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Deepening the Narrative: Qualitative Follow-up Study on the Third Impact Evaluation of *Pantawid Pamilya*

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Abstract

Consistent with previous evaluations, the third wave impact evaluation (IE3) of the Pantawid Pamilyang Pilipino Program provided evidence that the program is able to achieve its main goal of keeping children healthy and in school. However, the evaluation also noted unexpected results on some outcomes, specifically, child nutrition, maternal health, and labor market outcomes. The results of this study will benefit key stakeholders through the provision of inputs and recommendations on the general program design and implementation of Pantawid Pamilya, and other interventions specific to the selected outcomes of the study.

The study employs a qualitative methodology to gain deeper insights into these unexpected findings through the conduct of focus group discussions with program beneficiaries and non-beneficiaries from identified areas in IE3, and key informant interviews with program stakeholders. Thematic analysis is utilized to analyze interview transcripts to tease out relevant themes in the discussions. The analysis of the results shows that the lack of proper understanding of the importance of postnatal check ups can be the reason of low availment even if the utilization of pre-natal check-up is high. In the case of nutrition, there appears to be no differences in knowledge, attitudes, and practices (KAP) or supply-side factors between Pantanwid beneficiaries and their counterpart non-beneficiaries. Thus, the explanation for the perverse program impact on stunting may come from factors other than KAP or supply side factors. Finally, perverse employment outcomes appear to be the result of low educational attainment, and lack of and seasonality of job opportunities. Beneficiaries expressed preference for livelihood over employment because it is compatible with housework and expressed their hopes and aspirations that the Sustainable Livelihood Program (SLP) will be strengthened. The study recommends reinforcing the knowledge on maternal care. It is also recommends that a more indepth study on the source of the perverse impact on stunting be undertaken. Finally, it recommends that barriers to employment of Pantawid beneficiaries be addressed including the strengthening of the SLP.

Keywords: Cash transfers, health, nutrition, stunting, labor supply, adult work incentives

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Deepening the narrative: Qualitative follow-up study on the third impact evaluation of *Pantawid Pamilya*

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1. Introduction

1.1. Background

The Pantawid Pamilyang Pilipino Program or 4Ps is the Philippines' largest social protection program encompassing more than 4 million[2] households across the country. The main objective of the program is to break the intergenerational transmission of poverty through human capital investments in children from poor households. This is achieved through the provision of grants to support the health of program beneficiaries, particularly mothers and young children, and the education of school-aged children, contingent on compliance with program conditions.

Embedded in the program is a strong monitoring and evaluation (M&E) system in order to assess its performance in achieving its stated objectives. The main component of this M&E system is the conduct of regular impact evaluations to measure the impact of the program on outcomes such as education, health, and other related outcomes.

Since the program's inception in 2008, three impact evaluations have been conducted. These evaluations have found that the program generally has made gains toward its main objectives of instigating improvements in the domains of education and health, as well as socio-behavioral outcomes of program beneficiaries.

In the most recent evaluation, the 4Ps Third Wave Impact Evaluation (IE3) confirmed most of the results of the first two evaluations that the program was able to achieve significant gains in its target outcomes in education, health, and household welfare. However, the third wave evaluation also presented some results that are unexpected as well as confounding. This study is a follow-up study that delves deeper into these unexpected results of the IE3 on select maternal and child health, and labor outcomes.

The IE3 results show that the goal of increasing maternal health service utilization is only partially achieved by the program. The evaluation observed an increase in the utilization of prenatal care among beneficiary mothers, but not for utilization of postnatal care. The study aims to identify the factors that result in this discrepancy in the uitilization of maternal health care services and pathways through which this issue can be addressed.

Another concerning result in IE3 is increase in prevalence of severe stunting among program beneficiaries, despite positive results on this outcome in previous evaluations. Although this is partly explained by the accompanying IE3 RCT cohort study, this outcome still needs further investigation. The IE3 RCT cohort study, which focuses on

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[2] As of June 30, 2020

children that received program inputs at the critical period of their first 1000 days of life, observed a significant decrease in severely underweight children and positive, albeit insignificant, impacts on other nutrition outcomes analyzed. This difference highlights that timing of inputs is also crucial in instigating impact on nutrition outcomes of children. This will be explored further by looking at supply-side factors, re-evaluating the grant amount provided by the program, and assessment of the monitoring of program conditionalities.

Given that health outcomes, specifically those on maternal and child health, depend on inputs not just from the 4Ps, but also other stakeholders, such as the local health centers, these results could be explained by a number of factors and interpretation may not be as straightforward compared to other outcomes. With the conflicting findings for health outcomes in previous evaluations, it is important to understand supply-side conditions, as well as community knowledge, attitudes, and practices towards health-seeking for a more rounded analysis.

Finally, although program beneficiaries and non-beneficiaries are equally likely to be members of the labor force, Pantawid beneficiaries were observed to have a lower likelihood of being employed. In the urban/rural subgroup analysis, this difference was mostly isolated to beneficiaries in rural areas. Given this finding, the study aims to explore urban/rural heterogeneities in employment observed in IE3. The study will seek to investigate possible shifts in employment types and productivity, as well as compare experiences of urban and rural beneficiaries with regard to employment and job-seeking.

The results of this study will benefit key stakeholders through the provision of inputs and recommendations on the general program design and implementation of *Pantawid*, and other interventions specific to the selected outcomes of the study. An assessment of supply conditions, specifically health services will also be conducted in order to ascertain the extent to which they affect health service utilization and inform service providers whether interventions need to be initiated in this regard.

1.2. Objectives of the study

The study aims to gain deeper insights into select outcomes of the third wave impact evaluation (IE3) of the Pantawid Pamilyang Pilipino Program (4Ps), particularly outcomes wherein unexpected results were observed. Specific objectives of the study are as follows:

1) Survey supply side conditions, particularly in sites where unexpected results are concentrated;
2) Look into the type and quality of services being accessed by beneficiaries;
3) Investigate issues on the provision of health services and the corresponding reaction or demand from beneficiaries;
4) Look into health seeking behavior surrounding maternal health services and child health services, and the factors mediating health seeking behavior;
5) Examine infant and young child feeding knowledge and practices among Pantawid households; and

6) Conduct further investigation of heterogeneity in impact on labor market outcomes between urban and rural areas—particularly with regard to possible shifts in employment types, and productivity.

2. Review of IE3 Findings

2.1. Methods

The third impact evaluation of Pantawid Pamilya utilized quantitative methodologies, specifically Regression Discontinuity design (RDD), to measure program impact. RDD is a quasi-experimental research method which measures program impact by comparing groups above and below a pre-determined cutoff of program eligibility, such as the poverty threshold in the case of 4Ps. Observations above and below the threshold are selected as treatment and comparison groups, working under the assumption that observations close to the threshold of the running variable are similar and comparable (Thistlewaite and Campbell, 1960). This method was selected given the wide expansion of the program, making it difficult to establish a control group for a Randomized Control Trial (RCT) which is the gold standard for an evaluation. Although RDD is known to have strong internal validity, the limitation of this methodology is that it can only measure impact for observations close to the poverty threshold, excluding program beneficiaries at the lower end of the poverty scale.

2.2. Findings

Overall, the IE3 observed positive impact on outcomes such as education, child and maternal health, and household welfare. However, the evaluation also noted unexpected results on some outcomes, specifically, child nutrition and maternal health, and labor market outcomes.

The previous evaluations found improvements in terms of utilization of maternal health services. The first and third impact evaluations observed positive impact on attendance to prenatal checkups for Pantawid mothers. Positive results were also found on postnatal checkups, with Pantawid mothers having a higher likelihood of attending a postnatal check-up by a skilled health professional and in a health facility in the first and second visits. This positive result for postnatal care was not observed in IE3.

With regard to child health and nutrition outcomes, the evaluations show that the program is able to initiate positive effects on a number of outcomes, particularly those that correspond to program conditions. Practice of regular weight monitoring, and provision of vitamins and supplements such as Vitamin A and deworming pills is significantly higher for beneficiary children. However, contrary to previous findings, severe stunting was found to have a significantly higher prevalence among Pantawid Pamilya children in IE3. Although this is explained in part by the IE3 RCT Cohort Study – which shows positive impacts on child nutrition outcomes when the sample is restricted to a specific cohort which received program benefits at critical periods of development – this outcome needs to be explored further in order to identify the root causes of this finding and develop appropriate interventions.

Previous impact evaluations of Pantawid Pamilya have established that the program does not foster dependency. Positive impacts on labor market outcomes were observed in IE 2 and 3, particularly for job-seeking, secondary employment, and work hours. However, IE3 also observed lower employment among program beneficiaries, with impact concentrated on beneficiaries in rural areas. Although labor force participation is not significantly different for both groups, this finding warrants further investigation of urban-rural heterogeneities in types of employment opportunities and job-seeking.

2.3. Comparison of IE3 findings with available literature by outcome group

2.3.1. Utilization of Maternal Health Services

Many studies have noted positive impact of CCTs on the utilization of health services, not only among beneficiary children, but also among mothers (Bastagli et al. 2016). This is attributed to program conditionalities, additional resources to avail of health care, and supply-side improvements (Barber and Gertler 2008). In addition to this, an important factor noted was also the provision of workshops or seminars to beneficiaries that educate households on topics such as childcare and proper health practices—comparable to the Family Development Sessions implemented by Pantawid Pamilya.

With regard to prenatal care, the literature points towards an increase in prenatal care visits among beneficiary mothers. However, positive impact is more generally observed only for uptake of at least one prenatal visit during pregnancy (Barber and Gertler 2008; World Bank 2011). Findings are still mixed on attendance to multiple prenatal care visits during a pregnancy (Lim et al 2010), but nominally, the average number of prenatal care visits attended by beneficiary women are high (de Brauw and Peterman 2011).

Evidence on the positive impact of CCTs on postnatal care is still limited (de Brauw and Peterman 2011; Bastagli et al. 2016; Cahyadi et al. 2018). Similar to the observation in IE3, an obstacle to achieving impact on postnatal care has been identified as problems in messaging. This needs to be explored further in order to determine whether there is a need to focus FDS messaging, particularly for maternal health care—or to identify other obstacles and possible interventions in this regard.

2.3.2. Child Nutrition

CCTs have been observed by multiple studies to have a positive impact on child nutrition outcomes. With regard to stunting, studies on the PKH in Indonesia, and RPS in Nicaragua, observed declined prevalence of stunting among CCT beneficiary children. (Cahyadi et al. 2018; Maluccio and Flores 2005). However, this is not consistent across all contexts. A review of studies on the impact of CCTs on nutrition found that, in sum, CCTs tend to have a nominally positive, but insignificant, impact on the nutritional status of children (Manley et al. 2013). Some studies did not observe significant impact on stunting but noted an increase in height-for-age measures (Gertler 2004; Attanasio et al. 2005; Leroy et al. 2008; Macours et al. 2012).

The first impact evaluation of Pantawid also observed a significant decline in stunting, however no significant impact was observed in IE 2 (DSWD and WB 2013). Contrary to the results of the IE3 main study (RDD), the RCT Cohort sub-study of IE3 observed no significant impact on stunting. This suggests that timing is a crucial factor in achieving the desired impact on nutrition. In addition to this, positive impact on child nutrition outcomes is commonly attributed to the availability and accessibility of health services, and length and timing of exposure to program benefits, maternal education, as well as workshops and counselling for beneficiary households (Gertler 2004; Lagarde et al. 2009; Manley et al. 2013).

There have also been instances where negative impact on nutrition outcomes has been observed. This is commonly attributed to an incentive effect—wherein households operate under the misconception that inclusion in the program depends on the child's being malnourished and improvements in the nutritional status of the child will result in the household being excluded from program benefits (Morris 2004). Buser et al. (2014) also observed negative impact of income fluctuation—due to changes in eligibility status for the cash grant—on stunting and anthropometric measurements (i.e. height and weight) of young children.

2.3.3. Labor Market Outcomes

Previous impact evaluations of Pantawid Pamilya did not observe negative impact on labor market outcomes such as employment, job-seeking, and work hours (DSWD 2011; DSWD 2014). This is consistent with the most findings of the international literature on CCTs and adult labor outcomes, which observe no significant impact on adult work incentives (Maluccio and Flores 2005; Skoufias and di Maro 2006; Maurizio 2011 in ECLAC and ILO 2014)

In IE3, however, some contrary results on labor market outcomes were observed—particularly with regard to employment which are inconsistent with general findings on the impact of CCTs. Some studies did observe some indications of negative impact on adult labor market outcomes, these were often coupled with urban-rural heterogeneities in impact.

In Brazil, decreased work hours were observed among rural beneficiary mothers and urban beneficiary fathers (Ferro and Nicollela 2007). These outcomes were often explained as beneficiary parents needing to spend more time on childcare in order to comply with program conditions. This is exacerbated in rural settings given that there is less access to schools and fewer transportation options in these areas. Another explanation is that the household is able to afford more leisure time since they have an additional income source.

There were also observations of shifts in employment types. PROGRESA beneficiaries were observed to shift away from agricultural employment to other employment types which provide higher income (Alzua et al. 2013).

Banerjee et al. (2017) also observe that cash transfers can have both positive and negative impacts on labor supply and demand. Effects of cash transfers on labor are not

straightforward and depend on factors such as program design and underlying economic conditions, therefore further inquiry needs to be done specific to the Pantawid Pamilya.

3. Research Design and Methodology

3.1. Conceptual Framework

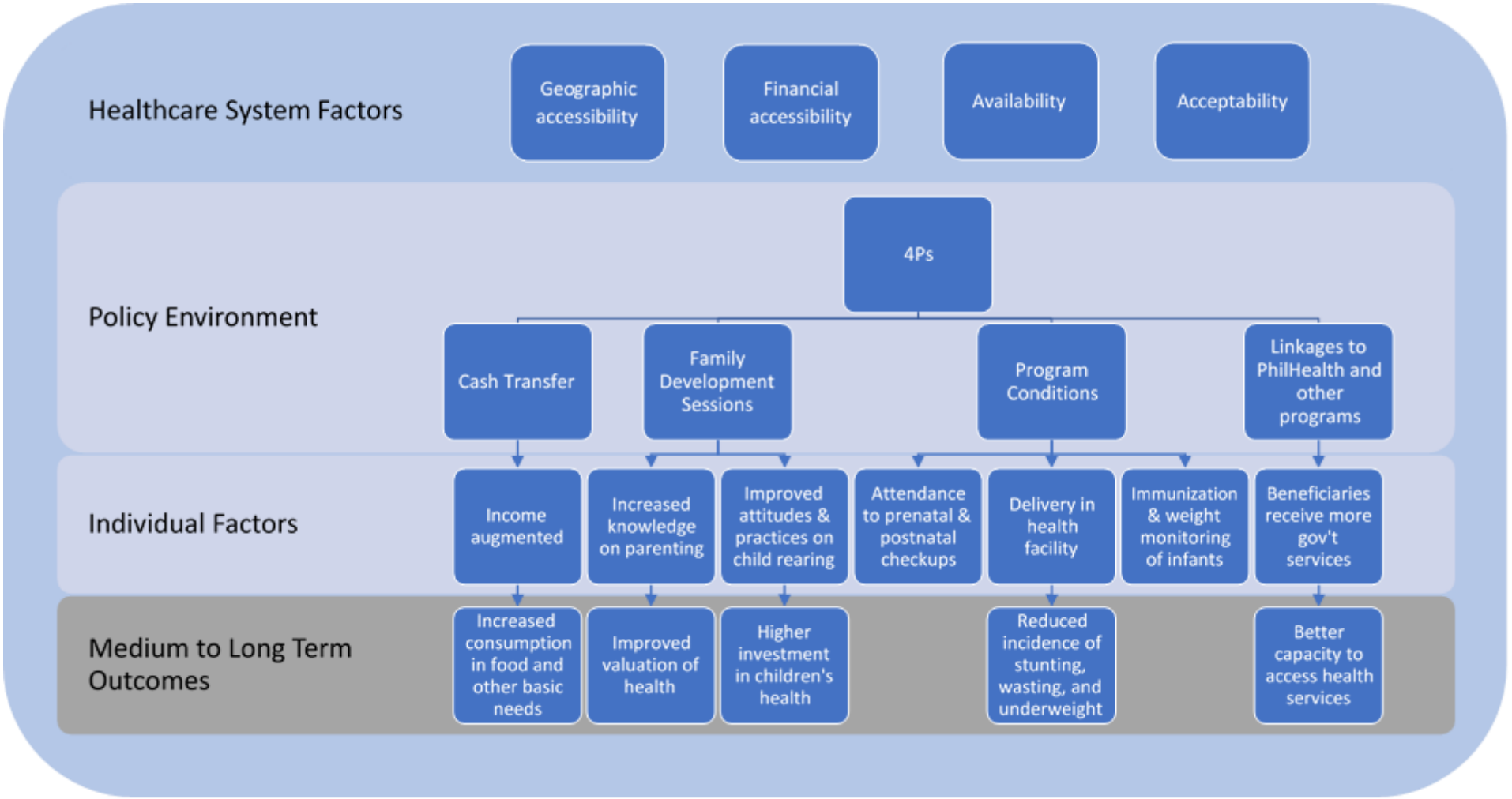
For the health component of the study, analysis will be conducted based on the theory of change detailed in the Third Wave Impact Evaluation of Pantawid Pamilya and the conceptual framework forwarded by Peters et al. (2008). This framework presents factors that contribute to health outcomes in the context of Pantawid Pamilya under three categories: (1) Policy Environment, (2) Individual Factors, and (3) Healthcare System Factors (see Figure 1).

The policy environment refers to programs and services that affect the supply and demand for health services in a community. Program inputs from Pantawid Pamilya are expected to affect individual factors with regard to health-seeking behavior. This set of factors will be analyzed in terms of four main codes namely provision of cash grants, monitoring of program conditions, provision of learning sessions (i.e. FDS), and linkages to other programs and services.

Individual factors pertain to factors identified by the study team which describe individual knowledge and practices of respondents with regard to health-seeking behavior, as well as their socioeconomic background and sources of information. Figure 1 illustrates the specific behaviors the program is expected to have an influence on, particularly with regard to maternal and child health.

Lastly, healthcare system factors, namely geographic and financial accessibility of the health facility, availability of services and supplies, and acceptability of these to the community, are considered the mediating factors to the overall access to healthcare services. These encompass both individual factors and policy environment in the community since these determine the availability of healthcare services for a particular community.

Figure 1. Framework for cash transfers and access to health services

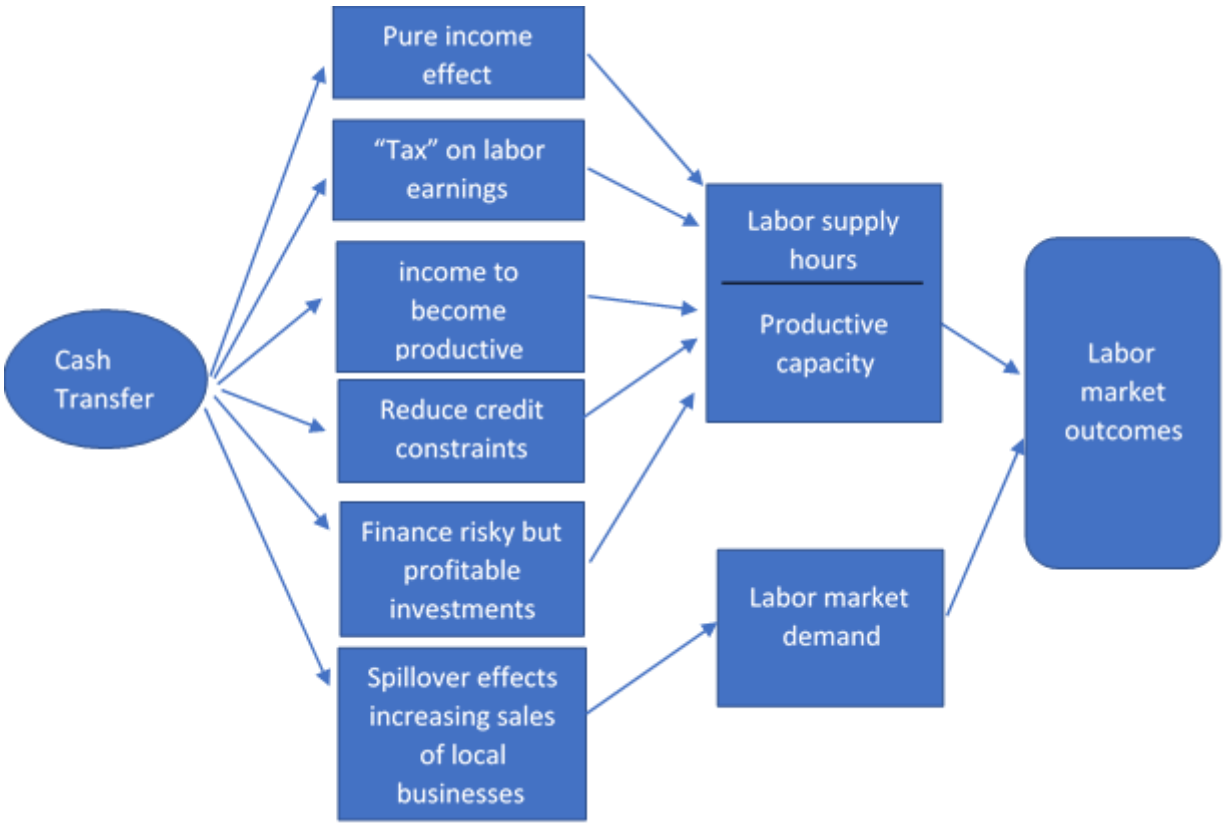


Source: Authors interpretation

With regard to labor market outcomes, the theory of change of Pantawid Pamilya expects the cash transfers to augment household income and increase consumption and investments in children's education and health. The cash transfers, however, are not expected to encourage dependency. Despite some mixed findings in IE3 with regard to labor market outcomes, the study concluded that these were not indications of dependency. Rather, the results were observed to be suggestive of a lack of available jobs, and a shift in types of employment. These hypotheses are to be validated by deeper investigation of the labor market and decision-making of households in urban and rural areas.

Following Banerjee et al. (2017), cash transfers can have both positive and negative impacts on labor supply and demand. Treated as a pure income effect, it can increase purchase of leisure lowering the labor hours. It can also be thought of as some form of a "tax" that discourages beneficiaries from working and earning more if it would result into their ineligibility from the program. It can also provide enough sustenance and make the beneficiary productive for work and/or more work. For those who are facing credit constraints, it will unlock opportunities for productive economic activities. It can also enable engaging in risky but profitable investments not available before. Finally, cash transfers may have spillover effects in local markets that may, in turn, increase overall labor demand. It is not clear theoretically which of these effects will dominate, hence, the impact of cash transfers is an empirical issue (see Figure 1Figure 2).

Figure 2. Framework for cash transfers and labor market outcomes



Source: Adapted from Banerjee et al. (2017)

3.2. Data Sources

3.2.1. FGDs

The study conducted a total of 32 focus group discussions (FGDs). The sample is composed of two municipalities from each island group (i.e. Luzon, Visayas, Mindanao), and two municipalities from NCR—with two barangays per municipality (Table 1). The sampling of municipalities and barangays was based on the areas sampled in IE3.

Table 1. Study sites by urban/rural classification

Cluster	Urban	Rural
NCR	Quezon City (2 barangays) Mandaluyong City (2 barangays)	N/A
Luzon	Nueva Ecija (2 barangays)	Pangasinan (2 barangays)
Visayas	Iloilo (2 barangays)	Northern Samar (2 barangays)
Mindanao	Agusan del Norte (2 barangays)	Zamboanga del Norte (2 barangays)

The study interviewed both beneficiaries and non-beneficiaries of the program in the sampled areas. The target respondent is the mother/main caregiver/guardian of the children in the household.

Beneficiaries were asked questions regarding their knowledge, attitudes, and practices on maternal health service utilization, and child health and nutrition, and their main sources of information on these topics. They were also surveyed on their access to health facilities and health services, and their assessment of the provision of these services in their community. Questions on household welfare were also asked, specifically on the sufficiency of their household income, coping mechanisms, and their main source of income and employment.

3.2.2. KIIs

Key informant interviews were conducted with program implementers, namely, the DSWD City/Municipal Link/s (C/ML) assigned to the sampled area, and health facility heads or staff from health centers in the community.

The main objective of the KIIs were to gain insights on their assessment of beneficiaries' health-seeking behavior and learn of how compliance monitoring and updating are conducted in their area of assignment.

The study conducted key informant interviews with health facility heads or staff in 18 health facilities. The top three health facilities per municipality mentioned by respondents as the main health facility that they visit were selected. When applicable, one barangay health station (BHS) and one rural health unit (RHU) per municipality, were selected.

Two DSWD City/Municipal links were interviewed per municipality, one per sampled barangay. DSWD C/MLs were interviewed regarding compliance to conditionalities, supply side condition in area, beneficiaries' access to health services, topics covered in the family development sessions, particularly those pertaining to maternal and child health, and their opinion whether these are sufficiently discussed. C/MLs were also asked regarding updating and monitoring of compliance to program conditions. Questions on beneficiary updating focused on pregnancy or newborn updating in order to ascertain if new pregnancies or newborns are monitored for compliance to program conditions.

3.3. Data collection implementation

The selection of target FGD sites was guided by need to cover the range of experience that will reveal the range of issues identified by the evaluation questions. Study sites were identified based on IE3 nutrition outcomes, selecting sites with high prevalence among the treatment group relative to the control group, and vice versa. The team also considered urban and rural classifications in the selection of sites to allow for some comparison, given urban/rural heterogeneities observed in the third wave evaluation. The selected sites by nutrition outcomes are presented in Table 2.

Two municipalities were selected for each island group, and two cities for NCR. Selection of these followed the following criteria:

- One municipality/city with relatively good outcomes (results for treatment are better than comparison group); and
- One municipality/city with relatively bad outcomes (results for treatment are worse than comparison group)

Table 2. Distribution of study sites by nutrition outcomes

Cluster	Negative Impact on Stunting	Positive Impact on Stunting
NCR	Quezon City (1 barangay) Mandaluyong City (1 barangay)	Quezon City (1 barangay) Mandaluyong City (1 barangay)
Luzon	Nueva Ecija (2 barangays)	Pangasinan (2 barangays)
Visayas	Iloilo (2 barangays)	Northern Samar (2 barangays)
Mindanao	Agusan del Norte (2 barangays)	Zamboanga del Norte (2 barangays)

Note: Study sites are identified using estimates of nutrition outcomes of IE3

The implementation of field activities under the project was done in two phases. The first phase covered study sites in NCR and Luzon, implemented from October to November 2019. The second phase of field visits cover study sites in Visayas and Mindanao, which were conducted from January to March 2020.

The main local contact of the study team was the DSWD city/municipal links. Activities in the study areas were coordinated with concerned DSWD C/ML, as well as the local chief executive or city/municipal health officer for health facilities.

Respondents for focus group discussions were pre-identified by the study team from the sample of 4Ps IE3. Focus group discussion participants were located and mobilized by the C/MLs. Replacements were identified and provided for respondents who could not be located or were not available to join the interview.

The study team developed questionnaires for both focus group discussions and key informant interviews in order to elicit responses to topics of interest/guide flow of the discussion. The interviews followed a semi-structured format. The duration of focus group discussions averaged 1.5 hours per session, while key informant interviews averaged around 1 hour per session. Study participants provided informed consent prior to participation in the interviews. Interviews were recorded with consent of the participants for later transcription and translation.

Interview questionnaires were translated to Filipino and administered in the same. The main language used in all interviews was Filipino. In areas where Filipino was not the local language, translation and clarification of interview questions and responses were facilitated by members of the study team knowledgable in the local language (i.e. Ilocano and Bisaya).

Two of the key informant interviews were conducted over online teleconferencing due to limitations in mobility due to the COVID-19 pandemic.

3.4. Method of analysis

The study employed thematic analysis to analyze qualitative data collected from focus group discussions and key informant interviews conducted by the study team. The steps followed are summarized in Box 1. This involves qualitative coding of interview transcripts in order to organize the data and identify themes that emerged during the interviews (Maguire and Delahunt, 2017).

Recordings of interview proceedings were transcribed and translated in order to facilitate analysis. Transcribers proficient in the native language of the interview participants were outsourced to translate sections of the interview that were in the local language of the interview participants. Final interview transcripts were checked and validated by the study team.

Computer-assisted qualitative data analysis software (CAQDAS), specifically NVivo, was used in the thematic analysis of interview transcripts. Transcripts were coded into pre-determined themes based on the interview questionnaire and data exploration was conducted using the "query" command of NVivo. Themes were further refined and focused in succeeding rounds of coding.

Patterns were identified within respondent groups and with comparison of subgroups. Subgroups were analyzed based on urban-rural characterization and groupings of municipalities based on IE3 nutrition outcomes. Lastly, triangulation was done through comparison of responses of beneficiaries, non-beneficiaries, DSWD program staff, and health facility.

Box 1. Data analysis procedure

1. Cleaning of interview transcripts
2. Import of interview transcripts to NVivo
3. Generation of cases and import of classification sheets to NVivo
4. Coding of data into pre-determined themes
5. Exploration of data using "query command"
6. Refinement of themes

3.5. Limitations

As a follow-up study to the Third Impact Evaluation of Pantawid Pamilya, the main objective of the study is to delve deeper into issues which arose from the previous impact evaluation. However, it must be noted that unlike the quantitative evaluation, differences observed between beneficiaries and non-beneficiaries are illustrative and are based on narrative accounts of the respondents. Limitations of thematic analysis are acknowledged by the study and interventions are implemented at various stages of the research process to minimize validity and reliability issues (Nowell et al., 2017).

At the interview stage, the study team anticipated potential biases for both interviews and respondents. To preempt biases on the side of the respondents, interview facilitators provided a short briefing on the objectives and purpose of the study, role of the study team, and obtained informed consent of interview participants prior to the conduct of each interview. In particular, program beneficiaries as well as program staff were reassured that responses to the interviews would remain confidential and would not affect their membership or employment in the program. On the interviewer side, probing was employed to limit biases such as acquiescence bias, wherein respondents have a tendency to agree with the interview moderator, or habituation bias, wherein respondents tend to give the same answers for questions that are repetitive or similar. Interviewers also avoided prompting of respondents and reiterated responses of repondents to allow room for clarification.

The study conducted thorough documentation of the interview proceedings. Interviews were recorded using an audio recorder and notes were taken during interviews. Audio recordings were transcribed and translated after for proper documentation and to support data analysis.

Measures are also taken in the analytic process to ensure credibility of study results. Triangulation is done by comparing responses of different groups of respondents, namely program beneficiaries, non-beneficiaries, DSWD program staff, and health facility staff, for cross-validation. Analytic memos are taken down using features provided by the CAQDAS during thematic coding in order to record coding decisions of the researcher. Observations are detailed comprehensively through use of thick description to capture the appropriate context of responses.

4. Results

4.1. Profile of Respondents

This section provides a brief discussion on the profile of respondents for FGDs and KIIs conducted under the study. Data on FGD respondents was collected using a brief survey questionnaire administered prior to the survey.

4.1.1. Descriptive statistics

4.1.1.1. *FGD Respondents*

The study conducted 32 FGDs across 16 barangays, with a total of 265 respondents. Two groups of respondents were interviewed per barangay, namely 4Ps beneficiaries and non-4Ps respondents from the identified comparison group in IE3. Of the 295 respondents, 135 were 4Ps beneficiaries while 160 were non-4Ps respondents, breakdown of respondents by cluster and beneficiary status can be seen in Table 3.

Table 3. FGD respondents by island cluster

Cluster	4Ps	Non-4Ps	Total
NCR	36	33	69
Luzon	34	53	87
Visayas	29	46	75
Mindanao	36	28	64
Total	**135**	**160**	**295**

Comparison households in the previous impact evaluations are households in the same barangay as the treatment households and have children 0-18 years old or pregnant household member at the time of targeting. These households have PMT scores on or slightly above the poverty thresholds for the province, hence they are expected to have comparable the demographic and household profile to the treatment group.

Majority of the 4Ps respondents reported having at least 7 years of program exposure at the time of the FGD (Figure 3). 85% of the respondents were the designated 4Ps grantee of the household, with 20 respondents (15%) reporting that they were parent leaders under the program (

Table 4).

Figure 3. Percentage distribution of 4Ps participants based on years of program exposure

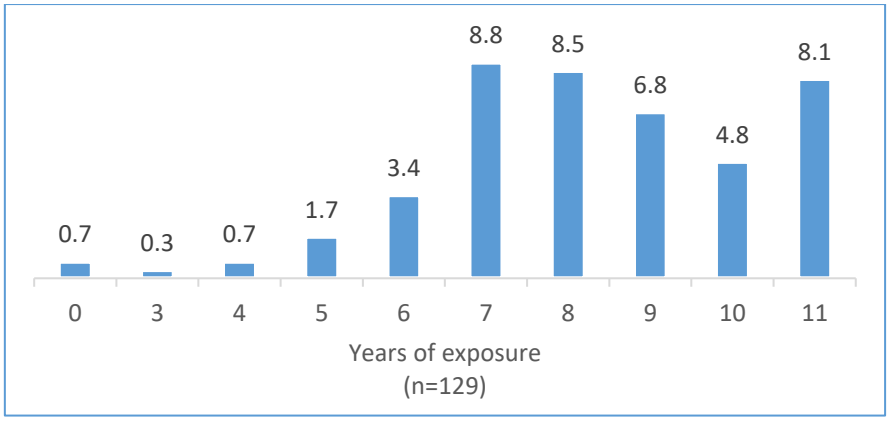


Table 4. 4Ps respondent characteristics

Characteristic	Percentage
Parent Leader	15%
Grantee	85%

Given the length of their membership in the program, 4Ps respondents also come from an older age demographic, with the average age of respondents being 44 years old (Table 5). The average age of non-4Ps respondents is also similar at 46 years old.

Majority of the respondents were female (91%) as the target respondent for the FGDs was the mother or main caregiver in the household. The proportion of female respondents among non-4Ps respondents is slightly lower, at 84%, but female respondents still comprise most of the sample on average 87%.

Table 5. Demographic characteristics of FGD respondents

Characteristic	All	4Ps	Non-4Ps
Age	45	44	46
Female	87.3%	91.0%	84.3%

The household size of 4Ps and non-4Ps respondents both average at six household members (Table 6). The average number of monitored children in 4Ps households is two, since many of the respondents report that they already have children who have graduated from the program. Although the number of children at ages eligible for the grant (0-18 years old) in 4Ps houseoulds is three, some of the children may be extended relative of the grantee living under the same household. The number of children aged 0-18 years old in non-4Ps households is lower at two children.

Table 6. Household characteristics by FGD group

Characteristic	All	4Ps	Non-4Ps
Household size	5.6	5.7	5.6
No. of children aged 0-18	2.6	2.8	2.4
No. of monitored children	n/a	1.7	n/a

Half of the respondents are employed or engaged in business (Table 7). This is slightly higher for 4Ps respondents (51.9%), compared to non-4Ps (48.1%). Employment is low

among FGD respondents since most are the primary caregivers of children in the household and report that it is their spouse that is the breadwinner of the household. Employment among respondents in urban areas is higher compared to rural areas, at 56% and 39%, respectively (Table 8).

Among those working, most of the respondents reported that they were in casual employment or the informal sector. These include laundry jobs, food or produce vending, or farm labor. A few also reported being employed by the barangay as administrative or health facility staff. Majority of respondents with businesses owned neighborhood "sari-sari" stores, some were engaged in buy and sell businesses, while others were engaged in animal breeding.

More than a quarter of 4Ps respondents reported being members of the DSWD's Sustainable Livelihood Program (SLP). In contrast, only 3 non-4Ps respondents (1.9%) reported being part of the program. For both groups, majority of the beneficiaries were under the micro-enterprise development track, with only one beneficiary of the employment facilitation track among the respondents.

Table 7. Livelihood and employment by FGD group

Characteristic	All	4Ps	Non-4Ps
Job or business in past week	49.8%	51.9%	48.1%
SLP beneficiary	13.6%	27.1%	1.9%

Table 8. Employment by urban/rural classification

Employment status*	Urban	Rural
Employed	56%	39%

*Job or business in past week

4.1.1.2. *KII respondents*

The study conducted key informant interviews with various program stakeholders and implementers in order to cross-validate responses by gathering multiple perspectives on the program. KIIs were conducted with program implementers and staff, specifically the DSWD Pantawid National Program Management Office (NPMO), DSWD city/municipal links from barangays visited, and health facility staff from identified health centers in the communities.

All of the health facilities visited were government facilities, as these are the ones partnered with 4Ps to monitor beneficiary compliance to health conditions. A total of 19 health facilities were visited, 10 barangay health stations, 8 rural health units, and one birthing home (Table 9). The study team was unable to interview health facility staff for one of the sites visited due to unavailability of the focal person for the health facility, however the checklist for the facility was administered successfully. A total of three health facilities per municipality were selected, specifically one barangay health station (BHS) per barangay and one rural health unit (RHU) per municipality. The study selected health facilities which were reported to be most frequently visited by IE3 respondents. The study team was unable to conduct interviews for 6 out of 24 identified

health facilities due to identification issues, and logistical and safety concerns because of the COVID-19 pandemic.

Table 9. Types of health facilities visited

Characteristic	Freq.	Percentage
Barangay Health Station	10	50%
Rural Health Unit	8	44%
Birthing Home	1	6%

Key informant interviews were conducted with respondents from 18 health facilities (Table 10. The intended respondent for interviews with health facilities is the facility head or 4Ps focal person. The designation of interview respondents was usually midwife or doctor at the health facility since they are usually the most knowledgeable on the role of the health facility in the implementation of the Pantawid Pamilya program.

Table 10. Designation of health facility respondent

Designation	Freq.	Percent
Midwife	7	39%
Doctor	5	28%
Nurse	2	11%
BNS	1	6%
Municipal Population Officer	1	6%
Nurse Assistant	1	6%
Public Health Nurse	1	6%
Total	**18**	**100%**

The study team targeted one city/municipal link per barangay for key informant interviews. A total of 16 key informant interviews with DSWD C/MLs were conducted (Table 11). Most C/MLs graduated with degrees in Social Work. Majority of the respondents have served as C/MLs for at least six years and have been assigned to their current area of assignment for more than four years. Reported caseloads range from 680 to almost 1000 households, with the average being around 780 households.

Table 11. City/Municipal link profile

Variables	Mean	Obs.	Min.	Max.
Number of years as C/ML	6.4	16	1	9
Number of years in area of assignment	3.9	16	0.67	7
Number of households in caseload	781	16	678	980

4.1.2. Background information on the areas included

The study team conducted focus group discussions and key informant interviews in a total of eight cities and municipalities. Study sites included two cities from NCR, and one urban and one rural area each from each of the three major island clusters. Two barangays were selected from each municipality by ranking barangays based on results of nutrition outcomes in IE3, for a total of 16 barangays in the sample (Table 12).

Table 12. Study sites by urban/rural classification

Cluster	Urban	Rural
NCR	Quezon City (2 barangays) Mandaluyong City (2 barangays)	-
Luzon	Nueva Ecija (2 barangays)	Pangasinan (2 barangays)
Visayas	Iloilo (2 barangays)	Northern Samar (2 barangays)
Mindanao	Agusan del Norte (2 barangays)	Zamboanga del Norte (2 barangays)

Three municipalities and five cities were included in the study areas (Table 13). Income class of rural areas range from 3rd to 4th income class. Poverty incidence is lower in urban areas compared to rural areas, with the exception of sites in Luzon with similar poverty incidence for both sites. Poverty incidence was observed to be highest in selected municipalities of Visayas and Mindanao, at 44.25 percent and 49.65 percent, respectively. Poverty incidence in selected cities in NCR is low.

Table 13. Profile of study sites

Cluster	Province	Urban / Rural	Income Class[a]	Poverty Incidence[b]
NCR	NCR	Urban	Special	3.31%
NCR	NCR	Urban	1st	2.41%
Luzon	Nueva Ecija	Urban	3rd	13.18%
Luzon	Pangasinan	Rural	1st	13.05%
Visayas	Iloilo	Urban	1st	13.51%
Visayas	Northern Samar	Rural	4th	44.25%
Mindanao	Agusan del Norte	Urban	1st	26.58%
Mindanao	Zamboanga del Norte	Rural	3rd	49.65%

[a]Philippine Statistics Authority (PSA) PSGC (2020-Q3)
[b]PSA City and Municipal-level Small Area Poverty Estimates (2015)

4.2. Findings

This section presents findings based on thematic analysis of FGDs and KIIs, discussed together with findings for relevant outcomes in IE3. The discussion focuses on knowledge, attitudes, and practices with regard to maternal and child health. This will be supported by observations on supply side conditions based on key informant interviews with health facility personnel and observations on program implementation, particularly monitoring of compliance with program conditions and updating.

Findings on labor participation, employment, and household welfare are also detailed in this section. This covers beneficiaries' opinion on grants, food security, and coping mechanisms, as well as topics on the type and nature of employment, productivity, and opportunities and barriers to employment.

Lastly, problems on program implementation and solutions forwarded by both program beneficiaries, DSWD city/municipality links, and health facility staff are discussed.

4.2.1. Maternal Health KAP

This section focuses knowledge, attitudes, and practices of Pantawid beneficiaries and their peers in the community with regard to maternal health. This is also supplemented by observations on health-seeking behavior and KAPS based on interviews with DSWD program staff and implementers and health facility staff.

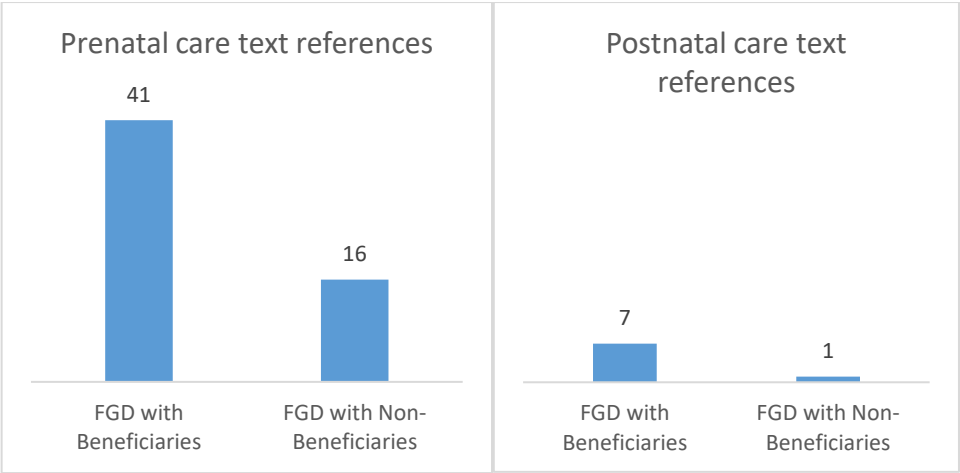
Although Pantawid Pamilya has initiated improvements in health-seeking and KAPS on maternal health, there are still gaps that need to be addressed. FDS and other parenting sessions are crucial in providing information to both beneficiaries and non-beneficiaries, however consistent messaging still needs to be implemented, particularly in terms of postnatal care. Program implementation, particularly with regard to updating, also needs to be strengthened in order to effectively monitor the health of members of Pantawid households.

4.2.1.1. KAPs during pregnancy, during and after delivery

In general, mothers know the appropriate practices during pregnancy to ensure the health of the mother and child. These include observing proper diet and exercise, avoidance of vices, and attendance to prenatal checkups. Family development sessions are an important source of information on maternal health. Besides FDS, majority of the respondents report that the health center is an important source of knowledge for them on these topics. These are communicated through learning sessions for pregnant women or "mother's classes", advice provided by the doctor or midwife during prenatal checkups, and during house-to-house visits by barangay health workers (BHWs).

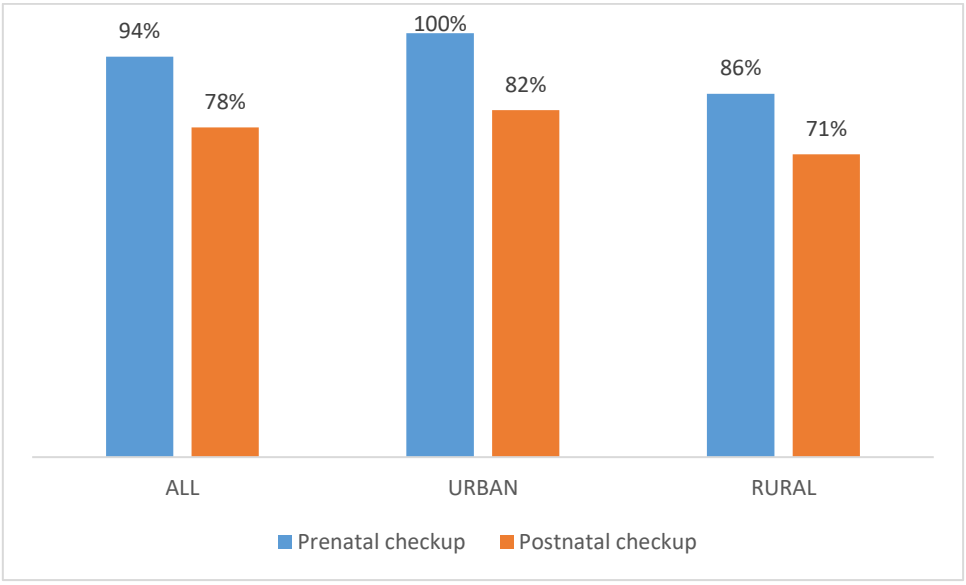
Both *Pantawid* and non-*Pantawid* mothers are aware of the importance of prenatal and postnatal care. However, awareness on prenatal care is higher compared to postnatal care (Figure 4). In some interviews, participants neglect to mention postnatal checkups for mothers when asked about proper health practices after pregnancy. There are also inconsistencies in terms of the knowledge of FGD respondents on the appropriate number and timing of prenatal and postnatal checkups. This is particularly true for postnatal checkups, where most respondents cite the appropriate timing being seven days after delivery, the actual recommended time of DOH for the first postnatal checkup being within 72 hours after childbirth. Many also had the perception that this health visit is mostly for the newborn, not for the mother.

Figure 4. Number of references in text for prenatal and postnatal care by beneficiary status



Consistent with uneven knowledge and awareness on prenatal and postnatal checkups, high compliance is observed with attendance to prenatal checkups for both groups, but inconsistent compliance with regard to postnatal checkups. This may also be due to lower provision of postnatal checkups in health centers compared to prenatal checkups (Figure 5).

Figure 5. Proportion of health facilities providing maternal health checkups by urban/rural classification



FGD respondents place importance on facility-based delivery and delivery by skilled health professional. Reasons for this ranged from compliance (i.e. “bawal na manganak sa bahay”) to health and safety reasons, such as the hospital is better equipped to deal with emergencies or complications. Although home births are reported by some respondents, most of these are for births that occurred more than five years prior to the interview. Most recent pregnancies were reported to have been delivered in health facilities, lying-in clinic, or hospital and by skilled health personnel (i.e. doctor or midwife).

4.2.1.2. *Understanding of program conditions related to maternal health*

Pantawid beneficiaries are aware that pregnant mothers are also monitored for health conditions under the program. Compliance to program conditions is one of the factors mentioned by beneficiaries when asked about the importance of prenatal care. Prenatal care is also mentioned as one of the conditions of the program for pregnant mothers. Postnatal care, however, was not explicitly mentioned as a program condition in any of the FGDs. Given the length of membership of 4Ps respondents in program, it is possible that awareness of other program conditions that beneficiaries are not continuously monitored for has decreased.

Facility-based delivery or delivery by skilled health professional is also not mentioned as one of the conditions of the program. Although Pantawid mothers have a higher likelihood of giving birth in a health facility, or being assisted by a skilled-health professional, these outcomes may still be improved through reeducation of program beneficiaries on program conditions on maternal health.

4.2.1.3. *Comparison between beneficiaries and non-beneficiaries*

In general, the level of knowledge of 4Ps and non-4Ps respondents on maternal health is similar. However, 4Ps are more confident on their knowledge on pregnancy and delivery compared to non-4Ps respondents. 4Ps beneficiaries participated more actively in FGDs compared to non-beneficiaries. This is likely due to exposure to and mastery of topics on maternal health during FDS in addition to lectures provided by health center staff. This may also be due to the fact that some Pantawid respondents were also staff of the health facility (i.e. BHW or BNS).

Both beneficiaries and non-beneficiaries have high compliance to the minimum number of prenatal checkups recommended by DOH during pregnancy. Differences in compliance are not observable in FGDs with program beneficiaries and non-beneficiaries. Health facility staff also do not observe any significant difference in their compliance, which is understandable since both groups have high compliance.

Differences between beneficiaries and non-beneficiaries are also not observed for postnatal care. However, slightly lower proportions of 4Ps beneficiary compliance with postnatal care observed in IE3 may mean that compliance monitoring for health conditionalities plays a large role in availment of maternal health care services among program beneficiaries. Raising awareness on conditions for pregnant mothers and strengthening monitoring for these conditions may improve uptake of postnatal care among program beneficiaries.

In terms of delivery, both Pantawid and non-Pantawid are aware of the importance of facility-based delivery, especially given local legislation prohibiting home births. Pantawid beneficiaries usually report that expenses of delivery in both public and private health facilities are covered by PhilHealth. Non-Pantawid beneficiaries report having to pay for fees for their delivery, however some are also able to avail of benefits or discounts from various sources (i.e. personal insurance, PhilHealth, SWA desk).

4.2.1.4. *Observations on health-seeking behavior and KAPs*

In terms of prenatal checkup, health facilities interviewed reported that pregnant women in their catchment areas fulfill, if not exceed, the recommended number of health visits under the program. Although pregnant women are able to fulfill the minimum number of visits, one doctor stressed that the challenge is getting beneficiaries to follow the proper timing of checkups, particularly for the first trimester checkup. In some cases, non-attendance to prenatal checkups in the first trimester of pregnancy is noted for teenage pregnancies or women with successive pregnancies due to apprehension that they will be judged or scolded by health facility staff.

Due to variations in the timing and venue for the administration of postnatal checkups, it is difficult to evaluate health-seeking behavior in this aspect. Not all health facilities require mothers to return for postnatal checkups, especially for pregnancies with no complications. For some areas, mothers are required to stay at the health facility for 24 hours after childbirth, and the routine for postnatal checkups are administered prior to the mother's discharge from the facility. Other areas conduct house-to-house visits for newly birthed mothers, so the onus of health-seeking is no longer on the mother.

Most health facilities report that differences in health-seeking behavior occur at the individual level. Given that the health center is accessible for most members of the community in terms of distance and expenses, reasons for non-attendance to prenatal or postnatal checkups is usually due to individual delinquency or need to attend to other responsibilities such as work or childcare.

4.2.1.1. *Opinion of program implementers on achievement of program objectives on maternal health outcomes*

The assessment of the DSWD Pantawid NPMO is that the program has made progress on maternal health outcomes, which is evidenced by consistently higher attendance to prenatal checkups by pregnant mothers and improvements in practice of facility-based delivery. The lower proportions of program beneficiaries' attendance to postnatal checkups, however, is not addressed.

Successful initiation of this behavior change is attributed to learnings of program beneficiaries from the conduct of Family Development Sessions and coordination with other key stakeholders such as the DOH and LGU. The DOH is identified as a key partner of the program, specifically in terms of compliance monitoring and updating of program beneficiaries. Achievement of program objectives also depend on the quality of health facilities and services provided by the DOH. The key contribution of the LGU is the deployment of BHWs to health facilities which contributed in compliance monitoring and recordkeeping of Pantawid beneficiaries.

4.2.2. Child Health and Nutrition

Further investigation on child health outcomes is conducted by the study in order to look into mixed results, particularly on child nutrition, observed by the previous impact evaluation of Pantawid Pamilya (4Ps IE3).

Interviews with Pantawid beneficiaries and their peers in the community, 4Ps program staff and implementers, and health facility staff reveal that there is a combination of gaps exist in terms of KAPs of parents, supply-side conditions, and program implementation which hinder achievement of program goals on child health and nutrition.

The FDS, as well as other parenting sessions provided in the community are helpful in educating both beneficiaries and non-beneficiaries on proper child rearing and health practices. Active involvement of health centers is crucial to improve health-seeking behavior of members of the community and health service delivery.

Although Pantawid Pamilya is able to improve health-seeking behavior of program beneficiaries through the conditions of the program and provision of program benefits such as the cash grant and PhilHealth, adjustments still need to be made in terms of program implementation, particularly with regard to the incentive structure for regular updating of the household roster for succeeding pregnancies and newborns.

Lastly, health facility staff identify that structural issues still exist which serve as barriers for parents to properly care for their children's health and nutrition. These need to be addressed not just by the Pantawid program, but also other key stakeholders such as DOH and the LGU, in order to achieve objectives on child health and nutrition.

4.2.2.1. *KAPs on child health and nutrition and services availed*

In terms of child health and nutrition, parents are knowledgeable on proper feeding practices and importance of proper nutrition for young children. However, awareness of the 1st 1000 days program is extremely low among respondents. There is also no consensus on breastfeeding information. Although many of the interview participants stressed the importance of breastfeeding, there was no consensus on the appropriate period for exclusive breastfeeding, as well as timing for the introduction of other foods. Exclusive breastfeeding is also not that common, especially for respondents in urban areas, with many reporting that they practice mixed feeding.

Respondents are aware of the importance of immunization and follow the immunization schedule of the health center. For most respondents, negative perceptions of Dengvaxia did not affect their perception of vaccines that they have been familiar with before. Some parents expressed they were reluctant to allow vaccines administered in school (i.e., HPV), but still trusted vaccines administered by the health facility. Health centers also bolster compliance with full immunization through the conduct of house-to-house visits.

Compliance with deworming is high, but the main barrier to full compliance are misconceptions regarding deworming. Some respondents are under the impression that deworming can be dangerous for children when not administered properly and are therefore afraid of side effects. Supply of deworming pills is at 100 percent among all health facilities visited and the deworming pill is administered both at school and by the health facility, usually for younger children.

Respondents usually bring their child to the local health center (i.e., BHS or RHU) for regular weight monitoring, vaccination, and preventive checkups. However, for cases of grave illness or emergencies, parents bring their children to the hospital or a private clinic where a doctor is sure to be present. Health facility visits for growth monitoring usually end with collection of weight and height of child. Parents rarely receive nutrition counseling or check-up after the visit. In facilities where health personnel are scarce, the children do not receive preventive health checkups. This is very much dependent on the availability of skilled health personnel. If only the BHW or BNS is present, the health visit only consists of weight and height measurement

4.2.2.2. *Understanding of program conditions related to child health*

Pantawid beneficiaries have high awareness of program conditions related to child health compared to maternal health (Figure 6). Central to their understanding of program conditions are conditions concerning their children, particularly school attendance, FDS, and conditions on the health practices for mothers and children. During FGDs, respondents are often able to recite all conditions pertaining to child health, specifically, regular checkups for weight monitoring, deworming, and immunization.

Knowledge on the proper timing of administration of deworming pills is correct, and parents report following the schedule for immunization indicated by the health facility. However, there is a need to strengthen knowledge on the proper timing of checkups for weight monitoring for children once they are past the age of receiving vaccination.

When asked whether beneficiaries have difficulty in fulfilling program conditions, Pantawid respondents do not find it difficult to comply with program conditions since they also recognize that these are part of their responsibilities towards their children.

Figure 6. Awareness of program conditions of 4Ps beneficiaries

4.2.2.3. *Comparison between beneficiaries and non-beneficiaries*

Pantawid beneficiaries in general have similar knowledge, attitudes, and practices with regard to availment of child health services. However, there are also some differences, which may be influenced by program conditions, and knowledge gained during FDS. These are summarized as follows:

- **Equal access to vitamin supplementation for 4Ps and non-4Ps.** Vitamin A is administered house-to-house or at the health center. Daily vitamin supplements are usually bought by parents since supply at the health facility is limited. Few parents mentioned that they provide iron supplementation to their child.
- **4Ps respondents often cited the 4Ps health conditionality as one of their reasons for bringing their child to the health facility** since under the program they are required to bring their child for weight monitoring. Non-4Ps respondents reported that they bring their child for regular checkups until 1 year old. After this, most visits to the health facility are for instances of illness.
- **Most beneficiaries and non-beneficiaries allow their children to take deworming pills at the school or the health facility.** For both groups, there are a few respondents that do not allow their child to be administered the pill due to misconceptions regarding deworming.
- **4Ps beneficiaries may have better appreciation of the importance of vaccination and are less susceptible to misinformation due to FDS.** Pantawid beneficiaries understand the importance of vaccination and ensure their child completes their vaccines. The same is true for non-Pantawid, however, some isolated cases of refusal to have vaccine administered to child were noted.
- **Consistent with IE3 RDD results, more Pantawid Pamilya children visit health facilities for weight monitoring.** Few caregivers reported keeping their own record of their child's weight, however, most relying on records of the health facility or day care.

4.2.2.4. *Observations on health-seeking behavior and KAPs*

With regard to health-seeking, health facilities report that the primary reasons for members of the community to bring their child to the health center is for checkups for illnesses such as cough and colds, and fever. Besides instances of illness, another reason for health center visits are vaccination. Most members of the community have their children vaccinated, however there were a few instances reported wherein households refused to have their children vaccinated due to misconceptions regarding immunization.

Health centers report that regular health visits for weight monitoring are usually done only by members of Pantawid Pamilya as fulfillment of program requirements. However, weight and height measurement of non-beneficiary children is included in the routine checkup when they are brought to the health facility for checkup and when house-to-house visits are conducted by the health center.

In terms of KAPs on nutrition, health facilities observe that although members of the community are aware of proper feeding practices, they may not be able to implement these in their homes due to limited household budgets. The provision of cash grants for education and health help address or reduce food insecurity among Pantawid households.

4.2.2.5. *Opinion of program implementers on achievement of program objectives on child health outcomes*

Based on reports of city/municipal links, compliance with program conditions on health is usually at 100 percent, with very minimal cases of non-compliance. They are able to monitor this closely since non-compliance with health conditions would result in deductions from the beneficiary's grant for the given period. C/MLs are also informed by health center staff if there are any issues in terms of beneficiary compliance to program conditions such as vaccination and weight monitoring. It is also stressed to beneficiaries that attendance to regular checkups should be followed not just for compliance to program conditions, but also for proper monitoring of the health of members of the household, even those who are not monitored for health conditionalities.

Key informant interviews with the DSWD 4Ps NPMO mentioned that while the program was making progress with regard to program objectives on maternal health, it was also acknowledged that results on child health outcomes, particularly on child nutrition were still inconsistent. Mixed findings on child health among Pantawid beneficiaries were attributed to the fact that CCTs are demand-side interventions and the achievement of program goals on health rely on supply-side factors such as the accessibility and quality of health facilities. Based on Spot Checks conducted, and studies commissioned by the DSWD, it is observed that health center resources, particularly in terms of infrastructure are still lacking. Variations in the implementation and practices of health facilities in the provision of health services may be one of the factors behind inconsistencies in health outcomes.

Another issue mentioned was underreporting of succeeding pregnancies and newborns in the family roster. In the quarterly status reports of the Pantawid Pamilya for 2019,

reports of pregnancy status and newborn children consistently have the fewest number of updates (DSWD 2019). According to the NPMO respondents, this gap is already recognized by the program management, and households are already being encouraged to report succeeding pregnancies and births so that the household roster is continuously updated.

4.2.3. General impression on the supply side conditions

4.2.3.1. *Resources of the health facilities*

The study administered a health facility checklist for all health facilities visited in order to evaluate the status of the health facilities and identify possible gaps in health service delivery.

All of the health centers visited reported having water supply, majority also reported having supply of electricity in the facility (Table 14). One site reported having experienced interruption in their electrical supply for almost two months.

Table 14. Electricity and water supply

	ALL		RHU		BHS		URBAN		RURAL	
Variables	**Mean**	**Obs.**	**Mean**	**Obs.**	**Mean**	**Obs.**	**Mean**	**Obs.**	**Mean**	**Obs.**
Has electricity supply	94%	17	89%	9	100%	9	91%	11	100%	6
Has water supply	100%	18	100%	9	100%	9	100%	11	100%	7

Health facilities visited still had gaps in terms of staffing. Many of the health facilities visited reported being understaffed based on ideal ratios of health personnel to community population (

Table 15). This is true for both skilled health professionals, such as doctors, midwives, and nurses, as well as other health personnel, like barangay nutrition scholars and barangay health workers.

Table 15. Ratio of health facility staff to sample population

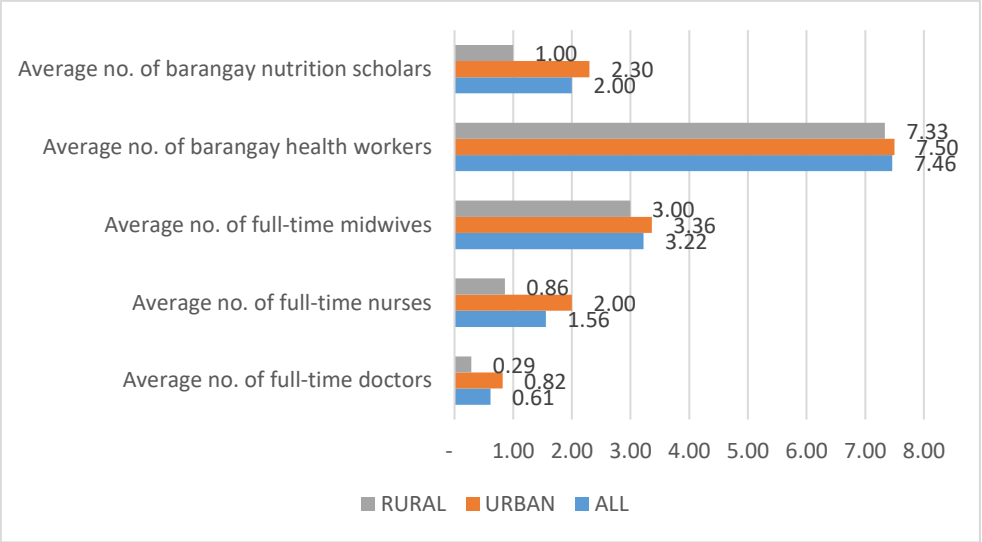
Position	Target Ratio (DOH)	Actual Ratio in Facilities Visited
Doctor	1:20,000	1:30,000
Nurse	1:10,000	1:20,000
Midwife	1:5,000	1:8,000

Source of target ratio: DOH National Health Objectives 2017-2022

As expected, the average number of full-time doctors in urban areas is much higher compared to rural areas (Figure 7). This is true even when comparing the number of doctors in RHUs for urban and rural areas. Health facilities in urban areas also have

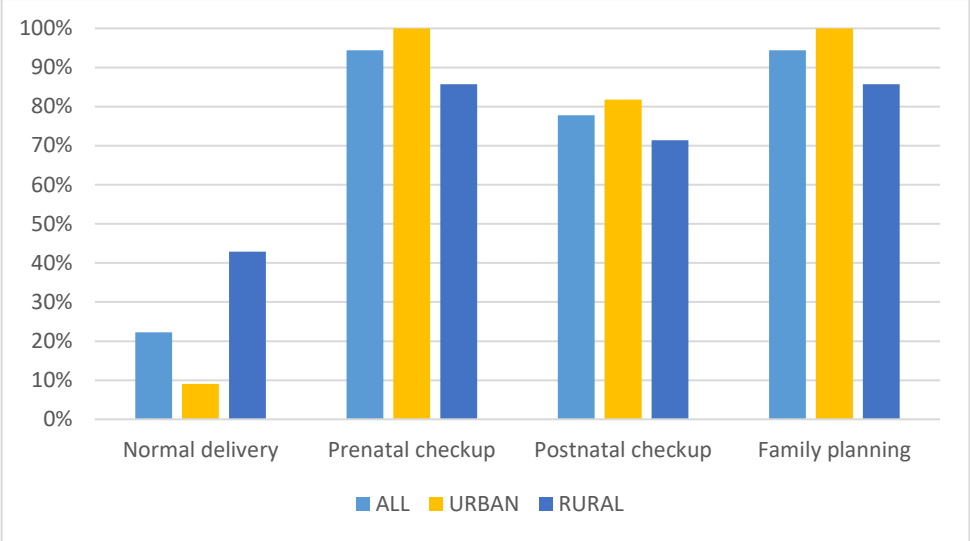
more nurses compared to those in rural areas. Numbers for other staff are similar between urban and rural health facilities.

Figure 7. Number of health facility staff by urban/rural classification



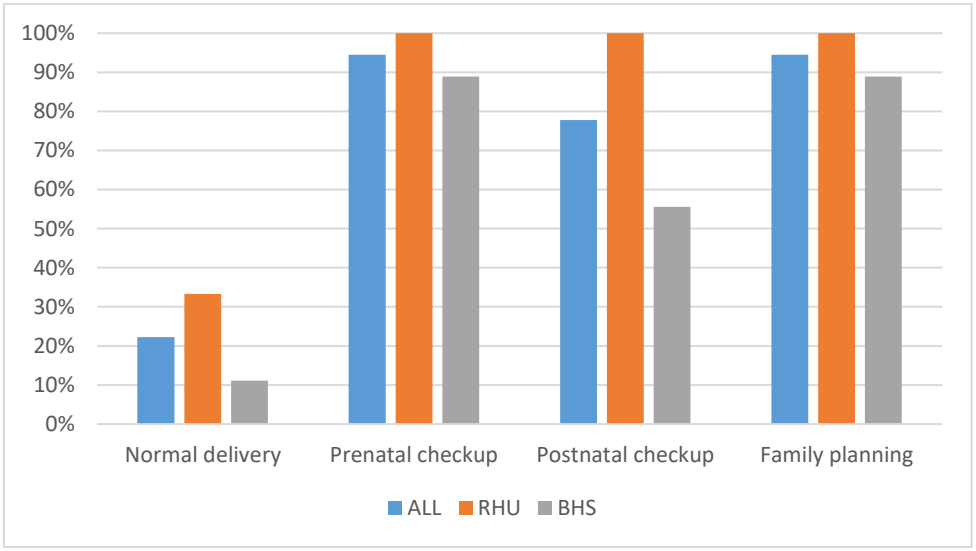
Health service delivery for mothers is better for health facilities in urban areas compared to rural areas in terms of the type of health services provided (Figure 8). Only a few of the health facilities report that they facilitate normal deliveries, but none accommodate caesarian deliveries as these are facilitated at the hospital.

Figure 8. Maternal health services by urban/rural classification



The proportion of health facilities providing prenatal checkups is higher than postnatal checkups which may be a factor in the lower postnatal care attendance by mothers (Figure 9). All of the health facilities visited provide iron supplementation for pregnant women, while more than 90 percent provide tetanus toxoid.

Figure 9. Maternal health services by health facility type



Provision of most child health services is at 100 percent in urban areas, while health facilities in rural areas are still lagging (

Figure 10). One notable observation is that weight monitoring and deworming are provided in all BHS that were surveyed, which displays the support of health facilities for the initiatives of Pantawid (

Figure 11).

Figure 10. Child health services by urban/rural classification

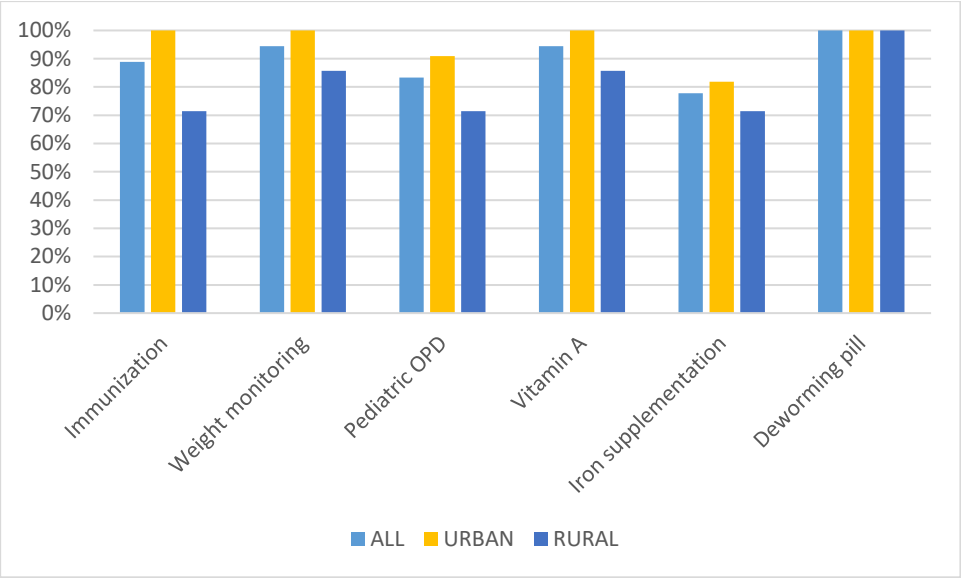
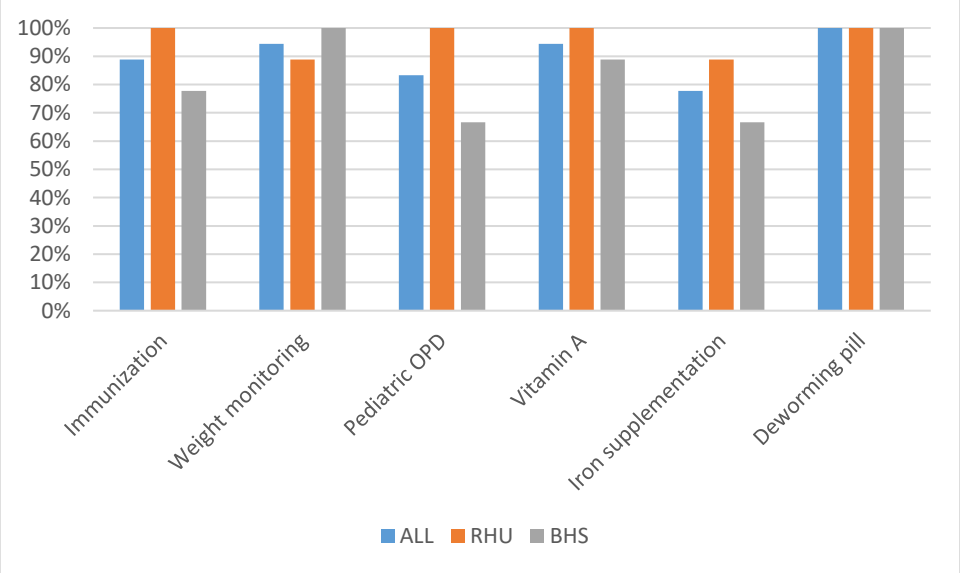


Figure 11. Child health services by health facility type



4.2.3.1. *Noted gaps*

FGD respondents often expressed satisfaction when asked about their overall opinion of health facilities in the community. However, when probed, they mentioned issues they experience with health service delivery in their respective facilities.

The most common grievance of FGD respondents regarding the health facility are long lines for checkups, which was reported for many of the sites. This was attributed to the lack of staff, particularly midwives and support staff. Respondents also note that they

are lacking doctors, with some facilities only having doctors part-time. This is inconvenient since members of the community need to return for their checkup or visit a private clinic during emergencies. Most of the respondents are satisfied with the qualifications and skills of health facility staff, but some issues regarding the attitude and disposition of some health facility staff were raised, which also affected the quality of care that they received.

It is also commonly reported that over-the-counter and sometimes prescription medicines are provided for free at health facilities, but there are limited stocks, so these are not always available. Most health facilities also lack diagnostic and laboratory exams, which requires members of the community to go to other public or private facilities that may charge fees for these tests.

Health facilities were reportedly convenient to access for the respondents in terms of cost and distance. For many respondents, the health facility visited by them is often walking distance, or a ride away. However, in the two barangays visited in one of the provinces in the sample, the barangay health stations in the community provided extremely limited services and had few medicines and supplies available. For health check-ups of pregnant women and children, respondents had to visit the rural health unit which is 15-30 minutes from their residence and costs from Php 20 to Php 30 per way to visit. Participants reported, however, that this was not a significant barrier for them to visit the facility.

Respondents reported that costs in government health facilities (i.e., BHS and RHU), and government hospitals were affordable, if not free of charge. Check-ups were noted to be free, with charges only for for tests, medical supplies (i.e., bandange, syringe, etc.), and medicines. They also reported being able to avail of social welfare benefits, such as PhilHealth, particularly for costs of delivery.

Interviews with DSWD city/municipal links also mention gaps in health service delivery in the community. With regard to staffing, C/MLs also observe that there is a shortage of skilled health professionals such as doctors, nurses, and midwives. One site noted, however, that the Nurse Deployment Program (NDP) of the DOH is effective in addressing such shortages.

The activeness of health facility staff is identified as crucial for quality health service delivery, particularly when servicing remote communities. C/MLs suggest that health facilities should have a monthly clinic day for GIDAs so that members of the community do not have to travel far to avail of the services. No hindrance in access to health facilities was reported for non-GIDA barangays.

Consistent with responses from FGDs, C/MLs find that facilities, supplies, and equipment need to be bolstered, through the support of the LGU. In particular, laboratory and diagnostic services should be provided so that members of the community to decrease transportation costs and fees at private laboratories.

Many of the health facilities visited also confirmed that they were understaffed based on ideal ratios of health personnel to community population. Although their current numbers are often enough to provide regular services in the health facility, respondents from health facilities noted that being understaffed restrains them from providing

house-to-house services to the community. Health facilities also identify the need for permanent positions for skilled health professionals like doctors, and capacity building and allowances for non-medically trained health workers such as the BHW and BNS.

4.2.3.2. *Support and coordination with the DOH, LGU, and other local actors*

Special services or programs for health are provided by the local government, NGOs, and religious groups. Although most are open for the entire community, not just Pantawid beneficiaries, 4Ps are usually targeted or prioritized for the programs through coordination with the C/ML. One example of a program by the LGU was the provision of sanitary toilets to the community, which was primarily targeted towards Pantawid beneficiaries.

Other government agencies frequently partnered with were POPCOM (Commission on Population and Development and the National Nutrition Council (NNC). Non-governmental organizations and civil society organizations also provided community programs, mostly feeding programs, to the community in general.

Most of the C/MLs are satisfied with their working relationship with the LGU, local health facilities, and other government stakeholders. Coordination is facilitated through regular meetings of city/municipal interagency committees or local advisory councils in the locality.

4.2.4. Program implementation observations

4.2.4.1. *Understanding of program goal*

Understanding of the goal of Pantawid is consistent among both FGD and KII respondents. The objectives of the program to uplift the wellbeing of beneficiaries through investments in the education and health of children from poor households is clear among program beneficiaries, DSWD program staff (i.e., city/municipal links), and health facility staff. Most also believe that the program is on track to achieve its goals, given observed changes in the behavior and welfare of the beneficiaries.

Program beneficiaries are aware that the provision of grants is contingent on their compliance with the program conditions, which are in line with the objectives of 4Ps. This awareness is also reflected in how they spend the grant, which is reported by beneficiaries to be spent primarily on the education and health of their children, as well as food for the household (Figure 12). They also share positive experiences as members of the program noting that the program helps augment their household budget, particularly for education expenses of their children. This in turn will enable their children to finish school, which beneficiaries identify as the pathway through which their lives may be uplifted.

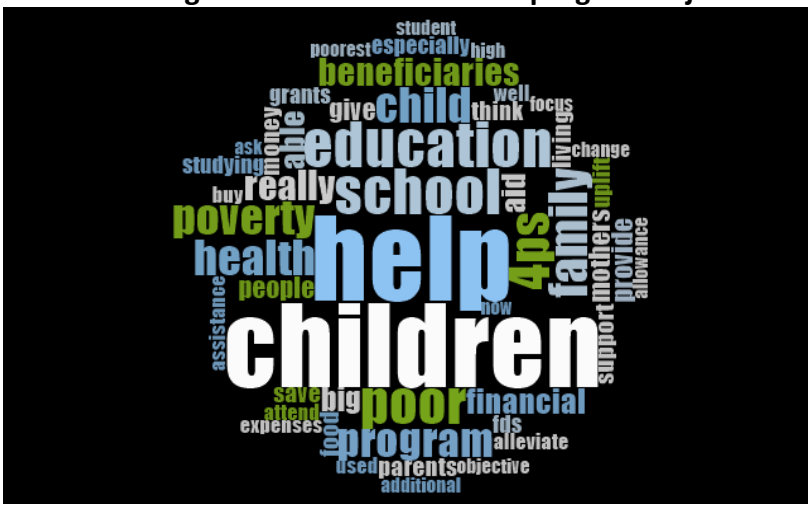
City/municipal links also cite poverty alleviation as the main objective of the program, which is achieved by keeping children healthy and in school. In addition to program objectives for children, C/MLs also mention interventions targeted protection of maternal health, specifically prenatal and postnatal checkups, and empowerment of parents, particularly mothers. When asked whether they believe the program will be

successful in achieving its goals, C/MLs cite success stories of graduated beneficiaries and observe that program beneficiaries are better off since their membership in the program. Besides improvements in terms of the beneficiaries' material wellbeing with the provision of grants, C/MLs also identify FDS as a crucial component of the program in initiating behavior change and empowerment of beneficiaries.

Health facility staff are also knowledgeable of the goals of Pantawid. The main purpose of cash grants for them is to cover education expenses of children, but some also mention that this also augments the household budget for food and health expenses. The role of the health facility in achieving the program objectives. This includes the provision of health services, particularly preventive care, education of beneficiaries on proper health and nutrition practices by serving as resource persons for the FDS, and monitoring of beneficiary compliance to program conditions.

Although most health facility staff believe that the program is on track to achieve its goals, they have more reservations regarding the achievement of program objectives compared to other respondents. For them, the success of the program depends on how beneficiaries utilize the grant and their compliance with program conditions.

Figure 12. Knowledge of 4Ps beneficiaries on program objectives



4.2.4.2. *Knowledge on program conditions and (possible) opportunity costs*

Pantawid beneficiaries are aware of the program conditions and are aware of deductions for non-compliance with these conditions. Program conditions that are more frequently recalled by the beneficiaries are conditions for regular attendance of children to school, regular checkups of young children (i.e., 0-5 years old), and monthly attendance to FDS. Besides these conditions, beneficiaries also mention prohibited acts under the program such as gambling and pawning of cash card. Program conditions for pregnant mothers are not mentioned as often. Although these are discussed in earlier parts of the interviews, prenatal care is enumerated as a program condition in only 4 of 16 sites, while postnatal is not explicitly mentioned in any of the sites visited. This indicates that despite beneficiaries being knowledgeable on topics on maternal health, this is not strongly associated with the program.

When asked, beneficiaries report that they do not experience difficulty complying with any of the program conditions. 4Ps respondents believe that it is their obligation as

members of the program to comply with program conditions, and members who are not willing to follow the conditions should opt out of the program. Some mention having to be absent from work in order to attend the FDS, but they also acknowledge that there are alternatives such as proxy attedance or make-up sessions as a solution for these instances. There were also isolated cases of parents reporting they were having difficulty keeping their child in school as they had "lost interest".

C/MLs also report that program beneficiaries have high awareness of program conditions and the corresponding grant amount for compliance with each condition. Program beneficiaries are observed to have generally high compliance with program conditions, particularly on health. FDS is mentioned as the program condition beneficiaries are most frequently not able to comply with, but C/MLs also report that there are occasions where beneficiaries are not able to comply with health conditions. For both instances, the main reason for non-compliance is that beneficiaries have to work and do not have enough time to comply with program conditions. Other reasons mentioned for non-compliance are non-attendance to health checkup due distance from health facility, refusal to follow recommended health practices due to social or cultural beliefs (i.e., misconceptions on deworming and preference for home birth).

4.2.4.3. *Knowledge on specific program design*

4Ps respondents from most of the study sites are only aware of education updates such as new enrollment or change of school. There is low awareness of updates for succeeding pregnancies and newborns, especially if the three-child limit has already been reached by the household. Others also report that they do not submit updates voluntarily, but only upon the advice of their city/municipal link or parent leader. Besides these, other updates mentioned were updates for selection or replacement of children beneficiaries, change of address, change grantee, and correction of basic information.

The most common update filed by beneficiaries are education updates for their children, which may be the reason why this is the update they are most familiar with. A few beneficiaries are aware that updates for newborns and succeeding pregnancies still need to be passed even though the roster for child beneficiaries is already full, but most are under the impression that updates only need to be filed for selection or replacement of child beneficiaries. Some report, however, that even though they do not file updates for new births or pregnancies, they are still monitored by their local health facility.

Table 16. Criteria for updates for newborns and succeeding pregnancies

Type of Update	Description
Newborn	Child/ren born resulting from the pregnancy of any member of the household at the time of assessment and during program period. Children born out of the pregnancy of the household member in the course of Program implementation.
Succeeding pregnancy	This category includes updating of pregnancy of a household member while under the program. The following are the household members eligible for the said update: a) Head (female) b) Wife of the Household Head c) Daughter of the Household Head

	d) Grand Daughter of the Household Head e) Daughter-in-law of Household Head

Source: Pantawid Operations Manual (DSWD 2015)

City/municipal links also have mixed responses with regard to program policies on updating. Similar to what is reported by program beneficiaries, not all C/MLs require beneficiaries to file updates for newborns and succeeding pregnancies when the household has already met the maximum number of child beneficiaries.

This is not consistent with actual program policies since based on the Pantawid Operations Manual (DSWD 2015), updates should be filed for newborns of any member of the household, and for succeeding pregnancies of household members who are related to the household head up to the second degree of consanguinity or affinity.

However, the common understanding is that updates are only filed when the household has less than two active beneficiaries. Once the three slots have been filled up, newborn updates are no longer required by the C/ML. However, it is also common for pregnant mothers and newborns are monitored by the health facility even though they are not added to the system, with some C/MLs keeping their own records of pregnant women for monitoring.

A few sites reported instances where the updating criteria outlined in 4Ps OM is followed – update for succeeding pregnancy and newborns filed even if household already has three beneficiaries. C/MLs state this is so that they can be monitored by the health facility. However, beneficiaries need to initiate the update for it to be filed, which includes submission of requirements such as diagnosis from physician (i.e., pregnancy) or birth certificate.

4.2.4.4. *Respondents' recommendations for program improvement*

Pantawid beneficiaries are generally content with the program and express satisfaction with the aid they receive from the program. In terms of program benefits, some mention that there is a need to increase the grant amount in response to rising prices of goods. Most, however, prefer adjustments in terms of other program benefits such as allowance to include additional children beneficiaries or extension of the program to cover students in college. Support for children in college is the most popular suggestion among beneficiaries as expenses are higher for children in college, especially for those who are not able to enter public universities. Besides benefits for children, program beneficiaries also suggest programs to support the livelihood of the household, such as training programs or provision of capital for the establishment of businesses to enable them to transition out of the program.

With regard to program implementation, 4Ps respondents recommend that the program have more stringent screening and monitoring of program beneficiaries. Specifically, they recommend enrollment of new beneficiaries, as they see that there are poor households that need the program who are not yet members. They also suggest better screening to be implemented and removal of program beneficiaries who do not comply with program conditions.

4Ps respondents also recommend improvements to the Pantawid implementation, particularly in terms of payment and updates. Glitches in the payment system, such as

non-provision of the grant, or wrong/incomplete amount being provided should be addressed. Processing of updates, particularly for change grantee, should also be streamlined to be faster.

City/municipal links had similar recommendations with regard to program implementation. They also recommended the review and updating of beneficiaries, to enroll new members as well as support graduation for old members of the program. Stricter implementation of program rules such as compliance monitoring, removal of delinquent members, processing of No Qualified Dependent (NQD), and sanctions for cash card pawning is also recommended to ensure that beneficiaries conform to the rules of the program.

C/MLs identified areas for improved support for beneficiaries. These include livelihood support and training for beneficiaries, and incentives for parent leaders. They also emphasize the need for human resource support and benefits for Pantawid Pamilya program staff. Specifically, these are regularization, benefits, and hazard pay for C/MLs, counselling, and training and development interventions. They also recommend the reevaluation of the workload of C/MLs, particularly in terms of the caseload.

The main recommendation of C/MLs with regard to the conduct of Family Development Sessions (FDS) is to decrease the load of C/MLs in the conduct of FDS in order to improve the quality of sessions held. This can be done by hiring dedicated staff to conduct the FDS instead of the C/ML, or reduction in their caseload so that class sizes may also be decreased.

On the conduct of FDS, C/MLs suggest improving the variety of topics as these are becoming repetitive, especially since many of the beneficiaries have been in the program for several years already. Suggested topics of the C/MLs include livelihood and family relationships. They also suggest tie-ups with resource persons, particularly for specialized topics such health and financial literacy, so that these may be discussed by experts and to expose beneficiaries to a variety of speakers.

The FDS venue and presentation materials are also a concern. Sessions are often held in public venues or facilities, such as the barangay hall, court, or local chapel, which are not conducive for learning due to noise or lacking facilities. C/MLs recommend designation of better venues for FDS, or possibly a dedicated venue, as well as presentation aids such as a projector to improve the quality of FDS meetings.

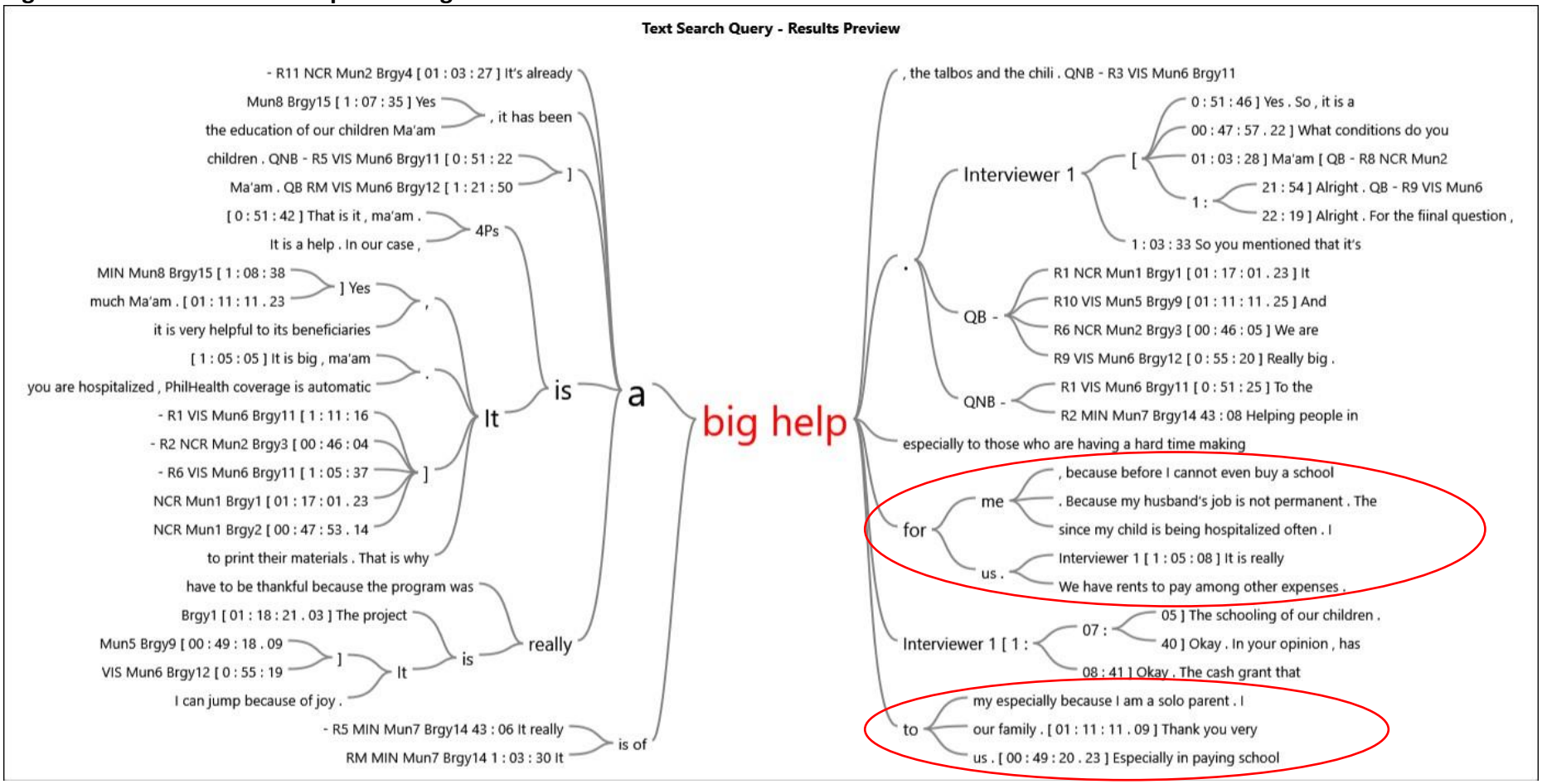
4.2.5. Grants, food security, coping mechanism

4.2.5.1. *Opinion on amount of grants received*

Beneficiaries are satisfied with the amount that they receive from the grants and appreciate the contribution of the grant to their household expenses. The grants are frequently described as a “big help” in getting beneficiaries through various situations in their lives (Figure 13). Respondents in most study sites do not express further opinions beyond this. When probed, a few responded that although the grant helps supplement the household budget, it is not enough to cover education expenses and clothing expenses for children. Most respondents however are firm on their opinion that

beneficiaries should not be demanding on the amount of grant provided. The purpose of the cash grant is just to supplement expenses for the education and health of children, and beneficiaries still need to work to earn money for their needs.

Figure 13. 4Ps beneficiaries' opinion on grants



4.2.5.2. *How grants are spent*

The 4Ps grant helps beneficiaries purchase their daily needs and schooling needs of their children. The most frequently cited expense the cash grants are used for are school expenditures (Figure 14). Beneficiaries report that the grant is commonly used for schooling needs of children, such as school supplies and uniforms, allowances, and money for school projects. Pantawid beneficiaries also prioritize food expenses, particularly rice, disclosing that part of the grant is apportioned for rice. The grant is also spent on milk and vitamins for young children.

A small number of respondents reported that they use leftover money from the grants as capital for businesses. These are generally small businesses such as neighborhood "sari-sari" stores, food vending, or small-scale livestock production.

Figure 14. Common expenses using cash grant reported by beneficiaries

4.2.5.3. *Budgeting constraints and coping mechanisms.*

There is no apparent difference between Pantawid beneficiaries and non-beneficiaries in terms of budgeting constraints experienced. The welfare of non-4Ps is not considerably different from that of program beneficiaries, as both groups find that their household budget is not enough to cover their basic needs. Education expenditures are often cited as having a large impact on the household budget, particularly school projects since the budget of these are not fixed and cannot be anticipated by the household. Rising prices of basic commodities and low and/or seasonal household income are also reasons why the household budget is lacking.

A common coping mechanism was the taking out of informal loans from relatives, neighbors or the neighborhood store, or loan sharks, this however is more common among non-4Ps beneficiaries (Figure 15). Both groups usually adjust their household spending and consumption or change what they "buy".

In the adjustment of household consumption, the primary expense adjusted are food expenses. This is done by limiting food portions, or the number of meals for the day, particularly for adult members of the household. Mothers also report that they prioritize

their husbands since they are the breadwinners of the family. Households also shift to low-cost meals by extending or replacing protein viands with vegetables and cooking soup or rice gruel.

Figure 15. Economic coping mechanisms by beneficiary status

Respondents also earn additional income by looking for additional work, such as washing laundry or hawking food. In rural communities, respondents take seasonal jobs such as planting or harvesting to supplement household income.

Backyard gardening is commonly practiced, particularly in rural areas. Households report that they are able use their harvested vegetables to supplement their meals. This is more consistently reported by 4Ps beneficiaries, as they cite that this part of the conditions of the program.

4.2.6. Labor market outcomes

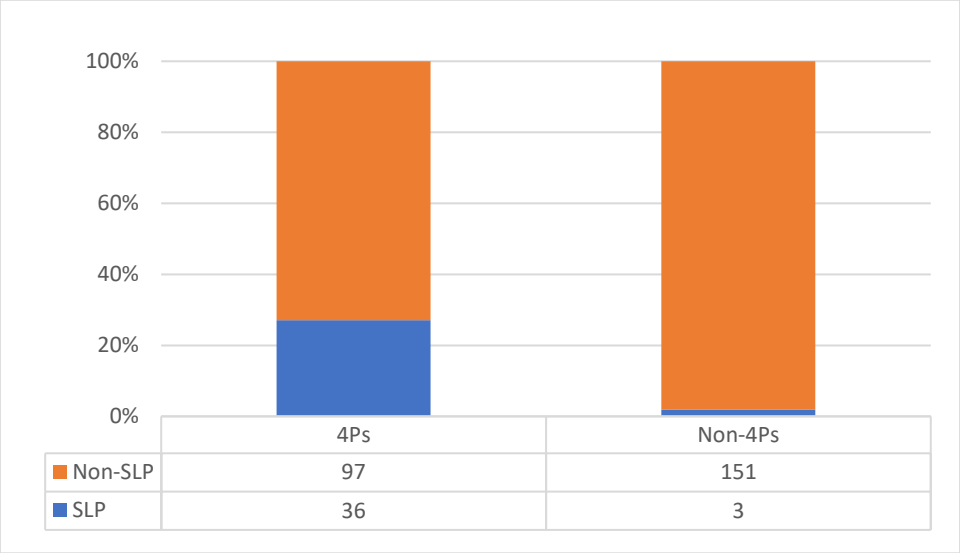
4.2.6.1. *SLP benefits and feedback*

Around one-quarter of 4Ps respondents reported being beneficiaries of the Sustainable Livelihood Program (SLP) of DSWD. The proportion of SLP beneficiaries among non-4Ps beneficiaries is only 2 percent, which is consistent with what is observed by IE3 (Figure 16).

Majority of respondents were under the micro-enterprise development track, under both individual and group-type projects, and only one respondent under the employment facilitation track. Livelihood support under the micro-enterprise track included assistance in kind such as provision of livestock and tricycle units, and capital for businesses such as community “sari-sari” stores or food vending.

Many of the respondents under the micro-enterprise development track reported experiencing issues during their membership in the program. This ranged from business failure, issues in management of their association, and lack of support from program staff.

Figure 16. Proportion of SLP beneficiaries among FGD respondents



4.2.6.2. *Opinion on criticism regarding dependency*

Pantawid beneficiaries are aware of the criticism that program beneficiaries are dependent on the cash grants and disagree with this characterization. They posit that the grant amount is not enough for the household to rely on as their sole source of income and they still need to work to fulfill all the needs of their household. They are conscious that the grants are meant mainly for the education and health expenses of their children. Non-beneficiaries also believe that 4Ps beneficiaries are not dependent on the grant since they are aware that the purpose of the grant is to aid with health and education needs of children, but it is not enough to cover all of the expenses of a household.

A small number of 4Ps and non-4Ps agree that some have become dependent on the grants, but this pertains only to a small proportion of beneficiaries who are perceived as delinquents of the program. Dependence on the grant is usually associated with other delinquent behaviors such as cash card pawning or engagement in vices such as drinking or gambling. Some respondents from urban areas also have the perception that dependence on the grant would be more possible in rural areas, where they believe cash card pawning is also more prevalent.

4.2.6.3. *Challenges in labor market participation and suggested program*

Both 4Ps and non-4Ps respondents reported that the work they were usually engaged are in construction, agriculture, freight transport, and trade jobs in electricity or plumbing. In rural areas, many were engaged in fishing and agriculture. The grantee or mother is usually not in the labor force since they serve as caretakers of children, particularly in rural areas. Employed female household members are usually employed part-time and in the informal sector, in domestic work such as laundering or caregiving, or as seasonal farm laborers in rural areas. Some are also self-employed or have small businesses such as wholesale/retail trade or food vending (Figure 17).

Figure 17. Primary occupation by urban/rural characteristics

URBAN | RURAL

The breadwinner of the household for both respondent groups held casual or contractual employment and found it difficult to find regular work. When probed, they mentioned the following as barriers to gaining regular employment: (1) qualifications (i.e. education, age), (2) lack of jobs in the community, (3) seasonality of jobs in the community, and (4) end of contract employment practices or "endo" by employers (Figure 18). In rural areas, seasonality of work and lack of available jobs are the main hindrances to gaining employment.

Figure 18. Barriers to permanent employment

When queried regarding potential programs to address their lack of livelihood opportunities, most responded that they preferred programs for microenterprise development over employment facilitation programs. This includes financial assistance and training to enable them to open their own small businesses, such as a small "sari-sari" stores or food vending businesses. It must be noted that most of the respondents are women who are caretakers of the house who may view livelihood as compatible to housework, who may have limited qualification for employment and are constrained by childcare duties.

5. Summary and Recommendations

5.1. Summary

5.1.1. Maternal Health Service Utilization

- **There is not much difference between program beneficiaries and non-beneficiaries with regard to knowledge, attitudes, and practices (KAP) on maternal health, and on the 1st 1000 Days of Life program.** Besides FDS, health facilities also provide information on maternal and child health to members of the community who are not members of Pantawid.

- **Respondents are not well-informed on the appropriate number and timing of prenatal and postnatal checkups.** Particularly for postnatal checkups, most respondents cite the appropriate timing being seven days after delivery, the actual recommended time of the first postnatal checkup being within 24 hours after childbirth (WHO 2013). Both Pantawid and non-Pantawid mothers are aware of the importance of prenatal care, but knowledge and awareness on postnatal care is mixed. Some believe this is only necessary for complicated cases or only for the newborn baby. 4Ps beneficiaries do not mention postnatal care when asked about program conditions.

- **Pantawid beneficiaries and non-beneficiaries complete, if not exceed, the minimum number of prenatal visits recommended by the Department of Health (DOH).** Prenatal care is cited by 4Ps beneficiaries as a condition of the program, but compliance with prenatal checkup for the community in general is also bolstered by monitoring of members of the community by barangay health stations.

- **Newborn updates are not filed when the limit for child beneficiaries has already been met.** Both beneficiaries and DSWD City/Municipal links often report that newborn updates are only filed when registering a new child beneficiary. Children exceeding the three-child beneficiary limit are often no longer included in the roster and updates for new pregnancies are also seldom processed, since program beneficiaries have no incentive to report these since it would entail being monitored for additional conditions for health.

- **Respondents are more likely to deliver at their local RHU if it is a PhilHealth-accredited maternity care package provider.** This bolsters support for expanding coverage of RHUs with delivery capabilities, even in urban areas, as well as investing in improving the facilities and staffing of RHUs.

5.1.2. Child Health and Nutrition

- **No consensus on the appropriate period of exclusive breatfeeding**. Although many of the interview participants stressed the importance of breastfeeding, there was no consensus on the appropriate period for exclusive breastfeeding. Most respondents are also unable to practice exclusive breastfeeding for six months for reasons such as lack of milk supply or needing to be at work.

- **Pantawid parents more diligent in bringing their children to the health facility for preventive checkups.** This is done in compliance with program conditions for regular weight monitoring compared to non-4Ps parents who usually bring their child only during instances of illness or for vaccination.

- **No perverse program incentive effect observed on child nutrition.** 4Ps parents have no impression that membership in 4Ps is related to their children's nutrition and are aware of the objective of the program to support their child's health through provision of grants and learnings through FDS. Negative impact on severe stunting observed in IE 3 cannot be attributed to difference in KAP or supply-side factors.

- **Structural issues still exist which serve as barriers for parents to properly implement knowledge on proper practices on child health care.** The provision of cash grants for education and health may still not be enough to address food insecurity among Pantawid households. These need to be addressed not just by the Pantawid Pamilya program, but also other key stakeholders such as DOH and the LGU, in order to achieve objectives on child health and nutrition.

- **Health facilities in rural areas are lagging in terms of provision of child health services.** Rural health units and barangay health centers are consistently less likely to provide services such as weight monitoring and pediatric outpatient consultations, the latter primarily due to the lack of skilled personnel and medical supplies. Vaccine provision is lower among rural health facilities, hovever it is also notable that the supply of vaccines is usually complete if these are offered by the health facility.

5.1.3. Labor Market Outcomes

- **Both beneficiaries and non-beneficiaries are casually employed.** Respondents mentioned lack of qualifications, particularly education, as barriers to gaining permanent employment. In addition to this, rural respondents specified that the deficiency of available jobs, and seasonality of jobs in their area hinders their employment.

- **Provision of capital is preferred to employment facilitation when asked regarding livelihood assistance.** It must be noted that most of the respondents are women who are caretakers of the house who may view livelihood as compatible to housework, who may have limited qualification for employment.

- **Implementation of DSWD's Sustainable Livelihood Program should be strengthened.** Some respondents also reported being members of SLP, however many

encountered issues during their membership in the program, with most reporting that they are no longer in contact with SLP program staff.

- **Compliance with program conditions does not appear to have an impact on time spent working for most program beneficiaries.** Program beneficiaries generally state that they do not have any difficulty complying with program conditions in terms of time and other expenses. With regard to FDS, where compliance is usually the lowest, both beneficiaries and the C/ML share that beneficiaries are allowed to have a proxy or take make-up sessions for FDS should they have conflicts in their schedule. However, similar to findings by Laigo (2016) there are also instances where beneficiaries report having to miss work to attend the sessions.

5.2. Recommendations

Given the insights gathered by the study based on the experience of program beneficiaries and their peers in the community, program staff, and program partners (i.e. health facility staff), the study has identified several areas for improvement in the pursuit of program objectives. This section presents the recommendations of the study for improved implementation of the Pantawid Pamilyang Pilipino Program, aspects in which to bolster partnership with stakeholder agencies, as well as areas for further study.

- **Pantawid Pamilya should consider updating its program conditions on maternal health.** Given the program's success in instigating positive impact on attendance to prenatal checkups, updating of the condition on prenatal visits and increase the minimum number of prenatal visits to reflect the number recommended by the World Health Organization (WHO 2013).[3]

- **Family Development Sessions (FDS) should be harnessed to reinforce knowledge on maternal health care.** Family Development Sessions and other similar parenting lectures conducted by the local health center are important sources of information for both beneficiaries and non-beneficiaries (Bautista et al. 2016). These venues should be utilized in order to bolster identified areas where knowledge and awareness is still lacking – particularly the timing and importance of postnatal care. Further study on the FDS should be conducted in order to evaluate and quantify its effectiveness in relaying information to beneficiaries.

- **Provide additional support for the conduct of FDS.** FDS has proven to be a significant factor in initiating positive change in program beneficiaries. Investments for the improvement of the conduct of sessions such as provision of appropriate venue and presentation materials should be made in order to improve the quality of sessions. The program should also engage resource persons, especially for specialized topics and consider delegating FDS to other program staff to reduce responsibilities of city/municipal link. Similar to recommendation of EPRI (2019), further rigorous study should be done on the FDS to measure outcomes.

- **Information campaign and implementation of the First 1,000 Days Law should be strengthened.** Low awareness of the First 1,000 Days Law was observed among both

[3] WHO (2013) recommends 8 prenatal contacts in the duration of a woman's pregnancy.

FGD and KII respondents. Given that this period was identified by the previous IE3 RCT Study to be a relevant factor to nutrition outcomes of young children, efforts should be increased to raise awareness on the importance of the First 1,000 days of Life and DOH should maximize the benefits of the law by strengthening its implementation.

- **Bolster health service delivery in rural areas.** Improvements need to be made in several areas such as staffing, facilities, and equipment. Health facility staff, particularly doctors and nurses should be increased in order to improve the quality of service delivery. Support staff such as barangay health workers and barangay nutrition scholars are also crucial for community outreach. Provision of basic health services for mothers and children should also be enhanced to meet those in urban areas. Laboratory and diagnostic services should also be provided, particularly in rural areas to reduce transportation costs and fees for patients.

- **The updating system of Pantawid beneficiary information should be assessed and clarified**. Both beneficiary and program staff respondents give conflicting responses when asked about filing of updates, particularly those concerning the health conditions. Criteria for updating should be clarified at the city/municipal levels to ensure that the family roster is continuously updated, even when households that have met the three-child beneficiary limit, in order to be able to monitor the health of all mothers and children of Pantawid households. This will ensure that all pregnant women and young children in the household are captured in the compliance monitoring.

- **Partnership with the DOH, DepEd, LGUs, and other stakeholders should be further strengthened.** Given the breadth of outcomes that Pantawid aims to address, strong ties with concerned agencies are needed in order for the program to succeed. Anecdotes from program staff demonstrate that active support of health facility staff is effective in improving health-seeking behavior of members of the community. Pantawid also provides beneficiaries with excellent links to accessing social services. The LGUs should utilize the ability of the program to mobilize potential beneficiaries for special programs of the LGUs. Venues such as city/municipal inter-agency committees may be employed in order to foster cooperation among agencies.

- **There should be continuous evaluation and updating of the grant amount.** The finding that households often experience a lack of budget for basic needs, and education expenses of their children highlights that the grant amount should continuously evolve to meet inflation. It must be noted, however, that field work for the study was conducted prior to the increase implemented in 2020 under RA 10931. Further studies should evaluate the impact of this increase in grant amount and whether this is sufficient to make up for the scarcity experienced by these households, particularly regarding expenses for food and the education and health of children.

- **Barriers to regular employment, particularly for those in rural areas, need to be addressed.** On the part of the DSWD, the existing mechanism of the Sustainable Livelihood Program (SLP) may be strengthened in order to improve outcomes on labor participation and employment. This, however, also needs to be looked into by other concerned agencies such as the Department of Labor and Employment as well as the local government units particularly in terms of job creation and regional economic development.

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