status of a 5-month-old infant (64% vs 11%, p-value <0.01), though the research team did not observe any significant differences for classification of older children. In contrast, service providers in comparison areas outperformed those in treatment areas in identifying the next steps for a child classified as SAM with a failed appetite test (76% treatment vs. 92% comparison, p-value <0.05).

Performance in the Supporting Nutrition in Emergencies Section

This section examines providers' knowledge of the objectives, minimum service package and priorities of NiE reflecting continuity of essential nutrition services in emergency contexts. The questions assess understanding of when blanket dietary supplementation should be implemented, target beneficiaries, and which activities must be carried out during the immediate impact phase versus the post-impact phase of an emergency. The module also tests familiarity with the NINA tool, its timing, and its role in providing rapid assessments of nutrition status among high-risk groups such as young children, pregnant and lactating women, and other vulnerable populations

The overall score in the supporting nutrition in emergencies section showed significantly greater knowledge for providers in the treatment group (54% vs 44%, p-value <0.05). Service providers in the treatment arm were more likely to identify the NiE minimum service package interventions (90% vs 75%, p-value <0.1), with a much larger proportion selecting the maternal, infant, and young child nutrition intervention (94% vs 67%, p-value <0.05). Treatment arm providers also more accurately identified the target beneficiaries of blanket dietary supplementation (45% vs 31%, p-value <0.1) and fewer incorrectly included children under six months as beneficiaries (50% vs 72%, p-value <0.01), reflecting greater knowledge of BDS in the treatment arm. Further, providers in PMNP areas performed better at identifying the nutrition-related activities that

should be conducted within the first 48 hours of an emergency (25% vs 8%, p-value <0.05) (Results Table A-6).

Differences in Practices for PCF Staff between Treatment and Comparison Areas

The effectiveness of capacity building activities on providers' knowledge was examined through assessment, and direct observations of service provision were also conducted to evaluate practitioner competencies and practices, determining whether improvements in knowledge translated into enhanced skills. Observations included growth monitoring sessions, IYCF and breastfeeding counselling sessions, and prenatal check-ups. During growth monitoring sessions, practitioners' skills were observed in measuring a child's length or height, weight (using infant, sling or floor scales as appropriate), head circumference, and MUAC, as well as checking for oedema. Additionally, observations were made to determine whether practitioners correctly plotted the measurements on the growth chart to assess the child's development and to identify potential concerns such as risk of underweight, stunting, or wasting. When concerns were identified, it was further noted whether providers communicated these concerns clearly to the parent and provided appropriate follow-up actions and referrals.

For the IYCF counselling sessions, the evaluation team focused observations on whether the practitioners appropriately conducted initial tasks such as gathering a child's age and basic anthropometric measurements, whether they conducted a physical examination of the child, whether they assessed a child's feeding history including whether and how they are breastfed and whether and how they have been introduced to other foods (complementary feeding). For each type of feeding, practitioners were evaluated on whether they explained key messages and ensured the parents' comprehension of the messages before moving on to other tasks.

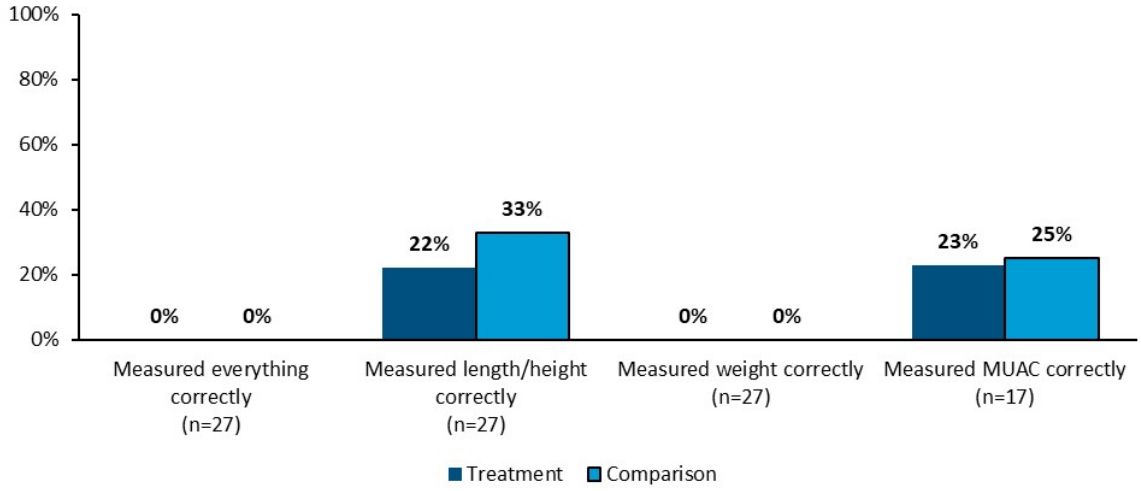
Finally, for the prenatal checkup, the observations determined whether the practitioner gathered the woman's obstetric and prenatal history, took the woman's anthropometric measurements, performed other health tests to check for vital signs including checking pulse and blood oxygen levels, assessed the woman's nutrition, and conducted routine prenatal checks of the baby and other pregnancy care (e.g., supplementation or immunizations). For each of these tasks, practitioners were also assessed on whether they identified issues, explained the issues clearly to the patient and provided guidance on what to do to ensure a healthy pregnancy and delivery and scheduled follow-ups or provided referrals, as necessary. For both the IYCF and prenatal counselling sessions, it was also noted whether practitioners exhibited specific listening and

learning skills and confidence building and support giving skills, and basic counselling sessions closure skills which were also relayed through the NPHC training. The remainder of this section provides the results of the observations by observation type and treatment status.

Growth Monitoring Observations. From the growth monitoring sessions, the research team *did not observe any practitioner conducting all child anthropometric measurements correctly*. On average, PHC workers performed 56% of all steps correctly: 59% of practitioners in treatment municipalities compared to 50% of those in comparison municipalities. However, these numbers reflect only the correct steps taken according to the measures the practitioner attempted during the visit (see growth monitoring observation protocol in Annex E). For instance, only two practitioners were observed measuring a child's head circumference—for those who did not, the number of head circumference measurement steps was not included in their count for number of steps conducted correctly. Of the practitioners that took head circumference or checked for oedema, they performed these measurements correctly.[59] Conversely, only 22% of practitioners in treatment areas and 33% of practitioners in comparison areas correctly performed the steps to measure a child's length or height. Similarly, 23% in treatment and 25% in comparison areas correctly measured a child's MUAC. Exhibit 5.3.8 provides a visual of the proportion of practitioners who correctly performed each task during the growth monitoring visit observed.

[59] While the NPHC training package did not explicitly train providers on the competency of measuring a child's head circumference, this measure can also provide important information regarding children's growth and is a standard pediatric practice for children under 24 months. Accordingly, the evaluation team included observation of providers' measuring children's head circumference in the protocol.

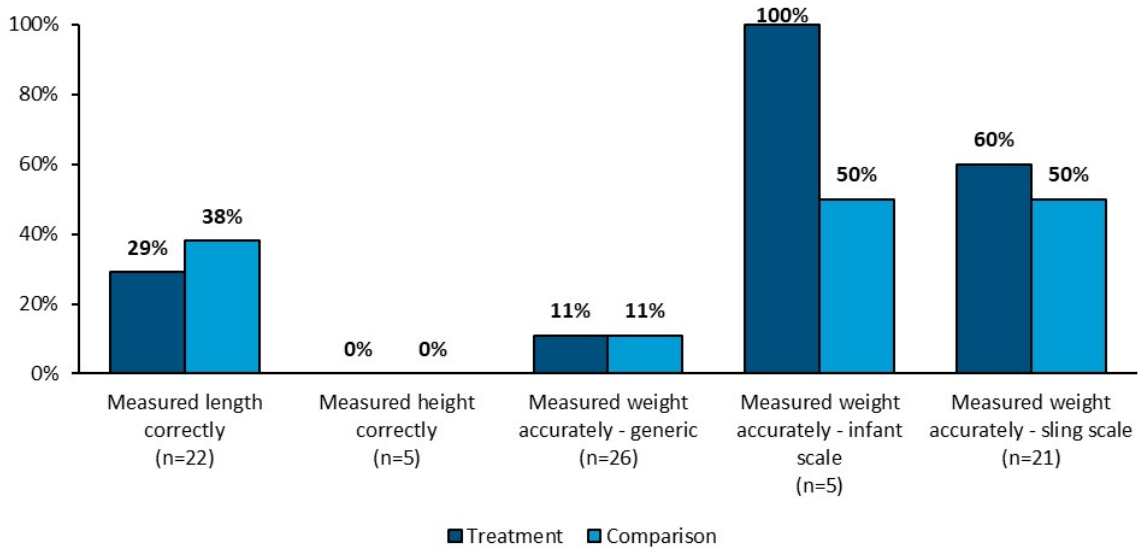
Exhibit 5.3.8. Practitioners Performing Measurement Steps Correctly - Growth Monitoring



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Given that practitioners were able to measure children's height and weight using various methods, the competencies of the practitioners were further examined according to the specific measurement method (see Exhibit 5.3.9). It was found that practitioners were more likely to measure a child's length (i.e., using a length board while the child lays down) correctly rather than their height (i.e., using a height board while the child stands); in fact, none of the practitioners who measured a child's height were observed measuring it correctly. PHC workers in both groups were observed properly following the generic weight measurement steps albeit at a low rate of only 11% of the observations. However, all PHC workers in treatment areas measuring children's weight via an infant scale followed the correct steps compared to only half of those in comparison areas. Similarly, more practitioners in treatment areas were able to correctly measure weight using a sling scale (60%) compared to those in comparison areas (50%). Given the small number of practitioners observed, however, there were no statistically significant differences found in either instance.

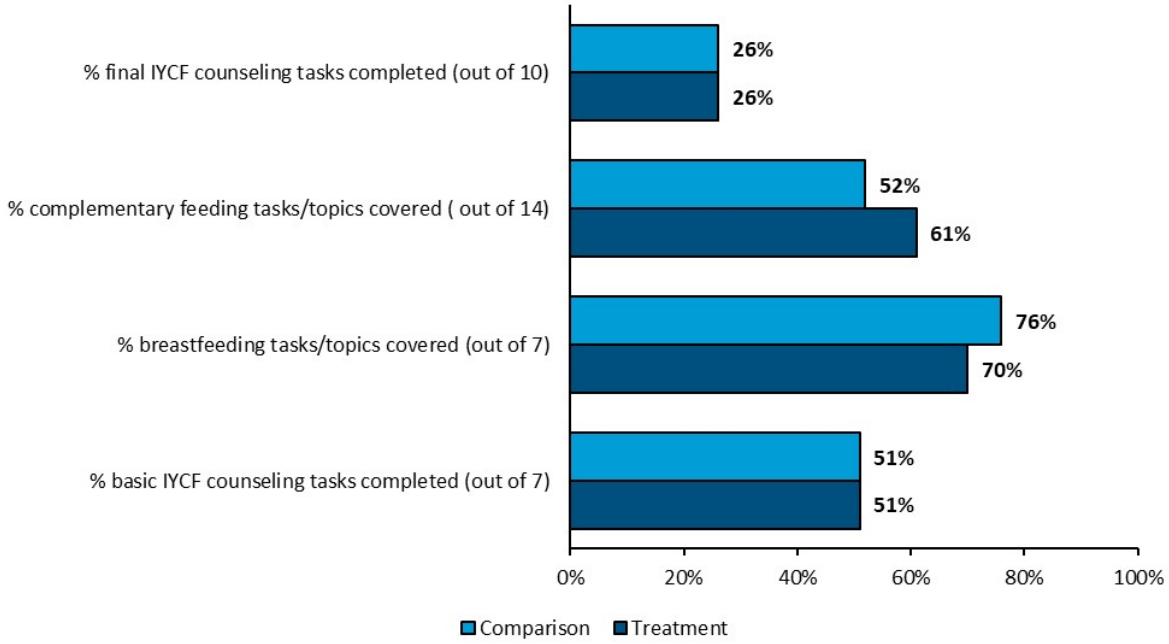
Exhibit 5.3.9. Practitioners Measuring Child's Length, Height or Weight Correctly by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

IYCF Counselling Observations. Over half of all practitioners observed during IYCF counselling sessions completed the relevant tasks (see Exhibit 5.3.10). The research team split these tasks into four main categories: i) basic IYCF counselling tasks including determining the child's age, measuring their MUAC, establishing a 24-hour feeding recall, and identifying whether the child was ever breastfed and is currently breastfed; ii) breastfeeding tasks including asking about specific practices such as latching, explaining key messages around exclusive breastfeeding and having clients repeat messages back to them as well as ensuring they understood the takeaways; iii) complementary feeding tasks including identifying whether the child has ever had food other than breastmilk, explaining complementary feeding such as key aspects like age to start introducing foods, frequency of feeding and diet diversification and providing key messages and ensuring comprehension; and iv) final IYCF counselling tasks including updating the mother-child booklet, updating the target client list and scheduling the next well-baby visit. The practitioners observed were less likely to complete the final tasks of updating booklets and scheduling follow-ups (only 26% of practitioners) though they completed most breastfeeding counselling-related tasks (70% and 76% in treatment and comparison areas, respectively).

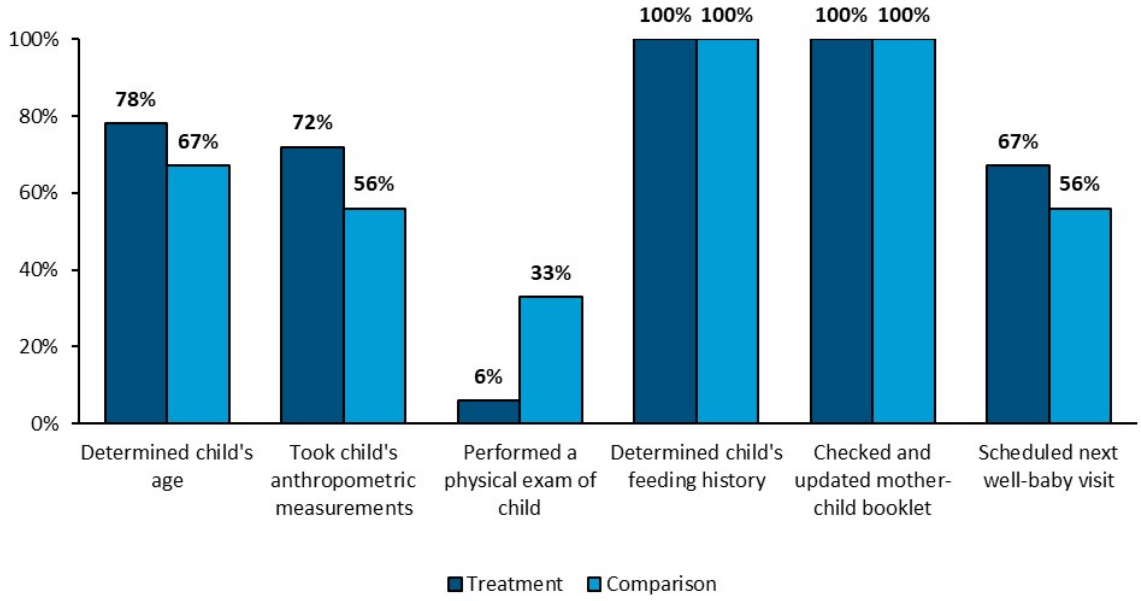
Exhibit 5.3.10. Practitioners Completing IYCF Counselling Tasks by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

There was no difference found between providers in the two treatment groups based on performing basic IYCF activities during the counselling session. Exhibit 5.3.11 shows the proportion of providers performing each activity out of the basic and final IYCF counselling task steps. All observed providers determined the child's feeding history and checked and updated the mother-child booklet at the end of the session, but only 6% of treatment and 33% of comparison providers performed a physical examination of the child. Over half of providers in both groups determined the child's age, took the anthropometric measurements of the child and scheduled the next well baby visit before the end of the session.

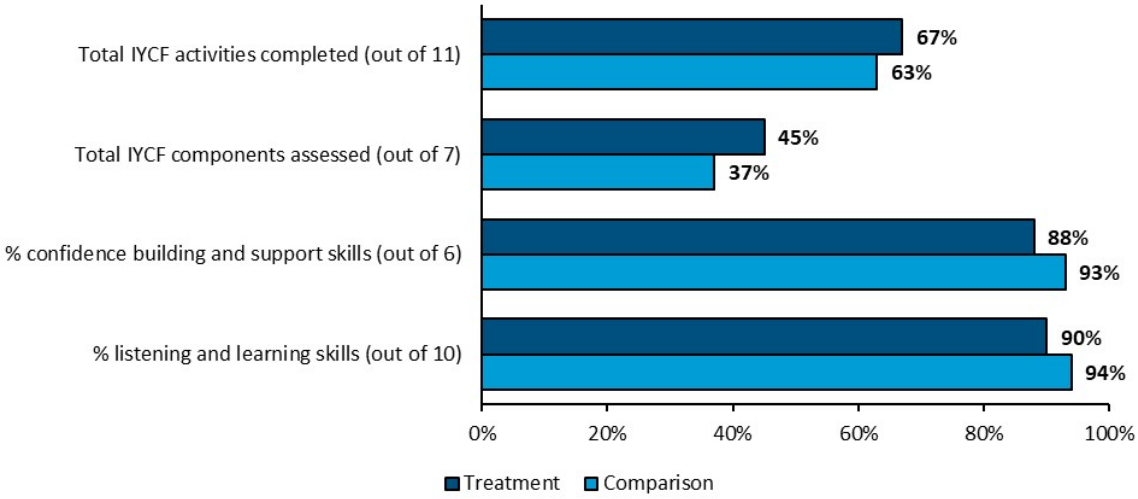
Exhibit 5.3.11. Proportion of Practitioners Performing Basic IYCF Practices by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

The NPHC training also trained practitioners in various soft skills such as listening and learning skills and confidence building skills which the observations of the research team aimed to capture as well. Additionally, for the IYCF counselling sessions, practitioners were also expected to assess various IYCF components (e.g., assess food and fluid intake, check on recent illness) and perform activities related to the information they gleaned throughout the sessions such as identify and address feeding difficulties, ensure the parent understood the steps and information discussed and make referrals as necessary. Exhibit 5.3.12 shows the proportion of each skillset practitioners exhibited during their IYCF counselling observations. Generally, no differences by treatment group were observed. On average, practitioners were seen exhibiting over 90 percent of the listening and learning skills whereas fewer than half of the ICYF components were assessed throughout the session. These components included assessing food and fluid intake, checking on recent illness, observing breastfeeding, checking on hygiene practices when feeding, and explaining the child's nutritional status using the growth curves.

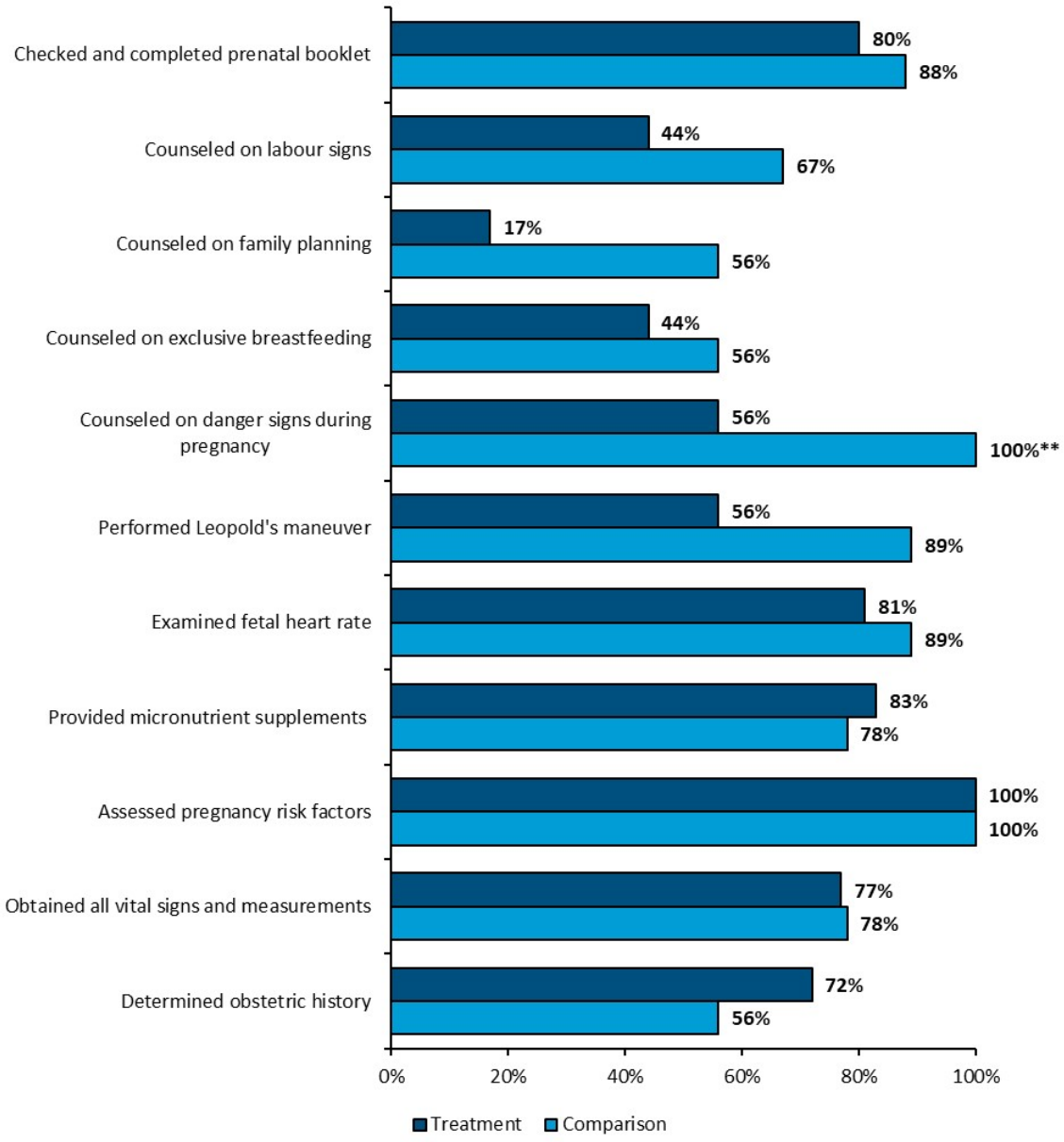
Exhibit 5.3.12. Proportion of Behaviours Exhibited by Practitioners During IYCF Counselling Session by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Prenatal Checkup Observations. As with growth monitoring and IYCF sessions, overall, no clear observable differences were found in practitioners' practices during prenatal checkups by treatment group. However, it was found that significantly more providers observed in the comparison municipalities counselling mothers on the danger signs to look out for during pregnancy than their counterparts in treatment municipalities (100% vs 56%, respectively; see Exhibit 5.3.13); though all providers were observed assessing the women's specific risk factors as they related to depression, substance use, foods to avoid, and domestic violence. Most providers were observed to be supplying women with micronutrient supplementation (83% T vs 78% C), checking all vital signs and obtaining weight and height (77% T vs 78% C), determining the women's obstetric history (72% T vs 56% C), and checking for and updating prenatal booklets (80% T vs 88% C). For those women in their second or third trimester (in 22 of 27 observations), most practitioners also examined the foetal heart rate (81% T vs 89% C) and conducted the Leopold's manoeuvre (56% T vs 89% C). In a smaller number of cases, the providers were observed to be counselling women on signs of labour, family planning or exclusive breastfeeding.

Exhibit 5.3.13. Proportion of Practitioners Performing Each Skill in Prenatal Checkup by Treatment Status

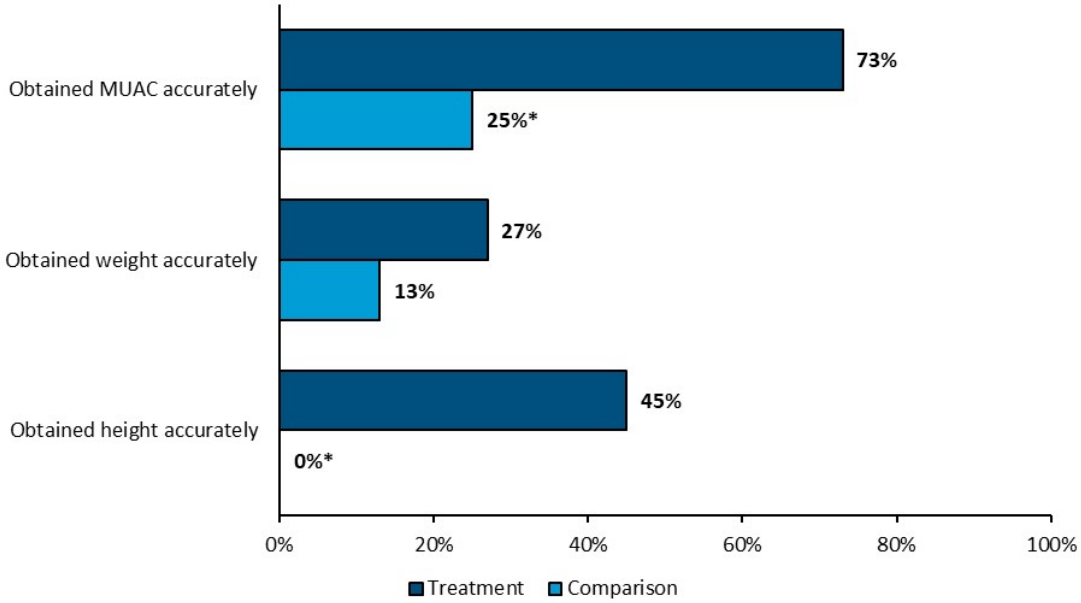


Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

While a similar proportion of providers in treatment areas and comparison areas were found to have obtained the woman's vital signs and measurements during the prenatal checkup, there was a notable difference in the proportion appropriately measuring a women's MUAC, weight and height (see Exhibit 5.3.14). More providers in treatment areas accurately obtained each measurement with a significantly higher proportion correctly measuring a woman's MUAC (75% vs 25%, p-value <0.10) and a woman's height (45% vs 0%, p-value <0.10). These results suggest that while providers might understand

they are meant to take these measurements as part of the prenatal checkup, they are not always taking the appropriate steps to obtain them.

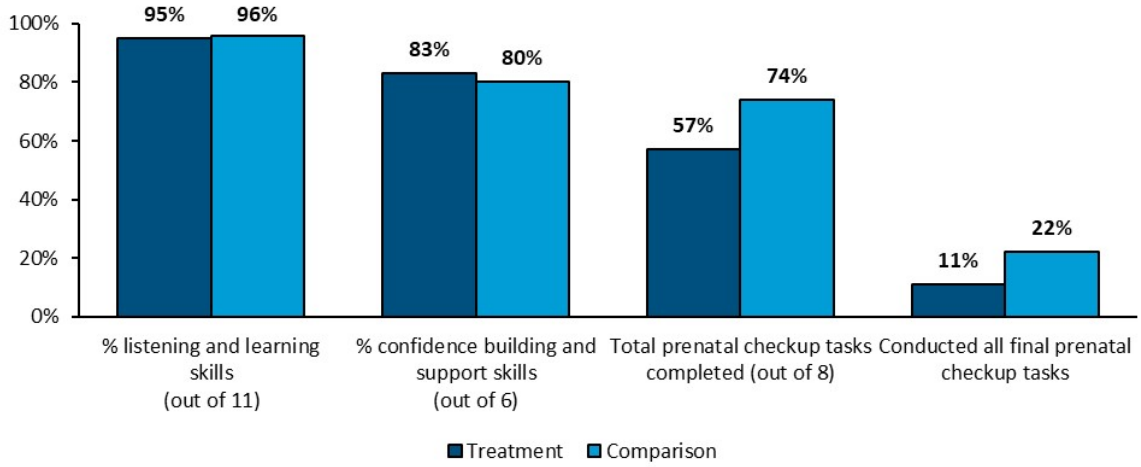
Exhibit 5.3.14. Proportion of Prenatal Checkup Providers Taking Accurate Measurements by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

As in the IYCF counselling sessions, providers conducting prenatal checkups were assessed on whether they exhibited certain soft skills and behaviours with their patients. Most practitioners exhibited all 11 of the listening and learning skills assessed while slightly fewer (around 80%) exhibited all confidence building and support skills (see Exhibit 5.3.15). Slightly more practitioners in comparison areas completed all eight prenatal checkup tasks compared to 57% of practitioners in treatment areas. Conversely, less than one-quarter of practitioners performed all the final prenatal checkup tasks such as helping the woman identify behaviours she could try to lower pregnancy-related challenges, using counselling cards, offering guidance on where the woman can seek additional support, making referrals and ensuring the woman had no outstanding questions or concerns.

Exhibit 5.3.15. Proportion of Behaviours Exhibited by Practitioners During Prenatal Checkup by Treatment Status



Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Perceived Capacity and Service Delivery Improvements

In line with the survey and observation data presented above, qualitative respondents at all levels consistently reported an *improved ability to manage malnutrition*, *enhanced capacity for weighing and measuring*, and *higher levels of confidence* among PCF staff over the past year. In terms of enhanced capacity to manage cases of malnutrition, a municipal level respondent explained, "*We now know how to manage the children who are malnourished starting here in our community so that it will not get worse*," a sentiment that other respondents echoed. At an RHU in Midsalip, ZDS, another respondent shared how BNS now not only know what malnutrition is but also how to treat it, and they have gained confidence in doing so. Relatedly, many respondents reported improvements in PCF staff's ability to accurately weigh and measure patients. Specifically, some had not known how to properly calibrate a scale prior to PMNP ("*It's been quite a while since I became an MNAO, but it was only [recently] that I actually learned how to calibrate a weighing scale*") or how to properly take MUAC measurements.

It is worth noting, however, that some caregivers still reported capacity gaps in weighing and measuring children. A mother from Leyte shared her recent experience: "*Sometimes when they [BHW] weigh the children, they don't know the child's exact weight. They still have to call someone else for help. In terms of training, it seems they still lack knowledge*." Although it was not mentioned as frequently as managing malnutrition and taking accurate weights and measurements, some respondents shared that PCF staff had gained more

comprehensive knowledge of breastfeeding through the recent trainings, specifically the proper position and latch and how women can potentially increase their milk supply. As a result of the trainings, respondents consistently reported that PCF staff were more confident in dealing with patients and had "levelled up" the services they provided.

Q3.3 To what extent have the nutrition leadership and governance (NLG) capacity-building interventions, including training and the NLG competency framework, contributed to improvements in the capacity of LCEs and LNCs to lead the development of multisectoral LNAPs, including as it pertains to budget planning and utilization and SBC activities?

Perceived usefulness of NLG training and capacity building

NLG training appears to have enhanced the ability of local leaders to formulate, update, and implement MNAPs. Participants frequently described learning about proper MNAP formulation, aligning plans with local situational analyses, and ensuring consistency between planned and implemented activities. For example, multiple respondents reported that the training walked them "*one by one*" through the nutrition programme management cycle, allowing time for reflection on current monitoring gaps and potential improvements.

A strong, recurring theme was increased awareness of nutrition budget rules, accountability, and transparency requirements among LNCs. A Barangay representative in Maigo described learning rules around non-modifiable planned budgets, proper documentation during Nutrition Month activities, and the expectation that LGUs utilize at least 80% of PMNP funds as planned. Discussions on liquidation, monitoring, and the inability to reallocate funds without justification indicate that participants perceived the training as clarifying LGU financial responsibilities. While participants framed these insights as useful, the data does not definitively show whether this knowledge has translated into consistent practice across LGUs.

Some municipal level respondents described the training as increasing their appreciation for leadership roles, evidence-based decision-making, and performance-based governance. Respondents noted that the sessions emphasized the need for LCE commitment, with regional actors highlighting that nutrition progress ultimately depends on local executive prioritization. The introduction of leadership competencies combined with planning, budgeting, and monitoring content may have contributed to improved leadership intentions. However, qualitative accounts also indicate that effectiveness may still depend heavily on individual LCE motivation.

Regional implementers also highlighted the integration of leadership, governance, and programme management as particularly valuable, as it helped participants reflect on existing practices and adopt more coordinated and accountable approaches.

LCE and LNC Knowledge of Nutrition Action Planning, Budgeting, and SBC interventions

NLG functions discussed, including budgeting and financial management for nutrition, programme planning, PBG management as well as leadership and governance were generally viewed as highly relevant to the needs of local leaders. Participants noted that these sessions strengthened their understanding of nutrition planning and budgeting and reinforced the importance of prioritising nutrition within local governance. Participants described the training as helping clarify concepts such as problem analysis and MNAP formulation, indicating that the content responded to existing gaps in technical knowledge. This is strongly in line with the rationale to ensure leadership and governance competencies are strengthened and malnutrition as a governance challenge is addressed.[60]

Beyond MNAP formulation, national-level stakeholders reported that the sessions provided guidance on aligning MNAPs to funding cycles and ensuring transparency in budget utilization. As one municipal level respondent explained, "*They emphasized that PMNP budget should be monitored if it was really used for the intended programme… liquidation should be done with transparency every month.*" Similarly, another participant at the municipal level noted, "*We are more adept at making the LNAP… starting with the problem tree, what is the main cause of malnutrition, the solution or intervention to break the cycle*."

Training efforts to support "*SBC into LGUs to ensure we're not making things on our own but integrating into existing procedures*" and integrating it into the MNAP appear useful, as primary data suggest that LGU staff gained a clearer understanding of how SBC components align with local plans (KII, National level representative). Respondents explained that the sessions helped them distinguish which SBC interventions could be included, what documentation was required, and which indicators such as attendance records or beneficiary tracking should accompany activity reporting. Regional and national-level participants also noted that SBC content was intentionally embedded within

[60] NLG-NPM Training for LNC Draft 14APR2025

broader governance modules, which they felt helped reduce siloed implementation and promote a more multisectoral approach.

Q3.4 How has the PBG improved the capacity of LGUs to implement nutrition services in terms of human resources, supply chain, and governance systems?

PBGs are a core financing mechanism within PMNP that provide targeted municipalities with grant assistance contingent on the achievement of mutually agreed-upon performance indicators related to health and nutrition indicators at the municipality and barangay levels. These grants are designed to enable local governments deliver a defined package of high-impact health and nutrition services, as outlined in their approved MNAPs. PBGs aim to serve as a source of flexible funding for locally relevant interventions, but also as an incentive for municipalities to invest in strengthening their human resources, systems, and multisectoral collaboration for nutrition.

Although flexible, PBG funds utilization should be anchored to the overall objective of PMNP, which that is to improve service coverage of targeted beneficiaries through strengthened delivery of nutrition interventions and primary health services. The POM provides a menu of interventions, services, and items that are eligible for PBG financing,[61] structured under two primary expenditure categories: A) "support for service delivery" (e.g., commodities and activities supporting antenatal care counselling, IFA supplements, RUSF and RUTF, medicines, vaccines, etc.); and B) "operations for the implementation of the first 1000 days strategy" (e.g., hiring additional frontline health personnel). As of December 2024, PMNP distributed PHP 1,073,160,000 (USD 18,191,929) in PBGs to 235 municipalities, leading to improvements in the supply of medicines, equipment, and staff in healthcare facilities as well as qualitative improvements in local nutrition governance capacity.

Analysis of PBG Tranche 1 Funding

PBGs are disbursed to municipalities in the form of three tranches over time, with Tranche 1 totalling PHP 560,423,197 (USD 9,500,148). As part of the midline evaluation desk review, the research team requested clean, compiled data on Tranche 1 PBG utilization through December 2025 showing the purpose of each expense, date, amount, and municipality. The goal was to assess PBG utilization by PMNP municipalities across several dimensions: fund execution capacity, common spending categories, and frequently acquired interventions, services, and items. Of the 235 municipalities receiving PBG Tranche 1 funding, 141

[61] POM, version Oct 2024. Table 18.

municipalities (60%) provided sufficiently cleaned and consolidated utilization data for analysis (Exhibit 5.3.16). Sixty-eight percent of the municipalities in the Visayas provided sufficient PBG data, followed by 61% in Luzon, and only 38% in Mindanao. The most common reasons for incomplete PBG data included missing information, lack of data consolidation, and errors.

Exhibit 5.3.16. PBG Tranche 1 Data Consolidation: Complete vs. Incomplete

Island Cluster	Region	Incomplete		Complete	
		Number	%	Number	%
LUZON		39	39%	60	61%
	Region III (Central Luzon)		0%	1	100%
	Region IV-A (CALABARZON)	2	8%	22	92%
	Region IV-B (MIMAROPA) Region	13	93%	1	7%
	Region V (Bicol Region)	24	40%	36	60%
MINDANAO		23	62%	14	38%
	Region IX (Zamboanga Peninsula)	4	44%	5	56%
	Region X (Northern Mindanao)	11	100%		0%
	Region XI (Davao Region)	1	17%	5	83%
	Region XII (SOCCSKSARGEN)		0%	3	100%
	Region XIII (Caraga)	7	88%	1	13%
VISAYAS		32	32%	67	68%
	Region VI (Western Visayas)		0%	5	100%
	Region VII (Central Visayas)	14	58%	10	42%
	Region VIII (Eastern Visayas)	18	26%	52	74%
Grand Total		94	40%	141	60%

For the 141 municipalities providing complete Tranche 1 PBG data, the average utilization was 90.4%, ranging from a minimum of 27.6% and a maximum utilization of 100%. Exhibit 5.3.17 reports the utilization of PBG Tranche 1 for the 141 municipalities, summarized by island cluster and region. Using the PMNP municipalities in Bicol Region as an example, the average utilization of these municipalities is 94%, the municipality with the lowest utilization has achieved a financial accomplishment of 58%, and the municipality with the highest utilization has spent 100% of the PBG Trance 1 disbursement. All PMNP regions report an average utilization of at least 84%, with the majority of

regions reporting an average utilization of at least 95%. Across the sample, mean and median average utilization are high and similar, indicating comparable PBG utilization progress within the analysis subsample. However, we expect average utilization among these 141 municipalities to be higher than that of the 235 LGUs because consistent financial reporting typically signals high administrative capacity, which is in turn correlates with resource execution capability.

Exhibit 5.3.17. PBG Tranche 1 Utilization (%) for 141 Municipalities

Island Cluster	Region	Mean	Min	Median	Max
LUZON		93.6%	58.3%	98.3%	100.0%
	Region III (Central Luzon)	95%	95%	95%	95%
	Region IV-A (CALABARZON)	93%	72%	99%	100%
	Region IV-B (MIMAROPA) Region	84%	84%	84%	84%
	Region V (Bicol Region)	94%	58%	98%	100%
MINDANAO		93.9%	74.3%	95.7%	100.0%
	Region IX (Zamboanga Peninsula)	89%	74%	94%	95%
	Region XI (Davao Region)	97%	88%	99%	100%
	Region XII (SOCCSKSARGEN)	95%	90%	96%	98%
	Region XIII (Caraga)	100%	100%	100%	100%
VISAYAS		86.9%	27.6%	93.1%	100.0%
	Region VI (Western Visayas)	95%	88%	95%	98%
	Region VII (Central Visayas)	96%	82%	99%	100%
	Region VIII (Eastern Visayas)	84%	28%	91%	100%
Grand Total		90.4%	27.6%	94.8%	100.0%

The POM specifies a menu of allowable expenditures and sets allocation ceilings for two primary expenditure categories: support to service delivery enhancement (capped at 60% of PBG funding) and LGU operations for the first 1,000 days (capped at 40%). On average, PBG utilization across the 141 PMNP municipalities with complete data fell within three percentage points of these ceilings, indicating general compliance with PBG spending criteria (see Grand Total, Exhibit 5.3.18). That said, some individual regions—Central Luzon, for example—exceed the ceilings by 8 percentage points. This likely reflects the fact

that utilization has not yet reached 100% in all municipalities within a given region, so the expenditure ratio between the two categories does not currently align with the 40:60 split. Once utilization reaches 100%, the ratio may well move into the compliance range at the regional level. At endline, we will revisit final and consolidated PBG tranche-1 utilization reports by municipality to assess whether the expenditures ceilings were individually followed by each of the 235 PMNP LGUs.

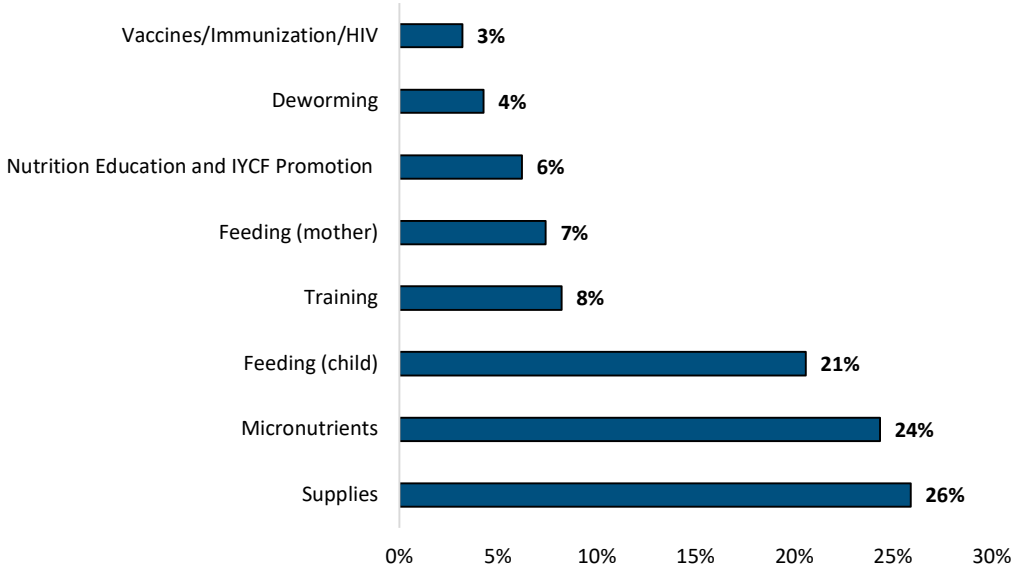
Exhibit 5.3.18. PBG Tranche 1 Utilization across Primary Expenditure Categories for 141 Municipalities

Island Cluster	Region	Support to Service Delivery		First 1,000 Days Operations	
		Mean	Median	Mean	Median
LUZON		63%	60%	37%	39%
	Region III (Central Luzon)	68%	68%	32%	32%
	Region IV-A (CALABARZON)	60%	60%	41%	40%
	Region IV-B (MIMAROPA) Region	53%	53%	47%	47%
	Region V (Bicol Region)	64%	61%	35%	39%
MINDANAO		67%	66%	32%	34%
	Region IX (Zamboanga Peninsula)	60%	60%	40%	40%
	Region XI (Davao Region)	75%	75%	20%	25%
	Region XII (SOCCSKSARGEN)	64%	66%	36%	34%
	Region XIII (Caraga)	65%	65%	35%	35%
VISAYAS		62%	61%	39%	39%
	Region VI (Western Visayas)	64%	63%	36%	37%
	Region VII (Central Visayas)	66%	61%	34%	39%
	Region VIII (Eastern Visayas)	61%	61%	41%	39%
Grand Total		63%	61%	38%	39%

Within support for service delivery, supplies, micronutrients, and child feeding commodities accounted for 26%, 24%, and 21% of the total expenditures. Trainings for services providers and local nutrition stakeholders, alongside nutrition education and IYCF promotion corresponded to about 14% of reported expenditures. Vaccines, HIV antiretrovirals, and deworming

commodities jointly accounted for 7%.[62] These findings suggest that PBG Tranche 1 Funding under "Support for Service Delivery" improved the capacity of most LGUs to implement nutrition services primarily through enabling their access to essential health commodities and supplies. Meanwhile, expenditures under "Operations for the implementation of the first 1000 days strategy" were complementary to those that appeared under "Support for Service Delivery" and mostly correspond to salaries and trainings related to municipal nutrition governance and planning.

Exhibit 5.3.19. PBG Tranche 1 Expenditures under "Support for Service Delivery"



Note: Analysis for a subsample of 141 municipalities with complete PBG Tranche-1 data

Perceived changes in capacity of LGUs to implement nutrition services attributed to PBGs Respondents attributed a variety of tangible improvements to the first tranche of PBGs. While each municipality used their grant differently, financial utilization data for quarter 1 of 2025 shows that PBGs were used to broadly strengthened the supply of medicines, immunizations, and nutritional supplements; and increased staffing for nutrition-specific services.

Women and PHC staff alike noted a marked increase in the availability of essential medicines, vitamins, and nutritional supplements within local health systems. With dedicated funding, respondents say that healthcare facilities are able to distribute a broader array of supplies, such as ferrous sulphate and MNP, ensuring that pregnant women and children have improved access to the

[62] The Research team leveraged Artificial Intelligence (AI) to categorize and label all expenditures detailed under support for service delivery in each of the 141 municipalities for which we have consolidated Tranche 1 PBG data.

resources they need. This shift has addressed previous gaps and shortages identified in the baseline report, making it possible for families to see health service delivery as more consistent and reliable. In addition, PBGs have supported improvements in the equipment needed to deliver nutrition-specific and -sensitive services. Many local governments have been able to acquire equipment such as weighing scales, height boards, and technology for data collection, and some also noted supporting feeding programmes at daycares through materials like eating utensils.

Furthermore, PBGs have facilitated the expansion and reliability of staffing within health facilities. Inadequate staffing undermines the health system's capacity to deliver First 1,000 Days services, and it decreases preparedness, surge capacity, and continuity of PMNP-support nutrition interventions during public health emergencies. With increased financial resources, municipalities have been able to hire (see Indicator 1.4 in Exhibit 5.3.1)[63], train, and mobilize additional health workers, resulting in a more consistent presence and higher quality of care. Health facilities now report that PHC staff are more regularly available, and service delivery is less likely to be interrupted due to staffing shortages. This improvement in human resources was noticed by service users, including a pregnant woman in Maigo who noted, *"Before, during my prenatal visits, sometimes the doctor or midwife wasn't there. But now, there is always someone at the centre."* By increasing staffing, qualitative accounts such as this indicates that PMNP has supported stronger presence of doctors, nurses, and midwives in barangay health stations, and has supported service demand by demonstrating the consistent availability of services.

Number of facilities equipped with technology to access information systems

While not a primary use of funds, some municipalities have used PBGs to equip healthcare facilities with improved technology for the purpose of accessing information systems. As a municipal respondent testified, "*PMNP provides everything that is lacking*" according to the requests identified by the RHU. In Calauag, this included weighing scales and medicines as well as a laptop for use by PHC staff.

The facility checklist showed that around half of sampled facilities had a computer or laptop, regardless of treatment status (see Exhibit 5.3.16). This is likely because laptops were a less common use of PBG funds. However, treatment municipalities had significantly better access to printers and

[63] According to PMNP national-level monitoring data, 59% of PMNP municipalities are appropriately staffed to provide F1KD services, a significant improvement since baseline (0%).

projectors as compared to control municipalities. This indicates a greater emphasis on training and SBC readiness as compared to monitoring and information system use.

Exhibit 5.3.20. Technology at Healthcare Facilities

Technology	Treatment	Control	N
Computer/Laptop	0.56	0.56	27
Printer	0.50	0.33*	27
LCD projector	0.39	0.11**	27
Sound system or microphone for group activities	0.33	0.11	27

Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Supporting this, PBG utilization from the sampled municipalities of Midsalip, Maigo, Capoocan, and Badiangan showed that none of them used PBGs to purchase technology and rather supported hiring, training materials, SBC, and monitoring activities (e.g., OPT+).[64]

Perceived adequacy of current human resources and skills in supply chain and governance systems in LGUs

The provision of PBGs is vital to capacity building efforts related to local nutrition governance by providing financial backing for the improved MNAPs. In qualitative data, it is clear that municipalities use PBGs to operationalize their MNAPs, putting to the test systems for planning, tracking, and monitoring nutrition programming at a greater scale. PBGs have also enabled the expansion and tailoring of programmatic activities, including feeding initiatives, as well as strengthened preparedness to provide services during public health emergencies. Respondents in LGUs also noted an increased emphasis on monitoring, reporting, and accountability within health and nutrition programmes attributed to PMNP. Several respondents particularly linked health programming to OPT monitoring, with a municipal level respondent describing, *"Through OPT, we've seen the targets, and now we have specific participants to focus on to improve their nutritional status. PMNP has been a big help because we now have resources to provide for their needs."*

While PBGs supported the supply of medicines, supplements, immunizations, and healthcare equipment, it is not clear that capacity for procurement and

[64] PBG Utilization: Fund Utilization Report (FUR) Q1 2025.

supply chain management has improved at the local level. On a promising note, qualitative data with municipal level respondents indicates greater coordination between nutrition staff such as BNSs and MNAOs and local budgeting and planning procedures related to management of the PBGs. On the other hand, local stakeholders did not indicate improved knowledge or confidence related to procuring supplies. Rather they largely referenced that PMNP handled procurement processes, saying things like "*PMNP…gave us our supplies" and "we received them from the project*." This indicates that LGU officials may be relying on project systems to address any supply chain management challenges they face.

Q3.5 To what extent have PMNP's interventions reached the most vulnerable and marginalized population groups including, women, children, geographically isolated and disadvantaged, 4Ps beneficiaries, Indigenous Populations (IPs), and people with disabilities?

PMNP targets several different vulnerable populations, including those living in GIDA, IPs, and 4Ps participants through PBG eligibility criteria and in the selection of its 235 municipalities. These strategies ensure the prioritization of geographically isolated and disadvantaged, IP, and 4Ps populations as beneficiaries of PMNP inputs. Further, there is clear evidence of PMNP coordination with the NCIP "to protect and promote" IP communities, as detailed in the POM. Women and children are also targeted through PMNP activities to strengthen health and nutrition services, including the provision of antenatal care, micronutrient supplements, and immunizations. Project documents do not include any specific targeting mechanism to ensure the inclusion of people with disabilities (PWDs). In qualitative data, several respondents said that PWDs are inadvertently reached through health and nutrition activities, along with other vulnerable groups; their inclusion occurred without targeted adaptations or systematic monitoring, however. Many municipal and barangay level respondents reported engaging with PWDs when conducting house-to-house visits, family development sessions, and providing sanitation facilities through the Zero Open Defecation programme.

While PMNP services target and reach some vulnerable groups, participants mentioned key challenges that limit their ability to meet the needs of marginalised populations. Qualitatively, many healthcare workers said that it can take hours for them to reach GIDA locations by foot *or* by vehicle. Families rarely have enough money to afford transportation to local health centres. Municipal and barangay level healthcare workers wanted more training and staff to reach those in GIDA areas and better support PWDs. Some healthcare providers also said that cultural beliefs and social norms among IPs and religious groups as well as language barriers affect their participation in health

programmes. A few providers seemed frustrated by IPs' resistance to healthcare services including vaccinations and family planning, suggesting the need for PMNP to take steps to facilitate the delivery of inclusive and culturally sensitive services. PMNP might also consider clarifying its approach to serving PWDs and provide capacity-building on PWD engagement to service providers.

Q3.7 To what extent did PMNP achieve desired results in relation to:

Q3.7.a PMNP convergence model/approach for delivery of nutrition-specific and nutrition-sensitive interventions for the first 1,000 days?

As of October 31, 2025, national level data from the Household Convergence Score Card shows that PMNP is providing 12 of its 15 targeted nutrition-specific/sensitive interventions to the vast majority of eligible populations in PMNP areas (Exhibit 5.3.17). These statistics suggest the project is on track to meet its target once SBC implementation improves.

Exhibit 5.3.21. HSCH National-level HCSC as of October 31, 2025

Nutrition Service	Current Coverage in PMNP Areas
ANC	83%
IFA / MMS	82%
TTN / TTD (Tetanus) Vaccine	51%
Facility Based Delivery	85%
Post Natal Care	88%
EBF (< 6 months-old children)	92%
MDD (6–23-month-old children)	4%*
Vitamin A supplementation	94%
Age-Appropriate Immunization	2%*
Growth Monitoring	95%
Nutritional Status: Weight-for-Age	88%
Access to Safe Drinking Water	99%
Access to Sanitary Toilet	90%
Attended SBC session	30%
Handwashing	99%

**Information on these indicators was still under validation as this report was being finalized.*

Although the individual HCSC statistics are very positive, they may overstate actual convergence. Particularly because certain indicators continue to be low (i.e., SBC attendance), therefore suggesting an important proportion of

caregivers in PMNP areas are not simultaneously receiving the full suite of nutrition services. Indeed, the individual figures do not indicate whether all eligible households are convergently receiving all relevant services at a given point in time, so it is imperative to triangulate with other data sources, as done below.[65]

Perceived Convergence

Qualitative respondents said PMNP's convergent approach helped facilitate the delivery of health and nutrition interventions at the barangay level. National, municipal, and barangay level participants described how PMNP supported municipalities and barangays in formulating MNAPs and BNAPS with complementary health and nutrition priorities. They discussed how these priorities were being implemented through activities to improve community-level access to maternal and child health and nutrition (MCHN) knowledge and services, clean water, and toilets. Many municipal and barangay-level health and nutrition actors said they coordinated with one another to monitor converging components using the household convergence scorecard. Municipal level respondents also reported integrating handwashing, waste disposal, and other hygiene reminders into health information sessions and feeding programmes.

However, budget disparities and coordination challenges between DOH and DSWD, unsynchronized implementation of components 1 and 2, and delays rolling out the household convergence scorecard all hindered the implementation of a fully convergent programme. While DOH and DSWD activities targeted the same communities, WASH and ECCD programming reached considerably fewer beneficiaries due to DSWD's smaller share of the project budget. A national representative explained, *"Since DOH's budget is 80% of PMNP, its target is all pregnant women in the municipality. For DSWD, since the funding is small, we cannot cater to the needs of all the pregnant." National representatives said coordination challenges at the national level led to a relatively fragmented intervention. Much of this was attributed to overloaded DOH personnel managing multiple programmes in addition to PMNP and complex bureaucratic processes slowing down coordination between DOH, DSWD, and LGUs. One national representative said, "One of the implementation challenges is the fragmentation of interventions at national and regional level -*

[65] *Because of this* limitation of the HCSC data, the endline impact evaluation will include a convergence analysis showing the proportion of eligible households receiving the full suite of nutrition services (e.g., growth monitoring, supplementation, and SBC combined). This will provide a clearer picture of actual service integration and help identify gaps where households are receiving only partial coverage.

bringing everything together is a big challenge. DOH, DSWD, even within DOH, its own systems - that's a big challenge in terms of coordination."

The DSWD Kalahi-CIDDS project was responsible for implementing most of the nutrition-sensitive activities under component 2 and had completed nearly all WASH and ECCD interventions by the time the DOH was ready to implement nutrition-specific activities under component 1. The DOH and DSWD adopted different procurement processes according to the activities under their components, resulting in implementation discrepancies between components 1 and 2. Qualitative national-level respondents said it took several months for the DOH to receive funds because of lengthy approval processes on the part of the World Bank and United Nations Office for Project Services (UNOPS). According to some national participants, DSWD Kalahi-CIDSS staff were less impacted by these challenges because the DSWD did not engage with UNOP[s] to avoid delays. World Bank representatives clarified that the DOH chose to change an already-approved procurement process after being told that it could lead to a 6-month delay in World Bank approval, and UNOPS timelines were moved several times as they were unable to meet DOH deadlines. The DOH also received loan proceed funds but was unable to withdraw them in time due to delays in release of the budget cover from the government in 2022 and 2023. Explaining how these challenges affected the project's convergence, a national representative said,

"One challenge was the lack of synergy and alignment between components 1 and 2. When component 2 had nearly ended, component 1 was just beginning. From what I experienced, this created difficulties for … our deliverables. We missed the opportunity to streamline the processes at the same time."

Convergence Scorecard

National, regional, and municipal-level stakeholders thought the household convergence scorecard was a useful tool to assess household access to nutrition-specific and nutrition-sensitive interventions and produce data to select appropriate interventions for communities. However, there were challenges with rollout and data collection. The subcontractor was not ready to launch the scorecard information system by the originally scheduled internal verification and third-party verification deadline in 2024 to release the second PBG tranche. Tablet procurement and distribution were also delayed. As a result, the second PBG tranche was delayed in order to first launch the information system. Once the information system was ready, BHWs and midwives were trained quickly to accommodate the new timeline. Some national representatives worried this could affect data quality. Additionally,

most municipal and barangay level healthcare workers – who were used to keeping paper records when collecting other barangay-level data - struggled to use the household convergence scorecard via tablet or computer. They required more training on technology and digital skills. Interviews with municipal respondents and BHWs indicated they were also generally understaffed and experienced regular turnover, leading to ongoing issues with training retention and data collection capacity.

Q3.7.b Nutrition and health systems strengthening in improving the delivery of high-impact nutrition interventions within primary health care?

Qualitative data suggest that PMNP activities to procure medical supplies and capacitate PHC staff successfully improved nutrition intervention delivery within primary healthcare (refer back to Exhibit 5.3.2 on health facility equipment and supply availability). Municipal level respondents, BHWs, and BNS' said it was easier for healthcare workers to monitor growth and address malnutrition because they had adequate MUAC tapes, weighing scales, height boards, and vitamins. Micronutrient powders, vitamin A, deworming tablets, and vaccines were increasingly distributed to pregnant women, caregivers, and children via health centres. One barangay level respondent said, "*Ever since the micronutrient powder and Ready-to-Use Therapeutic Food were provided, it really helped to reduce malnourishment among the children in the barangay*."

Most participants said PMNP's capacity building and training activities improved healthcare services. Municipal respondents and BHWs said PMNP trainings refreshed their previous knowledge and helped them build competencies, making it easier to conduct MUAC measurements and provide antenatal care. Quantitative findings from the knowledge survey and observations support these claims (see results in response to Q3.2). For instance, more providers in the treatment areas measured an infant's weight correctly via an infant (100% vs 50%) or sling scale (60% vs 50%) than in comparison areas. Pregnant women viewed nurses, midwives, and BHWs as a trusted source of information on nutrition and diet, supplement and medication use, and immunizations during their pregnancies. Some pregnant women and caregivers also said health workers educated them on the nutritional benefits of exclusive breastfeeding and complementary feeding during prenatal and regular check-ups. The research team observed providers in treatment areas covering 61% of complementary feeding tasks/topics in their sessions and 70% of exclusive breastfeeding tasks/topics.

Many barangay-level stakeholders perceived health workers to be more present in their roles following PMNP intervention. A pregnant woman from Maigo, LDN

said, "*From my experience before — during my prenatal visits — sometimes the doctor or midwife wasn't there. But now, there is always someone at the [health] centre."* Participants also believed PMNP strengthened health workers' ability to conduct house-to-house visits and monitor service use, reminding pregnant women to attend regular checkups. Many pregnant women across barangays indicated that they attend checkups once a month. A municipal level participant reported,

"I am one of those monitoring the children's weight, and I can say that PMNP has contributed greatly, particularly through the provision of vitamins distributed even to pregnant women. The additional budget has also been a big help. In terms of service delivery, there has been a noticeable improvement — since the implementation of PMNP, we have received sufficient supplies, including vitamins, which we can readily utilize. Moreover, most beneficiaries have been compliant with the scheduled visits."

Despite the general consensus that PMNP effectively strengthened nutrition services, challenges persisted. Healthcare workers in every barangay noted that while supplies increased, they still experienced medicine, vitamin, and equipment shortages. Even with additional funding from PMNP, LGUs still did not have sufficient budgets to cover all expenses. Some caregivers and pregnant women also perceived healthcare services in their communities to be the same as before PMNP arrived. They reported experiencing long wait times in overburdened health centres, said they were unable to access medicine and vitamins when they needed them, and had mixed perceptions of the attitudes and helpfulness of nurses, midwives, and BHWs, who some found to be disengaged.

Q3.7.c Performance-based grants facilitating implementation of services and fostering multi-sectoral planning, budgeting, finance management, and action at the subnational level?

Qualitatively, PBGs were considered effective for incentivizing LGUs to prioritize nutrition in their municipalities and barangays. Participants said that because the grants were directly tied to performance indicators, LGUs were motivated to meet the established targets and improve service delivery by developing quality MNAPs and BNAPs and selecting multisectoral nutrition interventions to implement in their communities. Municipal level respondents said the primary activities outlined in their MNAPs and BNAPs included providing supplemental feeding for young children and pregnant women, monitoring children's nutritional status, educating communities on nutrition and feeding practices, increasing access to toilets and safe drinking water, and promoting other

hygiene practices. A municipal respondent reported "We focus on educating the family, making sure the mother receives complete antenatal care, and promoting good practices in IYCF, such as proper breastfeeding. If these are followed consistently, our goal in the MNAP can really be achieved." Municipal and barangay-level facilities also appreciated the additional financial support PBGs provided to resource-constrained LGUs, enabling them to hire additional staff, train healthcare workers, and purchase medical supplies.

In national, regional, and municipal level interviews, many participants said PBGs facilitated multisectoral planning and budgeting across municipalities and barangays. The conditional funding structure required LGUs, frontline workers, and community members to coordinate across health, nutrition, WASH, and education sectors in order to access funds to plan and budget for nutrition interventions, strengthening multisectoral collaboration. A regional respondent said, "*I have seen how PMNP has improved coordination among regional agencies, local government units, and frontline workers through the conduct of regular meetings, technical provision of technical assistance, and shared accountability.*"

However, several challenges impacted LGUs' ability to implement nutrition services using PBGs. Aforementioned delays disbursing the second PBG tranche impeded implementation and affected retention of PBG-hired staff. Slow local procurement and accounting processes caused further delays. Many LGUs said they received funding late in the year and rushed activities, leading to compromised implementation quality. Additionally, the first PBG tranche included 15% of the total funding that will be distributed to LGUs. To-date, they have acquired needed supplies and implemented activities to qualify for tranche 2 funding, but they have not had the funds to implement substantial interventions. A national representative explained,
"Tranche 1 is basically just 15% of the total pot money that they will be receiving. Tranche 2 is 50%. So, 5-0. So, I think that's why for now they're just prioritizing activities or even supplies that's actually needed for your PBG verification, Tranche 2, just so that they can pass. But they hope to also include that in the planning for the Tranche 2 amounts. Because Tranche 2 is quite big. It's times 3 of the current fund that they actually got."

Q3.7.d Kalahi-CIDSS community-driven development approach facilitating the implementation of community-based nutrition programming and multisectoral nutrition convergence?

Qualitative respondents said community members were strongly involved in the KALAHI-CIDSS community-driven development approach. Many national

and municipal-level DSWD representatives reported that the projects implemented under component 2 were identified directly by communities, ensuring WASH and ECCD activities were in touch with their primary needs. As previously mentioned under EQ3.1, however, qualitative data from FGDs at the Mayor's Forum suggest that some LGU representatives, particularly in Leyte, felt that in order to implement subprojects on time, DSWD did not adequately consult communities during subproject selection and implementation. Others felt the subprojects were limited and did not sufficiently address WASH and ECCD needs at the community level. When asked about Kalahi-CIDSS, most participants said the project updated ECCD infrastructure - including kitchens - in their barangays, making it easier for daycares to implement feeding interventions for young children. An ECCD worker from Buhi, Camarines Sur said, "*Before, they had to bring wood into the daycare centre to cook. Now, we have a gas stove and we have a refrigerator, where we can keep the other food that we use for feeding*." To a lesser extent, participants also identified Kalahi-CIDSS' efforts to improve community WASH by distributing toilets and increasing access to clean water.

Some participants felt that the funding for Kalahi-CIDSS was insufficient to effectively improve WASH access in communities. Several national and municipal level staff felt that the PMNP budget limited their ability to improve community water sources. Some participants thought that PMNP directly covered the costs of toilet bowl distribution to households under component 2, but a World Bank representative clarified that this was a DSWD-funded program, which PMNP coordinated with through its multisectoral convergence efforts. Several municipal level respondents identified toilet distribution and comfort room construction as key needs for families, however, and said the toilets that were distributed to households in need were never utilized because families could not afford the labour and installation costs, which PMNP did not cover. One municipal participant explained,

"The DOH only gives me toilet bowl. The family cannot afford to construct it, so it is just useless. What is happening is I am giving those bowls to those who have the capacity for construction, which does not make sense. My point is to give those bowls to families who cannot afford to construct toilets and have many children."

Q3.7.e Use of SBC strategies and approaches to change key behaviours and practices known to reduce stunting?

In qualitative data, many respondents said that PMNP's SBC approach improved health and nutrition knowledge and led to some key behavioural changes

across municipalities and barangays. Caregivers and BHWs noticed an increase in awareness and adoption of exclusive breastfeeding and regular prenatal visits following targeted SBC activities. Mothers' classes, family development sessions, information provided at health centres, and other community engagement activities including seminars and barangay visits were considered particularly useful for promoting behaviour change. Respondents said information, education, and communication (IEC) materials such as posters, flyers, and audio recordings successfully reinforced key health and nutrition messages.

While participants believed SBC efforts were gradually influencing local health practice and behaviour, some community members remained resistant due to traditional beliefs and misunderstandings. Municipal and barangay-level respondents said that despite health education efforts, some pregnant women refused to take supplements like ferrous sulphate and iron due to misconceptions about their safety. Many parents would not vaccinate their young children – even after receiving information about vaccines through PMNP - because they still believed vaccines were harmful. In an extreme case in Midsalip, ZDS, municipal participants said that parents thought vaccines would kill their children. Some communities also held traditional beliefs that breastmilk is rotten and preferred to use formula. A municipal level respondent explained, *"There are myths that breastfeeding is not allowed, especially the first milk that comes out from the breast that is yellow in colour, because it is rotten already. That should be changed because they don't know that colostrum is more nutritious."*

Q3.7.f Institutional strengthening of DOH, DSWD, and LGUs to implement and manage nutrition interventions. To what extent were the approaches used effective (e.g., project management units at national and sub-national level; procurement and financial management; environmental and social management; information management; and M&E of the project, amongst others)?

Qualitatively, many respondents said that PMNP built the institutional capacity of LGUs. Technical working groups (TWGs) and project management offices (PMOs), which were established at the national, regional, provincial, and municipal levels, strengthened LGUs' ability to plan, implement, and prioritize nutrition interventions through technical assistance and training. RTWGs and RPMOs were instrumental in increasing local engagement and focus on nutrition by facilitating stronger coordination and information sharing amongst municipal and barangay leaders and helping LGUs formulate and implement MNAPs. MPMOs played an important role in capacitating LGUs by facilitating

meetings with municipal leaders, barangay officials, and multisectoral representatives to support municipal nutrition action planning. Regional and provincial offices also helped LGUs appropriately manage PBGs, which were used to conduct trainings, purchase equipment, and hire dedicated nutrition staff including MNAOs to strengthen LNCs in resource-constrained areas. Financial management improvements were noted, with the integration of nutrition programme transactions into LGU financial systems. Many national, regional, and municipal-level respondents felt that the technical assistance, additional funding, and coordination support provided by PMNP made LGUs more committed to nutrition programming. A regional level respondent reported,

"The most important contribution of PNMP in our region has been the strengthening of the local nutrition governance and planning. Through the PNMP, LGUs were able to update and improve their LNAPs and reactivate or strengthen their LNCs. So, this has helped institutionalize nutrition as a priority concern rather than an ad hoc activity."

PMNP also strengthened LGUs' ability to consult communities in the design and implementation of nutrition and health programmes and ensure nutrition information is widely disseminated. LGUs worked directly with communities to select nutrition-sensitive, needs-based interventions and implemented environmental and social frameworks (ESF)—including grievance boxes and regular community consultations—to ensure accountability and responsiveness of local programmes. Political tensions between barangay captains and mayors affected implementation, however; some barangays refused to install grievance boxes or follow municipal instructions due to political disagreements. RTWGs helped LGUs adapt SBC materials into local contexts and translate them into local languages. This made nutrition information more accessible and increased awareness and participation among caregivers and pregnant women. As one regional respondent explained,

"We help the LGUs adapt PMNP-developed materials into local languages for use in the barangays—in their dialects. Through these strategies, PMNP has enabled us to make nutrition messages more visible, consistent, and community-driven across the nine implementing sites in the region."

At the local level, institutional challenges persisted due to staff turnover and lack of personnel; MNAOs regularly held multiple roles, affecting their ability to coordinate with PMOs. As noted, PBGs enabled LGUs to hire additional nutrition staff, but delays due to the slow release of government budgets affected staff retention. In LGUs that did not have extra resources to allocate to technical

staff, MNAOs and health provincial officers (HPOs) left their positions because they had not been paid. Ongoing human resource constraints threatened the long-term effectiveness of activities to strengthen local nutrition governance, including capacity-building training. A national representative explained, "*There are high turnover rates now. We heard people are resigning from their posts. We invested in a lot of training but because of these issues, there are already people who resigned*." Some national representatives also felt that the capacity-building trainings could have been better tailored to the specific needs of each LGU.

There was less evidence that PMNP successfully strengthened the institutional capacities of the DOH and DSWD. PMOs and TWGs at the national level facilitated some coordination and planning between the two departments. Additional funds, training, and equipment procurement provided by PMNP helped the DOH and DSWD expand their reach and improve service delivery at the local level. Yet overloaded staff with competing priorities across both departments limited the DOH and DSWD's ability to fully focus on PMNP or nutrition activities in general. PMNP funds were also insufficient to address all of the budget and staffing concerns at the national level. Lack of synergy between the implementation of components one and two led to a fragmented intervention and negatively impacted DSWD and DOH coordination, as previously noted.

Efforts to strengthen DOH, DSWD, and LGU use of information systems and M&E capabilities were only *partially* successful due to system incompatibilities and staffing and technology constraints. Enhanced reporting systems, such as the HCSC, iClinicSys EMR and Data Quality Checks (DQC) were introduced, resulting in more complete data for monitoring nutrition outcomes. Trainings on the DQC, OPT+, and HCSC tools were cascaded from the national to local levels, with master trainers and technical managers providing ongoing support and follow-up to sustain best practices. Human resource and technology constraints at the barangay-level often hindered the effective use of these information systems for the M&E of health and nutrition interventions, however. As discussed under EQ 2.5, lack of computers, tablets, and internet resulted in discrepancies between manual and electronic data collection and encoding across barangays and limited the compatibility of information systems. The lack of nurses, midwives, BHWs, and digitally literate staff also affected data collection and utilization. Additionally, PMNP's M&E framework required LGUs to submit reports and undergo internal and external verification to receive PBG funds, which helped to ensure accountability and track local progress. While the focus on output-level indicators (such as MNAPs) was effective in achieving LGU compliance, there were concerns about the

continuity of quality monitoring after the project's conclusion, particularly without sufficient or dedicated staff.

Q3.8 What were the major factors influencing the achievement or non-achievement of PMNP intermediate results?

Barriers to Implementing PMNP Activities

Respondents at all levels consistently reported the core barriers to delivering PMNP activities were *funding gaps and delays*, *staffing limitations*, and *coordination issues*. A smaller number of respondents noted the challenges of having different timelines for the different components of PMNP (which reduced opportunities for synergies), and the implementation delays caused by local elections. In terms of funding and supplies, the most frequently mentioned challenges were damaged or missing scales and height boards and delays receiving other supplies. Even with the inputs provided by PMNP, some respondents said, "*We still have limited resources*" (regional respondent) and some women in treatment areas complained of lack of medicine: *"…they just say there's no stock*" (female caregiver, Leyte). Procurement issues also delayed the delivery of the grants (both PBGs and HPGs), and there were some reports of delayed payments to PMNP staff: "*For how many months, PMNP staff were not paid because there is no cash. We have been conducting activities and trainings, but we have not been paid any money*."

Regional, municipal, and barangay-level respondents consistently reported being understaffed and managing multiple programmes, with some claiming that PMNP created additional workload that was difficult to maintain. A municipal level respondent explained*, "We are only three…each of us have handled a lot of programmes…there are a lot of programmes from the DOH*" while another municipal participant shared,

"We really try our best to visit all the barangays, but because there are so many programmes from the DOH, instead of giving 100% focus to nutrition, only a small percentage of our attention remains for it. There are just too many programmes being implemented—we even have trainings almost every week. Another challenge we face is the lack of manpower. We also don't have our own office for nutrition, which makes it difficult to have proper focus on it."

Other municipal-level respondents referred to PMNP as an "additional function" that they could not give sufficient attention to without neglecting their primary functions. At the barangay level, respondents reported varying levels of nutrition-related personnel (some areas said they had sufficient staff, others

said they were chronically understaffed) and that volunteer positions such as BNS and BHW tended to turnover frequently, leading to challenges with continuity and capacity to deliver PMNP activities.

In terms of coordination, respondents noted difficulties collaborating across provinces and municipalities, and some complained they received incomplete or last-minute information from national-level stakeholders, such as being called to a mandatory training at the last minute and struggling to secure travel orders in time to attend. More problematic, however, were reports of the "lack of support from officials and departments" in delivering PMNP activities, and in some cases municipal- or barangay-level codes that restricted the implementation of PMNP activities. There were multiple examples of disagreements between LCEs and legislative bodies that resulted in the latter not approving PMNP activities, requiring changes to the activities, or delaying the implementation of activities.

Facilitators to Implementing PMNP Activities

Respondents identified four main factors that facilitated the implementation of PMNP activities: first, the *PBGs were perceived as highly motivational* for LGUs to prioritize nutrition. Secondly, *coordination across agencies*, the absence of which can also inhibit PMNP implementation, was recognized as a crucial factor in delivering multisectoral interventions under PMNP. Thirdly, the fact that PMNP operates through and strengthens *existing structures* was perceived as very helpful in the delivery of activities. Fourthly, the structure and content of the NLG training – and the focus on *interlinked MNAPs and BNAPs* – was perceived to enable better nutrition planning. To a lesser extent, respondents also noted that joint activities (such as combining immunization with FDS sessions) and visiting beneficiaries in their homes also helped to maximize the reach and effectiveness of PMNP interventions. Finally, some respondents felt that translating PMNP-developed materials into local languages increased visibility and ownership of nutrition messaging at the barangay level.

Respondents largely agreed that PBGs were motivational and led to enhanced emphasis on nutrition at the LGU level which then cascaded downwards. Of the PBGs, a national respondent commented that they "*really do motivate service delivery*" and a regional level participant referred to them as a "*very positive facilitating factor*" to prioritizing and delivering nutrition-related interventions. In terms of coordination, respondents consistently said that PMNP facilitated better collaboration across agencies and sectors. A regional respondent stated to this end,

"The main support is probably the inter-agency collaboration… the multisectoral collaboration because one agency cannot address the health and nutrition problem. So, we need to get data from other agencies, we need to get the involvement of other agencies so that the health and nutrition support that we provide to the communities can be more successful. I think that is one of the supporting factors why PMNP implementation was successful."

Having the support of the LCE, too, was critical to facilitate the timely implementation of PMNP activities, as was working through existing structures instead of creating new, parallel structures specific to PMNP. Through the NLG training, these structures increased their planning and budgeting capacity which was reflected in the MNAPs.

Q3.9 Are there any unintended results of PMNP at the national, LGU, municipality, and household levels?

Respondents consistently reported several positive indirect outcomes associated with PMNP, most notably a perceived increase in empowerment and engagement of service providers at the barangay level. There also appeared to be a positive externality from PMNP evaluation, where numerous participants in FGDs (both men and women) voiced appreciation for the opportunity to come together and share their IYCF and childrearing knowledge and experiences with one another. The only potentially negative unintended consequence of PMNP identified in the data is the risk that the programme could potentially be politicized in the future, such that if there are changes in leadership at any level, new leadership may wish to distance themselves from the priorities and programmes of the previous administration and establish new flagship priorities other than nutrition.

Additionally, some felt the involvement of local communities had positive ripple effects for other health services: "When PMNP comes, there's awareness, people are more aware through the support of the RHU down to the barangay level and to the people. When people are aware, the implementation starts, and other health services are more active" (KII, Municipal respondent). Lastly, other respondents, particularly at the municipal level, said PMNP and the associated data gathering efforts have helped them identify problems within the barangays and determine appropriate steps to address them.

5.4 Efficiency

Cost-efficiency from using existing programmes, structures, and systems (Kalahi-CIDSS, MNCs, MNAP cycles) and **condensed trainings**, but procurement/funding delays (e.g., PBG tranche timing, UNOPS/DBM cycles) caused cascading schedule slippage and staff retention issues.

MNCs coordinate and reduce duplication (regular meetings, tasking per MNAP TPA), though their existence and functionality notably vary by municipality.
Selective resource sharing examples (e.g., agriculture office & DOLE TUPAD for SBC) show potential efficiency gains when multisector ties are actively leveraged.

Q4.2 How efficiently did PMNP stakeholders coordinate and use resources and capacities to achieve results? Did PMNP coordination and collaboration structure avoid duplication and facilitate efficiency and effectiveness?

PMNP is generally perceived as cost-efficient due to its emphasis on working through existing systems and programmes such as Kalahi-CIDSS, MNCs, and MNAP planning cycles. While some inefficiency results from the way the project drives service demand while providers may continue to provide less-than-optimal healthcare (e.g., erroneous growth monitoring), its capacity building efforts actively work to address this by building the capacity of PCWs. The capacity building trainings were themselves perceived as cost efficient by national and regional stakeholders, due to their effort to condense multiple curriculums into a single training session.

While a full cost-effectiveness analysis—currently planned to coincide with the endline evaluation— is needed to confirm value-for-money, this indicates how PMNP model utilizes resources efficiently to enable the outcomes explored in section 5.3.

Key delays of project activities

Project delays and procurement systems sometimes undermined efficiency. Many qualitative respondents at various levels acknowledged systematic delays across different project components, especially related to PBG and HPG funding release, procurement, and capacity building training rollout. Exhibit 5.4.1 explains these delays, their causes, and any mitigation steps taken by the project.

Exhibit 5.4.1. Summary of PMNP delays

Delayed Activity	Explanation of Delays
PBGs	The first tranche of PBGs was planned to be released in 2023, but the third-party verification was delayed by procurement challenges to May 2024. The funds eventually reached municipalities in June 2024, and the utilization period was extended to June 2025 to allow municipalities to spend their grants.

	The second tranche of PBGs was planned to be released in 2024. The third-party verification took place in October 2025, and tranche two funds were released in December.
HPGs	Local elections delayed UNICEF's disbursement of HPG funds and SBC training between February and May 2025. HPG and SBC rollout are ongoing as of November 2025.
Procurement	Procurement delays stemmed from the slow flow of funds from the Bank to DOH and DSWD; difficulties recruiting specialized staff that met Bank requirements; and disagreements when developing TORs. This slowed project startup and led to cascading delays across the project timeline (e.g., initial staffing, commodity procurement, PBGs, information system development).
Capacity Building Activities	Scheduling challenges delayed the progress of NLG and PHC capacity building activities, leading to a 6-month rollout process (compared to the 3-month plan) according to respondents. An online training was developed to help facilitate access to capacity building trainings.

Most delays were described by municipal and barangay level respondents as manageable and were attributed to procurement bottlenecks, approvals processes, and funding release cycles. As a barangay level respondent noted, *"there are delays but not too far,"* while another municipal respondent explained, *"The procurement is delayed. As usual, that's also in the other LGUs."* Nonetheless, these delays had cascading effects at the local level, affecting training schedules and health facility supplies. For instance, one municipal level respondent noted that their PBG utilization rate was low because of procurement challenges. PMNP staff retention was also affected by funding delays from the highest level, with one regional participant explaining:

"DBM [the Department of Budget and Management] has the control. [PMNP] follows up but despite that there are delays. It has affected us because some quit and some did not renew their contracts because the project is not stable."

Overall, delays and inefficiencies revolve particularly around funding flows and procurement, so the release of the second tranche of PBGs will provide an opportunity to observe if the project has been able to overcome such issues.

Perceived capacity and success of MNCs to coordinate, collaborate, and prevent duplication of efforts

MNCs are multi-sectoral bodies, typically chaired by the mayor and including the vice mayor, municipal health officer (MHO), MNAO, planning and agriculture offices, social welfare (e.g., 4Ps municipal links), education (e.g.,

school nurse), private sector (e.g., AIMCOOP), and barangay leadership. Membership is sometimes expanded to include Non-Governmental Organizations (NGOs), Civil Society Organization (CSOs), and other local stakeholders for broader input. There is evidence in some municipalities of the MNC coordinating with other local governance bodies such as the Municipal Inter-Agency Committee (MIAC) in Maigo.

Municipal level respondents noted holding regular meetings, usually quarterly, but some respondents cited meeting more often as needed. Meetings are often recorded, with minutes kept for documentation and follow-up. Outside of meetings, MNCs commonly communicate through group chats and direct messaging, which helps ensure attendance and timely dissemination of information. MNC activities revolve around the MNAP planning and monitoring cycle, so meetings are usually used to plan, implement, discuss results, and troubleshoot challenges related to MNAPs. The committee also prevents duplication of efforts by making clear assignments for each Targeted Programme Activity (TPA) of the MNAP.

The multisectoral membership of most MNCs facilitates coordination and collaborative governance. Respondents broadly expressed a feeling that participation from new stakeholders was always welcome, as more perspectives are useful for carrying out the MNAP. As a municipal respondent stated,

“The strength of our MNC is that if we have a problem to face, we work together to find a solution. It's good because it feels like we're one, we don't conflict, we all give suggestions and we look for the best ones and then we implement them.”

As reported in EQ3.1, project monitoring data indicates that under half of treatment MNCs (39%) meet the full array of requirements to be ‘functional’ (e.g., MNAP planning and budgeting, monitoring, and quarterly meetings). While the municipalities in the sample appear to meet requirements for meeting and membership, they spoke less about monitoring efforts, suggesting this may be an area of weakness and a requirement that is more challenging for MNCs to achieve. Importantly, a national-level stakeholder emphasized that effective MNC coordination goes beyond these minimum requirements but extends to intangible aspects like decision-making authority, resource allocation, evidence-based adaptation, and managing competing sector priorities. In such areas, the treatment MNCs qualitatively appear to be strong thanks to their inclusive multisectoral approach and engaging LNAP planning processes. Nonetheless, turnover of elected leaders can be linked with turnover of key MNC officials (e.g., MNAOs). The effective coordination of MNCs

must be continuously reinforced by their procedures (e.g., meetings, LNAP planning).

In comparison municipalities, MNCs appear to be even less functional. While there are limited qualitative accounts of MNCs in control areas, the sampled MNCs indicate varying levels of coordination and collaboration. In one control municipality, the MNC appeared non-existent and respondents were unaware of the committee's function. In another comparison municipality, the MNC appeared somewhat functional, but the MNAO noted that there was little engagement in the committee from across sectors.

It is thus likely that PMNP, with its emphasis on local nutrition planning, revitalized MNCs in some municipalities. Naturally, risks to maintaining MNC functionality in the long-term include turnover of key members such as MNAOs, which are appointed by mayors, and the combination of a heavy workload and the lack of dedicated staff.

Extent of Resource sharing

Resource sharing within municipalities takes the form of sharing technical expertise and coordination to facilitate intervention convergence to provide multisectoral support. Calauag provides strong examples of both types of resource sharing. A municipal level respondent shared how nutrition activities related to diversified household and community food production led the MNC to partner with the municipal agricultural office and with the TUPAD programme operated by DOLE. The MNC drew on the expertise of the agriculturalist to lead some SBC programming (e.g., seed distribution, backyard gardening demonstrations). Additionally, the MNAO coordinates with the mayor to ensure that TUPAD beneficiaries- usually men who will engage in paid public works- belong to a family where there is a pregnant woman or young child (0-23 months). Examples of strong coordination and resource sharing are sporadic among sampled municipalities, with most relying on PBG and allocated municipal funding, but Calauag demonstrates the possibilities for synergy when the MNC can successfully coordinate efforts across sectors.

5.5 Sustainability

Institutionalization advancing—capacity building and the embedding of MNAPs/BNAPs suggest durability; stakeholders intend continuation but expect **smaller scale** without PMNP support.
Key risks—LGU budget constraints, staffing shortages/turnover (BHW/BNS/MNAO), lack of formal handover/transition plans, and partial digital integration (HCSC interoperability). **Scale-up potential with conditions**—approach is scalable if funding, dedicated technical assistance and monitoring roles, and cross-agency coordination are secured; alignment of training content with DOH certification and system interoperability are prerequisites.

Q6.1 How likely are the activities and results achieved likely to continue after PMNP has ended?

While respondents largely agreed that capacity building efforts (particularly at the LGU level and below) will help sustain positive changes regarding nutrition planning and service delivery, they also noted that additional practice, monitoring, and refresher trainings are needed over time to sustain these capacity gains. When asked about the long-term sustainability of PMNP changes, a regional respondent said, *"[Through PMNP] LGUs were able to update and improve their LNAPs and reactivate or strengthen their LNCs. So, this has helped institutionalize nutrition as a priority concern rather than an ad hoc activity*." Despite this positive step towards institutionalization, many respondents warned that resource gaps such as limited personnel and inadequate incentives for frontline workers may inhibit the sustainability of recent improvements in service delivery.

In terms of stakeholder commitments, respondents at all levels expressed their desire and intent to try to continue with PMNP activities after the programme ends. However, respondents were clear about the absence of a formal sustainability plan and said their commitments were largely informal and continuation of PMNP would likely be at a smaller scale than the current PMNP activities. For example, a barangay level respondent said of PMNP, "*It can be sustained, but if we make our own plan, it won't be the same as what PMNP provided — in the barangay, it would only be on a smaller scale*." Barangay-, municipal-, and LGU-level respondents emphasized limited LGU budgets as one of the key constraints to continuing PMNP activities at the current scale. Lastly, national-level stakeholders also said it was entirely clear how DOH would take ownership of PMNP when it ends, and that it was unclear who PMNP focal points would be at all levels.

Q6.2 What are the major factors that influence the achievement or non-achievement of sustainability?

The long-term sustainability of PMNP appears dependent on four primary factors: the programme's ability to *operate through and strengthen existing structures*, its ability to secure or influence *future funding allocations*, the continued *interest and engagement of key stakeholders*, and continued *coordination across key agencies*. Operating through existing structures is a core tenant of PMNP's approach to sustainability, and respondents repeatedly emphasized that the programme must be "anchored" in existing structures, with some saying there was room to further engage with local structures at the

community level (such as local water committees) to promote the continuity of PMNP interventions. As for funding, as discussed under the previous evaluation question, the availability of funding is a critical determinant of whether PMNP activities continue. Respondents from the regional and municipal levels consistently made comments such as, *"…even with PBGs and technical support, some municipalities rely heavily on external funding and have difficult sustaining interventions*" (regional level respondent) and "*The problem is, we don't have a source of funding if it weren't for PMNP*" (municipal-level respondent). While PMNP appears to have increased capacity for nutrition planning and budgeting, there do not appear to be resources available to continue activities at their current levels without external funding.
Regional and municipal respondents emphasized the importance of maintaining the interest and engagement of key stakeholders to keep nutrition a priority and carry PMNP activities forward. A regional respondent shared, "*…we keep reminding the LGUs that they really need to sustain this, of course, with our help*" while a municipal-level respondent suggested, "*There should really be someone assigned to closely monitor the programme. Because if no one monitors it, it'll easily be forgotten, especially since people already have so many other tasks and designations*." Respondents also expressed concern that staff turnover, especially at the LGU and LCE levels, could compromise commitments to carry PMNP initiatives forward. In addition to maintaining key stakeholders' interest and engagement with PMNP, agencies across sectors need to continue collaborating closely to ensure the continuity of multisectoral nutrition activities. One national level respondent expressed particular concern about this, explaining, *"…what happens is that the bulk of the health and nutrition is solved by the health sector alone when there are other sectors [who should be] contributing to addressing malnutrition*." Thus, the ability of the NNC or another body to facilitate collaboration across agencies and sectors will be essential to the long-term sustainability of PMNP.

Q6.3 Can PMNP model or approach(es) as a whole or in part (best practices) be institutionalized in government or scaled up?

As an approach, PMNP's emphasis on building capacity and working through existing structures appears well-suited for institutionalization. However, as described above, there are several potential inhibitors to institutionalization and scale-up, including funding and personnel limitations. One specific challenge is the large number of staff hired through PMNP: one national-level respondent asked the question, "*Because the project came in with so many people…if they are not there, how do we transition? How do they plan to do sustainability?*" As described under the previous EQs, there seems to be a lack of a clear transition plan or focal persons to continue PMNP activities. Related

to the absence of a transition plan, while some activities such as the Mother and Child Book have a clear plan for continuation after PMNP ends (DOH said they will pay to produce copies of it moving forward), other efforts to ensure sustainability are still underway. For example, the Household Convergence Scorecard is not yet interoperable with the existing KMITS infosystem, although the research team was told the scorecard is still under development and will ultimately be compatible with KMITS. In addition to the Household Convergence Scorecard, some respondents expressed concerns over the sustainability of the integrated NPHC training package. A national-level respondent explained, *"...the training of PMNP will only be used for PMNP side...it is not applicable to the actual certification that we will do for our regular programme...we were also hoping that the integration would help facilitate our capacity building to be more streamlined*." Thus, while the approach of building capacity and working through existing systems lends itself to institutionalization, there appear to be some logistical obstacles to institutionalizing or scaling up certain PMNP activities. Further, respondents consistently expressed significant concerns about having sufficient financial resources to carry activities forward.

6. Conclusion

This section collates the findings from the individual OECD-DAC criteria to generate the high-level midline findings along the three main PMNP implementation pathways: 1) governance, 2) service delivery, and 3) financing. After, this section defines some limitations of this evaluation and how they were overcome, where relevant.

PMNP Governance

The integration of nutrition, health, WASH, ECCD and 4Ps interventions combined with technical assistance, monitoring, and PBGs enabled LGUs to better coordinate and prioritize nutrition. Establishing nutrition committees and requiring LGUs to prepare MNAPs addressed critical planning and resource mobilization gaps, while executive forums for mayors and NLG training for LCEs and LNCs provided a strategic platform to deepen understanding of nutrition governance responsibilities. The NLG training specifically aimed to build competencies in supportive supervision, data-driven planning, and effective implementation of MNAPs with SBC initiatives. This training emphasized evidence-based planning and budgeting, improved monitoring systems, and leadership engagement to institutionalize nutrition governance and move beyond short-term feeding programmes toward comprehensive, multisectoral interventions. Though capacity building efforts focused mostly on national and

municipal levels as opposed to local levels, leaving local officials and workers to rely on flow down trainings and information sharing regarding their roles and responsibilities.

Mechanisms such as Kalahi-CIDSS mapping, negative lists, and the household convergence scorecard supported multisectoral harmonization, although data sharing remains largely manual due to resource constraints and the current poor integration between digital and paper-based systems. Despite these challenges, PMNP strengthened governance by achieving full MNAP compliance in project-supported municipalities and most barangays meeting BNAP requirements, driven by PBG-linked incentives. The proportion of municipalities with MNAP budgets aligned with PMNP standards rose from 0% to 100%, and PHP 1.07 billion (USD 18.2 million) in grants were distributed to 235 municipalities, improving healthcare supplies, staffing, and governance capacity. Fieldwork confirmed progress in MNAP drafting, which is essential for long-term nutrition outcomes.

However, coordination challenges at national and regional levels led to fragmented interventions, attributed to overloaded DOH personnel and bureaucratic delays. Misalignment between project components reduced synergy, and operational constraints such as lack of dedicated nutrition offices, staff shortages, and manual data systems hindered implementation. Political tensions between barangay captains and mayors also affected compliance, and respondents expressed concerns about sustainability due to staff turnover and the absence of dedicated monitoring roles. While PMNP is widely recognized for expanding existing health and nutrition initiatives, some LGUs viewed it as an additional burden on top of their current workload, and there is a risk of politicization if national leadership priorities shift. Further, PMNP assumes municipalities have the expertise and capacity to appropriately allocate funds, but this was found to not always be the case. Overall, PMNP's emphasis on anchoring interventions in existing structures and fostering multisectoral collaboration has driven significant progress in governance and advocacy, but sustaining these gains will require continued monitoring, resource investment, and alignment across all levels of government.

PMNP Service Delivery

PMNP training, particularly Integrated NPHC training, was considered highly relevant for building practical skills among health workers, particularly in using MUAC to diagnose Severe and MAM and delivering culturally appropriate SBC to populations, including IPs. These competencies were viewed as essential for accurate case management and community engagement. However, shortening

the integrated training from 15 to 5 days compromised quality and mastery of practical skills, with staff noting that condensed sessions and competing responsibilities often lead to skill attrition without refresher courses and adequate supervision.[66] It is important to note that under the current 5-day integrated Nutrition-PHC training, health facilities are not eligible for accreditation under the PhilHealth SAM OTC Benefit Package, which is part of its ongoing national rollout. Despite these limitations, PMNP improved service delivery by addressing shortages of vitamins, ANC supplies, and anthropometric tools, and by promoting facility-based deliveries through strengthened local guidelines. Health workers emphasized the need for sufficient time, resources, and oversight to apply learning effectively.

Convergence under PMNP refers to the coordinated delivery of nutrition-specific and nutrition-sensitive interventions across multiple sectors—health, WASH, ECCD, and social protection—to ensure comprehensive support for mothers and children during the first 1,000 days. The programme operationalized convergence through mechanisms such as joint planning via MNAPs, shared monitoring tools like the Household Convergence Scorecard, and performance-based grants that incentivized collaboration among LGUs, frontline workers, and community stakeholders. While national-level coordination was facilitated through technical working groups and regular communication, implementation revealed gaps, including fragmented efforts between DOH and DSWD and uneven resource allocation for WASH and ECCD activities. Despite these challenges, convergence at the municipal and barangay levels improved significantly, with strengthened Nutrition Committees and integrated service delivery becoming more common. Sustaining these gains will require continued alignment of sectoral priorities, adequate funding, and digital integration to overcome manual reporting and resource constraints.

At the systems level, PMNP demonstrated strong progress across components, though regional disparities persist. Component 1 improved staffing, training, and commodity distribution, but some regions remain under-staffed and under-supplied, and SBC participation varies widely. Component 2 completed 4,884 WASH and ECCD subprojects, providing nutrition-sensitive infrastructure, though timely subproject completion may have come at the expense of community involvement and responsiveness to actual needs.

Lastly, Component 3 demonstrates strong household targeting despite data accuracy issues, but also highlights uneven progress in terms of the existence and functionality of local nutrition committees. PBG funds enabled

[66] It is also important to note that with the 5 days integrated Nutrition PHC training health facilities cannot be accredited for the PhilHealth SAM OTC Benefit Package which is currently being rolled out countrywide.

municipalities to procure vaccines and expand essential medicines and supplements, improving reliability of health services and allowing facilities to hire and mobilize additional staff. Nevertheless, gaps remain in procurement capacity, supply chain management, and continuity of volunteer roles, with frequent turnover of BNS and BHW staff posing challenges to sustainability. Overall, PMNP strengthened local health systems and improved access to care, but persistent resource constraints and uneven implementation highlight the need for targeted support and ongoing capacity building.

PMNP Financing

The institutionalization of MNAPs as a prerequisite for budget approval signals that nutrition planning is becoming embedded in local governance processes. MNAPs now integrate both nutrition-specific and nutrition-sensitive interventions, ensuring these are reflected and budgeted for in AIPs. PBGs have incentivized compliance and supported service delivery for micronutrient supplementation, feeding programmes, and immunization, while training has improved awareness of budget rules, accountability, and transparency among LNCs. These efforts have strengthened coordination between nutrition staff and local budgeting procedures, and 81% of PMNP barangays now have budgeted BNAPs that meet project requirements. Furthermore, PMNP complements RA 11148 by providing LGUs with financial and logistical capacity to implement the law more effectively, signalling progress toward sustainable nutrition programming.

Despite these achievements, sustainability remains a critical concern. Persistent budget constraints at the LGU level, unsynchronized implementation of components, and delays in implementing convergence mechanisms have hindered full integration of services. WASH and ECCD programming reached fewer beneficiaries due to limited DSWD funding, and PMNP resources were insufficient to fully address budget and staffing gaps at national and local levels. Respondents reported delayed staff payments and emphasized that LGUs lack sufficient budgets to sustain PMNP activities at current scale, a vulnerability that could undermine project continuity once PMNP support ends. While the programme has increased capacity for nutrition planning and budgeting, many municipalities lack the resources to maintain current levels of activity without additional funding. Moving forward, addressing these financial and coordination challenges will be essential to ensure that PMNP's gains in governance, service delivery, and multisectoral collaboration translate into long-term improvements in maternal and child nutrition outcomes.

7. Lessons Learned

The integrated NPHC training seems to have increased providers' confidence, motivation, and knowledge, particularly with respect to PIMAM and NiE. Although the training was significantly shorter than originally intended, the evidence suggests that it led to increased knowledge among service providers, specifically on management of malnutrition and provision of nutrition services in emergency settings. Qualitative evidence also suggests that the training resulted in greater motivation and confidence among PHC staff, which are important aspects of service provision that positively impact provider performance, interactions with patients, job satisfaction and retention, and overall system efficiency.

Broad Service Menus Enable Locally-Responsive Implementation. Experience with PBGs demonstrates that providing a broad menu of eligible services and items enables municipalities to flexibly address their specific needs while staying aligned with program objectives. This lesson suggests that expanding Component 2's subproject menu could similarly improve efficiency by allowing communities to select nutrition-sensitive interventions that best match their local priorities.

There is a knowledge-to-practice gap whereby greater knowledge has not yet led to better practices, which suggests that the integrated NPHC trainings could benefit from a more experiential approach to ensure the practical application of knowledge. Overall, no significant differences were found in the quality and accuracy of practices between treatment and comparison providers during growth monitoring sessions and IYCF counselling. Although it was observed that treatment providers are more likely to accurately measure and weigh pregnant women during prenatal checkups, these are the only two aspects in which they are significantly better than their comparison counterparts. Qualitatively, health workers were aware of the training limitations as they emphasized the need for sufficient time, resources, and oversight to apply learning effectively.

Introducing additional data systems and requirements can increase administrative burden and reduce efficiency. In addition to the HCSC, which was introduced by PMNP to fill in household-level convergence data gaps, there are at least seven other government systems to monitor nutrition and health in the Philippines. This multiplicity of non-interconnected systems overburdens service providers as they are required to collect information, often manually, to upload to each platform separately. Furthermore, as data gets fragmented into

each system, it is difficult to access and analyse it in a prompt and comprehensive manner to inform policymakers and support local officials and nutrition field staff in their day-to-day jobs.

For PMNP to strengthen nutrition service delivery, increasing resources alone is not enough—capacity to execute those resources is critical. Local administrative staff, especially those responsible for procurement, need targeted training to understand procurement processes and navigate supply chains effectively. Building this capacity ensures timely and efficient resource utilization, reduces bottlenecks, and enhances accountability. Municipal-level teams must be equipped not only with technical knowledge but also with practical skills to manage procurement and logistics, enabling programs to translate resources into real impact. Administrative capacity varies widely by municipality, which calls for targeted technical assistance support based on local needs.

The staggered rollout of Component 1 and Component 2 resulted in missed opportunities for synergy. When Component 2 was nearing completion, Component 1 was only beginning, which hindered convergence at the beneficiary level and reduced the potential for integrated service delivery. This sequencing gap also weakened coordination between DOH and DSWD at both national and local levels and prevented the streamlining of processes that could have improved efficiency. DOH and DSWD should have coordinated closely during preparations for their own activities even if DOH budget and activities were delayed.

8. Recommendations

The table below presents recommendations that were initially developed based on the evaluation team's analysis of the midline data and were subsequently discussed, validated, and amended in consultation wi key stakeholders and through formal written feedback.

#	PMNP Component(s)	Recommendation	Responsible Party
1	1	Clarify how PMNP intends to target and meet the needs of people with disabilities (PwD). Train service providers including nurses, midwives, and BHWs and build their capacity to engage with PWD populations in the project's targeted municipalities.	DOH and UNICEF
2	1	Provide additional structured supervision and support to ensure that improved PCF staff *knowledge* translates to improve *practices* as well. This could include additional hands-on training, formal mentoring, and structured supervision to	DOH and UNICEF

		ensure that enhanced knowledge is applied during health and nutrition service delivery.	
3	1	Explore options to expand the training for PCF workers to better align with DOH's and potentially facilitate certification for trainees. While there are time and resource constraints to be mindful of, better alignment between PMNP trainings and existing DOH trainings would facilitate continuity and sustainability beyond PMNP.	DOH and UNICEF
4	1, 3	Support the establishment and proper functioning of Nutrition Committees (less than half of PMNP municipalities have them) and undertake a close examination of the main constraints preventing NCs from becoming fully functional according to DILG Memorandum Circular 2018-42.	DOH and NNC
5	1	Provide targeted support to regions and municipalities that have under-delivered on monitoring indicators. Monitoring data as well as PBG tranche 1 utilization information suggest wide variation in the execution of PMNP activities, and therefore a combination of monitoring and targeted technical assistance could be included as part of PMNP CONNECT. To facilitate proper monitoring, it is suggested bringing on a dedicated MEL partner to support continuous feedback loops or undergoing a high-quality process evaluation to identify bottlenecks in real time.	DOH and DSWD
6	1,2,3	Related to Recommendation # 5, expand and centralize the existent PMNPs monitoring framework. For all project components, include three types of indicators: 1) resource use indicators, 2) process indicators, and 3) beneficiary utilization indicators. Set up a dashboard to track progress in real time and identify municipalities requiring targeted assistance. **Annex G** provides additional, detailed recommendations on the monitoring framework.	DOH and DSWD
7	1	Conduct a "postmortem" to identify the core procurement issues that delayed the distribution of PMNP supplies (including life-saving therapeutic commodities such as RUTF and RUSF) and grant funds so that future procurement and grants distribution run more smoothly. o At the national level, ensure adherence to the PBG timeline to prevent service disruptions, personnel issues, and eroded trust at the municipal level. o At the local level, invest in the administrative capacity of LGUs (particularly the ones lagging	DOH

		in terms of resource execution) to ensure timely procurement following PBG disbursement.	
8	1,3	Provide basic digital literacy training to PCF staff and community volunteers to ensure they are comfortable with digital data collection and can properly and safely record and transmit digital health information. This recommendation should also improve workload for service providers, many of whom complain about the extra work that PMNP entails.	DOH
9	3	Support the digitization of current manual data collection methods (for FHSIS, OPT+, MELLPI Pro, HCSC, ECCD checklist, and other systems currently reliant or partially reliant on manual data collection) to facilitate an integrated data ecosystem, including government systems such as KMITs. Prioritize basic digital literacy training for frontline workers to ensure they have the skills needed to operate tablets, computers, and other data collection tools.	DOH and DSWD
10	1,2,3	Formalize sustainability and handover plans, perhaps mimicking the Kalahi-CIDSS which requires a detailed MOA when leaving an LGU. Specifically, DOH and DSWD should formalize sustainability agreements with LGUs, similar to the Kalahi-CIDSS MOA, to ensure a clear transition of personnel and funding responsibilities before the current project closes in 2026.	DOH and DSWD
11	3	Strengthen the compatibility of the Convergence Score Card with existing systems, such as KMITS, and establish a clear handover plan for continuing the Convergence Score Card after PMNP concludes.	DOH
12	1	Consider ways to further culturally contextualize SBC messages during PMNP CONNECT, especially for IP communities, to address specific local resistance to vaccines and exclusive breastfeeding practices.	DOH and UNICEF
13	2	Consider expanding the menu of nutrition-sensitive Component 2 subproject available to communities to better respond to their actual needs. In addition, coordination between DOH and DSWD should be present at all levels to ensure efficiency and service convergence.	DSWD and DOH

Annex A. Results Tables

Table A-1. Background Characteristics of Health Practitioners

	MEAN (SD)			SM DIFF	N
	All	Treat	Comp.		
Service Provider:					
Doctor/Physician	0.11	0.11	0.11	-0.00	54
	(0.32)	(0.32)	(0.32)	[0.19]	
Nurse	0.31	0.31	0.33	-0.06	54
	(0.47)	(0.47)	(0.49)	[0.11]	
Midwife	0.19	0.19	0.17	0.07	54
	(0.39)	(0.40)	(0.38)	[0.17]	
Barangay Health Worker	0.20	0.22	0.17	0.14	54
	(0.41)	(0.42)	(0.38)	[0.08]	
Barangay Nutrition Scholar	0.15	0.14	0.17	-0.08	54
	(0.36)	(0.35)	(0.38)	[0.08]	
Nutritionist-Dietician	0.04	0.03	0.06	-0.15	54
	(0.19)	(0.17)	(0.24)	[0.29]	
Average years of practice:	10.41	11.56	8.11	0.38*	54
	(9.05)	(9.49)	(7.87)	[0.19]	
Years of practice:					
Less than 1 year	0.02	0.00	0.06	-0.41	54
	(0.14)	(0.00)	(0.24)	[0.36]	
1-5 years	0.37	0.33	0.44	-0.23	54
	(0.49)	(0.48)	(0.51)	[0.26]	
6-10 years	0.20	0.25	0.11	0.34	54
	(0.41)	(0.44)	(0.32)	[0.21]	
>10 years	0.41	0.42	0.39	0.06	54
	(0.50)	(0.50)	(0.50)	[0.26]	
Highest level of formal education:					
Completed secondary school	0.28	0.25	0.33	-0.18	54
	(0.45)	(0.44)	(0.49)	[0.15]	
University degree (BSN)	0.15	0.17	0.11	0.15	54
	(0.36)	(0.38)	(0.32)	[0.36]	
Nursing school	0.04	0.03	0.06	-0.15	54
	(0.19)	(0.17)	(0.24)	[0.29]	
Medical School	0.07	0.11	0.00	0.42**	54
	(0.26)	(0.32)	(0.00)	[0.13]	
Licensure exam	0.31	0.28	0.39	-0.24	54
	(0.47)	(0.45)	(0.50)	[0.44]	
Master's degree	0.06	0.06	0.06	-0.00	54
	(0.23)	(0.23)	(0.24)	[0.32]	
Other	0.09	0.11	0.06	0.19	54
	(0.29)	(0.32)	(0.24)	[0.25]	
Training received in the last 12 months:					
Universal Health Care	0.81	0.81	0.83	-0.07	54
	(0.39)	(0.40)	(0.38)	[0.25]	

Infant & Young Child Feeding	0.54 (0.50)	0.64 (0.49)	0.33 (0.49)	0.61* [0.28]	54
Child Growth Monitoring	0.56 (0.50)	0.67 (0.48)	0.33 (0.49)	0.66 [0.37]	54
Nutrition in Emergencies	0.50 (0.50)	0.58 (0.50)	0.33 (0.49)	0.50 [0.30]	54
Management of Acute Malnutrition	0.57 (0.50)	0.67 (0.48)	0.39 (0.50)	0.56 [0.35]	54
Household Convergence Scorecard	0.52 (0.50)	0.69 (0.47)	0.17 (0.38)	1.05*** [0.28]	54
Field Health Services Information System	0.52 (0.50)	0.58 (0.50)	0.39 (0.50)	0.39 [0.34]	54
Operation Timbang Plus	0.59 (0.50)	0.69 (0.47)	0.39 (0.50)	0.62 [0.35]	54
Basic Course for BHWs	0.37 (0.49)	0.39 (0.49)	0.33 (0.49)	0.11 [0.34]	54
PIMAM Orientation	0.50 (0.50)	0.58 (0.50)	0.33 (0.49)	0.50 [0.27]	54

Notes: Standardized mean difference (SMD) estimated using linear regressions. Standard deviations for means are in parentheses; standard errors of SMD presented in square brackets. Observations are clustered at the municipality level. * $p<0.1$; ** $p<0.05$; *** $p<0.01$

Table A-2. Knowledge Survey: Basic Concepts of Nutrition

	MEAN (SD)			**SM DIFF**	**N**
	All	Treat	Comp.		
Average score (Out of 7)	4.97 (0.99)	5.11 (1.10)	4.68 (0.69)	0.43 [0.29]	54
Overall score (%)	0.71 (0.14)	0.73 (0.16)	0.67 (0.10)	0.43 [0.29]	54
Definition of malnutrition	0.96 (0.19)	0.97 (0.17)	0.94 (0.24)	0.15 [0.29]	54
Population groups are not equally vulnerable to malnutrition.	0.43 (0.50)	0.50 (0.51)	0.28 (0.46)	0.45 [0.32]	54
Can distinguish primary and secondary malnutrition	0.81 (0.39)	0.83 (0.38)	0.78 (0.43)	0.14 [0.20]	54
Can list characteristics of undernutrition:	0.51 (0.41)	0.50 (0.41)	0.53 (0.42)	-0.07 [0.36]	54
No. of correct answers (out of 4)	3.43 (0.74)	3.36 (0.80)	3.56 (0.62)	-0.26 [0.26]	54
Answer options:					
A. Low weight for height/length	0.96 (0.19)	0.97 (0.17)	0.94 (0.24)	0.15 [0.29]	54
B. Micronutrient deficiencies	0.87	0.86	0.89	-0.08	54

	(0.34)	(0.35)	(0.32)	[0.24]	
C. Micronutrient excess -Incorrect answer	0.41	0.42	0.39	0.06	54
	(0.50)	(0.50)	(0.50)	[0.35]	
D. Overweight-Incorrect answer	0.46	0.47	0.44	0.06	54
	(0.50)	(0.51)	(0.51)	[0.31]	
E. Low height for age	0.81	0.81	0.83	-0.07	54
	(0.39)	(0.40)	(0.38)	[0.20]	
Can list six categories of nutrients	0.85	0.86	0.83	0.08	54
	(0.36)	(0.35)	(0.38)	[0.27]	
Can identify micronutrient deficiency associated with night blindness	0.81	0.86	0.72	0.35	54
	(0.39)	(0.35)	(0.46)	[0.26]	
Micronutrients required more by pregnant women compared to non-pregnant women	0.59	0.58	0.60	-0.06	54
	(0.28)	(0.28)	(0.27)	[0.43]	
No. of correct answers (out of 5)	2.94	2.92	3.00	-0.06	54
	(1.38)	(1.42)	(1.33)	[0.43]	
Answer options:					
A. Vitamin C	0.41	0.33	0.56	-0.45	54
	(0.50)	(0.48)	(0.51)	[0.49]	
B. Iron	0.85	0.86	0.83	0.08	54
	(0.36)	(0.35)	(0.38)	[0.27]	
C. Vitamin A	0.41	0.44	0.33	0.22	54
	(0.50)	(0.50)	(0.49)	[0.41]	
D. Zinc	0.33	0.33	0.33	0.00	54
	(0.48)	(0.48)	(0.49)	[0.31]	
E. Folic Acid	0.94	0.94	0.94	-0.00	54
	(0.23)	(0.23)	(0.24)	[0.26]	

Notes: Standardized mean difference (SMD) estimated using linear regressions. Standard deviations for means are in parentheses; standard errors of SMD presented in square brackets. Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Table A-3. Knowledge Survey: Child Growth Monitoring and Nutrition Assessment

	MEAN (SD)			**SM DIFF**	**N**
	All	Treat	Comp.		
Average score (Out of 10)	4.78	4.70	4.93	-0.12	54
	(1.89)	(1.78)	(2.14)	[0.18]	
Overall score (%)	0.48	0.47	0.49	-0.12	54
	(0.19)	(0.18)	(0.21)	[0.18]	
Identified what a nutrition assessment involves	0.83	0.86	0.78	0.22	54
	(0.38)	(0.35)	(0.43)	[0.27]	
	0.31	0.34	0.25	0.26	54

Identified anthropometric measurements needed to assess the nutrition status of pregnant women	(0.35)	(0.36)	(0.33)	[0.29]	
No of correct answers (out of 3)	3.20	3.14	3.33	-0.26	54
	(0.76)	(0.76)	(0.77)	[0.40]	
Answer options:					
A. Length-Incorrect	0.54	0.50	0.61	-0.22	54
	(0.50)	(0.51)	(0.50)	[0.34]	
B. Height	0.91	0.86	1.00	-0.47	54
	(0.29)	(0.35)	(0.00)	[0.27]	
C. Weight	0.96	0.94	1.00	-0.29	54
	(0.19)	(0.23)	(0.00)	[0.18]	
D. Mid-Upper Arm Circumference (MUAC)	0.80	0.83	0.72	0.27	54
	(0.41)	(0.38)	(0.46)	[0.38]	
Anthropometric measurements to assess the nutrition status of children 0- <6 months	0.36	0.32	0.43	-0.25	54
	(0.45)	(0.43)	(0.48)	[0.26]	
No of correct answers (out of 2)	1.81	1.78	1.89	-0.25	54
	(0.36)	(0.35)	(0.38)	[0.27]	
Answer options:					
A. Length	0.89	0.86	0.94	-0.26	54
	(0.32)	(0.35)	(0.24)	[0.22]	
B. Height-Incorrect	0.56	0.58	0.50	0.17	54
	(0.50)	(0.50)	(0.51)	[0.22]	
C. Weight	0.93	0.92	0.94	-0.11	54
	(0.26)	(0.28)	(0.24)	[0.28]	
D. Mid-Upper Arm Circumference (MUAC)-Incorrect	0.56	0.56	0.56	0.00	54
	(0.50)	(0.50)	(0.51)	[0.21]	
Frequency of collecting W&L measurements: well-nourished children 0-23 months old	0.67	0.69	0.61	0.18	54
	(0.48)	(0.47)	(0.50)	[0.26]	
Frequency of collecting W&L measurements: well-nourished children 24-59 months old	0.44	0.44	0.44	0.00	54
	(0.50)	(0.50)	(0.51)	[0.30]	
Frequency of collecting anthropometric measurement: children with SAM in Outpatient Care	0.56	0.47	0.72	-0.50	54
	(0.50)	(0.51)	(0.46)	[0.39]	
Frequency of collecting anthropometric measurements for children with MAM	0.30	0.19	0.50	-0.66*	54
	(0.46)	(0.40)	(0.51)	[0.33]	
H&L adjustments when measuring a child's growth	0.69	0.78	0.50	0.59**	54
	(0.47)	(0.42)	(0.51)	[0.23]	

Classified child's nutritional status based on z-scores provided	0.30	0.22	0.44	-0.48	54
	(0.46)	(0.42)	(0.51)	[0.33]	
Identified correct statements regarding MUAC and WFL/H	0.33	0.38	0.25	0.32	54
	(0.39)	(0.42)	(0.31)	[0.24]	
No of correct answers (out of 2)	1.22	1.31	1.06	0.35	54
	(0.72)	(0.67)	(0.80)	[0.39]	
Answer options:					
A. MUAC and WFL/H can both be used to identify wasted or acute malnutrition in children 6 to 59 months old.	0.74	0.81	0.61	0.44	54
	(0.44)	(0.40)	(0.50)	[0.42]	
B. MUAC can be used to identify wasted or acute malnutrition in children 0 to 59 months old.	0.46	0.47	0.44	0.06	54
	(0.50)	(0.51)	(0.51)	[0.31]	
C. WFL/H can be used to identify wasted or acute malnutrition in children 0 to 59 months old.	0.48	0.50	0.44	0.11	54
	(0.50)	(0.51)	(0.51)	[0.33]	
D. MUAC and WFL/H can both be used to identify wasted or acute malnutrition in children 0 to 59 months old.	0.39	0.31	0.56	-0.51**	54
	(0.49)	(0.47)	(0.51)	[0.20]	

Notes: Standardized mean difference (SMD) estimated using linear regressions. Standard deviations for means are in parentheses; standard errors of SMD presented in square brackets. Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Table A-4. Knowledge Survey: Promoting Maternal, Infant, and Young Child Nutrition

	MEAN (SD)			**SM DIFF**	**N**
	All	Treat	Comp.		
Average score (Out of 11)	8.01	8.19	7.64	0.33	54
	(1.71)	(1.72)	(1.67)	[0.35]	
Overall score %	0.73	0.74	0.69	0.33	54
	(0.16)	(0.16)	(0.15)	[0.35]	
Sub-optimal maternal, infant, and young child nutrition practices are associated	0.70	0.72	0.66	0.27	54
	(0.24)	(0.23)	(0.25)	[0.30]	
No of correct answers (out of 3)	2.13	2.19	2.00	0.27	54
	(0.73)	(0.71)	(0.77)	[0.30]	
Answer options:					
B. Low birth weight	0.85	0.83	0.89	-0.15	54
	(0.36)	(0.38)	(0.32)	[0.32]	
C. Increase the risk of developing non-communicable diseases (NCDs) later in life	0.46	0.56	0.28	0.55	54
	(0.50)	(0.50)	(0.46)	[0.38]	
	0.54	0.50	0.61	-0.22	54

Minimum number of ANC visits for healthy pregnant women recommended by DoH	(0.50)	(0.51)	(0.50)	[0.24]	
Vitamin and mineral supplements to be routinely provided to a pregnant woman	0.44	0.42	0.50	-0.17	54
	(0.50)	(0.50)	(0.51)	[0.42]	
Interventions for a pregnant woman in her first trimester with a MUAC < 21 cm	1.45	1.43	1.49	-0.11	54
	(0.52)	(0.53)	(0.51)	[0.15]	
No of correct answers (out of 3)	2.37	2.36	2.39	-0.04	54
	(0.76)	(0.76)	(0.78)	[0.21]	
Answer options:					
A. RUSF for 90 days	0.76	0.86	0.56	0.71**	54
	(0.43)	(0.35)	(0.51)	[0.29]	
B. Counselling proper diet and nutrition using Pinggang Pinoy	0.89	0.83	1.00	-0.53**	54
	(0.32)	(0.38)	(0.00)	[0.19]	
C. Deworming by giving one tablet of Albendazole 400 mg or Mebendazole 500 mg-In	0.35	0.39	0.28	0.23	54
	(0.48)	(0.49)	(0.46)	[0.30]	
D. Multiple Micronutrient Supplementation	0.72	0.67	0.83	-0.37	54
	(0.45)	(0.48)	(0.38)	[0.23]	
MIYCN counselling cards topics identified	0.77	0.78	0.75	0.15	54
	(0.21)	(0.21)	(0.23)	[0.39]	
No of correct answers (out of 6)	4.80	4.86	4.67	0.15	54
	(1.34)	(1.31)	(1.41)	[0.39]	
Answer options:					
A. Breastfeeding	0.96	0.97	0.94	0.15	54
	(0.19)	(0.17)	(0.24)	[0.29]	
B. Complementary feeding	0.94	0.97	0.89	0.36	54
	(0.23)	(0.17)	(0.32)	[0.24]	
C. WASH	0.70	0.72	0.67	0.12	54
	(0.46)	(0.45)	(0.49)	[0.42]	
D. Early learning and stimulation	0.76	0.75	0.78	-0.06	54
	(0.43)	(0.44)	(0.43)	[0.31]	
Practices recommended for breastfeeding	0.83	0.84	0.81	0.18	54
	(0.19)	(0.20)	(0.18)	[0.37]	
No of correct answers (out of 4)	3.31	3.36	3.22	0.18	54
	(0.77)	(0.80)	(0.73)	[0.37]	
Answer options:					
A. Place the infant skin-to-skin with the mother immediately after birth	0.96	0.94	1.00	-0.29	54
	(0.19)	(0.23)	(0.00)	[0.18]	
B. Initiate breastfeeding within the first hour of birth	0.91	0.92	0.89	0.09	54
	(0.29)	(0.28)	(0.32)	[0.38]	

C. Breastfeeding on demand every time the baby asks to breastfeed	0.76	0.69	0.89	-0.45*	54
	(0.43)	(0.47)	(0.32)	[0.21]	
D. Breastfeed when the infant or mother is ill	0.69	0.81	0.44	0.77	54
	(0.47)	(0.40)	(0.51)	[0.42]	
Women with Hepatitis C should breastfeed their child	0.72	0.81	0.56	0.55*	54
	(0.45)	(0.40)	(0.51)	[0.26]	
Mothers living with HIV who take antiretroviral drugs should be encouraged to breastfeed their child	0.57	0.67	0.39	0.56	54
	(0.50)	(0.48)	(0.50)	[0.34]	
DOH recommendations for a mother of a 6-month-old healthy infant to start complementary feeding	0.98	1.00	0.94	0.41	54
	(0.14)	(0.00)	(0.24)	[0.36]	
Ways IYCF-Emergencies seeks to protect and support exclusive breastfeeding	0.68	0.70	0.66	0.12	54
	(0.30)	(0.31)	(0.28)	[0.24]	
No of correct answers (out of 3)	2.41	2.50	2.22	0.40	54
	(0.69)	(0.70)	(0.65)	[0.37]	
Answer options:					
A. Offering essential counselling and guidance to breastfeeding women during emergencies	0.94	0.97	0.89	0.36	54
	(0.23)	(0.17)	(0.32)	[0.24]	
B. Providing skilled breastfeeding assistance to help women resume lactation	0.89	0.92	0.83	0.26	54
	(0.32)	(0.28)	(0.38)	[0.29]	
C. Temporarily allowing donations of artificial feeding	0.33	0.39	0.22	0.35	54
	(0.48)	(0.49)	(0.43)	[0.25]	
D. Temporarily allowing a wet nurse to provide milk until the mother can produce	0.57	0.61	0.50	0.22	54
	(0.50)	(0.49)	(0.51)	[0.28]	
Infants born weighing <1.5kg may need other food in addition to breast milk for	0.31	0.33	0.28	0.12	54
	(0.47)	(0.48)	(0.46)	[0.29]	

Notes: Standardized mean difference (SMD) estimated using linear regressions. Standard deviations for means are in parentheses; standard errors of SMD presented in square brackets. Observations are clustered at the municipality level. * p<0.1; ** p<0.05; *** p<0.01

Table A-5. Knowledge Survey: Management of Acute Malnutrition

	Mean (SD)			**SM Diff**	**N**
	All	Treat	Comp.		
Average score (Out of 12)	6.96	7.63	5.63	1.04***	54
	(1.92)	(1.79)	(1.44)	[0.21]	
Overall score %	0.58	0.64	0.47	1.04***	54
	(0.16)	(0.15)	(0.12)	[0.21]	
	0.87	1.00	0.61	1.15***	54

Correctly answered T/F statement on acute malnutrition definition	(0.34)	(0.00)	(0.50)	[0.29]	
Defined Kwashiokor	0.56	0.67	0.33	0.66**	54
	(0.50)	(0.48)	(0.49)	[0.24]	
Defined Marasmus	0.54	0.61	0.39	0.44*	54
	(0.50)	(0.49)	(0.50)	[0.22]	
Health workers are advised to use a child's height to estimate their age in abse	0.70	0.75	0.61	0.30	54
	(0.46)	(0.44)	(0.50)	[0.43]	
All components of PIMAM identified	0.82	0.83	0.79	0.18	54
	(0.24)	(0.25)	(0.20)	[0.33]	
No. of correct answers (out of 4)	3.28	3.33	3.17	0.18	54
	(0.94)	(1.01)	(0.79)	[0.33]	
Answer options:					
A. Community mobilization and outreach	0.89	0.92	0.83	0.26*	54
	(0.32)	(0.28)	(0.38)	[0.11]	
B. OTC for the treatment of SAM children without complications	0.74	0.75	0.72	0.06	54
	(0.44)	(0.44)	(0.46)	[0.30]	
C. ITC for the treatment of SAM children with medical complications	0.72	0.72	0.72	-0.00	54
	(0.45)	(0.45)	(0.46)	[0.32]	
D. Management of children with MAM with targeted supplementary feeding programs	0.93	0.94	0.89	0.21	54
	(0.26)	(0.23)	(0.32)	[0.28]	
Outpatient Therapeutic (OTC) Component of the PIMAM	0.46	0.49	0.42	0.14	54
	(0.45)	(0.45)	(0.46)	[0.46]	
No. of correct answers (out of 3)	2.59	2.61	2.56	0.09	54
	(0.63)	(0.60)	(0.70)	[0.32]	
Answer options:					
A. Management of non-complicated cases of SAM in outpatient care using RUTF prov	0.93	0.94	0.89	0.21	54
	(0.26)	(0.23)	(0.32)	[0.42]	
	0.80	0.81	0.78	0.07	54

B. Provision of simple routine medicines and monitoring at orientation to the mo	(0.41)	(0.40)	(0.43)	[0.20]	
C. Offered through the decentralized health structures or within the outpatient	0.87	0.86	0.89	-0.08	54
	(0.34)	(0.35)	(0.32)	[0.21]	
D. Management of complicated cases of SAM according to WHO protocols on an inpat	0.44	0.42	0.50	-0.17	54
	(0.50)	(0.50)	(0.51)	[0.49]	
Identified false statement on Outpatient Treatment Care (OTC) PIMAM services	0.22	0.25	0.17	0.20	54
	(0.42)	(0.44)	(0.38)	[0.13]	
Classified the 10-month-old child's nutritional status	0.46	0.50	0.39	0.22	54
	(0.50)	(0.51)	(0.50)	[0.19]	
Classified the 15-month-old child's nutritional status	0.43	0.47	0.33	0.28	54
	(0.50)	(0.51)	(0.49)	[0.38]	
Classified the 5-month-old infant's nutritional status	0.46	0.64	0.11	1.05***	54
	(0.50)	(0.49)	(0.32)	[0.25]	
Identified next steps for a child classified as SAM and failed appetite test	0.81	0.76	0.92	-0.59**	54
	(0.27)	(0.30)	(0.17)	[0.23]	
No. of correct answers (out of 2)	1.74	1.67	1.89	-0.46	54
	(0.48)	(0.53)	(0.32)	[0.27]	
Answer options:					
A. Record the results in the OTC or hospital chart	0.80	0.75	0.89	-0.34	54
	(0.41)	(0.44)	(0.32)	[0.28]	
B. Offer the child a candy and repeat the appetite test-Incorrect	0.24	0.31	0.11	0.45	54
	(0.43)	(0.47)	(0.32)	[0.35]	
C. Refer the child to an Inpatient Treatment Care (ITC) facility	0.94	0.92	1.00	-0.36	54
	(0.23)	(0.28)	(0.00)	[0.24]	
	0.63	0.67	0.56	0.23	54

14-month girl passed appetite test, no bilateral pitting edema, 10 cm in MUAC and	(0.49)	(0.48)	(0.51)	[0.23]	

Table A-6. Knowledge Survey: Nutrition in Emergencies

	Mean (SD)			SM Diff	N
	All	Treat	Comp.		
Average score (Out of 9)	4.58	4.87	4.00	0.59**	54
	(1.48)	(1.45)	(1.41)	[0.24]	
Overall score %	0.51	0.54	0.44	0.59**	54
	(0.16)	(0.16)	(0.16)	[0.24]	
Objectives of Nutrition in Emergencies (NiE)	0.28	0.25	0.33	-0.19	54
	(0.43)	(0.42)	(0.45)	[0.24]	
No. of correct answers (out of 2)	1.78	1.78	1.78	0.00	54
	(0.46)	(0.48)	(0.43)	[0.33]	
Answer options:					
A. Preventing deaths	0.81	0.83	0.78	0.14	54
	(0.39)	(0.38)	(0.43)	[0.36]	
B. Preventing hazards-Incorrect	0.69	0.72	0.61	0.24	54
	(0.47)	(0.45)	(0.50)	[0.24]	
C. Protecting people's right to nutrition during an emergency	0.96	0.94	1.00	-0.29	54
	(0.19)	(0.23)	(0.00)	[0.28]	
Primary objective of delivering nutrition services in emergency situations	0.87	0.92	0.78	0.41	54
	(0.34)	(0.28)	(0.43)	[0.41]	
NiE minimum service package interventions	0.85	0.90	0.75	0.69*	54
	(0.22)	(0.19)	(0.24)	[0.32]	
No. of correct answers (out of 4)	3.41	3.61	3.00	0.69*	54
	(0.88)	(0.77)	(0.97)	[0.32]	
Answer options:					
A. Dietary Supplementation	0.87	0.89	0.83	0.16	54
	(0.34)	(0.32)	(0.38)	[0.30]	

B. Micronutrient Supplementation	0.89	0.92	0.83	0.26	54
	(0.32)	(0.28)	(0.38)	[0.29]	
C. Management of Acute Malnutrition	0.80	0.86	0.67	0.48	54
	(0.41)	(0.35)	(0.49)	[0.43]	
D. Maternal, Infant, and Young Child Nutrition	0.85	0.94	0.67	0.77**	54
	(0.36)	(0.23)	(0.49)	[0.25]	
Identified when Blanket Dietary Supplementation ought to be implemented	0.73	0.73	0.73	0.00	54
	(0.20)	(0.20)	(0.21)	[0.47]	
No. of correct answers (out of 3)	2.22	2.22	2.22	-0.00	54
	(0.60)	(0.59)	(0.65)	[0.47]	
Answer options:					
A. At the onset of an emergency when family food ration or family food packs are	0.76	0.72	0.83	-0.26	54
	(0.43)	(0.45)	(0.38)	[0.23]	
B. High prevalence of acute malnutrition, micronutrient deficiencies, and chronic	0.85	0.86	0.83	0.08	54
	(0.36)	(0.35)	(0.38)	[0.14]	
C. An increase in rates of malnutrition is predicted due to the possible spread o	0.61	0.64	0.56	0.17	54
	(0.49)	(0.49)	(0.51)	[0.47]	
Target beneficiaries of BDS	0.40	0.45	0.31	0.35*	54
	(0.39)	(0.41)	(0.35)	[0.15]	
No. of correct answers (out of 3)	2.57	2.64	2.44	0.27	54
	(0.72)	(0.68)	(0.78)	[0.36]	
Answer options:					
A. Children 6-59 months old	0.91	0.92	0.89	0.09	54
	(0.29)	(0.28)	(0.32)	[0.35]	
B. Children < 6 months old	0.57	0.50	0.72	-0.45***	54
	(0.50)	(0.51)	(0.46)	[0.13]	
C. Children 5-10 years old	0.48	0.50	0.44	0.11	54
	(0.50)	(0.51)	(0.51)	[0.29]	
D. Pregnant women	0.83	0.86	0.78	0.22	54
	(0.38)	(0.35)	(0.43)	[0.40]	

E. Lactating mothers until 6 months after delivery	0.83	0.86	0.78	0.22	54
	(0.38)	(0.35)	(0.43)	[0.37]	
NiE activities conducted within 0-48 hours after an emergency	0.19	0.25	0.08	0.56**	54
	(0.30)	(0.32)	(0.21)	[0.23]	
No. of correct answers (out of 4)	2.80	2.97	2.44	0.47	54
	(1.12)	(1.06)	(1.20)	[0.27]	
Answer options:					
A. Active Case Finding	0.76	0.83	0.61	0.51*	54
	(0.43)	(0.38)	(0.50)	[0.23]	
B. Provision of RUSF/RUTF for MAM/SAM cases	0.72	0.75	0.67	0.18	54
	(0.45)	(0.44)	(0.49)	[0.24]	
C. Determine the type of dietary supplementation based on the situation/condition	0.74	0.81	0.61	0.44	54
	(0.44)	(0.40)	(0.50)	[0.28]	
D. Provide micronutrient powder to children	0.57	0.58	0.56	0.06	54
	(0.50)	(0.50)	(0.51)	[0.45]	
E. Prepare of tools for nutrition assessment	0.74	0.67	0.89	-0.50*	54
	(0.44)	(0.48)	(0.32)	[0.24]	
F. Ensure availability of micronutrient supplements, supplementary foods, and PIM	0.76	0.75	0.78	-0.06	54
	(0.43)	(0.44)	(0.43)	[0.28]	
NiE activities conducted after 48 hours	0.33	0.34	0.31	0.07	54
	(0.40)	(0.41)	(0.38)	[0.38]	
No. of correct answers (out of 3)	2.31	2.33	2.28	0.09	54
	(0.64)	(0.68)	(0.57)	[0.31]	
Answer options:					
A. Referral and management of MAM cases to targeted dietary supplementation	0.89	0.89	0.89	0.00	54
	(0.32)	(0.32)	(0.32)	[0.27]	
B. Referral and management of SAM cases to appropriate therapeutic care	0.87	0.86	0.89	-0.08	54
	(0.34)	(0.35)	(0.32)	[0.24]	

C. Setup mother-baby-friendly corners/areas in an evacuation center	0.56	0.56	0.56	0.00	54
	(0.50)	(0.50)	(0.51)	[0.44]	
D. Implementation of blanket dietary supplementation	0.56	0.58	0.50	0.17	54
	(0.50)	(0.50)	(0.51)	[0.22]	
Period of conducting NINA recording tool	0.39	0.47	0.22	0.51	54
	(0.49)	(0.51)	(0.43)	[0.28]	
Nutrition vulnerable groups assessed by NINA	0.53	0.56	0.48	0.19	54
	(0.44)	(0.43)	(0.47)	[0.21]	
No. of correct answers (out of 3)	2.78	2.78	2.78	-0.00	54
	(0.50)	(0.48)	(0.55)	[0.35]	
Answer options:					
B. School-aged children, adolescents	0.50	0.47	0.56	-0.17	54
	(0.50)	(0.51)	(0.51)	[0.22]	
C. Pregnant and lactating women, women of reproductive age	0.96	0.97	0.94	0.15	54
	(0.19)	(0.17)	(0.24)	[0.29]	
D. Adults	0.35	0.33	0.39	-0.12	54
	(0.48)	(0.48)	(0.50)	[0.18]	
E. Elderly, persons with disabilities after onset of emergency or disaster	0.81	0.81	0.83	-0.07	54
	(0.39)	(0.40)	(0.38)	[0.33]	

Annex B. Desk Review

File Name	Title	Date	Author(s)	Resource Type	Dropbox Folder	Summary
6-FINAL DRAFT_TOR_PMNP Capacity Building on Nutrition and PHC	6-FINAL DRAFT_TOR_PMNP Capacity Building on Nutrition and PHC	Nov-24	UNICEF Philippines	TOR	Capacity building training materials	Draft TOR for implementers of PMNP capacity-building project aimed at enhancing the competencies of frontline workers in nutrition and primary health care services across 275 municipalities in the Philippines, including 40 municipalities in the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM).
PMNP National SBC Framework Strategy [DOH_UNICEF Copy - 4th and Final Pass] - AHA! BD	National Social and Behaviour Change (SCB) Framework Strategy for the Philippine Multisectoral Nutrition Project (PMNP)	Mar-25	DOH & UNICEF Philippines	National Framework	Capacity building training materials	National SBC framework/strategy to guide implementation of PMNP SBC interventions/activities. The document covers SBC strategy, objectives, and activities, the implementation plan, the M&E framework, and reporting and coordination mechanisms.
RM_Version 7_March 19 (evening)_FINAL	Reference Manual on Integrated Nutrition and Primary Health Care.	2024	DOH & UNICEF Philippines	Training Manual & Practice Guide	Capacity building training materials	Primary learning source for participants in the Training on Integrated Nutrition and Primary Health Care. Designed to support frontline

						workers in building their capacity to provide healthcare and nutrition services in their communities.
TM_Version 7_March 19 (evening)_FINAL	Integrated Nutrition and Primary Health Care Trainer's Manual	2024	DOH & UNICEF Philippines	Trainer's Manual	Capacity building training materials	This manual is the main resource in a package of learning development intervention (LDI) materials meant for participants in the Training of Trainers (TOT) on Integrated Nutrition and Primary Health Care.
Trainer's Manual_version 3_ao 16 Nov (12nn)	Trainer's Manual on Nutrition and Primary Care	2024	DOH & UNICEF Philippines	Trainer's Manual	Capacity building training materials	Previous draft of the final trainer's manual above.
Version 2_Inception Report November 11, 2024	Inception Report: Integrated Nutrition and Primary Care	Oct-24	DOH & UNICEF Philippines	Inception Report	Capacity building training materials	PMNP inception report. Outlines inception, project development, project implementation, and post-implementation phases.
PROGRAMMEDESIGN STS -_LNAP Formulation VER.6 (PresMat V.2) as of May 5	PMNP ProgrammeDesign (Learning and Development Design): Special Technical Session (STS): Local Nutrition Action	May-25	DOH	Technical Session Agenda	Documents shared by UNICEF_May to June 2025 > LNAP Planning Workshop	This document outlines the agenda for a technical session to strengthen the capacity of Regional Trainer Pools (RTPs) to facilitate and support the formulation of Local Nutrition Action Plans (LNAPs) by local government units (LGUs).

	Plan (LNAP) Formulation					
V6_Roll Out_LNAP	Local Nutrition Action Plan (LNAP) 2026-2028 Formulation Workshop		DOH	Workshop Agenda	Documents shared by UNICEF_May to June 2025 > LNAP Planning Workshop	This document outlines the comprehensive framework and detailed agenda for the Local Nutrition Action Plan (LNAP) 2026-2028 Formulation Workshop aimed at enhancing local government units' (LGUs) capacity in nutrition planning, implementation, and monitoring to address malnutrition in the Philippines.
[2025] PMNP - NMF - BREAKTHROUGH STRATEGIES BOARD	National Breakthrough Strategies Board: PMNP National Mayors Forum 2025	Jul-25	DOH, DSWD	Summit Presentation	Documents shared by UNICEF_May to June 2025 > Nutrition Governance Mayors	Presentation from the National Mayors Forum: Advancing Nutrition through Progressive Leadership and Governance. Looks at project goals, stories, strategies and best practices.
2025 PBG-T2 Mayors Forum Deck	PMNP Performance Based Grants Tranche 2 Mayors Forum Deck	Jul-25	DOH, DSWD	Summit Presentation	Documents shared by UNICEF_May to June 2025 > Nutrition	Presentation for mayors on performance-based grants tranche 2 (PBG T2) value, access, and purpose.

					Governance Mayors	
Mayors' Executive Masterclass	National Mayors Forum: Mayors' Executive Masterclass	Jul-25	DOH, DSWD	Summit Presentation	Documents shared by UNICEF_May to June 2025 > Nutrition Governance Mayors	Nutrition leadership and governance executive masterclass for mayors.
2_CALABARZON_Training Design_Blended_UPLBFI Proposal_ao 18 April 2025	LEARNING AND DEVELOPMENT INTERVENTION (LDI): Training on Integrated Nutrition and Primary Health Care	Apr-25	DOH Calabarzon Center for Health Development	Training Design	Documents shared by UNICEF_May to June 2025 > Training Design (Hybrid)	Integrated Nutrition and Primary Health Care training overview/agenda. Includes intended learning outcomes per topic, module/session time allotment, teaching methods and aids needed for each topic, and evaluation methods to measure learning outcomes.
1_CV_Training Design_3 days_UPLB Proposal_ao April 17, 2025_rev	LEARNING AND DEVELOPMENT INTERVENTION (LDI): Training on Integrated Nutrition and Primary Health Care	Apr-25	DOH Central Visayas Center for Health Development	Training Design	Documents shared by UNICEF_May to June 2025 > Training Design (Reduced Training Days)	Modified version of the training design document to accommodate a shorter implementation period.

NNS 2023 Highlights	2024 NATIONAL NUTRITION SUMMIT: Key Findings of the 2023 National Nutrition Survey (Part 1)	2023	Food and Nutrition Research Institute Department of Science and Technology (DOST - FNRI)	Summary of Results	Documents shared by UNICEF_May to June 2025	Summary of key 2023 National Nutrition Survey (NNS) results.
NNS 2023Monograph_scanned	2025 NATIONAL NUTRITION SUMMIT: Halfway Point to 2030: Key Findings of the 2023 National Nutrition Survey	2023	Food and Nutrition Research Institute Department of Science and Technology (DOST - FNRI)	Full Results	Documents shared by UNICEF_May to June 2026	Full 2023 NNS results. Only includes quant. stats, no description.
PMNP-LANA_Results_235_09Oct2024	Landscape Analysis and Nutrition Situation Assessment for 235 Priority Municipalities for the Philippine Multisectoral Nutrition Project	Oct-24	UNICEF Philippines, DOH	Summit Presentation	Documents shared by UNICEF_May to June 2027	This PowerPoint covers key results from a landscape analysis and nutrition situational assessment of the 235 priority (treatment) municipalities for PMNP project.
PMNP-LANA_Results_235_25Mar2025	Landscape Analysis and Nutrition Situation Assessment for 235 Priority	Mar-25	UNICEF Philippines, DOH	Summit Presentation	Documents shared by UNICEF_May to June 2028	Updated version of the above, includes recommendations.

	Municipalities for the Philippine Multisectoral Nutrition Project				
NOTE Concept Coaching for Supportive Supervision - NLG	Supportive Supervision with Coaching and Mentoring Support PMNP Nutrition Leadership and Governance	UNICEF Philippines, DOH	Framework	Nutrition Gov Training Materials Coaching and Mentoring	This document outlines a framework for enhancing nutrition leadership and governance through supportive supervision combined with coaching and mentoring, aimed at improving health outcomes via effective implementation of Local Nutrition Action Plans (LNAP) integrated with Social and Behaviour Change (SBC) initiatives.
Operations Guide for Supportive Supervision NGL VER.1	An Operations Guide to Implementing Supportive Supervision with Coaching and Mentoring for Nutrition Leadership and Governance	UNICEF Philippines, DOH	Operations Guide	Nutrition Gov Training Materials Coaching and Mentoring	PMNP operations guide for implementing supportive supervision with coaching and mentoring to enhance nutrition leadership and governance in local government units (LGUs) across the Philippines. It details the framework, objectives, methodology, roles, tools, and implementation phases for capacity building of Local Chief Executives (LCEs) and

						Local Nutrition Committees (LNCs).
Final Clean Version of the Concept Note in Integrating SBC in LNAP version 5	Concept Paper: Integrating Social and Behaviour Change (SBC) in the Local Nutrition Action Plan (LNAP)		UNICEF Philippines, DOH, Bagong Pilipinas, Human Capital Asia	Concept Paper	Nutrition Gov Training Materials_LNAP Planning with SBC Integration	This concept paper outlines the integration of Social and Behaviour Change (SBC) strategies into the Local Nutrition Action Plan (LNAP) in the Philippines to address malnutrition more effectively.
DESIGN Mayors Forum VER3 05JUN2025	Mayor's Forum on Nutrition Leadership and Governance	Jun-25	UNICEF Philippines, DOH, Bagong Pilipinas, Human Capital Asia	Forum Design	Nutrition Gov Training Materials_Mayor's Forum	Overview of the mayor's forum, including purpose and design, objectives, session structure, key content areas, and interactive methodologies.
PPT Mayors' Forum VER3 05JUN2025	MAYORS' FORUM ON NUTRITION LEADERSHIP AND GOVERNANCE: Advancing Local Leadership, Sustaining Nutrition Gains	Jun-25	DOH, Bagong Pilipinas	Summit Presentation	Nutrition Gov Training Materials_Mayor's Forum	Mayor's forum plenary session presentation.
rop_Competency Framework NLG VER.5.1 24June2025	NUTRITION LEADERSHIP AND GOVERNANCE	Jun-25		Framework	Nutrition Gov Training Materials_NLG	PMNP Nutrition Leadership and Governance Competency Framework aimed at equipping Local Chief

after NPMO comments	COMPETENCY FRAMEWORK			Competency Framework	Executives (LCEs) and Local Nutrition Committees (LNCs) with leadership and technical competencies to effectively manage nutrition programs within local public health systems.
Closing Activity	Closing Activity	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 1 Opening and Setting the Context	Session 1 Opening and Setting the Context	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 2 Understanding Nutrition Concepts, Challenges, and National Situation	Session 2 Understanding Nutrition Concepts, Challenges, and National Situation	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 3 Applying Systems Thinking in Analyzing the Current Local Nutrition Situation	Session 3 Applying Systems Thinking in Analyzing the Current Local Nutrition Situation	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM	PMNP training for LNCs.

				Training for LNC Materials	
Session 4 Nutrition Leadership with a Purpose	Session 4 Nutrition Leadership with a Purpose	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 5 Part A Leading the Local Nutrition Committee toward Collective and Strategic Action	Session 5 Part A Leading the Local Nutrition Committee toward Collective and Strategic Action	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 5 Part B Leading the Local Nutrition Committee toward Collective and Strategic Action	Session 5 Part B Leading the Local Nutrition Committee toward Collective and Strategic Action	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.
Session 6 Co-Creating Solutions and Next Steps	Session 6 Co-Creating Solutions and Next Steps	DOH, Bagong Pilipinas	Training Modules	Nutrition Gov Training Materials_NLG NPM_NGL-NPM Training for LNC Materials	PMNP training for LNCs.

NLG-NPM Training for LNC Draft 14APR2025	Nutrition Leadership and Governance: Training for Local Nutrition Committee (NLG4LNC)	Apr-25	UNICEF Philippines, DOH, Bagong Pilipinas, Human Capital Asia	Training Design	Nutrition Gov Training Materials_NLG NPM	Document outlines a comprehensive three-day training programmeaimed at enhancing leadership and governance skills among local government nutrition committees.
3-FINAL TOR for Nutrition Leadership and Governance			UNICEF Philippines	TOR	Nutrition Gov Training Materials	Final TOR.
4. GUIDELINES ON LOCAL NUTRITION PLANNING 2024 EDITION - Copy	Guidelines on Local Nutrition Planning	2024		Framework/Guidelines	Nutrition Gov Training Materials	Local nutrition planning guidelines for provincial, city, and municipal government units (LGUs) preparing local nutrition action plans.
548183983-NUTRITIONAL-ASSESSMENT-FORM-OF-CHILDREN	NUTRITIONAL ASSESSMENT FORM OF CHILDREN			Assessment Tool	Nutrition Gov Training Materials	Assessment form to identify nutritional status of children.
815025597-OPT-Plus-MOP-and-DQC-Protocol	MANUAL OF OPERATIONS AND DATA QUALITY CHECK PROTOCOL - Operation Timbang Plus	2023	UNICEF, DOH, National Nutrition Council, Korea International Cooperation Agency, University of the Philippines,	Operations Manual	Nutrition Gov Training Materials	Operational manual and data quality check protocol for OPT Plus to generate data on the nutritional status of children in a barangay, identify under- or-over-nourished children, and guide LGUs in nutrition programme management.

			Institute of Human Nutrition and Food (IHNF), UPLB Foundation Inc.			
dilg-memocircular-2024515_b46c88cce0_PPAN 2023-2028 Implementation - Copy	Adoption and Implementation of the Philippine Plan of Action for Nutrition (PPAN) 2023-2028	Jul-24	Department of the Interior and Local Government (DILG), Bagong Pilipinas	Memorandum Circular	Nutrition Gov Training Materials	Circular provides guidelines on the roles and responsibilities of the DILG Field Offices and LGUs on the implementation of the Philippine Plan of Action for Nutrition (PPAN) 2023-2028.
DOH DM 2025-0310 Reiteration of PBG T2 Protocol	Reiteration of the Protocol for Execution and Reporting of Verification of Municipal Performance Dossiers for Tranche 2 of the Philippine Multisectoral Nutrition Project (PMNP) Performance-Based Grants (PBGs)	Jul-25	DOH	Department Memorandum	Nutrition Gov Training Materials	Memorandum defines the roles and responsibilities of DOH implementing units for PMNP.

LNAP Quality_Support_Checklist	LNAP Development Workshops Quality Assurance and Support Checklist			Evaluation Tool	Nutrition Gov Training Materials	Checklist to evaluate the effectiveness of the LNAP trainers and the overall quality of LNAP Development Workshop.
Rollout Module 10 Drafting LNAPs as of May 05	Special Technical Session: Local Nutrition Action Plan (LNAP) Formulation	May-25	DOH, Bagong Pilipinas	Training Module	Nutrition Gov Training Materials	Technical session module on drafting LNAPs.
PMNP Cap Building Summary			UNICEF Philippines	Training Summary	PMNP Key Docs for Desk Review_from UNICEF_Capacity Building	Summary of capacity building trainings including the primary healthcare training package and governance training package. Includes duration and target staff for each training.
DRAFT_PMNP RAS Prelims_14Sept2023.pptx	PMNP Rapid Assessment Survey: Preliminary Results 31 August 2023 to 05 Sept Uptake	Sep-23	DOH	Rapid Assessment	PMNP Key Docs for Desk Review_from UNICEF_DOH Rapid Assessment Results	PMNP rapid assessment for baseline development. Includes stunting rates, MNC status, MNAP status, BNC and BNAP status, ICT landscape, and PCF equipment and anthropometry inventory.
1. DRAFT_Sampling Framework_PMNP Impact Evaluation	SAMPLING FRAMEWORK FOR THE IMPACT EVALUATION OF THE PHILIPPINE	Nov-23	UNICEF Philippines	Sampling Framework	PMNP Key Docs for Desk Review_Impact Evaluation_Sampling Design	Comprehensive sampling framework designed for the baseline and endline surveys of PMNP.

	MULTISECTORAL NUTRITION PROJECT (PMNP)					
Annex 1_Sample size calculation	Annex 1_Sample size calculation	Nov-23	UNICEF Philippines	Sampling Framework	PMNP Key Docs for Desk Review_Impact Evaluation_Sampling Design	Sample size calculation for impact eval sampling framework.
Proposed Sampling Approach and Sample Size Calculations _Comments Matrix Template	Proposed Sampling Approach and Sample Size Calculations _Comments Matrix Template	Nov-23	UNICEF Philippines	Comments Matrix	PMNP Key Docs for Desk Review_Impact Evaluation_Sampling Design	Comments matrix to review proposed sampling approach and sample size calculations for the impact evaluations.
TOR 1- Impact Evaluation- FINAL signed	TOR 1- Impact Evaluation- FINAL signed		UNICEF Philippines		PMNP Key Docs for Desk Review_Impact Evaluation_TOR	Final signed TOR for the impact evals of PMNP project.
TOR 2 - Landscape Analysis-FINAL signed	TOR 2 - Landscape Analysis-FINAL signed		UNICEF Philippines		PMNP Key Docs for Desk Review_LANA_Landscape Analysis Nutrition Assessment	Final signed TOR for the landscape analysis/nutrition situation assessment of the 235 priority PMNP municipalities.
DRAFT_LGU-IxISDP_23Aug2023 (1)	LGU Inputs and Information Systems Development	Aug-23	DOH	Training Module	PMNP Key Docs for Desk Review_PMNP	Draft training/session module on developing LGU inputs and information systems.

					Information System	
1a - DRAFT PMNP POM Manual_4 October 2022.docx	Republic of the Philippines Philippine Multisectoral Nutrition Project (PMNP) (Loan No. 9382-PH) Project Operations Manual (POM)	Oct-22	UNICEF Philippines, DOH	Operations Manual	PMNP Key Docs for Desk Review_PMNP Operations Manual	PMNP project operations manual (version 15).
1 - OS-PMNP Logframe 11Nov2021	1 - OS-PMNP Logframe 11Nov2021	Nov-21		Logframe	PMNP Key Docs for Desk Review Results Framework	PMNP log frame -includes input, outputs, outcomes, and impact across the 3 project components.
PMNP Results Framework_24Jan2024	PMNP Results Framework_24Jan 2024	Jan-24		Results Framework	PMNP Key Docs for Desk Review Results Framework	Results framework.
RF x OWPA Page 1_PMNP 13Feb2024	RF x OWPA Page 1_PMNP 13Feb2024	Feb-24		Results Framework	PMNP Key Docs for Desk Review Results Framework	Results framework notations.
SC230739_UNICEF Inception Report_January 31, 2023	Philippine Multisectoral Nutrition Project (PMNP) Inception Report	Jan-24	UNICEF Philippines, DOH	Inception Report	PMNP Key Docs for Desk Review UNICEF PMNP Inception Report	Earlier version of the project inception report (updated version above, row 9).

PBG Utilization_FUR2025 - WB	PBG Utilization_FUR2025 - WB	2025	World Bank	Spending Data	0_Documents_Background	PBG utilization data.
PMNP MUNICIPAL ACCOMPLISHMENT_Monitoring Data	PMNP MUNICIPAL ACCOMPLISHMENT_Monitoring Data	Jul-25		Monitoring Data	0_Documents_Background	PMNP municipal monitoring data.

Annex C. Knowledge Assessment

Section 1. Contact information and background characteristics

#	Question	Response
1.1	Date of interview	{v11}
1.2	Name of supervisor	{v12}
1.3	Name of enumerator	{v13}
1.4	Region	{v14}
1.5	Province	{v15}
1.6	Municipality	{v16}
1.7	Barangay	{v17}
1.8	Health Facility Name	{v18}
1.9a	Address	{v19a}
1.9b	PSGC Address	{v19b}
1.10	GPS Coordinate (LAT)	{v110}
1.11	GPS Coordinate (LON)	{v111}
1.12	First Name	{v112}
1.13	Last Name	{v113}
1.14	Identification Number	{v114}
1.15	Service Provider Type	Doctor/Physician..... ..1 Nurse.....2 Midwife..... ....3 Barangay Health Worker.....4 Barangay Nutrition Scholar.....5 Nutritionist- Dietitian.....6 Other, specify.....7 *{v115a}*_____ _____ {v115}
1.16	How many years have you been practicing as a [TYPE OF PROVIDER]?	_____ years *{v116a}* _____ months *{v116b}*

1.17	What was the highest level of formal education or training you received for this role? [Multiple answers allowed]	Completed secondary school....1 University degree (BSN).....2 Nursing school.....3 Medical school.....4 Licensure exam.....5 Master's degree.....6 Other, specify.....7 *{v117a}*_____	{v117}
1.18.a	In the last 12 months, did you complete training on Universal Health Care?	Yes ..... 1 No 2	{v118a}
1.18.b	In the last 12 months, did you complete training on Infant and Young Child Feeding?	Yes ..... 1 No 2	{v118b}
1.18.c	In the last 12 months, did you complete training on Child Growth Monitoring?	Yes ..... 1 No 2	{v118c}
1.18.d	In the last 12 months, did you complete training on Nutrition in Emergencies?	Yes ..... 1 No 2	{v118d}
1.18.e	In the last 12 months, did you complete training on Management of Acute Malnutrition?	Yes ..... 1 No 2	{v118e}
1.18.f	In the last 12 months, did you complete training on Household Convergence Scorecard?	Yes ..... 1 No 2	{v118f}
1.18.g	In the last 12 months, did you complete training on Field Health Services Information System?	Yes ..... 1 No 2	{v118g}

1.18.h	In the last 12 months, did you complete training on Operation Timbang Plus?	Yes ..... 1 No 2	{v118h}
1.18.i	In the last 12 months, did you complete training on Basic Course for BHWs?	Yes ..... 1 No 2	{v118i}
1.18.j	In the last 12 months, did you complete PIMAM orientation?	Yes ..... 1 No 2	{v118j}

Section 2. Basic Concepts of Nutrition

#	Question	Instruction	Choices	Response
2.1	What is the correct definition of malnutrition?	Select one	A. A condition caused only by eating too much food, leading to obesity. B. A temporary loss of appetite due to illness or stress. C. A condition that results from a deficiency, excess, or imbalance in a person's intake of energy or nutrients. D. A disease caused by bacteria in contaminated food.	{v21}
2.2	True or False. All population groups are equally vulnerable to malnutrition.	Select one	A. True B. False	{v22}
2.3	Which of the following statements best distinguishes between primary and secondary malnutrition?	Select one	A. Primary malnutrition is caused by excessive exercise, while secondary malnutrition is caused by poor sleep. B. Primary malnutrition results from genetic disorders, while secondary malnutrition is due to overeating. C. Primary malnutrition is due to inadequate or excessive dietary intake, while secondary malnutrition results from diseases that impair nutrient absorption or utilization. D. Primary malnutrition is always more severe than secondary malnutrition.	{v23}

2.4	Undernutrition includes:	Select all that apply	A. Low weight for height/length B. Micronutrient deficiencies C. Micronutrient excess D. Overweight E. Low height for age F. Low weight for age	{v24}
2.5	What are the six categories of nutrients?	Select one	A. carbohydrates, proteins, oils, vitamins, minerals, water B. carbohydrates, proteins, fats, vitamins, minerals, water C. sugars, proteins, oils, vitamins, minerals, water D. sugars, proteins, fats, vitamins, minerals, water	{v25}

2.6	Which micronutrient deficiency is most commonly associated with night blindness?	Select one	A. Vitamin C B. Iron C. Vitamin A D. Zinc	{v26}
2.7	Compared to non-pregnant women, pregnant women require more of which micronutrient?	Select all that apply	A. Vitamin C B. Iron C. Vitamin A D. Zinc E. Folic Acid	{v27}

Section 3. Child Growth Monitoring and Nutrition Assessment

#	Question	Instruction	Choices	Response

3.1	What does a nutrition assessment involve?	Select one	A. A brief interview to determine food preferences and exercise habits B. A systematic process that includes evaluating anthropometric, biochemical, clinical, and dietary data to determine nutritional status C. A one-time blood test to check for vitamin deficiencies D. A physical fitness test combined with a food diary	{v31}
3.2	Which anthropometric measurements are collected to assess the nutrition status of pregnant women?	Select all that apply	A. Length B. Height C. Weight D. Mid-Upper Arm Circumference (MUAC)	{v32}
3.3	Which anthropometric measurements are collected to assess the nutrition status of children 0- <6 months old?	Select all that apply	A. Length B. Height C. Weight D. Mid-Upper Arm Circumference (MUAC)	{v33}
3.4	How often should weight and length measurements be collected for well-nourished children 0-23 months old?	Select one	A. Daily B. Weekly C. Every two weeks D. Monthly E. Quarterly F. Semestral	{v34}
3.5	How often should weight and length measurements be collected for well-nourished children 24-59 months old?	Select one	A. Daily B. Weekly C. Every two weeks D. Monthly	{v35}

			E. Quarterly F. Bi-annually/Semestral	
3.6	How often should anthropometric measurements be collected for children with Severe Acute Malnutrition (SAM) in Outpatient Therapeutic Care (OTC)?	Select one	A. Daily B. Weekly C. Every two weeks D. Monthly E. Quarterly F. Semestral	{v36}
3.7	How often should anthropometric measurements be collected for children with Moderate Acute Malnutrition (MAM)?	Select one	A. Daily B. Weekly C. Every two weeks D. Monthly E. Quarterly F. Semestral	{v37}
3.8	When measuring a child's growth, how should height and length measurements be adjusted?	Select one	A. Use standing height for all children regardless of age B. Use recumbent length for children under 2 years old and subtract 0.7 cm to convert to standing height C. Use recumbent length for children over 2 years old and add 1 cm to convert to height D. Always use recumbent length to ensure consistency	{v38}
3.9	Josie is a 7-month-old girl who has the following anthropometric z-scores based on WHO Child Growth Standards: • Length-for-age z-score (LAZ): -2.3	Select one	A. Stunted, Underweight, and Wasted B. Stunted and Underweight only C. Underweight and Wasted only D. Stunted only	{v39}

	• Weight-for-age z-score (WAZ): -2.1 • Weight-for-length z-score (WLZ): -1.1 Based on these z-scores, how would you classify her nutritional status?			
3.10	Which of the following statements are correct?	Select all that apply	A. MUAC and WFL/H can both be used to identify wasted or acute malnutrition in children 6 to 59 months old. B. MUAC can be used to identify wasted or acute malnutrition in children 0 to 59 months old. C. WFL/H can be used to identify wasted or acute malnutrition in children 0 to 59 months old. D. MUAC and WFL/H can both be used to identify wasted or acute malnutrition in children 0 to 59 months old.	{v310}

Section 4. Promoting Maternal, Infant, and Young Child Nutrition

#	Question	Instruction	Choices	Response
4.1	Sub-optimal maternal, infant, and young child nutrition practices are associated with:	Select all that apply	A. Irreversible effects on both the physical and mental development of the child B. Low birth weight C. Increase the risk of developing non-communicable diseases (NCDs) later in life	{v41}

4.2	What is the minimum number of antenatal care visits for healthy pregnant women recommended by the Department of Health?	Select One	A. 4, with the first visit taking place during the 8th-13th week. B. 8, with the first visit taking place before the 8th-13th week. C. 4, with the first visit taking place before the 20th week. D. 8, with the first visit taking place before the 20th week	{v42}
4.3	A healthy 24-year-old pregnant woman in her first trimester visits an antenatal clinic. According to WHO recommendations, which of the following **vitamins and mineral supplements** should be routinely provided to her to support a healthy pregnancy?	Select One	A. Daily vitamin A and vitamin D supplements B. Daily IFA or MMS C. Daily IFA and MMS D. Weekly calcium and zinc supplements	{v43}
4.4	A pregnant woman in her first trimester has a MUAC < 21 cm. Which of the following interventions should be provided?	Select all that apply	A. Ready-to-Use Supplementary Food (RUSF) for 90 days B. Counselling proper diet and nutrition using *Pinggang Pinoy* C. Deworming by giving one tablet of Albendazole 400 mg or Mebendazole 500 mg D. Multiple Micronutrient Supplementation	{v44}

4.5	The MIYCN counselling cards cover the following topics:	Select all that apply	A. Breastfeeding B. Complementary feeding C. WASH D. Early learning and stimulation E. Nutrition during emergencies F. Family planning	{v45}
4.6	Which of the following practices are recommended for breastfeeding?	Select all that apply	A. Place the infant skin-to-skin with the mother immediately after birth. B. Initiate breastfeeding within the first hour of birth. C. Breastfeeding on demand every time the baby asks to breastfeed. D. Breastfeed when the infant or mother is ill.	{v46}
4.7	True or False. Women with Hepatitis C should not breastfeed as they may infect their child.	Select One	A. True B. False	{v47}
4.8	True or False. Mothers living with HIV who take antiretroviral drugs should be encouraged to breastfeed	Select One	A. True B. False	{v48}
4.9	A mother of a 6-month-old healthy infant asks when and how to start complementary feeding. According to DOH recommendations, which of the following statements is most accurate?	Select One	A. Complementary feeding should begin at 6 months, with a focus on energy-dense, nutrient-rich foods while continuing breastfeeding. B. Complementary foods should be introduced at 4 months of age to prevent growth faltering. C. Only fruit juices and cereals are recommended during the first month of complementary feeding. D. Complementary feeding should replace breastfeeding entirely by 9 months of age.	{v49}

4.10	IYCF-Emergencies seeks to protect and support exclusive breastfeeding in emergencies through:	Select all that apply	A. Offering essential counselling and guidance to breastfeeding women during emergencies. B. Providing skilled breastfeeding assistance to help women resume lactation. C. Temporarily allowing donations of artificial feeding D. Temporarily allowing a wet nurse to provide milk until the mother can produce enough milk herself.	{v410}
4.11	True or False. Infants born weighing less than 1,500 grams **may** need other food in addition to breast milk for a limited period.	Select One	A. True B. False	{v411}

Section 5. Management of Acute Malnutrition

#	Question	Instruction	Choices	Response
5.1	True or False. Acute malnutrition is sudden wasting and/or edema due to insufficient food intake, infection, and inappropriate childcare practices.	Select One	A. True B. False	{v51}
5.2	Kwashiorkor refers to:	Select One	A. Severe wasting B. Nutritional edema C. Low BMI and vitamin A deficiency D. Low BMI and calcium deficiency	{v52}
5.3	Marasmus refers to:	Select One	A. Severe wasting B. Nutritional edema C. Low BMI and vitamin A deficiency	{v53}

			D. Low BMI and calcium deficiency	
5.4	True or False. In the absence of a birth certificate, health card, or ECCD card, health workers are advised to use a child's height to estimate their age.	Select one	A. True B. False	{v54}
5.5	Which of the following components are part of PIMAM?	Select all that apply	A. Community mobilization and outreach B. OTC for the treatment of SAM children without complications C. ITC for the treatment of SAM children with medical complications D. Management of children with MAM with targeted supplementary food, routine health services, monitoring, and nutritional education	{v55}
5.6	Which of the following strategies best describes the Outpatient Therapeutic (OTC) Component of the PIMAM?	Select all that apply	A. Management of non-complicated cases of SAM in outpatient care using RUTF provided on a weekly or biweekly basis. B. Provision of simple routine medicines and monitoring at orientation to the mothers/ caregivers. C. Offered through the decentralized health structures: Rural Health Units (RHU), Barangay Health Centers (BHC), Barangay Health Stations (BHS), or within the outpatient department of hospitals. D. Management of complicated cases of SAM according to WHO protocols on an inpatient	{v56}

			basis at facilities with appropriate capacity, such as in hospitals	
5.7	Which of the following statements about Outpatient Treatment Care (OTC) PIMAM services is **NOT** true?	Select all that apply	A. OTC PIMAM services treat children with SAM/MAM who have an adequate appetite and no medical complications. B. Children 6-59 months old in OTC PIMAM services are treated at home with RUTF and routine medicines. C. Caregivers of children < 6 months old in OTC PIMAM receive breastfeeding support. D. Caregivers should attend OTC weekly with their child, and the child's progress should be monitored and recorded by the BNS/BHW on the patient card. E. Families with children in OTC PIMAM cannot be enrolled in supplementary feeding programs	{v57}
5.8	A 10-month-old child is brought to the clinic for a routine check-up. The following measurements and observations are recorded: • Mid-Upper Arm Circumference (MUAC): 12.4 cm • Weight-for-Height Z-score (WFH): -1.8	Select one	A. Normal B. Moderate Acute Malnutrition (MAM) C. Severe Acute Malnutrition (SAM)	{v58}

	• Presence of Bilateral Pitting Edema: Yes Based on this information, how would you classify the child's nutritional status?			
5.9	A 15-month-old child is assessed during a community health outreach. The following data are collected: • Mid-Upper Arm Circumference (MUAC): 110 mm • Weight-for-Height Z-score (WFH): -1.8 • Presence of Bilateral Pitting Edema: No How would you classify the child's nutritional status?	Select one	A. Normal B. Moderate Acute Malnutrition (MAM) C. Severe Acute Malnutrition (SAM)	{v59}
5.10	A 5-month-old infant is brought to a health facility for a growth monitoring session. The following data are recorded: • Weight-for-Length (WFL): -2.5 • Presence of Bilateral Pitting Edema: No How would you classify the infant's nutritional status	Select one	A. Normal B. Moderate Acute Malnutrition (MAM) C. Severe Acute Malnutrition (SAM)	{v510}

5.11	An 18-month-old child is brought to an Outpatient Treatment Care (OTC) facility after she was screened for MAM during a community outreach event. At the OTC facility, she was later classified as SAM and failed the appetite test. What are the next steps the health care provider must take?	Select all that apply	A. Record the results in the OTC or hospital chart B. Offer the child a candy and repeat the appetite test C. Refer the child to an Inpatient Treatment Care (ITC) facility	{v511}
5.12	A fourteen-month-old girl passed the appetite test, without bilateral pitting edema, measures 10 cm in MUAC, and WFH Z-score greater than -3SD but less than -2SD. Should she be admitted to OTC?	Select one	A. Yes B. No	{v512}

Section 6. Supporting Nutrition in Emergencies

#	Question	Instruction	Choices	Response
6.1	Nutrition in Emergencies (NiE) has the following objectives:	Select all that apply	A. Preventing deaths B. Preventing hazards C. Protecting people's right to nutrition during an emergency	{v61}
6.2	The primary objective of delivering nutrition services in emergency situations is to safeguard the	Select one	A. True B. False	{v62}

	nutritional well-being of affected populations, with a focus on individuals who are malnourished or at nutritional risk.			
6.3	NiE minimum service package covers which of the following interventions:	Select all that apply	A. Dietary Supplementation B. Micronutrient Supplementation C. Management of Acute Malnutrition D. Maternal, Infant, and Young Child Nutrition	{v63}
6.4	During emergencies, dietary supplementation is often the primary strategy for preventing and treating moderate acute malnutrition. There are 2 common types of supplementary feeding programs: Blanket Dietary Supplementation (BDS) and Targeted Dietary Supplementation. When should Blanket Dietary Supplementation (BDS) be implemented?	Select all that apply	A. At the onset of an emergency, when family food rations or family food packs are not adequately in place. B. High prevalence of acute malnutrition, micronutrient deficiencies, and chronic undernutrition before the onset of an emergency. C. An increase in rates of malnutrition is predicted due to the possible spread of diseases.	{v64}
6.5	Who are the target beneficiaries of BDS?	Select all that apply	A. Children 6-59 months old B. Children < 6 months old C. Children 5-10 years old D. Pregnant women E. Lactating mothers until 6 months after delivery	{v65}

6.6	Which of the following NiE activities should be conducted within 0-48 hours after an emergency took place (i.e., Impact Phase)	Select all that apply	A. Active Case Finding B. Provision of RUSF/RUTF for MAM/SAM cases C. Determine the type of dietary supplementation based on the situation/condition D. Provide micronutrient powder to children E. Prepare of tools for the nutrition assessment F. Ensure availability of micronutrient supplements, supplementary foods, and PIMAM commodities.	{v66}
6.7	Which of the following NiE activities should be conducted after 48 hours (i.e., Post-Impact Phase):	Select all that apply	A. Referral and management of MAM cases to targeted dietary supplementation B. Referral and management of SAM cases to appropriate therapeutic care C. Set up mother-baby-friendly corners/areas in an evacuation center. D. Implementation of blanket dietary supplementation	{v67}
6.8	The NINA recording tool is conducted within this period after the onset of emergencies.	Select one	A. Within 10-23 hours B. Within 24-72 hours C. Within 72-94 hours D. As early as possible	{v68}

6.9	The NINA tool is designed to provide immediate and initial assessment of the nutrition situation among the affected population, particularly among these nutrition vulnerable groups.	Select all that apply	A. Children 0-59 months B. School-aged children, adolescents C. Pregnant and lactating women, women of reproductive age D. Adults E. Elderly, people with disabilities after the onset of an emergency or disaster.	{v69}

Annex D. Health Facility Checklist

Section 1. Facility Identifiers

#	Question	Response	
1.1	Date	{v11}	
1.2	Name of supervisor	{v12}	
1.3	Name of enumerator	{v13}	
1.4	Region	{v14}	
1.5	Province	{v15}	
1.6	Municipality	{v16}	
1.7	Barangay	{v17}	
1.8	Type of facility	Rural Health Unit.....1 Barangay Health Center.....2 Birthing Home.....3	{v18}
1.9 a	Health Facility Name	{v19a}	
1.9 b	PSGC Address	{v19b}	
1.10	GPS Coordinate (LAT)	{v110}	
1.11	GPS Coordinate (LON)	{v111}	
1.12	Facility Respondent:	Doctor/Physician.....1 Nurse.....2 Midwife.....3 Barangay Health Worker.....4 Barangay Nutrition Scholar.....5 Nutritionist-Dietitian.....6 Other, specify.....7 *{v112a}*_____	{v112}
1.13	How many barangays are served by this facility?	{v113}	

1.14	Estimated number of households served by this facility	{v114}
1.15	Estimated population served by this facility	{v115}
1.16	Name of Head of Facility	{v116}
1.17	Contact Number	{v117}
1.18	E-mail Address	{v118}
1.19	Municipal Health Officer	{v119}
1.20	Contact Number MHO	{v120}
1.21	E-mail Address MHO	{v121}

Section 2. Health Services

#	Question	Response	
2.1	What service levels are available at this facility?	Outpatient only .....1 Inpatient only.....2 Both out and inpatient 3	{v21}
2.2	Which of the following services are currently provided in this facility?		
A	Primary Care/Universal	Yes.....1 No.....2	{v22a}
B	Prenatal Services	Yes.....1 No.....2	{v22b}
C	Birthing	Yes.....1 No.....2	{v22c}
D	Postnatal/Postpartum Services	Yes.....1 No.....2	{v22d}
E	Immunization	Yes.....1 No.....2	{v22e}
F	Micronutrient Supplementation	Yes.....1 No.....2	{v22f}
G	Child Growth Monitoring	Yes.....1 No.....2	{v22g}
H	Community Support Groups	Yes.....1 No.....2	{v22h}

I	Breastfeeding/Maternal, Infant, and Young Child Health and Nutrition Counselling	Yes.....1 No.....2	{v22i}
J	Outpatient Therapeutic Care Services (PIMAM)	Yes.....1 No.....2	{v22j}
K	Household Visits	Yes.....1 No.....2	{v22k}
L	Outreach Service	Yes.....1 No.....2	{v22l}
M	Deworming	Yes.....1 No.....2	{v22m}
N	General check-ups	Yes.....1 No.....2	{v22n}
O	Referrals	Yes.....1 No.....2	{v22o}
P	Complementary feeding demonstrations or recipe testing	Yes.....1 No.....2	{v22p}
Q	Mother's class or nutrition education	Yes.....1 No.....2	{v22q}

Section 3. Health Workforce

	Service Provider (PCP)	3.1 How many [SERVICE PROVIDER] are currently assigned to this facility? *{v31}* An assigned service provider is	3.2 Does this facility ever receive visits from a [SERVICE PROVIDER]? *{v32}* Yes.....1 >> .3.3 No.....2, >> Next Service Provider	3.3 On average, how often does this facility receive a visit from a [SERVICE PROVIDER]? *{v33}* Every day.....1 Every week.....2

		one who attends to the population served by the facility. If >0, >> Next Service Provider If = 0, >> go to 3.2 If 1 or above, >> go to 3.2		Every month.....3 Every 2-3 months.....4 Less often than every 3 months.....5
A	Primary Care Physician			
B	Midwife			
C	Public Health Nurse			
D	Nutritionist Dietitian			
E	Barangay Nutrition Scholar			
F	Barangay Health Worker			
G	Child Development Worker			
H	Breastfeeding/MIYCF counsellor			
I	Other, Specify *{v34}* _____			

Section 4. Equipment and Supplies

4a. Does the facility have any of the following equipment at the time of the interview?	Response *{v4aa}* Yes.....1 No.....2	Is it functional? *{v4ab}* Yes.....1 No.....2
Anthropometry		

1	25 kg weighing trousers for babies		
2	25 kg hanging scale		
3	MUAC tapes for children		
4	MUAC tapes for adults		
5	Two-level height board		
6	250 kg Weighing Mother-Baby Scale		
7	Weight-for-length and height-for-length WHO reference tables		
Basic Pack 1			
8	Blood Pressure Apparatus		
9	Cervical Inspection Sets (Small, Medium, Large)		
10	Scissor Set (Curved and Straight Surgical; Bandage; Suture Removal)		
11	Forceps Set (Ovum, Mosquito, w/ Teeth, w/o Teeth)		
12	Stethoscope		
13	Examining Table		
Basic Pack 2			
14	Instrument Table		
15	Foot Stool		
16	Examining Light		
17	Emergency Light		
18	Wheelchair		
19	Ophthalmoscope		
20	Otoscope		
Facility Beds [birthing homes and RHUs only]			
21	Delivery beds		
22	Recovery trolleys		
23	Inpatient beds (excluding delivery beds and recovery trolleys)		
24	Emergency unit beds		
Education Materials			
25	Breastfeeding and IYCF kits		
26	Breastfeeding flipchart		
27	IYCF counseling cards		
28	Complementary feeding materials		
Information and Computer Technology and Services			
29	Computer/Laptop		
30	Printer		
31	LCD projector		

32	Sound system or microphone for group activities		

4b. Does the facility have any of the following at the time of interview?		Response {v4ba} Yes……1 No…….2	Not yet expired? {v4bb} Yes……1 No…….2
Medications and Supplies			
1	Vitamin A 200,000 IU capsules		
2	Vitamin A 100,000 IU capsules		
3	Vitamin A drops or powder (510mcg per 10 mL)		
4	Ferrous sulfate with folic acid (60 mg elemental iron + 400 mcg folate)		
5	Calcium carbonate 1.25mg/tablet		
6	Multiple Micronutrient Supplement tablets (Multi-Vitamin Tablets)		
7	Albendazole 400mg/ tablet		
8	Mebendazole 500mg/ tablet		
9	Iron, 30mg elemental iron/5mL, syrup, 60mL		
10	Iron, 15mg elemental iron/0.6mL, drops, 15 or 30mL		
11	Iron Syrup (Ferrous Sulfate Heptahydrate 150mg/5ml)		
12	Zinc syrup		
13	Zinc tablet		
14	Ready-to-use Therapeutic Food (RUTF)		
15	Ready-to-use Supplementary Food (RUSF)		
16	Therapeutic milk F75		
Immunizations			
17	Bacillus Calmette-Guérin (BCG) vaccine		
18	HEP B vaccine		
19	Oral Polio Vaccine (OPV) vaccine		
20	Pentavalente vaccine		
21	Measles, Mumps, and Rubella (MMR) vaccine		
22	Pneumococcal		
23	Vaccine refrigerator		

Section 5. Health Facility Policy, Standards, and Performance

#	Question	Instructions to Enumerator	Response

5. Does the facility have the following documents?			Yes.....1 No.....2
1	Organizational Structure/Chart	Enumerator: Observe if the Organizational structure/chart is posted in a conspicuous area	{v51}
2	Vision and Mission	Enumerator: Observe if posted vision and mission in a conspicuous area	{v52}
3	Orientations on First 1,000 Days and PMNP	Enumerator: Ask if there is Documentation of orientation conducted (e.g., Dated Activity Reports, Dated Accomplishment Reports, Photos)	{v53}
4	Responsive Clinical Services	Enumerator: Observe if there is a list of services and a schedule of operation posted in a conspicuous area.	{v54}
5a	Population-based Primary Care Services	Document Review: Written policies and procedures based on the DOH issued guidelines 1. Health promotion	{v5a}
5b		2. Epidemiologic surveillance	{v5b}
5c		3. Health protection (vector control, environmental health, occupational safety, and food safety measures)	{v5c}
5d		4. Emergency preparedness and response	{v5d}
6a	Individual-based Primary Care Services	Document Review: Written policies and procedures based on the DOH issued guidelines 1. Maternal and Newborn Care and Child Growth Monitoring	{v6a}
6b		2. Infant and Young Child Feeding	{v6b}

6c		3. Executive Order 51, 1986, or the Milk Code of the Philippines	{v6c}
6d		4. Community Management of Acute Malnutrition	{v6d}
6e		5. Family Planning Services	{v6e}
6f		6. Nutrition Services	{v6f}

Section 6. Documents and Medical Records

6. Does the facility have any of the following documents or medical records?		Response Yes.....1 No.....2
A	Immunization lists	{v6a}
B	OPT+ lists	{v6b}
C	Growth monitoring records	{v6c}
D	Maternal list	{v6d}
E	Consultations	{v6e}
F	Nutrition counseling	{v6f}
G	Nutrition education or Mother's classes	{v6g}
H	Household visits	{v6h}

Section 7. Water and Sanitation

#	Question	Instruction		Response
A	Does the facility have a water source on the premises?	Yes.....1 No.....2 >> **Q7C**		{v7a}
B	Is the water from an improved water source?	Improved water sources: piped water, borehole, tubewell, protected well, protected spring, rainwater, bottled/packaged water	Yes.....1 No.....2	{v7b}
C	Does the facility have toilet facilities on the premises?	Yes.....1 No.....2>>**Q7L**		{v7c}
D	Is it an improved toilet facility?	Improved sanitation facility: flush toilets, pit latrine with slab, pour	Yes.....1 No.....2	{v7d}

		to flush, ventilated improved pit latrine, composting toilet		
E	How many toilets does the facility have?	[enter number]		{v7e}
F	How many of those toilets are functioning/usable right now?	Functioning/usable refers to a toilet that is currently operational, not broken, available and private		{v7f}
G	Does the facility have a dedicated toilet for the staff?	Only ask if Q7E >1	Yes.....1 No.....2	{v7g}
H	Does the facility have a dedicated toilet for the patients?	Only ask if Q7E >1	Yes.....1 No.....2	{v7h}
I	Does the facility have sex-separated toilets?	Only ask if Q7E >1	Yes.....1 No.....2	{v7i}
J	Does the toilet available for women and girls have menstrual hygiene facilities?		Yes.....1 No.....2	{v7j}
K	Is at least one toilet accessible for people with mobility issues?		Yes.....1 No.....2	{v7k}
L	Does the facility have a handwashing station?	Yes.....1 No.....2>>**Q7P**		{v7l}
M	Is there clean water for handwashing?		Yes.....1 No.....2	{v7m}
N	Is there soap available at the hand washing station?		Yes.....1 No.....2	{v7n}
O	Are handwashing stations available within five meters of toilets?		Yes.....1 No.....2	{v7o}

P	Are handwashing stations or alcohol-based rub available at all points of care?		Yes.....1 No.....2	{v7p}
Q	Does the facility have waste management facilities?	To include trash bins or bags for disposal of regular or medical waste	Yes.....1 No.....2 >>**Q7T**	{v7q}
R	Does the facility have separate waste facilities for the disposal of regular trash and medical waste?	Medical waste includes sharps (e.g., needles) and biomedical waste (items that have been in contact with blood, saliva, or other bodily fluids)	Yes.....1 No.....2	{v7r}
S	Does the facility appropriately separate sharps waste and biomedical/infectious waste?		Yes.....1 No.....2	{v7s}
T	Does the facility have protocols for cleaning and sanitization?		Yes.....1 No.....2	{v7t}
U	Are there unpleasant smells or tobacco odors?		Yes.....1 No.....2	{v7u}
V	Is there dust or dirt on the furniture (either in the waiting area or in the examination rooms)?		Yes.....1 No.....2	{v7v}

Annex E. Observation Protocols

Growth Monitoring

Instructions: You will fill out this observation form if you observed one of the intended practitioners (Nurse, Midwife, Nutritionist, BHW, BNS) conduct a growth monitoring session.

Before the observation begins, please:

1. Obtain Consent from Patient's Caregiver and Practitioner.
2. Ensure the child is 0-23 months old
3. Fill out the information about the facility

At the end of the observation, please:

1. Complete the section on the background of the health practitioner.
2. Follow up with the practitioner and/or caregiver if you have questions or need further information to respond to this questionnaire.

Standard Codes:	1 = Yes	2 = No	-44 = Not Applicable

ENUMERATOR CODE: _____

Section 1: Health Facility Information

#	Question	Response	
1.1	Date	{v11}	
1.2	Name of Supervisor	{v12}	
1.3	Name of Enumerator	{v13}	
1.4	Region	{v14}	
1.5	Province	{v15}	
1.6	Municipality	{v16}	
1.7	Barangay	{v17}	
1.8	Health Facility Name	{v18}	
1.9	Address	{v19}	
1.10	GPS Coordinates	{v110}	
1.11	Type of Facility	1 = Rural Health Unit 2 = Barangay Health Center 3 = Birthing Home 4=Other, specify:_____	{v111}

1.12	Where is the observation/session taking place?	1 = In the waiting area of the facility 2 = In a private room (enclosed space with door and walls with only the client and practitioner) 3 = In a room with other patients or practitioners 4 = In a private but open space (not a separate enclosed room with walls and a door, but a private space indoors) 5 = Outside 6 = Other, specify *{v112a}* _____	{v112}
1.13	What is the age (in months) of the child that you are observing? *Obtain the age of the child during the consent; the child should be 0-23 months old	_____months	{v113}

Section 2: Growth Monitoring Observation

#	Question	Response	
2.01	Are you observing a growth monitoring observation?	1 = Yes >> Continue with observation 2 = No >> End survey and find the correct observation form	{v201}

2.1 For each of the following, you will mark whether you observed the health practitioner complete the specific skill or task for the session you observed. Not all skills will be relevant to every interaction, so please answer all questions accurately.	Response {v21a}	Which provider performed this? {v21b} 1 = Doctor 2 = Nurse 3 = Midwife

				4 = Nutritionist 5 = Barangay Health Worker
1	Did the provider ask for the age or birthdate of the child?	1 = Yes 2 = No		
Child's length				
2a	Did they measure the child's length?	1 = Yes 2 = No		
2b	Did they ask another health worker to help them?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2c	Did they use a wooden length board (or length board of similar material)?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2d	Did they measure the child lying down?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2e	Did they have the parent or an assistant hold the child's head and make sure it was touching the base of the board?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2f	Did they ensure the child was looking straight upwards? (head not turned to one side)	1 = Yes 2 = No -44 = Length not measured/ N/A		
2g	Did they ensure the child was lying flat on the board?	1 = Yes 2 = No -44 = Length not measured/ N/A		

2h	Did they ensure the child's feet were flat against the foot piece?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2i	Did they read the child's length while the child was in the proper position on the board?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2j	Did they ensure the child was not wearing any bulky hairpiece on their head?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2k	Did they immediately record the measurement?	1 = Yes 2 = No -44 = Length not measured/ N/A		
2l	Did they sanitize the equipment used for length measurement after use?	1 = Before 2 = After 3 = Before and After 4 = No -44 = N/A		
Child's Height				
4a	Did they measure the child's height?	1 = Yes 2 = No		
4b	Did they ask another health worker to help them?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4c	Did they use a standing height board?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4d	Did they ensure the child had no footwear on before stepping on the stand?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4e	Did they ensure the child's head was straight (eyes looking straight ahead)?	1 = Yes 2 = No -44 = Height not measured/ N/A		

4f	Did they ensure the child's shoulders, buttocks, and heels were touching the back of the stand?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4g	Did they ensure the child kept their arms by their side?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4h	Did they ensure the child's shoulders were level? *(One did not rise higher than the other)*	1 = Yes 2 = No -44 = Height not measured/ N/A		
4i	Did they ensure the child was not wearing any bulky hairpiece on their head?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4j	Did they ensure the headpiece was placed firmly on the child's head?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4k	Did they read the child's height while the child was in the proper position in the vertical stand?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4l	Did they get down to eye level with the headpiece to read the height off the board?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4m	Did they immediately record the measurement?	1 = Yes 2 = No -44 = Height not measured/ N/A		
4n	Did they sanitize the equipment used for height measurement after use?	1 = Before 2 = After 3 = Before and After 4 = No -44=N/A		
Child's Weight				

5	Did they weigh the child?	1 = Yes 2 = No		
5a	Did they use an infant table scale, a hanging sling scale, or a floor scale? Floor scales include Beam Balance, Electronic, Digital, and Bathroom scales	1 = Infant scale 2 = Floor Scale 3 = Hanging sling scale -44= Weight not taken / N/A		
5b	Did they check whether the scale was weighing properly before using?	1 = Yes 2 = No -44= N/A		
5c	Was the scale readjusted to zero before weighing the child?	1 = Yes 2 = No -44= N/A		
5d	Was the child down to just a diaper/underwear with other clothing removed?	1 = Yes 2 = No -44= N/A		
5e	If the child was weighed with clothes, did the provider check the child for coins, bracelets, or similar items on the body and clothes that might add weight?	1 = Yes 2 = No -44= N/A		
5f	If the child was weighed with clothes, Did the provider take off the child's heavy clothes and shoes?	1 = Yes 2 = No -44= N/A		
5g	Did the provider wait until the child stopped moving to record the weight?	1 = Yes 2 = No -44= N/A		
5h	Did the provider record the weight immediately after?	1 = Yes 2 = No -44= N/A		

Child's Weight -- Infant Table Scale				
6a	If an infant table scale was used, did they lay the baby down on their back on the scale?	1 = Yes 2 = No -44= N/A		
6b	If an infant table scale was used, Did they make sure they recorded the weight when no one was touching the child?	1 = Yes 2 = No -44= N/A		
Child's Weight -------- Floor Scale ------- (Beam Balance, Electronic, Digital, and Bathroom scales)				
7a	If a floor scale was used, was the child asked to stand (or placed) in the middle of the scale with feet slightly apart?	1 = Yes 2 = No -44= N/A		
7b	If a floor scale was used, did they need to have the caregiver hold the child and step on the scale together?	1 = Yes 2 = No -44= N/A		
7c	If a floor scale was used, did they weigh the caregiver without the child?	1 = Yes 2 = No -44= N/A		
Child's Weight – Sling Scale				
8a	If the Sling Scale was used, did they hold the child's legs and put them through the leg holes?	1 = Yes 2 = No -44= N/A		
8b	If a Sling Scale was used, did they hold the child's feet?	1 = Yes 2 = No -44= N/A		
8c	If a Sling Scale was used, did they hang the child on the scale after	1 = Yes 2 = No -44= N/A		

	putting the child in the sling?			
8d	If a Sling Scale was used, did they read the scale at eye level?	1 = Yes 2 = No -44= N/A		
8e	If the Sling Scale was used, did they remove the child slowly and safely after weighing?	1 = Yes 2 = No -44= N/A		
Child's Head Circumference				
10a	Did they measure the head circumference of the child?	1 = Yes 2 = No		
10b	Did they wrap the tape around the child's head at the widest point? (Above the eyebrows and ears)	1 = Yes 2 = No -44= Child HC was not measured/N/A		
10c	Did they ensure the tape was not too tight or too loose on the child's head?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
10d	Did they immediately record the measurement after reading the tape?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
Child's Middle-Upper Arm Circumference (MUAC)				
11a	Did they measure the mid-upper arm circumference (MUAC) of the child?	1 = Yes 2 = No		
11b	Did they remove any clothing that was covering the child's arm?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
11c	Did they straighten the child's arm before	1 = Yes 2 = No		

	wrapping the tape around the arm?	-44= Child HC was not measured/N/A		
11d	Did they wrap the tape around the midpoint of the upper arm?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
11e	Did they ensure the tape was not too tight or too loose on the child's arm?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
11f	Did they immediately record the measurement after reading the tape?	1 = Yes 2 = No -44= Child HC was not measured/N/A		
Edema				
12a	Did they check the child for edema?	1 = Yes 2 = No		
12b	Did they apply normal thumb pressure on the child's feet for 3 seconds?	1 = Yes 2 = No		
12c	Did they note if they saw imprints remaining after 3 seconds?	1 = Yes 2 = No		
13	Did they plot the measurements in the **growth monitoring chart**?	1 = Yes 2 = No		
14	Did they use the right chart based on the sex and age of the child?	1 = Yes 2 = No		
15	Did they note any issues or concerns with the child's growth after looking at the growth chart?	1 = Yes 2 = No		

16	What concern did they mention? [Mark all that apply]	1 = Stunting (low height for age) 2 = Wasting (low weight for height) 3 = Underweight (low weight for age) 4 = Other, specify ***{v161}*** _____ -44= N/A		
17	Did they explain this concern to the parent/caregiver?	1 = Yes 2 = No -44=N/A		
18	Did they provide the parent/ caregiver with actions for improved care and feeding?	1 = Yes 2 = No -44=N/A		
19	Did they refer the child to the municipal hospital or health unit, as needed?	1 = Yes 2 = No -44=N/A		
20	Did they make a note to have the child followed up by the BNS or BHW?	1 = Yes 2 = No		
21	Did they mark everything in the child's records/health chart?	1 = Yes 2 = No		

Section 3: Health Provider Information

Instructions: Please ask these questions directly to the health provider you observed after the mother/parent/caregiver has left.

Identify the practitioners who conducted the Growth Monitoring Observation?

3.1a _____ (Main Provider)

3.1b _____

3.1c _____

1 = Doctor 2 = Nurse 3 = Midwife 4 = Nutritionist 5 = Barangay Health Worker

#	Question	Choices	Main Provider {v32a}	2nd Provider {v32b}	3rd Provider {v32c}

1	What is the sex of the health provider observed? [*Enumerator observes, do not ask*]	1 = Female 2 = Male			
2	How old are you?	[Enter age]			
3	How long have you worked at this facility?	1 = Less than one year 2 = 1-2 years 3 = 3-5 years 4 = More than 5 years			
4	Have you received any health and nutrition-related training in the last 12 months?	1 = Yes 2 = No			

What topics were you trained on?			Main Provider {v33a}	2nd Provider {v33b}	3rd Provider {v33c}
1	Growth monitoring (measurement)	1 = Yes 2 = No			
2	Growth monitoring (interpretation)	1 = Yes 2 = No			
3	Breastfeeding practices	1 = Yes 2 = No			
4	Complementary feeding practices	1 = Yes 2 = No			
5	Prenatal care	1 = Yes 2 = No			
6	Birthing / midwifery / obstetrics	1 = Yes 2 = No			
7	Adult nutrition (ages 18 and over)	1 = Yes 2 = No			
8	Older child nutrition (above age 5)	1 = Yes 2 = No			
9	OPT Plus	1 = Yes 2 = No			
10	Nutrition in emergencies	1 = Yes 2 = No			

11	Management of acute malnutrition	1 = Yes 2 = No			
12	Reporting or providing referrals	1 = Yes 2 = No			
13	Mentoring	1 = Yes 2 = No			
14	Counselling	1 = Yes 2 = No			
15	Other, specify *{v3315}* _____ __	1 = Yes 2 = No			

IYCF and Breastfeeding Counselling

Instructions: You will fill out this observation form if you observed one of the intended practitioners (Nurse, Midwife, Nutritionist, BHW, BNS) conduct counselling on infant and young child feeding to a mother or child caregiver.

Before the observation begins, please:

4. Obtain Consent from Patient's Caregiver and Practitioner.
5. Ensure the child is 0-23 months old
6. Fill out the information about the facility

At the end of the observation, please:

3. Complete the section on the background of the health practitioner.
4. Follow up with the practitioner and/or caregiver if you have questions or need further information to respond to this questionnaire.

Standard Codes:	1 = Yes	2 = No	-44 = Not Applicable

ENUMERATOR CODE: _____

Section 1: Health Facility Information

#	Question	Response
1.1	Date	{v11}
1.2	Name of Supervisor	{v12}
1.3	Name of Enumerator	{v13}
1.4	Region	{v14}
1.5	Province	{v15}
1.6	Municipality	{v16}
1.7	Barangay	{v17}
1.8	Health Facility Name	{v18}
1.9	Address	{v19}

1.10	GPS Coordinates	{v110}	
1.11	Type of Facility	1 = Rural Health Unit 2 = Barangay Health Center 3 = Birthing Home 4 = Other, specify _____	{v111}
1.12	Where is the observation / session taking place?	1 = In the waiting area of the facility 2 = In a private room (enclosed space with door and walls with only the client and practitioner) 3 = In a room with other patients or practitioners 4 = In a private but open space (not a separate enclosed room with walls and a door, but a private space indoors) 5 = Outside 6 = Other, specify *{v112a}* _____ __	{v112}

Section 2: IYCF and Breastfeeding Counselling Observation

#	Question	Response		
2.01	Are you observing an IYCF or breastfeeding counselling session?	1 = Yes >> Continue with observation 2 = No >> End observation	{v201}	
2.1 For each of the following, you will mark whether you observed the health practitioner complete the specific skill or task for the session you observed. Not all skills will be relevant to every interaction, so please answer all questions accurately.			Response {v21a}	Which provider performed this? {v21b} 1 = Doctor

				2 = Nurse 3 = Midwife 4 = Nutritionist 5 = Barangay Health Worker
1	Did they determine the child's age?	1 = Yes 2 = No >> **Q3**		
2	What is the child's age?	1 = 0 to 6 months 2 = 6 to 23 months 3 = 2 to 5 years 4 = Over 5 years 5 = Don't know -44=N/A		
3	Did they ask if the client was already covered by the Household Convergence Scorecard (HCSC)?	1 = Yes 2 = No		
4	Did they measure the child's height, length, weight, or MUAC? [If they measure any of these, select 'yes']	1 = Yes 2 = No		
5	Did they ask about the number of times a day the child was fed in the past 24 hours?	1 = Yes 2 = No		
6	Did they ask about when throughout the day the child was fed in the past 24 hours?	1 = Yes 2 = No		
7	Did they ask if the child was ever breastfed?	1 = Yes 2 = No		
8	Did they ask if the child was still being breastfed?	1 = Yes 2 = No		
Breastfeeding Practices				
9	Did they ask about the specific breastfeeding practices the mother uses?	1 = Yes 2 = No		
Which of the following breastfeeding practices did they mention?				

19a	1 = Positioning	1 = Yes 2 = No -44=N/A		
9b	2 = Latching	1 = Yes 2 = No -44=N/A		
9c	3 = Feeding on demand	1 = Yes 2 = No -44=N/A		
9d	4 = Other, specify ***{v10d}*** _____ _	1 = Yes 2 = No -44=N/A		
10	Did they explain the key messages for exclusive breastfeeding? * Exclusive breastfeeding is recommended for the first 0-6 months of a baby and entails giving nothing else than breast milk.	1 = Yes 2 = No -44=N/A		
11a	Did they ask the client to repeat the key messages and instructions on exclusive breastfeeding back to them?	1 = Yes 2 = No -44=N/A		
11b	Did the provider make sure the mother understood the key messages on exclusive breastfeeding?	1 = Yes 2 = No -44=N/A		
13	Did they ask if the child is fed food other than breastmilk?	1 = Yes 2 = No		
15	Did they ask about the types of food the child is eating? *Food types include starchy staples, pulses, nuts and seeds, dairy, eggs, meat, fish, dark green leafy vegetables, vitamin A-rich fruits and vegetables, and other fruits and vegetables.	1 = Yes 2 = No		

16	Did they explain what complementary feeding is? Complementary feeding is when children receive foods to complement breast milk or infant formula. Ideally, it begins at 6 months of age and continues to 24 months or beyond.	1 = Yes 2 = No		
18	Which of the following complementary feeding topics did the provider mention? *Select all that apply.	1 = Age to start 2 = Importance of complementary feeding after 6 months of age 3= Types of foods to introduce (7 food groups + breastfeeding) 4 = Frequency of feeding 5 = Portion size 6 = Child's satiety and hunger signs 7 = Importance of using good hygiene when feeding 8 = Importance of a diversified diet 9 = Other, specify ***{v18a}***_____ ____ -99 = None		
19 a	Did the provider ask the caregiver to repeat the key messages and instructions on complementary feeding back to them?	1 = Yes 2 = No		
19 b	Did they make sure the caregiver understood the key messages on complementary feeding?	1 = Yes 2 = No		

20	Did the service provider give the parent or caregiver printed education materials?	1 = Yes 2 = No		
21	Did they perform the physical examination of the child?	1 = Yes 2 = No		
22	Which parts of the body did they examine? [Mark all that apply]	1 = Skin 2 = Hair 3 = Eyes 4 = Ears 5 = Nose 6 = Mouth 7 = Chest 8 = Hands/Arms 9 = Feet/Legs 10 = Other, specify ***{v22a}***_____ ___ -99= None		
23 a	Did the service provider request the mother-child booklet?	1 = Yes 2 = No		
23 b	Was the mother-child booklet available?	1 = Yes 2 = No		
23 c	Did the provider update the mother-child booklet?	1 = Yes 2 = No -44 = N/A		
23 d	Did the provider update the target client list?	1 = Yes 2 = No		
24	Did they schedule the client for the next well-baby visit?	1 = Yes 2 = No		

The next set of questions ask about the health providers' behaviors while conducting the counselling session rather than specific tasks they completed.				
Did the counselor use the following listening and learning skills?				
25 a	Keep head level with mother/parent/caregiver	1 = Yes 2 = No		
25 b	Pay attention (eye contact)?	1 = Yes 2 = No		
25 c	Remove barriers (tables and notes)?	1 = Yes 2 = No		

25 d	Take time?	1 = Yes 2 = No		
25 e	Use technically appropriate touch	1 = Yes 2 = No		
25 f	Ask open questions?	1 = Yes 2 = No		
25 g	Use responses and gestures that show interest?	1 = Yes 2 = No		
25 h	Reflect back on what the mother said?	1 = Yes 2 = No		
25 i	Avoid using judging words, gestures, or expressions?	1 = Yes 2 = No		
25 j	Allow mother/parent/caregiver time to talk?	1 = Yes 2 = No		
Did the counselor use the following confidence building skills and give support?				
26 a	Accept what a mother thinks and feels?	1 = Yes 2 = No		
26 b	Listen to the mother's concerns?	1 = Yes 2 = No		
26 c	Recognize and praise what the mother and baby are doing correctly?	1 = Yes 2 = No		
26 d	Give practical help to address breastfeeding or other feeding issues?	1 = Yes 2 = No		
26 e	Use simple language?	1 = Yes 2 = No		
26 f	Make one or two suggestions, not commands?	1 = Yes 2 = No		
Did the counselor assess the following:				
27 a	Check on the recent child illness?	1 = Yes 2 = No		
27 b	Observe a breastfeeding?	1 = Yes 2 = No		
27 c	Assess other fluid intake?	1 = Yes 2 = No		
27 d	Assess other food intake?	1 = Yes 2 = No		
27 e	Ask about whether the child receives assistance when eating?	1 = Yes 2 = No		
27 f	Check on hygiene related to feeding?	1 = Yes 2 = No		

27 g	Provider explain the child's Nutritional Status using growth curves?	1 = Yes 2 = No		

Did the counselor do any of the following:				
28 a	Identify any feeding difficulty?	1 = Yes 2 = No		
28 b	Address feeding difficulties (example: breastfeeding difficulties)	1 = Yes 2 = No		
28 c	Praise the mother for doing best practices?	1 = Yes 2 = No		
28 d	Discuss age-appropriate feeding recommendations and possible discussion points?	1 = Yes 2 = No		
28 e	Help the mother select one or two options she can try to address feeding challenges?	1 = Yes 2 = No		
28f	Use Counselling Cards that are most relevant to the child's situation and discuss information with the mother?	1 = Yes 2 = No		
28 g	Ask the mother to repeat the agreed-upon behavior?	1 = Yes 2 = No		
28 h	Ask the mother if she has questions or concerns?	1 = Yes 2 = No		
28i	Refer as necessary?	1 = Yes 2 = No -44 = N/A		
28j	Suggest where the mother can find additional support?	1 = Yes 2 = No		
28 k	Thank the mother for her time?	1 = Yes 2 = No		

Section 3: Health Provider Information
Instructions: Please ask these questions directly to the health provider you observed after the mother/parent/caregiver has left.

Identify the practitioners who conducted IYCF/breastfeeding counselling?
3.1a _____ (Main Provider)
3.1b _____
3.1c _____
1 = Doctor 2 = Nurse 3 = Midwife 4 = Nutritionist 5 = Barangay Health Worker

#	Question	Choices	Main Provider {v32a}	2nd Provider {v32b}	3rd Provider {v32c}
1	What is the sex of the health provider observed? [*Enumerator observes, do not ask*]	1 = Female 2 = Male			
2	How old are you?	[Enter age]			
3	How long have you worked at this facility?	1 = Less than one year3 = 3-5 years 2 = 1-2 years 3 = 3-5 years 4 = More than 5 years			
4	Have you received any health and nutrition-related training in the last 12 months?	1 = Yes 2 = No			

3.3 What topics were you trained on?			Main Provider {v33a}	2nd Provider {v33b}	3rd Provider {v33c}
1	Growth monitoring (measurement)	1 = Yes 2 = No			
2	Growth monitoring (interpretation)	1 = Yes 2 = No			
3	Breastfeeding practices	1 = Yes 2 = No			
4	Complementary feeding practices	1 = Yes 2 = No			
5	Prenatal care	1 = Yes 2 = No			
6	Birthing/midwifery/obstetrics	1 = Yes 2 = No			
7	Adult nutrition (ages 18 and over)	1 = Yes 2 = No			

8	Older child nutrition (above age 5)	1 = Yes 2 = No			
9	OPT Plus	1 = Yes 2 = No			
10	Nutrition in emergencies	1 = Yes 2 = No			
11	Management of acute malnutrition	1 = Yes 2 = No			
12	Reporting or providing referrals	1 = Yes 2 = No			
13	Mentoring	1 = Yes 2 = No			
14	Counselling	1 = Yes 2 = No			
15	Other, specify *{v3315}* _____ _	1 = Yes 2 = No			

Pre-natal Checkup

Instructions: You will fill out this observation form if you observed one of the intended practitioners (Physician, Nurse, Midwife, Nutritionist, BHW, BNS) conduct a prenatal checkup.

Before the observation begins, please:

7. Obtain Consent from Patient and Practitioner.
8. Obtain gestational age (in weeks and days)
9. Fill out the information about the facility

At the end of the observation, please:

5. Complete the section on the background of the health practitioner.
6. Follow up with the practitioner and/or patient if you have questions or need further information to respond to this questionnaire.

Standard Codes:	1 = Yes	2 = No	-44 = Not Applicable

ENUMERATOR CODE: _____

Section 1: Health Facility Information

#	Question	Response
1.1	Date	{v11}
1.2	Name of Supervisor	{v12}

1.3	Name of Enumerator	{v13}	
1.4	Region	{v14}	
1.5	Province	{v15}	
1.6	Municipality	{v16}	
1.7	Barangay	{v17}	
1.8	Health Facility Name	{v18}	
1.9	Address	{v19}	
1.10	GPS Coordinates	{v110}	
1.11	Type of Facility	1 = Rural Health Unit 2 = Barangay Health Center 3 = Birthing Home	{v111}
1.12	Where is the observation/session taking place?	1 = In the waiting area of the facility 2 = In a private room (enclosed space with door and walls with only the client and practitioner) 3 = In a room with other patients or practitioners 4 = In a private but open space (not a separate enclosed room with walls and a door, but a private space indoors) 5 = Outside 6 = Other, specify *{v112a}*_____	{v112}

Section 2: Prenatal Checkup Observation

	Question	Response	
2.01	Are you observing a prenatal appointment?	1 = Yes >> Continue with observation 2 = No >> End survey and find the correct observation form	{v201}

2.1 For each of the following, you will mark whether you observed the health practitioner complete the specific skill or task for the session	Response {v21a}	Which provider

you observed. Not all skills will be relevant to every interaction, so please answer all questions accurately.				performed this? {v21b} 1 = Doctor/Physician 2 = Nurse 3 = Midwife 4 = Nutritionist/Dietitian 5 = Barangay Health Worker
1	Did they ask the client if they are already covered by the Household Convergence Scorecard (HCSC)?	1 = Yes 2 = No		
2	Did they determine if the woman is in for basic ANC or specialized ANC? * Specialized ANC is for women with pregnancy complications or those with high-risk pregnancies.	1 = Yes 2 = No		
3	Did they determine the date of the woman's last menstrual period?	1 = Yes 2 = No		
4	Did they determine if this is the mother's first prenatal visit for this pregnancy?	1 = Yes 2 = No		
5	Did they determine how many previous visits the mother has attended? If so, how many?	Specify the number of visits Code -44 = Did not determine/ N/A		

6	Did they determine the approximate gestational age? * Gestational age is the length of pregnancy, commonly measured in weeks and days from the first day of the mother's last menstrual period.	1 = Yes 2 = No	_____ weeks _____ days	
7	What trimester of pregnancy is the mother currently in?	1 = First trimester (0-13 weeks) 2 = Second trimester (14-27 weeks) 3 = Third trimester (>=28 weeks)		
8	Did they ask the mother about her obstetric history? *Obstetric history includes the number of pregnancies, the number of children born alive, the number of stillbirths, etc.	1 = Yes 2 = No		
9	Was the mother asked if this was her first pregnancy?	1 = Yes 2 = No		
10	Did she reply that this was her first pregnancy?	1 = Yes 2 = No Code -44 = Did not determine/ N/A		
11	Was the mother asked if she had experienced complications during pregnancy or birth in previous pregnancies?	1 = Yes 2 = No		

Woman's Height				
12	Did they measure the woman's height?	1 = Yes 2 = No >> **Q14**		
13a	Ensure the head was straight?	1 = Yes 2 = No		
13b	No footwear on?	1 = Yes 2 = No		
13c	Shoulders/buttocks/heels touching the back of the wall/stand?	1 = Yes 2 = No		
13d	The woman kept her arms at her sides?	1 = Yes 2 = No		
13e	Read the height from the proper position?	1 = Yes 2 = No		
Woman's Weight				
14	Did they weigh the woman?	1 = Yes 2 = No >> **Q19**		
15	Did they check whether the scale was working before using it?	1 = Yes 2 = No		
16	Did they readjust the scale to zero before weighing the woman?	1 = Yes 2 = No		
17	Was the woman asked to stand in the middle of the scale with her feet slightly apart?	1 = Yes 2 = No		
18	Did the provider wait until the woman stopped moving to record the weight?	1 = Yes 2 = No		
Woman's MUAC				
19	Did they measure the mid-upper arm circumference (MUAC) of the woman?	1 = Yes 2 = No >> **Q25a**		
20	Did they remove any clothing that was covering the woman's arm?	1 = Yes 2 = No		
21	Did they straighten the woman's arm before	1 = Yes 2 = No		

	wrapping the tape around it?			
22	Did they ensure the tape was around the midpoint of the upper arm?	1 = Yes 2 = No		
23	Did they ensure the tape was not too tight or too loose on the woman's arm?	1 = Yes 2 = No		
24	Did they immediately record the measurement?	1 = Yes 2 = No		
25a	Did they check the woman's pulse rate?	1 = Yes 2 = No		
25b	Did they check the woman's blood oxygen levels?	1 = Yes 2 = No		
25c	Did they check the woman's blood pressure?	1 = Yes 2 = No		
26	What method did they use for testing the blood pressure?	1 = Used a manual blood pressure cuff and stethoscope 2 = Used an electronic blood pressure cuff Code -44 = N/A		
27	Did they mention any concerns about the woman's measurements or health conditions?	1 = Yes 2 = No >> **Q31**		
28	What concerns did they mention?	1 = Underweight 2 = Overweight 3 = High blood pressure		

		4 = Low blood pressure 5 = Other medical conditions, specify Code -44 = N/A *{v28a}*_____ _____ ___		
29	Did they explain why this could be an issue or cause problems during pregnancy/birth?	1 = Yes 2 = No Code -44 = N/A		
30	Did they suggest actions the woman could take to fix the problem?	1 = Yes 2 = No Code -44 = N/A		
31	Did they assess the woman's nutrition?	1 = Yes 2 = No		
32	Did they ask how many meals she eats a day?	1 = Yes 2 = No		
33	Did they ask which meals she typically eats (e.g., breakfast, lunch, afternoon snack)?	1 = Yes 2 = No		
34	Did they ask about the types of food she eats? *Food types include starchy staples, pulses, nuts and seeds, dairy, eggs, meat, fish, dark green leafy vegetables, vitamin A-rich fruits and vegetables, and other fruits and vegetables.	1 = Yes 2 = No		

35	Did they mention any concerns about the woman's diet/nutrition?	1 = Yes 2 = No >> **Q39**		
36	What concerns did they mention?	1 = Too much sugar 2 = Not enough fruits or vegetables 3 = Not enough protein 4 = Not getting vitamins 5 = Too much fat 6 = Too much salt Code -44 = N/A		
37	Did they explain why this could be an issue or cause problems during pregnancy/birth?	1 = Yes 2 = No Code -44 = N/A		
38	Did they suggest ways the woman could improve her diet during the rest of her pregnancy? * Suggestions can include eating a more diversified diet, consuming less salt, consuming more fruits or vegetables, and taking micronutrient supplements	1 = Yes 2 = No		
38a	Did they ask whether the woman was taking her	1 = Yes 2 = No		

	micronutrient supplements during her pregnancy? * Supplements include iron, folic acid, MMS (multiple micronutrient supplementation), etc			
38b	Did they counsel the woman on what foods/drinks to eat and what food/drinks to avoid?	1 = Yes 2 = No		
39	Did they ask whether the woman had smoked, consumed alcohol, or used drugs during her pregnancy?	1 = Yes 2 = No		
39a	Did they ask the woman if she suffered from domestic violence?	1 = Yes 2 = No		
39b	Did they ask the woman if she was feeling anxious or depressed?	1 = Yes 2 = No		
40	Did they ask the woman when she first noted the baby first moved?	1 = Yes 2 = No		
41	Did they examine the fetal heart rate?	1 = Yes 2 = No		
42	Did they measure the fundic height?	1 = Yes 2 = No		
43	Did they perform Leopold's maneuver to determine the fetal position?	1 = Yes 2 = No		
44	Did they provide routine pregnancy care (laboratory tests, micronutrient supplementation, immunization)? * Micronutrient supplementation includes iron and folic acid, and	1 = Yes 2 = No >> **Q46**		

	multiple micronutrient supplements.			
45	Which care did they provide? *Select all that apply.	1 = Laboratory testing 2 = Micronutrient supplementation 3 = Immunization		
46	Did they counsel the woman on danger signs to look out for during pregnancy? * Danger signs include bleeding, excessive swelling, and severe headaches.	1 = Yes 2 = No		
47	Did they counsel the woman on exclusive breastfeeding? * Exclusive breastfeeding is recommended for the first 0-6 months of a baby and entails giving nothing else than breast milk.	1 = Yes 2 = No		
48	Did they counsel the woman on family planning postpartum? * Family planning includes the use of contraception and birth spacing.	1 = Yes 2 = No		
49	Did they assist the client in preparing a birth plan? * Birth plan includes a birthing location, things to bring to the facility on the day of birth, and other preferences.	1 = Yes 2 = No		

50	Did they counsel the woman on labor signs? * Labor signs include frequent contractions and water breaking	1 = Yes 2 = No		
51	Did they provide educational materials?	1 = Yes 2 = No		
52	Did they schedule the woman for her next prenatal visit?	1 = Yes 2 = No, this was her last visit before birth 3 = No		
53	Did the provider request the Prenatal Booklet?	1 = Yes 2 = No		
53a	Was the Prenatal Booklet available?	1 = Yes 2 = No		
53b	Did the provider update the Prenatal Booklet?	1 = Yes 2 = No, the booklet was available, but the provider did not update it 3= No, the booklet was not available		
The next set of questions asks about the health providers' behaviors while conducting the counselling session, rather than specific tasks they completed.				
Did the counselor use the following listening and learning skills?				
54a	Keep head level with mother	1 = Yes 2 = No		
54b	Pay attention (eye contact)	1 = Yes 2 = No		
54c	Remove barriers (tables and notes)	1 = Yes 2 = No		
54d	Take time	1 = Yes 2 = No		

54e	Use technically appropriate touch	1 = Yes 2 = No		
54f	Ask probing open-ended questions	1 = Yes 2 = No		
54g	Use responses and gestures that show interest	1 = Yes 2 = No		
54h	Reflect back what the mother said	1 = Yes 2 = No		
54i	Avoid using judging words, gestures, or expressions?	1 = Yes 2 = No		
54j	Allow mother time to talk	1 = Yes 2 = No		
54k	Allow the mother to ask questions	1 = Yes 2 = No		
Did the counselor use the following confidence building skills and give support?				
55a	Accept what a mother thinks and feels	1 = Yes 2 = No		
55b	Listen to the mother's concerns	1 = Yes 2 = No		
55c	Recognize and praise what the mother is doing correctly	1 = Yes 2 = No		
55d	Give practical help to address dietary or other issues	1 = Yes 2 = No		
55e	Use simple language	1 = Yes 2 = No		
55f	Make one or two suggestions, not commands			
Did the counselor do any of the following:				
56a	Praise the mother for doing recommended practices	1 = Yes 2 = No		
56b	Help the mother select one or two options she can try to address the challenges	1 = Yes 2 = No		
56c	Use Counseling Cards that are most relevant to the situation, and discuss information with the mother	1 = Yes 2 = No		
56d	Ask the mother to repeat the agreed-upon behavior	1 = Yes 2 = No		

56e	Ask the mother if she has questions or concerns	1 = Yes 2 = No		
56f	Refer as necessary	1 = Yes 2 = No		
56g	Suggest where the mother can find additional support	1 = Yes 2 = No		
56h	Thank the mother for her time	1 = Yes 2 = No		

Section 3: Health Provider Information

Instructions: Please ask these questions directly to the health provider you observed after the mother/parent/caregiver has left.

Identify the practitioners who performed the prenatal check-up.

3.1.a _____ (Main Provider)

3.1.b _____

3.1.c _____

1 = Doctor 2 = Nurse 3 = Midwife 4 = Nutritionist 5 = Barangay Health Worker

#	Question	Choices	Main Provider {v32a}	2nd Provider {v32b}	3rd Provider {v32c}
1	What is the sex of the health provider observed? [*Enumerator observes, do not ask*]	1 = Female 2 = Male			
2	How old are you?	[Enter age]			
3	How long have you worked at this facility?	1 = Less than one year 2 = 1-2 years 3 = 3-5 years 4 = More than 5 years			
4	Have you received any training in the past year?	1 = Yes 2 = No			

5	What topics were you trained on? [Mark all that apply]	1 = Growth monitoring (measurement) 2 = Growth monitoring (interpretation) 3 = Breastfeeding practices 4 = Complementary feeding practices 5 = Prenatal care 6 = Birthing/midwifery / obstetrics 7 = Older child nutrition (above age 5) 8 = Adult nutrition (ages 18 and over) 9 = OPT Plus 10 = Nutrition in emergencies 11 = Management of acute malnutrition 12 = Reporting or providing referrals 13 = Mentoring 14 = Nutrition counseling 15 = Routine data quality checks 16 = Report preparation 17 = Other, specify {v33}_____			

Annex F. Qualitative Guides

Focus group discussion with Midwives, nurses, and nutritionists

Objectives

- Investigate service provider capacity (for nurses, midwives, and nutritionists), any supports that have helped them, and any challenges they still face
- Investigate their awareness and interaction with local nutrition policy

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role and responsibilities.

1. Please introduce yourselves by telling me your role/title and the municipality you work in.
   a. How many months or years have you been in your position?
2. What are your primary responsibilities in your role?
3. Do you experience any challenges in fulfilling your job responsibilities? If so, what are they?
4. In your view, what are the main challenges to good health and nutrition among pregnant women in your municipality?
   a. What are the main challenges to good health and nutrition among children aged 0 to 5 in your municipality?

PMNP Experiences

** In non-PMNP municipalities, ask question 7 and then skip to the next section (nutrition services)

**In PMNP municipalities, begin with question 6 and continue onward.

5. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP) or accessed their materials? Is your municipality affected by PMNP in any way?

Next, I'd like to ask you about your experiences with the Philippine Multisectoral Nutrition Program (PMNP).

6. In your own words, what are the goals of the PMNP?
7. I understand you recently attended a training as part of PMNP. What did you find to be useful about that training?
   a. Was there any part of the training that was less useful or relevant to you?
8. What, if anything, did you learn during the training?
9. Will you/have you trained other service providers based on the training you received? If so, please explain. If not, why not?
10. Has the training changed the way you and the people you trained provide health and nutrition services in your municipality? If so, how? If not, why not?
11. Have you had previous training in any of the components highlighted in the PMNP training? If so, what were those components ? (e.g, nutritional assessment, growth monitoring, SBC, LNAP)

12. How did the training you received under PMNP differ from other trainings you've received in the past? Was it more or less useful? Why?
13. Are you familiar with the performance-based grants (PBGs) delivered through PMNP? Please tell me what you know about the PBGs. Probe: how the grant was spent, respondent's involvement, expectation of future PBGs.
14. Do you have any suggestions to improve the trainings, PBGs, communications, or other aspects of PMNP? If so, please share them.
15. Please tell me about some of the recent Kalahi-CIDSS projects in this community. What projects have been completed? When did they finish?
a. Do you think any of the recent Kalahi-CIDSS projects have helped strengthen health or nutrition services in this municipality? If so, how? If not, why not?
b. How would you change the Kalahi-CIDSS project activities, if at all?

Health and Nutrition Services

Next, I have some questions about the health and nutrition services offered throughout your municipality

16. What kind of services do you provide to support the health and nutrition of pregnant women? Please describe the services you offer to a woman for each trimester of her pregnancy.
17. What kind of services do you provide to support the health and nutrition of young children?
18. How many health staff do you have in the municipality? Is this sufficient? Why or why not?
19. Are you aware of a staffing or training plan for health staff in your municipality? If so, please tell me about this. If not, would this be a helpful resource?
20. Are there social behavior change campaigns (SBCC) or information, education, and communication (IEC) efforts related to health and nutrition in your municipality?
a. If so, please describe the topic and time frame of the SBCC/IEC activities. How were you involved in the SBCC/IEC activities, if at all?
b. If not, why not? Are there any SBCC/IEC activities planned for the future?
21. Does your municipality have sufficient supplies to deliver health and nutrition services? This includes things like MUAC tape, growth monitoring charts, scales, vitamins, micronutrient powder, and immunizations.
a. To your knowledge, has the supply of these materials changed (gotten better or worse) in the past year? If so, why?
22. Do you feel you have enough information and resources to support health and nutrition for vulnerable populations such as geographically isolated (GIDA), 4Ps recipients, people with disabilities, and indigenous peoples? Why or why not?

23. To your knowledge, does your municipality use any of the following monitoring or data management systems?

a. Field Health Services Information System (FHSIS)
b. Monitoring and Evaluation of Local Level Plan Implementation (MELLPI) Pro
c. Operation Timbang (OPT) Plus
d. Project Information Management System (PIMS)
e. Geotagging Web-Application (GTWA)
f. Unified Beneficiary Database
g. Early childhood care and development (ECCD) checklists

For each one used: What are the benefits of this tool/system? What challenges, if any, do you face when using this tool/system?

24. Can you think of any additional information and resources related to health and nutrition (e.g., breastfeeding, growth monitoring, etc.) that would help you in your role? If so, what are they?

Policy & Coordination

Next, I have some questions about the local institutions and policies related to health and nutrition.

25. What are some of the nutrition related policies in your municipality?
26. Do you coordinate with any of the following people in your work providing health and nutrition services?

a. Municipal Nutrition Action Officer (MNAO)
b. Municipal Planning & Development Officer (MPDO)
c. Municipal mayor or barangay captains
d. Sanitation inspectors
e. Disaster risk management staff
f. Barangay nutrition scholars (BNS)
g. Barangay health workers (BHW)
h. Day care workers/child development workers
i. 4Ps municipal link or parent leaders
j. Indigenous Peoples' Mandatory Representative (IPMR)

For each: please briefly explain how you work with them.

27. Which of these individuals do you work most closely with? Why?
28. Are you familiar with the local municipal nutrition committee (MNC) in your municipality? Please explain your experience with this committee.
29. Do the different barangays in this municipality have nutrition action plans? For instance, what percentage of barangays have nutrition action plans?

a. What makes it easy or difficult for barangays to prepare nutrition action plans?
b. Does the LNC take actions to help barangays develop nutrition action plans? If so, which actions? If not, why not?

30. To your knowledge, what are the goals of the municipality nutrition action plan (MNAP) in your area?

a. What are the goals of the barangay nutrition action plans (BNAPs) in your area?

b. In your opinion, is your municipality on track to meet the goals outlined in the MNAP and BNAPs? Why or why not?

31. To your knowledge, does your municipality have nutrition champions? If so, please explain their role and, if relevant, how you work with them.

32. Do you have any recommendations for improving coordination and collaboration on health and nutrition in this municipality? If so, what are they?

Conclusion

That brings me to the end of my questions.

(Tapos na po ang ating panayam.)

33. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Focus group discussion with Local chief executives (LCEs) and local nutrition committee (LNC) members

Note: If possible, focus groups should not include barangay captains, the Municipal Nutrition Action Officers (MNAO) and Municipal Planning and Development Officers (MPDO), as we will conduct individual interviews with these people.

Objectives

- Investigate local nutrition policy and services, including any strengths of the policy and services and any challenges or areas of improvement identified respondents
- Investigate their coordination as it relates to local nutrition policy

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role and responsibilities.

1. Please introduce yourselves by telling me your role/title and the municipality you work in.

2. What are your primary responsibilities in your role?

3. Do you experience any challenges in fulfilling your job responsibilities? If so, what are they?

PMNP Experiences

** In non-PMNP municipalities, ask question 4 and then skip to the next section (nutrition policy)

**In PMNP municipalities, begin with question 5 and continue onward.

4. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP) or accessed their materials? Is your municipality affected by PMNP in any way?

Next, I'd like to ask you about your experiences with the Philippine Multisectoral Nutrition Program (PMNP).

5. In your words, what are the goals of the PMNP?
6. I understand you recently attended a training as part of PMNP. What did you enjoy about that training?
7. What, if anything, did you learn during the training?
8. Was there any part of the training that was less useful or relevant to you? If so, which parts (e.g., lectures, workshops, exercises)
9. Will you/have you trained other individuals in your municipality based on the training you received? If so, please explain. If not, why not?
10. Are you familiar with the performance-based grants (PBGs) delivered through PMNP? Please tell me what you know about the PBGs. Probe: how the grant was spent, respondent's involvement, expectation of future PBGs.
11. Do you have any suggestions to improve the training, PBGs, communications, or other aspects of PMNP?

Local Nutrition Policy

Next, I have some questions about the health and nutrition services offered throughout your municipality

12. What are some of the nutrition related policies in your municipality?
13. In your words, what is the purpose of the local nutrition committee (LNC)?
14. Please tell me how your LNC typically functions, including how often you meet and who is involved.
    a. Are these meetings recorded?
15. What are some of the strengths of your LNC? How about weaknesses?
16. To your knowledge, does your municipality have nutrition champions? If so, please explain their role and how you work with them

Next, I have some questions about the local nutrition action plan (LNAP) in your municipality. (If the participant says their community doesn't have an LNAP, please inquire why this is the case.)

17. What are the key health and nutrition goals outlined in the LNAP?
18. Which activities or interventions will help your municipality reach these LNAP goals?
19. Is your municipality on track to meet the goals outlined in the LNAP? Why or why not?
20. How does the LNC monitor progress toward the LNAP goals? Please describe which monitoring tools/systems you use and how often you check progress.
21. Does the LNAP consider how to support the health and nutrition of vulnerable populations such as geographically isolated (GIDA), 4Ps recipients, people with disabilities, and indigenous peoples? Why or why not?

22. Is the LNAP costed, meaning each activity outlined has a cost associated with it? If not, why not? If so, please explain how the costs were determined.
a. Does your municipality have sufficient resources to finance the LNAP fully? Why or why not?
23. Do you feel confident that you can advocate for LNAP financing through your municipal Annual Investment Plan (AIP) in the future when there are no PBGs? Why or why not?
24. What are the strengths and weaknesses of your municipality's LNAP?
25. Does the LNAP include a staffing or training plan for health staff in your municipality? If so, please tell me about this. If not, why not?
26. Are there social behavior change campaigns (SBCC) or information, education, and communication (IEC) efforts related to health and nutrition in your municipality?
a. If so, please describe the topic and time frame of the the SBCC/IEC activities. How were you involved in the SBCC/IEC activities, if at all?
b. If not, why not? Are there any SBCC/IEC activities planned for the future?

27. Do the different barangays in this municipality have nutrition action plans? For instance, what percentage of barangays have nutrition action plans?
a. What makes it easy or difficult for barangays to prepare nutrition action plans?
b. Does the LNC take actions to help barangays develop nutrition action plans? If so, which actions? If not, why not?
Conclusion
That brings me to the end of my questions.
28. Is there anything else you would like to share with me today?
Thank you for speaking with me today!
Focus Group Discussion with Mothers/Male and Female Caregivers (Children between 0-23 months)
Objectives
• Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
• Examine consideration of gender equality, equity and inclusion in strategy and implementation.
• Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.
Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
We will start with some general questions, so I can get to know each of you.
1. How old are you?

2. How old are your children?
3. Are any of you a participant of 4Ps?
4. Are any of you indigenous? If so, which IP group do you belong to?

*Interviewer/transcriber: Please record responses to questions 1 to 4 in the attendance sheet.

5. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP)? If so, what have you heard about it?

Caregiver Information

6. For female caregivers: In the past year, have you received any information about pregnancy, child health, or nutrition from a government health worker or service provider (such as a midwife, Barangay Health Worker or a Nutrition worker)?

For male caregivers: In the past year, have you received any information about caring for your children from a government health worker or service provider (such as a Barangay Health Worker or a Nutrition worker)?

a. Who shared the information with you?
b. What was the topic?
c. Was the information useful to you? Why or why not?

7. Do you feel you have more information about how to raise your young child/children (ages 0–5)? Why or why not?

a. What kind of new information have you received?

Health Services and Care

8. Have you noticed any changes in the quality of care you received at the government health facility over the past year?

a. How do health workers speak or behave with you?
b. Do you feel your questions and concerns are listened to?

9. Have you noticed any changes in the supplies at the government health facility in the past year? (such as medicines, vitamins, vaccinations)

a. Has anything become easier or harder to get?
b. Are these items usually available when you visit?

10. Have your children received Vitamin A supplements, micronutrient powders or deworming tablets?

a. Were you informed on the importance and usage?
b. How easy or difficult was it to obtain them?

11. Have your children received any vaccinations in the past year?

a. Were you informed on the importance and usage?
b. How easy or difficult was it to obtain them?

12. Have you noticed any changes in the services and supplies at daycare centres or early childhood services over the past year?

Infant and Young Child Feeding (IYCF)

13. In the past year, has the programme changed how you feed or care for your children?

a. If yes, what changes have you made and why?
b. If no, why have your practices remained the same?
14. Has your understanding of child nutrition, or when to seek help for undernutrition or overnutrition, changed?
a. If yes, what do you do differently now?

Water, Sanitation, and Hygiene (WASH)

15. In the past year, has your access to water for drinking, cooking, or bathing changed? If so, what is different now?
a. Do you still face challenges accessing water? If so, what challenges do you face?
16. Has your access to toilets in your community or household changed? If so, what is different now?
a. Do you still face challenges accessing toilets? If so, what challenges do you face?
17. Have you learned anything new about maintaining hygiene or improving the sanitation in your household? If so, please tell me what you learned and how you learned it.
18. What actions do you now take to prevent your child from getting sick?

Conclusion

That brings me to the end of my questions.
19. Is there anything else you would like to share about your experience as a caregiver or your experience with the PMNP?
20. Is there anything else you'd like to tell me?

Thank you for speaking with me today!
(Salamat po sa pakikipagusap sa akin ngayon!)

Midline: Focus Group Discussion with Pregnant Women

Objectives

- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

We will start with some general questions, so I can get to know each of you.
1. How old are you?
2. Is this your first pregnancy?

3. If this is not your first pregnancy, please tell me your child/children's age and sex.
4. Are any of you a beneficiary of 4Ps?

*Interviewer/transcriber: Please record responses to questions 1 to 4 in the attendance sheet.

5. Are any of you indigenous? If so, which IP group do you belong to?
6. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP)? If so, what have you heard about it?
7. Have you begun to prepare for your baby? If so, what are some things you are doing to prepare?
a. Within the past year, have there been any changes in your health or eating habits? If yes, what influenced those changes?

Antenatal Information and Services

8. Over the past year, have there been any changes in the health and nutrition services that you have access to?
a. If yes, do you feel more (or less) able to use health and nutrition services during your pregnancy?
b. What contributed to this change (or lack of change)?
9. Have the sources of information you rely on for pregnancy-related topics changed in the last year?
a. What sources do you trust more, and why?
b. What new or surprising information have you learned recently, and how confident are you in relying on it?
10. Have you received any information or encouragement from the PMNP program to attend prenatal visits? If so, was it helpful? If yes, what specifically was helpful?

Antenatal Care: Micronutrients, Deworming, and Immunizations

11. Can you describe your experiences with antenatal care provided in government facilities since the program started?
a. Where did you go?
b. How were you treated?
c. What did you find helpful or unhelpful during the visits?
d. How do health workers speak or behave with you?
12. Have you received any supplements (like iron, folic acid, or zinc), deworming treatment, or immunizations during this pregnancy?
a. Who gave them to you?
b. Were they clearly explained?
c. Did you feel confident using them?
13. Based on your experience, what do you think is working well in the care you have received within government facilities?
14. What would you recommend improving within government health facilities for pregnant women like you?

Infant and Young Child Feeding (IYCF)

Note to interviewer: If participants are currently pregnant with their first child and do not have any children, skip to Question 18.

15. In the past year, have you changed how you feed or care for your children?

a. If yes, what changes have you made and why?

b. Are there practices you wanted to change but couldn't? If yes, please explain.

16. Has the PMNP program done anything to support you as parents in ensuring that children under six (6) months are well nourished? If yes, what?

17. Has the PMNP program done anything to help parents ensure that children aged from 6 to 23 months are eating healthy foods?

18. Has your understanding of child nutrition (types of food children should eat, for example) or when to seek help for malnutrition changed in the past year?

a. If yes, is different now?

Water, Sanitation, and Hygiene (WASH)

19. In the past year, have you made any changes to how you access or use water for your household?

20. Do you feel prepared to maintain hygiene for yourself and your baby?

a. Has this changed over the past year?

b. If you do feel prepared, what are some of the steps you take to keep yourself and your baby clean and healthy?

c. If you don't feel prepared, what challenges are you still facing in trying to keep yourself and your baby clean and healthy? Have you received any guidance on hygiene from PMNP or other sources? If not, what would you like to learn more about?

21. What water or toilet-related challenges remain in your home or community?

Conclusion

22. Is there anything new or surprising that you have learned from the PMNP program that you'd like to share?

23. Is there anything else you'd like to tell me?

Thank you for speaking with me today!

(Salamat po sa pakikipagusap sa akin ngayon!)

Key Informant Interview with National Agencies and Partners

- Department of Health (DOH)
- Department of Social Welfare and Development (DSWD)
- National Economic and Development Authority (NEDA)
- Department of Interior and Local Government (DILG)

- National Nutrition Council (NNC)

Objectives:

- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role.

1. How have you been involved in the Philippines Multisectoral Nutrition Program (PMNP) so far?
   a. If so, what are your primary responsibilities in this role?

PMNP Relevance and Coherence

2. I understand there was formative research done to inform the overall approach to the PMNP. Can you talk a little about whether/how this research influenced the design of activities?
   a. Did the formative research inform the PMNP's approach to reaching vulnerable or marginalized groups? If yes, how so?

3. Were you involved in developing the content for the capacity building trainings for nurses, midwives, and nutritionists? If yes:
   a. Can you talk a little about how that content was developed?
   b. Do you think the content was relevant to each type of service provider?
4. What about the nutrition governance training, were you involved? If yes:
   a. Do you know how that training content was developed?
   b. Do you think it was relevant?
5. Now that you are midway through the implementation of the PMNP, from your perspective, how would you assess the overall relevance of the activities implemented thus far? Probe for specific examples of which activities are more/less relevant and why.
6. From your perspective, do you think PMNP activities have complemented (or duplicated) any other programs or interventions in the health or nutrition space? Please explain. Probe for specific programs/interventions.
   a. Do you think PMNP information management/monitoring systems have complemented (or duplicated) any existing systems? Please explain.
7. Have there been any synergies with other DSWD programs such as the 4Ps or the Kalahi CIDSS project? Has PMNP taken advantage of any existing mechanisms from 4Ps/Kalahi-CIDSS?

PMNP Efficiency and Effectiveness

8. I understand there have been some delays in rolling out various PMNP activities. Can you talk a little about what was behind those delays?

a. Do you think any of them could have been avoided?

9. What do you see as the key barriers or bottlenecks to making key program decisions or rolling out PMNP activities?

10. Have there been any barriers to improving local nutrition planning (MNAPs, BNAPs, or AIPs)?

a. What has worked well to support LGUs to improve these plans?

11. To your knowledge, have there been any fundamental changes to planned PMNP activities? Any deviations from the original plans for the program? Probe for detailed explanation, including what led to the changes/deviations.

12. Now that PMNP activities are well underway, have you observed any challenges reaching vulnerable or marginalized individuals/households with PMNP services?

a. Have there been any best practices in terms of outreach targeting these groups specifically?

13. How would you characterize the coordination and collaboration between the many actors involved in delivering the PMNP? For example, DOH, NPMO/RPMO, DSWD, and the LGUs?

a. Are there any approaches (for example, regular meetings or collaborative platforms) that facilitate coordination?

b. Is there anything that impedes coordination between agencies?

14. Are you familiar with the performance-based grants (PBGs) under the PMNP? If yes:

a. Do you have a sense of whether those have been going according to plan or not? Do you think the PBGs have been successful in incentivizing good "performance"? Please explain.

15. Do you think the Health Promotion Grants (HPGs) have been an effective mechanism to support localized SBCC activities?

i. What has worked well with the HPGs?

ii. What hasn't worked well with the HPGs?

16. In terms of the key channels through which PMNP is operating (Performance-Based Grants, trainings, and SBCC) – which channel(s) do you think are most effective? Please explain.

a. How about those that are least effective? Please explain.

17. Of the many interventions/activities supporting improved maternal/child nutrition, water access, sanitation, hygiene services, etc., do you perceive any specific interventions (or set of interventions) to be the most impactful? Please explain.

18. From your perspective, have you directly observed or heard of any tangible improvements in service delivery since the municipal-level capacity building trainings for service providers? Please explain. Probe for specific examples.
19. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of nurses, midwives, and nutritionists to put what they learned during the trainings into practice?
20. Do you foresee any challenges putting into place the recommendations from the nutrition governance training? If yes, which ones?
21. Do you think there are still critical SBC-related capacity gaps for nurses, midwives, or nutritionists? If yes, what are they?
22. In thinking about future PMNP trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.
23. Do you have a sense of which PMNP activities are most cost-efficient? Please explain.
a. What about those that are the least cost-efficient?

Sustainability

24. Have any concrete steps been taken to ensure the sustainability of PMNP interventions beyond the project period? For example, any changes within DOH/DSWD or the LGUs? Please explain.
25. Has your [department] specifically considered the sustainability of its efforts under the PMNP? If yes, how so?
26. At the municipal and barangay levels, do you think there are committed "champions" to take the work forward following the end of the PMNP? What are their roles and how do you engage with them?
27. What do you see as the main barriers to sustaining PMNP interventions (and their benefits) over time?

Conclusion

That brings me to the end of my questions.
28. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Key Informant Interview with Barangay Nutrition Scholars and Barangay Health Workers

Objectives

- Investigate service provider capacity (for nurses, midwives, and nutritionists), any supports that have helped them, and any challenges they still face
- Investigate their awareness and interaction with local nutrition policy

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role at this health station.

1. When did you begin working at this barangay health station?

a. Are there any other barangays you are assigned to besides this one?

2. What are your primary responsibilities in this role?

3. Do you experience any challenges in fulfilling your job responsibilities? If so, what are they?

PMNP Experiences

** In non-PMNP municipalities, ask question 4 and then skip to the next section (nutrition services)

**In PMNP municipalities, begin with question 5 and continue onward.

4. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP) or accessed their materials? Is your municipality affected by PMNP in any way?

Next, I'd like to ask you about your experiences with the Philippine Multisectoral Nutrition Program (PMNP).

5. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP)? If so, what have you heard about it? And from whom?

6. To your knowledge, have you participated in any activities as part of PMNP? If so:

a. Please tell me which activities you participated in.

b. What did you enjoy about those activities? Was there anything you would change about those activities?

7. Are you familiar with the performance-based grants (PBGs) delivered through PMNP? If so, please tell me what you know about the PBGs.

Health and Nutrition Services

Next, I have some questions about the health and nutrition services offered throughout your municipality

8. How many health staff do you have in the municipality? Is this sufficient? Why or why not?

a. If you need to, whom do you refer your clients in need of help?

9. Are there social behavior change campaigns (SBCC) or information, education, and communication (IEC) efforts related to health and nutrition in your barangay?

If yes:

a. Please describe the topic, targeted audience, and time frame of the SBCC/IEC activities.

b. Who developed the SBCC/IEC activities? How were you involved in the SBCC/IEC activities, if at all?

If no:

c. Why not?

d. Are there any SBCC/IEC activities planned for the future?

10. Does your barangay have sufficient supplies to deliver health and nutrition services? This includes things like MUAC, weighing scale, height measuring board, MNPs, RUTF, and others.

a. To your knowledge, has the supply of these materials changed (gotten better or worse) in the past year? If so, why?

11. Do you feel you have enough information and resources to support health and nutrition for vulnerable populations such as geographically isolated areas (GIDA), 4Ps recipients, people with disabilities, and indigenous peoples? Why or why not?

12. To your knowledge, does your barangay use any of the following monitoring or data management systems?

a. Field Health Services Information System (FHSIS)

b. Monitoring and Evaluation of Local Level Plan Implementation (MELLPI) Pro

c. Operation Timbang (OPT) Plus

d. Project Information Management System (PIMS)

e. Geotagging Web-Application (GTWA)

f. Unified Beneficiary Database

g. Early childhood care and development (ECCD) checklists

For each one used: What are the benefits of this tool/system? What challenges, if any, do you face when using this tool/system?

13. Can you think of any additional information and resources related to health and nutrition (e.g., breastfeeding, growth monitoring, etc.) that would help you in your role? If so, what are they?

14. Please tell me about some of the recent Kalahi-CIDSS projects in this community. What projects have been completed? When did they finish?

a. Do you think any of the recent Kalahi-CIDSS projects have helped strengthen health or nutrition services in this barangay? If so, how? If not, why not?

b. How would you change the Kalahi-CIDSS project activities, if at all?

Policy & Coordination

Lastly, I have some questions about the local institutions and policies related to health and nutrition.

Do you work with any of the following people in your role? For each: please briefly explain how you work with them.

a. Municipal Nutrition Action Officer (MNAO)

b. Barangay captain (kapitan) and counselor (kagawad)

c. Sanitation inspectors

d. Disaster risk management staff

e. MHO staff (e.g., doctors, nurses, midwives, or nutritionists)

f. Day care workers/child development workers

g. 4Ps municipal link and parent leaders

h. Indigenous Peoples' Mandatory Representative (IPMR) (Note: For Indigenous Cultural Communities/Indigenous Peoples)
15. Which of these individuals do you work most closely with? Why?
16. Have you ever received any training or resources from MHO staff (e.g., doctors, midwives, nurses, or nutritionists)? If so, what was the topic of the training? When did it take place?
17. Are you familiar with the municipality nutrition action plan (MNAP) for your area? If so, please tell me what you know about it.
a. Are you familiar with the barangay nutrition action plan (BNAPs) for your area? If so, please tell me what you know about it.
18. To your knowledge, does your municipality have nutrition champions? If so, please explain their role and, if relevant, how you work with them.
19. Do you have any recommendations for improving coordination and collaboration on health and nutrition in this barangay or municipality? If so, what are they?
Conclusion
That brings me to the end of my questions.
20. Is there anything else you would like to share with me today?
Thank you for speaking with me today!

Key Informant Interview with Child Development Workers
Objectives
• Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
• Examine consideration of gender equality, equity and inclusion in strategy and implementation.
• Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.
Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role in providing ECCD services.
1. Are you familiar with the Philippines Multisectoral Nutrition Program (PMNP)?
2. Over the past year, have any aspects of your job become easier or more difficult? If yes, please explain.
3. Have you received any training, support, or resources in the past year?
a. Has this affected your work? If yes, how so?
4. Do you still face any challenges in fulfilling your job responsibilities? If so, what are they?

Program Implementation and Behavior Change

5. Have any new services or activities been introduced within the past year? For example, this could include early learning and stimulation, parenting or childcare education, hygiene and sanitation education, complementary feeding sessions, or cooking demonstrations.

If yes, what are they?

a. Have you been involved in supporting any of these activities?

b. Which activities do you think have been most helpful for families of young children? Why?

6. Which services or activities are most used or appreciated by parents/caregivers?

a. Are there services that are not used as much? Why do you think that is?

b. What services are the most important for supporting child development?

7. What challenges still persist for parents/caregivers in supporting the development of young children?

a. Have these challenges changed since the program began?

Community Needs and Changes

8. Have you noticed any changes in the needs of families with young children over the past year?

9. Have you seen any improvements in how families care for or support their children?

10. Do you think families have more information now about child development, health, or nutrition than before? Why or why not?

Local Alignment and Systems Integration

For questions 11 and 12 - only ask if the respondent is familiar with the PMNP programme

11. Are the data systems or tracking mechanisms introduced under PMNP compatible with your facility's current systems?

a. Have you faced any issues in reporting, monitoring, or data use?

12. Are you familiar with the "ECCD checklist"? If so, what are your experiences with the checklist?

a. What other monitoring tools do you use to record data?

13. Do you feel you now have more or better resources to support young children's development? If not, what are you still lacking?

14. Have there been changes in how you collaborate with volunteers or community-based workers?

ECCD Services and Provider Capacity

15. Have there been any changes in the services offered at this facility over the past year?

a. Which services are now more commonly used or appreciated by caregivers?

b. Are there services that remain underused? Why do you think that is?
16. Are there groups of caregivers who still do not access your services? If so, who are they and why might they not participate?
a. If yes, who are they, and what are some of the reasons they might not be participating (e.g., distance, lack of information, cultural beliefs)?
17. Over the past year, has there been any change in staffing levels or workload at your center?
a. Do you now have more, fewer, or the same level of resources (time, materials, training) to fulfil your responsibilities—especially in areas like health and nutrition?
b. What additional resources would help you do your job better now?
18. Have there been new partnerships or coordination mechanisms in the past year with DOH, DSWD, or other government agencies? If yes, how well are they working?

Conclusion
That brings me to the end of my questions.
19. Overall, what do you think has improved the most in your work or the services for children over the past year?
20. Is there anything else you would like to share?
Thank you for speaking with me today!
Key Informant Interview with Community Leaders (Barangay Captains)
Objectives:
- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.
1. Can you tell me about your role in this community?
2. Are you familiar with the Philippines Multisectoral Nutrition Program (PMNP)? If yes:
a. What do you know about the program?
b. Have you been directly involved in the PMNP? Please explain.
PMNP Relevance and Coherence
3. Are you familiar with the different activities under the PMNP?

a. If yes, which activities seem the most relevant and needed for this community? Probe for specific examples of which activities are more/less relevant and why.

4. From your perspective, do you think PMNP activities have complemented (or duplicated) any other programs or interventions in the health or nutrition space? Please explain. Probe for specific programs/interventions.

5. Have there been any synergies with other DSWD programs such as the 4Ps or the Kalahi CIDSS project?

a. Do the three programs (PMNP, 4Ps, Kalahi-CIDSS) seem well coordinated? Please explain.

PMNP Efficiency and Effectiveness

6. From your perspective, have the PMNP activities happened as scheduled so far? Or have there been delays? Please explain.

7. Does your barangay have a nutrition action plan?

a. If so, please briefly explain the priorities outlined in the plan. Why did you choose these?

b. If not, why not?

8. Have there been any barriers to improving the local nutrition plans (MNAPs, BNAPs, or AIPs) in your LGU?

9. What has worked well to support your barangay/municipality in improving these plans?

10. To your knowledge, have there been any fundamental changes to planned PMNP activities? Any deviations from the original plans for the program? Probe for detailed explanation, including what led to the changes/deviations.

11. Now that PMNP activities are well underway, have you observed any challenges reaching vulnerable or marginalized individuals/households with PMNP services?

a. Have there been any best practices in terms of outreach targeting these groups specifically?

12. How would you characterize the coordination and collaboration between the many actors involved in delivering the PMNP? For example, DOH, NPMO/RPMO, DSWD, and the LGUs?

a. Are there any approaches (for example, regular meetings or collaborative platforms) that facilitate coordination?

b. Or anything that impedes coordination between agencies?

13. In terms of the key channels through which PMNP is operating (Performance-Based Grants, trainings, and SBCC) – which channel(s) do you think are most/least effective? Please explain.

14. Do you think the Health Promotion Grants (HPGs) have been an effective mechanism to support localized SBCC activities?

a. What has worked well with the HPGs?

b. What hasn't worked well with the HPGs?

15. Of the many interventions/activities supporting improved maternal/child nutrition, water access, sanitation, hygiene services, etc., do you perceive any specific interventions (or set of interventions) to be the most impactful? Please explain.

16. From your perspective, have you directly observed or heard of any tangible improvements in health service delivery as a result of PMNP? Please explain. Probe for specific examples; mention nurses, nutritionists, and midwives specifically.

17. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of nurses, midwives, and nutritionists to serve this community?

18. Do you think there are still critical capacity gaps for nurses, midwives, or nutritionists? If yes, what are they?

Sustainability

19. Do you know whether there have been any concrete steps taken to ensure the sustainability of PMNP interventions beyond the project period? For example, any changes within your LGU? Please explain.

20. At the community level, do you think there are committed "champions" to take the work forward following the end of the PMNP?

21. What do you see as the main barriers to sustaining PMNP interventions (and their benefits) over time?

Conclusion

That brings me to the end of my questions.

22. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Key Informant Interview with Municipal Nutrition Action Officers (MNAO)

Objectives

- Investigate local nutrition policy and services, including any strengths of the policy and services and any challenges or areas of improvement identified respondents
- Investigate their coordination as it relates to local nutrition policy

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role.

1. Please introduce yourself by telling me your role/title and how long you have been in this role.

a. Do you have any other work positions or responsibilities in this municipality?

2. What are your primary responsibilities in this role?

3. Do you experience any challenges in fulfilling your job responsibilities? If so, what are they?
4. In your view, what are the main challenges to good health and nutrition among pregnant women and young children (age 0-5) in your municipality?
5. To your knowledge, what are some of the main challenges faced by health and nutrition service providers in your municipality?

PMNP Experiences

** In non-PMNP municipalities, ask question 6 and then skip to the next section (nutrition policy)

**In PMNP municipalities, begin with question 7.

6. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP) or accessed their materials? Is your municipality affected by PMNP in any way?

Now, I'd like to ask you some questions about the Philippines Multisectoral Nutrition Program.

7. In your words, what are the goals of the PMNP?
8. I understand you recently attended a training as part of PMNP. What did you enjoy about that training?
9. What, if anything, did you learn during the training?
10. Was there any part of the training that was less useful or relevant to you? If so, which parts?
11. Will you/have you trained other individuals in your municipality based on the training you received? If so, please explain. If not, why not?
12. Are you familiar with the performance-based grants (PBGs) delivered through PMNP? Please tell me what you know about the PBGs. Probe: how the grant was spent, respondent's involvement, expectation of future PBGs.
13. Do you have any suggestions to improve the training, PBGs, communications, or other aspects of PMNP?

Local Nutrition Policy

Next, I have some questions about the local institutions and policies related to health and nutrition.

14. What are some of the nutrition related policies in your municipality?
15. In your words, what is the purpose of the local nutrition committee (LNC)?
16. Please tell me how your LNC typically functions, including how often you meet and who is involved.
17. What are some of the strengths of your LNC? How about weaknesses? Probe: project management, budgeting, monitoring, technical design.
18. To your knowledge, does your municipality have nutrition champions? If so, please explain their role and, if relevant, how you work with them.

Next, I have some questions about the local nutrition action plan (LNAP) in your municipality. (If the participant says their community doesn't have an LNAP, please inquire why this is the case.)

19. Does your municipality have an LNAP? If so, when was it developed and most recently updated? If not, why not?

(Note: if there is no LNAP, skip to question 29)

20. What are the key health and nutrition goals outlined in the LNAP?

21. Which activities or interventions will help your municipality reach these LNAP goals?

22. Is your municipality on track to meet the goals outlined in the LNAP? Why or why not?

23. How does the LNC monitor progress toward the LNAP goals? Please describe which monitoring tools/systems you use and how often you check progress.

24. Does the LNAP consider how to support the health and nutrition of vulnerable populations such as geographically isolated areas (GIDA), 4Ps recipients, and indigenous peoples? Why or why not?

25. Is the LNAP costed, meaning each activity outlined has a cost associated with it? If not, why not? If so, please explain how the costs were determined.

a. Does your municipality have sufficient resources to finance the LNAP fully? Why or why not?

26. What are the strengths and weaknesses of your municipality's LNAP?

27. Does the LNAP include a staffing or training plan for health staff in your municipality? If so, please tell me about this. If not, why not?

28. Are there any resources or information that would help you to implement the LNAP and monitor its progress? If so, what are they?

29. Are there social behavior change campaigns (SBCC) or information, education, and communication (IEC) activities related to health and nutrition in your municipality?

a. If so, please describe the topic and time frame of the SBCC/IEC activities. How were you involved in the SBC/IEC activities, if at all?

b. If not, why not? Are there any SBC/IEC activities planned for the future?

30. Do the different barangays in this municipality have nutrition action plans? For instance, what percentage of barangays have nutrition action plans?

a. What makes it easy or difficult for barangays to prepare nutrition action plans?

b. Does the LNC help barangays develop nutrition action plans? If so, how? If not, why not?

Conclusion

That brings me to the end of my questions.

31. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Key Informant Interview with Municipal Planning and Development Officer (MPDO)
Objectives
- Investigate local nutrition policy and services, including any strengths of the policy and services and any challenges or areas of improvement identified respondents
- Investigate their coordination as it relates to local nutrition policy

Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.
1. Please introduce yourself by telling me your role/title and how long you have been in this role.
2. What are your primary responsibilities in this role?
3. Do you experience any challenges in fulfilling your job responsibilities? If so, what are they?
4. Please describe how projects and activities are prioritized for funding at the municipal level.
5. Please explain your experience working to support health and nutrition outcomes in your municipality.
6. To your knowledge, what are the main challenges to good health and nutrition among pregnant women and young children (age 0-5) in your municipality?

PMNP Experiences
** In non-PMNP municipalities, ask question 7 and then skip to the next section (nutrition policy)
**In PMNP municipalities, begin with question 8 and continue onward.
7. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP) or accessed their materials? Is your municipality affected by PMNP in any way?

Now, I'd like to ask you some questions about the Philippines Multisectoral Nutrition Program.
8. Have you heard of the Philippines Multisectoral Nutrition Program (PMNP)? If so, what have you heard about it?
a. Have you been informed about PMNP activities? Please describe.
b. What is your opinion on the activities you learned about?
(Ano ang iyong opinyon sa mga aktibidad na inyong nalaman?)
c. Please describe how PMNP is situated in the overall municipal development plan. For instance, is it a separate entity, integrated, treated by activity etc.?

9. Are you familiar with the performance-based grants (PBGs) delivered through PMNP? Please tell me what you know about the PBGs. Probe: how the grant was spent, respondent's involvement, expectation of future PBGs.
10. Do you have any suggestions to improve the training, PBGs, communications, or other aspects of PMNP?

Local Nutrition Policy

Next, I have some questions about the local institutions and policies related to health and nutrition.

11. Do you have a role on the local nutrition committee (LNC)? If so:
a. Please explain your role.
b. Please tell me how your LNC typically functions, including how often you meet and who is involved.
12. Are you familiar with the local nutrition action plan (LNAP) for your municipality? If so:
a. Please tell me what you know about it (key goals, key activities).
b. What role does the MPDO have regarding the LNAP?
c. Is your municipality on track to meet the goals outlined in the LNAP? Why or why not?
13. In your opinion, do members of the LNC in your municipality have enough skills and knowledge related to the following:
a. Health and nutrition?
b. Program/project management?
c. Budget tagging and financial management?
d. Monitoring and data management?
14. Do you have any recommendations for improving the skills and knowledge of LNC members?
15. Are there social behavior change campaigns (SBCC) or information, education, and communication (IEC) activities related to health and nutrition in your municipality?
a. If so, please describe the topic and time frame of the SBCC/IEC activities. How were you involved in the SBCC/IEC activities, if at all?
b. If not, why not? Are there any SBCC/IEC activities planned for the future?
16. Do you coordinate with any of the following people in your work?
a. Municipal Nutrition Action Officer (MNAO)
b. MHO staff (nurses, midwives, nutritionists)
c. Barangay Nutrition Scholars (BNS)
d. Barangay health workers (BHW)
e. Municipal mayor or barangay captains
f. Sanitation inspectors
g. Disaster risk management staff
h. Day care workers/child development workers

i. 4Ps Municipal Link or parent leaders
j. Indigenous Peoples' Mandatory Representative (IPMR)
For each: please briefly explain how you work with them.
17. Do you have any recommendations for improving coordination and collaboration on health and nutrition in this municipality? If so, what are they?
Conclusion
That brings me to the end of my questions.
18. Is there anything else you would like to share with me today?
Thank you for speaking with me today!

Key Informant Interview with Municipal level DSWD staff (4Ps municipal link and Kalahi CIDSS staff)
Objectives:
- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.

Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.
1. How has MSWD been involved in the Philippines Multisectoral Nutrition Program (PMNP) in your municipality so far?
2. What are your primary responsibilities in your role?
3. Are you also involved in 4Ps and/or the Kalahi-CIDSS program? Please explain your role.
PMNP Relevance and Coherence
4. Now that we are midway through the implementation of the PMNP, from your perspective, how would you assess the overall relevance of activities implemented thus far? Probe for specific examples of which activities are more/less relevant and why.

5. From your perspective, do you think PMNP activities have complemented (or duplicated) any other programs or interventions in the health or nutrition space? Please explain. Probe for specific programs/interventions.
6. Have there been any synergies with other MSWD programs such as the 4Ps or the Kalahi CIDSS project?
a. Has PMNP taken advantage of any existing mechanisms from 4Ps/Kalahi-CIDSS?
b. How could the PMNP better coordinate with or leverage 4Ps or Kalahi-CIDSS resources?
PMNP Efficiency and Effectiveness

7. I understand there have been some delays in rolling out various PMNP activities. Can you talk a little about what was behind those delays? Do you think any of them could have been avoided?
8. What do you see as the key barriers or bottlenecks to making key program decisions or rolling out PMNP activities?
9. Have there been any barriers to local nutrition planning (MNAPs, BNAPs, or AIPs)? What has worked well to support LGUs to adopt these plans?
10. To your knowledge, have there been any fundamental changes to planned PMNP activities? Any deviations from the original plans for the program? Probe for detailed explanation, including what led to the changes/deviations.
11. Now that PMNP activities are well underway, have you observed any challenges reaching vulnerable or marginalized individuals/households with PMNP services?
a. Have there been any best practices in terms of outreach targeting these groups specifically (vulnerable or marginalized individuals/households)?
12. How would you characterize the coordination and collaboration between the many actors involved in delivering the PMNP? For example, DOH, NPMO/RPMO, DSWD, and the LGUs?
a. Are there any approaches (for example, regular meetings or collaborative platforms) that facilitate coordination?
b. Or anything that impedes coordination between agencies?
13. Are you familiar with the performance-based grants (PBGs) under the PMNP? If yes:
a. Do you have a sense of whether those have been going according to plan or not?
b. Do you think the PBGs have been successful in incentivizing good "performance"? Please explain.
14. In terms of the key channels through which PMNP is operating (Performance-Based Grants, trainings, and SBCC) – which channel(s) do you think are most/least effective? Please explain.

15. Of the many interventions/activities supporting improved maternal/child nutrition, water access, sanitation, hygiene services, etc., do you perceive any specific interventions (or set of interventions) to be the most impactful? Please explain.
16. From your perspective, have you directly observed or heard of any tangible improvements in hygiene/sanitation/health at the household level?
a. What about changes at the community level? Please explain. Probe for specific examples.
17. Have there been any changes or improvements at ECCD centers? Any improvements in the availability of supplies or linkages to other services?

18. In thinking about future capacity building trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.
19. Do you have a sense of which PMNP activities are most cost-efficient? Please explain.
a. What about those that are least efficient? Please explain.

Sustainability

20. Have any concrete steps been taken to ensure the sustainability of PMNP interventions beyond the project period? For example, any changes within DOH/NPMO/RPMO/DSWD or the LGUs? Please explain.
21. Has your [office] specifically considered the sustainability of its efforts under the PMNP? If yes, how so?
22. At the municipal and barangay levels, do you think there are committed "champions" to take the work forward following the end of the PMNP? What is their role and how do you engage with him/her?
23. What do you see as the main barriers to sustaining PMNP interventions over time?

Conclusion

That brings me to the end of my questions.
24. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Key Informant Interview with National Program Management Office (NPMO) and Regional Program Management Office (RPMO)

Objective: Investigate the design and delivery of nutrition governance and capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators.

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role.
1. What are your primary responsibilities in this role?

Design and Delivery of Capacity Building Training

2. Were you involved in the design of the capacity-building trainings for nurses, midwives, and/or nutritionists?
a. Were you involved in developing the training content? If yes, please explain how the content was determined.
b. Were DOH and/or UNICEF SBC capacity-building materials leveraged for these trainings? Please explain.
c. In just one sentence, how would you describe the overall objective(s) of the trainings? Probe for specific core competencies the trainings were meant to enhance.

3. What about the nutrition governance trainings, were you involved in those?
a. How was the content developed?
b. Do you think the content was relevant / highlighted the most important nutrition governance capacity gaps?
4. Were you involved in scheduling the trainings?
a. If so, did you encounter any difficulty in scheduling the training?
b. How about in the selection of participants, did you have a word as to who or who may not participate in the training? Please explain.
5. Were you involved in delivering or observing any trainings? If yes, please describe.
6. I understand the trainings used a cascade approach, where master trainers were identified and trained at the national/regional level and then deployed to target municipalities.
a. How were the master trainers identified?
b. Do you think the approach was effective to secure highly skilled master trainers?
7. Can you briefly describe how the trainings were delivered, first to the master trainers and then rolled out to the different groups? Probe for location, duration, pedagogical approach.
a. Nurses
b. Midwives
c. Nutritionists
8. To your knowledge, did the trainings in the target municipalities include opportunities for trainees to apply their skills in a practical setting? Please explain. Probe for differences across training groups.
9. Do you think the length of time for each master training/training of trainers was sufficient? Why or why not? Probe for differences across training groups.
10. Were there any obstacles to delivering the trainings? For instance, in terms of resources available or attendance/participation? Probe for differences across training groups.
11. Did some of the trainings run more smoothly than others? Please explain.
a. Why do you think this was the case?
12. From your perspective, were there any critical gaps in the content covered during any of the trainings? Please describe.
Post-Training Monitoring and Reporting
13. Following the training of master trainers and the municipal-level trainings, was there a post-training feedback survey conducted? Or was there any other way of getting feedback from participants on the perceived effectiveness of the trainings?

14. Did the master trainers do any follow-ups, observations, or additional technical assistance following the municipal-level trainings?
a. If not the master trainers, did any other agency/individual follow up with participants after the training or provide technical assistance?
b. Do trainees have a way to reach out to the master trainers or to someone else if they have questions or concerns?
15. From your perspective, have you directly observed or heard of any tangible improvements in service delivery since the municipal-level trainings? Please explain. Probe for specific examples.
a. Do you think these improvements will be sustained over time? Why or why not?
16. Are there any plans for additional trainings or refresher trainings at either the national/regional or municipal level? Please explain.
17. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of nurses, midwives, and nutritionists to put what they learned during the trainings into practice?
a. Is there anything that could undercut the effectiveness of the training?
18. Do you think there are still critical SBC-related capacity gaps for nurses, midwives, or nutritionists? If yes, what are they?

19. In thinking about future capacity building trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.
PMNP Coordination and Delivery
20. Have there been any changes or updates made to the project operations manual (POM)? Please explain.
21. Now that the PMNP is operational, do you think it is well aligned to the First 1,000 Days Law, PPAN, and other relevant policies? Please explain.
22. Do you have any other observations about the implementation of the PMNP so far?
a. What are things that you perceive are working well?
b. How about those that are not working well?
Conclusion
Konklusyon
That brings me to the end of my questions.
23. Is there anything else you would like to share with me today?
Thank you for speaking with me today!

Key Informant Interview with Provincial Health Office (PHO) representatives
Objectives

- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role.

1. Could you briefly describe your current role?
2. How long have you held this position?
3. How have you been involved in the Philippines Multisectoral Nutrition Program (PMNP) so far?

Local Needs and Community-Level Changes

4. To your knowledge, how does PMNP try to support the health and nutrition of pregnant women and young children (age 0 to 5 years) in this province?
5. Are you familiar with PMNP's performance-based grants? If yes, how have municipalities in your area used performance-based grants?
   a. What is your understanding of how they work?
   b. How have municipalities in your area used performance-based grants?

Note for interviewer: Refer to the provided list of municipalities when asking this question

6. With the support of PMNP, have you noticed any changes in how pregnant women and caregivers of young children access nutrition or health services in the municipality where you work?
   a. If so, what changes have you observed?
   b. How, if at all, have community service providers contributed to or been affected by these changes?
7. Has your office tried any social behavior change (SBC) or Information, education and communication (IEC) approaches with the support of PMNP?

For example: Multimedia materials (radio spots, posters, social media content), facilitation packages (demo-guides, flipcharts) and locally adapted communication aids (illustrated job aids, picture cards).

8. Do you think that PMNP reaches the most vulnerable and marginalized people in your province (e.g., GIDA areas, persons with disabilities, 4Ps households, and indigenous peoples)? Why or why not?
   a. How, if at all, has your office tried to ensure that PMNP reaches vulnerable groups?

PMNP Planning and Involvement

9. Has your office received clear communication or guidance from PMNP implementers about your roles, planned activities, and timelines? Please describe the type and frequency of communication received.
a. Are these activities integrated into the systems and policies of your office?
b. Have there been any delays affecting these activities? If so, what happened?
10. What have been the most noticeable changes in your office's work since PMNP began? Probe: monitoring, coordination, or new processes or demands.
11. Have there been any changes in how your office plans or monitors health and nutrition outcomes since PMNP implementation began?
12. What do you think are the main factors supporting or hindering PMNP implementation in your area?
13. In your opinion, is the current PMNP funding sufficient to achieve project objectives? Why or why not?

Provincial Capacity and Resources

14. Do you have enough staff to implement PMNP activities effectively? Why or why not?
15. Have you received sufficient resources (training, tools, technical support, etc.) to deliver on your PMNP responsibilities?
a. If not, what additional support would help your office implement PMNP more effectively?
b. If you encounter challenges with PMNP activities, who can you turn to for help (within or outside your agency)?

Coordination with other Stakeholders

16. Which DOH offices or national agencies do you coordinate with for PMNP implementation?
17. Which non-health actors or local agencies (e.g., DSWD, NNC, LGUs such as the Mayor's office, MSWDO, PHO, MHO) do you coordinate with for PMNP?
18. In your view, has PMNP improved coordination across stakeholders?
a. If yes, how?
b. If not, what challenges remain?
19. Have you encountered any challenges or gaps in coordinating with municipalities or barangays to implement PMNP activities?
20. Overall, what has been the most important contribution of PMNP in your area so far?

Conclusion

That brings me to the end of my questions.
21. Is there anything else you would like to share?
Thank you for speaking with me today!

Key Informant Interview with UNICEF Nutrition Section

(National-level respondents x 2)
Objectives:
- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.
1. How have you been involved in the Philippines Multisectoral Nutrition Program (PMNP) so far?
2. What are your primary responsibilities in this role?

PMNP Relevance and Coherence
3. I understand there was formative research done to inform the SBC strategy, materials, and approach. Has this research influenced the design of SBC activities?
a. Did the formative research inform the PMNP's approach to reaching vulnerable or marginalized groups? If yes, how so?
4. Were you involved in developing the content for the capacity building trainings for nurses, midwives, and nutritionists? If yes:
a. Can you talk a little about how that content was developed?
b. Do you think the content was relevant to each type of service provider?
5. What about the nutrition governance training, do you know how that training content was developed?
a. Do you think it was relevant?
6. Now that we are midway through the implementation of the PMNP, from your perspective, how would you assess the overall relevance of the SBC-related activities implemented thus far? Probe for specific examples of which activities are more/less relevant and why.
a. Are the PMNP's objectives, strategies, and activities relevant to the priorities of the targeted LGUs?
7. From the lens of UNICEF's support to DOH and DSWD, what do you think are the most useful aspects of your support and why?
8. From your perspective, do you think PMNP activities have complemented (or duplicated) any other programs or interventions in the health or nutrition space? Please explain. Probe for specific programs/interventions.
a. Could the PMNP be easily replicated in additional LGUs? Why or why not?

PMNP Efficiency

9. I understand there have been some delays in rolling out various PMNP activities.
a. Can you talk a little about what was behind those delays?
b. Do you think any of them could have been avoided?
10. Has UNICEF been involved in procurement for the PMNP? Please explain.
a. How would you assess the efficiency of the procurement process?
11. What do you see as the key barriers or bottlenecks to making key program decisions or rolling out PMNP activities?
12. To your knowledge, have there been any fundamental changes to planned PMNP activities? Any deviations from the original plans for the program? Probe for detailed explanation, including what led to the changes/deviations.
13. How would you characterize the coordination and collaboration between the many actors involved in delivering the PMNP? For example, DOH, NPMO/RPMO, DSWD, and those at the provincial/municipal levels?
a. Are there any approaches (for example, regular meetings or collaborative platforms) that facilitate coordination?
b. Or anything that impedes coordination between agencies?

PMNP Effectiveness

14. In terms of the key channels through which PMNP is operating (Performance-Based Grants, trainings, and SBCC):
a. Which channel(s) do you think are most effective? Please explain.
b. What about the lease effective? Please explain.
15. Do you think the Health Promotion Grants (HPGs) have been an effective mechanism to support localized SBCC activities?
a. What has worked well with the HPGs?
b. What hasn't worked well?
16. Of the many interventions/activities supporting improved maternal/child nutrition, water access, sanitation, hygiene services, etc., do you perceive any specific interventions (or set of interventions) to be the most impactful? Please explain.

17. From your perspective, have you directly observed or heard of any tangible improvements in service delivery since the municipal-level capacity building trainings for service providers? Please explain. Probe for specific examples.
18. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of nurses, midwives, and nutritionists to put what they learned during the trainings into practice?
19. Do you think there are still critical SBC-related capacity gaps for nurses, midwives, or nutritionists? If yes, what are they?

20. In thinking about future capacity building trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.
21. Are you familiar with the performance-based grants (PBGs) under the PMNP? If so:
a. Do you have a sense of whether those have been going according to plan or not?
b. Do you think the PBGs have been successful in incentivizing good "performance"? Please explain.
22. Do you have a sense of which PMNP activities are most cost-efficient? Please explain.
a. What about the least cost-efficient?
Sustainability
23. From your perspective, are PMNP activities likely to continue without external support at the LGU level? Why or why not?
24. Have any concrete steps been taken to ensure the sustainability of PMNP interventions beyond the project period? For example, any changes (in terms of coordination, funding, manpower, knowledge sharing, monitoring, etc.) within DOH, DSWD or at the provincial/municipal level? Please explain.
25. Has UNICEF taken concrete steps to ensure the sustainability of its efforts under the PMNP? If yes, how so?
26. At the municipal and barangay levels, do you think there are committed "champions" to take the work forward following the end of the PMNP? If so, what are their roles and how do you work/coordinate with him or her?
27. What do you see as the main barriers to sustaining PMNP interventions over time?
Conclusion
That brings me to the end of my questions.
28. Is there anything else you would like to share with me today?
Thank you for speaking with me today!

Key Informant Interview with a representative from the University of the Philippines Los Baños Foundation Inc. (UPLBFI) and the Nutrition Governance Training Implementer
Objectives
• Investigate capacity building services provided as part of the PMNP, including design considerations, implementation, barriers faced, and perceived impact
Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.

1. Please introduce yourself by telling me your role/title and how long you have been in this role.
2. What are your primary responsibilities in this role?
3. How have you been involved in the Philippines Multisectoral Nutrition Program (PMNP) so far?

Design and Delivery of Capacity Building Training

For UPLBFI: Next, I have some questions about the design of the trainings you deliver as part of PMNP. Please note that our evaluation does not cover the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), so I am interested to hear about your work outside of BARMM.

For the TBD Governance Contractor: Next, I have some questions about the design of the "Capacity building of Local Government Units on Nutrition Leadership and Governance," work of [organization name. Please note that our evaluation does not cover the Bangsamoro Autonomous Region in Muslim Mindanao (BARMM), so I am interested to hear about your work outside of BARMM.

4. In your words, what are the objectives of the activities implemented by your organization?
5. What steps are you taking to achieve these objectives? (What are the core activities?)
6. Please tell me about some of the central factors that you considered when designing these activities and training. Probe: service provider capacity, contextual factors, resource constraints.
7. Did you consult or coordinate with other individuals or organizations in designing these activities? If so, who? If not, why not?

a. Were you satisfied with the level of support you received from PMNP, UNICEF, DOH, and other project stakeholders? Why or why not?

8. Are these activities designed to integrate into existing systems, policies, and interventions? Why or why not?
9. What do you see as the biggest risks to meeting the objectives of these capacity building efforts?

I'd now like to ask specifically about the training of frontline workers.

10. I understand the trainings used a cascade approach, where master trainers were identified and trained at the national/regional level and then deployed to PMNP municipalities. Can you briefly describe this cascade approach, including how trainings were rolled out to other service providers? Probe for location, duration, pedagogical approach.

a. How were the master trainers identified?
b. Do you think the approach was effective? Why or why not?

11. Do you think the length of time for the master training was sufficient? Why or why not? Probe for differences across training groups.

12. Were there any obstacles to delivering the trainings? For instance, in terms of resources, duration of the training, and/or attendance and participation? Probe for differences across training groups.
13. Did some of the trainings run more smoothly than others? If so, which ones and why?
14. Please briefly describe the content covered during the master training.
a. Did the training provide resources for serving vulnerable populations such as geographically isolated (GIDA), 4Ps recipients, people with disabilities, and indigenous peoples? Why or why not?
15. From your perspective, were there any critical gaps in the content covered during any of the trainings? What makes you say this?
16. Do you think master trainers were satisfied with the training content? How do you know?
a. If master trainers face a challenge when doing rollout trainings, is there someone they can reach out to for additional support and resources? If so, who?

Post-Training Monitoring and Reporting

Lastly, I have some questions about how you monitor the effects of the capacity building activities.
17. Please briefly describe how you monitor the rollout trainings and the effectiveness of the capacity building activities. Probe: indicators measured, frequency of reporting, monitoring system used.
a. Are these monitoring mechanisms integrated into existing health systems, policies, and interventions? Why or why not?

18. To your knowledge, did the rollout trainings include opportunities for trainees to apply their skills in a practical setting? Please explain. Probe for differences across training groups.
19. From your perspective, have you directly observed or heard of any tangible improvements in service delivery/nutrition governance since the municipal-level trainings? Please explain. Probe for specific examples.
a. Do you think these improvements will be sustained over time? Why or why not?
20. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of healthcare providers/local chief executives (LCEs) to put what they learned during the trainings into practice?
21. Is there anything that could undercut the effectiveness of the training in terms of increased capacity at the municipal level? Probe for potential moderators, including lack of resources or support.
22. Are there any plans for additional trainings or refresher trainings at either the national/regional or municipal level? Please explain.

23. Do you think there are still critical capacity gaps for healthcare providers/local chief executives (LCEs)? If yes, what are they?
24. In thinking about future capacity building trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.

Conclusion

That brings me to the end of my questions.

25. Is there anything else you would like to share with me today?

Thank you for speaking with me today!

Key Informant Interview with WASH Representative

Objectives

- Explore relevance, coherence, efficiency, perceived effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.
- Investigate the design and delivery of capacity building trainings (for nurses, midwives, and nutritionists); expected results from trainings; and potential moderators to effects.

Reminder: Read consent script and obtain verbal consent before proceeding.

Introduction

To begin, I have some general questions about your role at this health station.

1. Are you familiar with the Philippines Multisectoral Nutrition Program (PMNP)?
2. Over the past year, have any aspects of your job become easier or more difficult? If yes, please explain.
3. Have you received any training, support, or resources in the past year? Provided by area coordinating teams, regional project management offices, relevant LGU department and personnel or a third party training provider.
   a. Has this affected your work? If yes, how so?
4. Do you still face any challenges in fulfilling your job responsibilities? If so, what are they?

WASH Context

5. In the past year, have there been any noticeable changes (positive or negative) in how caregivers support the health and hygiene of children under five (5) years old?
   a. What challenges remain, if any?
6. Have there been changes in access to clean water or sanitation facilities?
   a. What improvements have you seen, if any?
7. What are the most common illnesses affecting young children in the community?

a. Have rates of these illnesses changed during the past year?
b. What do you think contributed to this change (or lack thereof)?
8. Have you seen improvements in how WASH-related information is shared with caregivers?
a. What methods or approaches have been most effective in sharing this information?
b. Are there still areas where caregivers seem to lack knowledge or need support?

WASH Services and Capacity

9. Have any specific WASH-related services or activities been introduced, improved, or expanded in the past year? If yes, please explain.
10. Have you received any guidance, training, or support in the past year that helped improve how WASH activities are planned, implemented, or maintained in your area?
a. If so, what kind of support was most helpful?
b. What gaps still exist?
11. Are more families accessing WASH services?
a. Who still remains hard to reach and why?
12. Have there been changes over the year in how the municipality identifies and supports vulnerable or marginalized groups (e.g., remote households, 4Ps participants, persons with disabilities) through WASH services?
13. Over the past year, have you received additional resources (materials, time, training, tools) to support WASH services?If you did receive additional resources, ere these resources adequate?
a. If not adequate, what is still needed?

Systems, Data, and Coordination: Changes Due to PMNP

13. Have there been any changes in how you collect, store, or report WASH service data over the past year?
a. Have these changes improved your ability to serve the community?
14. Have you coordinated more closely with other government units or sectors over the past year (e.g. DSWD, ECCD)?
a. How has that collaboration changed since the program began?
15. Have you been involved in any community-driven projects like Kalahi-CIDSS?
a. If yes, what WASH-related activities were supported through those projects?
b. Do you think the project activities have helped you deliver WASH services? If so, how? If not, why not?

Conclusion

That brings me to the end of my questions.

16. Overall, what do you think has improved the most in terms of WASH services or your ability to support household hygiene and health for over the past year?

17. What challenges still need to be addressed?
18. Is there anything else you would like to share about WASH in this area?
Thank you for speaking with me today!
(Salamat po sa pakikipagusap sa akin ngayon!)

Key Informant Interview with World Bank
Objectives:
- From the perspective of the funder, explore perceived relevance, coherence, efficiency, effectiveness, and potential sustainability of PMNP activities, including implementation fidelity and delivery/coordination challenges and successes.
- Examine consideration of gender equality, equity and inclusion in strategy and implementation.

Reminder: Read consent script and obtain verbal consent before proceeding.
Introduction
To begin, I have some general questions about your role.
1. How have you been involved in the Philippines Multisectoral Nutrition Program (PMNP) so far?
2. What are your primary responsibilities in this role?
PMNP Relevance and Coherence
3. I understand there was formative research done by UNICEF to inform the SBC strategy, materials, and approach.
a. Has this research influenced the design of SBC activities? If so, how?
b. Did the formative research inform the PMNP's approach to reaching vulnerable or marginalized groups? If yes, how so?
4. In thinking about the capacity-building trainings for service providers (nurses, midwives, and nutritionists), are you familiar with how the training content was developed?
a. If so, do you think the content/delivery was relevant to each type of service provider?
5. Now that we are midway through the implementation of the PMNP, from your perspective, how would you assess the overall relevance of the SBC-related activities implemented thus far? Probe for specific examples of which activities are more/less relevant and why.
6. From your perspective, do you think PMNP activities have complemented (or duplicated) any other programs or interventions in the health or nutrition space? Please explain. Probe for specific programs/interventions.
PMNP Efficiency and Effectiveness
7. I understand there have been some delays in rolling out various PMNP activities.
a. Can you talk a little about what was behind those delays?
b. Do you think any of them could have been avoided?

8. From your perspective, what do you see as the key barriers or bottlenecks to making key program decisions or rolling out PMNP activities?

9. To your knowledge, have there been any fundamental changes to planned PMNP activities? Any deviations from the original plans for the program? Probe for detailed explanation, including what led to the changes/deviations.
10. How would you characterize the coordination and collaboration between the many actors involved in delivering the PMNP? For example, DOH, NPMO/RPMO, DSWD, and the LGUs?
a. Are there any approaches (for example, regular meetings or collaborative platforms) that facilitate coordination?
b. Or anything that impedes coordination between agencies?
11. Do you feel like the World Bank receives timely information and updates about PMNP progress? Please explain.
12. In terms of the key channels through which PMNP is operating (Performance-Based Grants, trainings, and SBCC):
a. Which channel(s) do you think are most effective? Please explain.
b. How about the least effective channel/s? Please explain.
13. Do you think the Health Promotion Grants (HPGs) have been an effective mechanism to support localized SBCC activities?
a. What has worked well with the HPGs?
b. What hasn't worked well with the HPGs?
14. Of the many interventions/activities supporting improved maternal/child nutrition, water access, sanitation, hygiene services, etc., do you perceive any specific interventions (or set of interventions) to be the most impactful? Please explain.
15. From your perspective, have you directly observed or heard of any tangible improvements in service delivery since the municipal-level capacity building trainings for service providers? Please explain. Probe for specific examples.
16. From your perspective, what challenges have you observed (or do you foresee) in terms of the ability of nurses, midwives, and nutritionists to put what they learned during the trainings into practice?
17. Do you think there are still critical SBC-related capacity gaps for nurses, midwives, or nutritionists? If yes, what are they?
18. In thinking about future capacity-building trainings, is there anything you would suggest doing differently moving forward? Either in terms of the cascade approach or the design/delivery of content at the municipal level? Please explain.
19. Are you familiar with the performance-based grants (PBGs) under the PMNP? If yes:

a. Do you have a sense of whether those have been going according to plan or not?
b. Do you think the PBGs have been successful in incentivizing good "performance"? Please explain.
20. Do you have a sense of which PMNP activities are most cost-efficient? Please explain.
a. What about the least cost-efficient activities?

Sustainability

21. Have any concrete steps been taken to ensure the sustainability of PMNP interventions beyond the project period? For example, any changes within DOH/NPMO/RPMO/DSWD or the LGUs? Please explain.
22. At the municipal and barangay levels, do you think there are committed "champions" to take the work forward following the end of the PMNP?
23. What do you see as the main barriers to sustaining PMNP interventions over time?

Conclusion

That brings me to the end of my questions.
24. Is there anything else you would like to share with me today?
Thank you for speaking with me today!

Annex G. Recommendations for Expanding and Centralizing the Existing Project Monitoring Framework

Below are additional, more detailed recommendations to expand, improve, and centralize the existing project monitoring framework.

1. Include *resource utilization indicators* to track the ability of municipalities to execute funds and assess how these are being used.

Illustrative indicators:

- Utilization of PBG/MGA/HPG funding (% utilized)
- Categories of fund utilization (% utilized by category):
    - For PBGs: track expenditures by category of eligible services/items.
    - For MGA: track expenditures by type of subproject.
    - For HPG: track expenditure by category of eligible SBC approaches.

2. Include more *process indicators*, particularly for Component 2.

Illustrative indicators:

- Adequate subproject staffing (% of subproject with adequate number of operational staff)
- Community-based subproject management (% of subprojects with maintenance and operations committee)

3. Include more *utilization indicators*, particularly for Component 2.

Illustrative indicators:

- Attendance to ECCD centres. (% of children under five years of age attending ECCD centre at least 3 days a week)
- IP's Attendance to ECCD centres. (% of IP children under five years of age attending ECCD centre at least 3 days a week)
- Subproject operability (% of subprojects currently operational). For example, for ECCD centres, % of ECCD centres operating at least 3 days a week.

Centralize monitoring information from all project components and create a dashboard for real-time tracking.