



FINAL EVALUATION

Cambodia

Thematic window
Children, Food Security and Nutrition

Programme Title:

Joint Programme for Children, Food Security
and Nutrition in Cambodia

Prologue

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

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

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

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

MDG-F Secretariat

The analysis and recommendations of this evaluation are those of the evaluator and do not necessarily reflect the views of the Joint Programme or MDG-F Secretariat.



Joint Programme
For Children, Food Security and Nutrition
in Cambodia,

Final Programme Evaluation

EVALUATION REPORT

September 2013

Frank Noij

Acknowledgements

The evaluator would like to express his gratitude to the leadership and staff of all the Ministries, Departments and UN agencies who generously shared their insights, experiences, analysis, documents, and other inputs. These include the Council for Agricultural and Rural Development, the Ministry of Health (MOH), the Ministry of Education, Youth and Sports (MoEYS), the Ministry of Labour and Vocational Training (MoLVT), the Ministry of Agriculture, Forestry and Fisheries (MAFF), and the Ministry of Information as well as United Nations Children's Fund (UNICEF), World Health Organization (WHO), Food and Agricultural Organization (FAO), World Food Programme (WFP), International Labour Organization (ILO) and United Nations Educational, Scientific and Cultural Organization (UNESCO) in Cambodia and NGO partner agencies including Hellen Keller, Population Services International Cambodia, Magna and RACHA. Thanks also goes to the staff of Departments of Health, Agriculture and Labour in Kampong Speu and Svay Rieng Provinces as well as the staff of Health Centers and garment factories visited and the Village Health Support Group members and household members interviewed. All these contributions were highly appreciated and enriched the evaluation process as well as the present evaluation report.

The viewpoints presented in this report are those of the independent evaluator and do not necessarily represent the position of RGC, UN agencies in Cambodia and partner agencies.

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Acronyms & Abbreviations

AAA.....	Accra Agenda for Action
AECID.....	Spanish Agency for International Development Cooperation
ANC	Ante Natal Care
BFC	Better Factories Cambodia (ILO supported programme)
BCC.....	Behaviour Change Communication
BMI.....	Body Mass Index
CARD	Council for Agriculture and Rural Development
CCWC.....	Commune Committee for Women and Children
CDHS.....	Cambodia Demographic and Health Survey
CMDG	Cambodian Millennium Development Goal
CSB++	Corn Soy Blend Plus
CSES.....	Cambodia Socio-Economic Survey
DOE	Department of Education
EAP	East Asia and the Pacific
ECCD.....	Early Childhood Care and Development
EDI.....	Enterprise Development Institute
FAO.....	Food and Agricultural Organization of the United Nations
FFS.....	Farmer Field School
FSN	Food Security and Nutrition
FSSP	Food Security Support Programme
GDP	Gross Domestic Product
HACT.....	Harmonized Approach to Cash Transfer
HC.....	Health Centre
HIS.....	Health Information System
HRBA	Human Rights-Based Approach
HSP	Health Strategic Plan
IFA	Iron and Folic Acid
ILO.....	International Labour Organisation
JP	Joint Programme
JPTT	Joint Programme Technical Team
KG.....	Kilogram
LDC.....	Least Developed Country
MAFF	Ministry of Agriculture, Forestry and Fisheries
MAM	Moderate Acute Malnutrition
MDG	Millennium Development Goal
MDG-F	Millennium Development Goal Achievement Fund
MIC.....	Middle Income Country
MNP	Multiple Micro-Nutrient Powders

MoEYS	Ministry of Education, Youth and Sports
MOH	Ministry of Health
MoLVT	Ministry of Labour and Vocational Training
MSc.....	Master of Science
MSG.....	Mother Support Group
MTE	Mid-Term Evaluation
MUAC	Mid-Upper Arm Circumference
NGO.....	Non-Governmental Organization
NIS.....	National Institute of Statistics
NNS	National Nutrition Strategy
NSC.....	National Steering Committee
NSFSN	National Strategy on Food Security and Nutrition
OD	Operational District
OECD DAC.....	Organization for Economic Cooperation and Development – Development Assistance Committee
OSH	Occupational Safety and Health
PCC.....	Provincial Coordination Committee
PHD	Provincial Health Department
PMC.....	Programme Management Committee
PSI	Population Services International
RGC.....	Royal Government of Cambodia
RUTF	Ready to Use Therapeutic Food
SAM.....	Severe Acute Malnutrition
TOC.....	Theory of Change
TOR.....	Terms of Reference
UN	United Nations
UNCT	United Nations Country Team
UNDAF.....	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP.....	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	Children’s Fund of the United Nations
UNRC	UN Resident Coordinator
USD.....	US dollar
VHSG	Village Health Support Group
WCCC.....	Women and Children Consultative Committee (at provincial level)
WFP	World Food Programme
WHO.....	World Health Organization

EXECUTIVE SUMMARY

Introduction

- i. The Joint Programme on Children, Food Security and Nutrition is part of the Children, Food Security and Nutrition window of the Millennium Development Goal – Fund (MDG-F) a global partnership between the Government of Spain and the United Nations Development Programme (UNDP). The Joint Programme aimed to accelerate the achievement of the Cambodian MDGs, in particular CMDG 1: Eradication of extreme hunger and poverty, CMDG 4: Reduction of child mortality and CMDG 5: Improvement of maternal health, and to contribute to national health and nutrition strategies and plans. The programme was implemented from January 2010 to December 2012 with a six month extension till the end of June 2013 to finalize selected activities. The programme responded to the development context in Cambodia. Significant economic development has occurred, with growth rates from 6 to 11 % in the last two decades.¹ However, inequalities have increased and food insecurity and poverty persist amongst vulnerable groups and areas, and maternal mortality rates and levels of stunting and underweight of children till 59 months of age remain high.
- ii. In order to achieve its goals, the programme adopted four intermediate strategic objectives, which were informed by earlier successes of Behaviour Change Communication (BCC) campaigns in combination with support at sub-national level.²
 - Nationwide development and implementation of BCC initiatives for breastfeeding, complementary feeding and iron and folic acid (IFA) supplementation for women during pregnancy and post-partum period;
 - Provide support to an integrated comprehensive package of nutrition and food security interventions, delivered with intensity and high coverage in two selected food insecure provinces in the areas of education, agriculture, food safety and nutrition;
 - Review and strengthening of the implementation of existing nutrition, food security and agricultural policies and support to the development of new nutrition policies;
 - Support to the development of an integrated national food security and nutrition (FSN) monitoring system.
- iii. The present evaluation was implemented after the end of the extension period of the Joint Programme. Its purpose includes mutual accountability amongst RGC and UN agencies and towards the MDG-Fund as well as lesson learning and the generation of substantive evidence-based knowledge on FSN programming in Cambodia. The evaluation objectives included the OECD DAC / UNEG evaluation criteria of relevance, efficiency, effectiveness, impact and sustainability. Geographically the evaluation paid particular attention to Kampong Speu and Svay Rieng, the two provinces in which the sub-national activities of the programme have been implemented.
- iv. The evaluation made use of a mixed methods approach in which qualitative and quantitative means of data gathering were combined and data triangulated. A participatory approach, involving a wide range of stakeholders in the process, allowed for triangulation of data across the various parties concerned. A desk review and on-going secondary data gathering informed the evaluation process. Interviews were conducted with RGC, UN and NGO partners in Phnom Penh as well as at the sub-national level in the two

¹ United Nations Development Assistance Framework 2011-2015, May 2010.

² Joint Programme for Children, Food Security and Nutrition in Cambodia. Joint Programme Document. 2009.

focus provinces. Visits were paid to provincial departments, operational districts, health centres, farmer field schools, garment factories and discussions conducted with programme implementers and beneficiaries. The timing of the evaluation, overlapping with the period of the National Election, made access to RGC officials difficult while for some UN staff the months of implementation coincided with their holiday period. Several of the UN staff members, in particular those specifically recruited for the implementation of the programme, had moved on, though several of these could be tracked and interviewed.

Evaluation Findings

- v. The Joint Programme proved well aligned with the objectives and strategies of the RGC and well in line with the National priorities, including the National Nutrition Programme and the National Strategy for Food Security and Nutrition. Also alignment with the UNDAF was strong, including alignment with selected outcome areas as well as cross cutting issues. The objectives of the programme, moreover, addressed clear needs in the country, with stunting and underweight of children 0-59 months remaining relatively high, at 40 and 28 % respectively.³ Moreover, the two provinces where sub-national activities were focused are amongst the six provinces with high child malnutrition.
- vi. The programme made use of a multi-sector approach which was meant to address multiple issues related to adverse nutritional conditions of children and women in selected areas. While some of the components were piloted, others appeared at a stage that they could be scaled up. In the design it was not made sufficiently clear what these aspects were and how the different elements of the multi-sectoral approach were meant to converge and create synergy at the local level. A clear theory of change as part of the programme document could have helped but the results framework included was not sufficiently developed to play this role.
- vii. The programme, as part of the MDG-F, combined two broad objectives, one concerning accelerated achievement of the CMDGs while the other focused on cooperation across UN agencies and delivering as One UN. The design did include joint governance and management mechanisms across RGC and UN agencies, though no linkages to the wider UN reform process in Cambodia were included, and how the joint programme was meant to enhance this process.
- viii. The programme governance and management arrangements made use of existing governance mechanisms and added means for joint management and implementations across the RGC and UN agencies concerned. While programme steering and management arrangements received high level participation and were truly joint, the more practical implementation arrangements through the Joint Programme Technical Team (JPTT) could have benefitted from more regular RGC participation beyond CARD.
- ix. The programme was a joint initiative, however the responsibility for the delivery of outputs remained with the individual UN and RGC implementing agencies. Though this was possible at the output level, this was not feasible at the outcome level, where objectives were shared across RGC and UN agencies. The lack of sufficient outcome level monitoring meant that the realisation of these shared objectives was not adequately assessed in order to inform the management of the programme and its components at the sub-national level.

³ Kingdom of Cambodia, *National Strategy for Food Security and Nutrition, NSFSN 2014-2018*. Draft, 2013.

- x. For the assessment of the effectiveness of the Joint Programme, the evaluation focused on aspects of contribution as many of the UN agencies were involved in other FSN initiatives in the selected provinces and beyond and so were RGC and other development partners. Most of the activities planned for each of the programme components could be implemented and outputs achieved. In some cases, like the distribution of micro nutrient powders (MNPs), the activity was scaled up and results ended up far above the target. Also the training of OSH workers was above target. Treatment of SAM and MAM remained below target, mainly due to the discontinuation of incentives to Health Centre (HC) staff and Village Health Support Group (VHSG) members. It proved indispensable to make the system work and which were not absorbed by the health SWAP pooled fund, nor by the regular health budget.
- xi. Based on the comparison of outcome level data at baseline and end line studies several positive changes can be observed in the intervention areas. These include improvements in the dietary intake of young children, reduction of the incidence of diarrhoea and increased use of IFA, Vitamin A and practice of deworming. Changes in knowledge, attitudes and practices appear to vary and show less of a consistent pattern of improvement. The data on food security show a decrease in food secure households, which does not seem consistent with the other findings and the economic improvements of households concerned.
- xii. The functioning governance and management systems of the Joint Programme proved important enabling factors to reaching results. The limited convergence of components at the local level proved an important constraining aspect. Though there was coordination in terms of selection of geographical areas across the various programme components, the coverage of each of the components within these areas differed substantially which resulted in lack of synergy at the local level.
- xiii. Impact level indicators show improvements in the prevalence of moderate as well as severe anaemia among children under 5 years of age as well as an increase of non-pregnant women with normal haemoglobin levels. Moreover, the prevalence of both stunting and underweight in children dropped in the intervention areas. Assessment of impact level changes was constrained by data limitations. The baseline and end line surveys did provide useful data. However, since the comparison areas were no real control groups, this limited the analysis based on this comparison. This affected the level of certainty with which one can draw conclusions from the surveys and results are therefore used indicatively.
- xiv. Impact level changes were confirmed through qualitative data from interviews with staff of HCs, VHSG members and programme beneficiaries. In particular the positive effects of SAM and MAM treatment at the HC and community level and the use of MNPs on child health and performance stand out. Apart from Joint Programme implementation, the impact level results have been affected by the overall economic growth in the intervention areas, as implied by an increase in economic status indicators in the and end line survey.
- xv. In terms of sustainability the FSN agenda is increasingly owned by RGC, which has been reflected in the National Seminar on food security and nutrition of mid-2012 and the development of the new National Food Security and Nutrition Strategy (NFSNS). In terms of the Joint Programme the coordination role played by CARD stand out, co-chairing the PMC and participating in monthly JPTT meetings.
- xvi. The Joint Programme was able to develop capacities at the enabling environment, organizational and individual levels. Joint Programme components have mostly worked through Government systems and sub-national service providers as well as through selected NGOs. Moreover, work on home gardening and small livestock rearing was conducted through existing farmer field schools. At the national level the

support to the FSN data analysis team resulted in a functioning mechanism to periodically consolidate and publish FSN data.

- xvii. An organizational capacity developed concerns the support to the establishment of the Food Security and Nutrition data analyses team, which monitors data from participating Line Ministries on FSN and publishes those in a quarterly bulletin. This team remained operating with support from WFP.
- xviii. In financial terms progress has been made to sustain results with the purchase of ready to use therapeutic food (RUTF) and MNPs through the pooled Health SWAP fund (HSP II), which enhances the likeliness of these expenses to be absorbed in future in the RGC health budget. The costs of incentives needed to make the SAM and MAM management at HC and community level operational, however, have not been incorporated into the HSP II fund so far.
- xix. The merger of meetings of the Provincial Coordination Meeting of the Joint Programme with the Women and Children Consultative Committee (WCCC) provided an example of how FSN coordination could continue at the sub-national level. Replication and scaling-up were not systematically addressed across the Joint Programme but were dealt with component-wise. The three year time frame of the Joint Programme proved to provide limitations in terms of the level of systemic sustainability that can be reached in such a period of time.

Conclusions

- xx. The relevance of the programme was relatively high, with a clear alignment with RGC policies and strategies and with the UNDAF and responding to clear needs with high levels of stunting and underweight of children in parts of Cambodia. Quality of the programme design varied and was limited in various respects. The multi-sector programme approach proved relevant in practice, though the rationale and workings of it were not made sufficiently explicit in the programme document. The programme was not built around an explicit and shared theory of change on the whole of FSN in Cambodia. Some programme components were in a pilot stage while other were being scaled up, while management and monitoring requirements were not necessarily sufficiently adapted to these different implementation practices.
- xxi. In terms of efficiency the governance and management mechanisms set up proved to work well. So did the coordination systems at the national and sub-national levels, which benefitted from the placement of coordinators at the national and the provincial level. The main limitation in efficiency concerns the focus on activities and their immediate outputs in programme planning and monitoring. This at the expense of sufficient attention to outcome level changes, limiting assessment of those changes that were shared amongst participating UN and RGC agencies. This severely limited results based management. The spot visits and the baseline and end line surveys did provide important data, but they have not been able to sufficiently cover this gap. The outcome and impact level data from end line survey became available only after Joint Programme completion.
- xxii. The programme has been relatively effective and has been able to reach impact and outcome level changes. In particular the decrease in moderate as well as severe anaemia levels and the decrease of underweight among children under 5 years of age in the intervention provinces stands out. These impact level changes appear to be affected by the outcome level results identified, in particular improvements in dietary intake of small children, improved feeding practices, reduced incidence of diarrhoea, and enhanced use of IFA and Vitamin A supplementation. The changes in knowledge,

attitudes and practices on nutrition and hygiene related issues showed mixed results. Impact and outcome level changes have been affected by the outputs that could be reached by the Joint Programme in each of the programme components.

- xxiii. Sustainability levels vary. Ownership of the FSN agenda has been further enhanced over the programme period. Capacities have been developed with Joint Programme components making use of Government systems for implementation and supporting the development of additional capacities at enabling environment and individual levels. Financial sustainability for FSN has been slightly improved. The nutrition investments in local health plans will be the litmus test for enhanced financial sustainability at the sub-national level in the near future.
- xxiv. Some of the components of the programme could be scaled up, including MNP distribution. Though this did improve the actual outputs, there remain various challenges in the supply chain that needed to be addressed. The treatment of SAM at the HC on the other hand could not yet be scaled up significantly. The use of the WCCC to discuss FSN related issues across the different RGC Departments and agencies is a good example of how existing sub-national mechanisms can be used to enhance coordination of FSN related issues in the future.

Lessons Learned

1. The Joint Programme needs to be seen as a project within a wider programme based approach to FSN in Cambodia;
2. In the allocation of resources across the participating UN agencies the scale required for each of the components needs to be considered in order for programme implementation to result in synergy at the local level;
3. The need for comparable targeting of programme components to enhance convergence at the local level
4. In a Joint Programme that works at both national and sub-national levels, sub-national level representatives need to be included from the start in national level coordination mechanisms;
5. The use of take home rations in the out-patient treatment approach to SAM at the Health Centre is a viable and efficient approach but does require some incentives for the system to operate in practice
6. Risks to the early scaling up the distribution of Micro-Nutrient powders
7. The methodology of baseline and end line studies needs to be adapted to the expected levels of change in a Joint Programme

Recommendations (Abridged, see full recommendations in main report)

For Royal Government of Cambodia at National Level

- a. To lead the process on the development of a Theory of Change as part of the new National FSN Strategy;
- b. Make use of the TOC in the development of a monitoring and evaluation framework and plan for the assessment of medium and longer term changes in food security and nutrition;

At Sub-National Level

- c. Continue and further strengthen the provincial level coordination on FSN among parties concerned;
- d. Make use of the NFSNS and the TOC to develop a provincial level results framework tailored to the context of the province and the priority objectives and actions identified;
- e. Develop a provincial level plan to monitor and evaluate FSN related changes;
- f. Establish a cross sector Food Security and Nutrition Data Analysis Team at provincial level;

- g. Continue trainings to commune/district/provincial level officials on the concepts and practice of FSN.

For UN Agencies

- h. Continue support to FSN making use of a programme based approach, supporting RGC in the development of a TOC adapted to the Cambodian context in line with the NFSNS;
- i. Enhance attention to aspects of the quality of the design of a Joint Programme;
- j. Support the monitoring of FSN indicators at the outcome level in the field of competence of each of the UN agencies and related RGC counterpart agencies at national and sub-national levels;
- k. Enhance support at the demand side of FSN.

For MDG-F

- l. Keep the number of UN agencies participating at a manageable level and avoid adding agencies with relatively few resources allocated to them.
- m. Relate the division of the budget among agencies with the scale of each of the programme components.

1 INTRODUCTION

MDG-Fund

- 1.1 In December 2006, the UNDP and the Government of Spain signed a major partnership agreement for the amount of €528 million with the aim of contributing to progress on the Millennium Development Goals (MDGs) and other development goals through the United Nations (UN) System. In addition, in September 2008 Spain pledged €90 million towards the launch of a thematic window on Childhood and Nutrition, one of the eight windows⁴. The MDG-Fund (MDG-F) supported countries in their development process by funding innovative programmes that have an impact on the population and promise potential for scaling up and replication.
- 1.2 The MDG-F operated through the UN teams in each country, promoting increased coherence and effectiveness in development interventions through collaboration among UN agencies. The Fund used a Joint Programme mode of intervention and supported 128 Joint Programmes in 49 countries. These were part of eight thematic windows that contributed in various ways towards progress on the MDGs.
- 1.3 The Joint Programme for Children, Food Security and Nutrition in Cambodia was part of the MDG-Fund supported initiatives and aimed to accelerate achievement of the Cambodian MDG 1: Eradicate extreme hunger and poverty, CMDG 4: Reduce child mortality, and CMDG 5: Improve Maternal Health.
- 1.4 The programme with an original implementation period from January 2010 to December 2012 was extended till the end of June 2013. The present evaluation is the final evaluation at the end of programme period. The evaluation used the OECD DAC evaluation criteria, endorsed by the UNEG. It aims at assessing the programme, its implementation and results. The evaluation provides recommendations and identifies lessons learned which can be used to inform support to food security and nutrition issues in Cambodia, Southeast Asia and beyond. The evaluation is underpinned by the UNEG Norms and Standards for Evaluation in the UN System.

Background

- 1.5 Cambodia has made significant progress in terms of economic as well as social development in particular during the last decade of the 20th and the first of the 21st century. Economic growth ranged from 6 to 11 per cent per annum in much of this period and overall poverty rates reduced dramatically from 47 per cent in 1993 to 20 per cent in 2011.⁵ Though Cambodia presently is one of the Least Developed Countries (LDC) in Asia, it aspires to become a Lower Middle Income Country (MIC) by 2015 and a Higher MIC by 2030.
- 1.6 Economic development has been uneven and inequalities have increased over time. Notwithstanding the achievements one third of the population was reported to remain living below the poverty line and about 18 % below the food poverty line in 2007.⁶
- 1.7 After 2007 economic development slowed down mainly due to the fall out of the global economic downturn, with a substantial decline in the building sector and the textile industry, two pillars of Cambodia's economic development. The agricultural sector is the only sector of the economy that has continued to grow at an average rate above 5 % per annum. With over 80 % of the population living in rural areas, Cambodia is looking at the agricultural sector as a source for economic growth and sustainable livelihoods. The sector contributed 34.4 per cent to the GDP in 2008, which was an increase of 13 per cent compared to 2007. Agriculture in Cambodia is primarily subsistence oriented with relatively low level of technology and a limited level of commercialization. Dependent primarily

⁴ The other seven windows of the MDG-Fund concern: Gender Equality and Women's Empowerment; Environment and Climate Change; Youth, Employment and Migration; Democratic Economic Governance; Development and the Private Sector; Conflict Prevention and Peacebuilding; and Culture and development.

⁵ Poverty in Cambodia – a New Approach: redefining the poverty line 2013, Ministry of Planning, Royal Government of Cambodia.

⁶ Context details are informed primarily by the *Joint Programme for Children, Food Security and Nutrition in Cambodia*. Joint Programme Document, 2009 and the *United Nations Development Assistance Framework 2011-2015*, May 2010.

on a single annual rain fed crop the sector as well as the country is vulnerable to the effects of climate change.

- 1.8 Cambodia has realized significant progress in terms of social development with a reduction of the infant and under 5 mortality rates from 96 (2000) to 36 (2011) and 124 (2000) to 43 (2011) deaths per 1,000 live births respectively.⁷ This is in particular related to a remarkable increase in exclusive breast feeding which rose from 11 to 74 per cent between 2000 and 2011.⁸
- 1.9 Notwithstanding these developments, important challenges persist. The maternal mortality rate has remained high and with 250 deaths per 100,000 live births remains among the highest in the region.⁹ Nutrition and food security remain pressing issues at sub-national level for a substantial number of vulnerable groups and households. The share of the lowest quintile in national consumption fell from 8.5 % in 1993 to 6.6 % in 2007, far below the projected target of 10.1 %. Latest figures on stunting and underweight show that 39.9 % of children aged 0-59 months are moderately or severely stunted (Height for Age < - 2SD) while 28.3 % of children aged 0-59 months are moderately or severely underweight (Weight for age < -2SD).¹⁰
- 1.10 Cambodian households are exposed to a number of risks and remain vulnerable to a range of shocks including harvest failure due to natural disasters, macro-economic shocks like increasing food and fuel prices, loss of assets due to natural disaster and health risks and shocks due to high morbidity and limited access to quality healthcare services. The lack of safety nets has led to negative coping mechanisms, in particular amongst poor and vulnerable households, including withdrawing children from school (especially girls), increased incidence of child labour, reducing expenditure on health services, changing food patterns to less expensive and often less nutritious food and reduced intake of food (especially for women and older girls).
- 1.11 While gender attitudes are changing, important gender inequalities persist. The high prevalence of gender based violence further compromises health, dignity, security and autonomy of women and girls. Progress has been observed in integration of gender into key policy documents, with the remaining challenge in implantation of these policies and achieving gender related goals.
- 1.12 Governance is at the centre of the Royal Government of Cambodia's (RGC) rectangular strategy. It encompasses transition of administrative and political powers to sub-national level in order to provide a local voice in governance and improve public service delivery. Commune councils were established as the first tier of sub-national administration in 2002. More recently Commune Committees for Women and Children (CCWC) were established and Women's and Children's Consultative Committees proposed in order to manage social issues at the sub-national level. These committees have the potential to increase the participation of local communities in planning, budgeting and delivery of social services. Challenges that have been identified include the development of institutionalized mechanisms for the participation of civil society. Moreover, partaking of youth remains an important issue, with young people constituting more than one third of the total population of Cambodia, which has one of the youngest populations in Southeast Asia.
- 1.13 Various strategies and plans of the RGC address food security and nutrition issues which include the Health Strategic Plan for 2008 – 2015, which prioritizes improving the health of women and children, and the National Nutrition Strategy 2008 – 2015, which entails reduction of maternal and child morbidity and mortality through improving the nutritional status of women and children. The Strategic Framework for Food Security and Nutrition (2008 – 2012) guides design and planning of programmes and projects aimed at improved food security and nutrition.

⁷ Levels & Trends in Child Mortality Report 2012. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. See www.childmortality.org

⁸ CDHS 2010.

⁹ CDHS 2010.

¹⁰ Kingdom of Cambodia, *National Strategy for Food Security and Nutrition, NSFSN 2014-2018*, draft, 2013.

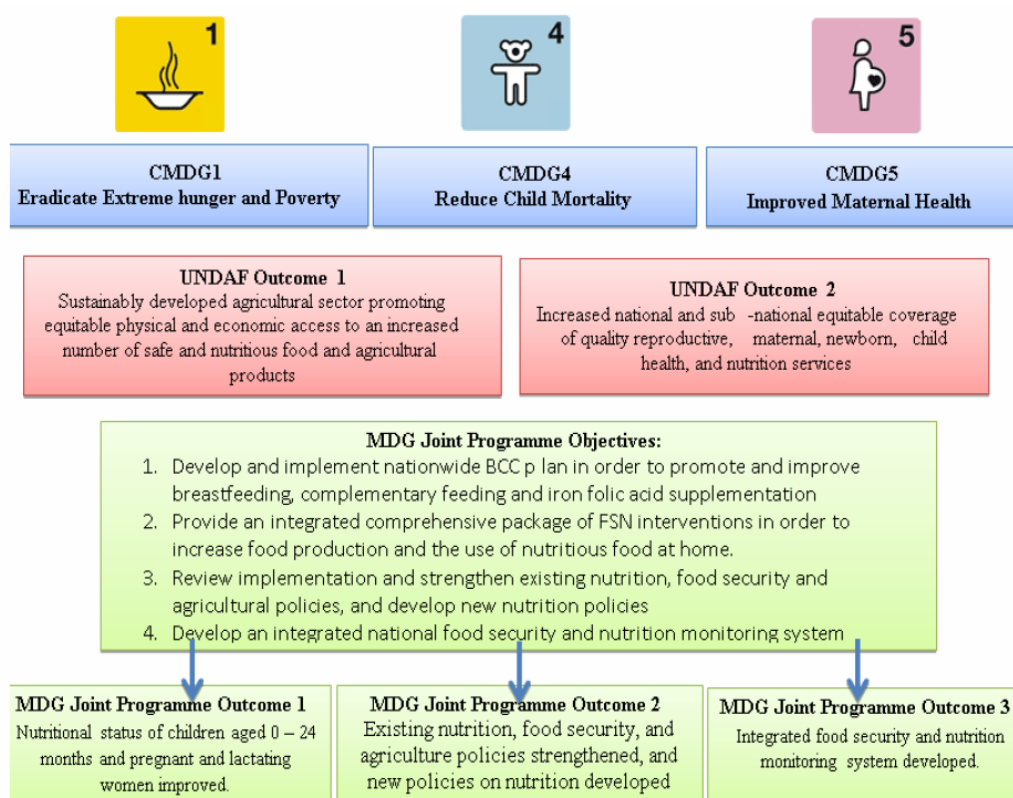
The Joint Programme for Children, Food Security and Nutrition in Cambodia

1.14 The Joint Programme aimed to address the adverse food and nutrition conditions in Cambodia and to improve the nutritional status of children and pregnant and lactating women. The programme was meant to contribute to reaching MDG 1: Eradication of extreme poverty and hunger, MDG 4: Reducing child mortality and MDG 5: Improving maternal health. In order to achieve its goals, the programme adopted four intermediate strategic objectives¹¹.

- Nationwide development and implementation of Behaviour Change Communication (BCC) initiatives for breastfeeding, complementary feeding and iron and folic acid (IFA) supplementation for women during pregnancy and post-partum period;
- Provide support to an integrated comprehensive package of nutrition and food security interventions delivered with intensity and high coverage in two selected food insecure provinces in the areas of education, agriculture, food safety and nutrition;
- Review and strengthening of the implementation of existing nutrition, food security and agricultural policies and support to the development of new nutrition policies;
- Support to the development of an integrated national food security and nutrition (FSN) monitoring system.

1.15 The linkage between the programme strategies and outcomes and the CMDGs and UNDAF outcomes (2011 - 2015) is presented in figure 1 below.

Figure 1: Linkages between the MDG Joint Programme outcomes and objectives and Cambodian MDGs and UNDAF Outcomes



Source: MDG-F Joint Programme Advocacy and Communication Strategy 2010-2012. Phnom Penh, May 2011.

¹¹ Joint Programme for Children, Food Security and Nutrition in Cambodia. Joint Programme Document. 2009.

- 1.16 The design of the programme built on the country successes in the area of behaviour change communication (BCC) for breastfeeding and antenatal care promotion in the period 2004-2008. More recently an Ante Natal Care (ANC) initiative which started in January 2009 showed promising results based on a combined nationwide BCC plan and intensive support to seven selected provinces. These initiatives informed the development of the MDG-F Joint Programme, which made use of a similar combination of national level BCC activities with sub-national level interventions for breastfeeding, complementary feeding and iron foliate supplementation. Moreover, the experience with the Baby Friendly Community Initiative was used, which worked through the establishment of village level Mother Support Groups and which integrated additional aspects of maternal nutrition, early childhood stimulation, hygiene promotion and referral for antenatal care. The project design was, moreover, informed by a range of lessons learned outside of Cambodia.¹²
- 1.17 The programme was governed and managed by joint arrangements between RGC and six UN agencies. Programme implementation was the responsibility of multiple RGC Ministries and Departments including the Council for Agricultural and Rural Development, the Ministry of Health (MOH), the Ministry of Education, Youth and Sports (MoEYS), the Ministry of Labour and Vocational Training (MoLVT), the Ministry of Agriculture, Fishery and Forestry (MAFF), and the Ministry of Information. Programme implementation was done in cooperation with and supported by six participating UN agencies, including United Nations Children's Fund (UNICEF), World Health Organization (WHO), Food and Agricultural Organization (FAO), World Food Programme (WFP), International Labour Organization (ILO) and United Nations Educational, Scientific and Cultural Organization (UNESCO).
- 1.18 The programme design was aligned with the National Strategic Development Plan (NSDP) 2009-2013 and the United Nations Development Assistance Framework (UNDAF) for Cambodia 2006-2010 and 2011-2015) which aim to improve health, nutrition and education for rural poor and vulnerable groups and to improve livelihoods and food security through agriculture and rural development initiatives.
- 1.19 The Joint Programme moreover contributed to reaching other national strategic development goals as part of various national strategic frameworks, including:
- The second **Health Strategic Plan (HSP-2)** for 2008-2015, which includes Cambodia's priority to improve the health of women and children
 - The first **National Nutrition Strategy (NNS)** 2008-2015, which includes the overall goal of contributing to reduced maternal and child morbidity and mortality by improving nutritional status of women and children and which stresses cross sectoral collaboration to reach these goals
 - The Cambodia **Child Survival Strategy** in which one third of interventions focus on improving the nutritional status of children and the **National Policy on Infant and Young Child Feeding (2009)**.
 - The national multi-sectoral **policy on Early Childhood Care and Development (ECCD)**
 - The **Strategic Framework for Food Security and Nutrition**, 2008-2012 which includes guidelines for the design and planning of programmes and projects for improved food security and nutrition
 - The **Food Security Support Programme (FSSP)** which supports the strategy for Agriculture and Water
- 1.20 In the programme design gender was mainstreamed in all Joint programme activities. Women were a main target group of the programme with particular focus on pregnant and lactating women, young women of reproductive age in the workplace and teachers at the community level. Activities not directly targeting women were meant to include gender and have equal male and female

¹² Joint Programme for Children, Food Security and Nutrition in Cambodia. Joint Programme Document. 2009

participation and representation. Monitoring and reporting data were planned to be disaggregated and analysed by gender.

- 1.21 For governance of the programme, a National Steering Committee (NSC) was included in the design, while for programme management oversight a joint Programme Management Committee (PMC) was to be established. The National MDG-Fund Steering committee was designed to be comprised of the UN Resident Coordinator and a senior representative from the RGC who both co-chaired the committee, with membership of the Spanish mission in Cambodia and other representatives and observers invited as based on needs. The NSC was meant to meet twice a year and provide overall guidance to the programme, approving the programme document and annual workplans, reviewing the bi-annual reports and providing solutions for key challenges to programme implementation.
- 1.22 The Joint Programme Management Committee (PMC) was designed to be co-chaired by the UN Resident Coordinator and a senior representative of CARD, with membership of government ministries and participating UN agencies. The PMC was to meet quarterly and needed to ensure operational coordination, manage programme resources and coordinate overall planning and reporting. The PMC, moreover, prepared for the meetings of the NSC.
- 1.23 The programme recruited one national programme coordinator, responsible for coordination across UN agencies, government ministries and other implementing partners and two provincial programme coordinators, one in each of the selected provinces for sector coordination and support to implementation at the sub-national level. While the National coordinator was meant to operate based in the CARD, the PPCs were meant to work from the Provincial Governors' offices.
- 1.24 The programme applied a pass-through fund management arrangement in which UNDP was the administrative agent. UNDP transferred annual instalments to participating UN Organizations, who were meant to follow their respective organization's regulations and decided on the execution processes with RGC counterparts and other partners following the UN organization's own guidelines.

2 EVALUATION PURPOSE, SCOPE & OBJECTIVES

Evaluation Purpose

- 2.1 The evaluation which is timed at the end of the programme period is summative in character. The evaluation is meant to generate substantive evidence-based knowledge concerning the thematic window of the Joint Programme by identifying good practices and lessons learned that could be useful to other development interventions at national and international level and to contribute to development of the agenda for future food security and nutrition programming in Cambodia. The evaluation results, moreover, will feed into the learning of the global food security and nutrition window of the MDG-Fund.
- 2.2 The evaluation is also meant for accountability purposes, including mutual accountability across UN and RGC partners as well as accountability towards the MDG-Fund secretariat, the management agent (UNDP) and the donor (AECID).
- 2.3 Users of the evaluation results include RGC Council for Agricultural and Rural Development, Ministry of Health (MOH, including NCHP, NNP, PHD's and CDC), Ministry of Labour and Vocational Training (MoLVT), Ministry of Agriculture, Forestry and Fisheries (MAFF), and the Ministry of Planning (MoP) as well as the Joint Programme participating UN agencies: UNICEF, WHO, FAO, WFP, ILO and UNESCO. The MDG-F secretariat moreover, is expected to make use of the results of the evaluation as an input to a meta-evaluation of the Children, Food Security and Nutrition thematic window and to synthesize the overall impact of the MDG Fund at the international level.
- 2.4 The evaluation results are meant to be disseminated based on a plan developed by the Joint Programme Technical Team with the aim to advocate for sustainability, replicability and scaling-up and sharing of good practices and lessons learned on FSN programming.

Scope of the Evaluation

- 2.5 At the **level of the design** of the joint programme, the evaluation looked at the extent to which the objectives of the programme were consistent with the needs and interest of the target groups, the Cambodian MDGs and the national policies and strategies related to food security and nutrition. Moreover, stakeholder's involvement in the design process was included in the analysis.
- 2.6 At the **process level** the evaluation assessed aspects of efficiency, i.e. the extent to which resources were turned into results through the efficient use of inputs. This included the use of governance and management systems in programme implementation. Additionally, the assessment focused on the extent to which results were achieved through a process of capacity development and how the various levels of capacity development at individual, organizational and enabling environment level were interconnected and whether they were mutually reinforcing. The monitoring system and its use in programme management was assessed alongside the review of outcome 3, in which the development of an integrated food security and nutrition monitoring system was supported. As nutrition and food security are cross-sectoral the coordination and cooperation amongst the various programme components and the participating RGC Departments and UN agencies was an important focus for review.
- 2.7 At the **results level** the evaluation assessed the extent to which the objectives of the programme were realised, taking into account their relative importance. Data were disaggregated to the extent possible by gender and other relevant vulnerability criteria in order to probe the extent to which results reached vulnerable and worst-off groups. To assess the contribution of the programme to outcome level changes the results of the end line survey that was conducted as part of the Joint Programme were compared against the baseline data gathered at the start of the programme. Qualitative data from desk review and key informant interviews were included in the analysis to triangulate information. Lessons learned and good practices were identified in terms of what appeared to work and what not, beyond the context concerned.

- 2.8 In terms of **sustainability** the evaluation focused on aspects of ownership of the design, process and results of the program; whether capacities to sustain results were sufficiently developed; whether the financial capacity was adequate to keep up programme benefits, and whether organizational capacities were sufficiently strengthened to carry out the roles that the Joint Programme was performing.
- 2.9 In terms of **geographic focus**, the evaluation combined a focus at national and sub-national levels. The latter included the two food insecure provinces of Kampong Speu and Svay Rieng, which were selected for sub-national programme implementation. The time frame of the evaluation covered the period 2010 until mid-2013.
- 2.10 The evaluation focused on the design, process and results of the Joint Programme. The unit of analysis of the evaluation was the Joint Programme. The evaluation applied the UN Evaluation Norms and Standards, and used the five OECD DAC Evaluation Criteria, i.e. relevance, efficiency, effectiveness, impact and sustainability, which have been endorsed by the UN Evaluation Group.¹³ In annex 2 the evaluation questions of the TOR have been further detailed and specified informed by the desk review with additional questions in italic.

¹³ United Nations Evaluation Group *Standards for Evaluation in the UN System*, April 2005 and United Nations Evaluation Group *Norms for Evaluation in the UN System*, April 2005.

3 EVALUATION METHODOLOGY

- 3.1 The methodology of the final evaluation of the Joint Programme applied a mixed-methods approach, in which quantitative and qualitative methods were combined. This allowed for triangulation of data across a variety of methodologies.
- 3.2 A desk review included all relevant documentation on the programme and its implementation. This comprised an analysis of the programme design document and mid-term evaluation report, annual workplans, bi-annual and quarterly progress reports, Minutes of NSC and PMC meetings, baseline and end-line survey reports, national strategies and policy documents related to food security and nutrition as well as materials developed as part of the programme, including the FSN bulletins.
- 3.3 Interviews were conducted with key informant of RGC and participating line Ministries at national level as well as provincial, district and commune level officials in selected provinces. Moreover, interviews were conducted with the UN Resident Coordinator's office and with staff of the six participating UN agencies as well as with civil society organizations. Interviews also included staff that moved on to other positions. The interviews were semi-structured; interview protocols included a list of topics for discussion, tailored to the specific stakeholders concerned and their role in the programme. In order to gather perceptions on the effects and outcome level changes of the programme at the sub-national and local level, focus group discussions were conducted in particular at district and commune levels, including participants of village health support groups at the local level. Details on the various methods used as part of the evaluation process are presented in annex 3.
- 3.4 The evaluation applied a participatory approach, including stakeholders as much as possible in the evaluation process. This was meant to enhance ownership of evaluation results and to enable triangulation of data across a range of stakeholders at national as well as sub-national levels. Inputs on recommendations were gathered from all stakeholders as part of the evaluation process.
- 3.5 At key stages of the evaluation process the evaluator met with the evaluation reference group. Meetings were organized at the start of the country visit in order to discuss the draft inception report and at the end of the country visit to discuss the preliminary findings of the evaluation.
- 3.6 In terms of analysis the evaluation included:
 - Analysis of the involvement and roles of stakeholders at national and sub-national levels including Government agencies and institutions, UN agencies, other development partners, civil society organizations, and the private sector
 - Identification of strengths as well as weaknesses of the Joint Programme and its implementation
 - The results chain of the programme and the underpinning Theory of Change
 - Contextual analysis at national and sub-national level and identification of enabling and constraining factors in the external environment of the Joint Programme
- 3.7 The inception phase was an important part of the evaluation process. This phase included the desk review as well as initial discussions of the TOR and the draft inception report. These discussions informed the fine-tuning of the evaluation objectives and questions and the evaluation methodology. At the end of the inception phase a final inception report was produced incorporating comments on the draft version.
- 3.8 The Evaluation was guided by the UNEG Norms and Standards for Evaluation in the UN System, including its ethical guidelines.¹⁴ The evaluation applied a socially and culturally sensitive process, Informed by the contextual analysis conducted as part of the desk review.

¹⁴ United Nations Evaluation Group *Standards for Evaluation in the UN System*, April 2005 and United Nations Evaluation Group *Norms for Evaluation in the UN System*, April 2005.

Limitations of the Methodology and constraints to the Evaluation process

- 3.9 The set-up of the methodology and the evaluation process had limitations and faced several constraints. One of the limitations was related to the requirement to have the evaluation report finalized at the end of August, a timing which is already one month behind the original requirement and could not be further postponed. This meant that case studies that were originally planned as part of the evaluation process could not be included. These will be conducted as a separate process after the evaluation itself is finalized, which means that these will not be able to further inform the evaluation process and results. This limitation was addressed by including overall aspects of the three selected topics for case studies as part of the fieldwork of the evaluation, so that the evaluation report could include general aspects on these topics. The case-studies will be used to gather and analyse additional in-depth information on the specifics of each of the topics concerned.
- 3.10 The scheduling of the evaluation process during the months of July and August proved a constraint as the programme had closed at the end of June 2013 (with several components finished at the end of 2012). This meant that several key informants, including the persons responsible for programme implementation of some of the UN agencies had left or were in the process of leaving when the evaluation started. Moreover, the fieldwork for the evaluation was scheduled during the month of July, which is a holiday period for many of the international staff of UN agencies in Cambodia. Moreover, the National elections were held on 28th of July, within the fieldwork period of the evaluation. This meant that there was limited availability of government officials at national and sub-national levels. This constraint was addressed by working with the participating UN agencies in identifying those Government officials which had been involved in the programme and which could be available for a one hour interview, but gaps remained in terms of coverage of Government respondents.
- 3.11 The baseline and end line surveys were important sources of quantitative data at the outcome and impact level changes. The delivery of the end line report was delayed and the report only became available at the end of the field work period of the evaluation. The quantitative database was not available which meant that no additional analysis could be conducted and use could be made solely of the results as presented in the end line report.

4 EVALUATION FINDINGS

RELEVANCE

- 4.1 In order to review the relevance of the Joint programme the alignment of the programme with national priorities and the UNDAF was assessed as well as the responsiveness to existing needs. Furthermore, consistency of the programme design and linkages with the aid effectiveness agenda and the UN reform process were reviewed.

Alignment with RGC strategies, UNDAF and existing needs

- 4.2 The programme provided a good fit with the objectives and strategies of the RGC. The programme objectives were in line with National priorities, including the National Nutrition Programme and the National Strategy for Food Security and Nutrition. This finding was also confirmed by the Mid-Term Evaluation conducted in the third quarter of 2011.
- 4.3 The programme aligns well with the UNDAF of the period 2006-2010 which informed programme design as well as the UNDAF of the period 2011-2015. Regarding the latter, the alignment is in particular with outcome statement 1 on Economic Growth and Sustainable Development and outcome statement 2 on Health and Education as well as with sub-objectives across other outcome areas. The latter include gender mainstreaming as part of outcome statement 3, enhanced capacities for collection, access and utilisation of disaggregated information as part of outcome statement 4 and improved coverage of social security for both formal and informal sector workers of outcome statement 5.¹⁵
- 4.4 The programme document makes a clear case for the implementation of a food security and nutrition focused programme, underpinned with data on child nutrition and under five mortality rates. The findings of the baseline study conducted in April/May 2010 confirmed the need for and timeliness of the interventions.¹⁶ Moreover, the new National Strategy for Food Security and Nutrition, NSFSN 2014-2018, mentions that several nutrition related indicators, including levels of stunting and underweight of children under 6 years of age, remain relatively high, notwithstanding economic development in Cambodia¹⁷:
- 39.9 % of children aged 0-59 months who are moderately or severely stunted (Height for Age < - 2SD)
 - 28.3 % of children aged 0-59 months who are moderately or severely underweight (Weight for age < -2SD)
- 4.5 The two selected provinces for sub-national interventions, i.e. Kampong Speu and Svay Rieng, are considered two out of six provinces in Cambodia in which child malnutrition is prevalent. While the MDG-F programme focuses on two of these provinces, RGC has focused on the other four. The learnings of the MDG-F are meant to inform further programming through the National Nutrition Programme in all six provinces.

Consistency of design

- 4.6 In terms of the consistency of the design of the Joint Programme, the assessment focused on the approach of the programme, including the presence and use of theory of change and its fit for the programme's purpose. Additionally, the ways in which objectives were meant to be achieved were assessed. The quality of the design document appeared to vary, and limitations in the design negatively affected programme implementation.
- 4.7 The programme made use of a multi-sector approach in which addressing aspects of health, nutrition and food security interventions were interrelated in order to enhance the nutritional conditions of children and women. The inclusion of multiple duty bearers, including those in the health, education and private sectors, underpinned this multi-sector approach. With the high levels of wasting and

¹⁵ United Nations Development Assistance Framework 2011-2015. May 2010.

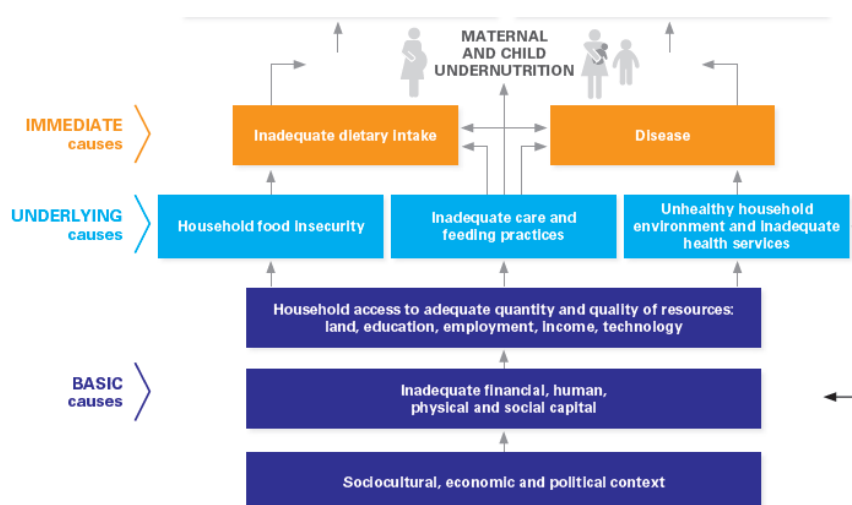
¹⁶ Judy McLean, Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Baseline Survey Design and Protocol (2009-2010).

¹⁷ Kingdom of Cambodia, National Strategy for Food Security and Nutrition, NSFSN 2014-2018, draft, 2013.

stunting of children from 6-59 months of age in Cambodia, tackling malnutrition from different perspectives seems fit for purpose. One of the challenges of a multi-sector approach is the alignment and coordination of activities in multiple sectors to reach common objectives. Such a set-up needs a clear outlining of the linkages of the outputs and objectives of the various sector initiatives, informed by the underlying causes of malnutrition of women and children, i.e. a theory of change (TOC).

- 4.8 Though the UN agencies make use of several overlapping frameworks regarding malnutrition and its immediate and underlying causes, there was no explicit theory of change included as part of the design, nor was such a framework developed during implementation. A basic framework was used in the baseline and end line surveys (see figure 1 below). The results framework included in the programme design document is limited to the programme itself and appeared to have several shortcomings (which are presented under efficiency in box 1). The lack of a shared theory of change has affected programme implementation, with implementing parties focusing primarily on the outputs under their responsibility rather than on shared objectives included as part of a results chain.

Figure 2: Framework representing types of causes for maternal and child under nutrition



- 4.9 In terms of implementation the programme design included piloting of selected components¹⁸ as well as implementing others at scale. Piloting concerned for example the implementation of SAM and MAM, which was supported at a limited scale in Kampong Speu and Svay Rieng Provinces. The distribution of MNPs on the other hand, was meant to be done at scale in the selected provinces, informed by earlier research on MNPs in Cambodia.¹⁹ Piloting and scaling-up require different types of management based on different needs and requirements for learning and different monitoring needs. As the piloting and scaling-up aspects of the programme were not clearly identified and justified in the design document, it was often unclear which of the components fitted which way of working and what kind of management approach was required. With piloted and scaled up components implemented at a different scale, it was not clear how these components were meant to bring about synergy at the local level. This limited the implementation practice of the multi-sectoral approach.
- 4.10 Combining piloting and working at scale is, moreover, difficult, as each of these ways of working has different requirements in terms of the selection of provinces to work in. As Kampong Speu and Svay Rieng provinces were selected based on their food insecurity levels, they appear to fit in particular

¹⁸ Piloting included the development of models. The discussion on the Mid-Term evaluation during the fourth MPC meeting mentions that the purpose of the Joint Programme is the development of 'a model that is scalable', though no further details were provided. Source: Minutes of the fourth PMC Meeting, conducted 16 September 2011.

¹⁹ The differences in piloting and scaling up relate to the level to which the results of the components have been proven to work in practice and can be regarded as 'good practice'. This is the case for example with distribution of MNPs and IFA supplementation. Management of acute malnutrition at the health centre and VHS level on the other hand were new to Cambodia. While good practice can be scaled up, new initiatives often need a piloting phase to test the approach and its results.

with a scaling-up approach. Their comparability to other poor provinces in Cambodia, required for a piloting approach, is less clear.

Focus on citizens and duty-bearers

- 4.11 With its focus on nutritional conditions of young children as well as female adolescents and pregnant and lactating women, the programme included a focus on vulnerable groups. Through the combined attention to citizens and duty bearers the programme made use of a rights-based approach. Citizens were addressed through the BCC campaigns, which informed citizens on FSN issues and services available. They were, moreover, targeted through sub-national activities, which focused on the provision of an integrated and comprehensive package of preventive and curative nutrition services and food security interventions. Duty bearers were supported through the work on FSN policies and guidelines and through the development of capacities of local Government agencies and service providers at provincial and local levels.

Building capacities at multiple levels

- 4.12 The combination of sub-national interventions with national level policy initiatives and BCC campaigns appears a useful approach in that it addresses aspects at the three levels of capacity that are usually distinguished, i.e. the individual level, the organizational level, and the level of the enabling environment. How the work at these different levels was meant to come together and provide results at sub-national levels was, however, not made explicit.
- 4.13 The need for capacity development in nutrition, for policy makers as well as for individuals working in the field of nutrition and food security, became apparent as a crucial prerequisite to strengthening leadership on food security and nutrition in Cambodia. In order to address this issue in a systemic way the development of a Master course in Nutrition for higher level training was included as part of the Joint Programme.²⁰ This has added to the relevance of the programme.

Linkage with aid effectiveness & UN reform

- 4.14 As part of the wider MDG-F framework, the programme aimed to combine acceleration of achievement of the Cambodian MDGs with reinforcing the UN to deliver results together in a concerted effort. However, the programme design paid limited attention ways for the UN agencies to work together at national and sub-national levels and organizational aspects concerned. In particular, the contribution of each of the agencies to shared objectives was not made clear. The financial system which made use of 'pass through' mechanism did not facilitate a joint approach. Funds were channelled through each of the UN agencies, using their own financial systems and mechanisms. Besides UN agencies were primarily responsible for the activities that each of them supported rather than for shared objectives.

EFFICIENCY

- 4.15 To review the efficiency of the Joint Programme the evaluation focused on governance and management arrangements, coordination amongst parties concerned and the application of results-based management.

Governance arrangements

- 4.16 The overall governance of the programme was usefully adapted to the context in Cambodia. The National Steering Committee functioned through the annual UNDAF monitoring meetings, in which RGC and UN partners discussed the performance of the Joint Programme. The Steering committee was jointly chaired by RGC and the UN Resident Coordinator and included representation of the Spanish mission in Cambodia, in line with the programme document. This governance arrangement

²⁰ WHO, *Challenges and Lessons Learned from one and a half year implementation of the Joint Programme*.

included the MDG-F project presently evaluated as well as the MDG-F Creative Industry Support Programme. This shared governance arrangement across the two MDG-F programmes is in line with the MDG-F guidelines and with the aid effectiveness agenda and enhance the efficiency of the arrangement.

- 4.17 Key decisions by the National Steering Committee were taken through consultations amongst members, without necessarily arranging face-to-face meetings. Though this contributed initially to the delay of the workplan approval for 2011, it turned out to be an efficient approach afterwards.

Figure 3: MDG-F Joint Programmes Governance and Management set-up



Management arrangements

- 4.18 The Programme Management Committee (PMC), which was established in line with the MDG-F guidelines, had high level representation of both RGC and UN agencies. The committee met regularly and functioned well over the period of programme implementation, providing an effective oversight and accountability mechanism.
- 4.19 The role of the PMC was to ensure successful performance of the JP and that programme implementation was in line with the Joint Programme design and RGC policy objectives and national and UNDAF priorities. The primary function of the Programme Management Committee was technical and operational oversight of programme implementation, monitoring, evaluation and endorsing finalized programme documents for the National Steering Committee's approval.²¹
- 4.20 The PMC was chaired by the Deputy Secretary General of CARD and the UN Resident Coordinator. Its membership included representatives from Line Ministries and UN Agencies, with the latter mostly represented by the heads of agencies. The PMC was responsible for the recruitment of programme coordinators, review of monitoring and evaluation reports, and identification of lessons learnt. The PMC recommended approval of the workplans and annual budgets to the NSC as well as intermediate action plans. This meant a substantial leading role in management issues for the PMC with the NSC more at a distance, approving decision-making prepared by the PMC.
- 4.21 The PMC appears to have functioned well with continued high level representation of RGC and UN partner agencies. As the members were not directly involved in the day to day management of the programme the committee appeared to have provided, in practice, more of an oversight than a management functions. The quarterly meetings of the PMC brought together the key partners from RGC and UN in order to discuss and review project implementation and progress and to address any constraining issues. The participation of the Deputy Governors of both Kampong Speu and Svay Rieng province during the sixth and last PMC meeting in June 2012 provided added value in terms of relating the national and sub-national project components.

²¹ Joint Programme for Children, Food Security and Nutrition in Cambodia, Programme Management Committee, Terms of Reference.

4.22 The Joint Programme Technical Team (JPTT, in figure 2 above referred to as Programme Management Team 2) was established to support the day-to-day implementation process of the programme. This appeared a useful addition to the organizational set-up of the programme, as the PMC performed more of an oversight rather than a management function. The membership of the JPTT included the Deputy Secretary of CARD and staff from the six UN agencies. In addition, the National Programme Coordinator and the two Provincial level coordinators participated. The Mid-Term Evaluation (MTE) recommended inclusion of RGC Ministries and Departments, something which was not sufficiently realized. The JPTT met monthly from the outset of the programme, but this became bi-monthly after the MTE. The JPTT team discussed actual programme implementation and coordinated across the UN agencies as well as with RGC through CARD representation at the meetings. The JPTT developed as a more hands on management team. Though this team was not foreseen in the programme document, the MDG-F guidelines do provide an option for such an implementation-oriented team.

Coordination at national and provincial levels

4.23 The positioning of designated coordinators at National and Provincial level enhanced coordination and cooperation amongst parties concerned. The national and provincial coordinators participated in the meetings of the PMC and the JPTT. Each of the coordinators was meant to be located in a government office, the national coordinator in CARD and the provincial coordinators in the office of the Provincial Governor. In one of the provinces this could not be realized due to logistical constraints. Overall though this location in RGC offices was considered to enhance contact and relationship with RGC counterparts, and to be beneficial for project coordination and implementation.

4.24 Coordination at the provincial level was supported by the Provincial Coordination Committee (PCC), chaired by the Provincial Governor with representation of each of the relevant Departments of the participating Line Ministries. PCCs met on a regular basis and supported the efficient implementation of the programme at the sub-national level.

Work planning

4.25 Though the programme was rather complex, with multiple RGC, UN and civil society stakeholders involved, the implementation was organized using a single workplan. This workplan remained virtually unchanged during the three years of implementation. This reinforced an activity and output oriented approach and did not encourage the adaptation of programme implementation based on learnings obtained in the process. The single workplan did also not fit well with the multi-sector approach of the programme, in which the various initiatives needed to be combined and provide results at the local level, something on which a lot needed to be learned.

4.26 Limited adaptations were, however, made to the programme workplan. These included the addition of a Master in Nutrition programme under the University of Health Sciences which was later adapted to the National Institute of Public Health (NIPH). Adaptations further included a larger role of WFP in the development of the Quarterly bulletin and WFP rather than UNICEF procuring Corn Soy Blend Plus (CSB++) for treatment of MAM. All adaptations were made within the existing programme budget.

Financial Management

4.27 The programme practiced a pass through mechanism for financial management, in which resources were channeled through each of the UN agencies making use of its own financial systems and regulations. Each of the UN agencies together with RGC partners implemented their part of the programme with financial and performance responsibilities limited to their respective components. In this way the financial management set-up did not necessarily align with the joint character of the programme, in particular not with outcome level objectives whose realization was shared among multiple agencies.

- 4.28 An overview of the programme budget and its distribution amongst the six participating agencies is presented in table 1 below, as well as levels of disbursement at the mid-term and end of the programme. The relatively limited pace of expenditure, with about one third of the budget disbursed at mid-term, picked up in the second part of the programme implementation period. At the end of 2012 a total of 92 % of funds were spent. Part of the remaining 8 % concerned activities that were planned for the extension period, including the end line survey. At the end of the programme 100 % of programme funds were disbursed.
- 4.29 At the start of programme implementation the different UN agencies applied different local DSA and transportation rates, based on the regulations of each of the agencies concerned. In the first PMC meeting it was decided to use the government policy (Sub-Decree No.10) for all travel support through the programme. This is in line with the aid effectiveness agenda in which programmes are meant to make use as much as possible of government systems and procedures.
- 4.30 A limited number of changes were made to the allocation of funds across existing budget lines. This concerned in particular the management of malnutrition with complications in referral hospitals, which budget line was considerably over spent. This related to an enhanced caseload when transport to referral hospitals was removed as a barrier for care seeking. All budgetary changes were made within the approved programme budget.²²

The results framework of the programme and its use

- 4.31 The programme design document included a results framework which was the basis of the monitoring framework of the programme. The results framework focused on three outcomes, which details are presented in Annex 5. The framework, however, had several limitations which affected its use. One of these concerned the inclusion of impact amongst outcome level changes and the mixture of output and outcome level indicators in the monitoring framework. This limited the use of the framework for results based management (for details see box 1 below).
- 4.32 Monitoring has been conducted through targeted field visits and spot checks, focusing on activity and output level issues. Part of the monitoring was conducted through shared monitoring visits. In practice, the monitoring of the programme was focused on activities and their outputs, which details were provided in quarterly colour-coded reports.
- 4.33 The attention to output level monitoring stands in sharp contrast to the monitoring of outcome level changes. Outcome level indicators were not sufficiently identified as part of the results framework (which was also identified in the MTE) and responsibilities for their monitoring not made explicit. The inclusion of selected outcome level indicators in the baseline and end line surveys was useful but did not resolve the lack of outcome level data during programme implementation. The lack of outcome monitoring limited opportunities for managing for results beyond the output level changes. This meant that the programme could primarily be managed based on what was within the management control of the various implementing agencies. It was much less able to respond to the ways in which programme participants reacted to these initiatives and their initial effects. This left a considerable gap in terms of results based management.

²² Joint Programme Progress Report Semester 2 – 2012.

Table 1: Overview of Budget Details for each of the participating UN Agencies

UN Agency	Approved Budget *		Disbursed at Mid Term **		Disbursed at end 2012 ***		Disbursed at end June 2013 ****	
	USD	%	USD	%	USD	%	USD	%
UNICEF	2,501,874	50	725,256	29	2,356,517	94	2,501,874	100
WHO	789,660	16	318,296	40	684,123	87	789,660	100
FAO	493,270	10	131,733	27	483,122	98	493,270	100
WFP	638,790	13	177,961	28	511,486	80	638,790	100
ILO	345,610	7	133,134	39	340,694	99	340,694	99
UNESCO	230,157	5	109,335	48	223,815	97	230,157	100
Total	4,999,361	100	1,595,715	32	4,599,757	92	4,999,361	100

* Joint Programme for Children, Food Security and Nutrition in Cambodia, Programme Document

** Joint Programme for Children, Food Security and Nutrition in Cambodia, Progress Reports 2-10 (second bi-annual monitoring report) and 1-11 (third bi-annual monitoring report)

*** Joint Programme for Children, Food Security and Nutrition in Cambodia, Progress Report 2-12 (sixth bi-annual monitoring report)

**** Figures from the UN participating Agencies in the Joint Programme

Box 1: Aspects of the Joint Programme Results Framework

The results framework as included in the Joint Programme document has several limitations:

First of all there are some structural concerns to the results framework. The first outcome combined two implementation level: BCC initiatives at the national level and an integrated food security and nutrition package at sub-national level (in two selected provinces). The first outcome level change itself had a focus on nutritional status of children and women and was as such at the impact level rather than at the outcome level. For this impact level change to occur also the changes as formulated under outcomes 2 and 3 would have been required.

The sub-national food security and nutrition packages, which were part of the first outcome, consisted of multiple aspects including food and nutrition related issues as well as health, education and agricultural activities. With all these interventions clubbed together as one output there was no clear outlining of how these different sector interventions interrelated to address nutrition and food security concerns.

Most of the indicators in the framework are located at the output level with only few indicators at the outcome level. This left the framework with a gap in between outputs and impact level changes, an issue which was also highlighted in the mid-term evaluation report.

EFFECTIVENESS

4.34 For the review of effectiveness the evaluation focused on the realisation of outputs of the programme and their contribution to outcome level changes. Outcome and output level changes were identified in the results framework of the programme, which has guided the assessment on effectiveness. To start with, aspects of the programme which affect the monitoring and evaluation of results will be discussed. Then the outcome level changes will be presented after which the outputs that supported these outcomes are discussed.

MDG-F programme as one amongst many types of support to FSN in Cambodia

4.35 The Joint Programme, as part of the wider MDG-F initiative, was set-up as a means to accelerate achievement of the MDGs. As such the programme was organized around UN agencies that were already working on food security and nutrition issues as part of their programming in Cambodia. Thus Joint Programme activities cannot be seen as stand-alone but are inter-related to other FSN initiatives of the participating UN agencies.²³ Many of the UN agencies as well as other organizations have been supporting initiatives in the two selected provinces of Kampong Speu and Svay Rieng on FSN issues. In addition, there are regular RGC programmes on vaccination, Vitamin A distribution and de-worming which influence health and nutritional conditions of children and women. Thus monitoring and evaluation of the results of the MDG-F programme cannot focus on attribution, as the changes supported by MDG-F programme cannot be isolated from those supported by other initiatives. Therefore the analysis focused on aspects of contribution, i.e. what were the output level changes realized and how did these contribute to the outcome and impact level changes reached.

Outcome level changes

4.36 Outcome level changes as identified in the Joint Programme design document are presented in table 2 below. Based on the comparison of baseline and end line survey data,²⁴ there appear to be many positive changes at the level of nutrition related outcomes. Though changes have been achieved, these do not always reach the targets set in the results framework of the Joint Programme. This is as the outcome level changes depend on the response of the target population and changes in the actions and behavior of a range of actors, including service providers, factory management and community based volunteers.

Table 2: Outcome level changes of the Joint Programme

Outcome 1	Outcome 2	Outcome 3
Improvement of the nutritional status of children aged 0-24 months and pregnant and lactating women	Implementation of existing nutrition, food security, and agricultural policies strengthened, and new policies on nutrition developed	Integrated food security and nutrition monitoring system developed

4.37 Positive changes include the dietary intake of young children as an immediate cause of malnutrition. Feeding practices of young children appeared to be improved and breastfeeding within the first hour as well as feeding of colostrum went up between baseline and end line survey as did overall

²³ UNICEF for example was supporting local level councils to address community related issues, including the provision of social services, working with the Ministry of Interior. Another UNICEF related programme concerned the Baby Friendly Hospitals, with 20 out of 91 hospitals in Cambodia so far having achieved this status. FAO provided support to the EU funded Food Facility Project (2009-2011) which included agricultural, gardening, IPM as well as nutritional education support in 10 provinces in Cambodia.

²⁴ The limitations of the set-up of the baseline and end line surveys (presented in box 3 below) mean that the studies cannot be used as a comparison between intervention and control areas. Thus the outcome level data presented focus in particular on the intervention areas. More details on the results of the baseline and endline surveys are presented in annex 6. McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Baseline Survey Design and Protocol (2009-2010)* and McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Endline Survey (2013)*.

incidence of breastfeeding. The amount of food consumed by the youngest child as well as by children 36 – 59 months of age increased as did the number of meals and snacks taken. The introduction of solid, semi-solid or soft foods to infants 6 to 8 months of age went up in intervention provinces. Also the minimum dietary diversity for children 6-23 months of age improved. The number of households that received MNP for the youngest child was much higher in intervention than in comparison provinces.

- 4.38 The incidence of disease, another important immediate cause of malnutrition, showed a number of positive changes. The prevalence of diarrhea reduced for children and treatment with zinc slightly improved with advice often sought from drug sellers, which the programme supported through social marketing of zinc. Also the use of iron foliate tablets, Vitamin A and deworming increased substantially. In terms of maternal health and nutrition, the percentage of pregnant as well as non-pregnant women who received iron foliate tablets went up, while the increase in deworming was substantial. Moreover, ante-natal care increased as did delivery in health centres.
- 4.39 When looking at changes in knowledge, attitudes and practices the results varied. Knowledge on diarrhea treatment remained the same while knowledge on food sources that contain iron went up, though the knowledge on the reasons for taking IFA supplements reduced. A large proportion of caregivers had seen messages on vitamin A, though the knowledge on the reasons for taking Vitamin A decreased, as did the knowledge on food sources of vitamin A. Virtually all caregivers reported seeing or hearing messages on hand washing with soap but most of the indicators on hand washing had decreased between baseline and end line, with the use of hand soap and use of it with children both diminished.
- 4.40 In terms of household food security the results showed a decrease in food secure households in both intervention and comparison provinces (more in intervention provinces). Approximately one-quarter of households reported running out of rice in a normal year.²⁵ These findings do not appear to be in line with the economic improvement levels that were found in all four provinces. The methodology and scale used in the assessment are not uncontested.²⁶ Homestead gardening appeared not very common. The proportion of households with a homestead garden further decreased over the three year programme period. The main use of fruits and vegetables grown in the homestead garden was home consumption. Large amount of households (over 4/5) owned some type of livestock at the end line survey.

Output level changes

- 4.41 Output level changes as identified in the Joint Programme design document are presented in table 3 below. Assessment of output level changes was informed by the programme bi-annual reporting and cross checked with the interviews conducted in the field. A four point scale was used, with the four points of the scale referring to: far above target, target reached, below target (50 - 100%) and far below target (less than 50% reached). Results are presented in tables 4 - 7 below.
- 4.42 Overall, the programme was able to implement most of the activities concerned and did reach the targets set on many output level indicators. In some cases scaling up has taken place and in those instances results were far above target. In only limited cases results proved to be below expectation.
- 4.43 Behavioral change communication (BCC) focused on the development and implementation of three types of campaigns: breastfeeding, complementary feeding and IFA supplementation during pregnancy and in the postpartum period. The campaigns involved multiple RGC and UN agencies and included nationwide mass media campaigns (MOH supported by UNICEF and WHO), the

²⁵ Possible explanations of a reduction in food security levels include the effects of the large scale flooding in Sept-Nov 2011 which affected all of the 4 provinces included in the endline survey and which disaster led to significant loss of food stocks, agricultural crops, and loss of livelihood opportunities. The effects of the flood increased borrowing as a coping strategy, which enhanced indebtedness. All these effects resulted in medium and long term impact on households and their levels of food security.

²⁶ The scale used to measure household food security is the Household Food Insecurity Access Scale developed by the Food and Nutrition Technical Assistance (FANTA). This scale consists of a nine question method focusing on occurrence of levels of severity of food insecurity and frequency of such occurrence. FANTA has adapted its use of the scale, focusing on three out of nine questions.

development of a Nutrition handbook (MAFF supported by FAO), media training to journalists (CARD supported by UNESCO), establishment and training of OSH committees and adapted BCC materials and radio spots in factories (MoLVT and MOH, supported by ILO). All three BCC campaigns were designed and implemented, though the complementary feeding campaign was started late, in 2012. With additional funds that were leveraged, the latter campaign was implemented beyond the two selected provinces to include one Operational District (OD) in eight other provinces, which meant that the campaign though initiated relatively late, actually surpassed the targets.

Table 3: Output level changes of the Joint Programme

Output 1.1	Output 1.2	Output 1.3	Output 2.1	Output 2.2	Output 3.1	Output 3.2
BCC plans and communication materials developed on: breastfeeding, complementary feeding, IFA supplementation during pregnancy and in the post-partum	BCC plans implemented on: breastfeeding, complementary feeding, IFA supplementation during pregnancy and in the post-partum period	Provision of an integrated comprehensive package of nutrition and food security interventions delivered with high coverage in two food insecure provinces - Kampong Speu and Svay Rieng	Review implementation status of legislation, policies and strategies on nutrition, food security and agriculture and provide responses for practical action	New policies, strategies and guidelines developed	Integrated national food security and nutrition monitoring system established, based on existing information systems and surveys	Management, coordination, monitoring & evaluation of JP

- 4.44 At the sub-national level the programme focused on the provision of an integrated comprehensive package of nutrition and food security interventions, with high coverage in the two selected food insecure provinces, i.e. Kampong Speu and Svay Rieng. This consisted of an integrated nutrition package (including breastfeeding, complementary feeding, Vitamin A, mebendazole, MNPs, Zinc and ORS for diarrhea and management of severe and moderate acute malnutrition) implemented through the Provincial Health Department, supported by UNICEF, WFP and WHO. This package, moreover, included the promotion of homestead food production (MAFF supported by FAO) and enhancing knowledge and skills of education and local level officials in ECCD and life skills, mainstreaming nutrition (MoEYS supported by UNESCO).
- 4.45 Results on output level indicators of the integrated nutrition package (presented in table 7 below) show that most of the targets set were reached. The number of OSH workers trained reached above target as did the provision of MNPs, which was done blanket to children of 6-24 months of age across the two provinces. Under target remained provision of IFA and the number of acutely malnourished children treated in health centers or hospitals with the latter reaching below 50% of the set target.
- 4.46 The set-up of the SAM and MAM identification and treatment was based on identification of malnourished children through mass screening and treatment of most of the MAM and SAM cases at the health center. Only those children with complications would be sent to the referral hospital. The treatment at the health center was based on out-patient consultation which considerably reduced the costs involved. Caretakers received take home rations of the Ready to use therapeutic food (RUTF) BP100 for SAM cases and CSB++ for MAM cases and were asked to return after weekly or bi-weekly periods for SAM and monthly for MAM treatment.

Table 4: Achievements of Indicators of Outputs 1.1 and 1.2 on Behavioural Change Communication Activities

Indicator	Achievement	Rating
1.1 Behaviour Change Communication BCC plans and communication materials developed		
Number of BCC plans finalized and agreed with key stakeholders	The following 3 BCC plans finalized with endorsement of government and other key stakeholders: (i) breastfeeding, (ii) complementary feeding, (iii) IFA Supplementation during pregnancy and in the postpartum period. BCC plans were launched at national and subnational levels. Training materials for hospital based management of acute malnutrition reviewed and new packaging for IFA introduced to improve compliance.	g
# of BCC plans adapted to workplaces	BCC plans and materials for IFA supplementation, breastfeeding and complementary feeding were adapted to the workplace, resulting in the production of tailored spots and programmes, and print materials. Since October 2010, 46 radio spots & programmes were produced (3 radio magazines, 18 radio roundtable discussion, 22 radio spots, and 3 radio talk shows). Spots and programmes focused on infant and young child feeding, antenatal care, and reproductive health. Print materials, such as posters and leaflets, were distributed to workplaces.	g
1.2 Behaviour Change Communication BCC plans and communication materials implemented		
Number of nation-wide media campaigns implemented on annual basis	Implementation of nationwide mass media for breastfeeding and IFA started in 2010. The complementary feeding campaign was launched at national level in Q1 2012 with mass media starting at that time. The IPC component started in 10 provinces in 2012. Additional funds from USAID and HSP2 were leveraged to continue both mass media and IPC in 2013 and 2014	dg
Number of Khmer language FAO Family Nutrition manuals distributed to food insecure households	2,100 copies of Nutrition Hand Book for family has been finalized and published in December 2011. The book has been distributed to PDA and all trained farmer and provincial government.	g
Number of media personnel trained in food security and nutrition reporting	89 media personnel and journalists (34 in 2010, 25 in 2011 and 30 in 2012) trained by Media Training Centre of Ministry of Information. The objective of the training was to increase awareness of journalists about FSN and learn media techniques on how to report accurately about issues on FSN. In 2012 a FSN media award ceremony was held to promote reporting on the topic. In addition, a media handbook for food security and nutrition was developed and launched; and community radio in SVR regularly broadcasted on food security and nutrition. Community radio broadcasting has expanded to Ratanakiri province, where there is a large population of ethnic minorities.	g
Number of radio spots broadcasted in garment factory Workplace	Radio spots were broadcasted 3,407 times through FM National Rumduol Svay Rieng Radio Station (FM 98.70) and Radio Sarika (FM 106.05)	g
Number of trained OSH workers in BCC plans	23 operational OSH committees established at the enterprise level, with 322 (154 females) OSH Committee members representing the total workforce of 31,772 (26,210 females) workers in the 2 provinces. Since June 2010, 96 trainings on OSH and maternity protection for workers & employers were conducted; reaching 4,209 workers, employers, and infirmity staff attended the trainings. An impact assessment of the training was carried out. In addition labour officials received training in nutrition and first aid.	dg

Table 5: Achievements of Indicators of Output 1.3 - Nutrition package in 2 Food Insecure Provinces

Indicator	Achievement (<i>in italic data from baseline and end line surveys</i>)	Rating
Proportion of children aged 0–6 months who are exclusively breastfed	At the start of the programme the provinces had already achieved a high rate of exclusive breastfeeding. <i>The percentage of women ever breastfeeding their child went up from 95.7 to 99.2% though the average duration and frequency went slightly down (from 9.9 to 9.7 times per day and 18.1 and 16.6 months respectively) in the two intervention provinces</i>	0
Proportion of breastfed children aged 6-24 months who receive appropriate (age appropriate frequency with 4+ food groups) complementary Feeding	<i>% of children 6-23 months of age receiving solid, semi-solid, or soft foods the minimum number of times or more increased from 93.9 to 97.7% in the two intervention provinces</i>	3
Proportion of estimated number of undernourished who receive supplementary feeding	3,051 children with moderate acute malnutrition received Super Cereal Plus (CSB++) and were managed at 10 HCs in Kong Pisey OD and 5 HCs in Kampong Speu OD, Kampong Speu province since the start of the programme in September 2010 through June 2013. For therapeutic feeding of severely malnourished children 105 were treated at health centre in the two target provinces. Caretakers of all children hospitalized received financial support for transportation and food. 29 health centres implemented management of acute malnutrition in the 2 target provinces. NGO partners will bring the national number to 66 health centres implementing management of acute malnutrition in 2013. With the exception of RUTF, all commodities for SAM on the Essential Drugs List. No significant stock-outs.	0
Number of VHSG members who are trained on BF & CF counselling using BFCI package (Output indicator) Timeframe: 2010-2012	1,282 VHSG received training on interpersonal communication and complementary feeding, bringing the total number of VHSG trainings in the two provinces to 2,432. In addition, a number of VHSGs received full refresher training for the Baby Friendly Community Initiative, which includes comprehensive Infant and Young Child Feeding information.	3
Number of VHSG members who are trained on Micronutrient/Sprinkles promotion	4,196 VSHG were trained on MNP Powder/Sprinkles (1,380 VHSG in SVR and 2,816 VHSG in KPS). In addition, all health centres received training on MNP. MNP training is now integrated into the BFCI and MPA 10 training packages for scale up	3
Number of VHSG members who are trained on management of acute malnutrition at the community level	1184 VHSG have been trained on management of acute malnutrition with direct financing from the JP (868 in KPS and 266 VHSG in Svay Rieng). More VHSG have been trained outside of the focus provinces with several NGO partners now active. In addition, staff from all 29 participating health centres has been trained, including training on the updated IMCI. Training materials integrated into MPA10 and IMCI for scale up Impact assessment of training carried out.	3

Indicator	Achievement <i>(in italic data from baseline and end line surveys)</i>	Rating
Proportion of children 6-59 months who received Vitamin A supplementation in the past 6 months	According to HIS data both provinces achieved universal coverage: 78,595 (102%) of children 6-59 months in Kg. Speu and 50,661 (101%) in Svay Rieng received Vitamin A supplementation in the past 6 months. <i>Percentage of Children 6 to 35 months receiving Vit A increased from 15.2 to 65.8 % while for children 36 to 59 months of age it increased from 10.6 to 67.4 %. A similar increase was found in both age groups in the comparison provinces.</i>	g
Proportion of children 12-59 months who received Mebendazole for deworming in the past 6 months (Timeframe: 2010 - 2012)	According to HIS both provinces achieved the target: 76,418 (113%) children 12-59 months in Kg. Speu and 43,991 (88%) in Svay Rieng received mebendazole tablet in the past 6 months. <i>Percentage of Children 6 to 35 months receiving any drug for intestinal worms increased from 9.6 to 50.1 % while for children 36 to 59 months of age it increased from 8.3 to 68.1 %. An even higher increase was found in both age groups in the comparison provinces which started off at a lower percentage for the baseline.</i>	g
Proportion of children under 2 years of age who regularly receive multiple micronutrient powders (MNPs) with their complementary feeding	An estimated 55% of children in the two provinces received MNP after distribution of 2.3 million sachets. In KPS 82,975 children received MNPs within first 6 months (48.4% coverage). In SVR 73,835 received MNPs within the first 6 months (66%). There has been significant stock out of MNP in second half of 2012, but supply is available for 2013 <i>The youngest child that ever received MNPs increased from 4.2 to 53.8 % in the intervention provinces. The receipt of MNPs for young children remained much lower in comparison provinces where it rose from 1.0 to 15.1 %.</i>	o
Proportion of children aged 12-23 months who are undernourished	<i>Prevalence of underweight children decreased from 33.0 to 28.8 % (with a slightly larger improvement in comparison provinces) Prevalence of stunting in children decreased from 36.2 to 32.3 % (with a even larger improvement of 8.7 % in comparison provinces)</i> <i>Prevalence of wasting in children decreased from 14.0 to 10.9 % (with less improvement in comparison provinces)</i>	g
Proportion of pregnant women who received Iron Folate supplementation (at least 60 tab)	Both provinces did not achieve targets according to HIS: 16,361 (67%) pregnant women in Kg. Speu and 10,442 (72%) in Svay Rieng received IFA supplementation (at least 90 tablets) in 2012. <i>Percentage of pregnant women receiving or buying IFA increased from 75 to 83.9 % in intervention areas, with a similar rise in comparison provinces</i>	o
Proportion of postpartum women who received Vitamin A supplement within 6 weeks after delivery	Both provinces did not achieve targets according to HIS: 12,713 (52%) post-partum women in Kg. Speu and 12, 920 (82%) in Svay Rieng received Vitamin A supplementation within 6 weeks of delivery in 2012.	o
Proportion of postpartum women who received Iron Folate supplementation (42 tablets)	Provinces partly achieved targets: 13,585 (56%) post-partum women in Kg. Speu and 15,291 (105%) in Svay Rieng received IFA supplementation (42 tablets) in 2012.	o
Home Gardening, Education and ECCD		
# of food insecure households trained by	As of December 2011, a total 2,100 families has been trained in home gardening technique, chicken raising and complementary feeding practice for children age 6-24 months. Small equipment was distributed to 30 farmer field	g

Indicator	Achievement <i>(in italic data from baseline and end line surveys)</i>	Rating
Farmer Field Schools (FFS)	schools. An impact assessment of training was carried out.	
# of trained education officers in mainstreaming nutrition in Early Childhood Care Development and life skills through non formal education	Training on FSN was conducted for 40 teacher trainers and 11 POE and DOE staff in April 2012 in Kg. Speu and Svay Rieng province. Main objective is to increase knowledge of teacher trainers in the province on importance of understanding issues on FSN and incorporate into the lessons.	0
# of commune officials and village leaders trained by education officers in Early Childhood Care Development and life skills through non formal education	364 (254 females) people were trained (CCWC, VSHG members and mother support group leaders) on FSN in Sept. 2011. Training was conducted by 8 DOE staff in Svay Rieng. Main objective is to increase knowledge/ awareness of the all participants in FSN.	0

Table 6: Achievements of Indicators of Outputs 2.1, 2.2 and 3.1

Indicator	Achievement	Rating
Output 2.1:		
Review implementation status of legislation, policies and strategies on nutrition, food security and agriculture and provide responses for practical action		
Number of policies, strategies and legislations reviewed	The Early Childhood Care and Development National Action Plan was submitted to the Council of Ministers by MOEYS officials in April 2012 for final approval. Report on Workplace Policies/ Regulations drafted. A study on the Perception of Garment Factory Owners on Nutrition and the Feasibility for Pursuing Canteen Services in the Garment Sector in Cambodia" were conducted and finalized with the financial support from ILO BFC, Hagar Catering.	8
Number of PHD staff, district and commune level officials trained in FSN concepts and objectives in 2 provinces	Total training in the 2 provinces is 162 people. 69 people were trained in 2010. Another 93 people were trained in the 2 provinces for 2011. Assessment of training carried out.	8
Output 2.2		
New policies, strategies and guidelines developed		
Number of new policies, strategies and legislation developed	2 guidelines and one curriculum developed, endorsed, printed and disseminated: National Guidelines for the Management of Acute Malnutrition National Policy and Guidelines for the Micronutrient Supplementation to Prevent and Control Deficiencies in Cambodia Proposal and curriculum for setting up a Master in Nutrition Programme In addition, IMCI, MPA10, BFCI, and Outreach Guidelines all revised to match new policies	8
Output 3.1:		
Integrated national food security and nutrition monitoring system established, based on existing information systems and surveys		
Number of FSN reports produced by national food security and nutrition monitoring system	From July-Dec 2012 the Food Security and Nutrition Data Analysis Team produced two issues (#7 and #8) of the Cambodia food security and nutrition quarterly bulletin. Bulletin production is now part of routine analytical work by Government partners and is	8

	<p>supported by other financing. Content and format of Atlas project have evolved and expanded to cover FSDAT outputs, commune-level poverty maps and ID Poor data. Massey, WFP and NIS produced the draft final report and maps of the small area estimation study. Report will be disseminated in Q2 2013. GIS maps produced for Cambodia food security nutrition quarterly bulletin (Issues #7 and #8)</p>	
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Table 7: Results of Joint Programme Output 1.3 – Nutrition package in 2 Food Insecure Provinces

No	Output level indicators	Planned	Total Achieved	Rating*
1	No. of VHSGs trained on micronutrients, BFCI and/or malnutrition treatment	4,000	4,196	g
2	No. of trained Occupational Safety and Health (OSH) workers in BCC plans on BF, CF and IFA	360	608	dg
3	No. of acutely malnourished children treated in health centre or hospital	8292	3213	r
4	No. of children 6-59 months received Vitamin A supplementation and Mebendazole for deworming in the past 6 months	111,144	120,409	g
5	No. of children 6-24 months received multiple micronutrient powders	47,384	156,810	dg
6	No. of pregnant women who received Iron Folic Acid supplementation (90 tabs)	38,851	28,833	o

* Rating : **Dark Green (dg)** – far above target (above 125 %) Source: Joint Programme Progress Report Semester 2-2012
Green (g) – target reached (100 – 125 %)
Orange (o) – below target (50 – 100%)
Red (r) – far below target (below 50%)

- 4.47 There proved to be two main constraints to the implementation of malnutrition treatment. One concerned the treatment of moderate acute malnutrition. With quite a large number of MAM cases identified, this was considered to provide an extra burden to the health center by staff concerned. Though at mass screening identification levels were high (much higher than SAM) the number of children treated in practice remained limited. The approach in Svay Rieng did not include MAM, which was done deliberately so as to create different models in the two focus provinces.
- 4.48 The SAM cases are considerably less in quantity so the extra workload that these provided to the health centers was accordingly less. However, the follow up after the first visit and the attention to defaulters proved to require incentives for health center staff that needed to travel to villages to visit non-returning children and their caretakers. Also the VHSG members, who played an important role in the management of SAM, needed incentives to do their work as opportunity costs proved to be high.
- 4.49 In the first quarter of programme implementation of SAM treatment in Kampong Speu incentives were provided through the organization of meetings and reimbursement of transportation costs for VHSG members who attended the meeting. However, as the programme was meant to work through RGC systems, these small incentives were discontinued and were meant to be taken up by the Health SWAP (HSP II), which did however not occur in practice. Though the benefits were relatively small, once removed the system proved to no longer function and the default rate went up sharply.
- 4.50 Based on the implementation problems in Kampong Speu and the high level of default, WFP put in place a programme monitor who visited the field 3 days per week and who provided additional support to Health Centers and VHSGs. Though the monitor is meant to build capacities, in practice opportunities appeared limited as the HC staff often did not join the field monitor on her visits, notwithstanding being invited to do so. The placement of the field monitor resulted in enhanced programme implementation and showed the need for additional support in order for the SAM and MAM treatment to work in practice.
- 4.51 Regarding the promotion of homestead food production the targets for number of families trained in home gardening techniques, chicken raising and complementary feeding practices for small children was reached. Moreover, training was provided on organizational aspects of farmer field schools to

FFS leaders and members. The number of trainees on awareness of ECCD and FSN for local level officials remained below target.

- 4.52 As part of the activities to develop and strengthen nutrition policies, existing policies were reviewed, which included the early childhood care and development national action plan that was submitted to the Council of Ministers by MoEYS in April 2012. Additionally, a study was conducted on the perception of garment factory owners on the feasibility of pursuing canteen services in their factories, in order to enhance nutrition and health conditions of workers.²⁷
- 4.53 National guidelines were developed for the management of acute malnutrition, which were used in the management of SAM and MAM training courses in Kampong Speu and Svay Rieng provinces. Moreover, the national policy and guideline for Micronutrient supplementation was developed. A curriculum for set-up a Masters Nutrition Programme in Cambodia was developed and implemented.
- 4.54 For the development of an Integrated food security and nutrition monitoring system, a data analysis team was established, which brought together existing data related to food security and nutrition in a quarterly bulletin, publication of which has become a regular feature. It included routine administrative data as well as data from periodic national sample surveys such as the Cambodia Demographic and Health Survey (CDHS) and Cambodia Socio-Economic Survey (CSES). The first three bulletins were developed in English only, however, from the 4th edition, both Khmer and English versions were available. Five line Ministries were involved in data gathering and development of the bulletin, led and coordinated by CARD. Capacities on data collection, database management and data analysis were built in the process. Dissemination of the bulletin was the responsibility of CARD and concerned a wide range of RGC and other agencies in Cambodia, including high level policy makers. For data presented in the bulletin see table 8 below.
- 4.55 The development and publishing of the quarterly bulletin reinforced data gathering on FNS related issues and improved the availability of such data to relevant policy makers and stakeholders. What remains less clear is how this contributed to capacities of the individual line ministries to gather primary data and how the bulletin can be used to inform early realization of emerging issues in food security and nutrition at sub-national and national levels.

Table 8: Line Ministries, Departments and Data they provided for the Quarterly Bulletin

No	Line Ministry	Department	Data provided
1	Ministry of Agriculture, Forestry and Fisheries	Department of Planning and Statistics	<ul style="list-style-type: none"> ▪ Cultivated area for rice and other crops ▪ Rice and other crops production ▪ Rice and other crops areas affected/damaged by disaster ▪ Wholesale price of rice ▪ Unskilled wage rates
2	Ministry of Water Resources and Meteorology	Department of Meteorology Department of Hydrology and River Works	<ul style="list-style-type: none"> ▪ Rainfall ▪ River water levels
3	Ministry of Health	Nutrition Department, Mother and Child Health Department Communicable Disease Control Department	<ul style="list-style-type: none"> ▪ Diarrhoea cases
4	Ministry of Planning	National Institute of Statistics	<ul style="list-style-type: none"> ▪ Consumer price index ▪ Food price index

²⁷ Study on the Perceptions of Garment Factory Owners on Nutrition and the Feasibility for Pursuing Canteen Service in the Garment Sector in Cambodia. February 2013.

5	National Committee for Disaster Management	Department of Emergency Response and Rehabilitation	▪ Disaster damage (people and infrastructure)
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Enabling and constraining factors to reach results

- 4.56 Several enabling and constraining factors to reaching results can be identified both within the Joint Programme as well as factors from outside the programme. An overview of main enabling and constraining issues is presented in table 9 below. The functioning governance and management systems were an important internal enabling factor as were the RGC strategies and programmes on FSN being in place. The existing health system proved an important enabling aspect as the programme intended to work through the existing RGC system, reinforcing its capacities on nutritional aspects. At the local level the existence of a village health support group (VHSG)²⁸ proved important for providing a linkage between the health centre and communities. The existence of Farmer Field Schools enabled activities on home gardening and food security.
- 4.57 An important constraining factor for results at the local level was the limited synergy across the different programme components at the community and household level. Though the various implementing and UN agencies coordinated their activities and the geographic areas to be covered this has been limited in practice due to the specific requirements of each component and their specific target groups. Though this did result in overlap in terms of areas covered by the components, substantial differences in the number of communities covered by each of the components meant that in many instances communities received single sector rather than multiple sector support. The uneven spread of the various (parts of) components constrained the synergy that was meant to occur by combination of the multiple sector based approach to influence the same local level communities.
- 4.58 The three year timeframe proved another important overall constraint to the Joint Programme. This in particular given the ambitious goals of the programme, with the intention for high coverage rates in the selected provinces, in combination with national level activities. On the one hand the time frame proved short as all the components required capacity development of individuals as well as the organizations involved. Moreover, capacity development usually takes a considerable period of time. On the other hand, the results were meant to be reached with the involvement of a variety of stakeholders including RGC, UN and NGO stakeholders. The set-up as a Joint Programme had substantial transaction costs, which in particular slowed down the start-up of the programme, with many respondents commenting that the programme effectively had two rather than three years of implementation.

Table 9: Enabling and Constraining Factors to reaching Results internal and external to Joint Programme

Kind of Factors	Internal to JP	External to JP
Enabling Factors	<ul style="list-style-type: none"> ➤ Functioning governance and management system with a National Steering Committee, Programme Management Committee and JP Technical Team ➤ Building on experience of the UN agencies in nutrition programming in the selected provinces and Cambodia at large 	<ul style="list-style-type: none"> ➤ Strategies and RGC programmes in place ➤ Health system in place at national, provincial and Operational district levels and with Referral Hospitals and Health centres in place ➤ The existence of a Village Health Support Group system of two village volunteers who support health and nutrition initiatives at local level ➤ Existence of Farmer Field Schools ➤ Other programmes of UN agencies which contribute to the same objectives

²⁸ The village health support group (VHSG) consists of two volunteer members supporting health outreach and other activities at the commune level. The members of the VHSG are elected by the health center management committee.

Kind of Factors	Internal to JP	External to JP
Constraining Factors	<ul style="list-style-type: none"> ➤ Relatively short time frame of the programme with substantial amount of transaction costs at the start of the programme ➤ The Need for incentives for HC staff and VHSG members to be able to perform activities as costs and opportunity costs prove otherwise too high ➤ Change of supplier of MNPs, after which the quality proved to be inferior leading to a halt in distribution as re-order takes about 2 months ➤ Difficulties in combining meetings of different initiatives at the local level, including those for SAM/MAM, MNPs and BFC ➤ Different levels of scale of the various programme components limited the synergy across the various sector and cross sector interventions ➤ Different levels of provenness of interventions made it difficult to combine them in a single pilot approach as some are meant to be scaled up from the start while others need to be piloted 	<ul style="list-style-type: none"> ➤ Low salaries of RGC staff which makes it difficult to implement activities without the provision of fringe benefits which are regarded by development partners as undermining aspects of sustainability ➤ Low level of coordination across the various sectors involved in FSN including health, education, labour, agriculture ➤ Budgets of the commune councils were frozen so that supporting the allocation of local funds for nutrition related issues was not feasible ➤ Under nutrition is often not recognized as a health problem by mothers or caretakers of young children ➤ Grandparents often take care of small children in particular if their mothers work in a factory so that the programme needs to include a particular focus on grandmothers ➤ Distance to the health centre and related transport costs are a main constraint for follow-up of mothers and grandmothers to SAM and MAM treatment of small children in the HC ➤ Turnover rates of VHSG members require an on-going systemic training effort of these village based volunteers, rather than one off training and refresher as provided by the programme ➤ Low levels of education make it more difficult for the advocacy messages to resort effect

IMPACT

4.59 To assess the impact of the Joint Programme, the evaluation focused on the contribution towards the improvement of nutritional conditions of children and women. Use was made of the baseline and end line surveys²⁹ conducted as part of the programme in April/May of 2010 and 2013 respectively. Though it was a plus that quantitative data at the impact level was available, there were limitations to the data and its use. Methodological constraints around the 'control provinces' and the limitations of the analysis conducted so far meant that the quantitative data could mostly be used at the level of the intervention provinces, comparing baseline and end line conditions. Quantitative data was triangulated with qualitative data from interviews with a variety of stakeholders and programme participants.

Contribution towards the improvement of nutritional conditions of children and women

4.60 The impact level changes that have been observed by comparing the baseline and end line survey data are considerable, though do not all show a significant change. In particular the decrease in moderate as well as severe anemia levels in children under 5 years of age stand out. The prevalence of moderate anemia among children under 5 years of age dropped from 56.1% to 35.7% in the intervention group and from 44.7% to 28.1% in the comparison group. The prevalence of severe anemia was low in both groups; however, the change from 2.3% at baseline to 0.9% at end line in the

²⁹ McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Baseline Survey Design and Protocol (2009-2010)* and McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Endline Survey (2013)*.

intervention group was significant. The proportion of non-pregnant women with a normal hemoglobin increased substantially in both groups: from 43.6% to 59.4% in the intervention group and from 43.8% to 63.5% in the comparison group. The proportion of pregnant women with normal hemoglobin was more than 35 percentage points higher at end line than at baseline.

Box 2: Baseline and Endline Surveys

Baseline and end line surveys were conducted 'in order to assess the ability of the joint programme to modify the situation at the beneficiary level, as well as any possible undesired effects, whether anticipated or not'. Both surveys focused on health and nutrition status indicators, food security, as well as health and nutrition related knowledge and practices. In addition to the two selected provinces of the programme, the studies covered Takeo and Prey Veng provinces as comparison. The latter were selected based on comparable indices on nutrition related indicators in the Cambodian Demographic Health Survey (CDHS) of 2005 and the Cambodian Anthropometric Survey (CAS) of 2008. The end line was conducted at the same time in the year as the baseline in order to reduce aspects of seasonality

The studies were designed as cross-sectional sample surveys. This meant that they were designed to assess the prevalence of issues concerned at two different points in time. Both reports were largely descriptive in their approach and focused in terms of statistical analysis on the significance of the differences between intervention and comparison provinces.

The baseline and end line survey could not make use of a quasi-experimental approach as the comparison provinces, though similar in key nutrition related indicators, had FSN interventions implemented of UN agencies as well as RGC and other development partners. Thus Takeo and Prey Veng province were no real 'control group', areas in which there would have been no interventions.

Programme implementation in the two selected provinces of Kampong Speu and Svay Rieng was not fully identical in terms of timing as well as implementation process of programme components. The end line report focuses on comparing results from the two interventions with the two comparison provinces and does not pay attention to any other options for analysis, including comparison between the two intervention provinces.

The baseline and endline studies are further limited to the application of a quantitative approach in which the statistical significance of relationships between variables can be established, but which does not necessarily indicate the social relevance and content of such relationships. To address aspects of social relevance and qualitative relationships between programme activities and outcome level changes, additional qualitative inquiry is needed. The programme has planned case studies for this purpose, in order to supplement the quantitative findings of the baseline and endline surveys and to deepen lessons learned.

- 4.61 The proportion of underweight children under five years decreased from baseline to end line in both groups: from 33.0% to 28.8% in the intervention area 34.2% to 27.9% in the comparison group. Correspondingly, the prevalence of stunting dropped from 36.2% to 32.3% in the intervention group and from 36.1% at baseline to 27.4% at end line in the comparison group. Moreover, the proportion of pregnant women with normal hemoglobin increased substantially. Mean BMI was 21.0 kg/m² at end line in both groups, which represents a significant increase of 0.62 kg/m² from baseline in the comparison group, but a non-significant increase of 0.3 kg/m² in the intervention group.
- 4.62 The impact level changes in particular on severely and moderately malnourished children and the effects of MNPs on the conditions of young children were confirmed in qualitative interviews. Staff of Health Centres, VHSG members and selected programme beneficiaries commented on the fast recovery and growth of severely as well as moderately malnourished children when taking RUTF. These results were well recognized and highly appreciated. So were the results of the use of MNP, which was considered responsible for growth of children concerned as well as for their shiny skin and a healthy appearance.
- 4.63 The set-up of the baseline and end line surveys can only identify these changes in an indicative way. It cannot substantiate these findings in rigorous way as the comparison provinces were no real

control group and thus cannot be used as such in the analysis of the data. What the lack of a real control groups meant for the findings and options for analysis was not made clear in the methodology of the baseline report.

Box 3: Key findings of the Baseline and End line Surveys

Nutritional conditions

- Reduction in the prevalence of moderate anemia in children 6 to 59 months of age (in both 'intervention' as well as 'comparison' provinces)
- Reduction in the prevalence of underweight children (more in comparison than intervention provinces)

Dietary intake

- Increase in children 6 - 24 months of age with minimum dietary diversity (in both 'intervention' as well as 'comparison' provinces)
- Increase in the number of caregivers who ever received micronutrient powders to add to their child's food (much larger in 'intervention' compared to 'comparison' provinces)

Prevalence of disease

- Reduction in the proportion of children reporting diarrhea in the past 2 weeks (in both 'intervention' as well as 'comparison' provinces)

4.64 In addition to programme interventions, the impact level changes are influenced by the overall economic growth, which is reflected in the improved economic conditions in survey areas, in which there was an increase in permanent housing materials, increased access to electricity and increased possession of televisions, mobile phones and water pumps.³⁰ Moreover, aspects of access to clean drinking water are likely to have contributed to the impact level changes. The survey found an increase in hand pumps and purchased water as well as a rise in availability of water within the dwelling rather than outside, as well as a decrease in household dependence on pond, river or canal as main source of drinking water. In terms of sanitation, the use of closed latrines doubled and there was a decrease in both open field / bush defecation by adults as well as children around the house. Nevertheless, the incidence of open defecation, which remained around 50 % for both adults and children, was identified as a persistent concern.

SUSTAINABILITY

4.65 In order to assess sustainability, the focus was on ownership of the FSN agenda and the Joint Programme and its components, capacities at national and sub-national levels to continue interventions and replicability and scaling-up.

Issues of ownership

4.66 Enhancement of the ownership of the FSN agenda can be observed over the Joint Programme period. This both at the national level as well as at the level of the two targeted provinces.

4.67 High level of ownership of the FSN agenda was reflected in the national seminar on food security and nutrition conducted in mid-2012. The Seminar focused on the theme of Child and Maternal Nutrition and was opened by **Samdech Prime Minister Hun Sen** and closed by the **Deputy Prime Minister, Dr. Yem Chhay Ly**, the chairman of CARD. As part of the seminar a roadmap for further improvement of child and maternal nutrition in Cambodia was developed.

4.68 Moreover, CARD is in the process of updating the National FSN strategy and will develop a Nutrition Action and Investment Plan for Cambodia. Furthermore, there is to be a program-based approach including the scaling up of evidence-based nutrition intervention in the health sector, food

³⁰ McLean, Judy, Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Endline Survey (2013).

fortification and integrated community-based programs.³¹ The MDG-F experience could feed into these initiatives.

- 4.69 At the programme level the participation and involvement of CARD stands out, co-chairing the PMC and participating in the monthly JPTT meetings. The participation of Line Ministries in the PMC has been consistent but has been much less in the JPTT related to actual aspects of implementation. At the provincial level the FSN issues were increasingly owned over the life of the programme. However, the financial management through the individual UN agencies tended to reduce levels of ownership at both national and provincial levels. At the local level ownership was constrained by the need for incentives without which the opportunity costs for volunteers often proved too high.
- 4.70 The BCC campaign has been conducted making use of RGC systems and has been well owned by government health staff. In addition to the MDG-F programme, HSP II pooled fund resources were used to deliver the messages through mass media and parts have received funding through USAID.

Capacities built

- 4.71 The Joint Programme has worked through RGC systems in programme implementation and has built additional capacities at the individual, and enabling environment level. This combination of approaches enhanced longer term results, though a three year period remains a relatively short period for sustainable capacity changes to be realized.
- 4.72 Capacities were built at multiple levels, including at the enabling environment, organizational and individual level. At the enabling environment one of the results concerned the development of the ECCD National Action Plan which has been submitted for approval to the Council of Ministers. The programme, moreover, aimed to influence workplace policies and regulations in garment and other industries. National guidelines for the management of acute malnutrition, and the national policy and guidelines for micronutrient supplementation, developed as part of the programme were started to be used. The support to the development of a curriculum for a Master course in nutrition, which was added to the programme design, resulted in a functioning course.
- 4.73 One of the organizational aspects at the national level concerns the establishment of the Food Security and Nutrition data analyses team. The team is part of the Technical Food Security and Nutrition Management Taskforce, which is part of the Technical Working group on Food Security and Nutrition. The set-up of the group means that an organizational structure is in place, with inclusion of relevant parties concerned. Line Ministries as a result have developed a routine to provide FSN data on a regular basis to the working group and it is an on-going initiative. However, the initiative does receive on-going support primarily from WFP after the phasing out of MDG-F. In addition WFP supports the monthly bulletin on Food price and wages with a combination of RGC and WFP data.
- 4.74 At the sub-national level the programme has worked through provincial departments and operational districts, through health centres and referral hospitals, as well as through Departments of Education and Agriculture and local level farmer field schools and village health support groups. Capacities built at this level have focused in particular at the individual staff level and focused on technical aspects of FSN. There has been less explicit attention to development of organizational capacities with a focus on organizational development aspects.
- 4.75 Much progress has been achieved in particular in SAM treatment, though important constraints need to be dealt with in order for results to sustain in the longer term. An important aspect is the need to focus more on demand side issues, with the occurrence of undernutrition often not recognized by caretakers as something that needs to be addressed in a therapeutical way.
- 4.76 The distribution of MNPs has been most successful in terms of its scaling up to the whole province. In order for the initiative to become sustainable capacities for supply chain management need to be

³¹ Opening remarks of H.E. Mr. Srun Darith, Deputy Secretary General of CARD and co-chari of the PMC, during the sixth PMC Meeting of 27 June 2012. Minutes of the Sixth PMC Meeting of the MDG-F Joint Programme on Children, Food Security and Nutrition

further enhanced, something which also goes for the distribution of RUTF for the treatment of SAM and MAM.

Coordination

- 4.77 Throughout programme implementation, the national level nutrition working group has been functioning and sectoral aspects of food security and nutrition have been brought together and interconnected. Moreover, working relationships have been enhanced across the various sectors involved in FSN as well as across the UN agencies at the national level.
- 4.78 At the provincial level the Programme coordination meetings at the provincial level appeared to have enhanced the understanding of the cross sectoral aspects of FSN issues. The country wide establishment of WCCC in 2009 was followed up in Kampong Speu and the WCCC took over the MDG-F PCC meetings which has enabled continuation of an integrated approach to FSN at the provincial level. This provides opportunities to also use this mechanism to discuss FSN issues and their multi-sectoral nature in other provinces.
- 4.79 The Mid-term evaluation suggested transferring the responsibilities to a permanent provincial forum, like the Provincial Consultation Committee for Women and Children under the Ministry of Interior.³² The Women and Children Consultative Committee (WCCC) of the Provincial Council in one of the intervention provinces, established since 2010 appeared to have much overlap of participants with the PCC, as all the agencies participating in the MDG-F programme were also part of the WCCC. As the MDG-F programme period was coming to an end the last PCC meetings were shifted to be conducted as WCCC meetings so that coordination across the various Departments within the province will continue.³³

Replicability, scaling up and follow-up

- 4.80 Aspects of replicability and scaling up have not been systematically addressed across all programme components and have remained issue specific and agency related, rather than based on a programmatic approach.
- 4.81 The level of scaling up differs across the programme components. Scaling-up was realized for the provision of MNPs to all households in the two selected provinces for children between 6 and 24 months of age. It could not be realized for SAM which is in an earlier stage of implementation in Cambodia and which component had to deal with a variety of constraints.
- 4.82 The materials of the BCC campaigns have been open access resources and have been widely shared with other organizations and used by multiple parties. This was a way of scaling up the BCC part of the programme. Focus of the campaign was on child feeding behaviours. There was no tracking system put into place assessing who used which BCC resources and no systematic monitoring of the effects of the campaign was conducted apart from the baseline and end line surveys.
- 4.83 Many of the issues identified in the course of the programme will be followed-up in the programming of the participating UN agencies. An example includes UNESCO's intent to support work on socio-cultural factors including food taboos related to the cultural context of Cambodia.
- 4.84 A three year time frame proved short for a relatively complex programme to reach sustained results, aspects of replicability, scaling up and follow up need to be included after the programme

Financial sustainability

- 4.85 Financial sustainability of programme results remains quite a distant objective though some steps have been made in this direction. This includes the agreement of the Health SWSP to use part of the pooled funds for the purchase of BP 100 for SAM treatment and for MNPs an important step has been made towards financial sustainability of management of SAM in health centres and hospitals

³² Ibid.

³³ Minutes of the Sixth PMC meeting, 27 June 2012.

and MNP distribution. Though the fund as such is supported by several development partners, inclusion in the fund enhances the likeliness of expenses to be included in the RGC budget afterwards.

- 4.86 The National Nutrition Strategy does include several of the components supported by the programme but these are not necessarily included yet in health plans. Incorporation of these issues in sub-national level health plan and budgets would be the litmus test for enhanced sustainability of results in the near future. The National Health strategic plan is due next year.
- 4.87 At the local level the lack of financial and other incentives proved to be an important constraint for the on-going implementation of SAM management and MNP distribution. Such incentives were not included in the HSP II though the programme management advocated for this. In a separate programme UNICEF and WB piloted budget delivery through the Ministry of Interior to the village council and VHSG which could provide an alternative approach to funding community level initiatives in particular support to the VHSG as an important player in the management of SAM and distribution of MNPs.

5 CONCLUSIONS

- 5.1 The relevance of the Joint Programme was high in terms of alignment with RGC and UNDAF objectives. The programme addressed relevant needs with the latest figures indicating remaining relatively high levels of stunting and underweight of children in parts of Cambodia.
- 5.2 The programme design makes use of a multi-sector approach in which health, food security and nutrition are interrelated in order to enhance nutritional conditions of children and women. The rationale of this approach was not made explicit nor sufficiently reflected in the results framework of the programme, limiting the options for monitoring and evaluation of cross-sector results of the programme. The design, moreover, is not clear on aspects of piloting and scaling up with the mixture of components at different stages of standardized practice.
- 5.3 The programme worked at national and sub-national levels, combining aspects of an enabling environment with issues of organizational and individual capacity level. How these different levels interrelated was, however, not made sufficiently explicit in the design.
- 5.4 Levels of efficiency of the programme varied. The governance arrangement functioned well with the National Steering Committee operating at a distance and management overseen by the Programme Management committee. For day to day management the JP Technical Team could have enhanced its operation with additional participation of point persons of Line Ministries. The joint set-up of the programme was not matched in its financial arrangements, with funds passing through each of the six UN agencies, making use of a pass through funding modality.
- 5.5 Provincial coordination was managed by the Provincial Coordination Committee, which was in Kampong Speu merged with the WCCC in which way the cross sectoral coordination could be sustained beyond the programme period. Programme coordinators at national and provincial level effectively facilitated coordination amongst the various RGC and UN partners as well as participating NGOs.
- 5.6 The implementing capacities of the UN as well as the RGC agencies improved over time. Though expenditure was relatively slow till the mid-term of the programme, the speed of programme implementation picked up afterwards with 92 % of funds spent at the end of 2012 and 100 % at the end of the extension period, end June 2013.
- 5.7 Monitoring focused largely on activities and their outputs which were consistently reported in quarterly reports. What was missing is monitoring of outcome level changes, which often concern aspects shared across the various sector level components. The inclusion of some of the outcome level indicators as part of the baseline and end line surveys was useful, though it meant that the information was not available during programme implementation, which reduced the options for results based management across the programme components.
- 5.8 The Joint Programme has been relatively effective in the implementation of activities and outputs and most of the planned outputs were realized. Moreover, many of the outcome level indicators included in the baseline and end line survey show positive changes in breast feeding, complementary feeding practices and dietary diversity for small children, as well as MNP distribution. There is, moreover, a reduction in the prevalence of diarrhoea and improvement in the use of zinc for treatment. Also aspects of maternal health and nutrition have improved. The results concerning enhanced knowledge based on the BCC campaigns were varied. The proportion of households owning a homestead garden reduced and was only at 13 % at the end line survey in the intervention area. Such a low level of access to a homestead garden questions the relevance of the approach to home gardening as part of the programme. The overall food security levels appeared to have decreased over the three year period which is not consistent with the trend of economic development in these provinces.
- 5.9 In terms of causal relationships it is not straightforward to connect the outcome level changes with the outputs of the programme. As comparison provinces were also targeted for FSN interventions by RGC and other development partners, they constituted no real 'control group'. The surveys made use

of random sampling based on the assumption that many of the interventions would be implemented at scale. In practice the scale of most of the interventions has been more limited, which reduced to ability of a random sample to assess outcome and impact level changes affected by the programme. With these limitations, the analysis of baseline and end line data needs to focus more on the changes in the intervention areas (rather than on a comparison of intervention and comparison areas). Additional qualitative data could enhance linkages in particular across output and outcome level changes.

- 5.10 Important constraining factor for reaching results at the community and household level concerned the limited synergy created across the various programme components at the local level. Though components did coordinate their targeting amongst the various UN and RGC agencies, with the components implemented at different scales, outputs did not necessarily come together at the local level. Moreover, a three year timeframe proved to be a relatively short period for a Joint Programme which has a relatively high amount of transaction costs at the start.
- 5.11 In terms of impact level changes, in particular the decrease in moderate as well as severe anaemia levels among children under 5 years of age and the decrease of underweight of children in the intervention provinces stand out. Moreover, the proportion of pregnant women with normal haemoglobin increased substantially. These findings were confirmed in interviews at commune level where in particular results of SAM treatment were asserted as well as the effects of the use of MNPs for small children. It is likely that the outcome level results have contributed to these impact level changes, though the limitations in the analysis of baseline and end line surveys means that no definite linkage could be established so far.
- 5.12 In addition to programme interventions, changes in nutritional and health conditions of children and women are affected by overall economic growth in the survey areas as reflected in the socio-economic data gathered in both baseline and end line surveys. In terms of sanitation, levels of open defecation, though reduced, remain a serious issue of concern.
- 5.13 In terms of sustainability there is an increased level of ownership of the FSN agenda in Cambodia, demonstrated in the National Seminar on Food Security and Nutrition of mid-2012, which focused on the theme of Child and Maternal Nutrition. Moreover, a new National FSN strategy is being developed. This ownership of the FSN agenda is also increasingly reflected at the provincial level. Ownership of the programme varied, being high at CARD but less pronounced for other Line Ministries. The financial set-up of the programme tended to reduce ownership at national as well as provincial levels.
- 5.14 Capacities have been built at multiple levels. Programme support of initiatives on policy and guidelines has enhanced the enabling environment for FSN interventions. Working through RGC systems has resulted in enhanced capacities at multiple levels in partner agencies, in particular at the sub-national level. Such systemic capacities are likely to enhance sustainability. Much of the work at provincial focused on building individual staff capacities, which appear less sustainable given the relatively high levels of staff turn-over.
- 5.15 The national Nutrition Strategy does include the components supported by the MDG-F Joint Programme, though these are not necessarily included yet in health plans, which will form a litmus test for the near future, in particular in terms of inclusion of budgeting of nutrition related issues. With the pooled fund agreement to budget for the purchase of BP 100 (for SAM treatment) and MNPs it has become more likely that these items will be incorporated in the RGC health budget in the near future. This would mean an important step towards future financial sustainability of management of SAM in health centres and hospitals and distribution of MNPs to young children.
- 5.16 The Joint Programme has brought the various RGC, UN and NGO partners at both the national and the sub-national level closer together in their understanding of FSN issues, including the cross-sectoral characteristics and linkages, which can enhance future FSN programming.

6 LESSONS LEARNED

The Joint Programme needs to be seen as a project within a wider programme based approach to FSN in Cambodia

- 6.1 The Joint Programme on Children, Food Security and Nutrition in Cambodia includes a number of UN agencies which each support several RGC Ministries and Departments and implementing agencies, including sub-national service providers and NGOs. The Joint Programme consisted of the implementation of a given set of activities during a limited time period. However, the activities of each of the stakeholders, UN as well as RGC as part of the Joint Programme did not stand alone but were part of a wider set of initiatives focused on addressing FSN in Cambodia both before the JP period as well as afterwards.
- 6.2 Monitoring and evaluation made use of the results framework of the Joint Programme, focusing on the activities conducted and their immediate and medium term results. With the focus of the design on the programme period, there was no opportunity to include the way in which the activities fitted in the programmatic work of each of the agencies. The focus of the design did not enable this, nor did the evaluation framework of the MDG-F.
- 6.3 For a Joint Programme to be part of a programmatic approach the design of the programme would need to reflect this programmatic approach and identify how the Joint initiative fits within the overall programmatic issues to be addressed by a variety of stakeholders. This would not only better highlight the objectives of the initiatives as part of a wider programmatic goal but would also enhance monitoring and evaluation. The latter could in this way include not only whether project activities were implemented and outputs and outcomes reached, but focus on outcome level changes of the project and how these contribute to the wider programmatic goals that all the partners try to achieve in the medium to longer term, as part of a programmatic approach.

In the allocation of resources among the participating UN agencies the scale required for each of the programme components needs to be considered in order for implementation to result in synergy at the local level

- 6.4 The Joint Programme budget was divided over the participating UN agencies in an uneven way. This division of resources was not based on an assessment of the needs of FSN interventions but depended to a large extent on the level of inputs provided by UN agencies in the development phase of the proposal in response to the RFP from MDG-F. Agencies that put substantial effort in the design were more able to realize their objectives.
- 6.5 The division of resources did not sufficiently take into account the scale of the various initiatives and what level of scale of each of the components would be required to create synergy at the local level. Though multiple issues were addressed in the programme, given the differences in scale of the activities, which is partly related to the division of resources amongst the UN agencies, the synergy at the local level remained limited.

The need for comparable targeting of programme components to enhance convergence at the local level

- 6.6 In order for programme components that focus on various aspects of food security and nutrition to converge together at the local level and to make a difference for the same households there needs to be sufficient coordination across these components on targeting, focusing on the same geographical areas and having comparable and overlapping coverage within those areas.
- 6.7 There appeared to be substantial coordination across the various components of the Joint Programme in the selection of the target areas for each of the components. However, there were substantial differences in coverage of components within those geographical areas. This meant that the outputs of the various types of support did often not converge at the local level. Thus the linkages between aspects of food production (in particular gardening and small livestock rearing), in-

home food fortification and management of malnutrition were often not realized in the same localities.

In a Joint Programme that works at both national and sub-national levels, sub-national level representatives need to be included from the start in national level coordination mechanisms

- 6.8 The participation of the Deputy Governors of both Kampong Speu and Svay Rieng province during the sixth and last PMC meeting in June 2012 provided added value in terms of relating the national and sub-national project components. In a programme that combines national and sub-national activities such a set-up would be advisable from the start of the programme to enhance coordination at the programme management level.

The use of take home rations in the out-patient treatment approach to SAM at the Health Centre is a viable and efficient approach but does require some incentives for the system to operate in practice

- 6.9 The handling of Severe Acute Malnutrition at the Health Centre with the use of send home rations worked well at the start and reduced costs. The out-patient treatment at the health centre is much more efficient compared to in-patient treatment in a referral hospital. For children and their caretakers not to have to visit the HC on a daily basis, which would prove to be prohibitive for many of them in terms of transport as well as opportunity costs, send home rations are an essential part of the package. However, incentives are needed to ensure that HC staff and VHSG are able to follow-up on distribution and address cases of default. Though ideally such incentives would be part of the regular health budget, there may be an interim period needed where these are (partly) funded from outside.

Risks to the early scaling up of Micro-Nutrient powders

- 6.10 There are substantial risks to the early scaling-up of the distribution of MNPs, in particular when capacities of local systems have not yet sufficiently been developed. The MNP component of the programme was scaled up in an early stage, with many households responding positive to the distribution of MNPs. However, stock out issues occurred, indicating problems with the supply chain and its management. Moreover, problems occurred with the quality of the MNPs after moving to a new provider. The scale of these problems can be reduced if the piloting period of distribution of MNPs is extended and sufficient time is taken to develop the supply chain and other capacities concerned.

Adapting the methodology of baseline and end line studies to the expected levels of change in a Joint Programme

- 6.11 There is a need to be prudent when developing baseline and end line studies. The goals and objectives of a programme tend to be aspirational and the targets set on indicators can be relatively high. However, during project implementation the scale of the activities can be reduced and the targets on indicators scaled down. This possibility needs to be taken into account when designing the impact assessment. The methodology applied needs to be able to register not only the aspirational level of change included in the design document, but also the change that actually occurs based on adaptations made during programme implementation. While a sample survey may be the best option for implementation at scale, a longitudinal study might be better able to capture changes on a more limited scale, following the same targeted households over a longer time period.

7 RECOMMENDATIONS

For Royal Government of Cambodia, at National Level

To lead the process on the development of a Theory of Change as part of the new National FSN Strategy

- 7.1 With the relative success of Joint Programme implementation there is a need to follow-up the multiple sector approach to FSN in Cambodia, making use of the learnings of the Joint Programme so far. Such follow-up could be greatly enhanced through the development of a theory of change (TOC) on food security and nutrition. Development of a TOC would make use of the objectives, programmatic priorities and priority actions as identified in the draft NFSNS and of existing frameworks as used in several UN agencies. Such a theory of change needs to cut across sectors and be specific to the context in Cambodia. It needs to be shared by RGC national and sub-national agencies, UN and civil society partners. A TOC will enhance the understanding of all parties concerned on how the various sector initiatives interrelate in order to reach the objectives of the National FSN strategy and can as such support its implementation. It can also support the process of incorporation of initiatives of all stakeholders in a common framework. This process could be led by CARD and supported by UN agencies, other development partners and civil society organizations;

Make use of the TOC in the development of a monitoring and evaluation framework and plan for the assessment of medium and longer term changes in food security and nutrition

- 7.2 The development of a theory of change can inform the M&E framework that is presently being developed for the new NFSNS. This monitoring framework will need to be able to assess FSN related issues from a programmatic, longer term perspective. Focus needs to be at outcome and impact level changes, including those behavioural and systemic changes that are beyond the control of project and programme management but need to take place in order to generate longer term effects. Such changes are often affected by multiple sector initiatives with shared objectives of multiple stakeholders. The framework needs to include indicators that are able to assess change at the immediate, intermediate and longer term and needs to be informed by the data that are already available on various aspects of FSN. The framework should remain relatively light and manageable rather than overly comprehensive. It will need to be accompanied by an M&E plan in which the details of regular monitoring as well as intermittent evaluation activities are operationalized and budgeted for.

At Sub-National level

- 7.3 Continue and further strengthen the provincial level coordination on FSN among parties concerned, in particular through the WCCC meetings, making use of the experiences in Kampong Speu and Svay Rieng. Make use of this mechanism to coordinate the implementation of FSN related programmes and initiatives at the provincial level. Further develop capacities of members that are part of the coordination mechanism;
- 7.4 Make use of the NFSNS and the TOC to develop a provincial level results framework tailored to the context of the province and the priority objectives and actions identified. Include indicators at the level of outcomes as well as outputs, with the outcome level indicators including cross sector changes. Set realistic targets on indicators in line with existing sector strategies and plans. In order to be able to assess change at the short, intermediate and longer term the set of indicators need to include multiple indicators for each of these time frames;
- 7.5 Develop a provincial level plan to monitor and evaluate FSN related changes making use of the result framework mentioned in 7.4. Such a plan should include procedures for data collection and analysis, responsibilities concerned, reporting mechanisms, use of data for decision-making, capacity development on M&E and a budget;

- 7.6 Establish a cross sector Food Security and Nutrition Data Analysis Team at provincial level, who bring together monitoring data at the sub-national level on a regular basis and who will feed this information to the national level. Through feed-back from the national level, provinces will be able to compare their performance with other provinces on a regular basis;
- 7.7 Continue trainings to commune/district/provincial level officials on the concepts and practice of FSN and how to mainstream nutrition related issues into local development plans, making linkages with food, health and related issues.

For UN Agencies

- 7.8 Continue support to FSN making use of a programme based approach, supporting RGC in the development of a TOC adapted to the Cambodian context in line with the NFSNS development (see 7.1);
- 7.9 Enhance attention to aspects of the quality of the design of a Joint Programme and in particular aspects of a theory of change and the ways in which the various sector components supported by different UN and RGC agencies are meant to create synergy at the local level. For this to happen the issue of scale needs to be addressed in the design with the scale of the individual components oriented towards the creation of synergy at the local level;
- 7.10 Support the monitoring of FSN related indicators at the outcome level in the field of competence of each of the UN agencies and related RGC counterpart agencies at national and sub-national levels. Make use of the TOC for FSN developed and support the building of monitoring capacities for FSN related indicators, including early identification of stress and emerging problems;
- 7.11 Enhance support at the demand side of FSN, focusing on the local perceptions of malnutrition and reasons why malnutrition is often not recognized and addressed and identifying ways to enhance demand side issues in a systemic way, including working with civil society stakeholders.

For MDG-F

- 7.12 The design of the future Joint Programmes should keep the number of UN agencies participating at a manageable level avoid adding agencies with relatively few resources allocated to them;
- 7.13 Align and relate the division of the budget among agencies with the scale of each of the programme component and position the project within a wider programmatic approach to the issues concerned.
- 7.14 Position a more clear outlines of an M&E plan as part of the programme design, in which both monitoring and evaluation functions are operationalized and include sufficient outcome level changes and indicators in the programme results framework.

ANNEXES

Annex 1: Terms of Reference

1. BACKGROUND AND CONTEXT

During the last decade, Cambodia has been rice self-sufficient and could produce increasingly larger surpluses for export (in 2010/11 3.9 million tons which is equal to 2.5 million tons of milled rice). Since 1994, poverty has decreased significantly from 47% to an estimated 26% currently and also food consumption of households improved. Also the nutritional status of children under 5 year improved considerably until 2005.

However, data from the Cambodian Anthropometric Survey in 2008 and the last Cambodian and Demographic and Health Survey in 2010 show that since then improvements in reducing child under-nutrition have come to a halt.

Improving Food Security and Nutrition Security (FSN) is an important development objective of the Royal Government of Cambodia and essential for achieving the Cambodian Millennium Development Goals (CMDG). FSN is directly addressed in the CMDG 1 "Eradicate extreme poverty and hunger" but food security and nutrition are also crucial to achieving most of the other CMDGs. The National Strategic Development Plan (NSDP) Update 2009-2013 states under key policy priorities and actions that "...to improve food security and nutrition for the poor in the context of the current crisis the Royal Government of Cambodia (RGC) will intensify efforts to enhance physical, and economic access to sufficient, safe and nutritious food through targeted and coordinated efforts across various sectors as outlined in the Strategic Framework for Food Security and Nutrition 2008-2012 developed by Council for Agricultural and Rural Development (CARD)". Food Security is further recognized as a basic human right under the Universal Declaration on Human Rights and the International Covenant on Economic, Social and Cultural Rights which was signed by Cambodia.

Recognizing such importance of food security and nutrition, the RGC has paid special attention on improving food security and nutrition and placed it as a development priority in national policies, strategies and plans. However, since food security and nutrition is a complex cross-cutting issue, there is a need for joint efforts of government and development partners in achieving ultimate goals set in these policies and strategies.

Global Context

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

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

A result oriented monitoring and evaluation strategy is under implementation in order to track and measure the overall effects of this historic contribution to the MDGs and to multilateralism. The MDG-F M&E strategy is based on the principles and standards of United Nations Evaluation Group (UNEG) and Organisation for Economic Co-operation and Development (OECD/DAC) regarding evaluation quality and independence. The strategy builds on the information needs and interests of the different stakeholders while pursuing a balance between their accountability and learning purposes.

Interventions range from providing low cost nutritional packages that can save lives and promote healthy development to engaging with pregnant and lactating mothers ensuring they are healthy and aware of key nutrition issues. Advocacy for mainstreaming children's right to food into national plans and policies is also a key element of the fight against under nutrition.

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

National Context

The "Joint Programme for Children, Food Security and Nutrition in Cambodia (CFSNC)" was approved in August 2009, signed by the Royal Government of Cambodia (RGC) and UN representatives in November 2009 and officially commenced on the 13th January 2010. The duration is 3 years and the programme was set to end on 13th January 2013. In 2012 the programme received a no-cost extension to 30 June 2013.

The overall goal of the Joint Programme (JP) is to reduce mortality and under nutrition among children 0-24 months and pregnant and lactating women and improving food security. The JP will contribute to the achievement of the following MDGs in Cambodia:

- MDG 1 - eradicating extreme poverty and hunger,
- MDG 4 - reducing child mortality,
- MDG 5 - improving maternal health.

In addition, the JP outcomes are expected to significantly contribute to the following United Nations Development Assistance Framework (UNDAF) targets:

- Improved health, nutritional and education status and gender equity of rural poor and vulnerable groups,
- Agriculture and rural development activities have improved livelihoods and food security, as well as reinforcing the economic and social rights of the most vulnerable in targeted rural areas.

The JP interventions are based on the analysis that significant causes for mortality and undernutrition of 0-24 month children are high rates of micronutrient deficiency and inappropriate infant and young child feeding. The JP aims to prevent child malnutrition through national behaviour change communication (BCC) campaigns, micronutrient supplementation, and homestead food production. The programme also includes a curative component for children that are already affected by undernutrition.

In order to improve the broader environment that these interventions take place in, the JP supports improvements to the policy context and to national level capacity for the management, monitoring and evaluation of food security and nutrition (FSN). While the JP had a national implementation and coverage as such, it provided an integrated comprehensive package of nutrition and food security interventions with higher coverage in two food insecure provinces, namely Kampong Speu and Svay Rieng.

The JP has three planned outcomes and seven outputs (Annex IV) that partner organisations together with the UN were responsible intended to achieve. In line with the **first outcome** to promote integrated approaches for alleviating child hunger and undernutrition, the proposed Joint Programme aimed to improve the nutritional status of children 0-24 months and pregnant and lactating women through two strategies: improving infant and young child feeding practices at population level through a nationwide behaviour changer communication (BCC) intervention and protecting vulnerable populations through an integrated comprehensive package of nutrition and food security interventions delivered with high coverage in two food-insecure provinces, namely Kampong Speu and Svay Rieng.

Measurable outputs for this outcome include a finalized Behaviour Change Communication (BCC) strategy, implementation of the BCC mass-media campaign nationwide, the development and production of BCC training materials, training of Village Health Support Groups and other community communicators throughout the country in BCC and the development and operationalization of the comprehensive integrated package of interventions with high coverage in two food-insecure provinces, namely Kampong Speu and Svay Rieng.

For the **second outcome** of advocating and mainstreaming access to food and nutrition into relevant policies, the Joint Programme aimed to strengthen the implementation of existing nutrition, food security and agricultural policies and develop new innovative policies addressing malnutrition. Measurable outputs for this outcome include a report on the implementation status of current relevant policies; policy implementation guidelines; well-trained staff in relevant ministries in the application of the guidelines; intersectoral and relevant Technical Working Group meetings on policy implementation; and the development and adoption of new policies on the following: using MUAC for screening to identify malnourished children; the management of moderate and severe malnutrition; and universal micronutrient supplementation for children aged 6-12 months. In conjunction with these new policy initiatives, additional outputs include the development of training materials and an implementation plan for achieving universal coverage of management of moderate and severe malnutrition and the development of an implementation and procurement plan for universal micronutrient supplementation.

For the **third outcome** of assessment, monitoring and evaluation, the Joint Programme proposed to revise and strengthen the Health Information System (HIS) and improve coordination between existing monitoring systems, including food security monitoring, and establish a national Nutrition Surveillance System. Measurable outputs for this outcome include the following: a functional national Nutrition Surveillance System; well-trained staff at the Ministry of Planning, National Institute of Statistics and MOH in the area of nutritional surveillance; a revised HIS which incorporates universal MUAC screening for malnutrition; and well-trained HIS staff at national and sub-national levels in the area of coordinating the collection, management and use of nutrition-related data.

The total budget of US\$ 5,000,000 is all funded by the MDG-F. The budget of each of the participating UN organisations is:

Participating UN Organization	Budget
UNICEF	\$2,501,874
WHO	\$789,660
FAO	\$493,270
WFP	\$638,790
ILO	\$345,610
UNESCO	\$230,157
Unallocated	\$639
TOTAL	\$5,000,000

As stipulated under the MDG-F M&E strategy and Programme Implementation Guidelines, the CFSNC established an M&E system during the design phase. The M&E system includes an M&E framework, plans for a baseline/end line survey, and both mid-term and final evaluations.

Monitoring according to the M&E Framework and reporting requirements of the MDG-F Secretariat has been on-going since the beginning of the programme. A baseline survey, commissioned by WHO, was carried out in early 2010 and the MDG-F Secretariat commissioned a mid-term evaluation with a formative focus in 2011. The end line survey is currently being commissioned by WHO and will be completed by May 2013. The final evaluation, planned for mid-2013, will be the last implemented component of the M&E system. Outside of the formal M&E system, agencies and groups of agencies have carried out small evaluations of specific activities and interventions throughout the life of the joint programme. The final evaluation will build on the monitoring and evaluation work done under the joint programme, including activities within and outside of the formal M&E system.

On behalf of the CFSNC, UNICEF is seeking a high-qualified consultant to conduct the final evaluation of this joint programme with a summative focus.

2. PROGRAMME AREA AND SPECIFIC PROJECT INVOLVED

Section:	MNCH-N
Intermediate Result:	IR-2: Nutrition
Activity:	Support Implementation of Complementary Feeding Communication Campaign

3. PURPOSE OF THE EVALUATION

Final evaluation is **summative** in nature and its main purpose is to generate substantive evidence based knowledge, on one or more of the MDG-F thematic windows by identifying good practices and lessons learned that could be useful to other development interventions at national and international level. The evaluation will also contribute in setting the agenda on the future of the programme or some of its components by synthesizing the overall effect of the thematic window on Childhood and Nutrition fund at national and international level.

The **primary users of the evaluation** are the Joint Programme participating agencies, including UNICEF, WHO, FAO, WFP, ILO and UNESCO and the Royal Kingdom of Cambodia, and more specifically are the Ministry of Health, (NCHP, NNP, PHD's, CDC), Ministry of Labour and Vocational Training (MoLVT), Ministry of Agriculture, Forestry and Fisheries (MAFF), Council for Agricultural and Rural Development (CARD) and Ministry of Planning. The findings and recommendations will be used to influence the relevant policies and sectoral actions plans for achieving better results and improve the situation on malnutrition and food security in the country. In addition the findings, conclusions and recommendations generated by this evaluation will be part of the thematic window Meta evaluation that will be undertaken by the Secretariat to synthesize the overall impact of the fund at national and international level.

The Programme Technical Group for the joint programme will design and implement a dissemination plan for the evaluation findings, conclusions and recommendations with the aim to advocate for sustainability, replicability, scaling up or to share good practices and lessons learnt at local, national or/and international level.

4. SPECIFIC OBJECTIVES

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

1. Determine to what extent the joint programme has contributed to solve the needs and problems identified in the design phase.
2. Analyse the joint programme's degree of implementation, efficiency and quality delivered on outputs and outcomes, against what was originally planned or subsequently officially revised.
3. Determine to what extent the joint programme has attained its development results benefiting the targeted population, beneficiaries, participants whether individuals, communities, institutions, etc.
4. To what extent the programme is in aligned to the overall MDG fund objectives at local and national level. **(MDGs, Paris Declaration and Accra Principles and UN reform).**
5. To identify and document substantive lessons learned and good practices on the specific topics of the thematic window, MDGs, Paris Declaration, Accra Principles and UN reform with the aim to support the sustainability of the joint programme or some of its components.

5. SCOPE OF THE EVALUATION

The final evaluation is summative in nature and will focus on measuring development results and potential impacts generated by the **Joint Programme** for Children, Food Security and Nutrition in Cambodia (CFSNC) that was implemented from January 2010 – June 2013, based on the criteria included in this terms of reference.

The evaluation will consider joint programme interventions with national scope with a greater focus on the two provinces targeted by the Joint Programme: Kampong Speu and Svay Rieng.

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

For Development Results the evaluation should build on the JP M&E Framework to determine the implementation status and overall effectiveness of the programme and interventions under each outcome. Annual Monitoring Reports, Assessments (Annex III) and the End-Line Survey Report (Annex V), along with other methodological tools and analysis determined by the evaluator including stakeholders' perceptions will be used to measure each outcome.

6. EVALUATION CRITERIA

The evaluation questions are divided into Development Results (covering objectives 1-3) and Lessons Learned (objective 5) and are included below. Evaluation questions are clustered according to the following criteria: efficiency, effectiveness, sustainability, relevance and impact. The evaluation sub-questions will be discussed in more details in the inception phase with the evaluation reference group after identification of the consultant(s).

A. Development Results Evaluation Questions

Relevance

- a) To what extent the objectives and interventions of the joint program were pertinent to contribute in achieving the national priorities and policies as well as participating UN agencies³⁴ as well as human rights (Right to Health, Rights of the Child)?
 - What is the merit or relevance of the joint programme in relation to the needs and reducing the inequalities of the worst-off groups/most vulnerable people and others?
- b) To what extent did the joint programme align itself with the National Development Strategies and to the UNDAF, MDGs, Paris Declaration and Accra Principles and UN Reform?

Efficiency

- a) To what extent did the joint programme's management model (i.e. instruments; economic, human and technical resources; organizational structure; information flows; decision-making in management) was efficient to the results attained?
- b) To what extent the governance of the fund at programme level (PMC) and at national level (NSC) contributed to efficiency of the joint programme? To what extent these governance structures were useful for development purposes, ownership, for working together as one? Did they enable management and delivery of outputs and results?

³⁴ UNICEF, WHO, FAO, WFP, ILO and UNESCO

Effectiveness

- a) To what extent the joint programme model and interventions have contributed to nutrition, food security and agricultural policies? Either in terms of implementation or revision of existing policies or to the development of new ones?
- b) To what extent the joint programme approach has been effective to better address and advocate for the food security and nutrition of children and women at national and subnational level?
- c) What are the intended and unintended results of the joint programme in respect to:
 - The extent to which the joint programme was able to reach most vulnerable people.
 - The extent to which the joint programme contributed to decreasing inequalities related to the food security and nutrition status between the worst-off and best-off.
 - To what extent the joint programme contributed to the change in nutritional and food security practices of population and stakeholders?

Sustainability

- a) What are major factors that influence the achievement or non-achievement of sustainability of the joint programme outcomes?
 - Are the interventions and its impact on the worst-off/most vulnerable people likely to continue after joint programme is completed and external support is withdrawn?
 - How likely the joint programme be replicated or scaled up at national or subnational levels?
- b) To what extent the joint programme decision making bodies and implementing partners have undertaken the necessary decisions and course of actions to ensure the sustainability of the effects of the joint programme?

At local and national level:

- i. To what extent did national and/or local institutions support the joint programme?
- ii. Do these institutions show technical capacity and leadership commitment to keep working with the programme or to scale it up?
- iii. Have operating capacities been created and/or reinforced in national partners?
- iv. Do the partners have sufficient financial capacity to keep up the benefits produced by the programme?

Impact

- a) To what extent has the joint programme contributed to the attainment of the development results to the targeted population, beneficiaries and participants, whether individuals or communities?
- b) To what extent and how the joint programme contributed to the nutritional status of children aged 0-24 months and pregnant and lactating women?

Cross-cutting issues

- a) What were the challenges and to what extent have this affected the joint programme?

B. guiding questions for case studies

In addition to the evaluation questions the JP would like to address some specific areas with more detailed questions. These questions should be used to guide the development of case studies including lessons learned that the JP intends to inform for domestic scale-up and/or replication internationally. Selected interventions

include food security and nutrition information management, multiple micronutrient powder in home fortification, and management of acute malnutrition. Additional questions are:

Food Security and Nutrition Data Analysis Team and Quarterly Bulletins

- a) How and why was the data analysis team established?
- b) Has the data analysis team functioned as planned?
- c) What is the added value/impact of current practices and is it an improvement over former food security and nutrition information systems?
- d) Can the current system be considered sustainable and has it contributed to integration?
- e) Should the system be replicated in other countries?

Multiple Micronutrient Powder In-Home Fortification

- a) How and why did implementation start?
- b) Has implementation proceeded as planned and what are the key factors that help or hinder implementation?
- c) What have been the results, both short and long term, of the intervention?
- d) What is required for scale-up and sustainability of the intervention?

Management of Acute Malnutrition

- a) How effective is management of acute malnutrition at the health center level?
- b) Are there differences in effectiveness between implementation modalities or areas (ngo support, province)? If so, what are the implications?
- c) Can the intervention be effectively scaled up within the current public health system?

7. METHODOLOGICAL APPROACH

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

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

8. EVALUATION DELIVERABLES

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

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

This report will be 10 to 15 pages in length and should be in line with UN standards for inception reports and will contain initial findings from the desk review; proposed methods, sources and procedures to be used for data collection, timeline of activities and submission of deliverables. The inception report will propose initial lines of

inquiry about the joint programme. This report will be used as an initial point of agreement and understanding between the consultant and the evaluation manager. The report will follow the outline stated in Annex 1.

Draft Case Studies

These case studies will be 10 to 15 pages in length and will describe programme history, current implementation, and future strategic choices. Case studies will be based on literature review and stakeholder interviews.

Draft Final Report (to be submitted within 20 days after the completion of the field visit)

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

Final Evaluation Report and power point presentation (to be submitted within 10 days after receiving the draft final report with comments)

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

Deliverables	Estimated Due Date ³⁵
Inception report	10 working days
Draft case studies	30 working days
Draft final evaluation report	20 working days
Final evaluation report and power point presentation on evaluation	10 working days

9. KEY ROLES AND RESPONSIBILITIES IN THE EVALUATION PROCESS

There will be 3 main actors involved in the implementation of MDG-F final evaluations:

1. UNICEF as **commissioner** takes the accountability of the final evaluation and will designate the evaluation **manager** that will have the following responsibilities:
 - Lead the management of the evaluation process throughout the 3 main phases of this final evaluation (design, implementation and dissemination and coordination of its follow up)
 - Convene the evaluation reference group
 - Provide inputs and lead the finalization of the evaluation ToR
 - Facilitate the participation of those involved in the evaluation design
 - Coordinate the selection and recruitment of the evaluation team by making sure the lead agency undertakes the necessary procurement processes and contractual arrangements required to hire the evaluation team
 - Safeguard the independence of the exercise and ensure the evaluation products meet quality standards

³⁵ Exact dates will be identified after selection of the consultant(s) and should be specified in the inception report.

- Connect the evaluation team with the wider programme unit, senior management and key evaluation stakeholders, and ensure a fully inclusive and transparent approach to the evaluation
 - Facilitating the evaluation team's access to all information and documentation relevant to the intervention, as well as to key actors and informants who should participate in interviews, focus groups or other information-gathering methods
 - Provide the evaluators with overall guidance as well as with administrative support
 - Oversee progress and conduct of the evaluation the quality of the process and the products
 - Take responsibility for disseminating and learning across evaluations on the various joint programme areas as well as the liaison with the National Steering Committee
 - Disseminate the results of the evaluation
- 2. The Programme Technical Committee** that will function as the **Evaluation Reference Group**, this group will comprise the representatives of the major stakeholders in the joint programme. In addition, UNICEF as commissioner of the final evaluation will include its Evaluation Specialist and Regional Evaluation Advisor as additional members to the evaluation reference group. The ERG will:
- Provide clear specific advice and support to the evaluation manager and the evaluation team throughout the whole evaluation process
 - Review the ToR, inception report and draft evaluation report and ensure final draft meets the UNICEF-Adapted UNEG Evaluation Reports Standards.
- 3. The MDG-F Secretariat** that will function as a **quality assurance member** in the evaluation reference group
- Review and provide comments and feedback on the quality of the evaluation process as well as on the evaluation products (comments and suggestions on the TOR, draft reports, final report of the evaluation).
- 4. The evaluation consultant/team** will conduct the evaluation study by:
- Fulfilling the contractual arrangements in line with the TOR, UNEG/OECD norms and standards and ethical guidelines; this includes developing an evaluation matrix as part of the inception report, drafting reports, and briefing the commissioner on the progress and key findings and recommendations, as needed.

10. EVALUATION PROCESS: TIMELINE AND SUPERVISION

Estimated Duration of Contract (Dates and period):

Total 70 working days in a period of four months.

Payment Schedule (Please link to deliverables to the extent possible):

Payment is contingent on approval by the evaluation manager and will be made in three instalments.

1. 15 % of the total contract will be paid upon submission of the inception report;
2. 35 % of the total contract will be paid upon submission of case studies
3. Remaining 50 % per cent will be paid upon submission of finalised evaluation report.

Official Travel Involved (specify if yes):

It is expected that the consultant/team would make a visit to the country (if located outside) including provinces for field work as per methodology. It is estimated that 47 in-country working days are required.

Contract Supervisor/Evaluation Manager:

The consultant will work under the supervision of the Evaluation manager, i.e. UNICEF Nutrition Specialist.

The consultant/team will also work in close consultation with the Council for Agricultural and Rural Development, with the Ministry of Health's National Nutrition Programme, and with the JP Technical Committee.

Type of Supervision that will be provided:

Supervisor will have frequent interactions with the consultant at various stages in order:

- to brief the consultant on the situation/assignment; agree on the process and clarify the deliverables;
- to introduce the consultant to key stakeholders and counterparts;
- to provide feedback and get agreement on the deliverables
- to track the progress made by the consultant.

The supervisor will approve the deliverables and evaluate the consultant's/team's work in consultation with Evaluation reference group and will process the payments after submission of the deliverables that respond to the quality standards.

Consultant's Work Place/Any facilities to be provided by office:

UNICEF will provide office space and field work support, if required.

Nature of 'Penalty Clause' to be Stipulated in Contract:

Unsatisfactory performance: In case of unsatisfactory performance the contract will be terminated by notification letter sent 5 days prior to the termination date. In the meantime, UNICEF will initiate another selection in order to identify appropriate candidate.

Performance indicators: Consultants' performance will be evaluated against the following criteria: meeting TOR requirements, timeliness, quality of due deliverables that are in line with UNEG Evaluation standards, work relations, initiative/drive for results, communication, dependability/reliability in carrying out the assignments.

Estimated Cost of Contract (Inclusive of fee, travel, DSA, etc)

Remuneration will be based strictly on complexity of the assignment as indicated in ToR and based on the cost provided by the competitive proposal received. UNICEF will select the proposal with the lowest fee among those who are deemed suitable for achieving all tasks in time, and as per the criteria and deliverables stipulated in the terms of reference and based on the evaluation report.

The proposals should include all-inclusive fees, including lump sum travel and subsistence costs (see paragraph 13 below).

11. ETHICAL PRINCIPLES AND PREMISES OF THE EVALUATION

The final evaluation of the joint programme is to be carried out according to ethical principles and standards established by the United Nations Evaluation Group (UNEG).

- **Anonymity and confidentiality.** The evaluation must respect the rights of individuals who provide information, ensuring their anonymity and confidentiality.
- **Responsibility.** The report must mention any dispute or difference of opinion that may have arisen among the consultants or between the consultant and the heads of the Joint Programme in connection with the findings and/or recommendations. The team must corroborate all assertions, or disagreement with them noted.
- **Integrity.** The evaluator will be responsible for highlighting issues not specifically mentioned in the TOR, if this is needed to obtain a more complete analysis of the intervention.
- **Independence.** Evaluation in the United Nations systems should be demonstrably free of bias. To this end, evaluators are recruited for their ability to exercise independent judgement. Evaluators shall ensure that they

are not unduly influenced by the views or statements of any party. Where the evaluator or the evaluation manager comes under pressure to adopt a particular position or to introduce bias into the evaluation findings, it is the responsibility of the evaluator to ensure that independence of judgement is maintained. Where such pressures may endanger the completion or integrity of the evaluation, the issue will be referred to the evaluation manager and, who will discuss the concerns of the relevant parties and decide on an approach which will ensure that evaluation findings and recommendations are consistent, verified and independently presented (see below Conflict of Interest)³⁶.

- **Incidents.** If problems arise during the fieldwork, or at any other stage of the evaluation, they must be reported immediately to the evaluation manager. If this is not done, the existence of such problems may in no case be used to justify the failure to obtain the results stipulated in these terms of reference.
- **Validation of information.** The consultant will be responsible for ensuring the accuracy of the information collected while preparing the reports and will be ultimately responsible for the information presented in the evaluation report.
- **Intellectual property.** In handling information sources, the consultant shall respect the intellectual property rights of the institutions and communities that are under review. All materials generated in the conduct of the evaluation are the property of the agency and can only be used by permission. Responsibility for distribution and publication of evaluation results rests with the Country Office. With the permission of the agency, evaluation consultants may make briefings or unofficial summaries of the results of the evaluation outside the agency.
- **Delivery of reports.** If delivery of the reports is delayed, or in the event that the quality of the reports delivered is clearly lower than what was agreed, the penalties stipulated in these terms of reference will be applicable.

12. REQUIRED QUALIFICATIONS

- At least 5 years of experience in leading of similar scale and level of complex evaluations
- Advanced degree in public health, nutrition, agriculture, international development and/or an associated field;
- Experience with and strong skills in quantitative and qualitative research and approaches;
- More than 5-year working experience (international and local) in the area of nutrition and food security
- Excellent analytical and report writing skills;
- Good communication and facilitation skills;
- Fluency in English;
- Knowledge of Cambodian context and experience with food and nutrition security preferred.

13. EVALUATION CRITERIA

A two stage procedure shall be utilized in evaluating proposals, with evaluation of the technical proposal being completed prior to any price proposal being compared.

Applications shall therefore contain the following required documentation:

³⁶ UNEG Ethical Guidelines for Evaluation

1. **Technical Proposal:** Containing a cover letter, updated CV and Personal History Form (P11), and copies of 2 relevant evaluations performed earlier by the consultant.

2. **Financial Proposal:** Lump-sum offer with the cost breakdown: Consultancy fee, travel costs, per-diem and other costs.

Travel costs (if involved) shall be based on the most direct and economy fare.

The maximum allowed per-diem cost for Phnom Penh is **USD 116/day** to cover lodging, meals, and any other cost related to the consultant's stay in Phnom Penh, including transportation inside the city.

No financial information should be contained in the technical proposal.

For evaluation and selection method, the Cumulative Analysis Method (weight combined score method) shall be used in this recruitment:

a) Technical Qualification (max. 100 points) weight 70 %

- Experience in conducting similar evaluations (30 points)
- Knowledge of Food Security and Nutrition (20 points)
- Experience with quantitative and qualitative research and approaches (30 points)
- Quality of past work (e.g. understanding, methodology) (20 points)

b) Financial Proposal (max. 100 points) weight 30 %

The maximum number of points shall be allotted to the lowest Financial Proposal that is opened /evaluated and compared among those technical qualified candidates who have attained a minimum 70 points score in the technical evaluation. Other Financial Proposals will receive points in inverse proportion to the lowest price.

The Contract shall be awarded to candidate obtaining the highest combined technical and financial scores, subject to the satisfactory result of the verification interview.

I. Outline of the inception report

Introduction

1. Background to the evaluation:
2. Objectives of the evaluation
3. Scope of the evaluation and overall approach
4. Identification of main units and dimensions for analysis and possible areas for assessment
4. Methodology of the Evaluation for the compilation and analysis of the information
5. Evaluation work plan specifying the outputs that will be delivered by the evaluation team, key stages of the evaluation process and the project time line including the field visits; clear roles and responsibilities for evaluator/evaluation team members, the commissioning organization and other stakeholders in the evaluation process.

II. Outline of the draft and final evaluation reports

1. Cover Page

2. Executive Summary (include also Glossary page)

3. Introduction

- Background including context of key social, political, economic, demographic, and institutional factors
- Object of the evaluation
- Purpose, objective and scope of the evaluation
- Methodologies used in the evaluation
- Constraints and limitations on the study conducted

4. Findings: Development Results

For each outcome and based on evaluation criteria:

- Detailed description of the development intervention(s) undertaken
- Measure to what extent the joint programme has fully implemented their activities and delivered outputs
- Measure to what extent the joint programme has been effective at the outcome/impact level
- Judgement on how the programme worked with respect to efficiency, ownership and sustainability.

5. Lessons Learned

- Case studies on food security and nutrition information management system, and multiple micronutrient powder in home fortification
- Lessons Learned for Management of Acute Malnutrition
- Other Lessons

6. Conclusions

- Judgement of the joint programme contribution to objectives of the thematic windows as well as the overall MDG fund objectives at local and national level. **(MDGs, Paris Declaration and Accra Principles and UN reform)**.
- Other Conclusions

7. Recommendations

8. Gender and Human Rights, including child rights

The report illustrates the extent to which the design and implementation of the object, the assessment of results and the evaluation process incorporates a gender equality perspective and human rights based approach, including child rights

9. Annexes

III. Documents to be reviewed

MDG-F Context

1. MDG F Joint Programme Document: results framework and monitoring and evaluation framework
2. Joint Programme indicators
3. Joint Implementation Guidelines FINAL July 2009
4. MDG JP Advocacy plan

Specific Joint Programme Documents

5. Bi-Annual Reports
6. Quarterly color-coded report
7. Minutes of Programme Management Committee Meetings
8. JPTWG Meeting and mission reports
9. MDG JP Annual Work plan/Provincial Work plan
10. The challenges and lesson learned of MDG JP
11. Terms of Reference for cross-sectional end line nutrition survey (led by WHO)
12. Terms of Reference for Qualitative Assessment of Child Nutrition Programmes (led by UNICEF)
13. Mid-term evaluation of the “Joint Programme for Children, Food Security and Nutrition in Cambodia”

Other in-country documents or information

14. The MDG baseline evaluation report
15. Study report on Women Working in Factories and Maternal Health - Focus on the Nutrition Component
16. 2010 ASSESSMENT OF INITIAL IMPLEMENTATION OF MAM
17. Family Nutrition Handbook
18. Food Security Bulletins (Issue No.1-No.7)
19. National Interim Guidelines for the Management of Acute Malnutrition
20. Media Handbook for FSN by UNESCO
21. Caretaker Perceptions of MNP
22. FAO-EDI training report in SVR Feb 2011
23. FAO-EDI training report in KPS Feb 2011
24. National Communication Strategy and IEC/BCC materials to Promote the Use of Iron/Folic Acid (IFA) Supplementation for Pregnant and Post Partum Women and IEC/BCC materials
25. CMDG_Report_2010_Eng
26. NSDP 2009-2013
27. Strategic Framework Food Security and Nutrition 2008-2012
28. Review report of Strategic Framework Food Security and Nutrition 2008-2012
29. Cambodia_UNDAF_2011-2015
30. CMB_NSDP_2006
31. 30-CMDG_Report_2010_Kh
32. Curriculum for MSc in Nutrition (No e-file)

IV. Outcomes and outputs for JP on Children FSN in Cambodia

Outcomes	Strategies	Outputs	Implementing agencies and partners
Outcome 1: Improvement of the nutritional status of children aged 0-24 months and pregnant and lactating women	BCC activities for the promotion of breastfeeding, complementary feeding and IFA supplementation through mass media (nationwide), interpersonal communication (2 provinces) and social mobilisation (2 provinces). Geographically focused implementation of an innovative, integrated and comprehensive food security and nutrition package	Output 1.1: Behaviour Change Communication (BCC) plans and communication materials developed on: (i) breastfeeding, (ii) complementary feeding, (iii) IFA supplementation during pregnancy and in the post partum period \$595,000	MoH (NCHP, NNP, PHD's, CDC), MoLVT, MAFF, CARD, MoEYS, UNICEF, WHO, WFP, ILO, FAO, UNESCO
		Output 1.2: Behaviour Change Communication (BCC) plans implemented on: (i) breastfeeding, (ii) complementary feeding, (iii) IFA supplementation during pregnancy and in the post partum period \$919,000	
		Output 1.3: Provision of an integrated comprehensive package of nutrition and food security interventions delivered with high coverage in two food insecure provinces - Kampong Speu and Svay Rieng \$1,752,000	
Outcome 2: Implementation of existing nutrition, food security, and agricultural policies strengthened, and new policies on nutrition developed	Review of implementation and strengthening of existing nutrition, food security, and agricultural policies; and the development of new nutrition policies	Output 2.1: Review implementation status of legislation, policies and strategies on nutrition, food security and agriculture and provide responses for practical action \$283,600	MoLVT, MoEYS, MAFF, CARD, MoH, ILO, UNESCO, FAO, UNICEF, WHO
		Output 2.2 New policies, strategies and guidelines developed \$250,000	
Outcome 3: Integrated food security and nutrition monitoring system developed	Development of an integrated national food security and nutrition (FSN) monitoring system	Output 3.1: Integrated national food security and nutrition monitoring system established, based on existing information systems and surveys \$397,000	CARD, MoP/NIS, MoH (DPHI, PHDs), WFP, UNICEF, WHO, FAO
		Output 3.2: Management, coordination, monitoring & evaluation of JP \$475,700	

Annex 2: Objectives of the Evaluation

Relevance

- To what extent are the objectives and interventions of the Joint Programme pertinent to contribute towards the achievement of national priorities and policies of RGC including the CMDGs and the implementation of food security and nutrition related strategies and policies?
- To what extent are the objectives and interventions in line with the priorities of the participating UN agencies, the UNDAF priorities and with a human rights based approach, including the right to health and child rights?
- To what extent was the joint programme aligned with Aid Effectiveness Agenda and UN reform?

Efficiency

- How efficient were the governance arrangements of the Joint Programme in providing leadership and guidance during programme implementation?
- How well did the management model of the programme work in terms of human resources, financial management, and arranging for technical support to programme implementation and what means of coordination across parties and sectors were in place as part of the management system to enhance programme implementation?
- How did governance and management arrangements affect the ownership of the joint programme, working as one and to what extent did these arrangements enhance and/or constrain reaching development results?
- *What monitoring, reporting and evaluation systems were in place, to what extent were these aligned with and built capacities of RGC systems and to what extent and in which way have M&E systems informed and enhanced results-based management?*

Effectiveness

- To what extent and in which ways has the joint programme contributed to nutrition-, food security- and agricultural policies, either in terms of their enhanced implementation or through the development of new policies?
- To what extent and in which ways has the joint programme been effective in advocating for enhanced food security and nutrition for children and women?
- *What are the results in terms of the development of an integrated food security and nutrition monitoring system, what has been the use of the system and how has the implementation of the system resulted in enhanced decision-making on FSN related issues?*
- To what extent has the programme focused on and been able to reach most vulnerable households and worst-off groups and to what extent has it contributed to reducing inequalities related to food security and nutrition; have there been any unintended results in this respect?
- *How can the results identified in the end line survey be related to the project interventions at the sub-national level in a qualitative way, making use of a results chain?*
- *What have been enabling and what have been constraining factors for achieving results in the three outcome areas of the joint programme?*

Impact

- To what extent and in which ways has the joint programme contributed to improve the food security and nutritional conditions of children and women at sub-national and national levels, in particular to the status of children aged 0-24 months and pregnant and lactating women?

Sustainability

- Are the interventions supported through the joint programme likely to be continued after the phasing out of the programme, in particular in order to sustain the impact on worst-off groups and most vulnerable people?
- To what extent are capacities of national and sub-national partners in place in terms of leadership commitment, organizational and technical capacity and financial resources?
- How likely is the programme approach to be replicated or scaled up at sub-national or national levels or in an international context?

Cross-cutting issues

- Has the joint programme in its design and implementation focused sufficiently on the needs of worst-off groups and vulnerable people and reducing inequalities concerned?
- *To what extent has a gender focus been mainstreamed in the project approach and its implementation?*
- *What has been the balance between development of supply side issues, supporting the development of capacities of service providers' and other duty bearers, and demand side aspects, supporting the development of the demand for food security and nutrition related services of vulnerable households and women and children?*

Annex 3: Evaluation Methodology

Table 1: Methodologies for Data gathering and their characteristics

Method	Description	Objective	Comments
Desk review	Study and review of selected documents relevant to the present evaluation	To be informed on the background and context as well as details on progress and other relevant aspects of the Joint Programme through secondary resources	Main learning from the desk review will be used to develop the inception report, which includes details on the methodology applied in the remainder of the evaluation process
Review of secondary data on site	Review of quantitative and qualitative data from programme monitoring, partner agencies and other relevant sources	To review monitoring data and to triangulate these data with the primary data gathered; to obtain secondary information from partner agencies	This will build on the review of secondary data in the desk review and will be an on-going process throughout the evaluation
Semi-structured interviews	Face-to-face and Skype / telephone interviews with key stakeholders making use of a set of topics for discussion	To gather qualitative data from a variety of stakeholders	Informed by the desk review and evaluation objectives and questions
Focus Group Discussions	Discussion at the local level with programme beneficiaries making use of a set of topics for discussion	To assess aspects of programme results at the local level, to obtain feedback from beneficiaries and to triangulate data	Informed by the desk review and evaluation objectives and questions and discussions at national level
Case Studies	In-depth data gathering and analysis on selected topics of the Joint programme	To enhance the understanding of selected topics of programme implementation and results and to enhance lessons learned	Case studies will cover three topics identified in the TOR
Process Documentation	Capturing critical processes of the programme and its components from the viewpoint of a variety of stakeholders	To gather systematic information on the intervention strategies and how these developed over time	Process documentation will focus primarily on the time frame of the programme
Mini Survey(s)	Focused questionnaire surveys for selected stakeholders	To gather quantitative data from groups and individuals who have provided / received services from the joint programme	Making use of a printed questionnaire as well as a web-based interface based on the target groups concerned

Table 2: Details on topics of case studies (*questions added to those specified in TOR in italic*)

Topic of Case Study	What the topic is meant to illustrate, what the case is an example of	Specific Questions
Food Security and Nutrition data analysis team and produce of quarterly bulletins	The role of the set-up of a data analysis team in the process of development of an integrated Food Security and Nutrition monitoring system	<ul style="list-style-type: none"> ➤ Rationale and process of the establishment of the data analysis team? ➤ Ways in which the team has functioned compared to plans? ➤ Added value/results of current practices compared to former information systems? ➤ <i>In what ways has coordination amongst stakeholders taken place; to what extent has the process resulted in integration of information systems?</i> ➤ <i>What have been the changes in the demand for FSN information and how do these changes relate to programme interventions?</i> ➤ <i>How is the system related to other joint programme components in terms of implementation process and results?</i> ➤ Is the developed system likely to be sustainable? ➤ Does the model appear viable for replication in other countries?
Multiple Micro-nutrient powder (MNP) in-home fortification	Development of capacities of service providers and households to make available and use MNP for in-home nutrient fortification	<ul style="list-style-type: none"> ➤ What has been the rationale and process of implementation for MNP in-home fortification? ➤ What has been the actual implementation process compared to the planned process and what has been the rationale for adaptations? ➤ <i>How has the demand side of households for MNP been addressed?</i> ➤ What are the short and longer term results of the intervention? ➤ <i>How is the intervention related to other joint programme components in terms of implementation process and results?</i> ➤ <i>What are the factors that supported and what are the factors that hindered implementation and obtaining results?</i> ➤ Do the results of the intervention appear to be sustainable and what would be required for scaling-up?
Management of Acute Malnutrition	Development of capacities of service providers to deal with acute malnutrition of children and of poor households to demand these services	<ul style="list-style-type: none"> ➤ <i>What has been the approach to management of acute malnutrition and what is the rationale behind this approach?</i> ➤ How effective and efficient has the approach been at the health center level and at the commune level in terms of both demand and supply of services? ➤ Are there differences in effectiveness and efficiencies between implementation modalities or -areas and what are the implications? ➤ <i>How is the intervention related to other joint programme components in terms of implementation process and results?</i> ➤ Would it be feasible to scale up the intervention within the current public health system?

Annex 4: Evaluation Work Planning

The proposed evaluation workplan includes a total of 70 working days which will be implemented within a four months period. This will comprise an inception phase, a data gathering phase and a phase of data analysis and reporting. The workplan is set up for the evaluation process to focus first on delivery of the evaluation report. In the second phase of the workplan focus will shift towards the three selected case studies. The outline of the proposed work plan of the evaluation is presented in table 4 below.

Table 1: Timing and Location of activities as part of the evaluation process

Dates	Activity	Location
June 17 – July 05	Desk review and preparation of draft inception report	Home based
July 08	Delivery of draft Inception Report	
July 15 – Aug 02	First field work period focused on final evaluation	Cambodia: Phnom Penh and selected provinces
Aug 05 – Aug 16	Reporting	Home based
Aug 16	Delivery of the draft evaluation report	
Aug 23	Deadline for comments on draft evaluation report	
Aug 26 – 30	Preparation of final evaluation report and PowerPoint presentation	Home based
Aug 30	Delivery of final evaluation report and PowerPoint presentation	
Sep 02 - 20	Second field work period focused on three case studies	Cambodia: Phnom Penh and selected provinces
Sep 23 – Oct 04	Preparation draft case studies report	Home based
Oct 04	Delivery of draft case studies report	
Oct 18	Deadline for comments on draft case study report	
Oct 21 – 25	Preparation of final case study report	Home based
Oct 25	Delivery of final case studies report	

Annex 5: Results Framework of the Joint Programme

Outcomes	Strategies	Outputs	Implementing agencies and partners
Outcome 1: Improvement of the nutritional status of children aged 0-24 months and pregnant and lactating women	BCC activities for the promotion of breastfeeding, complementary feeding and IFA supplementation through mass media (nationwide), interpersonal communication (2 provinces) and social mobilisation (2 provinces).	Output 1.1: Behaviour Change Communication (BCC) plans and communication materials developed on: (i) breastfeeding, (ii) complementary feeding, (iii) IFA supplementation during pregnancy and in the post-partum period	MoH (NCHP, NNP, PHD's, CDC), MoLVT, MAFF, CARD, MoEYS, UNICEF, WHO, WFP, ILO, FAO, UNESCO
		Output 1.2: Behaviour Change Communication (BCC) plans implemented on: (i) breastfeeding, (ii) complementary feeding, (iii) IFA supplementation during pregnancy and in the post-partum period	
	Geographically focused implementation of an innovative, integrated and comprehensive food security and nutrition package	Output 1.3: Provision of an integrated comprehensive package of nutrition and food security interventions delivered with high coverage in two food insecure provinces - Kampong Speu and Svay Rieng	
Outcome 2: Implementation of existing nutrition, food security, and agricultural policies strengthened, and new policies on nutrition developed	Review of implementation and strengthening of existing nutrition, food security, and agricultural policies; and the development of new nutrition policies	Output 2.1: Review implementation status of legislation, policies and strategies on nutrition, food security and agriculture and provide responses for practical action	MoLVT, MoEYS, MAFF, CARD, MoH, ILO, UNESCO, FAO, UNICEF, WHO
		Output 2.2 New policies, strategies and guidelines developed	
Outcome 3: Integrated food security and nutrition monitoring system developed	Development of an integrated national food security and nutrition (FSN) monitoring system	Output 3.1: Integrated national food security and nutrition monitoring system established, based on existing information systems and surveys	CARD, MoP/NIS, MoH (DPHI, PHDs), WFP, UNICEF, WHO, FAO
		Output 3.2: Management, coordination, monitoring & evaluation of JP	

Annex 6: Results of Baseline and Endline Studies

Based on the comparison of baseline and endline survey data,³⁷ there appear to be many positive changes at the level of nutrition related outcomes.

Immediate causes: dietary Intake

These include enhancement of breastfeeding practices, increased amount of food and number of meals and snacks for young children, as well as those of 3 to 5 years of age, and increase in the minimum dietary diversity for children 6-23 months of age. More MNPs were received in intervention provinces where the use of MNP starts at an earlier age.

Feeding practices of young children appear to be improved in the intervention provinces (more than in the comparison provinces). Breastfeeding within the first hour and feeding colostrum went up (from 63 to 74% and from 96 to 98% respectively) as well as overall breastfeeding ('ever breastfed the child', which further increased from 96 to 99%).

The amount of food consumed by the youngest child as well as the number of meals and snacks taken per day increased. Though most of these improvements can also be observed in comparison provinces, the change in intervention provinces is substantially higher. The introduction of solid, semi-solid or soft foods to infants 6 to 8 months of age goes up in intervention provinces, while it diminishes in comparison provinces. The percentage of thick rice soup consumed in the last 24 hours (food recall) goes up but the amount of medium consistency (porridge like) of Borbor kroeung remains high at 72 %. In terms of food storage, there did not appear to be much improvement in intervention as well as comparison provinces.

The minimum dietary diversity for children 6-23 months of age improved, with dietary diversity up 20 % for intervention provinces, reaching 49 %, while at the same time it went up to 40% in comparison areas. Encouraging the child to eat went up slightly in intervention provinces reaching upto 89%, while it went down in comparison areas.

Also children in the age group 36-59 months did consume more food compared to the baseline with in particular those children eating more than 2 bowls per day increased from 58 to 71 %. This increase was much less in comparison provinces (from 48 to 51 %). While the number of meals remained almost the same over time, it is the number of snacks that increased for this age group, more in intervention than in comparison areas.

The number of households that received MNP for the youngest child is much higher in intervention than in comparison provinces (54 % versus 15%). Moreover, infants started taking MNP earlier in the intervention areas (at 10 months compared to 13 months in comparison area) and consumed for substantially longer periods (27 months compared to 17 months in comparison provinces). This was also found for the age group 36-59 months, though to a lesser extent, with 24 versus 8 % receiving MNP in intervention versus comparison provinces. The age at which MNPs were received proved much earlier in intervention areas (at 16 rather than 37 months of age) and the period taken proved longer (3.7 rather than 0.5 months)

Immediate causes: disease

Also in health related issues there are a number of positive changes which include a reduction in the prevalence of diarrhea in children. Treatment with zinc improved in the intervention areas with advice sought mostly from drug sellers (60 %) while the support sought from HC reduced by 10 %. The prevalence of diarrhea reduced more in intervention than in comparison provinces. The use of iron foliate tablets and deworming has increased substantially. Most of the indicators on hand washing have decreased with the use of hand soap and use of it with children both gone down in particular in the intervention provinces.

In terms of maternal health and nutrition the percentage of pregnant as well as non-pregnant women who received iron tablets went up in both survey areas, while the increase in deworming is substantially higher in intervention areas. Ante-natal care increased but more in comparison than in intervention areas. The average number of ante-natal visits is the same for both survey areas at 2.7. Delivery at home reduced over time from 55

³⁷ McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Baseline Survey Design and Protocol (2009-2010)* and McLean, Judy, *Report: Joint Programme for Children, Food Security and Nutrition in Cambodia, Endline Survey (2013)*.

to 21 percent while the delivery in health centers increased from 23 to 51% in intervention areas (compared to a decrease from 37 to 19 % home deliveries and increase of 42 to 55 % of deliveries in health centers for comparison provinces). This shift went hand in hand with less frequency of traditional birth attendants at delivery. Vitamin A and deworming went up substantially.

Underlying causes: knowledge, attitudes and practices

Access to media and communication has increased over time with increased proportions of respondents having access to television, radio and mobile phones. Looking at the results of the BCC campaigns knowledge of breastfeeding and complementary feeding practices in both survey areas proved good. Significantly more caregivers reported receiving complementary feeding advice in the intervention group vs. comparison group (71% vs. 61%) which meant an increase of over 10% compared to the baseline.

The proportion of caregivers reporting that they had seen or heard messages on iron-folic acid supplementation for women remained high in both groups at end line (91.6% in the comparison group and 90.6% in the intervention group). Over the 3-year intervention period, the proportion of women who knew the reasons for taking IFA supplements increased from 66% to 78% in the comparison group, but decreased from 73% to 67% in the intervention group. However, the proportion of women who could identify food sources of iron significantly increased by 9.5% in the comparison group and 8.8% in the intervention group.

The proportion of caregivers who reported hearing or seeing messages about vitamin A was also high in both groups at end line. The proportion of caregivers who knew the reasons for taking vitamin A decreased from 83% to 60% in the intervention group and 75% to 69% in the comparison group. Similarly, the proportion of caregivers who could identify food sources of vitamin A fell to just over 40% in both groups at end line.

At baseline and end line, virtually all caregivers in both groups reported that children should drink more when they have diarrhea. The proportion of caregivers who accurately responded that a child should eat more food when they have diarrhea remained stable from baseline to end line, and was 78% and 66% in the comparison and intervention groups at end line, respectively. Approximately four-fifths of all caregivers had heard or seen messages on treating diarrhea at end line. Virtually all caregivers also reported seeing or hearing messages on hand washing with soap in both groups at end line.

The proportion of women receiving paid maternity leave increased in both groups from baseline to end line; however, the proportion of women receiving time off or incentives to breastfeed seemed to decrease in both groups over the course of the 3-year intervention period.

Underlying causes: Household food security

Household food security status was assessed using the Household Food Insecurity Access Scale. This scale is composed of nine questions, each with a subsequent question regarding the frequency the experience occurred. At end line, considerably fewer households were classified as food secure in the intervention vs. comparison provinces (27.8% vs. 50.5%) with percent change in prevalence of food security minus 10 % in comparison provinces and minus 21.5% in intervention provinces. The end line survey does not discuss this finding in any detail, nor provides any explanation.

Ownership of a homestead garden was not very common. The proportion of households with a homestead garden actually decreased over the three year programme period, from 37% to 13% in the intervention group and 23% to 15% in the comparison group. The main use of fruits or vegetables grown in the homestead garden was home consumption in both groups at end line, and slightly more households in the intervention group reported consuming "almost all" of the fruits/vegetables that were produced. In both groups, 85 % of households owned some type of livestock, herds, farm animals, or fish ponds at end line. The average number of types of vegetables grown in the garden was greater in the comparison group (3.5 vs. 2.8), but the number of varieties of fruit plants was greater in the intervention group (2.9 vs. 2.3). Households in the intervention group reported consuming a greater amount of rice in comparison to the control group (50.7 vs. 44.8 kg). Approximately one-quarter of households reported running out of rice in a normal year.

The FFS support of FAO was assessed making use of a quantitative approach. This assessment showed increased levels of vegetable growing and chicken rearing. Moreover, the knowledge on breastfeeding, MNPs and other child feeding aspects appeared relatively high amongst members interviewed in the assessment.³⁸

Contextual changes

The responsibilities for preparing meals and feeding young children shifted, with a substantial increase towards grandparents in both intervention and comparison provinces (from 9 to 30% in intervention areas and from 5 to 25 % in comparison areas). This is related to the increasing amount of young mothers working in garment and other factories in the provinces and leaving their children with grandparents to take care of them. Women working outside the home increased and was higher in intervention than in comparison areas at the baseline, and further increased to 59 % in intervention provinces, compared to 45% in comparison areas.

The increase of young mothers working in factories can also explain the decrease in the duration of breastfeeding, which went down one month on average in both intervention and comparison areas. The young mothers also get more often to be the main income earner with the role of the father as income earner diminishing in both surveyed areas with 10% to about 70%. Employment of caretakers in agriculture declined, while work in manufacturing about doubled and the percentage of caretakers engaged in small businesses and petty trade close to tripled between baseline and end line survey.

³⁸ FAO communication.