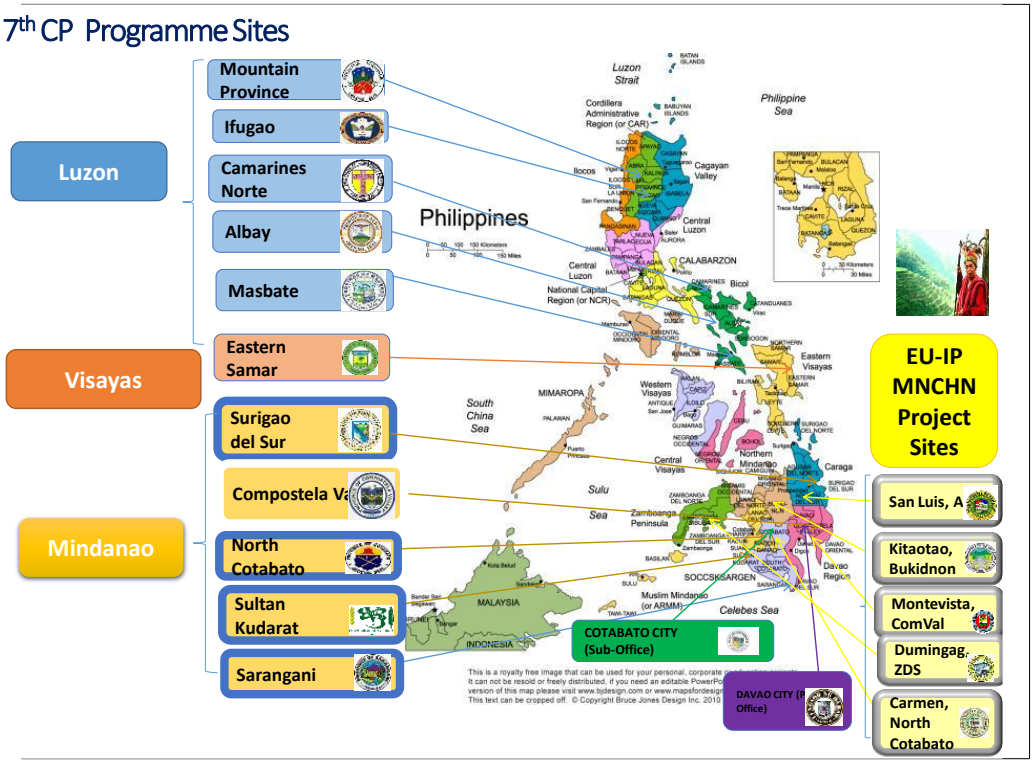
EVALUATION OF THE UNFPA 7TH COUNTRY PROGRAMME OF ASSISTANCE TO THE PHILIPPINES

Final Report

August 2018

Philippines Country Map

(indicates the 7th Country Programme Intervention Areas)



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Disclaimer: This is a product of the independent evaluation by the above team and the content, analysis and recommendations of this report do not necessarily reflect the views of the United Nations Population Fund (UNFPA), its Executive Committee or Member States. The report is not professionally edited.

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Annexes (Part 2)

Abbreviations and Acronyms

AIDS	*Acquired immune deficiency syndrome*
AO	Administrative Order
APRO	Asia Pacific Regional Office
ARH	Adolescent Reproductive Health
APCRSHR	Asia Pacific Conference on Reproductive and Sexual Health and Rights
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
BAFP	Business Action for Family Planning
BDP	Bangsamoro Development Plan
BeMONC	Basic Emergency Obstetric and Newborn Care
BDA	Bangsa Moro Development Agency
BMMS	Bangsa Moro Medical Society
CAR	Cordillera Administrative Region
CATW-AP	Center Against Trafficking in Women Asia Pacific
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CFSI	Community Family Services International
CHED	Commission on Higher Education
CHR	Commission on Human Rights
CHSI	Center for Health Solutions Innovations Philippines
CIP	Costed Implementation Plan
CIAGV	Comprehensive Intervention Against Gender-Based Violence
CP	Country Programme
CP6	6th Country Programme
CP7	7th Country Programme
CP8	8th Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Program Evaluation
CSE	Comprehensive Sexuality Education
CO	Country Office
CPN	Child Protection Network
CPNF	Child Protection Network Foundation
CSO	Civil Society Organization
DAC	Development Assistance Committee
DD	Demographic Dividend
DepEd	Department of Education
DFAT	Department of Foreign Affairs and Trade (Australia)
DHS	Demographic and Health Survey
DLSU	De La Salle University
DOH	Department of Health
DRRM	Disaster Risk Reduction and Management
DSWD	Department of Social Welfare and Development
DREAMB	Disaster Response Assistance and Management Bureau
EmOC	Emergency Obstetrics Care

EmoNC	Emergency Obstetrics and New Born Care
EO	Executive Order
ERG	Evaluation Reference Group
ET	Evaluation Team
EU	European Union
EVRMC	Eastern Visayas Regional Medical Centre
FHS	Family Health Survey
FP	Family Planning
FFPD	Forum for Family Planning and Development
GAA	General Appropriations Act
GAD	Gender and Development
GBV	Gender Based Violence
GDI	Gender Development Index
GDP	Gross Domestic Product
GE	Gender Equity
GIDA	Geographically Isolated and Disadvantaged Areas
GOP	Government of the Philippines
GRCM	Gender Responsive Case Management
HB	House Bill
HDI	Human Development Index
HIV	Human immunodeficiency virus
HLGP	Health Leadership and Governance Program
LGU	Local Government Units
ICPD	International Conference on Population and Development
INGOs	International Non-Governmental Organization
IPs	Implementing partners
IPMNCHN	Indigenous People Maternal Newborn Child Health and Nutrition
JPMNH	Joint Program on Maternal and Neonatal Health
MCW	Magna Carta of Women
MDG	Millennium Development Goal
MDT	Multi-Disciplinary Team
MHO	Municipal Health Officer
MLGP	Municipal Leadership and Governance Program
MLGU	Municipal Local Government Unit
MNCHN	Maternal, Newborn, Child Health and Nutrition
M&E	Monitoring and Evaluation
MTSP	Mid-Term Strategic Plan
NASWEI	National Association for Social Work Education, Inc.
NAPC	National Anti-Poverty Commission
NCDA	National Council on Disability Affairs
NCIP	National Commission on Indigenous Peoples
NDHS	National Demographic and Health Survey
NEDA	National Economic and Development Authority
NGA	National Government Agency
NGO	Non-Governmental Organization
NIDI	Nederlands Interdisciplinair Demografisch Instituut
NIT	National Implementation Team
NNS	National Nutrition Survey

NYC	National Youth Commission
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
OFDA	Office of the United States Foreign Disaster Assistance
OECD	Organisation for Economic Cooperation and Development
OP	Office of the President
OXFAM	Oxford Committee for Famine and Relief
PCW	Philippine Commission on Women
PD	Population and Development
PHO	Provincial Health Officer
PDP	Philippine Development Plan
PMU	Project Management Unit
PO	Programme Officer
POPCOM	Commission on Population
PPMP	Philippine Population Management Program
PSA	Philippine Statistics Authority
PSB	Protective Services Bureau
PSDP	Philippine Statistical Development Plan
PSRP	Philippine Society for Responsible Parenthood
PWD	Person with disability
RA	Republic Act
RH	Reproductive health
RHAN	Reproductive Health Advocacy Network
RHD	Regional Health Director
RHR	Reproductive Health and Rights
RPRH	Responsible Parenthood and Reproductive Health
SALIGAN	Sentro ng Alternatibong Lingap Panlegal
SBN	Senate Bill Number
SDG	Sustainable Development Goal
SDS	Social Development Staff
SITAN	Situational Analysis
SOCTECHB	Social Technology Bureau
SP	Strategic Plan
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TA	Technical assistance
TOR	Terms of Reference
TRO	Temporary restraining order
TWG	Technical working group
UN	United Nations
UN GIHA COP	United Nations Gender in Humanitarian Action Community of Practice
UNCT	United Nations Country Team
UNCT HAP	United Nations Country Team Humanitarian Action Plan
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNRC	United Nations Resident Coordinator
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAWC	Violence Against Women and Children
WB	World Bank
WCC	Women's Crisis Centre
WCPMIS	Women and Child Protection Management Information System
WCPU	Women and Children Protection Unit
WDARE	Women with Disability taking Action on Reproductive and Sexual Health
WFS	Women Friendly Space
WHO	World Health Organization
YAFSS	2013 Young Adult Fertility and Sexuality Study
YDI	Youth Development Index
YPS	Young Public Servants

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Box 1: Structure of the Philippines Country Programme Evaluation (CPE) Report:

This report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook issued by the UNFPA Independent Evaluation Office.

Chapter 1, the **Introduction,** provides the background to the evaluation, objectives and scope, the methodology used, including the limitations encountered, and the evaluation process. The **second chapter** describes the Philippines country context including the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country in sexual and reproductive health area, population and development and in gender equality. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (which is annexed); the **fifth chapter** discusses conclusions and the **sixth chapter** concludes with recommendations under strategic and programmatic level, based on the conclusions.

Annexes 1-5 contain the required documents for CPE, Annexes A-E provide additional reference documents and compiled as CPE Part2. Due to the CPE page limit some details could not be included in the main report and additional information which may be useful to the country office and other interested readers could be found in the annexes.

Key Facts Table

Table 1: Key Facts and MDG Progress

Geographical location	South-eastern coast of Asia and bordered by waters
Land area	300,000 sq. km.
Terrain	Composed of 7,641 islands with three island groups, namely: Luzon, Visayas, and Mindanao
People	
Population	100.981 million (Aug 2015) and 92.338 million (May 2010) with annual population growth rate at 1.72% between 2010 and 2015 Source: Phiilippine Statistics Authority [PSA]. *Philippine Statistics in Brief 2017, p. 18*
Urban/ rural ratio	Level of urbanization: 45.3% in 2010 from 42.4% in 2007 Source: PSA website https://psa.gov.ph/content/urban-barangays-philippines-based-2010-cph
Total Fertility Rate	2.7 (National Demographic and Health Survey [NDHS] 2017), 3.0 (NDHS 2013), from 3.3 (NDHS 2008)
Government	
Type of government	Presidential system
% of seats held by women in national parliament	26.0% (2013) Source: PSA (2016*) Factsheet on Women and Men in the Philippines, FS-201603-PHDSD-01*
Economy	
GDP per capita in constant (2000) pesos	19,905 (Q3 2017) from 18,893 (Q3 2016) Source: PSA National Accounts (*3rd Quarter* 2017)
GDP Growth rate	6.9 percent between 3rd Quarter 2016 and 3rd Quarter 2017 Source: PSA National Accounts (*3rd Quarter* 2017)
Main industries	Manufacturing trade, and real estate, renting and business activities
Social indicators	
Human Development Index Rank	114 (2015) Source: *2016 Human Development Report*
Gender Inequality Index Rank	Gender Development Index =1.001. The Philippines belong to Group 1 (Group 1 comprises countries with high equality in HDI achievements between women and men, i.e. absolute deviation of less than 2.5 %) Source: *2016 Human Development Report*
Unemployment.	5.7% (April 2017) from 6.1% (April 2016) Source: PSA. *Philippine Statistics in Brief 2017*
Life expectancy at birth	72.9 years (women), 66.9 years (men) based on 2010 population projections Source: PSA (2016*) Factsheet on Women and Men in the Philippines, FS-201603-PHDSD-01*
Under-5 mortality (per 1000 live births)	31 in 2013 from 30 in 2011 Source: PSA. *Philippine Statistics in Brief 2017*
MMR	221 (2011) from 209 (1990) Source: PSA. *Philippine Statistics in Brief 2017*
.Health expenditure (% of GDP)	4.5% (2015-2016) Source: https://psa.gov.ph/content/total-health-expenditures-grew-105-percent-in 2016
% of births attended by skilled health personnel.	84.4% (NDHS 2017), 72.8% (NDHS 2013), 62.2% (NDHS 2008)
Antenatal care coverage by at least 4 visits	86.5% (NDHS 2017), 84.3% (NDHS 2013), 77.8% (NDHS 2008)
Total Fertility Rate	2.7 (NDHS 2017), 3.0 (NDHS 2013), 3.3 (NDHS 2008)

Adolescent fertility rate	47 births per one thousand women age 15-19 (NDHS 2017), 57 births per one thousand women age 15-19 (NDHS 2013), 54 births per one thousand women age 15-19 (NDHS 2008)
% of people living with HIV, 15-24 years old	28% of about 51,000 reported cases from Jan. 1984 to 2018 were from 15-24 year age group. Source: National HIV/AIDS & STI Surveillance and Strategic Information Unit, Epidemiology Bureau, Department of Health (DOH), Jan. 2018.
% of people living with HIV, 15-49 years old	97% of about 51,000 reported cases from Jan. 1984 to 2018 were from 15-49 year age group Source: same as above
Millennium Development Goals (MDGs): Progress by Goal (details in the Annex) Source: NEDA (2014) The Philippines Fifth Progress Report - Millennium Development Goals *Executive Summary*	
1 - Eradicate Extreme Poverty and Hunger	ON TRACK—The probability of attaining the target in all 4 indicators range between 0.5 and 0.9
2 - Achieve Universal Primary Education.	ON TRACK—The probability of attaining the target for Elementary education net enrolment rate, Elementary education cohort survival rate, and Elementary education completion rate are greater than 0.9; between 0.5 and 0.9, and less than 0.5, respectively
3 - Promote Gender Equality and Empower Women	ON TRACK—The probability of attaining the target in 6 of 7 indicators is greater than 0.9 while the probability of attaining the target for the proportion of elective seats held by women was below 0.5
4 - Reduce Child Mortality.	ON TRACK—The probability of attaining the target is greater than 0.9 for the 2 indicators.
5 - Improve Maternal Health	OFF TRACK—The probability of attaining the target for MMR is below 0.5.
6 - Combat HIV/AIDS, Malaria and other Diseases	OFF TRACK—The probability of attaining the target for 4 of 6 indicators is below 0.5 while the probability of attaining the target for the remaining two indicators was between .05 and .09.

Executive Summary

Background: The 7th Philippines Country Programme (CP7, 2012-2018), initially planned until 2016 with a budget of 28.5 million US dollars, was extended up to 2018 with an additional approved funding of USD 11.4 million to align the programme with the United Nations Development Assistance (UNDAF) cycle 2012-2018. It is the UNFPA Evaluation Policy to conduct an independent evaluation of the country programme a year before the programme cycle ends. Thus UNFPA commissioned this external independent evaluation in November 2017.

The purpose of the Country Programme Evaluation (CPE) is to demonstrate accountability to stakeholders on performance achieved; to support evidence-based decision-making; to contribute important lessons learned to the knowledge base of the organization; and, in turn, to provide independent inputs to the next UNFPA country programme (CP) cycle and the strategic direction of the continued role for UNFPA support to the Government of the Philippines. **The audience** of this evaluation is the UNFPA Country Office (CO), Regional Office, HQ and the UNFPA Executive Board; national partners, relevant government agencies, other development partners including the donors, UN agencies in the country.

The specific objectives of the CPE are to: (a) provide an independent assessment of the relevance, effectiveness, efficiency, and sustainability of the approaches adopted by the current CP; (b) provide an assessment of the CO's strategic positioning within the development community and national partners; and (c) draw key lessons from past and current cooperation and provide strategic and actionable recommendations for the next CP. The **scope** is to evaluate the initiatives implemented from 2012 to 2017 under the three outcomes and six outputs given below. CP7 covers ten provinces, in five regions of the three island groups. Humanitarian response is mainstreamed into the three outcomes. CPE identified key unintended effects and assessed the managerial, operational, and monitoring and evaluation systems and structures of the CO. Interventions under Sexual and Reproductive Health and Rights (SRHR), Population and Development (PD) and Gender Equality (GE), were evaluated applying Relevance, Effectiveness, Efficiency, and Sustainability criteria. UNFPA's coordination role within UNCT and the added value that UNFPA brings to the development community were also assessed.

Programme: With the strategic plan goal to "achieve universal access to sexual and reproductive health, promote reproductive rights, reduce maternal mortality, and accelerate progress on the ICPD agenda and MDG 5 (A & B)," CP7 pursues three programme outcomes in the areas of SRH, PD and GE. SRH outcome is to increase utilization of integrated, high-quality RH, maternal and neonatal health services by women and their newborn infants, young people, and men by increasing RH supply and by increasing RH demand among women, young people and men, including Muslims and indigenous peoples, for them to have access to high quality RH services in programme areas, particularly in selected geographical areas that are isolated and disadvantaged.

PD outcome is focused at creating a national and local policy environment conducive to population management, including the allocation and utilization of funds for its execution by assisting the relevant government agencies to be able to generate, analyze and disseminate data on population, SRH, HIV/AIDS, gender and youth, and to utilize data in national and local policymaking and development planning in programme areas (Data and Planning). To achieve the PD outcome, CP7 promotes evidence based advocacy by strengthening capacity of civil society, including faith-based

organizations, youth, and media and private sector groups, to advocate the passage of population policies that will establish the legal framework to implement RH programmes.

GE and gender-based violence (GBV) interventions expect to strengthen the capacity of the Government to protect, fulfill and promote the rights of women and girls, especially the marginalized, as defined and guaranteed in the Magna Carta of Women (MCW). This outcome is to be achieved by increasing the capacity of national government agencies (NGAs) and local government units (LGUs) to undertake gender-responsive programming to enforce MCW provisions especially on reproductive rights and GBV. Increasing the capacity of civil society organizations (CSOs) to advocate for the implementation of the MCW is also part of CP7 under GE interventions. Emergency preparedness and response are mainstreamed throughout the CP interventions.

Assuming a catalytic role in comparison to the service delivery in CP6, CP7 operates in ten provinces seeking to strengthen institutions and systems and leverage partnerships, while expanding public-private partnerships, to leverage resources to provide effective programme models. For 2015-2017, CO increased its emphasis on policy, advocacy and catalytic work and strategic partnerships at the national level providing technical assistance to the government to accelerate the implementation of the RPRH Law along key result areas (maternal health, family planning [FP], adolescent sexual and reproductive health [ASRH], HIV/AIDS, GBV), establishing non-traditional partnerships with the private sector, and generating high-quality evidence to support policy-making and programming. A few examples of such evidence-based knowledge products are the study on the demographic dividend (DD), a 15-year longitudinal cohort study on the girl- and boy-child, and studies on the social determinants and socio-economic impact of teenage pregnancy.

Direct local government unit (LGU) engagement was concentrated in fewer and geographically contiguous provinces, prioritizing support to priority provinces of the Philippine Development Plan (2011-2016), and initiating support to Bangsamoro areas that are integral to UNFPA's peace-building efforts. The country faces major disasters regularly with increasing intensity and UNFPA played a major role in responding to the need for humanitarian assistance.

Methodology: The evaluation, divided into design, data collection, analysis and reporting phases, was structured based on evaluation criteria: relevance, effectiveness, efficiency, and sustainability; and UNFPA strategic positioning on coordination and added value. Based on purposive sampling method, six out of ten (i.e., Mountain Province, Ifugao, Eastern Samar, Sarangani, Sultan Kudarat, North Cotabato) programme provinces that are spread across the three island groups were visited for data collection. Using both secondary and primary sources, mixed method of data collection included documentary review, monitoring and evaluation (M&E) data review, financial and operations system review, structured and semi-structured, face-to-face, individual and group interviews, and observations. Triangulating the sources and methods of data collection, evaluation used both qualitative and quantitative data in the analysis. The evaluation adopted an inclusive approach, involving a broad range of partners and stakeholders. Totaling 369 (with two thirds being female) respondents, UNFPA CO staff, national and local level development partners, UNCT, service beneficiaries and providers, contributed their input to this evaluation. To validate the design of the evaluation and preliminary findings, two workshops were held. A workshop was held at the final stage to validate and disseminate the findings involving a broader stakeholder group.

Main Conclusions: Aligned with national interests, policies, the International Conference on Population and Development Programme of Action (ICPD POA), strategic plans and mode of

operation, CP7 stays relevant to the country priorities, UNFPA mandate, and the needs of the beneficiaries. CP7 shifted its focus, successfully, from direct service delivery to strengthen institutions and systems, establishing and expanding public-private partnerships to leverage resources. Increased emphasis on high-level policy advocacy and catalytic work, and establishing strategic partnerships have provided effective and replicable programme models as evident from the evaluation findings (Ref: SRH, GE, PD effectiveness sections).

UNFPA has been a knowledge broker and partner in successfully bridging and facilitating various players engaged in the development field. Advocating RH, ASRH, gender equality and women's empowerment, and the access to information and knowledge as a human right, CP7 implementation has employed gender-accommodating, and to some extent gender-sensitive, and human rights-based approach. Strategically, UNFPA has maintained its strong presence in all policy and key decision functions related to UNFPA's mandate. UNFPA's corporate strengths are well recognized and acknowledged by other UN members for UNFPA's contribution to improving the UN Country Team (UNCT) coordination mechanism. Value added by UNFPA as a development partner is high, particularly where UNFPA has taken the lead in advocating sensitive issues on human rights, ASRH, GBV, FP and HIV&AIDS.

UNFPA CO has established sustainable and strategic partnerships enabling a healthy environment to lobby in areas that are sensitive and difficult to be tabled by other agencies. The strong technical support given by UNFPA to ensure the passage and implementation of the Responsible Parenthood and Reproductive Health (RPRH) Law is now etched in the history of Philippine health development. Given the reduced funding environment for CP8, diversifying resource mobilization approaches will be an added role for the CO. Country Office built effective partnership with the donors by establishing confidence in providing technical expertise and trust in the management of financial resources. Expansion of partnership with private business groups (such as the Employers Confederation of the Philippines or ECOP) in family planning is an efficient strategy for SRHR as in the Business Action for Family Planning Access. UNFPA has promoted creativity and innovation through its risk taking ability and leadership qualities.

CO, with its limited staff and limited funds amid several major emergency situations, has managed to achieve most of the planned results in the CP7 implementation. With a slow down during Typhoon Haiyan (2013) due to involvement of some implementing partners (IPs) in the humanitarian response themselves, UNFPA was able to flexibly adjust its development work plan and funds for humanitarian assistance in concurrence with IPs. Despite interruptions due to humanitarian crises in the first two years and the strategic changes in the mode of programme implementation, CP7 has achieved remarkable accomplishments, as evident from results discussed in the report. In programme implementation, project funds were released at a foreseen level in the work plans (WPs), however, releases to IPs were usually delayed indicating a need for simplified and well-coordinated financial procedures for more efficient and timely disbursements of funds.

Most of the initiatives of CP7 are likely to be sustained throughout the next decades since various legislations, policies, Presidential Executive Orders (EOs), department administrative orders (AOs), local government ordinances, community organizations, effective partnerships with international partners, national government agencies, LGUs, CSOs and communities are well installed and strongly supported by the present leadership in the Philippines.

UNFPA was instrumental in aligning the Philippine Development Plans (PDPs) with the ICPD goals, Millennium Development Goals (MDGs) and the new Sustainable Development Goals (SDGs). The shift in focus from service delivery and individual-focused capacity building interventions to more of institutional capacity-building/technical assistance and strategic policy advocacy/advice types of support resulted in the generation of knowledge products on PD, SRH, FP, among others, that served as evidence for more informed policy making and program planning at the national and local levels.

Leveraging funds for large scale surveys and innovative research activities was successful and adoption by government of innovative and effective UNFPA initiated activities was documented. The YDP has been aligned with the PDP particularly with the DD initiative. UNFPA is the key UN organization that provides technical support on work relating to generation of quality data.

The GE component has contributed to improving policy and legislative frameworks. The interventions have evolved according to the country context and implemented different courses of action by reflecting the needs and priorities of the UNFPA supported provinces contributing to increased awareness on and improved responses to GBV, particularly in emergency situations. Despite advocacy efforts to prevent GBV, there is an increased reporting of VAWC cases in UNFPA areas. Most of the UNFPA interventions were on secondary and tertiary responses to GBV and had limited focus on its prevention. Based on cursory review of GBV training materials produced under CP7, less attention has been paid to challenging patriarchy and engaging men and boys to end VAWC. The VAWC programme strategies have no robust M&E framework. “Capacity development” had been employed as a key strategy to support the implementation of MCW, particularly on reproductive rights and GBV. However, how changes in capacity will be captured and measured to understand the success of the capacity development process is not well articulated.

UNFPA has channeled its resources to well-established state institutions whose mandates are to promote GE and prevent GBV. Such strategy is to ensure that financial resources of UNFPA will have catalytic effect and results in gender equality will last beyond the end of CP7.

Evident from documents, feedback from almost all respondents, and CO staff, UNFPA is recognized as effective in responding to humanitarian needs and as a leading advocate for preventing GBV in emergencies. UNFPA’s coordination ability to make the optimum use of IP networks and the leadership displayed were highly commended by UNCT members, donors as well as national agencies. The visibility of UNFPA during humanitarian response had been remarkably high and efforts in mainstreaming of humanitarian response within all three programme components (mainly SRH and GE) have made the way forward for bridging the humanitarian and development nexus.

The national as well as provincial level institutions expressed the need for continuous engagement with UNFPA for technical assistance, especially in ASRH, thus engagement in national strategic development in ASRH to sustain the continuity would be useful. It was evident that the continuity of the interventions through several CP cycles has brought sustainable results in the provinces visited. The evaluation results prove that UNFPA has been able to, with shrinking budget and limited human resources, to achieve sustainable key results in the mandated areas. Resource mobilization and maximizing the UNFPA comparative advantage are considered increasingly important in the resource-constrained environment. Evidence revealed good examples of joint programmes, and almost all development partners voiced positive opinions on UNFPA’s added value and their willingness to collaborate with UNFPA in development interventions.

Recommendations: At strategy level, continue to strengthen the strategic partnerships with key government and non-government agencies. Given the mode of engagement and programming needs, for UNFPA should maintain its leadership in assisting the government with strategy and policy development, advocacy role and technical assistance where necessary. Continue with innovative interventions (e.g., cohort study beyond one CP cycle) that encompass all UNFPA programmatic areas and multiple implementing and development partners.

Design Related: CP8 to follow an integrated programming approach across development programme components in the design of CP8 interventions, ensuring adequate skills and capacity of staff that participate in formulating the results framework. Advocacy and policy dialogue/negotiating, lobbying, and advising role will be the major focus of UNFPA's development agenda in CP8, thus the need for targeted HR capacity building plan for this transition. Two key initiatives implemented in CP7 (Longitudinal Cohort study and DD initiative) will form part of CP8 as well. These initiatives are multifaceted, cut across all UNFPA mandated programme areas (SRH, GE, ASRH, Youth, PD), needing to work with multi-partners.

Programmatic level: CO to diversify the base for resource mobilization (within as well as outside the country), going beyond current established partnerships and traditional resource mobilization methods anticipating the budgetary changes/reductions in CP8. Pursue the development of definitive strategies in dealing with teenage pregnancies and HIV/AIDS among young people as part of ASRH. A strong ASRH component integrated in CP8 is highly recommended. Mainstream HIV in protection of women's rights and key populations and ASRH strategies should be customized based on local level epidemiology, contexts, and the institutional structures of the local health system.

Engage youth as a partner in the development and formal peace process (development, reaping the benefits of the DD, UN Security Council Resolution on Youth, Peace, and Security). In an environment such as Mindanao, gender, culture, and conflict sensitivity to be mainstreamed in all activities engaging youth. UNFPA's contribution of support for youth and adolescent should be monitored and documented (e.g., U4U initiative).

Stronger public health interventions and multi-sectoral interventions aiming to address Violence Against Women (VAW). This programme should focus not only on the role of men and boys as agents of change to promote GE and end violence but also recognize their vulnerabilities and needs in relation to GBV. This is relevant in the context of armed conflict areas in the Philippines, particularly in Mindanao. Women's economic empowerment has long been considered a key ingredient in structural interventions to reduce gender equality and the experience of GBV amongst women and girls hence it is recommended, to develop a UN Joint Programme to address these.

More research is needed to understand population dynamics and the changing attitudes and behavior of population groups particularly the youth, migrants and the older persons. The quality of UNFPA research outputs, policy briefs and other knowledge products must be ensured through the reactivation of a multi-disciplinary research advisory team to review research proposals and to vet potential research publications or policy papers. Advocate and lobby for building a resource base for capacity building of young scholars to develop a pool of next generation PD, SRH, GE thought leaders. For UNFPA to continue its policy advocacy and evidence-based research, employ strategic interventions to make quality data accessible and available for evidence based planning and policy making across all programme areas.

Chapter 1: Introduction

The Seventh Philippines Country Programme (CP7), implemented in cooperation with the national and local government partners, UN agencies, donors, INGOs, NGOs, CSOs and private partners, consists of three strategic outcome areas, namely: Reproductive Health and Rights (RHR); Gender Equality (GE); and Population and Development (PD). The initial country programme, 2012 to 2016 with an approved budget of 28.5 million US dollars, was extended up to 2018 with an additional approved funding of USD 11.4 million to align CP7 with the United Nations Development Assistance Framework (UNDAF) cycle 2012-2018. In line with UNFPA Evaluation Policy, an independent evaluation of the country programme was conducted in 2017.

1.1 Purpose and Objectives of the Country Programme Evaluation

The Country Programme Evaluation (CPE) serves three main purposes: (a) it is a means to demonstrate accountability to stakeholders on performance achieved; (b) it supports evidence-based decision-making; and (c) it contributes important lessons learned to the knowledge base of the organization. The evaluation aims to provide independent inputs to the next UNFPA country programme cycle and the strategic direction of the continued role for UNFPA support in the context of assistance to the Government of the Philippines in its commitments towards attaining the goals of ICPD, the SDGs as well as ICPD Beyond 2014 and the post-MDG agenda.

The Country Office, national partners, relevant government agencies, other development partners including donors, Asia & Pacific Regional Office (APRO), and UN agencies in the country are part of the **audience** who will contribute to as well as benefit from the evaluation process and the findings.

Specific Objectives: With the overall objective of creating a broadened evidence-base for the design of 8th Country Programme (CP8), the specific objectives of the CPE are to:

a) provide an independent assessment of the relevance, effectiveness (programme progress towards the expected outputs and outcomes in the CP's results framework), efficiency, and sustainability of the approaches adopted by the current CP;
b) provide an assessment of the CO's strategic positioning within the development community and national partners, in view of its ability to respond to national needs while adding value to the country development results; and
c) draw key lessons from past and current cooperation and provide a set of clear and forward-looking strategic and actionable recommendations for the next programming cycle.

1.2 Scope of the Evaluation

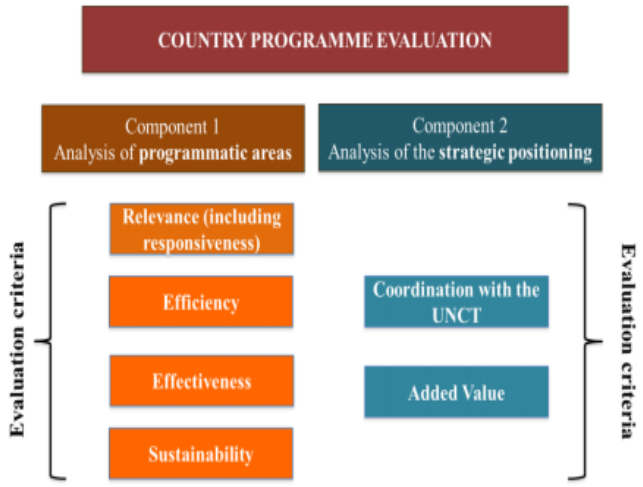
The scope of the evaluation is the CP implementation period from 2012 to 2017, covering selected initiatives based on agreed criteria under the three outcomes and six outputs implemented and focused on how CP design and implementation aimed to achieve the planned results. While CP7 covered ten provinces across the country's three island groups, the CPE prioritized visiting six of these sites based on the parameters outlined in Table 2. The CPE considered the extent to which CP7 provided SRH access to marginalized groups such as indigenous populations (including muslim women), women with disabilities, young and unmarried women, the urban poor and populations most at risk, including how it encouraged greater participation of women in the peace process. Three-stage filtering (page 23) explains how targeting was ensured during design stage. Humanitarian response, which is mainstreamed into the three outcomes, was also covered. Besides assessing the intended effects of the programme, the CPE identified key unintended effects. To complement the assessment of programme components, the CPE also assessed the operational

(e.g., financial, administration, procurement) and M&E systems and structures of the CO. Although it was not part of the terms of reference (TOR), as part of the design assessment the team reviewed the CP7 programme logic, or how the programme is designed to achieve the said outcomes and if any reconstruction of the theory of change was required prior to the evaluation planning.

1.3 Methodology and Process

Evaluation criteria and evaluation questions: The CPE analyzed the programmatic areas and the strategic positioning of UNFPA within UNCT. The evaluation focused on two components covering six evaluation criteria as shown below. The first is the analysis of programmatic areas: Reproductive Health and Rights (RHR), Population and Development (PD) and Gender Equality (GE) using OECD/DAC evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability. The second is the analysis of UNFPA Strategic Positioning in the country with a focus on UNCT Coordination and UNFPA's Added Value in the development agenda within the development community and national partners in responding to national needs. An assessment of the Organizational Effectiveness and Efficiency is addressed within both the programmatic as well as UNFPA strategic positioning component. The TOR indicated sixteen questions, out of which ten questions were selected for the evaluation.

Figure 1: Evaluation Criteria for the CPE



Source: CPE Handbook (UNFPA, October 2013)

Upon desk review of key documents and CO programme staff's presentation of the detailed overview of the programme components and approaches supporting the method of programme implementation, the team prepared evaluation design matrices (Annex 4) that included ten evaluation questions, assumptions, indicators, data sources and data collection methods. Stakeholder map was used in identifying the sources for interviews, discussions, and feedback. The methods for data collection and analysis were determined by the type of evaluation questions formulated to test the assumptions. The following are the evaluation questions:

Evaluation Questions:
Relevance 1) To what extent is UNFPA support in the fields of RH and rights, population and development, and gender equality (i) adapted to the needs of the population and (ii) in line with the priorities set by the national policy frameworks? (Addresses all three programmatic areas) 2) To what extent did the country programme integrate a gender responsive and human rights-based approach to programme planning and implementation? (Cross-cutting issue and relevant to all three areas) 3) To what extent has the CO been able to respond to changes in national needs and priorities or to shifts caused by crisis (this includes disasters and emergencies) or major political change?

Effectiveness
4) To what extent have the 7th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 7th CP outcomes? (Applies to all three areas)
5) Humanitarian assistance: To what extent has UNFPA responded to the RH and rights issues affecting pregnant and lactating women, young people (girls and boys), and women of reproductive age in general during the major humanitarian crises that occurred from 2012 to the present?
Efficiency
6) To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 7th CP outcomes in a timely manner? (Applicable to all programmatic areas as well as OEE)
Sustainability
7) To what extent has UNFPA support helped to ensure that SRH and rights, and the associated concerns for the needs of young people (girls and boys), gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country? (Applicable to all three programmatic areas)
8). To what extent has the CO established, maintained and leveraged different types of partnerships to ensure that UNFPA can make use of its comparative strengths in the achievement of the country programme outcomes across all programmatic areas? (this question is part of Sustainability, Efficiency and Added value assessments)
UN Country Team Coordination
9) To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?
Added Value
10) What is the main UNFPA added value in the country context as perceived by national stakeholders?
10a) To what extent has UNFPA made good use of its comparative strengths to add value to the development results of the Philippines?

1.3.1 Selection of the Sample

To answer the evaluation questions objectively, the selection of sites for data collection was based on the teams' knowledge of the programme interventions, beneficiary populations, and the characteristics of geographic locations[1]. The sites selection employed purposive sampling method to represent the country programme as comprehensively as possible, and was finalized after discussions with the CO staff and ERG members. The sites illustrated a mix of interventions (e.g., development and humanitarian response programming, soft activities, etc.), extent of targeting marginalized/vulnerable populations, size of resource allocation, type of implementing partners, maturity and scalability of interventions, and other specific coverage on gender, human rights approach, and vulnerability to disasters to reflect different strategies that the CO had followed in implementing across the country's major island groups – Luzon, Visayas, Mindanao (Ref. Table 2).

CP7 covered 10 provinces of the three island groups and based on document review and initial consultations with CO staff, ET covered six programme areas based on the selection criteria below. The selection was a non -probabilistic sample based on knowledge and informed decisions.

Table 2: Selected Sites for Field Visits

Island group/ Region	Province	Criteria (justification) for selection
Luzon/ CAR	Ifugao	Comprehensive intervention programme, covering all strategic outcome areas, relatively high investments, maturity of the interventions (CP6

[1] The team studied the CO- CP7 site selection criteria (targeting strategy) and procedures as mentioned later and described in detail in Annex A.

		presence as well), national implementing partners (IPs), Indigenous populations
	Mountain Province	Comprehensive intervention programme, covering all strategic outcome areas, relatively high investments, maturity of the interventions (CP6 presence as well), national implementing partners, Indigenous populations. (selection of two provinces with similar background is partly due to efficiency reasons, e.g. geographically difficult to access area, and adjoining area is included in the selection due to logistical reasons, accessibility)
Visayas/ Region VIII	Eastern Samar	Both Development programmes and humanitarian response (natural disaster response), mature programme
Mindanao/ Region XII	North Cotabato	Comprehensive programme intervention, development programme and humanitarian response (conflict environment), joint programming, EU funded project targeting Indigenous populations, peace-building interventions
	Sarangani	Comprehensive programme intervention, development program, joint programming, Indigenous populations
	Sultan Kudarat	Comprehensive program intervention, highest resource allocation/expenditure, development program, joint programming, indigenous populations (Accessibility of the three provinces during one visit/ET efficiency)

1.3.2 Data Sources, Collection and Analysis

Sources of data were both secondary and primary.[2] The type of data was based on a mix of quantitative and qualitative, derived from multiple sources. The evidence in this evaluation included data collected from the field, desk review of documents, direct observations, structured and semi-structured interviews, key informant interviews(KII), focus group discussions (FGD), and secondary sources. Desk review included CP-related documentation, relevant national policies, strategies and action plans, national statistics, review reports etc. A detailed list of documents reviewed is attached (Annex 3). The evaluation triangulated investigators, data sources, data types, and data collection methods and the data shed light on how UNFPA has been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to achieve planned results, ensure ownership and the sustainability of effects and the extent to which UNFPA activities were designed in a manner that ensured a reasonable handover to local partners.

A convenient sample of beneficiaries was used for focus group discussions to gather information on service quality and its accessibility and utility. The evaluation made use of the monitoring reports (quarterly reports, project-specific reports, annual reports, trip reports) submitted by IPs and UNFPA staff. The triangulation of data collection minimized the weaknesses of one method, and was offset by the strengths of another, enhancing the validity of the data. The following table shows the rich mix of primary data sources. Validation was achieved through stakeholder meetings, such as debriefing meetings with UNFPA staff and the ERG members.

Table 3: List of Representing Institutions and Number of Stakeholders Met

Institution	Male	Female	Total
UNFPA	12	8	20
Other UN Agencies (UNRCO, UNDP, UNICEF, WHO, UNOCHA, UNAIDS, UN Women)	5	6	11

[2] primary data is mainly qualitative in nature

National Government Level (DOH and POPCOM, NEDA, DSWD, NYC, CHR, PSA)	7	20	27
Provincial Level (Governors, PHOs, health and pop staff)	24	50	74
Municipal Level (Mayors, Health staff) MPDC, other LGUs District Hospital	13	54	67
Barangay Level (Medical staff, CHT)	15	29	44
Other development partners (DFAT, USAID), and academic institutions	5	10	15
NGOs/CSOs (ZFF, CHSI, Likhaan, PLCPD, BDA, OPS, Forum)	10	17	27
Students (U4U programme), Health Scouts, and school staff	12	38	50
Beneficiaries of health facilities, income gen projects), Half way home mothers and accompanying husbands, teenagers (Health service beneficiaries)	6	28	34
Total (Approximate numbers)	**109**	**260**	**369**

(the list of names is available in Annex 2)

The CO staff provided a list of stakeholders representing the national and local government, UN Agencies, donors, other development partners, and most importantly, the beneficiaries of the programme. ET had extended consultations with the CO staff and finalized the list of stakeholders for interviews based on the programme interventions and review of documents. The evaluation focused on major categories of stakeholders distributed across the CP7 programme themes. The selection covered all three strategic outcome areas. Though not a representative sample, a purposive sample was selected to reflect the interventions and the participants involved.

Data collection via individual face-to-face interviews, group interviews and focus group discussion adopted a participatory approach. The respondents (e.g., implementing partners, civil society, programme participants, donors etc.) were given the opportunity to discuss freely about the programme and allowed an opportunity for them to propose what would work for them to make the programme better in their own context.

Data Quality: Data quality was maintained by triangulating the data sources and methods of collection and analyses. Validation of preliminary findings, by key stakeholders, enhanced quality of data collected ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings.

Data Analysis: Analysis of quantitative data was based on the availability of primary and secondary data, their quality, and comparability. Content analysis was employed to interpret qualitative data. Qualitative data, secondary quantitative data and other evaluation findings from existing reports were triangulated in making conclusions from the findings. Special consideration was made, where feasible, to include and reflect how boys, girls, men and women, and those belonging to marginalized groups are included in the programme design and implementation.

Retrospective and prospective analysis and the evaluation criteria: The evaluation team assessed the extent to which results have been sustainable, where expected results have already been generated, and examined the prospects for sustainability, i.e., the likelihood that the effects of UNFPA interventions will continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was mainly based on respondents' perceptions. The same was applied to effectiveness: evaluators assessed the extent to which the objectives have been achieved or likely to be achieved. Previous evaluation findings and programme documents, country office monitoring and performance data, and field observations were combined with interview data to

substantiate ET findings. Relevance and Efficiency were assessed mainly by reviewing the related policy and strategy documents, financial documents and face-to-face interviews with relevant stakeholders.

1.3.3 Process Overview

The CPE process includes five phases: a) Preparation, b) Design, c) Field visits, d) Reporting, and e) Management response, dissemination and follow up.

On completion of the preparatory phase by the country office, the ET completed the Design Phase which included desk review of key documents; stakeholder mapping; analysis of the programme/intervention logic; finalization of the evaluation questions and development of data collection, analysis strategy and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and country office.
The Implementation Phase/ Data collection and Analysis Phase: After the design phase, the team undertook field visits based on the sample provinces selected. At the national level, data were collected from lead departments, selected donors, UNFPA staff and other strategic partners (UN agencies). At the end of the field phase a debriefing on the preliminary results took place with CO staff and ERG members to validate the findings and test tentative conclusions and recommendations.

Reporting Phase: After the presentation of preliminary findings, the draft report was reviewed by the CO staff, the ERG, Regional Office M&E advisor, and the Evaluation Manager for quality assurance. The second draft was presented to the national stakeholders and CO staff for further validation and finalization of the CPE report was done based on feedback from the reviewers. The Evaluation Team worked in close consultation with the Evaluation Reference Group in each of the phases and steps of the entire evaluation process.

Validation mechanisms: Besides a systematic triangulation of data sources and data collection methods and tools, the CPE design and preliminary findings were validated via two workshops with ERG and UNFPA CO staff members. Another broader stakeholder workshop, with implementing partners, donors, UN agency staff, and other relevant stakeholders, was held to present the findings and recommendations of the evaluation.

Evaluation results dissemination plan: Preparation of the management response and the dissemination of the final recommendations will be the CO's responsibility. The CPE findings and recommendations will inform the development of the CP8. The preparation of the management response and the dissemination of evaluation results will be the responsibility of the CO and the evaluation manager will upload the CPE into Docushare once the report is finalized. In addition, the executive summary of the evaluation report will be prepared as a standalone piece which can be used for dissemination purposes.

Ethics and maintaining the quality of evaluation: Several precautions were taken to ensure the protection of respondents' rights. Informed consent was sought before all interviews were made and the data collected were confidentially kept, with no identifiers. Where written consent was not applicable or feasible, verbal agreement was sought. UNFPA CO informed the respondents about the evaluation purpose and the rights and confidentiality of those participating in the evaluation.

The evaluation team made every effort to ensure that evaluation findings were credible based on reliable data and observations. Conclusions and recommendations will show evidence of consistency and dependability in data, findings, judgments and lessons learned appropriately reflecting the quality of the methodology, procedures, and analysis used to collect and interpret data. The ET followed the UNEG guidelines and standards as well as UNFPA's Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA" in carrying out the CPE to ensure quality.

Evaluability Assessment, Limitations and Risks: While the theory of change of CP7 was not fully developed to measure the links from outputs to outcome level, CO programme staff were able to provide necessary information for the ET to develop the assumptions required to assess the achievements. The ET re-constructed the programme logic (see Annex D1-3). Critical assumptions and limitations were not included in the CP7 programme logic (proposed theory of change), though the CO faced major humanitarian situations and setbacks in government policies with regard to FP interventions.

The results frameworks of CP7 have changed in response to keeping in line with two Strategic Plans (SP 2012-2013 and SP 2014-2017) within one programme cycle, at the time of the evaluation in 2017. Furthermore, aligning with the implementation modality (the Philippines as an "Orange" country) in the context of the new mode of engagement, CO and IPs shifted the focus from service delivery to policy, advocacy and capacity development to achieve the results defined in the results framework. Given the coverage from 2012-2017, the ET observed a mix of programme intervention strategies in this CPE.

The size of the country and the spread of the programme interventions in geographically remote areas were a constraint in establishing a representative sample for data collection. A thorough understanding of the programme interventions was, however, obtained by meeting programme staff and a purposive sample was selected to reflect the interventions to avoid or minimize the selection bias. In the field, only a few municipalities and barangays were visited and those may not be the representative health centers out of the total number. The team observed that some centers visited were hard to reach and with less service facilities, thus it may have provided the team with a balanced picture. All programme sites visited were selected by the implementing partners and there may have been a selection bias. This limitation was mitigated by triangulating the data/findings by documented results of previous independent evaluations, direct observations, interview of stakeholders (policy makers, service providers, and intended service receivers) at multiple levels.

Data Gaps: While current administrative- and survey-based information systems of the country provide sex- and age-disaggregated data, there is limited data available to identify changes in the development conditions of specific target populations of CP7 such as indigenous peoples, people with disabilities, poorest of the poor, etc. across all programme sites. To address this constraint, the ET took into account of and contextualized targeting-related findings and conclusions using project-specific data obtained from the EU-UNFPA Indigenous Peoples' Maternal, Newborn, Child Health and Nutrition (IP MNCHN) Project and from the Nossal Institute – UNFPA partnership where the 2013-2015 Participatory Action Research program was conducted aiming to improve the SRH of women with disability in the Philippines. Data on coverage of the poorest of the poor were obtained from the UNFPA-UNICEF-WHO Joint Programme on Maternal and Neonatal Health (JPMNH) where families covered by the Government's Conditional Cash Transfer (CCT) programme were specifically targeted.

Chapter 2: Country Context

The Philippines is a lower middle income country (real GDP per capita USD 1,781 in 2016 and USD 1,393 in 2010)[3] with a population of 100.98 in 2015 (92.3 million in 2010). It is an archipelago of more than 7,000 islands and about 160 ethnic groups[4]. Based on 2015 data, 21.6% of the population lived below the poverty line, with 25.2% recorded in 2012.[5] However, there were also wide income disparities among regions. CARAGA and the Autonomous Region of Muslim Mindanao (ARMM), both located in southern Philippines, were the poorest regions in 2009, with poverty rates of 54.4% and 47.4%, respectively[6]. Out of 188 countries assessed by the United Nations Development Programme (UNDP) 2016 Human Development Report, the Philippines ranked 115th in the Human Development Index. This places the country at the lower half of the 188 countries, lower than its neighbors Thailand and Indonesia.

Based on the 2011 Family Health Survey, the maternal mortality ratio (MMR) was high and reported at 221 maternal deaths per 100,000 live births, which is not significantly different from the 1993 baseline of 209[7]**.** Data from the National Demographic and Health Survey (NDHS[8]) reveal that the unmet need for family planning consistently declined from 30% in 1993, 22% in 2008, 18% in 2013 to 17% in 2017, as the proportion of currently married women using modern contraceptive methods increased from 25% in 1993, 34% in 2008, 37% in 2013 to 40% in 2017. It is also worth noting that modern contraceptive prevalence rate (CPR) in 2017 is higher in rural than in urban areas (42.2% and 38.1%, respectively.). Conversely, traditional CPR is lower in rural than in urban areas (12.8% and 15.3%, respectively). There were stock-outs of contraceptives in many provinces and cities and about 560,000 abortions per year.

NDHS data reveal that the percentage of deliveries by skilled birth attendants increased from 73% in 2013 to 84% in 2017 (from 42% to 64% for the poorest quintile and from 96% to 97% for the richest). Deliveries in health facilities also increased from 61% in 2013 to 78% in 2017 (from 33% in 2013 to 58% in 2017 among the poorest and from 91% to 97% for the richest).

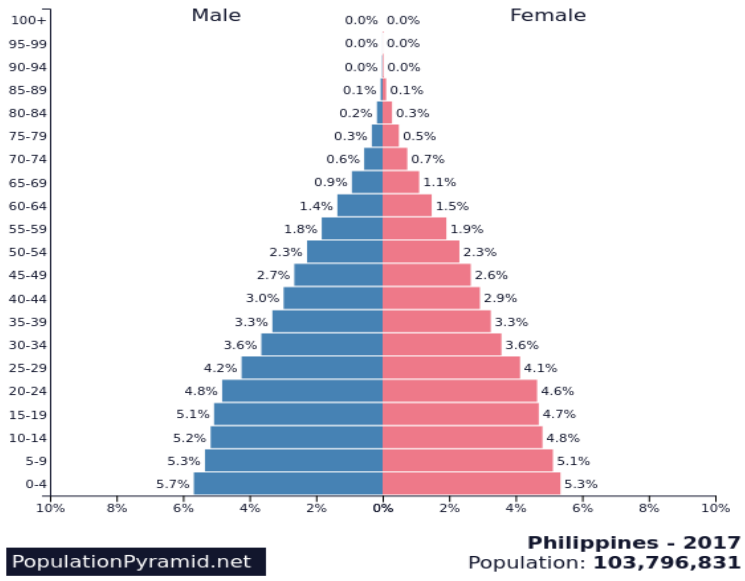
The country ranked 96th in the UNDP Gender Inequality Index, which measures RH, empowerment and labor participation. As of 2010, the Philippines ranked 59th of 108 countries on the gender empowerment measure and 10th of 144 countries on the global gender gap index (2017).[9] Despite this, violence against women (VAW) remains a continuing public health and human rights concern.

Young people aged 10-24 made up 30 per cent of the population.[10] The adolescent fertility rate (54 births per 1,000 women aged 15-19 in 2008, 57 in 2013 and 47 in 2017)[11] was especially high among

[3] Selected Economic and Financial Indicators, Bangko Sentral ng Pilipinas
[4] Danver, S. (2013). Native peoples of the world: an encyclopedia of groups, cultures, and contemporary issues. Armonk, NY: ME Sharpe, Inc.
[5] The Philippine Statistical Authority
[6] 2012 Full Year Official Poverty Statistics, National Statistical Coordination Board
[7] 2011 State of the World Population Report, UNFPA
[8] 2013 National Demographic and Health Survey and 2017 National Demographic and Health Survey 2017: Key Indicators Report
[9] www3.weforum.org/docs/WEF_GenderGap_Report_2017.pdf
[10] http://www.wpro.who.int/topics/adolescent_health/philippines_fs.pdf
[11] 2008 National Demographic and Health Survey, National Statistics Office

the poor. Young people accounted for half of all reported sexually transmitted infections and a third of new HIV infection cases in 2010.[12]

Figure 2: Population Pyramid, Philippines, 2017



The Philippines is one of the most disaster-prone countries in the world experiencing an annual average of 8-9 typhoons[13] and earthquakes[14]. Climate change and the long-running armed conflict in the south due to secessionist insurgency and various extremist groups exacerbated the vulnerability of the country. The resultant displacements of people and adverse socio-economic impacts contributed to the fragile environment for peace and development particularly in Mindanao.

2.1 Development Challenges and National Strategies

Philippines CP7 consists of three strategic outcomes in the areas of: SRHR, GE, and PD. Key areas under SRH are maternal health, family planning, HIV/AIDS and Adolescent SRH (ASRH), including in humanitarian settings. The development challenges discussed below are focused on the areas related to the UNFPA mandate.

A. Development Challenges: Sexual and Reproductive Health and Rights (SRHR)

Reproductive Health: While the total fertility rate (TFR) has been decreasing, though rather slowly, quality of and access to RH services continue to be major challenges as evident in the continuingly high maternal and neonatal mortality rates and high unmet need for family planning services especially among younger people and unmarried women. Tracking or identification of women with need for RH services, counseling, referral or follow-ups remains weak.

Maternal health: Glaring regional disparities in quality care remains. The high proportion of those not practicing proper birth spacing, which is indicative of inadequate provision of health information-education, is a cause for concern because of its dire implications for the health and survival of both the mother and the child.

[12] DOH NEC HIV AIDS Registry December 2010

[13] On average, eight or nine tropical storms make landfall in the Philippines, with another 10 entering Philippine waters. Philippine Atmospheric, Geophysical and Astronomical Services Administration (PAGASA). (January 2009). *See also* United Nations Office of Disaster Risk Reduction, The Human Cost of Weather Related Disasters 1995-2015 (2015).

[14] *See* Earthquake Impact Reduction Study for Metropolitan Manila, Republic of the Philippines, Final Report, Volume 1 (March 2004), http://ndrrmc.gov.ph/attachments/article/1472/Earthquake_Impact_Reduction_Study_Volume_1.PDF.

Family planning: Aside from varying capacities and lack of strong political will to bridge the unmet need for FP, there are also operational challenges, such as: 1) the lack of a national level FP communications strategy; 2) the inadequacy of trained human resources; 3) absence of a responsive information system to track women with unmet needs and navigate them through service uptake; and 4) difficulty to operationalize service delivery networks (SDNs) for FP due to the absence of coordinated support or technical assistance and strong leadership. The temporary restraining order (TRO) issued by the Supreme Court in June 2015 affected both implant, progestin-only pills (POPs) and the registration of all contraceptives, and has had a damaging effect on women's SRHR.

Male participation: Male participation in SRH remains wanting, as evident for example in male condom use that remained constant at 2% and the low uptake of vasectomy services. This can be attributed to access and availability issues as well as weaknesses in demand generation.

Neo-natal health: Neonatal mortality rate (NMR), which constitutes 59% of infant deaths, has remained relatively constant at 17 per 1,000 live births from 1993 to 2008 before declining to a rate of 14 per 1,000 live births in 2017. High NMR negates accomplishments in the provision of FP and ante-natal services and shows much remains to be done for the nutrition of would-be mothers.

Adolescent Sexual Reproductive Health (ASRH): Opposition to young people's access to modern methods of family planning and to HIV testing, parental consent (as provided for in the RPRH Law and the AIDS Prevention and Control Act, respectively), weak or ineffective IEC campaigns on ASRH, and the lack of operational guidelines for ASRH service provision are stumbling blocks in preventing early pregnancies and STI/HIV infection among young people. Overall, the prevalence of premarital[15] sexual activity has increased, the use of contraception/protection against STI remains low, with 78% of the first premarital sex unprotected against the risk of pregnancy and/or STI.

HIV/AIDS: The Philippines has the fastest-growing HIV/AIDS epidemic in Asia-Pacific. The inability to forge and sustain results-focused inter-agency collaboration, the lack of ownership and commitment of local government units in preventive efforts, and the presence of laws that prevent timely interventions (e.g., provision in the AIDS Prevention and Control Act of 1998 requiring individuals below 18 years old to seek the written consent of their parents or legal guardian before availing of HIV testing services; provision in the Dangerous Drugs Act which criminalizes the possession of paraphernalia for dangerous drugs, even by peer outreach workers, thus prohibiting harm reduction for injecting drug users) are main factors that have made the epidemic progress to what it is now.

SRH related National Strategies: For maternal and neonatal health, the DOH advocates and provides resource and training support for the adoption of a MNCHN core package of services consisting of interventions at each life stage: pre-pregnancy, pregnancy (through antenatal care), delivery (service delivery networks), post-partum (postnatal care), newborn (essential intrapartum and newborn care, exclusive breastfeeding, immunization) and child care (national immunization program, integrated management of childhood illnesses and nutrition).

For family planning, enabling policies and plans had been issued towards harmonization of efforts on FP (e.g., "National FP Costed Implementation Plan 2017-2020"). Availability of FP commodities is

[15] The RPRH Law dispensed with the requirement of written parental consent for minors who were already parents or suffered a miscarriage, in Section 7. The Supreme Court decision in *Imbong v. Ochoa*, G.R. No. 20481 (April 4, 2014), however, nullified the exception.

now better ensured with the provision of buffer stocks. FP logistics coordinators have been designated by the Population Commission (POPCOM) to monitor and fast track delivery of commodities to different regions. Routine generation of consumption reports on the ground has prompted DOH to start shifting towards consumption-based allocation. National campaigns have also been launched to promote FP coupled with community-based demand generation and increased service provision (e.g., making FP services available in selected government hospitals, workplace) and by capacitating FP service providers. To encourage male involvement in RH, PhilHealth has been covering the cost of no-scalpel vasectomy (NSV) for its members since 2006. Sporadic IEC activities are also conducted and linkages with NGO service providers forged to facilitate uptake of NSV services via outreach clinics.

The overall goal of the Adolescent Health and Development (AHD) Program managed by POPCOM is to contribute to the improvement and promotion of the well-being of young Filipinos ages 10-14; 15-19 and 20-24 through their SRH. Specifically it aims to contribute to the reduction of the incidence of teenage pregnancies and STIs and HIV/AIDS among young people. Among the major policy initiatives on adolescent health are: 1) the development by DOH of an Adolescent Health and Development Strategy; and 2) the integration of Adolescent SRH in Emergencies. Local government units were encouraged to develop policies, plans and programs in support of ASRH implementation at the local level. ASRH awareness-raising includes the provision of comprehensive sexuality education in schools, and local IEC campaigns through POPCOM. ASRH service provision is enhanced with the establishment of adolescent-friendly health facilities, establishment of a service delivery network for ASRH, HPV vaccination for girls, and capacity building of health service providers.

HIV/AIDS prevention rests on the following strategies: 1) capacity building (including training on VCT) for various stakeholders including service providers, youth peer educators/counselors, LGU officials/staff and other stakeholders; 2) IEC for HIV awareness and for generating demand for VCT aimed at most vulnerable populations; 3) procurement of commodities, including antiretroviral drugs, and provision of free and confidential HIV testing, and STI diagnosis and treatment in Social Hygiene Clinics and treatment hubs nationwide; 4) issuance of guidelines for the prevention of Mother-to-Child Transmission especially in the provision of antenatal care; and 5) condom promotion and distribution.

As to women and children in emergencies, the MISP for SRH is provided for in the Magna Carta of Women (MCW) enacted in 2009, and in the Responsible Parenthood and Reproductive Health Law enacted in 2012. This point is elaborated under GE national response elsewhere in the report. An administrative order has been issued by DOH on the "National Policy on the Minimum Initial Service Package (MISP) for SRH in Health Emergencies and Disasters" on February 2016. The AO identifies services for safe motherhood, family planning, STI/HIV/AIDS, and GBV that shall be made available in all areas affected by emergencies and disasters.

B. Development Challenges: Population and Development

The 101 million Philippine population in 2015 is still growing but at a manageable rate of 1.72% per annum between 2010 and 2015.[16] The country's GDP grew by 6.9%, which is second highest in Asia during the third quarter of 2017.[17] Such economic performance has been attributed to exports and

[16] PSA (2016) Highlights of the Philippine Population 2015 Census of Population. Viewed on 29 Nov. 2017 from https://psa.gov.ph/content/highlights-philippine-population-2015-census-population.

[17] Pernia, E.M. Press Conference on the Performance of the Philippine Economy for Third Quarter 2017 (16 Nov. 2017). Viewed on 29 Nov. 2017 from http://www.neda.gov.ph/2017/11/17/statement-of-socioeconomic-planning-secretary-

improvements in public spending that in turn enhanced manufacturing and services. Unemployment rate during the past 12 months remained below 6%.[18]

Analysis of linkages among population processes: Literature abounds with the analysis of levels, patterns and trends in fertility and mortality in the country. However, studies on internal and international migration appear to have been left out for the past three to four decades along with its linkages with the two other population processes mainly due to the lack of data sources that collect indicators for all three processes. With the inclusion of migration questions in the 2017 NDHS and fertility questions in the first ever National Migration Survey to be conducted in 2018, there are opportunities for further examining the interlinkages among these population processes.

Strengthening of national statistical systems

Recent programs to improve the measurement of maternal mortality through the vital registration system have been initiated. However, 100% coverage of maternal mortality may take a while unless all systems changes have been efficiently implemented. In the interim, the opportunity to measure MMR using a large sample size is in the forthcoming 2020 census.

Migration/displacement of population due to natural calamities, peace and order, etc.: Internal conflict and natural calamities have dispersed a large number of the population in the country during the last five years such as the Bohol earthquake, Zamboanga siege and typhoon Haiyan (locally, Yolanda) in 2013 as well as the Marawi siege.

Youth Bulge: Reaping the benefits of Demographic Dividend

The long-drawn-out demographic transition in the Philippines may be attributed to the slow decline in fertility despite reaching already low mortality levels during the past two decades. This has resulted in a youth bulge that could be instrumental in attaining a demographic dividend as earlier experienced by many East and South-East Asian countries. As the Philippine population is expected to continue to grow to the middle of the 21st century, the country's main challenge is how to take advantage of its youth bulge rather than trapping the next generation of citizens in poverty.

Lower HIV/AIDs awareness and knowledge among the youth. There was an evident decline in the awareness of HIV/ AIDs among the youth from about 95% in 1994 and 2002 to about 83% in 2013. The results of the 2013 Young Adult Fertility Study (YAFS4) revealed that only 17% percent of the Filipino youth had comprehensive knowledge on HIV/AIDS. These alarming results of YAFS4 may partly explain the increasing HIV/AIDS incidence and prevalence rates among the youth in the country today.

Population & Development: National Strategies

The Philippine Development Plan 2017-2022 was based on a long-term economic outlook under the National Economic and Development Authority's (NEDA) *(Ambisyon Natin 2040[19]). It is* anchored on middle-class aspirations such as eradication of poverty, equality of opportunities, human capital

ernesto-m-pernia-during-the-press-conference-on-the-performance-of-the-philippine-economy-for-the-third-quarter-of-2017/

[18] PSA *National QuickStat* as of October 2017

[19] *"The Philippines by 2040: matatag, maginhawa, at panatag na buhay [strong-rooted, comfortable, and secure]. The country is a prosperous middle-class society where no one is poor. People live long and healthy lives and are smart and innovative. The Philippines is a high-trust society where families thrive in vibrant, culturally diverse, and resilient communities." AmBisyon Natin 2040*

development; global competitiveness in the knowledge economy, products and services; resilience in shocks and disasters; high trust, caring and peaceful society, among others. The salience of population in development concerns is articulated in Chapter 13 of the PDP as it is devoted to reaping the demographic dividend.

C. Development Challenges: Gender Equality

Gender gaps are evident in employment outcomes. Labor force participation remains low for women at 49. 6% compared to that of men at 76.9%, which means that, among others, the former are dissuaded from searching for work.[20] In 2015, unemployment rate for men is 5.9%, which is slightly higher than that of women at 5.2%.[21] Amongst the ASEAN countries, the Philippines has the highest unemployment record from 2010-2013, despite the growing economy[22].

Women are poorly represented in decision-making positions. This is an unachieved MDG target. Albeit slow, there is an increase in the proportion of women's share in elected positions. In the present Congress (2017), women occupy six of the 24 senatorial seats (25%) and about 30% of the congressional seats. At the local level, there is an increase in percentage of women provincial governors, from 15.4% in 1998 to 22.5% in 2013, and in women mayors, from 15.26% in 2004 to 20.86% in 2013. As of 2013, the target 50-50 in the bureaucracy is short by 5 percentage points with 45% of third level positions occupied by women.[23]

Gender-based violence, impunity, and culture of silence are tolerated. Violence against women and girls (VAWG) is one of the country's widespread social problems. According to the latest NDHS report[24], one in five (20%) women has ever experienced emotional violence, 14% has ever experienced physical violence, and 5% ever experienced sexual violence by their current or most recent husband or partner. Below is a snap shot of attended cases on Violence Against Children and Women in the Philippines from 2004 to 2016 (*Source: CPNF, Inc. presentation).*

In many parts of the country, VAWG, particularly rape and any discussion of rape is a taboo. Another element is a culture of silence and shame that veils it. It is indeed alarming that despite efforts to address the concern, VAW persists.

[20] http://psa.gov.ph/tags/gender-statistics

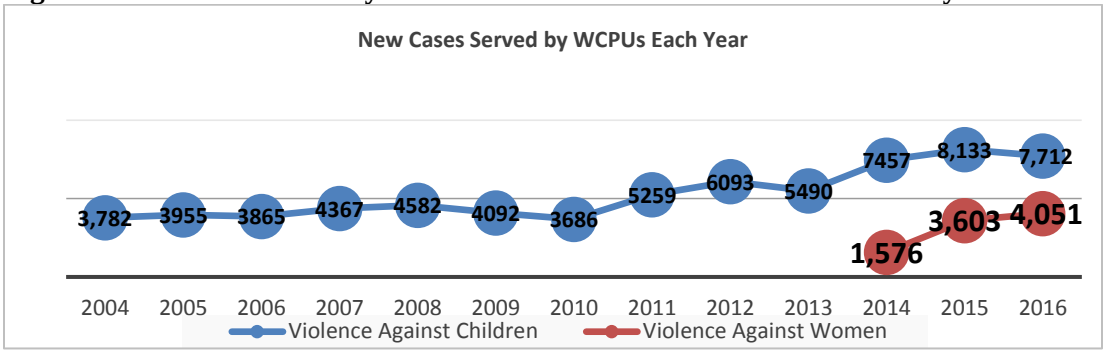
[21] ibid

[22] *PSA; DOLE; PCW; UNCT Report to CEDAW, Final Draft, 2016; The Philippine Government Report to CEDAW, 2015.*

[23] *Sources: IPU; PCW; House of Representative website; The Philippine Fifth Progress Report Millennium Development Goals; Combined 7th and 8th Philippine CEDAW Progress Report.*

[24] NDHS, 2017

Figure 3: New cases served by Women and Children Protection Units each year



Marginalized women, particularly indigenous and Muslim women face particular challenges. Despite the 19 years of implementation of Indigenous People's Rights Act (IPRA), indigenous women continue to be marginalized particularly on land certification and representation at the local government level, amongst others. The indigenous people population is estimated to be about 12 to 15 million; however there is no sex-disaggregated data available.[25] Of particular concern to the UN is the situation of lumads in Mindanao.

Specific needs of women and girls, specifically GBV, in humanitarian crisis (armed conflict and natural disasters). Decades of armed conflict, particularly in Mindanao, and recurrent natural disasters overstrained Philippine resources. Assessments conducted after Typhoon Yolanda indicate that the needs of women and girls, specifically on the prevention of and response to GBV, were not consistently prioritized and considered even if GBV prevention and response are increasingly recognized as life-saving interventions.[26]

Women migrant workers still in peril. According to the latest CEDAW periodic report (2010), Filipino women migrant workers continue to outnumber men but their proportion to the total has narrowed compared to the mid-2000. It has been noted that the Philippine Government "has made well-intentioned efforts to protect women migrant workers,"[27] however, these efforts fail to completely prevent abuses against female domestic workers.[28]

National Strategies*: *Policy Environment for Progress toward Gender Equality

The 1987 **Philippine Constitution** in article II, section 14 maintains that the State,"recognizes the role of women in nation building and shall ensure the fundamental equality before the law of women and men." It makes a strong statement on the equal rights of all its citizens. Key examples of landmark laws passed under the Women's Priority Legislative Agenda[29] include: The Magna Carta of Women (RA 9710), considered as the translation of the CEDAW into the nation's legal system; the RPRH Law (RA 10354), which gives women access to RH services and information and mandates

[25] *UNCT Report to CEDAW, Final Draft, 9 June 2016*

[26] ibid

[27] ibid

[28] http://library.pcw.gov.ph/sites/default/files/Combined%207th%20%26%208th%20CEDAW%20Philippine%20Progress%20Report.pdf

[29] http://pcw.gov.ph/wpla,

government to allocate funds for the same; and the Batas Kasambahay (RA 10361) or An Act Instituting Policies for the Protection and Welfare of Domestic Workers.

Efforts on the prevention of and response to VAW. To prevent VAW, the Philippine Commission on Women (PCW) spearheaded the development of an advocacy agenda which includes: (a) improved access to justice by victims of abuse and violence; (b) expanded access to affordable comprehensive women's health care and services; (c) improved convergence of efforts in building peaceful, safe and violence-free communities, and (d) institutionalized provision of women and child-friendly spaces in evacuation centers. The Department of Social Welfare and Development (DSWD) initiated its Women Friendly Space (WFS) project in recognition of women's need for private space especially in the aftermath of disasters when sexual violence also happens.

Women's Political Participation. The most notable legislation to promote women's participation and representation in decision-making bodies is the Magna Carta of Woman, which mandates the government to institute the several affirmative action measures - so that women can participate meaningfully in the formulation, implementation, and evaluation of policies, plans, and programs for national, regional, and local development.[30]

2.2 The role of external assistance

The total Official Development Assistance (ODA) of the UN Portfolio in the Philippines from 2012 to 2017 amounted to over US$2 billion, which consisted of support from 16 UN Resident Agencies. The top three contributors are UNDP (27.13%), WFP (16.89%), and FAO (16.56%) while the UNFPA ranked as the 8th largest (2.71%). Table below provides the totals per year as well as per agency contribution.

Table 4: UN Agency Budgets based on ODA Report, 2012-2017 (in USD Million)

Year	2012	2013	2014	2015	2016	2017	Total per Agency	% Share
UNDP	80.33	41.59	168.82	96.29	162.88	98.84	**648.75**	**27.13%**
UNFPA*	12.99	18.35	13.95	7.34	6.59	5.64	**64.86**	**2.71%**
UNICEF	87.38	126.78	112.32	17.29	9.77	14.35	**367.89**	**15.39%**
FAO	12.92	19.23	75.24	62.07	51.22	175.13	**395.81**	**16.56%**
ILO	1.12	132.88	10.43	14.92	7.23	6.17	**172.75**	**7.23%**
UNIDO	6.86	10.03	14.92	8.91	11.16	10.88	**62.76**	**2.63%**
WFP	62.83	17.43	155.08	97.38	30.90	40.16	**403.78**	**16.89%**
WHO	12.46	27.03	24.16	26.15	No data	11.54	**101.34**	**4.24%**
IOM	0.35	0.14	No data	No data	No data	No data	**0.49**	**0.02%**
IFAD	14.94	14.74	18.38	17.25	No data	No data	**65.31**	**2.73%**
UNAIDS	No data	No data	No data	0.12	0.01	0.03	**0.16**	**0.01%**
UNHABITAT	No data	1.68	No data	5.15	5.15	9.38	**21.36**	**0.89%**
UNWomen	0.06	No data	No data	1.48	0.35	0.38	**2.27**	**0.09%**
UNHCR	8.89	2.58	No data	21.83	27.90	No data	**61.20**	**2.56%**
OCHA	1.05	No data	No data	1.44	2.79	No data	**5.28**	**0.22%**
UNOPS	No data	No data	No data	No data	No data	16.82	**16.82**	**0.70%**
TOTAL PER YEAR	**302.18**	**412.46**	**593.30**	**377.62**	**315.95**	**389.32**	**2,390.83**	**100%**

***** *2017 data remain unofficial pending the issuance of the final ODA report by NEDA*

[30] http://pcw.gov.ph/focus-areas/leadership-political-participation

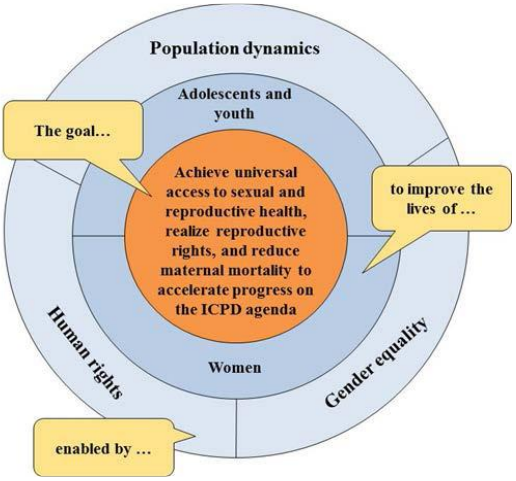
Chapter 3: UNFPA Response and Programme Strategies

3.1 UNFPA Strategic Response

In line with the Paris Declaration of Aid Effectiveness, UNFPA continues to work closely with the Government of the Philippines and other national implementing partners supporting Government development priorities. UNFPA supports furthering of the ICPD agenda and attainment of the MDGs. In the development of CP7 (2012-2018) UNFPA has taken into account the national development policies, goals and objectives of ICPD and its reviews, MDGs, SDGs and UNFPA Strategic Plans. CP7 was synchronized with the United Nations Development Assistance Framework (UNDAF) 2012-2018.

CP7 started in 2012, during the Strategic Plan 2008 – 2011 which was subsequently extended until 2013, defining three broad programmatic areas: SRHR,, PD, and GE. Following the Mid-Term Review of the Strategic Plan (2011), UNFPA adopted a set of seven interrelated outcomes which, in turn, supported a single overarching goal: to achieve universal access to SRH, promote reproductive rights, reduce maternal mortality and accelerate progress on the ICPD agenda - the strategic direction "bull's eye."

Figure 4: Strategic Direction of UNFPA, The "Bullseye"



The strategic direction represented by the "bullseye," was reaffirmed in SP 2014-2017, but no longer strictly associated with the three previous programmatic areas. Instead, they formed a coherent package of core areas to allow the organization to better focus its support. UNFPA strategic response was to focus on four strategic outcomes[31] and present a set of organizational changes to improve management effectiveness with a strengthened results framework, a new business model, and improvements to the funding arrangements. The new SP 2018-2021 goal is the same as that of SP 2014-2017.

CP7 has crossed three SP cycles since 2012. While the programme focus did not deviate much due the strong alignment of the planned programmes to the UNFPA mandate, the mode of engagement shifted as per the UNFPA business model. The Philippines being classified in the *Orange Category*,

[31] • **Outcome 1:** Increased availability and use of integrated sexual and reproductive health services that are gender-responsive and meet human rights standards for quality of care and equity in access.
• **Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health services.
• **Outcome 3:** Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.
• **Outcome 4:** Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

the mode of engagement is via capacity development, partnerships and coordination, including South-South and triangular cooperation, knowledge management, advocacy, policy dialogue and advice. However, in humanitarian settings, when the country responds to natural or man-made emergencies, in addition to the above, service delivery can be deployed (SP 2017-21) without requiring justification in the form of a business case.

3.2 UNFPA Response through the Country Programme

3.2.1 Brief description of the UNFPA previous cycle strategy, goals and achievements

UNFPA implemented its 6th programme of assistance from 2005 to 2011 (originally up to 2009, then extended to 2011), with the central level focusing on policy issues and at field level supporting efforts to improve the RH situation in three municipalities in each of 10 provinces. Focusing on RH, Population and Development Strategy (PDS), and Gender and Culture (G&C), the overall goal was "to improve the reproductive health (RH) status of the Filipino people through better population management and sustainable human development." The efforts at a provincial level were intended to demonstrate successful arrangements for the implementation of RH care which would be appropriate for more widespread replication throughout the programme and in non-programme provinces. The evaluation of the 6th Country Programme Cycle (CP6) identified the need to: (a) increase emphasis on the quality of RH care and services; (b) improve programme design by integrating different thematic components; (c) strengthen programme sustainability; (d) develop a dynamic monitoring system; (e) reduce transaction costs; (f) and improve efficiency in programme delivery. The evaluation also recognized the importance of government ownership, committed leadership, the inclusion of young people's concerns, and good documentation of processes.

3.2.2 Current UNFPA country programme

UNFPA's 7th Country Programme of Support to the Philippines
CP7 contributes to the UNFPA Strategic Plan Goal: Achieve universal access to SRH, promote reproductive rights, reduce maternal mortality, and accelerate progress on the ICPD agenda and MDG 5 (A & B).

Table 5: Financial Allocations (indicative, not actual) for CP7

Programme Areas		Regular resources	Other	Total	
		2012 to 2016 period (USD million)			*2017 to 2018
1	Reproductive Health & Rights	12.8	3.6	16.4	7.55
2	Population & Development	5.4	1.5	6.9	1.53
3	Gender Equality	3.2	0.9	4.1	1.12
4	Programme Coordination & Assistance	1.1	-	1.1	0.60
Total		22.5	6.0	28.5	10.80

Source: CPD *Extension beyond 2016, for 2017 and 2018. The Government of the Philippines and the UNCT agreed to extend the country programmes of UNFPA, UNDP and UNICEF to align them with the extended UNDAF (2012- 2018) and to synchronize them with the national planning processes.

Assuming a catalytic role in comparison to the service delivery in CP6, CP7 shifted its focus to upstream policy support and catalytic interventions in selected geographical areas and UN convergence sites, based on identified needs, political commitment, and the government conditional cash transfer programme for poverty reduction. The programme sought to strengthen institutions and systems and leverage partnerships rather than emphasize direct service delivery,

while expanding public- private partnerships to leverage resources for good practices and to provide effective programme models. Efforts on Advocacy continue to play a key role in the programme.

Moving from SP 2008-2013 to SP 2014-2017, UNFPA changed its implementation approach from siloed to integrated programming across components. At the same time there were changes in implementation contexts (2012-2014) such as the passage of the RPRH Law in December 2012 (14 years after it was first filed in the 11th Congress), major humanitarian emergencies occurring with regularity and increasing intensity every year (e.g., Typhoon Sendong, Typhoon Pablo, Super Typhoon Yolanda, Bohol earthquake, Zamboanga siege, displacement in Central Mindanao due to protracted conflict), and relatively substantial[32] core and non-core (donor) resources for UNFPA COs.

From 2015 to 2017, further changes took place in CP7 implementation contexts due to the UNFPA classification of the Philippines as an "Orange" country, downward trend in core and non-core resources for UNFPA COs, continuous political and legal challenges to RPRH Law, FDA certification of all contraceptives submitted for review in November 2017, 2030 Agenda for Sustainable Development (or the SDGs), election of new government at national and local levels in May 2016 and adoption by the new government of strengthening RPRH Law implementation as part of its 0+10-point national agenda.

In the same period, the CO increased its emphasis on upstream and catalytic work and strategic partnerships at the national level, such as technical assistance to government to accelerate the implementation of the RPRH Law along key result areas (maternal health, FP, ASRH, HIV/AIDS, GBV), non-traditional partnerships such as with the private sector, and in generating high-quality evidence to support policy-making and programming (e.g., study on the demographic dividend, 15-year longitudinal cohort study on the girl- and boy-child, studies on the social determinants and socio-economic impact of teenage pregnancy). The launch of FP 2020 global partnership also took place during this time.

Direct LGU engagement was concentrated in fewer and geographically contiguous provinces, prioritizing support to priority provinces of the Philippine Development Plan (2011-2016), and initiating support to Bangsamoro areas as integral to UNFPA's peace-building efforts. UNFPA shifted the mode of engagement with provinces from direct programme implementation to more catalytic approaches such as twinning/coaching (exchange of "good" practices between provinces), participation in NGA or national NGO-led capacity building, national workshops/ conferences on issues related to RH and rights, and participation in national advocacy events.

The country faces major disasters regularly with increasing intensity and UNFPA plays a major role in humanitarian response (Typhoon Pablo in 2012, Bohol earthquake, Zamboanga siege, conflict and displacement in Central Mindanao, Typhoons Yolanda 2013 and Ruby in 2014).

Geographical coverage of CP7 Interventions

CP7 covered 10 provinces, in five regions of the three island groups. Selection criteria of the intervention areas had involved a rigorous exercise with stakeholder participation. Site selection was conducted through a three-stage filtering[33] and mapping process, where areas were

[32] UNFPA received financial input beyond what was originally planned for CP7, to fulfill responsibilities of emergency work, thus changing the implementation context within the available human resource capacity in the country office.

[33] See Annex A1 for details on three-stage filtering and mapping process.

prioritized/ranked based on who exhibited the highest need and on where CP7 could generate the highest impact. The three selection rounds are described as follows:

First Round Filtering selected six highest ranking regions based on the following criteria based on their corresponding weights (explained in detail in Annex A) Poverty Incidence, Reproductive Health which includes MMR, AFR, CPR and Skilled Birth Attendance/number of unattended deliveries and Violence Against Women which Includes Sexual Violence and Physical Violence. The **Second Round Filtering selected** the 20 highest ranking provinces within the 6 highest-ranked regions based on the following criteria, with their corresponding weights: Population Size, Gender Development Index and Reproductive Health Indicators that include Maternal Mortality Ratio, Contraceptive Prevalence Rate, and Skilled Birth Attendance. **Third Round Mapping** included different qualitative characteristics of the 20 ranked provinces that were mapped to determine their suitability and viability for UNFPA operations to provide guidance in the design and costing of packages based on differentiated needs. The following operational indicators were used in the process: Contiguity of sites, Potential for replicability, Presence of an RH/Gender and Development (GAD) code, With budget allocated for Family Planning commodities, % of indigent enrollment in Philhealth, Availability of CSO networks, Presence of VAW/women's desk/center and/or inter-agency mechanisms, Geographic accessibility, Security situation, Presence of other UN agencies, Presence of other development agencies not duplicative, Forms part of Joint Programme sites – "yes" if the site is a Joint Programme area, "no" if otherwise, Forms part of the UNDAF Convergence Sites – "yes" if the site falls under the UNDAF convergence area, "no" if otherwise and Political climate – whether the local leadership is perceived to be pro-RH or otherwise (detailed explanations in Annex A1 under site selection criteria)

The Table below provides a snap shot of the final selection of CP7 programme areas:

Table 6: Mapping of Major UNFPA Initiatives in 7th Country Programme Priority Provinces (2012-2017)

Island Group	Region	7th CP Priority Provinces	Funds utilized (in USD) based on 2012-2016 AWPs with UNFPA	Sum of Exposure to Major UNFPA Programmes and Initiatives
Luzon	CAR	Ifugao	248,497.73	7
		Mountain Province	210,579.65	6
	Region V	Albay	151,597.96	6
		Camarines Norte	227,845.83	5
		Masbate	48,657.32	4
Visayas	Region VIII	Eastern Samar	159,954.94	8
Mindanao	CARAGA	Surigao del Sur	184,384.72	3
		Compostela Valley	160,426.13	8
	Region XII	North Cotabato *	88,955.06	12
		Sarangani	186,887.77	11
		Sultan Kudarat	329,595.27	13

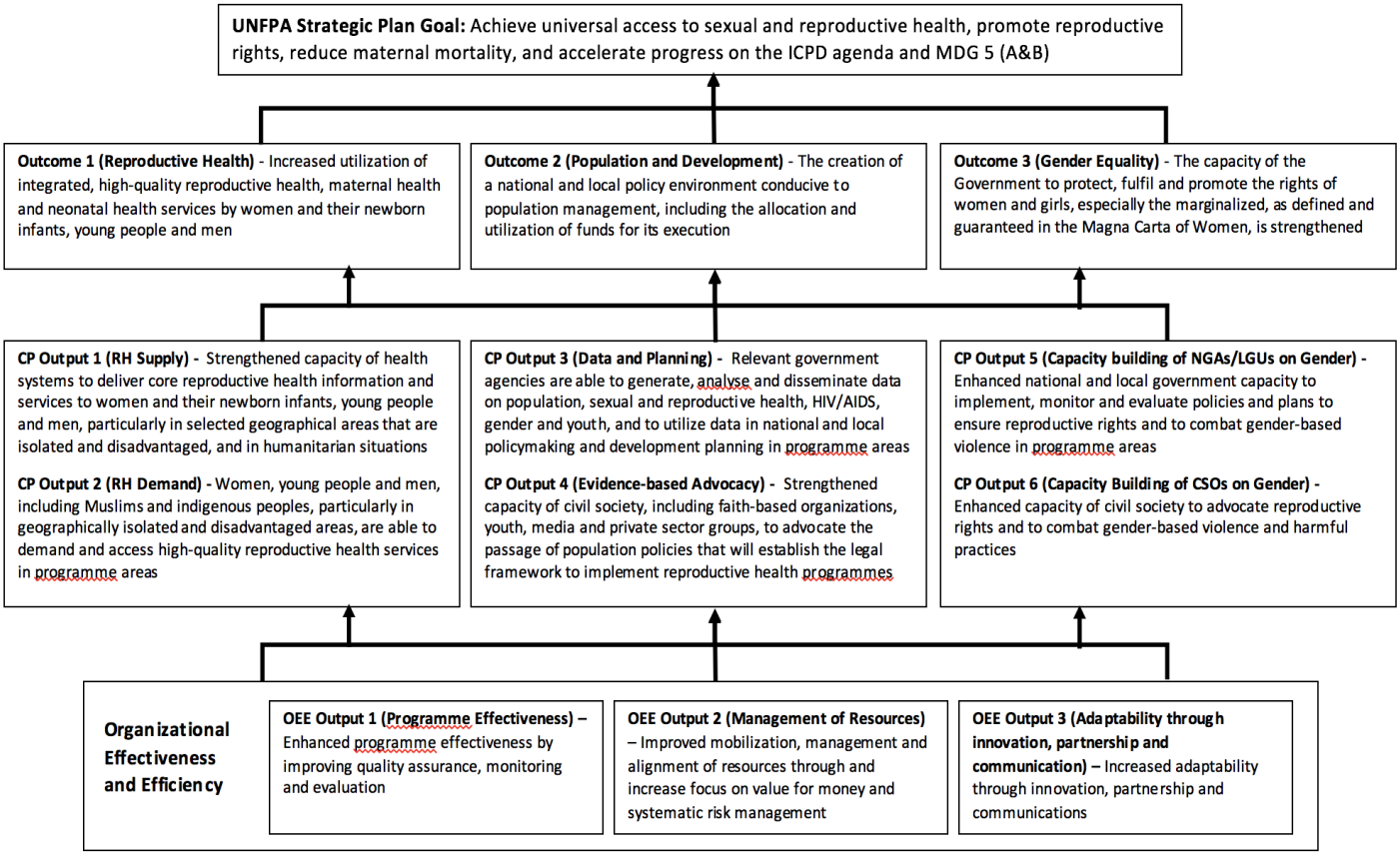
Source: Country Office

CP7 made special effort to include marginalized populations. The following provides evidence on targeting for marginalized/vulnerable Populations. EU-UNFPA Project on "Addressing Reproductive and Maternal Health Needs of Indigenous Communities/ Peoples and Other Disadvantaged Communities in Mindanao" (IP MNCHN Project) had the overall objective of improving access to and utilization of quality RH services in selected indigenous peoples' areas and other disadvantaged

areas in Mindanao through a comprehensive and culturally-sensitive implementation of the family planning and RH component of the national Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy. UNFPA-UNICEF-WHO Joint Programme on Maternal and Neonatal Health (JPMNH) Phase 2 targeting the rural/urban poorest of the poor (Conditional Cash Transfer [CCT] beneficiaries) represented the collective effort of three UN agencies in support to the Philippine government, towards attaining its commitment to the international community in achieving MDGs 4 and 5. JPMNH harnessed the technical expertise and organizational capacities of the three agencies to establish a functional and effective service delivery network (SDN) in the selected vulnerable sites that will be worthy of adoption by the Department of Health as a model for replication in similar localities at the sub-national level, which exhibit parallel geographical contexts and suffer the same MNCHN issues. The details are described in Annex A.

Programme Focus: CP7 focuses on three outcomes and six outputs covering SRH, PD and GE and identifies three key areas to increase the organizational effectiveness and efficiency to achieve CP7 results. The following diagram depicts the theory of change as documented by CO.

Figure 5: Theory of Change for the UNFPA CP7 (Source: UNFPA Country Office)



3.2.2 The Country Programme Financial Structure

The financial tables below show that the UNFPA CO has mobilized 60% more than the indicative level of resources foreseen in the original and extension documents of CP7. Of the USD 32 million in

non-core resources, around 70% went to regular development programmes while 30% were for humanitarian interventions. The CO's funding base included the following donors:

- 2012 – Australia (Joint Programme on Maternal & Neonatal Health; Typhoon Bopha response)
- 2013 – European Union (Indigenous Peoples MNCHN Project), Australia (Typhoons Bopha/Haiyan response), CERF (Humanitarian response to IDPs in Central Mindanao, Zamboanga siege, Bohol earthquake, Typhoon Haiyan)
- 2014 – Japan (Haiyan recovery activities), United Kingdom (Zamboanga/Bohol/Haiyan response), Canada (Haiyan), USAID (strengthening GBV response capacities), Virgin Unite (Haiyan), UNFIP (Business Action for FP)
- 2016 – Australia (Humanitarian preparedness for RH and GBV; Longitudinal Cohort Study on the Girl- and Boy-Child), UNICEF (Cohort Study)
- 2017 – UNFIP (advancing provision of sub-dermal implants through CSOs; Business Action for FP Phase 2), CERF (Humanitarian response to Marawi siege)

CO utilized 96% of its total planned resources for the 2012-2017 period. Consistent with the predominance of SRH issues in the country, whether in a development or a humanitarian context, SRHR/Humanitarian interventions received around 70% of the total CP7 funding. Gains in resource mobilization notwithstanding, a downward trend in both core and non-core resources was observed over the six-year period. Discounting the year 2014 when funds poured into the country on account of the humanitarian response to Typhoon Haiyan, core resources decreased by 8% from 2012-2014, by 26% from 2014-2015, by 17% from 2015-2016, and by 36% from 2016-2017. The latter decrease was particularly attributable to the decision by the United States to withhold funding for UNFPA.

Table 7: Overview of the budget (Allocation, expenditures and utilization rate) for the programmatic areas of CP7-Philippines: 2012-2017 (All figures are in US Dollar)

Thematic Area	Core Resources		Non-Core Resources		Total Resources		% Utilized
	Planned	Utilized	Planned	Utilized	Planned	Utilized	
SRHR and Humanitarian	20,486,123.88	20,009,831.35	24,206,501.72	23,468,819.86	44,692,625.59	43,478,651.20	97%
Gender and Humanitarian	3,710,469.52	3,418,333.72	4,586,838.72	4,081,803.93	8,297,308.23	7,500,137.65	90%
Population and Development	5,004,795.24	4,729,354.03	1,524,359.10	1,474,669.07	6,529,154.35	6,204,023.10	95%
PCA*, other non-thematic/cross-cutting costs	1,526,164.36	1,459,089.32	20,228.90	13,826.29	1,546,393.26	1,472,915.61	95%
GRAND TOTAL	**30,727,553.00**	**29,616,608.41**	**30,337,928.44**	**29,039,119.15**	**61,065,481.44**	**58,655,727.56**	**96%**

* Humanitarian programme resource allocations are within SRHR and Gender thematic areas. PCA refers to Programme Coordination and Assistance. (Source: Country Office)

Table 8: Overview of the budget on an annual basis (Allocation, Expenditure and Utilization Rate)

Year	Core Resources			Non-Core			Total Resources		
	Planned	Utilized	% Utilized	Planned	Utilized	% Utilized	Planned	Utilized	% Utilized
2012	6,518,172	6,149,483	94%	6,655,727.00	6,442,910.26	97%	13,173,899.00	12,592,393.63	96%
2013	9,335,738	9,178,099	98%	6,389,226.44	6,148,348.89	96%	15,724,964.44	15,326,448.25	97%
2014	5,440,000	5,191,983	95%	8,520,626.00	8,175,782.00	96%	13,960,626.00	13,367,764.52	96%
2015	3,830,000	3,721,786	97%	3,987,219.00	3,609,178.00	91%	7,817,219.00	7,330,963.89	94%
2016	3,368,097	3,140,793	93%	2,542,251.00	2,423,045.00	95%	5,910,348.00	5,563,837.51	94%
2017	2,235,546	2,234,465	100%	2,242,879.00	2,239,855.00	100%	4,478,425.00	4,474,319.76	100%
GRAND TOTAL	**30,727,553.00**	**29,616,608.41**	**96%**	**30,337,928.44**	**29,039,119.15**	**96%**	**61,065,481.44**	**58,655,727.56**	**96%**

Chapter 4: Findings- Answers to the Evaluation Questions

This chapter has two components, answering the evaluation questions at the programmatic and strategic levels. CPE Component 1 analyzes CP programme areas against the evaluation criteria of relevance, effectiveness, efficiency and sustainability. Component 2 analyzes the strategic positioning of UNFPA CO using criteria: *coordination* with the UNCT and *added value* of UNFPA. Detailed evaluation matrices for Programmatic Areas and Strategic Positioning indicating the assumptions that were considered during the evaluation are in Annex 4.

4.1 Answer to Evaluation Questions on Relevance

EQ1: To what extent is UNFPA support in the fields of RH and rights, population and development, and gender equality (i) adapted to the needs of the population and (ii) in line with the priorities set by the national policy frameworks? (Addresses all three programmatic areas)
EQ 2: To what extent has the CO been able to respond to changes in national needs and priorities or to shifts caused by crisis (including humanitarian) or major political change?
EQ3: To what extent did the country programme integrate a gender responsive and human rights-based approach to programme planning and implementation? (Cross-cutting issue and relevant to all three areas)

4.1.1 Sexual and Reproductive Health: Relevance

Summary of findings:
The portfolio of interventions in the CP7 design was grounded on validated baselines in the covered areas, ensuring relevance in terms of addressing jurisdictions' respective health indicators and SRH epidemiology. CP7 development has likewise been aligned with the two outcomes of the prior Philippine Country Programs, the visionary direction of the current Philippine Governement under NEDA's AmBisyon Natin (Our Vision) 2040 and the ICPD.

Across implementation, important paradigm shifts such as country's remodeled commitment from the MDGs to the SDGs in 2015 were considered, thereby highlighting the complementarities of the right to health (especially SRH-related SDG sub-goals) with distinct social determinants. A strategic shift from field-focused, limited-scale direct service delivery and individual-focused capacity building interventions towards catalytic high-impact institutional capacity-building, technical assistance, and policy institutionalization served as an important CP7 response to changing national and international priorities in SRHR. This is especially positive for CP7 relevance in crisis situations of a humanitarian nature, where SRHR promotion innovations were widely accepted.

The development of CP7 programmatic interventions were based on validated baseline data from the areas covered and national socioeconomic and SRHR policies, including the MDGs and later, SDGs, economic development plans, and the ICPD POA, . This policy coherence and alignment across jurisdictional hierarchies facilitated responsiveness of interventions for SRH-specific health indicators and epidemiology and translated to local support of the CP7 SRHR components (see Annex A. CP7 Performance Data). The adoption of LGUs of particular CP7 interventions (development of similar programs and reiteration of policies) highlights the program's high level of relevance in the vantage of the communities.

UNFPA research and technical support findings also fed into the design and development of local and national policies on SRHR; thereby solidifying relevance based on policy alignment and

coherence. National policies that considered UNFPA data included the *Philippine Development Plan 2017-2022* on reaching the demographic dividend, and E.O. 12, s. 2017 and DOH A.O. 2017-05 on reducing unmet need for modern family planning. With UNFPA technical support, LGUs also adopted local development and annual investments plans that meet minimum POPCOM/DOH standards on SRHR, as well as ordinances and resolutions (e.g., eight provincial ordinances/budget allocation, seven city ordinances, and 24 municipal ordinances on RH, FP,or MNCHN).

UNFPA's RPRH support included organizing legislative fora and symposia, consolidating evidence-based data for congressional deliberation, and support to community-based RH awareness. UNFPA also supported the RPRH Law National Implementation Team through M&E framework and high-level policy support and advice.

CP7 interventions facilitated critical national policy shift towards increased SRHR awareness and acceptance, by supporting RPRH Law design and implementation and *fatwas* (on the Model Family in Islam and on forced and early marriage, pre-marriage counselling and GBV).

SHR in Humanitarian Response (Relevance)

Throughout CP7, the Philippines has been subjected to several humanitarian crises, both natural disasters and and armed conflict, that have put severe burden in local health systems. In such contexts, the hierarchically structured health services intervention, more often than not, puts less priority to SRHR, as compared to other medical and healthcare interventions as addressing acute traumatic injuries, the suppression of infectious diseases, and the maintenance of nutritive supplies have been seen by local and regional policy-makers as more fundamental. In response to the need of protecting and promoting SRHR in times of humanitarian crises, UNFPA has established a catalytic role by partnering with the National Disaster Risk Reduction and Management Council (NDRRMC), the Department of National Defense's (DND) Office of Civil Defense (OCD), the DOH, and the Department of Social Welfare and Development (DSWD).

To contribute to building resilience and increasing government's capacity to fulfill SRHR in both humanitarian preparedness and response settings, UNFPA provided policy advice, technical support and capacity building leading to the issuance of DOH AO 2016-0005 (National Policy on the MISP for SRH in Health Emergencies and Disasters) and Joint Memorandum Circular (JMC) 2017-0001 covering the DOH, DILG, OCD and DSWD re. Implementation of MISP and its integration in the N/LDRRMPs as well as institutionalizing MISP in DRR courses of the Local Government Academy. This also led to the DOH and four Metro Manila quadrants completing the MISP Training cum Planning to prepare for a 7.2 magnitude earthquake and prepositioning in-country of PHP40M worth of humanitarian goods on SRH and GBV to support government's response to disasters.

4.1.2 Population and Development: Relevance

Summary of findings: UNFPA support to PD focused on vulnerable and disadvantaged groups such as youth, women, teen mothers, and the urban poor. Needs of these groups were expressed in UNFPA special events and symposia to which they are invited and they are considered during regular programming and dialogues on various pressing issues with prospective implementing partners. The objectives and strategies of the PD interventions have been agreed upon with national and local partners. During half-yearly CO meetings, CP7 interventions were reviewed to make sure that they are aligned with the ICPD, the 2030 Agenda and the national policy framework.

When crises or political changes occurred during CP7, UNFPA flexibly adjusted its programme funds. In accommodating humanitarian assistance during crisis situations in the country, AWP implementation was not affected, except during Typhoon Haiyan when PD partners had to slow down on work plan implementation as they themselves were involved in the response. The strategic shift in UNFPA business plan minimally affected the level of PD project funds, but releases to IPs were usually delayed. The shift in AWP focus minimally affected the prioritization of project funds since the new priorities are also within the organizational priorities of the IPs.

Per interviews conducted with IPs, beneficiaries and CO, and review of planning documents, UNFPA accounted for the needs of vulnerable groups during the programming/planning process as they were included in the criteria used in the selection of target groups for intervention. Vulnerable groups were given the opportunity for their voices to be heard. Urban youth and women's groups present their demands through UNFPA-produced videos shown during special events like the World Population Day and SWOP Report launch. UNFPA has been working with the NCIP and NCDA in ensuring that indigenous peoples and PWDs, respectively, were well-represented in special events and symposia. Although the issue of population and development is national in reach and scope, particular focus was given to disadvantaged and marginalized groups like the poorest of the poor, women, youth and Muslim communities in research and programme support with partners.

CP7 started with a dialogue with prospective partners to map out the strategic direction of each programme component. Thereafter, issue-based dialogues with PD stakeholders were conducted as needed. UNFPA and its PD partners (PLCPD, FORUM, POPCOM, YPS) conducted at least 10 dialogues on various pressing issues such as then RH bill advocacy, RH Law strategic planning (every year from 2013 onwards), demographic dividend, population dynamics, women's empowerment, and youth. At least five of these dialogues, i.e., 7th CP start-up, RH bill advocacy, demographic dividend, youth, and population dynamics, were UNFPA-initiated. Objectives and strategies of the PD interventions have been discussed and agreed to by national and local partners. Some of the challenges encountered during agreement negotiations between UNFPA and national and local partners are the latter's overly-ambitious proposals and the varying capacities of partners in program planning and implementation, as some may require more UNFPA technical assistance than others.

To ensure that CP7 interventions are in line with the ICPD and 2030 Agenda, the CO meets twice every year to agree on priority support to partners and to decide on priority outputs and indicators to commit to HQ. During these meetings they also ensured that SRH and other needs of target populations and that gender responsive and human rights-based approach were integrated in the planning and implementation of PD projects. The CO undertook a quarterly collegial review where quarterly work plans of all partners were discussed. The CO program team also included AWP

updates as an important agenda in weekly meetings. Usually one day is involved for each round of review.

During CP7 there were many crises or political changes that occurred: two national/local elections and numerous natural calamities (typhoons and earthquakes). UNFPA has responded to the emergencies from 2012 to 2017[34] by way of support to damage assessment and data collection, as well as conduct of RH medical missions. Every major response has been prompted by an official request from the national/local government. UNFPA provided humanitarian assistance from two weeks (such as the pre-emptive evacuation support for residents around Mayon volcano) to six months. It was only during Typhoon Haiyan when many PD partners had to slow down on AWP implementation as they also had to get involved in the response. In other crises, AWP implementation was not affected. The shift in AWP focus minimally affected the prioritization of project funds, if at all, since the new priorities were also within their own organizational priorities.

At the start of CP7, there were three PD partners: POPCOM, PLCPD/FORUM (as NGO advocacy consortium convenor), and NAPC. As UNFPA has flexibly adjusted its program funds to accommodate humanitarian assistance during crisis situations in the country, funds of all PD partners were reduced and extra funds were reallocated for the Haiyan response. PD projects were neither delayed due to crisis or major political change nor AWPs delayed due to the crisis despite some funds being diverted for the response. In particular, PLCPD and POPCOM acceded one training or forum each (at about PhP. 250,000 or USD 5000 each) to augment UNFPA support for the 2016 Lawin response. Project funds were released at foreseen level in the AWPs as reported by IPs, but releases were usually delayed due to prolonged discussions and delays in fund processing at CO.

4.1.3 Gender Equality: Relevance

Summary of findings: The GE component of CP7 is in line with the principles of the UNFPA Strategic Plan and normative international frameworks (ICPD, CEDAW, MDGs and SDGs) with the support to the Magna Carta of Women being the most remarkable. The national and field-level activities (Regional-Provincial-Municipal down to the Barangay level) were aligned with the Implementing Rules and Regulations of MCW, particularly on GBV.[35] It has been proven that concrete investments in gender equality and women's empowerment are a catalyst to economic and social develoment. Building on the gains of CP6, gender equality in CP7 is central by having a stand-alone outcome that focuses on SRHR and GBV.

Building on the momentum of CP6[36], increased attention to gender equality in CP7 was given by having a stand-alone outcome that focused on reproductive rights and GBV. This is a strategic investment by UNFPA even if the Philippines scored well on international gender equality measures

[34] Displacements in Maguindanao, Lanao del Sur, North Cotabato and Sultan Kudarat Provinces due to armed conflict and flooding from 2012 to 2015; Typhoon Bopha/Pablo in Davao Oriental and Compostela Valley in 2012 to 2013; Zamboanga Siege in 2013 to 2014; Bohol Earthquake in 2013 to 2014; Typhoon Haiyan/Yolanda in Leyte, Eastern Samar, Capiz and Iloilo in 2013 to 2015; Typhoon Hagupit/Ruby in E. Samar in 2014 to 2015; Typhoon Koppu/Lando in N. Luzon in 2015; Typhoon Melor/Nona in N. Samar in 2015, Typhoon Nock-ten/Nina in Catanduanes in 2016; Marawi Crisis in 2017; Leyte Earthquake in 2017; and the 2017-2018 Mayon eruption.

[35] UNFPA supports MCW particularly the the following provisions: Section 9. Protection from Violence; Section 17. Women's Right to Health; Section 13. Women Affected by Disasters, Calamities, and Other Crisis Situations; Section 30. Women in Especially Difficult Circumstances; and Section 31. Services and Interventions.

[36] Gender investments in CP6 included the passage of local GAD codes or ordinances, and capacity building activities that paved the way for gender-responsive development programmes in UNFPA supported areas.

and indices, where the country ranks 59th of 108 countries on gender empowerment measure and 10th of 144 on the global gender gap index 2017. Despite these outcomes, violence against women is a continuing health and human rights concern. Secondary data showed that one in five (20%) women has ever experienced emotional violence, 14% ever experienced physical violence, and 5% ever experienced sexual violence by their current or most recent husband or partner (NDHS, 2017). Discriminatory provisions persist in major national legislations such as the Family Code, Anti-Rape Law and the Code of Muslim Personal Laws.

UNFPA support to women's access to RH services, efforts to prevent and end VAW, and support to women's political participation, were in line with national policies (RPRH, MCW). In UNFPA sites, increased reporting of incidences of GBV could be attributable to effective enforcement of various laws that protect women and children (e.g. Anti-Violence Against Women and Their Children Act of 2004); formulation of programmes to eliminate VAWC; creation of mechanisms to ensure the integration of VAWC messages in the training modules; GAD plans and budgets; and development of comprehensive programmes for victims-survivors including gender-responsive case-referral management. CP7 interventions have high relevance to national policies and the agency mandate. Summary achievement under GEWE and GBV is listed under Annex A.

CP7 has witnessed the political transition from the Aquino Administration, 2010-2016, to the Duterte Administration, 2016-2022. CP7 through UNDAF 2012-2018, has ensured that gains from the previous administration wre preserved. The specific interventions (in SRH/ASRH, GE, PD) being supported by UNFPA remain relevant and appreciated by NEDA, the country's premier socio-economic planning body. In a FGD with NEDA, they reported highly valuing the UNFPA commissioned policy paper "Demographic Sweet Spot and Dividend in the Philippines: The Window of Opportunity is Closing Fast" (October 2015), which contributed to shaping Chapter 13 "Reaching for the Demographic Dividend" of the PDP 2017-2022.

4.2 Answer to Evaluation Questions on Effectiveness

EQ4: To what extent have the 7th CP outputs been achieved, and to what extent have these outputs contributed to the achievement of the 7th CP outcomes?
EQ5: Humanitarian assistance: To what extent has UNFPA responded to the RH and rights issues affecting pregnant and lactating women, young people, and women of reproductive age in general during the major humanitarian crises that occurred from 2012 to the present?

4.2.1 Sexual and Reproductive Health: Effectiveness

Summary of findings: Majority of indicators met defined targets with demonstrable strong accomplishments in advocacy formation and weakness in health systems capacity strengthening and ASRH. Improvements in key SRH indicators, primarily MMR, attendance at birth by health professionals, birth attended in health facilities, IMR, and CPR, were observable in provinces where engagement with the CP7 menu of interventions were fully made.

The improvement in provincial health indicators were particularly attributed to the following: (1) Maternal Death Audits (MDAs) or the Maternal death surveillance and response (MDSR); (2) Buntis (Pregnant Women) Congress; (3) Community Health Teams (CHTs); and (4) infrastructure development activities such as the equipment assistance to district hospitals and birthing centers. These projects were seen to complement each other towards a synergistic, integrated response to the unique SRH situation in the respective provinces.

The majority of CP7 indicators met defined targets, with demonstrated strong accomplishments in advocacy formation (Outputs 4, 5, 6) and weaknesses in health systems capacity strengthening (Output 1) and ASRH, as shown in table 12 below and Annex A.

CP7 provinces demonstrated notable improvements across SRHR indicators, e.g., skilled birth attendance, facility-based delivery, CPR, with the improvements sustained from 2013 when the programme began up to the present (see Table 13 and Figure 4 below). These secondary data were backed by service provider, Community Health Teams (CHT) as well as selected beneficiary feedback. UNFPA interventions were also synergistic with projects by the IP-MNCHN Project-Mindanao (launched 2012), particularly those that are also covered by respective localized manual of operations like CHTs, which were seen by stakeholders and end users as instrumental in generating demand for safe deliveries. Local resource constraints, however, continue to limit procurement towards health facilities enhancement, which affect the supply chain and logistics management information system adoption, where LGUs faced implementation barriers.

Mothers with their spouses at a Halfway Home

Overall, UNFPA engagement provided evidence for increased local health investment in SRHR. For instance, in Sultan Kudarat—the Lambayong District Hospital—the birthing centers in Bagumbayan, Esperanza, Sagada, Lagawe, and Eastern Samar (Salcedo, Quinapondan, Giporlos), all assisted by UNFPA, are still functional, fully equipped, and managed by dedicated health personnel. Responses during our interviews from a few selected mothers who gave birth in these centers expressed appreciation and commendation to the health services which they and their newborn babies have received.

Table 9: Maternal Deaths and Trends in Service Use

	# of Maternal Deaths			Births w/ SBA			Facility based deliveries		
Province	***2012***	***2014***	***2016***	***2012***	***2014***	***2016***	***2012***	***2014***	***2016***
North Cotabato	33	9	9	70.50	68.69	79.72	50.59	59.61	69.62
Sarangani	17	7	6	64.00	73.47	85.99	58.23	73.60	85.44
Sultan Kudarat	11	12	11	76.20	83.76	86.48	70.61	83.03	72.57
Surigao del Sur	6	17	39	81.30	87.29	95.00	79.78	88.14	94.00
Compostela Valley	11	24	no data	76.10	81.53	-	71.11	77.65	-
Eastern Samar	14	8	13	84	90	94	75	89	92
Ifugao	1	0	1	85.14	87.11	92.85	70.75	74.94	84.54
Mt. Province	3	2	3	82.33	89	96	62.06	74	87.07

(source: Provincial Health Service Facilities)

Results under FP and Maternal Health

The BEMONC Functionality Study, a health policy research supported by UNFPA, triggered evidence-based discussions within the RPRH Law National Implementation Team (NIT) on ensuring the quality of services delivered in the BEMONC Centers (Basic Emergency Obstetric and Neonatal Care Centers). Eighty-three per cent of Birthing Centers supported by UNFPA became BEMONC accredited by the DOH and by PhilHealth. The expansion of CEMONC (Comprehensive Emergency Obstetrical and Neonatal Care) in district hospitals in sites under the Joint Programme on Maternal and Neonatal Health (JPMNH) is also an important input in SRH ensuring that a pregnant woman about to deliver but needed a comprehensive emergency obstetrical care could be referred properly. Further manifestations are: UNFPA's technical assistance in the formulation of the Implementing Rules and Regulations of the RPRH Law; TA to the RPRH NIT on developing an M&E framework for the law; and drafting of the National Family Planning Costed Implementation Plan (CIP) 2017-2020.

Table 10: Output 1 Performance Data

Output 1: Strengthened capacity of health systems to deliver core reproductive health information and services to women and their newborn infants, young people and men, particularly in selected geographical areas that are isolated and disadvantaged, and in humanitarian situations			
Indicators	**Baseline**	**Target**	**End-line data**
% of health facilities meeting minimum national standards in the provision of core reproductive health information and services, including services on maternal and neonatal health, FP, ASRH, sexually transmitted infections and HIV/AIDS, in programme areas.	Baseline : 20%	Target : 60%	*83%* *Out of 224 birthing facilities targeted by the ten partner provincial local government units of UNFPA from 2012-2013, 185 or 83% have been granted Philhealth – Maternity Care Package (MCP) accreditation as a result of direct technical assistance to the local governments and through the Philhealth – Department of Health – Local Government dialogues brokered by UNFPA.*

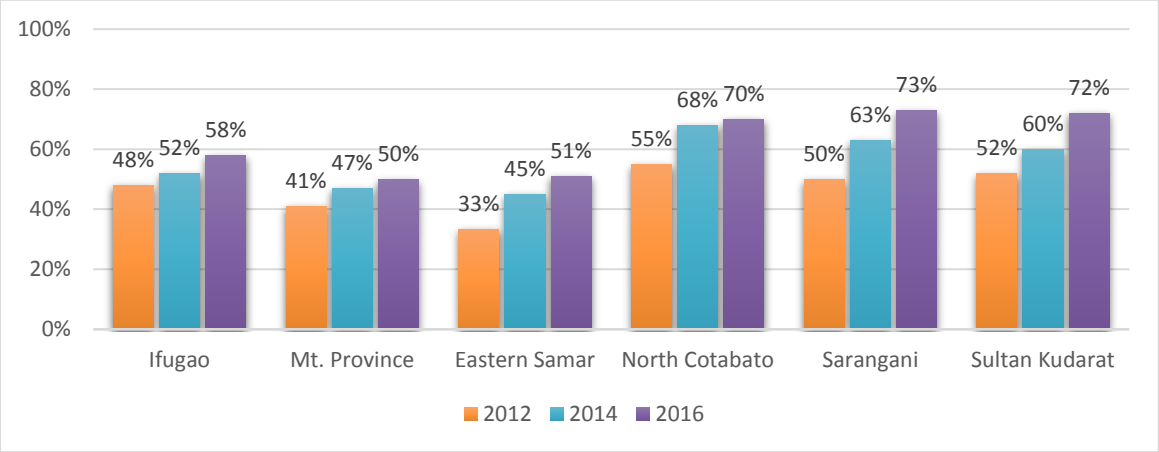
Source: Country Office performance data

CPR was reported to be increasing (as shown below), which was validated by interview respondents (service provides, planners, and selected beneficiaries), and was evident when compared with baseline data. As UNFPA is the sole UN agency working with the provincial partners, this outcome could be attributable to UNFPA CP interventions. .

Inputs were made during latter part of CP7 to enhance the responsiveness of contraceptive supplies in the field through the Track and Trace[37] (with information sent digitally in real time to the DOH) and the Lot Quality Assurance Sampling (LQAS). The evaluation team participated in a meeting with a large group of officials engaged in this programme. Discussions with CO programme officers and the monitoring reports of this project show the need to closely follow up with DOH to scale up the intervention to secure its sustainability.

[37] The Track and Trace is an electronic data system installed at the municipal and city levels with direct interactions with the provincial and national monitoring teams in ensuring the stock of contraceptives are updated on a daily basis.

Figure 6: Contraceptive Prevalence Rate, 2012-2016 (six sample provinces)



Source: Provincial data

CSO Engagement in SRHR

CSO engagement was instrumental in "filling the gap" in service provision left by court injunctions against the RPRH Law and contraceptive implants throughout CP7. For instance, UNFPA pro-actively supported the popularization of Progestin-Only Subdermal Implants (PSI) and funded the training of health care providers in acquiring the skills in inserting these sub-dermal implants especially in the selected CP7 provinces. Even with the TRO imposed by the Supreme Court on Implanon (therby precluding public funding), UNFPA mobilized its CSO partners like Friendly Care, PSRP, and FPOP to continuously deliver services using Implanon.. With the TRO lifted in 2017, public sector health care providers trained through UNFPA assistance are now functional again in promoting the use of Implanon.

Grassroots sector engagement was seen to facilitate greater community ownership through a more participatory/interactive policy-making process. CSOs like Likhaan, CHSI, FriendlyCare, PSRP, etc. expressed their commitment to support the national and local efforts to address the issue of teenage pregnancy and even forming a National Coalition for ARH.

Private Sector Implementation of workplace Family Planning Program

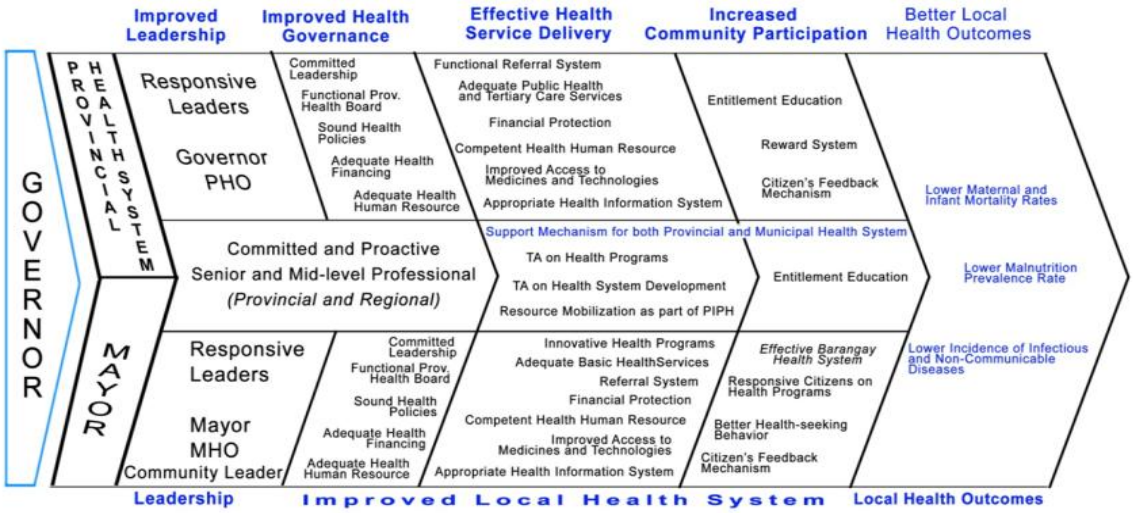
As part of the Business Action for Family Planning (BAFP) project, nine new companies have been identified as partners and have formed their respective FP Project management teams. The nine companies came from different sectors like automotives, machinery, food, hotel, canning, and microfinance. The project was able to reach out to labor unions, the Department of Labor and Employment as well as national and regional private sector employers' groups.

Systems development: UNFPA's RH program also included health leadership and governance courses for local chief executives, health managers and DOH representatives through the Health Leadership and Governance Programme (HLGP) co-implemented with the Zuellig Family Foundation (ZFF). The contribution of the HLGP was reported as catalytic in facilitating better health information systems (as pre-requisite for utilization) for SRHR in covered LGUs. It also enhanced policy-makers' salience of SRHR issues in their jurisdictions. A positive case study of the outputs of the HLGP is in

the Province of Sarangani, where the two trained governors (in succession during CP7) manifested their commitment to SRH, maternal and child health and family planning by making Sarangani the first and only province in the Philippines where every barangay has a midwife and a health center. The diagram below illustrates the system's approach where health and non-health administrative and other staff embraced the health program thereby enhancing the health outcomes.

The HLGP is expected to improve and strengthen the capacity of national and local health systems to deliver core reproductive health information and services to women and their newborn infants, young people and men, particularly in selected geographical areas that are isolated and disadvantaged, and in humanitarian situations. During the field visits, the Evaluation Team interviewed the beneficiaries of the programme at each step/link shown below.

Figure 7: Health Leadership and Governance Programme Components



Source: Zuellig Family Foundation

The diagram depicts how, starting from theprovincial governor down to the community level, the intervention was planned and implemented to achieve the expected health outcomes. Respondents' feedback pointed out to the programme's acceptability across respondents at all levels and the ET's observations of health facilities, charts, reports and individual interviews also substantiated the CO programme staff and ZFF staff's claims about the positive outcomes of HLGP. Based on the reports, interviews with all the governors and mayors of the provinces visited, HLGP was seen as a programme that connects all levels of staff, health and non-health, in the improvement of the health system. Currently, this model is considered worthy of replication nationwide.

RH – Demand Generation

Increasing FP Demand thru Family Development Sessions was introduced and adapted in the Conditional Cash Transfer (CCT) Program of the Philippine Government under the DSWD. CCT is known in the country as the Pantawid Pamilyang Pilipino Program or 4Ps. UNFPA-UNICEF-WHO Joint Programme on Maternal and Neonatal Health (JPMNH) Phase 2 specifically targeted the poorest of the poor (Conditional Cash Transfer [CCT] beneficiaries). At the end of its implementation, JPMNH achieved an overall decrease in maternal and neonatal mortality in its project sites. Absolute number of maternal deaths decreased by 11% and the maternal mortality ratio decreased by 9%;

and for newborns, absolute number of deaths decreased by 8% and the neonatal mortality rate went down by 7%.

This impact was achieved through improvements in health systems and services to which JPMNH interventions contributed. Facility-based deliveries increased by 8 percentage points and skilled birth attendance increased by 2 percentage points; all sites had functional Basic Emergency Obstetric and Newborn Care facilities whereas only two sites had these at baseline. These facilities also institutionalized the practice of Essential Intrapartum and Newborn Care and the delivery of client-centered and culturally sensitive care; Specific to UNFPA's contribution to the Joint Programme, rates of postpartum counselling for availing FP services improved by 38 percentage points, and 7,442 women from disadvantaged households were able to use modern FP methods for the first time; Overall use of modern contraceptives improved by 19 percentage points. Improvements in these multiple aspects in delivering quality maternal and newborn care worked synergistically to achieve JPMNH impact (details in Annex A).

EU-UNFPA Project on "Addressing Reproductive and Maternal Health Needs of Indigenous Communities/ Peoples and Other Disadvantaged Communities in Mindanao" (IP MNCHN Project) had the overall objective of improving access to and utilization of quality RH services in selected indigenous peoples' areas and other disadvantaged areas in Mindanao through a comprehensive and culturally-sensitive implementation of the family planning and RH component of the national Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy.Culture-sensitive MNCHN Programming has been demonstrated in the provinces of Ifugao and Mountain Province whose majority of the populations are indigenous peoples. The special project in Mindanao called the IPMNCHN or Indigenous Peoples Maternal and Neonatal Child Health and Nutrition Program was another expression of culture-sensitive MNCHN design.

This was implemented in six ancestral domains in Mindanao. Implementation took place in selected indigenous communities that were jointly identified by a broad base of stakeholders. They included Certificate of Ancestral Domain Title (CADT) areas in nine priority provinces based on criteria to select sites for this targeted programmes. Data showed an increase in the number of maternal deaths in one ancestral domain site between 2013 and 2014 which can be attributed to improved maternal death reporting. Reporting of maternal deaths was emphasized to the indigenous communities via the community health teams (CHTs) organized. Only two of the five ancestral domain sites achieved the Department of Health-prescribed national target of 80% for skilled birth attendance, the rest of the sites exhibited increasing trends coming from relatively low baselines in 2012. Similarly, while only two ancestral domains reached the DOH national target of 65% for contraceptive prevalence rate, the rest of the sites exhibited consistent improvements in this indicator comparing the latest (2016) data and the baseline (see Annex A for details).

Institutionalizing CHTs was seen by stakeholders and end users as instrumental in generating demand for safe deliveries. CHTs (led by midwives) provided community-level care and services during the pre-pregnancy, pregnancy, delivery, and post-partum periods. Other UNFPA-supported or -led projects that contributed to these better outcomes include the (1) quarterly maternal death surveillance and response (maternal death audits) and (2) "Buntis Congress," which were both adopted and continued by LGUs.

Table 11: Output 2: Performance Data

Output 2: Women, young people and men, including Muslims and indigenous peoples, particularly in geographically isolated and disadvantaged areas, are able to demand and access high-quality reproductive health services in programme areas.			
Indicators	**Baseline**	**Target**	**End-line data**
Percentage of local government units (LGUs) with organized community support networks, including women's and community health teams, in programme areas	Baseline: 30%;	Target: 60%	*80%* *(Eight out of the 10 provincial local government partners of UNFPA reported having organized functional community health teams (CHTs) supporting demand generation for RH services at the village level from 2012-2013.*

Source: Country Office performance data

Eight provincial local government partners of UNFPA reported having organized functional community health teams (CHTs) supporting demand generation for RH services at the village level from 2012-2013, but only 66% (4,143 out of 6,315) of those trained were assessed as functional after post-training monitoring was conducted (across nine provinces). Despite this, the credibility and quality of services in the birthing centers with CHTs were validated by end users. As shared by one midwife in Sagada, Mountain Province: *"In my community, the people are aware. The health seeking behavior of the community is established. So, they are the ones to come in the clinic for consultation. Not like before when they did not care that much about their health. And … as to deliveries, they are aware that they have to go to hospitals to give birth. There are no more home deliveries."*

Group meeting with CHTs-Barangay Health Centre-Sagada

Results under ASRH

CP7 contributed the following on ASRH: the Revised DOH Policy on Adolescent Health, the 2013 Young Adult Fertility and Sexuality Survey (YAFS), the 2014 Youth Development Index (YDI), Economic Implications of Teen Pregnancy (Researches on Young Parenthood), Social Dimensions of Teen Pregnancy, Teen Pregnancy Bill, Adolescent Health Technical Working Group, U4U, Comprehensive Sexuality Education (CSE) with UNFPA Implementing Partners: the PCPD and Likhaan. All these spurred the PopCom and NEDA to assign the main responsibility for ASRH to the National Youth Commission (NYC) in collaboration with the DOH, Department of Education, and Department of Labor and Employment (DOLE).

Challenges in ASRH

The six provinces visited showed increasing trends in the area of teenage pregnancy, despite five of these provinces having established their respective ASRH programmes. The statistics in these areas follow the national trend as the Philippines is the only country in the Asia-Pacific Region where the rate of teenage pregnancies rose over the last two decades. The complexity and dynamics of

teenage pregnancy warrant a re-examination of the extant national and sub national policies in relation to ASRH and its social determinants which cut across administrative jurisdictions.

Table 12: Teenage pregnancy and motherhood: Percentage of women age 15 to 19 who have begun childbearing, Philippines

	Percentage who have begun childbearing
Philippines	8.6%
Region	
Cordillera Administrative Region	**3.5**
V - Bicol	4.4
VIII – Eastern Visayas	6.9
XII - SOCCSKSARGEN	14.5
Teenage pregnancy and motherhood in Mindanao	
Region	
IX – Zamboanga Peninsula	7.5
X – Northern Mindanao	14.7
XI – Davao	17.9
XII – SOCCSKSARGEN	14.5
XIII – Caraga	8.2
ARMM	8.5

Source: NDHS 2017

Meeting with a group of U4U members

The U4U, a youth caravan designed to increase the awareness of ASRH in schools and communities and improve access to quality of SRH information and services for the Filipino youth has been initiated in target provinces with Sultan Kudarat, North Cotabato, and Ifugao having had sizable penetration and participation. POPCOM eventually adopted U4U (with UNFPA's implementing partner, Center for Health Solutions and Innovations [CHSI], providing technical assistance) as a program for nationwide implementation. Since 2014, U4U has reached 9,507,442 young Filipinos through various platforms (e.g. teen trails, social media, mobile texts [SMS]). It also won the Grand Anvil Award for Best Communication Campaign for Non-profit Organizations in 2015. U4U's outcomes and impact, however, have yet to be validated.

Results for HIV/AIDS

While information specific to the six sample provinces was not available, the national figures on HIV/AIDS prevalence are alarming and call for programmes of prevention and treatment together with awareness initiatives. Out of 51,000 reported cases of people living with HIV, from January 1984 to 2018, 28% are from the 15-24 year age group, and 97% fall within 15-49 age group.[38] The Philippines is one of the few countries in the world where HIV/AIDS incidence continues to grow exponentially. Whereas during the period 2000 to 2010, only one case a day of HIV/AIDS was reported, by year 2010 it grew from 10 cases a day to 30 cases a day in 2017. In this regard, UNFPA supported several policy studies to effectively respond to the changing environment on HIV/AIDS in the Philippines. Notable among these are the Female Condom Acceptability Study, HIV-FP-GBV Integration, Condom Use at Sexual Initiation and Subsequent Condom Use among Young MSMs (men having sex with men).

[38] Source: National HIV/AIDS & STI Surveillance and Strategic Information Unit, Epidemiology Bureau, DOH, Jan 2018.

SRH in Emergencies: ***Effectiveness of Responses (Humanitarian)***

CP7's humanitarian efforts after natural and man-made disasters have put at the forefront the need to integrate SRHR as a key component of post-disaster rehabilitation and response in the personal, family, community, and health systems levels. Throughout, UNFPA introduced SRHR as a core area of intervention, thereby supplementing public and private sector efforts in bridging the gap towards disaster recovery. Technical support for policy development has also been given (see Section 4.1).

UNFPA worked closely with DOH in setting-up functional referral systems for persons displaced by emergencies needing BEmONC services. It partnered with DOH and DOH-ARMM in deploying mobile RH medical teams in conflict areas in Maguindanao, Lanao del Sur and North Cotabato. It supported RH Medical Missions (RHMM) in disaster-affected areas ensuring that pregnant and lactating women (PLWs) can avail of antenatal/postnatal care even during emergencies. UNFPA capacitated partners from various government agencies, NGOs and LGUs on MISP for SRH in Emergencies. Thirty-nine provincial and municipal LGUs have integrated the MISP in their respective LDRRMPs.

The case of Eastern Samar province is a notable example of the effectiveness of UNFPA's humanitarian response for SRHR promotion. Ten municipalities in the province's southern portion were severely affected and health facilities were destroyed by Typhoon Haiyan in November 2013. According to the feedback from the health officials and the records, four years after, the health systems have been restored and the MMR, IMR, and CPR in these municipalities are more improved as compared to municipalities not affected by Typhoon Haiyan in the province's northern side.

4.2.2 Population and Development: Effectiveness

Summary of findings: Targeting national and local government agencies, CO has achieved CPD output 3 on capacity building towards generation, analysis and dissemination of data on population, SRH, HIV/AIDS, gender and youth. This was even before such initiative was downsized when UNFPA strategically shifted from field-focused limited-scale direct service delivery and individual-focused capacity building to more catalytic institutional capacity-building and policy advice support.

This shift produced knowledge products on PD, SRH, FP, among others, which policy makers and program planners at national and LGU levels could use to benefit disadvantaged and vulnerable population sub-groups such as women, youth, children, etc. UNFPA completed more than the targeted number of research for CP7 as of December 2017. Findings from completed researches were used extensively in evidence-based advocacy for action and budget allocation, policy-making and development planning, thereby giving UNFPA the leverage as a vital development partner of the government in achieving national and local development goals as well as securing funds for the the Longitudinal Cohort Study on the Girl and Boy Child.

UNFPA supported surveys, such as YAFS, and studies (population dynamics, demographic dividend etc.) served as solid evidence for the passage of national and local policies like the PDPs, PPMP, BDP, RPRH Law, EO 12 on zero unmet need for FP, among others. They were also used during HLGP trainings. However, access to data needed for planning at the municipal/city and barangay levels remains unresolved as census disaggregated data come at a cost.

Building on NEDA's capacity building on PD for about 15 years as well as UNFPA gains from CP6, Output 2 of the PD programme contributed to developing a large cadre of RPRH and PD champions

who were able to pass national and local policies that served as legal framework for implementing population and RH programs. During the crafting of such policies and in the development of sectoral and provincial investment plans, UNFPA's technical assistance was highly regarded as it brought in the experiences of other countries on topics or issues of interest.

CP7's PD program has two main components: Data and Planning, and Evidence-based Advocacy. Under the first component, UNFPA provided capacity building to improve data availability and analysis of population dynamics for the national government and LGUs for enhancing development planning. As shown below, and based on feedback from the field visits, UNFPA had achieved the targets set for this intervention. Trained at the national level were development planners through POPCOM, NAPC, PLCPD, and the Forum for ten LGU[39] beneficiaries. Participants in the training included at least 250 development planners from POPCOM national and regional offices, and about 195 local-level gender focal points from NAPC.

During the training, participants learned how to do sectoral planning or how to do policy development which fed into national and local government policies. Some of the policies to which they contributed at the national level were the two PDPs for the periods 2011-2016 and 2017-2022, the Philippine Population Management Program (PPMP) Directional Plan, the poverty reduction framework, the *Bangsamoro* Development Plan (BDP), the Fatwa on the Model Family in Islam, and the FP Costed Implementation Plan (CIP) for the RPRH law, among others.

Table 13: Output 3 Performance Data

Output 3: Relevant government agencies are able to generate, analyse and disseminate data on population, sexual and reproductive health, HIV/AIDS, gender and youth, and to utilize data in national and local policymaking and development planning in programme areas			
Indicators	**Baseline**	**Target**	**End-line data**
% of national govt agencies and local govt units (LGU) with personnel capable of formulating national and local development plans that integrate population situation analyses and population data	Baseline: about 3%;	Target: 20%	*89% (Out of 44 LGUs targeted from 2012-2013, 39 or 89% have adopted local development plans that meet the minimum standards prescribed by the Commission on Population for integrating population situation analysis and data.)*
% of LGUs with personnel trained to undertake participatory pro-poor and gender-responsive budget preparation, analysis and implementation.	Baseline: 0%;	Target: 20%	*77% (Out of 53 LGUs targeted from 2012-2013, 41 or 77% have adopted local annual investment plans that are gender-responsive and integrate population situation analysis and data (based on standards prescribed by the Commission on Population).*

Source: CO performance data

During CP7, personnel of LGUs were also trained to undertake participatory pro-poor and gender-responsive budget preparation, analysis and implementation. Out of 53 LGUs targeted from 2012-2013, 41 or 77% have adopted local annual investment plans that were gender-responsive and

[39] The LGU beneficiaries for the training were Ifugao, Mountain Province, Masbate, Camarines Norte, Albay, Eastern Samar, Compostela Valley, Surigao del Sur, Sultan Kudarat, and Sarangani

integrate population situation analysis and data (based on standards prescribed by POPCOM). Such UNFPA contribution in this field may, however, be considered as complementary as *"NEDA has provided long-term capacity building on population and development for almost 15 years and this has benefitted the regional and local planning…" –SDS, NEDA.*

While in general the availability of sex-disaggregated data is limited in the provinces that the evaluation team visited, one data problem mentioned during the provincial visits is the lack of data for policy and planning at the municipal/city and barangay level. In particular, census data was cited as expensive as PSA charges a fee for generating requested tables. "*This is partially resolved by the availability of CBMS data in these provinces ...so they are not able to utilize data from PSA …" –SDS, NEDA.* Most PSA survey data are representative at the national and regional levels (e.g., NDHS), while some are representative at the province level (e.g., FHS).

During CP7, UNFPA also supported fellows from government (including Congress), civil society and UNFPA staff to participate in international (e.g., Women Deliver, APCRSHR) and national (e.g., Philippine Population Association) conferences, and sub-national conferences/workshops as resource person, convenor/chairperson/facilitator or participant on RH/PD/Gender and related topics such as development financing, M&E, procurement of FP commodities, use of media, indigenous peoples issues, SDG statistics, national transfer accounts study, humanitarian fast-track procedures, etc.

The catalytic effect of a province-wide ARH survey findings on LGU planning and programming is articulated by the PPO of Ifugao: *"The Ifugao Youth Risky Behavior Survey findings helped me to assert to MLGUs and other partner agencies the necessity to invest on youth programs and to include in all our development plans in coming up with appropriate programs and projects."*

When UNFPA shifted its strategic plan around 2014, CPD Output 3 on capacity building activities has already been achieved. Following the shift in strategic focus, research and "trigger papers" that address population dynamics for evidence-based advocacy were supported. Many of the UNFPA-supported survey data and researches fed into national/local development planning. Of the targeted 14 research studies, 15 were completed, five were on-going and one was under discussion as of December 2017. Annex B contains the complete list of research studies. Included in the on-going research projects is the Longitudinal Cohort Study, which follows life course changes of 10 year old boys and girls until 2030.

On national policies that were able to consider findings from these UNFPA-supported data and research studies, examples are the Philippine Development Plan 2017-2022 (Chapter 13 on DD), Presidential Executive Order 2017-12 and DOH Administrative Order 2017-05 on Zero Unmet Ned for Modern FP, Proposed Presidential Executive Order creating a Presidential Arm on FP (2018); and the proposed teenage pregnancy bills of Rep. Sol Aragones (HB 4742) and Senator Risa Hontiveros (SBN 1482). Formulation of the Costed Implementation Plan (CIP) also provided support to the zero unmet need for FP policy of the government as cited by then Health Secretary Paulyn Ubial[40]. The HLGP/MLGP also used these data for planning and evidence-based programming.

UNFPA contributed in the development of a cadre of champions for the passage of national and local policies that served as legal framework for the implementation of population and RH programs. During the last stretch of the RH bill deliberations (2012), the national advocacy community consisted of at least 130 legislators and 15 senators. UNFPA support for the passage of

[40] https://www.rappler.com/nation/146186-doh-proposed-2017-budget-reproductive-health

the RPRH law was through the conduct of legislative fora/symposia, consolidation of evidence-based data for congressional debates, and support to community-based RH awareness, which increased demand generation.

Under CP7, policy dialogues on RPRH, ASRH, GBV, population dynamics, among others, were co-sponsored by parliamentarians, CSOs, faith-based organizations, and the media. Seven out of 7 or 100% of CSOs targeted have organized and/or sponsored evidence-based policy dialogues on population and RH from 2012-2013 in 5 out of the 10 CP7 provinces. This is double the 50% target under CPD Output 4. Such achievements were made through the Advocacy consortium, Purple Ribbon Movement, RHAN and four private sector companies under the Business Action for Family Planning (BAFP) Project. Given the non-passage of the BBL, the MNCHN amended SRH policy in Bangsamoro was no longer applicable. The amended HIV/AIDS law is still under discussion in Congress. UNFPA policy advocacy assistance included capacity building of local legislators through the support of CSO partners such as the 30 institutional members of the Purple Ribbon Movement.

During the crafting of national/local policies and in developing sectoral and provincial investment plans, the technical assistance of UNFPA CO and through its IPs was considerably regarded. Interviews made in the provinces visited expressed that UNFPA brings in the "experiences of other countries on SRH and PD issues." Moreover, during the interview with the PSA National Statistician and Civil Registrar General, underscored was the good partnership between UNFPA and PSA as it ensured that the Philippines would be able to generate internationally comparable statistics. The strong UNFPA-PSA partnership in the past was in terms of standardizing concepts and definitions. A respondent commented *"I believe the reason why there is no direct link now is because the Philippine government funds most, if not all, of our major surveys."*[41] Notably, the PDPs have taken into consideration the ICPD agenda, MDGs and the new SDGs[42]. Six MDGs were adopted in the previous PDP while SDGs 3, 5, and 10 are adopted in the current PDP. CP7 performance for PD outputs 3 and 4 are summarized in Annex A.

Observations and Challenges

A. Data and Planning

- The impact of capacity building and training for national agencies and local governments on data and planning would be contingent on availability and access to quality data needed for planning. Since only national and regional demographic indicators from PSA are commonly available for planning purposes, there may be a need for UNFPA to support, in the interim, training for demographers/statisticians on small area estimation (SAE) towards generation of key demographic indicators for each province and city/municipality in the country. Such

[41] The International Cooperation Unit of PSA receives requests from international agencies such as UNFPA for PSA to provide data. Since PSA is the central statistical authority of the government, it is mandated to collect, compile, analyze, abstract and publish statistical information relating to the country's economic, social, demographic and general activities and condition of the people, among its other functions. It also ensures data collection and availability of recommended statistics in accord with international cooperation agreements to which the Philippines is signatory to that are also needed for monitoring progress in the indicators included in the PDPs.

[42] **MDG 1:** Eradicate Extreme Poverty and Hunger; **MDG 2**: Achieve Universal Primary Education; **MDG 3:** Promote Gender Equality and Empower Women; **MDG 4:** Reduce Child Mortality; **MDG 5:** Improve Maternal Health; **MDG 6:** Combat HIV/AIDS, Malaria and other Diseases; **SDG 3:** Ensure healthy lives and promote well-being for all at all ages; **SGD 5:** Gender Equality & Empowerment of Women and Girls; **SDG 10:** Reduced inequalities

indicators would be crucial in developing sectoral and investment plans at the LGU level. To ensure continuous updating of such SAEs in the future, UNFPA support to institutionalize such activities can be in partnership with an academic institution that can provide technical support to appropriately use and interpret demographic indicators for policy and planning.

- Given the limited core funds of UNFPA, it would be more strategic for CO to support participation in national and sub-national conferences/workshops to disseminate research findings under CP8 instead of international conferences. Funds may be leveraged by CO from other donor partners to disseminate findings of UNFPA-supported research in international conferences.
- The inclusion of the Demographic Dividend (DD) in the new PDP calls for more inter-disciplinary research to guide the identification of strategic programs for DD realization.
- With UNFPA strategically moving towards developing knowledge products to help the country push for the realization of the demographic dividend, there appears to be a need for a multi-disciplinary research advisory group to vet the technical quality of UNFPA research and publications and the development of a young cadre of researchers (demographers, statisticians, econometricians) or "thought leaders" who could examine the intersectionalities of population, health, environment, culture, among others, through scholarships/ research funds.
- The TOC for DD needs to be developed as guide in strategizing key interventions and in developing an M&E plan.

B. Evidence-based Advocacy

- There were fewer numbers of advocacy activities and enacted policies under CP7 as compared to CP6. This is partly due to the passage of the RPRH law in 2012 and the strategic shift in UNFPA focus to supporting relevant research studies and modeling work on SRHR and GBV prevention resulting in the smaller CP7 budget for policy advocacy.
- Six years since the passing of the RPRH law and the release of its IRR, challenges remain in its implementation particularly at the LGU level where LGU officials are elected every three years. There is no guarantee that SRH/PD/GE policies already enacted at the national and local levels would be fully supported and implemented; hence, the need to continue HLGP that integrates all components (SRH, PD, VAWC, etc.) for newly elected national and local officials as well as middle level line personnel for sustainability.

4.2.3 Gender Equality: Effectiveness

Summary of findings:

Delivering on gender equality depends on the responsiveness and accountability of institutions at all levels of government. In order to accelerate the implementation of MCW, particularly on reproductive rights and GBV, UNFPA has channeled its resources to well-established state institutions whose mandates are to promote gender equality and prevent GBV. Such strategy ensured that financial resources of UNFPA will have catalytic or leverage effect and results in gender equality will last beyond the end of CP7. Capacity development, through education and training, has been used by UNFPA to support the implementation of MCW, particularly on reproductive rights and GBV. Empowering and including women and girls with disability in decision-making was one of the ground-breaking initiatives of UNFPA in partnership with De la Salle University and PWD Advocating for Rights and Empowerment. Civil society groups are one of UNFPA's most impactful constituents. In this regard, UNFPA has embarked on partnerships with selected women CSOs to

deliver programme support on the ground particularly during Typhoon Haiyan and Marawi crisis. These CSOs have been a source of non-traditional ideas and policy perspectives, partnerships and support. UNFPA and its partners within the UN System, and state and non-state actors have placed importance to facilitating a more predictable, accountable and effective protection response to GBV in complex humanitarian crisis settings. UNFPA's response to GBV in humanitarian settings is well appreciated by the UN Humanitarian Country Team as well as implementing partners, stakeholders, and beneficiaries at all levels.

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> In 2016, UNFPA and CHR Philippine Gender Equality and Women's Human Rights Centre embarked on a National Inquiry on RH and Rights: 'Let our voices be heard,' which was in response to the calls of women's organizations and RH rights advocates to address the perennial challenges and barriers in the enjoyment of women's rights to RH.*"This was a pioneering project because it will help us advocate strongly for the enforcement of RPRH Law and likewise fulfill our role as Gender Ombud under the MCW."(Key informant)*.

Empowering and including women and girls with disability in decision-making was one of the major initiatives of UNFPA, which was in partnership with Nossal Institute, De la Salle University and PWD Advocating for Rights and Empowerment. The three-year (2013-2016) participatory action research on "Women with Disability taking Action on Reproductive and Sexual Health (W-DARE)" was conducted in the urban and peri-urban slums of Quezon City (Metro Manila) and Ligao City in Albay province. The research process centerd on empowerment and included women and girls with disabilities at all stages. It also included capacity development activities for representatives of PWD organizations, local research institutes, and service providers so they have skills and competence as active research partners. The research points out to a wide array of services that have been denied to intended beneficiaries, such as disability-friendly facilities and services. There was also absence of sign interpreters in courts, which is critical as women and girls with disabilities are victims and survivors of sexual and GBV. It was envisioned that this pioneering study will lead to a conscious effort in generating disability disaggregated data to inform policy, programming and budgeting.

Another partnership with CHR is the development of Gender Ombud Guidelines, a comprehensive toolkit that addresses gender-based discrimination and violence by identifying legal remedies, describing procedures, and creating a case referral mechanism aimed at ensuring that all complaints of gender based discrimination are heard. Forty CHR regional focal persons have been capacitated on CEDAW, the MCW, and on CHR's Gender Ombud Role. The Spanish Agency for International Development Cooperation (AECID) built on this work and provided funding support to CHR.

Civil Society Groups are one of UNFPA's major constituents. UNFPA has embarked on partnerships with selected women CSOs to deliver programme support on the ground. CSOs were sources of non-traditional ideas and policy perspectives, partnerships and support. To ensure gender responsive programming on reproductive rights and GBV, CP7 has strengthened the capacity of 250 LGU officials and staff members and CSO groups in UNFPA provinces[43] through an NGO partner, Women's Education, Development, Productivity, and Research Organization (WEDPRO).

The evaluation teams' interviews validated that trained LGU officials and staff[44] were now capacitated to develop gender-responsive LGU plans/budgets and enact/update GAD ordinances. Evidence of Administrative Orders (AOs), Gender and Development (GAD) Codes, and GAD plans/budgets have been documented in CP7 sites in Sarangani, Sultan Kudarat, Ifugao, Mountain Province and Eastern Samar.

To strengthen health sector response to GBV, UNFPA has engaged with Child Protection Network Foundation in establishing Women and Children Protection Units (WCPU) in DOH-managed and local government-supported hospitals. This has resulted in nine WCPUs in hospitals established in seven provinces; two WCPUs strengthened in post-disaster sites (Zamboanga City and EVRMC, Region 8); and Multi-Disciplinary Teams (MDTs) on VAWC established in 47 municipalities. The MDT is a group of professionals (doctors, social workers and police officers, investigators) who are at the front-line of responding to VAWC cases. Currently, there are 317 service providers handling VAWC cases through multi-disciplinary, gender-sensitive and rights-based approaches. To generate timely data on GBV cases being referred to WCPUs, a Women and Child Protection Management and Information System (WCPMIS)[45] was set up.

While the number of VAWC cases is on the rise, less attention has been paid to challenging patriarchy and engaging men and boys to end VAWC. These VAWC programme strategies have no robust monitoring and evaluation framework.)

In 2013, UNFPA supported the first roll-out of the Comprehensive Intervention Against Gender-Based Violence (CIAGV) in four LGUs and now, there are 115 LGUs that replicated CIAGV[46]. In the Province of Ifugao where the CPE Team visited, the Provincial Social Welfare Development Officer presented the evolution of UNFPA's gender investments from CP6 to CP7. One of the many concrete outputs, amongst others, is the development of *'AMMA, INA, and IMFALOY'*[47] – a locally home-grown mechanism to promote active engagement of family members for the promotion of volunteerism, peace and *'Ayod'* (Community Health Teams). However, despite the promotion of *AMMA, INA, and IMFALOY* as a tool to prevent any form of violence, the Municipality of Lamut, Ifugao, alone, has documented 20 rape cases from January to June 2017, which they reported as very alarming.[48] In UNFPA-supported provinces (Ifugao, Mountain Province, Sarangani, Sultan

[43] The Provinces are: Mountain Province, Ifugao, Camarines Norte, Albay, Masbate, Eastern Samar, Compostella Valley, Surigao de Sur, and Compostella Valley (source: provincial data)

[44] LGU Heads and Officers of Gender and Development Focal Committees, Health Offices, Planning Offices, and Social Welfare Offices

[45] It is system that generates accurate information on VAWC. Designed to reflect case management process, the WCPMIS has also been instrumental in identifying challenges and obstacles in the implementation of services and contributes to the improvement of WPCU programmes.

[46] The implementation of CIAGV is based on several laws mandating Department of Social Welfare and Development, Local Government Units (LGUs) and other government entities to prevent and respond to gender-based violence. It also ensures the safety, protection and reintegration of victims and survivors and their families in their respective communities.

[47] AMMA – Active Male Movement against Violence and for Ayod; INA- "I" Power of Women for Nonviolence and for Ayod; and IMFALOY- Ifugao young Male and Female Advocates and Leaders for Others and for Ayod.

[48] http://www.sunstar.com.ph/baguio/local-news/2017/11/17/rape-remains-major-concern-cordillera-575377.

Kudarat, Eastern Samar, and Iligan for the Marawi crisis), visited by the CPE Team, **multiple expressions of GBV were shared by service providers**. These include: spike in rape cases of women and children (Ifugao); amicable settlement/mediation of domestic violence (Mt. Province); amicable settlement of rape cases in indigenous communities and teenage pregnancy (Sarangani); trafficking of women and teenage pregnancy (Eastern Samar); and anecdotal reporting of rape against a minor during the Marawi crisis (Marawi City). Except for Marawi City, the same cases of GBV had been reported by the National Anti-Poverty Commission (NAPC) during the National Feedback Forum on the Strengthening of LCAT-VAWC Systems held in September 2014[49].

UNFPA and its partners within the UN System and state and non-state actors have placed importance to facilitating a more predictable, accountable and effective protection response to GBV in complex humanitarian crisis settings. Several catastrophic events that occurred in the Philippines (Typhoons Ketsana (Ondoy, 2009), Washi (Sendong, 2012), Bopha (Pablo, 2012), Haiyan (Yolanda, 2013), and the 2013 strong earthquakes in Bohol and Western Visayas) resulted to incalculable losses to life, livelihood and property. These events have prompted the UN Humanitarian Country Team (HCT) to address GBV in humanitarian settings. Some of the key GBV interventions of UNFPA in emergencies are outlined below:

- DSWD with support of UNFPA, has pioneered the establishment and implementation of Women Friendly Space as an integral part of Camp Coordination and Camp Management. The establishment of WFS in evacuation camps (as proven globally) is an appropriate intervention to address gender issues during crises. There were 47 WFS established with 428 WFS facilitators trained; while 140,395 women and girls, and 40,728 men and boys were reached with awareness-raising sessions on VAWC/GBV. The CPE team visited a permanent WFS in GMA Kapuso Foundation in Tacloban where a discussion with a group of almost 20 WFS trained facilitators and GBV watch groups took place.
- DSWD with UNFPA support has enhanced the capacity of 28 Disaster Risk Reduction and Management (DRRM) focal points from 17 regions; and 11 training specialists specializing on GBV prevention and response in humanitarian settings. To date, GBV prevention and response in emergencies has cascaded to 81 provinces, 144 cities, and 1,490 municipalities. To meet the hygiene needs of displaced women, DSWD has started to allocate budgets to purchase dignity kits in preparation for emergencies.
- UNFPA (with the assistance of the Office of the United States Foreign for Disaster Assistance or OFDA-USAID), has supported the strengthening of state and non-state actor capacities on GBV prevention and response. Currently, a total of 723 Local DRRMC Members and inter-agency protection mechanism members were trained on CIAGV; 386 trained on GBV prevention and response; and 90 NGO members trained on psychosocial interventions.
- During Typhoon Yolanda, a consortium of NGOs (Women's Crisis Centre; Women Health, Philippines; CATW-AP; SALIGAN; and Engenderights) was immediately mobilized by UNFPA to train displaced women and Barangay officials as GBV watch groups[50].

The Humanitarian Action Plan (2013) for Mindanao has paved the way for UNFPA to strengthen its support to partners in mainstreaming GBV in Humanitarian Protection and Health Clusters. The HAP for Mindanao integrates a gender sensitive approach throughout the plan to ensure that gender-based discrimination and exploitation are not exacerbated by humanitarian interventions.

[49] https://mail.google.com/mail/u/0/#search/LC/16073343ab26795c?projector=1&messagePartId=0.1
[50] http://verafiles.org/articles/sex-traffickers-prey-yolanda-children

After the typhoon, 19 community GBV Watch Groups were formed. Resource material on Feminist Approaches to Crisis Intervention was developed while the Anti Trafficking in Persons Act of 2003 and the amended act (RA10364) were popularized in four major dialects.

- During the Maguindanao conflict in 2013-2014, UNFPA supported Magungaya Mindanao, Inc. (MMI) to help establish seven WFS and conducted awareness-raising sessions on VAW in three municipalities – Datu Piang, Mamasapano, and South Upi.
- Within and outside of the UN HCT, UNFPA's leadership role in the prevention of GBV in humanitarian settings was recognized by stakeholders. UNFPA is an active member of the Gender in Humanitarian Action Community of Practice (GIHA COP)[51] along with the Philippine Commission on Women, UN Women, UNOCHA, OXFAM, and Christian Aid.
- The latest Philippines Humanitarian Country Team: An Update on Human Response and Resource Overview, 2017 (Displacement by Conflict in Marawi), reported that UNFPA took a leading role in providing essential actions to reduce GBV risks through the establishment of 10 WFS, security patrolling, profiling of vulnerable groups, and distribution of dignity kits, partitions and mosquito nets. These accomplishments were substantiated by MMI, a UNFPA partner NGO in Mindanao, during the CPE Team interview with them. As of 13 November 2017, 11,013 women and girls and 4,459 men and boys have been reached with information sessions on GBV prevention and response. Below is a snapshot of UNFPA's achievement on GEWE/GBV vis-à-vis outcomes and outputs. Details of CP7 output performance are contained in Annex A.

Table 14: Output 5 Performance Data

Output 5: Enhanced national and local government capacity to implement, monitor and evaluate policies and plans to ensure reproductive rights and to combat gender-based violence				
		Achieved	Partially Achieved	Not Achieved
Indicator 1: Percentage of national and government agencies and local government units with functional monitoring mechanisms for the implementation of laws (the MWC and laws relating to VAW)	Baseline: 0 Target: 10% Endline data: 40%	Overachieved		
Indicator 2: Percentage of national government agencies and local government units with functional GAD database	Baseline: 5% Target: 20% Endline data: 100%	Overachieved		
Indicator: 3 Number of legislative bills that will ammend or discriminatory provision of existing laws	Baseline: 0 Target: 3 Endline data: 1		Partially achieved	
Output: 6 Enhanced capacity of civil society to advocate reproductive rights and to combact GBV and harmful practices				
Indicator 4: Percentage of CSOs with personnel able to advocate on behalf of reproductive rights and the prevention of GBV	Baseline: 5% Target:20% Endline data: 34%	Overachieved		
Indicator 5: Percentage of local government units with quick-responsive teams to combat VAW and which can readiily deployed in humanitarian crisis situations	Baseline: 10% Target: 50% Endline data: 21%		Partially achieved	

Source: UNFPA Country Programme Perfomance Summary

There were weaknesses in the design of monitoring and evaluation of CP7, noticed at the inception of the CPE, that presented challenges in measuring outputs and outcomes. First, some of the indicators listed above are percentages without adequately documented baselines. Second, operative words such as 'functional,' 'able' and 'quick-responsive' were difficult to measure unless

[51] See GIHA COP Terms of Reference.

further defined or elaborated. Third, in provinces where the ET visited, there was lack of evidence of monitoring and evaluation systems set by UNFPA and its IPs.

Overachieved indicators could be attributed to UNFPA's presence in three major island groups fielded with a Programme Management Unit that worked directly with 10 provincial LGU partners. The strong support of DSWD and DOH at the national, regional, provincial and municipal levels facilitated exceeding the targets. The partnership between these entities could be traced back in CP6 where the foundation for promoting GEWE and prevention of GBV has been cemented. On the other hand, various members of CSO groups (with direct and indirect partnership with UNFPA) were advocating for the passage of the RPRH Law and the prevention of GBV. The partially achieved output indicator #3 can be attributed to unstable 'political dynamics' in a couple of UNFPA target provinces and the high expectations that national level government entities will provide the much needed funding for GBV prevention and GAD programmes instead of the LGUs. The low funding support by LGUs was evident by the LCAT-VAWC evaluation where only four out of the 10 created LCAT-VAWC mechanisms have allocated budgets to support its operationalisation. On output indicator #5, there had been changes in the Government's Women's Priority Legislative Agenda, which was beyond the control of UNFPA. Notably, three project evaluation exercises were conducted in relation to the functionality of LCAT-VAWC, WFS, and WCPU. These evaluations assisted the CO in assessing the project performance and drawing lessons on what worked (or otherwise), which informed their decision-making and taking stock of lessons from experience.

4.3 Answers to evaluation questions on Efficiency

EQ 6*:* To what extent has the CO made good use of its human, financial, technical and administrative resources, and has used an appropriate combination of tools and approaches to pursue the achievement of 7th CP outcomes in a timely manner?

4.3.1 Sexual and Reproductive Health: Efficiency

Summary of findings*:*
CP7 utilized an eclectic approach in its direct field implementation activities (2012-2014), that all capitalized on the involvement of credible sub-national CSO partners and NGAs to deliver its wide range of services. The formulation of studies or “trigger papers” that provide high quality evidence for intervention design allowed for optimization of resources, ensuring that interventions are properly contextualized, evidence-based, and impactful. CP7 efficiently responded to administrative changes in 2015-2017 by increased emphasis on SRHR policy development and reform and technical assistance to NGAs in RPRH implementation; shifting from direct programme implementation to “catalytic approaches” through policy reform and development.

The formulation of rigorous studies that provide high quality evidence for intervention design allowed for optimization of resources by ensuring that interventions are properly contextualized, evidence-based, and impactful. For instance, UNFPA, using the results of the Young Adult Fertility Survey (YAFS), leveraged with national and local policy makers, to highlight the need for designing effective ASRH services and modalities in the Philippines.

Convergences were also important in addressing constraints in the effective implementation of common SRHR and ASRH activities. The UN Joint Programme on Maternal and Neonatal Health

(JPMNH) with UNFPA, UNICEF, WHO, and DOH served as a hallmark in organizational and programmatic effectiveness and efficiency. Reviews of the JPMNH have shown that, at the end of its implementation, the JPMNH achieved an overall decrease in maternal and neonatal mortality in its project sites. The JPMNH Phase 2 Project Completion Report (January 2017) added that: "The absolute number of maternal deaths decreased by 11% and the maternal mortality ratio decreased by 9%. For newborns, the absolute number of deaths decreased by 8% and the neonatal mortality rate went down by 7%. This impact was achieved through improvements in health systems and services to which JPMNH interventions contributed."

Thus, despite lack of core funds by the mid-period of CP7, UNFPA was able to cope well with the downsizing of field staff and shift in program focus from direct service delivery to policy advocacy/research because the technical assistance and expertise of UNFPA staff were responded to and reinforced by implementing partners who were willing to take on the advocacies of UNFPA. The expansion of partnership with private business groups (such as ECOP) in FP was particularly an efficiency strategy for SRHR. To this end, UNFPA and ECOP initiated the Program Management Training Course for Business Action for Family Planning Access, which prepared participants to install a maternal and child health and FP program in their workplace, identify delivery mechanisms, draw up a work plan, including M&E tools.

Humanitarian: Efficiency of Responses

Collaboration and partnership with UNFPA are evident with the UN Office for the Coordination of Humanitarian Affairs (OCHA), NDRRMC, DOH, DSWD, OCD, and all LGUs affected during humanitarian crises. Funds for humanitarian crises, however, took off more than core funds especially during Typhoon Haiyan. To address this resource constraint, CSOs were tapped to do work for both humanitarian and non-humanitarian programs, which was an efficient way of restoring effective health systems development in SRHR.

Coordinative mechanisms institutionalized through policies like DOH AO 2016-005, which established the RH Coordination Team, and the JMC on MISP for SRH also maximize the roles of these partners and reduce redundancies by facilitating streamlined functions across the network.

4.3.2 Population and Development: Efficiency

Summary of findings: UNFPA funding support was received by beneficiaries at the planned level but with delays. Given the lower than planned core funds for CP7, UNFPA successfully leveraged funds from non-traditional development partners for large scale surveys/studies and was strategic in its approaches for sharing technical expertise in population and RH. UNFPA staff shared their technical knowledge through national and local coordination mechanisms including bilateral dialogues and per special request received from government agencies and implementing partners. In particular, the UNFPA M&E team led the technical work on the formulation of the M&E plan for the RPRH Law.

On efficiency, beneficiaries of UNFPA support received the resources that were planned. However, fund releases to IPs were delayed due to prolonged discussions with partners and delays in fund processing at the CO. Some IPs in provinces visited by the CPE team revealed that they either delay their activities until the funds are released but still complete the deliverables on time as in the AWP

with all activities conducted at a shorter period of time, or they end up using their own funds first so as not to delay the planned activities.

UNFPA leveraged funding support for the conduct of the following surveys/projects: Young Adult Fertility and Sexuality Study (YAFS4), Longitudinal Cohort Study, and Business Action for Family Planning Access (BAFP). The government provided additional funds for YAFS and committed to do so for the cohort study while commitment of non-traditional development partners was secured such as IPMNCHN and DFAT. Merck for Mothers also provided around USD 750,000 of additional support for BAFP through the UN Foundation. Given such joint funding arrangements, UNFPA contributions were through popularization of the survey research findings by quoting them in speeches, events, etc., and supporting further analysis such as in YAFS4[52]. Moreover, the initially planned further analysis of YAFS4 on the generation of regional ASRH papers was eventually taken over by POPCOM, which is considered a welcome development in the context of reduced CP7 core funds and the reallocation of some funds for humanitarian assistance.

Various approaches were used by UNFPA in sharing technical expertise in population and RH. For example, to contribute directly to the crafting of the teenage pregnancy bills, UNFPA used the JPMNH technical working group setup (UNICEF, WHO and UNFPA). National and local coordination mechanisms including bilateral dialogues were explored where UNFPA participates in either as a member or as a leader such as in the RH law NIT, TWG on NDHS, South-South Cooperation between Philippines and Indonesia. Technical expertise was also shared through requests received from government agencies and implementing partners for technical expertise on matters relating to population or RH[53]. UNFPA has been regularly invited by DOH and POPCOM to provide technical assistance/advice in the drafting of the annual report on the implementation of the RPRH law, which is submitted to Congress and the Office of the President beginning 2015. UNFPA was also instrumental in advising DOH and POPCOM to focus on five Key Result Areas of RPRH, i.e., Maternal and Neonatal Health, Family Planning, Adolescent SRH, HIV/AIDS, and GBV.

In the field of M&E, UNFPA was recognized as a leading or principal actor. During RPRH Law national implementation team meetings, the UNFPA M&E team led the technical work on the formulation of the M&E plan for the RPRH Law. M&E indicators for national and sectoral policies were set up based on UNFPA SP and MDGs/SDGs.

4.3.3 Gender Equality: Efficiency

Based on interviews with key implementing partners at the national and local levels, UNFPA pursued partnerships and resources that helped connect shared gender equality goals and targets to the specific priorities of partners both in development and humanitarian. Across the board, most IPs commended UNFPA for coming at the right time with financial and technical resources. However, it was noted by partners that the administrative and financial procedures and mix of implementation modalities did not allow for a smooth execution of the programmes and projects, and did not minimize the complex bureaucratic procedures and programming processes of UNFPA. For some IPs, the use of existing (organic) structures and systems proved to be challenging while for some, the creation of PMUs has ensured timely implementation of activities and relatively smoother funds disbursement and utilization as in the case of Eastern Samar and CAR.

[52] In particular, the research studies on "Socio-Economic Implications of Parental Involvement in Adolescent Health» is a further analysis of the YAFS4 data.

[53] UNFPA has also been a member of the Technical Working Group of the 2013 and 2017 NDHS.

4.3.4 Organizational Efficiency and Effectiveness

OEE Output 1 (Programme Effectiveness) – Enhanced programme effectiveness by improving quality assurance, monitoring and evaluation:
Evident from the document review (progress monitoring reports) and interviews with relevant staff from the CO and implementing partners, the progress at the level of project activities and outputs has been regularly monitored and reported and corrective measures attended to. Monitoring data have been considered during planning processes. Targets and milestones have been revised based on monitoring visits, research studies and reviews. The programme documents lacked evaluability assessments and theory of change (TOC), however, during the discussions it was evident that TOC was clear to the POs and M&E staff. Another observation was the lack of indicators on behavior change measurement. The absence of risks and assumptions and risk mitigation plans and conflict sensitivity management plans were weaknesses in the system. In the joint programmes the specific roles were clear, however, there was no apparent integrated indicators set up to enable the measurement of each party's contribution to the planned outcomes. This in part, is due to the absence of a theory of outcome for the intervention. One advantage in the joint programme was the defined rules of engagement at different levels (national, provincial, municipal) avoiding any duplication of efforts.

Based on the ET's interview feedback, internal programme reviews had been conducted on a quarterly and annual basis, with annual review meetings held around November-December. Limited or insufficient CO budget to invest in additional surveys to collect baseline data and monitoring targets; and lack of up-to-date official data, have affected monitoring of outcome-level results. Joint monitoring mission reports showed evidence that monitoring was done extensively with detailed reports on results and target achievement with action plans that were established as follow up. All parties engaged in the joint activities have participated in the monitoring exercise to review the progress in a systematic and rigorous way. This, evident from back-to-office reports and feedback from review participants, could be documented as a "good practice" example by UNFPA CO. The CO also supported independent evaluations of selected interventions, for accountability to the donors and other stakeholders.

Recurrent issue that IPs brought for discussion was the fund transfer delays. While this was not specific to the Philippines CO, the same has been an unsolved issue for some time, as evident from other country CPEs, thus some input from HQ may be helpful in solving these delays related to fund transfer. Same rigid rules may not be feasible for IPs with different financial regulations, level of financial capacity and type of communities reached by them. However, one key informant mentioned that the Global Programming System Phase 2 which will be introduced soon might help reduce time spent on back and forth exchange of documents and rectify errors with fund activity codes.

Although monitoring reports do mention about the problems encountered by the IPs on UNFPA fund transfer system, there had not been a permanent solution according to interview feedback. While there are capacity issues on both sides (IPs and CO) that caused some delays in rectifying the problems, there were also some limitations in the rigid fiscal regulations that are inherent to the UNFPA financial system that added to the delays.

For quality assurance and speedy implementation, HACT micro assessment of IPs has been done. UNFPA's IP base has been an added benefit to the government and other development partners as well. UNFPA, with its limited human resources and budget has been able to work with strategic

partners to leverage and deliver, optimizing on the technical expertise within UNFPA CO and outside if and when it was needed.

Management of Resources – Improved mobilization, management and alignment of resources through an increased focus on value for money and systematic risk management

CO has been able to manage the limited resources (financial and human) as evidenced by the long list of achievements during CP7. Flexibility in accommodating programme demands with a small staff has been remarkable. The resources provided by UNFPA have had a leveraging effect which triggered provision of additional resources from other development partners.

The ET observed a few under-used/unused equipment that were given to the health facilities. While these were not purchased directly by the CO (ordered through Copenhagen and may have been purchased during CP6) and has little or no control on the specifications of the equipment, they did not serve the purpose for the health facility. Examples are the suction pumps (not used at all), and birthing/delivery beds, which have not been used in some places, while some have adjusted them to the required size.

UNFPA CO managed and mitigated risks as they foresee them during the programme cycle, however, as stated above, any systematic Risks and Assumptions analysis documentation was not available for assessment. Despite the absence of a risk assessment and mitigation plan, CO has adapted the programme to the changing environment without hampering the planned programme. For example, except during Typhoon Haiyan where the entire country focused on humanitarian assistance and response, UNFPA was able to balance development work and humanitarian response without affecting the planned programme during other recurring emergency situations. This is explained in detail in the context of programme effectiveness elsewhere in the report, under Effectiveness and Efficiency sections.

Adaptability through innovation, partnership and communications

UNFPA has advocated in establishing effective partnerships for most parts of the programme. Even before the UNFPA Business Model shifted from service delivery to upstream advocacy, UNFPA had already established grounds for advocacy role and was quick to identify suitable implementing partners as strategic partners. Where it was applicable and appropriate, UNFPA was able to establish formal South- South Collaboration agreement with Indonesia, and facilitated study visits by key stakeholders from Bangladesh and Vietnam to the Philippines.

Having suffered some coordination issues during phase one (CP6) of the joint programme implementation (JPMNH), the CPE Team's assessments of the completed joint partnership programmes showed successful results on the ground (examples of success related to this is explained elsewhere in the report) that partners were willing to venture into similar joint progammes in the future to achieve the outcomes efficiently and effectively contributing to sustainable development. Examples of these are the joint programme of UNFPA with UNICEF and WHO through DFAT-funded JPMNH, and EU funded programme on Maternal and Newborn Health for Indigenous People. UNFPA also achieved positive results, as commented by all those interviewed, on the high impact scalable programme through the HLGP that has been cited throughout this report under different sections (see under SRH, PD and partnerships).

The partnerships with FP2020 on Sub-dermal Implant implementation, DFAT on humanitarian preparedness and prepositioning and DFAT, UNICEF and Government on the 15 year cohort study were other examples of how UNFPA was adapting to work with partners. UNFPA's ability to embark on risk taking innovations is evident from the longitudinal cohort study that goes beyond more than one CP cycle. Emerging private sector work has been a milestone, as UNFPA has worked with two large micro-finance institutions who in total have more than six million clients mostly women of reproductive age.

Challenges: With limited staff and budget, UNFPA has made sustainable development initiatives, as described throughout the report. Main challenge and the issues that were brought up by almost all IPs were about the delays in fund transfer. In the case of semi-annual fund release, these were not that problematic; however, one IP had preferred quarterly funding, as opposed to semi-annual, due to internal book-keeping issues related to company practices and procedures. Another problem faced by IPs is UNFPA's inability to commit funds, for the particular intervention, beyond one year. One year was seen as short and partners would like to engage in a multiyear partnership with a commited budget. Although there is an option for multiyear work plans, not being able to commit to multi-year budget was still a challenge, as mentioned by IPs since they are unable to plan the programme in the next year. UNFPA operates within fixed corporate regulations, but partners view this as *"opportunistic*" where *"UNFPA asks for programs when they have funds."* Despite this situation partners still report: *"even with that we still like to work with UNFPA.*" Other challenges faced by the country office POs as well as finance staff were the concerns about the start-up costs and difficulty with having to train new IPs and their finance staff almost every year, sometimes quarterly (due to staff turnover of IPs). Despite the trainings provided in finance procedures, repeated mistakes in the preparation of workplans and finance documents have been a challenge.

4.4 Answers to evaluation questions on Sustainability

EQ7: To what extent has UNFPA support helped to ensure that SRH and rights, and the associated concerns for the needs of young people, gender equality, and relevant population dynamics are appropriately integrated into national development instruments and sector policy frameworks in the programme country? (Applicable to all three programmatic areas)

EQ8: To what extent has the CO established, maintained and leveraged different types of partnerships to ensure that UNFPA can make use of its comparative strengths in the achievement of the country programme outcomes across all programmatic areas? (this question also addresses part of Efficiency and Added value assessments)

4.4.1 Sexual and Reproductive Health: Sustainability

Summary of findings: National and local policy reforms introduced have institutionalized SRHR as a cornerstone of public health intervention, especially in the implementation of the RPRH Law, which defined positive policy declarations for SRHR. Current (sin tax incremental revenues for health under the DOH's HFEP and MDG components) and foreseeable increases in health investments (through the UHC reform agenda) contribute to resource/fiscal sustainability in the long-term.

Sustainability of the Programme; The Supreme Court resolutions on the RPRH Law and the lifting of the TRO on Implanon have paved the way for a high gear implementation of the RPRH Law. Along this line, UNFPA was able to leverage with the DOH, through technical assistance in policy

development, towards the organization of National Implementation Team (NIT) of the RPRH Law. The continuous increase in public funding for health through incremental revenues under the Sin Tax Reform Act has the potential to guarantee the financing of RPRH implementation and other SRHR interventions under the DOH, especially with respect to health facilities improvement under the Health Facilities Enhancement Program, the Family Health and Responsible Parenting program (under the "attainment of health-related SDGs" item), and SRHR-related health literacy interventions (under the Health Awareness Program).[54]

In provinces and municipalities where the HLGP has taken root and in such LGUs where the leadership will continue beyond 2019, it is anticipated that efforts in maternal and neonatal health and SRH under the CP7 will be sustained. The popularization of the aforementioned *fatwas* will also ensure sustainability of programmatic interventions in Bangsamoro and Muslim communities.

Sustainability of Humanitarian Programs: All policies and programs of UNFPA with regard to SRHR humanitarian response are now embedded in various relevant government agencies responsible for dealing with humanitarian crisis (see Section 4.1). The humanitarian response process set during the CP7 has become institutionalized practices in addressing SRHR-based health needs. Policy initiatives like the MISP and Dignity Kits are outstanding features adopted by the Philippine government at all levels of governance.

4.4.2 Population and Development: Sustainability

Summary of findings: Four UNFPA initiatives under CP7 will be sustained as they are adopted by the government. The DOH is continuing the HLGP starting in 2019 for local executives and middle level managers and the CIP for FP will be updated using the 2017 NDHS findings. YAFS has been included in the 2018-2023 Philippine Statistical Development Program (PSDP) with DOH co-funding it along with the Longitudinal Cohort Study on the Girl and Boy Child (2016-2030). Moreover, the 2013 Philippine Youth Development Index (YDI) study was one of the basis for the crafting of the Philippine Youth Development Program (PYDP).

Four UNFPA-supported initiatives on data and planning, as well as evidence-based advocacy are to be adopted by national government agencies. First is the HLGP which is a frequently cited UNFPA initiative. Recognizing the high ownership of RPRH programs by HLGP graduates, the DOH has adopted the HLGP starting in 2019 to include local executives and middle level management. Expansion of SRH champions will ensure the continuous engagement and commitment for the population and SRH agenda at national and local levels. Second is the Costed Implementation Plan (CIP) that was instrumental in securing resources for DOH to address unmet need for FP which will be adjusted with new data from NDHS 2017. Next, UNFPA's consistent advocacy for regular updating of ASRH data has been heeded as PSA has included YAFS in the Philippine Statistical Development Program (2018-2023) with possible co-funding from DOH. YAFS results have always placed adolescents and the youth at the center of public interest and research, e.g., HIV/AIDS, teenage pregnancy. Finally, the study on the cohort of the boy and girl child has gained commitments from various sectors for the period 2016-2030.

Likewise, the UNFPA supported the NYC in the past CPs for the development of the Philippine Youth Development Program (PYDP) as well as the Youth Development Index (YDI) study under CP7. The

[54] See DOH, Sin Tax Law Incremental Revenue For Health Annual Report C.Y. 2017, http://www.doh.gov.ph/sites/default/files/publications/2017%20DOH%20Sin%20Tax%20Report_0.pdf.

YDI is one of the major foundations in the crafting of the final version of the PYDP that was the basis for Republic Act No. 10742, otherwise known as the *Sangguniang Kabataan* Reform Act of 2015. The new PYDP (2017-2022) is aligned with the PDP 2017-2022.

4.4.3 Gender Equality: Sustainability

Summary of findings:
UNFPA's initiatives in gender equality and GBV are clearly to be sustained within the work of DSWD, particularly on CIAGV, GRCM, and WFS among others, and with the work of CPNF, Inc. on WCPUs and WCPMIS. The implementation of GAD codes, including proper utilization of GAD budgets to support gender equality initiatives; development and production of gender knowledge products and studies for use in policy advocacy and programming will ensure the sustainability of UNFPA's efforts beyond the life of CP7.

A sustainability mechanism that was observed by the CPE Team, particularly amongst state partner institutions, was the integration of UNFPA's work (whether in SRH, Gender, or PD) in their mainstream work right at the outset of project development. DSWD is a case in point where it has ensured that UNFPA's interventions on GE and GBV both in development and humanitarian settings are taken on by its various Bureaus (SOCTECH, PSB, DREAMB). These bureaus will ensure that valuable support of UNFPA's investments will contribute to the long-term success of DSWD. Issuance of various Department Administrative Orders and Memorandum Circulars (DSWD 2015 MC06 on WFS; DOH 2013 AO 001 on WCPU; DOH/DSWD/DILG/OCD Units, Levels and Attached Agencies LGUs, PS and CSOs; 2017 JMC 0001 on MISP Implementation for SRH in Emergencies and Disasters). In a meeting with CPNF, Inc., they have committed to continue supporting WCPUs and maintaining the WCPMIS even sans the support of UNFPA. The implementation of GAD codes including proper utilization of GAD budget to support gender equality initiatives; development and production of gender knowledge products and studies for use in policy advocacy and programming, are good initiatives that can be cited, too.

Facilitating and Hindering factors (Overall for CP7):

The relevance of CP7 programs was facilitated by the ability and adaptability of the IPs to take over/accommodate programming changes in times of crisis. The readiness and willingness of the implementing partners during Typhoon Haiyan to have their AWP budget reduced enabled UNFPA to reallocate such funds to humanitarian assistance.

One of the most important factors that enabled the success of the CP7 in terms of meeting its programmatic goals in SRHR is the strong support from the President of the Philippines, both past and present (the administrations of Benigno Aquino III and Rodrigo Duterte). Their "political will" translated into both legislative and executive policies that have furthered reproductive justice in the country. The same "political will" was fostered locally with the ZFF, UNFPA, and partner agencies' HLGP, which enhanced the support and salience of participating local chief executives to health promotion and community health.

Apart from this, factors for the CP7's success included the fiscal sufficiency for accessible contraceptives through excise tax earmarking, which has resulted to gains in the budget of the healthcare system and in increasing public insurance coverage; the strong commitment of DOH and

POPCOM to improving ASRH outcomes; demonstrable local enthusiasm for U4U; and the integration of CHTs[55] that effectively generated demand for SRH services and interventions.

Established network of implementing partners on the ground, including HLGP trainees in public office, has been a strong facilitating factor in responding to emergencies.

UNFPA has been sharing technical knowledge in population and RH through various coordination mechanisms and eventually becoming recognized as advisers in these fields, which could more readily sway policy and programmatic discussions. For example, the UNFPA M&E team was praised by members of the NIT secretariat for its significant contribution in the drafting of the M&E guide for the RPRH law implementation.

With greater GAA budgetary allocation of government agencies, securing commitment to take on successful UNFPA-supported initiatives was more easily facilitated compared to earlier CPs. Examples are the HLGP, YAFS, CIP for FP and the cohort study that will be adopted by DOH. The challenge is the availability of full-time human resources at the DOH who will be managing these expanding engagements.

Adaptability of CO staff to share responsibilities and come up with the funds needed despite delays, and as almost all implementing partners mentioned, collegiality, friendliness and professionalism of CO staff have been a facilitating factor. Ability to promote creativity, innovative ideas and willingness to take risks are also facilitating factors.

Despite these successes, however, several hindering factors were noted throughout CP7. In particular, conservative sectors in Philippine society have utilized the legal/judicial system to restrict SRH programmatic interventions, which culminated in the constitutional challenge to the RPRH Law and the injunction on Implanon use. This resistance continues to affect implementation of SRHR-related interventions, as demonstrated by negative statements of conservative groups to the Zero Unmet Need for Modern Family Planning (EO No. 12, s. 2017).[56] The sensitive nature of introducing artificial FP methods, among other SRHR interventions, is also observable across local government jurisdictions, which can potentially adversely affect political acceptability or sustainability.

Program implementation was usually affected by delays in the release of project funds to the IPs and beneficiaries. While prolonged discussion with IPs toward agreements on AWPs may be justifiable, the CO administrative and financial procedures may need to be examined to streamline the process and enable timely release of funds. The problem with fund transfer delays recurring over the years and not being able to come up with a clear solution affects efficiency and effectiveness of the IP managed interventions, as well as CO staff time management.

Unintended Effects:

The evaluation seeks to note unintended effects, positive or negative, as a result of CP7. The CPE team observed a few results that were not specified as CP7 programme objectives or targets.

[55] CHT is not synonymous with TBAs

[56] Reuters, Duterte's family planning program faces opposition (Jan. 23, 2017).

Unintended Effects PD: The Spectrum training supported by UNFPA has generated interest among some participants to pursue post-graduate demography training to better understand population dynamics.

Unintended effects SRH: Birthing Clinics with CHTs have attracted mothers from other municipalities, despite the distance, to give birth in a facility that is complete, with a good referral and where the community stands by to provide support to the mother. While it is understandable those mothers from other barangays within a municipality would go to the birthing center, for mothers from other municipalities, with no affiliation or connection to these centers, to have trust and confidence to give birth in a facility is a positive unintended effect.

Investment of UNFPA in HLGP and taking risks with a CSO organisation – eventually UNICEF, USAID following UNFPA example to invest in HLGP to deliver a functional health care system. Finally, the willingness of the DOH to invest in HLGP nationwide.

Support to SRHR humanitarian assistance has developed a sustainable health care system in villages and towns affected by Typhoon Haiyan as compared to those not affected by the typhoon.

Investment of UNFPA on indigenous peoples has shown that the inputs, outputs and processes usually applied to non-indigenous communities have been *indigenised* by the communities being served.

As noted during CPE team field interviews, investments in provinces known for armed conflicts (Sarangani, Sultan Kudarat and North Cotabato) have resulted to a more peaceful setting "compared to before," since UNFPA assisted these provinces.

Unintended effects Gender Equality and GBV: In CP7, UNFPA only targets Sections 9 and 17 of MCW but due to its interventions in humanitarian settings, vulnerable groups - IPs, Moro, senior citizens, young people (girls and boys), persons/ women with disabilities, solo parents, female- headed households/single and child-headed households, chronically ill and elderly women, 4Ps participants, and internally displaced women - have been served by or benefited from UNFPA's interventions.

Good Practices

- The effective and efficient leadership of UNFPA --- consistent and high profile --- have been acknowledged positively by national and local leadership, and in the UN Country Team. This has led to the adoption of UNFPA's advocacies.
- CSOs have been good partners of UNFPA in delivering SRHR services if government is constrained to deliver such as in the case of Implanon and during the humanitarian crises.
- Demand generation at the community level together with good governance and leadership are the key to achieving the MDGs and SDGs especially at the local level.
- In health systems development for SRHR, Governance and Leadership of Governors and Mayors for SRHR are key pillars at par with demand generation and supply systems. HLGP is worth expanding as a good practice example.

The effective response to the humanitarian crisis in Typhoon Haiyan areas became a good model to build the health systems quickly. For example: In Eastern Samar, Typhoon Haiyan areas have better MMR, IMR, CPR compared to non-Typhoon Haiyan areas. The various humanitarian responses of CP7 are now considered good practices in addressing the other equally important but often

neglected aspects of the disaster response such as SRHR. Policy initiatives like the MISP and Dignity Kits are notable features adopted by the Philippine government at all levels of governance.

Lessons learned:

- Passionate and committed champions and advocacy network for RH/PD/GE were effective when capacitated with solid data/evidence to argue for policy shift and tools to effectively implement the change at the national and local levels. Such positive experience may be replicated given the new YDP challenge.
- Leveraging funds for innovative initiatives such as the cohort study was facilitated by tapping national and local coordination mechanisms in place and expanding engagements beyond traditional partners. Given the new DD challenge, resource mobilization for human capital development and research funds of the future thought leaders in RH, PD and GE could also be pushed considering the confidence/recognition that UNFPA has attained under CP7 and UNFPA branding as a UN RH and rights agency.
- Addressing the system as a whole, engaging all responsible authorities, as evident in the mode of planning and implementation of HLGP is a good example that can be replicated.

CPE Component 2:

This section presents the analyses of strategic positioning based on the evaluation criteria *coordination* and *added value*. The first part assesses the extent to which UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms. The second part assesses the UNFPA added value in the country context as perceived by national stakeholders and the extent to which UNFPA made good use of its comparative strengths to add value to the development results of the Philippines. The feedback under component 2 is from in-depth interviews conducted with key informants at senior level that included heads of agencies and departments (both government and non-government), donors and other senior staff.

4.5 Answer to evaluation questions on Coordination

UN Country Team Coordination

EQ.9: To what extent has the UNFPA CO contributed to the functioning and consolidation of UN Country Team (UNCT) coordination mechanisms?

Summary findings for Coordination:
UNFPA Country Office contributed positively to the UNCT, especially technical cooperation through coordinated programmes and by its strong leadership role. Perceived and reflected by UNCT members as an influential key player, UNFPA led several task teams and joint initiatives in line with its mandate, representing several technical groups and committees that contribute to better coordination mechanisms of the UNCT. In addition to the feedback received from UNCT members, the active contribution was evident from the role UNFPA played in participating as chair, co-chair, lead and member in working groups, thematic groups and joint initiatives.

UNFPA brought in technical expertise that enhanced the work of other agencies. All key UN agencies who responded to the interviews reiterated UNFPA's positive contribution in the country's overall development agenda, contributing effectively to improving UNCT coordination mechanism, particularly strengthening advocacy in several areas useful to other UN agency members.

Seen as an influential and useful leader in the UNCT coordination role, UNFPA held key responsible positions in various committees and working groups contributing to the country's development agenda. The ability to bring multiple strategic partners together and linking with UN agencies to increase the efficiency and effectiveness of the development contribution to the country has been highly valued and UNFPA's leadership was recognized as vital to the UNCT. *"We really value the experience UNFPA brings to the table– bringing the development partners together, good coordination and leadership role …the fact that we sit with three UN agencies together on one programme with DOH itself is an achievement" (key Informant).*

Strategically, UNFPA has maintained its strong presence in policy and key decision functions related to UNFPA mandate, evident from the list of active working groups and the role that UNFPA plays in these. UNFPA's corporate strengths are well recognized and acknowledged by other UN members who responded to the interviews. Some examples of current engagement in various capacities are: H6 Partnership (UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank) (2017-2018) as Chair; UNDAF Outcome Group 1 (Universal Access to Quality Social Services with focus on MDGs) with DSWD, UNICEF and WHO as co-Chair; UNDAF Strategic Focus Area on Youth (2015-2018) with NYC as co-Chair; UNDAF People Pillar – Co-Lead with UNICEF; Leading thematic groups - FP2020 Philippines Core Group, Co-lead with DOH and USAID and continuous serving member of Humanitarian Country Team; Security Management Team; Child Task Force Monitoring and Reporting; National Steering Committee on the Cohort Study (2016-present); Mindanao Working Group (2012-2017); IASC Health Cluster – Head of Agency (HOA); IASC Protection Cluster – HOA; Theme Group on HIV AIDS – HOA; UNDAF Planet/Prosperity Pillar (2017 and onwards) and UNDAF Peace Pillar (2017 and onwards). A detailed list of UNFPA's participation in UNCT and other development partners during CP7 period is illustrated in the Annex E.

All the interview respondents affirmed the positive role played by UNFPA and this feedback from another key informant reflects the majority's view of UNFPA's role within UNCT:

"UNFPA plays a very important role in UNCT…active participant in UNCT….very much contributing to forging consensus and putting issues on the table, stimulating discussions and trying to bring agencies together…..strategic approaches, this is how we appreciate the role of UNFPA…major player in the Country Team … going beyond its own programmatic mandate.." (key informant)

The IPMNCHN in Mindanao was funded by the EU through UNFPA with the National Commission on Indigenous People (NCIP) and the DOH. FP2020 is a Global Initiative of UNFPA, USAID and the Bill and Melinda Gates Foundation to ensure 100 million women meet their unmet needs for Family Planning in 63 countries. In the Philippines, FP2020 has been organized by UNFPA, USAID, the DOH and Likhaan (a CSO) to meet the unmet needs of 6 million women belonging to the lowest socio economic quintile. A Joint Program on MNCHN by UNFPA, UNICEF and WHO has given rise to new insights and achievements from the implementation in selected Mindanao Provinces. At the national level, UNFPA coordination is evident with the DOH, PopCom, DepEd, NYC, DSWD as well as CSOs at the national and local levels. Coordination with Governors and Mayors are well established.

Not only within UNCT, the government as well as other development partners also saw UNFPA as a leader that has contributed positively towards linking partners and contributing to development initiatives that are recognized as more robust and sustainable. Evidence to this was well documented under the programmatic findings in this report.

As discussed under the GE section, within and outside the UN HCT, UNFPA's leadership role in the prevention of GBV in humanitarian settings was highly recognized. UNFPA is an active member of the Gender in Humanitarian Action Community of Practice (GIHA COP)[57] along with the Philippine Commission on Women, UN Women, UNOCHA, OXFAM, and Christian Aid.

4.6 Answer to evaluation questions on Added Value

EQ 10: What is the main UNFPA added value in the country context as perceived by national stakeholders?
EQ10a: To what extent has UNFPA made good use of its comparative strengths to add value to the development results of the Philippines?

Summary of findings
UNFPA's strong advocacy role, especially related to sensitive issues affecting women and SRH, ASRH, youth, marginalized groups, GBV etc. added value to other development partners. CO has entered into strategic partnerships that produced results and are important and worth replicating and institutionalizing. With the ability to lobby and advocate, strategically, UNFPA has maintained its strong presence in policy and key decision related functions and is perceived to have its strongest comparative advantage in advocacy specifically in the areas mentioned above, related to SRH, GBV with specific mention on MDR and ASRH.

Global experience that UNFPA brings in to the country was valued and the development partners looked up to UNFPA for technical assistance. With a mandate that is accepted by the government, UNFPA is a strong partner with the national and local government, CSOs, donors, private sector and other partners. UNFPA was described as a "*respected one in development.*" A unique contribution that UNFPA brought to the development table was the strength and ability to champion both at the programmatic and upstream advocacy levels, supporting development strategies and policies.

UNFPA's ability to contribute at the programmatic as well as strategic levels was recognized as an added value which was evident in the review of documents, observation of the interactions at high level meetings and feedback from various respondents. A key informant stressed this point: *"Good balance between programmatic interventions they [UNFPA] support ..and developmental approach that involves more effort on strategy and policy development ….UNFPA is one of the agencies that have both strengths..bridging these two [programmatic level and strategic level] ..not all other agencies have this combination…." (key informant).*

UNFPA's leadership in promoting creativity and innovation was another added value to the development agenda. Such is the case of the HLGP of the ZFF. By taking risks and leading the

UNFPA strategies and interventions in SRH, ASRH, GBV, Data availability, and emergency response add value to the work of other development partners, especially the UN system. In addition to the contribution in the development work, the UN agencies, national counterparts and other development actors recognized UNFPA's leadership in response to crises situations in the country. More importantly, the contribution to SRH, MISP, provision of Dignity Kits and above all, the coordination of a large network of implementing partners on the ground to make the response timely, effective and efficient (feedback from several key informants).

[57] See GIHA COP Terms of Reference.

investments in HLGP, UNICEF and USAID and the DOH bought into the HLGP. This was a good example of other development partners adopting UNFPA strategies and good practices. Unique contribution of bringing non-traditional partners from the private sector under the Business Action for Family Planning added value to others who were engaged in improving access to FP information and education in the work place. UNFPA has been a catalyst in bringing this service to a total of about 1.3 million women. Thirteen private sector companies have been part of this programme in 2017 and two of them had officially committed to support global family planning.

Referring to the recent crisis due to the eruption of Mayon volcano, a respondent mentioned that UNFPA had been there within a week and contribution and quality of response were very good. Availability of sex disaggregated data in the humanitarian sector has been better with UNFPA efforts to make the data available for planning in emergency situations. Overall, support to surveys and research, making quality data accessible and available, is seen as a unique contribution that UNFPA brings to the development community.

Majority of the respondents repeatedly used these characteristics explaining the way how UNFPA staff interacts with them:"*Credible partner, People Centered, Flexible, Committed, Dedicated, Collegial, Responsive, Friendly, and Innovative.*" Consensus among all respondents was that UNFPA has a *"Strong Leadership."*

National counterparts and other development actors perceived, recognized and recalled UNFPA's performance as unique. UNFPA's engagements in advocacy role had been reported to bring positive results and are valued by other development partners. With its ability to work within the county context and the long partnership with implementing agencies, UNFPA CO has established healthy grounds for lobbying in areas that are sensitive and difficult to be reached by other agencies. *"DOH will be indebted to UNFPA because the Adolescent Health which did not exist for the longest time now has a face, at least it has germinated and the UNFPA has stirred so much interest such that there were researches made on teenage pregnancies, violence against…., and all those types of topics." (DOH Dialogue interview)*

Evidence and various examples of UNFPA contribution to the development agenda, over and above the mandated areas of responsibility, have been notable. Operating within the corporate business model (Philippines in "Orange" category), UNFPA was well situated and strategically positioned to continue to offer its advocacy and technical assistance role. UNFPA has been successful in working with the government in advocating and lobbying for the country's development agenda and is in a strong position to leverage this position/capacity to bring on board those implementing partners capacitated and supported by UNFPA, but who are less empowered, to enable their voices to be heard at higher levels.

Chapter 5: Conclusions

5.1 Strategic level

1. **Extending to non-traditional public-private partnerships, CO established strategic and sustainable partnerships facilitating a smooth transition to the new business model during CP7.** The **i**ncreased emphasis on upstream advocacy and catalytic work together with established strategic partnerships have provided effective and replicable programme models as evident from the evaluation findings. Efforts on Advocacy played a key role in achieving programme results/outcomes. Through long-term partnership with implementing agencies and the continuity of the programme over several CP cycles, UNFPA CO has established a sustainable programme. A good number of UNFPA advocacies have been adopted and funded by both national and local governments (outstanding examples are the HLGP, Implanon, U4U, MDAs, Buntis Congress, MISP, and Dignity Kits). Leveraging funds for large-scale surveys and innovative research activities was successful and adoption by government of innovative and effective UNFPA-initiated activities was documented. Several national government agencies have recognized UNFPA as a strategic partner in the country's development. The strategic partnerships established with DOH, NEDA, PopCom, DepEd, DSWD, and CHR have the potential to last a long time beyond next CP cycles. (Origin: EQs 4, 5, 6, 8, 10)

2. CO has a particular advantage where UNFPA's corporate strengths are well recognized and acknowledged by other UN members. The value added by UNFPA in the development field is considered high according to almost all other development partners. Strategically, UNFPA CO has maintained its strong presence in policy and key decision functions that are related to the UNFPA's mandate. Taking a lead in advocating sensitive issues on human rights, ASRH, GBV, FP and HIV/AIDs, CO had been a knowledge broker in successfully bridging and facilitating various players engaged in the development field. Advocating RH, ASRH, gender equality, women's empowerment, and the access to information and knowledge as a human right, CP7 has employed gender-accommodating human rights-based approach in the CP7 design and implementation. UNFPA's stature has been elevated to knowledge steward as the expertise of its technical staff in population, RH, and M&E systems, to name a few, have been sought after especially for sharing of international experiences that could serve as principles to further guide or bear on important policy decisions relating to RH including FP, and youth development in the country. However, given the recent focus on demographic dividend, cohort study and quality data for evidence-based planning which will be continued in CP8, CP7 is now leaning more towards a multi-sectoral, integrated approach with emphasis on demography. To meet the increasing demands in the above interventions, the current level of CO technical capacity and resources seem inadequate (Origin: EQs 1, 2, 3, 4, 5, 9, 10)

Operations and Management

3. With limited staff and funds, amid several major humanitarian crises, CO has managed to achieve most of the planned results in the CP7 implementation by channeling its resources to established institutions and implementing partners to ensure that UNFPA resources will have a catalytic and leveraging effect to achieve UNFPA's strategic goals. Deficiency in costing of "soft activities" (e.g. staff-time on advocacy work, coordinating role) does not allow an assessment of cost-efficiency or effectiveness. However, given the number of high impact and sustainable achievements with a positive affect on millions of people, and risks averted, as evident in the findings, UNFPA interventions can be considered as cost-efficient and effective. Joint programming

with other UN agencies, though very few, is an example of having a combined voice and effort to increase efficiency, and effectiveness of the programme. In light of the business model and shift to more upstream advocacy work in the reduced funding environment for the next CP, resource mobilization has created a higher demand for programme and operations staff to scale up fund-raising activities, to enhance technical quality of fund proposals, and to identify specific niches that will attract donor funding. Internal coordination (Programme and Operations) on documentation and monitoring of fund disbursements to IPs seems weak as evident from the findings. Observed by the CPE team was a lack of/weak internal communication and coordination to simplify the financial procedures to make the fund transfer system more efficient. (Origin: EQs 6, 8, 9, 10, OEE findings)

4. Knowledge Management (KM): CP7 contribution in KM is visible and the stakeholders value the quality of work. UNFPA value proposition is further elevated with SDGs needing much valued accurate data for monitoring indicators. UNFPA is seen as one of the key, if not the only UN agency, that assists in generating and disseminating credible and internationally comparable data. The utility value is obvious in the references made to and application of the products. The shift in focus from service delivery and individual-focused capacity building interventions to more of institutional capacity-building and strategic policy advice types of support resulted in the generation of knowledge products on PD, SRH, FP, among others, that served as evidence for more informed policy making and program planning at the national and local levels. The passage of the RPRH law was strengthened by UNFPA knowledge products as they were widely used by the large pool of SRH, ASRH, PD, and GE champions at the national and local levels. UNFPA is the key UN organization that works with data generation by providing technical support. The integration of all UNFPA programs and activities into the provincial organizational structures and programs are a major breakthrough for efficient implementation of SRHR services in CP7. However, the generation, analysis, and dissemination of data needed for policy, planning and programming particularly at the municipal/city and barangay levels remain a challenge. (Origin: EQs 3, 4, 7, 8, 10)

5.2 Programmatic Level

5. Capacity development: Investments in capacity development at various levels across CP7 programme is high but has limited monitoring data to measure outcomes. While it is not easy to measure institutional changes and individual behavior changes, there is an absence of tools to measure these within the CP7 system. The absence of a clearly articulated theory of change for CP7 outcomes partly contributes to the gaps in measurement issues. Under Gender Equality, "capacity development" had been employed as a key strategy to support the implementation of MCW, particularly on reproductive rights and GBV. However metrics that will capture change in capacity to understand the success of the capacity development process are not well articulated. (Origin: EQs 4, 5, OEE findings)

6. UNFPA CP7 has remained resilient in the face of political changes and crisis situations and focuses on disadvantaged populations in geographically isolated and disadvantaged (GIDA) areas and stays relevant to the country priorities, UNFPA mandate, and the needs of the beneficiaries keeping in line with national interests, policies, ICPD POA, UNFPA mandate, strategic plans and mode of operation. Given the emphasis and the criteria employed in the selection of populations for CP7, a deliberate focus on disadvantaged and vulnerable groups in the design and implementation of the programme is evident. However, there is limited data to measure the reach and the change in the situation of these disadvantaged groups. Despite interruptions due to humanitarian crises in the first two years and strategic changes in the mode of programme implementation, CO was able to flexibly adjust its development work plan funds for humanitarian

assistance in concurrence with IPs. CP7 has achieved intended results, in the face of crisis situations, as evidenced in the findings discussed in the report. (Origin: EQs 1, 2, 3, 4, 5)

7. Youth: Building on national data, which demonstrates an opportunity for reaping the "demographic dividend", UNFPA is well placed to advance the national agenda for youth, especially related to their SRHR. There are several data sources in the country and technical assistance in population dynamics projections to the government which will become a priority issue in the years to come. Data for planning have become more important with UNFPA initiatives such as the cohort study and reaping the benefits of DD. UNFPA is a champion in generating and disseminating data and there is a much greater role in CP8 given that the SDGs are in place with an increased need and the emphasis on the use of credible and quality data. (Origin: EQs 1, 4, 7, 10)

8. ASRH is still an underdeveloped area in the programme sites visited. UNFPA will have a better opportunity to address this given the availability of UBRAF and the work with UNAIDS and the implementation of CSE ASRH strategies/plans are not fully customized based on local level epidemiology, contexts, and the institutional structures of the local health system. Youth have been sensitized (e.g. U4U) in ASRH area, but not yet fully engaged as a partner, especially in the design of context specific interventions that could benefit local communities. National agencies like the DOH, DSWD, DepEd, among others, are not fully capacitated to enable them to provide technical expertise and assistance in dealing with the devolved set-up of community health services to address ASRH issues adequately. (Origin: EQs 4, 5, 7)

9. By default many of CP7 interventions, specifically under SRH, are Gender-accommodating; although CP7 recognises and works around existing gender differences through enacted policies and programs, existing evidence is inadequate to ensure and be explicit that their implementation will reach a gender-sensitive stage. Sex-disaggregated data was limited and lacked evidence on gender analysis for planning or designing of programmes. CPE team did not observe a clearly articulated theory of change to address gender discriminatory norms, attitudes, beliefs and practices; and power relations in SRH programmes. Comprehensive sexuality education (CSE) programme which might help change gender related social norms is yet to be implemented. (Origin: EQs 2, 4,5, 7)

10. CP7 contribution in the humanitarian assistance has been very effective and UNFPA is considered as a leading advocate for preventing GBV in emergencies. Gender component has contributed to improving policy and legislative frameworks contributing to increased awareness on and improved responses to GBV, particularly in emergencies. Effective contribution to humanitarian assistance has proved UNFPA to be a leading advocate for preventing GBV in emergencies. Mainstreaming of humanitarian response within all three programme components (mainly SRH and GE) has made the way forward for bridging the humanitarian and development nexus and could provide valuable lessons that can be shared with other countries. However, Most of the UNFPA interventions are on response to GBV and had limited focus on its prevention. There is scope for further integration of prevention and response to gender-based violence across development and humanitarian settings. The number of VAWC cases is on the rise, but less attention has been paid to challenging patriarchy and engaging men and boys to end VAWC. These VAWC programme strategies have no robust monitoring and evaluation framework. (Origin: EQs 2, 3, 4, 5, 7,10)

Chapter 6: Recommendations

The following recommendations, at strategic and programmatic level, are based on the evaluation findings and conclusions discussed above and feedback received from key stakeholders. Operating within the corporate business model (Philippines in "Orange" category), UNFPA is well situated and strategically positioned to continue to offer its advocacy and technical assistance role. Evidence shows that the capacity is available, but may have to assess the skill mix based on the CP8 work plan. During the CPE process, the evaluation team learned that CP8 will be focused on Mindanao and also the core funding will be drastically reduced. Thus this context of CP8, the SP 2018-2021 and the UNFPA transformative agenda are given due consideration when presenting these recommendations. As per request, only eight recommendations that have high priority are selected.

6.1 Strategic Level

Recommendation 1 (linked to conclusions 1,2): Coordination, Advocacy Role and Strategic Partnerships: UNFPA to operate through strategic partnerships as the key mode of engagement Continue to strengthen the relevant strategic partnerships with key government and non-government and private agencies. Given the mode of engagement and programme needs, UNFPA to maintain its leadership and in assisting the government with strategy and policy development.
Responsibility: Country Office, Priority level: High
UNFPA Country Office: Given the environment with limited funds, UNFPA's strength is in the technical capacity, both in the development approach, strategy, and policy development. Thus the need is to strengthen the technical capacity of UNFPA or linking required expertise from the global pool of experts within UNFPA to maintain high quality and brand reputation of UNFPA. Strategically, UNFPA has maintained its strong presence in all policy and key decision functions related to UNFPA's mandate and the country development priorities within the mandate. UNFPA to continue and maintain the same quality role as a development partner, particularly where UNFPA has taken the lead in advocating sensitive issues on human rights, ASRH, GBV, FP and HIV/AIDS. As UNFPA plays a more catalytic role, targeted capacity building to be part of country office staff development plan (matching skills to programmatic needs). SDGs are very relevant and fitting to the UNFPA mandate and create an increased demand for UNFPA technical assistance in several areas.
Recommendation 2 (linked to conclusions 2, 3, 7,9): CP Design Related- CP8 design to be more focused on integrated programming approach (across development programme components – these may include peace building interventions as well) Accompany with theories of change that encompass the entire results chain, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework.
Responsibility: Country Office, Priority level: High
To achieve the above recommendation the country office to work on two key areas. Programme planning and HR capacity building, during the CP7 remaining period, continuing to CP8. The action plan could include the following: Programme planning:

Two key initiatives implemented in CP7 (Longitudinal Cohort study, and DD initiative) will be part of CP8 as well. These initiatives are multifaceted needing to work with multi-partners. Building on past experience, maximize comparative advantage and resources available, explore joint programming with other UN agencies if it adds value mutually, and specifically to UNFPA planned programmes. This to be finalized upon availability of shared resources, mutual agreement, and on added value.

Formulate integrated indicators (in joint programmes and/or integrated programmes) that are agreed on upfront based on the mandate and expertise of the Agency with clearly defined roles and responsibilities. Clear and detailed theory of change (TOC) to be included where a contribution analysis can be conducted. Map out the specific expertise that each Agency contributes to the results chain, finally measuring the integrated indicator.

In CP8 new initiatives, conduct evaluability assessment (ex-ante evalautions) at the onset of the programme for each outcome, assessing availability of data for measuring progress (with built- in M&E system, monitoring tools for assessing quality improvement; Improve on programme design related issues: based on identified programme gaps/needs, develop clear and detailed intervention logic model with TOC, risk assumptions and mitigation plans included). Prioritize UNFPA input with explicit sustainability strategies (exit strategies) in the work plan.
Human Resource capacity building:

More weight given to advocacy and policy dialogue/advice and technical assistance in UNFPA programme of assistance may require some adjustments to the skill sets possessed by current CO staff. Targeted capacity building of staff, including Change Management, would be useful.

Conflict sensitivity (conflict resolution) component to be integrated (mainstreamed) in the remaining period of CP7 and in CP8. Integration of conflict sensitivity analysis/assessments to understand various opinions of multiple stakeholders in areas thatare sensitive to the culture and social fabric of the country and the immediate working environment (e.g. U4U, SRH, GBV, FP and male involvement, Peace and Conflict etc.). This could produce and enhance expected results minimizing the anticipated conflicts and maximizing the opportunities for service receivers' acceptance and national ownership. Mainstreaming conflict sensitivity (including gender-sensitivity) approach as part of HRBA could produce more sustainable outcomes - specifically in the Mindanao context.

Recommendation 3 (linked to conclusions 1,2, 3): Programme, Operations and Management related: CO to diversify Resource Mobilization (within as well as outside the country), going beyond current established partnerships and traditional resource mobilization methods, anticipating the budgetary changes/reductions in CP8.

Responsibility: Country Office, Priority level: High

Explore non-traditional (out-of-the-box thinking) methods to mobilize resources (high competition for the same sources, thus the need for quick and innovative methods). For this, CO may have to seek HQ approval for CO independence/freedom to adapt RM approaches to suit the country context and situation.

Leverage innovation across the organization and with strategic partners to amplify the impact. For CP8, when the resource envelope is to be further reduced, the strategy for UNFPA engagement would be to maintain the high level of advocacy role that UNFPA played and to support the established institutions to scale up the successful interventions. Although CO has already established negotiations with the government, private sector and foundations, CO has room to fully explore other possibilities to mobilize resources. However corporate regulations might have some limitation on the freedom to be flexible at CO-level innovations.

RM involves preparation of high quality, innovative, proposals that is relevant and unique to attract donor funding. Enhance required skills and capacities at all levels of the organization to deliver. UNFPA has specific technical niche (e.g.: High quality data generation, SRH, high level advocacy) that can be used positively in mobilizing resources.

RM to be done in partnership with the IPs – state and non-state actors. Other countries have been doing this already as donors or other development partners respond quickly if RM is seen as a relevant joint effort between UNFPA and IPs. This calls for creativity and the use of emerging lessons and practices from other parts of the world to find locally applicable solutions to development challenges in the Philippines where UNFPA champions. RM means forging a new partnership with non-traditional actors and innovation in others – all with a focus not just on financial resources but deployed towards the realization of UNFPA-GPH development objectives. RM could be done within the ambit of UNDAF.

6.2 Programmatic Level

As noted above, recommendations include feedback and suggestions from the key informants and other stakeholders.

Recommendation 4 (linked to conclusions 1, 2, 5, 7, 8, 9): To pursue the development of definitive strategies in dealing with teenage pregnancies and HIV/AIDS among young people as part of Adolescent Sexual and Reproductive Health.

The complexity and dynamics of teenage pregnancy warrant a re-examination of the extant national and sub-national policies in relation to ASRH and its social determinants which cut across administrative jurisdictions. With the current challenges of rising teenage pregnancies and increasing incidence of HIV/AIDS especially among the youth sector, a strong ASRH component of the next Country Program is highly recommended. Mainstream HIV in protection of women's rights and key populations.

Responsibility: Country Office, Priority level: High

- Considering the UNFPA's comparative advantage in promoting rights for SRH, UNFPA should consider mainstreaming HIV through FP programme to ensure key populations and women living with HIV benefit from FP programme and interventions; Gender equality and GBV interventions to reach the most vulnerable populations to ensure these populations benefit from such interventions; youth programme to empower young people to protect themselves from HIV (through information, U4U, prevention services etc.); Ensure PD programme generate data to support evidence-based HIV programming/interventions, etc. in the context of promoting the rights of key populations/ women living with HIV, young adolescent girls, etc. This will be an essential

input for planning interventions, facilitating the reaping of benefits of the demographic dividend. A well formulated comprehensive sexuality education (CSE) programme and gender sensitive programming approach may serve as a platform to change deep-rooted social norms related to gender relations

- UNFPA to maintain the partnerships already built and well established with various departments, other UN agencies, CSOs, youth networks, advocates and champions, and media, generating evidence-based information and using the data to move the advocacy agenda.

- Increase utilization of the various tools of social media to popularize and promote SRHR, ASRH. ASRH strategies should be customized based on local level epidemiology, contexts, and the institutional structures of the local health system, while national government agencies like the DOH, DSWD, DepEd, among others, should be capacitated to enable them to provide technical expertise and assistance in dealing with the devolved set-up of community health services.

Recommendation 5 (linked to conclusions 7, 8, 9) Youth Engagement: Engage Youth as a partner in development and in the formal peace process

Engage Youth as a partner in development and in the formal peace process (e.g. DD process to reap the benefits, UNSC resolution on Youth, Peace, and Security, addressing VAWC).

Responsibility: Country Office, Priority level: High

- Continue the work on empowerment of youth.
- Identify the social norms where behavior change can be anticipated for the desired outcomes and develop measures to monitor progress. Current efforts on BCC do not have solid measurement of change. Develop indicators for behavior change measurement. For an effective Measurement of change behavior, the interventions should be based on systematic barrier analysis embedded in context specific social norms, cultural beliefs and practices.
- CO to be a catalyst in speeding up the implementation of comprehensive sexuality education (CSE) programme and gender sensitive programming approach as a platform to change deep-rooted social norms related to gender relations.
- Inject conflict sensitivity aspects in the programmes directed to youth.
- Advocate and lobby for the relevant partners to translate the learnings/findings from Cohort Study to draw up age-specific action plans.

Recommendation 6 (linked to conclusions 1,2,7,8,9) Stronger public health interventions aiming to address Violence Against Women (VAW)

At the design of CP8, consider stronger public health interventions aiming to address VAW (primary, secondary, and tertiary preventions), and adopt an integrated, ecological framework for understanding the root causes of gender-based violence.

Responsibility: Country Office, Priority level: High

In partnership with sister UN agencies (UNICEF, UN Women, WHO, UNDP, ILO, and IOM) that have equal mandates on the promotion of GEWE and the prevention of GBV, implement programmes that have a transformative impact on gender roles through Gender Transformative Programming (GTP), which addresses institutional, social and cultural dynamics that influence the behaviors and vulnerabilities of women and girls and men and boys in a given context. This programme focuses not only on the role of men and boys as agents of change to promote GE and end violence but also recognizes men and boys' particular vulnerabilities and needs in relation to GBV. This is particularly relevant in the context of armed conflict areas in the Philippines.

- In order to prevent GBV, UNFPA should have an interconnected overarching approach strategy, which includes: preventing violence (zero tolerance), strengthening legal and policy frameworks, and continue improving response services to victims-survivors and their affected family members. For CP8, UNFPA should focus on primary prevention strategies aimed at preventing violence before it happens. Prevention efforts should start early in life and be directed to girls and boys through transformation of norms and behaviors that underpin GBV.

- UNFPA to support programmes that recognize multiple expression of violence that are occurring in various contexts such as: inter-personal violence, sexual violence by non-partners, conflict-related SGBV, early/forced child marriage, violence against LGBTI persons, trafficking in human beings, women and men in prostitution, women and girls belonging to minority and indigenous groups, women and girls with disabilities and elderly women.

- A well formulated comprehensive sexuality education (CSE) programme and gender sensitive programming approach may serve as a platform to change deep-rooted social norms related to gender relations

- Employ life cycle approach to combat GBV: GBV can occur throughout a person's life cycle hence it is suggested to identify different forms of violence that may be experienced throughout a person's life (female and male) – from pre-natal to infancy, childhood, adolescence, adulthood, and old age.

- In designing CP8, UNFPA could learn from good practice examples of GBV prevention projects. Some highly recommended and documented examples are: (1) SASA (Uganda), which addresses the core drivers of VAW; (2) Engaging Young Men for Gender Equality (PROMUNDO); and (3) Women, Citizenship and Peace building (DR Congo).

Recommendation 7 (linked to conclusions 2, 4, 5,6,7,8): More research to understand population dynamics and the changing attitudes and behavior

More research is needed to understand population dynamics and the changing attitudes and behavior of population groups particularly the youth (girls and boys), migrants and the older persons. The quality of UNFPA research outputs, policy briefs and other knowledge products must be ensured through the reactivation of a multi-disciplinary research advisory team to review research proposals and to vet potential research publications or policy papers.

Responsibility: Country Office, HQ and other donor partners, Priority level: High

UNFPA Country Office:

- Support to strengthening the generation, analysis and dissemination of data needed for policy planning and programming particularly at the municipal/city and barangay levels.
- Continue support for research on fertility, mortality, migration, SRH, health and nutrition, employment, schooling and their interrelationship with development as they relate to the implementation of the PDP Chapter 13 on DD.
- Continue advocacy for youth participation in the implementation of the DD plans and programmes in accord with PYPD and PDP.
- Integrate Population dynamics within SDG agenda at national/regional/LGU development and planning processes.
- Make disaggregated data (by sex and age at a minimum) available for gender analysis to improve gender-sensitivy and finally to make CP8 gender-tranformative.

UNFPA HQ or other donor partners:

- Continue support for research dissemination activities at both national and international levels to ensure that research findings are integrated in policy advocacy and targeted programme/planning processes.
- Advocate for support for capacity building for the next generation of PD, SRH, GE thought leaders through scholarships and research funds for young demographers, econometricians and statisticians.
- The reactivation of the research advisory board and leverage funds for scholarships through other sources. This includes not only scholarships but also research funds for young researchers who will be the next generation of thought leaders in the fields of PD, SRH, GE.

Recommendation 8 (linked to all conclusions): Support to data accessibility and availability

Strategic interventions to make data accessible and available for evidence-based planning and policy making. (This applies to all programme areas – SRH, GE and GBV, PD and Humanitarian response – and covers most of the conclusions in general)

Responsibility: Country Office, Priority level: High

Continue to support the building of national capacities for data collection, analysis, dissemination, and in fostering the use of data to inform evidence-based policies. Continue to support increased availability of disaggregated quality data for evidence-based policymaking, planning, implementation, monitoring and evaluation. Data harmonization (for all administrative data, like for GBV) to be achieved through inter-agency work on data acquisition, as well as inter-agency collaboration and partnerships to move forward the ICPD agenda. Appropriate data to be made available to perform gender analysis, where applicable, for designing, planning and implementing of CP8 interventions.

- UNFPA has technical capacity and the relationships in place to support the Government to strengthen the evidence-base for national development planning. Build on the past work and the relationships in place to support other studies, e.g., on DD, Youth, ASRH, GBV, etc.
- Support training on small-area estimation of demographic indicators in partnership with an academic institution that will institutionalize the updating of small-area estimates of demographic indicators and provide future technical assistance to LGUs on appropriate use and interpretation of demographic indicators for policy and planning.

- Besides counting and profiling of affected population for administrative purposes, the collected basic demographic data may be used for monitoring and further analysis of population processes among the displaced population in aid of policy and program development.

Note:
The following documents/annexes form CPE part 2 and are in the following order.

Annexes

(Annex 1- 5 CPE required documents)
Annex 1 Terms of Reference
Annex 2 List of Persons/Institutions met
Annex 3 List of documents consulted
Annex 4 Evaluation Matrices
Annex 5 Data Collection Tools

Annexes A-E: Additional information for reference
Annex A CP7 Site selection criteria (A1) and Output Level Performance Data (A2)
Annex B PD Research Studies and Surveys under CP7
Annex C RH Policies in local government units enacted during CP7 (as of October 2017)
Annex D Programme Intervention Logic (SRH, PD and GE)
Annex E UNFPA Coordination – working groups