A Study on the Enabling Factors and Challenges in the Utilisation of Maternal Health Care and Family Planning Services of Pantawid Pamilya Beneficiaries

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Table of Contents

List of Tables 3

List of Figures 5

Glossary of Terms 6

Acknowledgements 7

EXECUTIVE SUMMARY 8

1. INTRODUCTION 10

1.1 Program Information 10

1.2 Significance and Research Questions 10

1.2.1 Policy Question 11

1.2.2 Research Question: 11

1.3 Study Objectives: 11

2. RESEARCH FRAMEWORK 11

3. A REVIEW OF EVIDENCE AND LITERATURE 13

4. METHODS 15

4.1 Study Design 15

4.2 Study Population 15

4.3 Sample Size and Sampling Design 16

4.4 Scopes of Inquiry 17

4.5 Data Processing and Analysis 18

5. BACKGROUND INFORMATION ON THE STUDY SITES 19

6. HOUSEHOLD CHARACTERISTICS 21

6.1 Profile of Women Grantee or Main Respondents 21

6.1.1 Respondents' Profile by MMR Category of Province 21

6.1.2 Urban- Rural Profile 22

6.1.3 Provincial Profile 23

6.2 Profile of Husbands/Partners of Pantawid Grantees and Socio-economic Characteristics of Households 25

6.2.1 Profile of Women Grantees Husbands/Partners 25

6.2.2 Some Background on the Household Socio-Economic Conditions 25

6.3 Profile of Pantawid Membership 26

7. UTILIZATION and UNMET NEED 27

7.1 Profile of Utilization of Antenatal Care and Family Planning services 27

7.1.1 Respondents 4 or more ANC visits 28

7.1.2 Respondents utilization of ANC services 28

7.2 Delivery in Facility 29

7.3 Postnatal care visits 30

7.4 Family Planning and Contraception 30

7.4.1 Consulted at the health facility for family planning services 30

7.4.2 Modern Contraceptive Method Used 31
7.4.3 Reasons for Stopping Use of Modern Contraceptives 31
7.4.4 Willingness to Use Modern Contraception 32
7.4.5 Unmet Need for Family Planning 32
8. KNOWLEDGE, ATTITUDES, AND PRACTICES 33
8.1 Results 33
8.1.1 On Pregnancy and Sex 33
8.1.2 On Health Facility Utilization 34
8.3 On Family Planning with Spouse 36
8.2 Discussion 37
9. HEALTH SYSTEM/DELIVERY SIDE PERSPECTIVE 37
9.1 Results 37
9.2 Discussion 48
9.3 Conclusion 50
10. DEMAND 50
10.1 Introduction 50
10.2 Dependent Outcomes 50
10.2 Independent Variables 51
10.3 Results (Reduced form) 51
11. Family Development Sessions 52
11.1 Results 54
11.2 Discussion 56
11.3 Conclusion 58
12. PROGRAM ASSESSMENT 58
12.1 Results 59
12.2 Discussion 59
13. RECOMMENDATIONS 60
14. CONCLUDING REMARKS 63
15. REFERENCES 64
APPENDIX ONE 66
APPENDIX TWO 69

List of Tables

Table Number	Caption
1	Summary of Sampling Sites
2	Sampling Design
3	Site Municipal Class
4	Site Fertility Rate
5	Site Stunting and Wasting Prevalence
6	Profile of Respondents by Low-High MMR Status of Province
7	Profile of Women Grantee Respondents, Urban-Rural
8	Women Respondents' Profile by Provincial Distribution
9	Background Information on Husbands/Partners of Women Grantees
10	Background Information on the Household Socio-Economic Conditions of Women Grantees
11	Profile of Pantawid Membership
12	ANC Visits by Province, Low-High MMR, and Urban-Rural
13	Utilization of ANC Services by Province, Low-High MMR, and Urban-Rural
14	Delivery by Province, Low-High MMR, and Urban-Rural
15	Postnatal Care Visits by Province, Low-High MMR, and Urban-Rural
16	Consultation at the Health Facility by Province, Low-High MMR, and Urban-Rural
17	Modern Contraceptives Used by Province, Low-High MMR, and Urban-Rural
18	Reasons for Stopping Use of Modern Contraceptives by Province, Low-High MMR, and Urban-Rural
19	Willingness to Use of Modern Contraceptives by Province, Low-High MMR, and Urban-Rural
20	Unmet Need for Family Planning
21	Knowledge of the Respondents towards Maternal Health Care and Family Planning per Province: Pregnancy and Sex
22	Knowledge of the Respondents towards Maternal Health Care and Family Planning per Setting: Pregnancy and Sex
23	Knowledge of the Respondents towards Maternal Health Care and Family Planning per MMR Status: Pregnancy and Sex
24	Knowledge of the Respondents towards Family Planning per Province: Health Facility Utilization
25	Attitude of the Respondents towards Family Planning per Setting: Health Facility

	Utilization
26	Attitude of the Respondents towards Family Planning per MMR Status: Health Facility Utilization
27	Knowledge of the Respondents towards Maternal Health Care and Family Planning per Province: Family Planning with Spouse
28	Knowledge of the Respondents towards Maternal Health Care and Family Planning per Setting: Family Planning with Spouse
29	Knowledge of the Respondents towards Maternal Health Care and Family Planning per MMR Status: Family Planning with Spouse
30	Health Facilities Surveyed and Staff Respondents
31	Health Facilities Surveyed per Province
32	Maternal Health Care Providers Reported at Barangay Health Stations and Rural Health Units
33	Training Profile of Maternal Health Care Staff in the Past Two Years Reported at the Barangay Health Stations and Rural Health Units
34	Profile of Family Planning Commodities Reported at Barangay Health Stations and Rural Health Units
35	Prenatal Medicine Reported Barangay Health Stations and Rural Health Units
36	Availability of Laboratory Tests Reported at the Barangay Health Stations and Rural Health Units
37	Infrastructure and Equipment Reported at the Barangay Health Stations and Rural Health Units
38	Communication Equipment Reported at the Barangay Health Stations and Rural Health Units
39	Maternal Health Care Services Reported at the Barangay Health Stations and Rural Health Units
40	Immunization Services Reported at the Barangay Health Stations and Rural Health Units
41	First Priority Facility to Visit by Household Survey Respondents when Sick
42	Health Facility Regularly Visited by Household Survey Respondents
43	Health Facility where Sick Household Members are Brought
44	Preference for Mode of Transportation Going to Health Facilities
45	Cost of Different Modes of Transportation Going to Health Facilities
46	Transportation Cost of Going to Different Types of Facilities

47	Likelihood of Getting Pregnant as Pantawid Members
48	Factors for Delivery Outside of Health Facility
49	Final Model: Factors Associated with Absence of Antenatal Care
50	FGD Respondent's Profile
51	FDS Sessions Observed
52	Tabulation of Significant Statements from FGDs and KIIs
53	Summary of FGD Responses on the Pantawid Program Assessment

List of Figures

Figure Number	Caption
1	Overall Framework of the Study
2	Stages and Scopes of Inquiry
3	Maternal Health Percentages by Supply, Demand, and Quality
4	Family Planning Percentages by Supply, Demand, and Quality
5	Provider's Perceived Role in the Pantawid Program
6	Provider's Involvement in the Planning and Coordination of Pantawid Meetings
7	What Pantawid Members will Need Differently in Health Care
8	Whether there are Services just for Pantawid Members
9	Whether there are Special Arrangements for Pantawid Members
10	Perceived Health Service Utilization of Pantawid Members
11	Health Facility Access Determinants
12	Whether the Pantawid Pamilya Implementation should be Continued

Glossary of Terms

BHS	Barangay Health Station
CCT	Conditional Cash Transfer
FDS	Family Development Session
FGD	Focus Group Discussion
FP	Family Planning
KAP	Knowledge, Attitude, and Practice
KII	Key Informant Interview
MCH	Maternal Health Care
RHU	Rural Health Unit
SARA	Service Availability and Readiness
SWDI	Assessment
WHO	Social Welfare and Development Indicators
YDS	World Health Organization
	Youth Development Session

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Ad Majorem Dei Gloriam

EXECUTIVE SUMMARY

This study examined the enabling factors and challenges in the utilization of maternal health care and family planning services of Pantawid Pamilya beneficiaries, using quantitative and qualitative methods. The Pantawid program extends to extremely poor Filipino families, as a poverty alleviation program, incentives (cash) for the fulfillment of conditions related to keeping their young and high school-aged children in school, as well as to encourage appropriate health seeking for pregnant women (antenatal and postnatal care) and young children (immunization and deworming). The education and health investments, acting to improve human capital, are intended to break the cycle of intergenerational poverty. In addition, families are also required to attend monthly Family Development Sessions (FDS) for values and life skills formation. Key to the mindset and behavioral changes required to move families out of poverty is the empowerment of women, who are the direct grantees of the program, with respect to sexual and reproductive health. The demand for reproductive health services (including use of modern contraception) is viewed as a byproduct of a desire to control fertility and limit the number of children to the level that can be supported by the family's resources. Aside from analyzing demand for reproductive health and family planning (FP) and supply-side or health service conditions, it situates the utilization of maternal health care and FP services in the context of program implementation elements (e.g., through the FDS and intersectoral partnership with the health sector) that may impact on changing perceptions of family life and poverty alleviation pathways among extremely poor participants.

- Some 390 Pantawid households composed of 2111 individuals, to include wife as grantee, a smaller number of husband and teenager as target respondents, from six provinces across the country, were interviewed. Key program implementers and partner institutions' (e.g., social workers, health centre personnel, health volunteers and local officials) views were gleaned through informant interviews and focus group discussions (FGDs). Program document reviews and participant observation of an ongoing FDS were assessed against standard elements of effective programming involving poverty groups.
- The surveyed families had on average, four (4) years of Pantawid membership and have complied well with the conditions of the program in terms of antenatal care, with 92 percent of women having visited four or more times a health facility, 68 percent reported current use of modern contraceptives and 70 percent gave birth in a facility. These figures compare favorably with the last Demographic and Health Survey (DHS) of 2013, though not so much for antenatal care, with Pantawid's 92 percent slightly below DHS' at 95 percent.
- Knowledge, Attitudes and Practices (KAP) responses to questions showed relatively poor knowledge of sexual and reproductive health and parents' discomfort talking about such matters with their teenage children; 72% reported not being comfortable talking about such matter.
- Public health facilities nearest to these families were visited and assessed using a modified Service Availability and Readiness Assessment (SARA) tool of the World Health Organization (WHO. Moderate to high service capacities were observed, however, the health service staff was not fully engaged with Pantawid, having no mechanisms in place to distinguish Pantawid from non-Pantawid clients.
- The FDS monthly meetings provide a platform by which health messages and other community initiatives can be disseminated and can be utilized and maximized by other sectors (agriculture, environment, industry) for reaching the poor.
- The demand models showed that for every peso increase in Pantawid amounts received, the odds of getting pregnant decreased by 0.31 percent. Having more children prior to 4Ps, living in a high mortality region, having a teen-age child, living far (self perceived) from the health centre, marrying at a younger age, and not completing a high school degree increased the odds of being pregnant. Those living in a high MMR area and of some distance (far) from the health centre were less likely

to deliver in a facility. Having a teenager in the family increased the likelihood of mothers seeking sufficient number of antenatal care visits. Some slackness was noted in the use of antenatal care visits by those who have been married longer. The challenges posed by relatively weak support structures (arising from inattention of health workers to Pantawid status and workload of municipal social work links) situate the recommendations for effective approaches in program implementation particularly in high mortality areas where deliveries are likely to be non-facility based.

- Modern contraception uptake, not explained by the model which looked at individual and community characteristics, with health service characteristics limited to access, may require more medical care inputs with methods being medically prescribed and therefore may require more knowledge and skills upgrade for health workers. While information is well provided through FDS, staff engagement at health centre and community levels, particularly on sexual and reproductive health matters, can be reinforced. This is critical particularly in the context of teenage behavior where parents' do not feel in control or sufficiently empowered to engage with their children.
- The study showed that teenagers and spouses needed to be reached in ways that reflect their interests, not just through surveys, but also through focus group discussions. The FDS can be more systematized in helping parents promote better strategies in engaging with adolescent children as well as pursue more 'project' type activities that engage the families, women and their spouses and children, in solidarity and social capital building activities.

1. INTRODUCTION

1.1 Program Information

The Pantawid Pamilyang Pilipino Program, popularly known as 4Ps, is a flagship anti-poverty programme that is both a social welfare and a social development intervention. As a social welfare program, it is a form of conditional cash transfer (CCT) program, providing cash grants to targeted families in extreme poverty. As a social development program, it hopes to break the cycle of intergenerational poverty by ensuring investments in education (P5,000 per year) and health (P500 per month for a total of P3,000 per year), per household, depending on household composition[1]. The grant is conditional to pregnant women availing themselves of antenatal care and regular health checks for women and children aged 0-5, deworming of school aged children 6-14 years old, school enrolment of children and attendance in family development sessions. During the 2016 Research Colloquium, the Department of Social Welfare and Development (DSWD) showed that by October 30, 2016, there were 4,393,114 active members, of which 572,809 were from indigenous peoples (IP) households and about 219,149 households have members with disabilities. For the same period, a total of P27.15 billion cash grants have been availed of, of which P13.2 billion was for education and P13.9 billion was for health.

This study focused in understanding enabling factors and barriers to maternal health care and family planning services. DSWD, during the 2016 Research Colloquium, showed high compliance rates for Pantawid families. 94.94% attendance was reported for family development sessions and 95.95% coverage for health visits of pregnant women and children aged 0-5. An earlier research (Reyes, 2012) showed Pantawid families had more members, roughly 6 members, compared to non-Pantawid families' 4. The family size for 23% Pantawid families was at least 8 members. The Pantawid Pamilya 2nd Wave Impact Evaluation (Orbeta, 2014) showed that women beneficiaries did try modern FP method at least once. Contraceptive Prevalence Rate was reported at 74% for Pantawid families compared to 68% of non-Pantawid counterparts. "The higher incidence of trial use, however, is not translating into sustained use of modern FP methods". There was a high awareness of modern family planning methods - 43% vs. 39%, for Pantawid families against non-Pantawid families, though this difference was not statistically significant. Compared to an earlier national DHS-sourced average of 84%, the Impact Evaluation (Orbeta, 2014) found 80% of Pantawid mothers made at least four antenatal visits. The challenge is therefore on increasing maternal care visits, as well as sustaining the program benefits with adoption of modern family planning methods. It appears that knowledge gained from family development sessions on responsible parenting, health and life skills are yet to imbed into practice and behavior. Understanding the enabling factors and the barriers to uptake of modern methods would necessitate a more holistic approach that links families' understanding of their present conditions, their compliance to expected behavior (conditions to the grant) and health seeking behavior, with their overall aspirations to get out of poverty.

1.2 Significance and Research Questions

While the program has been successful in terms of FDS attendance rates and antenatal care utilization, issues still remain. These issues include whether the knowledge from the FDS are impacting into practice and behavior, like fertility knowledge and practice, modern

[1] Education grants are for P300 and P500 per month per primary and high school going child, respectively, up to maximum of 3 children per household.

contraceptive use, use of health facilities and/or professionals and basic compliance to at least four antenatal visits and one postnatal visit per DOH guidelines. For Pantawid families, ANC is still lower than national average (DHS) and awareness is not translating into sustained use of modern FP methods. Specific interventions of the program may be investigated to see where gains should still be made. The FDS, which is one conditionality, can be studied to determine how it makes families understand their situation, how it facilitates compliance to grant conditions, how it improves health seeking behavior, and how it contributes to the overall aspirations to get out of poverty.

1.2.1 Policy Question

How has Pantawid Pamilya influenced maternal and reproductive health seeking behavior?

1.2.2 Research Question:

What are the facilitating factors and challenges in the utilization of maternal health care (MHC) and family planning (FP) services by members of the 4Ps program? How has the FDS conditionality affected health-seeking behavior of women grantees, particularly for reproductive and FP services?

1.3 Study Objectives:

This action-research seeks to identify and examine facilitating factors and challenges in the utilization of maternal health care (MHC) and family planning (FP) services by way of the following tasks:

1) To describe the **knowledge, attitudes and practices (KAP)** of Pantawid women and men grantees on MHC and FP;
2) To assess the **unmet need** for MHC and FP services among grantees;
3) To identify **demand side factors associated with the utilization** of MHC and FP services;
4) To examine current **supply side conditions and identification of the barriers** in the **access to health facility services** for deliveries and MHC and FP intervention and services;
5) To assess the **role and effectiveness of Family Development Session (FDS) materials and implementation** in increasing awareness of MHC and FP services; and,
6) To make recommendations for policies to increase awareness and utilization of MH and FP services among Pantawid Pamilya families.

2. RESEARCH FRAMEWORK

The framework (Figure 1) views the utilization of reproductive health services of both men and women, including teenagers, in terms of its availability, accessibility, acceptability, and quality. It is a rights' based perspective, recognizing individuals' human right to choice and access to quality health care services. For 4Ps families, utilization may hinge on their receptivity and responsiveness to the empowering messages received from Family Development Sessions- a key program requirement. The interplay of personal/individual, family and household dynamics, along with institutional and programmatic elements influencing behaviour and perceptions, are viewed to influence uptake and continual utilization or such services. This framework is adopted from UN's Human Rights Based Approach.

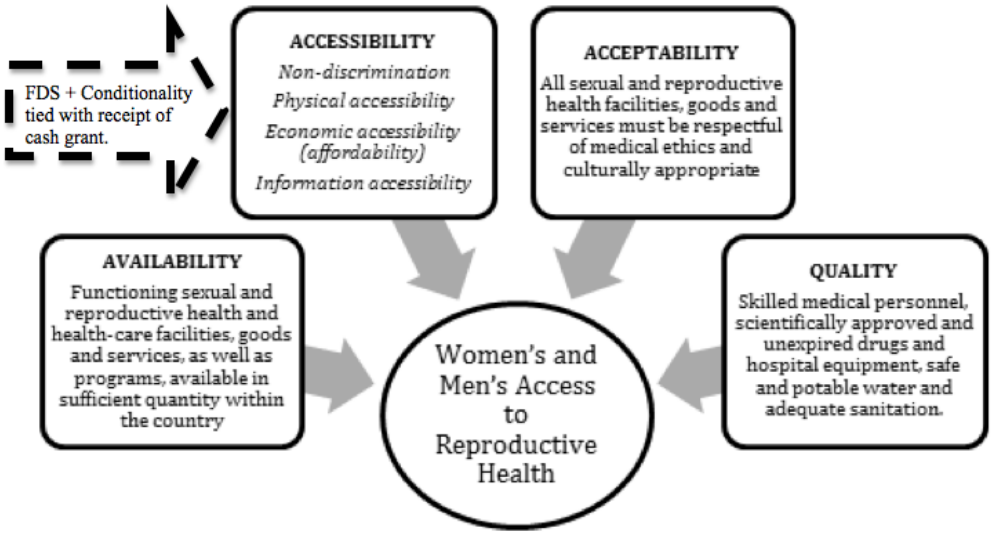


Figure 1. Overall Framework of the Study

The 4Ps health conditionality refers to: a) antenatal (at least 1 per trimester or 3 for the whole pregnancy) and postnatal visit (within 6 weeks of birth as per DOH Guidelines[2]) for pregnant members and birth delivery in facilities; b) immunization and monthly weigh-in for the young children from 0-3; c) twice a year deworming for school-aged children; and d) sick children are brought to health centres for integrated management. The health cash incentive is P500 per month per family or P3000 for the year. This amount is fungible and grantees are free and not monitored on how the cash grants are used. Since services are provided free from public health centres, the health grant can be used for transportation costs to health centres and/or purchase of medicines and other supplies that cannot be provided in the centre. The grant eases the physical and economic constraints in the households' access to reproductive health

For reproductive health, a wider 'merit good' argument (supported by WHO and national guidelines) posed in terms of positive externalities gained, when the women, for example, after childbirth are given advice and counselling on FP and provided with FP supplies. Couples wanting to limit or space their children should also be provided with FP advice, modern contraception and monitored regularly by health professionals. Even if not expressed among 4Ps conditions, the quality of service provision of maternal health care can be assessed in terms of completeness of services provided to include FP as reproductive health issues underpin maternal care. Changes in reproductive care attitudes and practices upon participation in the 4Ps program, even if FP is not explicitly part of the conditionalities, can be viewed as consequences of coming into contact with a trained health worker for the Pantawid program. The information gleaned from health service encounters is expected to improve demand for reproductive health services.

To condition the receipt of Pantawid grants on the use of health services requires that these services are available and within reasonable access to families, neither discriminating, nor imposing discomfort or costs. The availability of these services is premised on the collaboration and support of LGUs, their health departments, and the central Department of Health. Considerations of supply-side have been the weak links in programs such as CCT

[2] As per November 2016, WHO introduced new Guidelines for Maternal and Child Health, but Philippine health authorities' adoption of these new guidelines is not known. This study follows previous guidelines on at four antenatal visits.

which bolsters the demand side with the transfers given to families (Schmidt and Hossain, 2010). Supply side considerations, particularly the quality of information dissemination, training, stock-ups of essential supplies are the remit of the health sector, and the quality of integration with the health sector of the CCT program can provide the sustainability needed. Access to modern contraception, which regulates fertility decisions, is key to success in maternal and child health (Darney et al, 2013).

The FDS is a learning program that seeks to impart to Pantawid families- better parenting, child development, gender and development, child laws, active citizenship, home management, among others. How the FDS is conducted, its 'fit' in terms to contexts (low level education of women grantees), community acceptance, understanding of family dynamics, including practical considerations of timing, duration, care for younger children of women participants, and participation of other family members like husbands, are all critical considerations. The lessons imparted form the deepening component for Pantawid families to break poverty's intergenerational cycle. The breadth of information needed to instill in women grantees the knowledge, attitudes and practices needed to move them out of poverty would depend on the extent to which resources available in the community and elsewhere are brought to bear, both formal and informal networks of civil society, health and community practitioners.

3. A REVIEW OF EVIDENCE AND LITERATURE

Orbeta and Paqueo (2016) reviewed two national survey waves, using experimental approaches for the impact of evaluation of Pantawid Pamilya. The first survey covered benefit periods June 2008-April 2009 and done in October 2011-February 2012. The second survey was conducted in October - Dec 2013. The results from the first wave showed modest improvements in antenatal care of women making at least 4 visits, with controls having no more than 54% utilization. These visits per se were just 0.6 more ANC visits than the controls' 4.2 visits. Postnatal care services within 24 hours, obtained at home, were 10 percentage points higher than controls' 14%. With wave 2 families having more years (average 4 years) as beneficiaries of Pantawid, there were higher increments of 14, 20 and 17 percentage points for facility based delivery, postnatal by a health professional and postnatal at a health facility, with controls at 56%, 59% and 55% respectively. There was no change reported for antenatal and health professional assisted deliveries. This was noted to possibly be due to higher utilization already registered for antenatal care (95% for one visit, though just 74% for four visits). There was no impact on fertility observed.

Reviews of CCT programs in other countries showed mixed results and different pathways on maternal care choices and modern contraceptive use by beneficiaries. Darney, et al (2016) sought to examine if CCT in Mexico, called Prospera, had any direct effect on pregnancy and contraceptive use among young rural women. The study had the benefit of 3 survey waves; it found that the program appeared not to have influenced fertility, with the proportion of adolescent and young adult women reporting ever pregnant being flat at range of 33-36%. Contraceptive use steadily increased from 13% to 19% across 1992-2009. Its multivariate analyses suggest that "exposure to Oportunidades was not associated with pregnancy experience among adolescents. Educational attainment, marital status, pregnancy experience and access to health insurance—but not exposure to Oportunidades—were positively associated with current modern contraceptive use among adolescent and young adult women" (p. 205).

Sosa-Rubi, et al (2010) examined the length of exposure to Oportunidades and found that in localities with longer exposure, women, on average report 2.1% more ANC visits than women living in localities with less exposure. The women were also likely to choose physician/nurse for childbirth; though not for indigenous women who were less likely to seek care from physician or nurse. That length of program exposure being a critical explanation to

utilization, particularly ANC visits, the authors attributed this as learning effect of the program. The women were required to attend health talks and seek care in facilities. The regular contact with a professional or facility was expected to change prejudices and negative perceptions of the public health system in a setting where the private health system is perceived as better quality.

A review paper analyzed CCT programs with respect to health and nutrition in four Latin American and two Caribbean countries (Glassman, Todd and Gaarder, 2007) to provide evidence based on demand side interventions. They found only two assessments that modeled health effects - the demand for health services in Honduras and nutrition effects in Mexico and Nicaragua. On the overall, utilization of conditioned preventive health services increased significantly. Baseline settings, such as in rural areas, with poorer households, registered larger increases, possibly indicating larger unmet needs. The use of prenatal care was viewed as mixed for Oportunidades, Mexico's CCT, while no significant difference in prenatal care initiated in first trimester of pregnancy across 3 clinic types. Urban beneficiaries showed increased percentage (6.12) of births with appropriate prenatal care. There was no impact for the rural sample. Intervention groups reported seeking prenatal care earlier in pregnancy, made more visits and were generally satisfied using a care index compared to control group.

The authors also explored further fertility impacts and found Colombia, Mexico and Nicaragua data indicated that fertility rates decreased with the program, while Honduras experienced fertility increase. How payments were made may be the source of differences. It reported that Honduras had different incentive structure, varying payments by number of children and the number of women in the household and this may explain a 2-4-percentage point increase in fertility. Mexico and Nicaragua on the other hand paid lump sum.

The same study observed that Mexican studies did not find differences between intervention and control localities in their use of family planning methods, even as the proportion of women using these methods decreased for both groups. The average number of children per woman in reproductive age decreased nonetheless. Colombia reported large decline in fertility across intervention and control groups between baseline and follow-up periods, however no reasons were cited.

The same authors (Glassman, Todd and Gaarder, Ibid.) found a few studies exploring supply side inputs and outputs. They point that it is not a 'trivial exercise to evaluate how well and how quickly the planned supply side resource transfers were executed. Up to this point researchers have been unable to fully separate the effects of the various components of the program, especially the differences between impacts due to the cash transfers versus supply-side improvements. However, without determining the changes that occur in the supply of services, it is impossible to conduct such analysis" (p. 25).

Qualitative studies showing increased workloads, with urban settings reporting more beneficiary visits on a wide range, 23 – 87 percent were also reported. Staff shortages, saturation of services and lack of supplies were reported by the Meneses et al's, 2005 study for Mexico. They reported that there were cases some medical staff charged beneficiaries for visits not related to the program; with some even prescribing additional appointment to be able to charged for the 'extra consultation'. Supply responses were reported with increased physical facilities, in public budgets and better salaried staff.

They pointed out that for Nicaragua, supply side scale up were made through NGOs. Overall impact on quality of care or the effect of health lectures on health related behavior and knowledge of beneficiaries were not discussed. They noted that while beneficiaries had higher number of procedures done to them, the results of interventions were "not encouraging, suggesting supply-side strengthening" to improve care quality. One study in Mexico showed that public health clinics in Oportunidades localities had insufficient medicine

supply and that beneficiaries perceived medicines to be of low quality. Beneficiaries were driven to private pharmacies, signifying more expense. One study cited showed that diabetes diagnoses increased but the beneficiaries were "no more likely to have the disease properly treated, suggesting that there is much room to improve the quality of health care that beneficiaries receive" (p. 26).

The quality of prenatal and delivery care was reported for Mexico's rural Oportunidades sample (cf. Prado et al 2004) which showed on average the intervention group received larger number of procedures than stipulated in protocols. "No significant differences were observed between the groups with respect to births in a medical facility, although a smaller proportion of cesareans were recorded in the early intervention group than in the control groups "(p.26).

In Asia, India's conditional cash transfer was intended to increase institutional delivery and encourage the use of reproductive and child health related services. Carvalho, et al (2014) used propensity score matching with logistic regression to find that the program increased post partum check up rates and early breastfeeding and childhood immunization rates. Schmidt and Hossain (Ibid.) noted supply side constraints, with health staff not feeling any benefit compared to CCT beneficiaries in Bangladesh. The CCT program in Bangladesh was focused on maternal and child care services for a number of localities.

Other factors that can affect health care utilization include health insurance. A systematic review of the use and provision of maternal health services and Maternal and Neonatal Health Outcomes as the effect of health insurance showed positive effects, though only four studies showed causal relationships (Comfort, Peterson and Hatt, 2013).

This Philippine study is focused on maternal and reproductive health behavior, including utilization of FP planning services using a sample of Pantawid Pamilya families. Unlike some of the Latin American studies cited in the reviews, which utilized data sets not specifically designed to address just one question but a myriad of impacts, this purposive approach allows a direct case perspective on enabling factors and constraints to utilization of maternal care and reproductive health services. Supply side considerations are explored adapting WHO SARA tool. The FDS' conduct and effects on behavior is incorporated in the analysis. Since demand models are fairly well applied across services in the health sector, the research thrust is relatively straightforward to support policy and programming objectives in maternal and reproductive health services.

4. METHODS

4.1 Study Design

This is a multi-level mixed methods study consisting of surveys, interviews, and focus group discussions.

4.2 Study Population

The study population included the region program coordinators, assistant regional directors, provincial operations office staff, provincial health officers, RHUs, and health center heads, on the regional and municipal level; municipal cluster coordinators and FDS facilitators on the provincial level; and women of reproductive age, their husbands and teenage children on the household level were the chosen participants.

4.3 Sample Size and Sampling Design

A multi-stage purposive sampling design was followed. The three major island groups, Luzon, Visayas, and Mindanao, were the first level of stratification. Provinces that were selected are provinces having one or more of the following characteristics: vulnerability to disasters, the presence of Indigenous peoples communities, and both high and low maternal mortality ratios. Purposive sampling was conducted for the household level surveys, which sought Pantawid family members in randomly selected villages in the selected cities/municipalities. Table 1 below summarizes the study sites and Table 2 shows the sampling plan.

Table 1. Summary of Sampling Sites

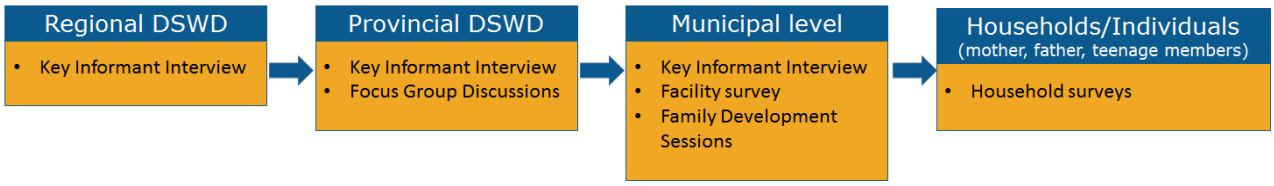
Provincial Sites	Municipalities	Maternal Mortality		Vulnerability to Disasters		Presence of IP Communities		Urban/Rural	
		High	Low	Yes	No	Yes	No	Urban	Rural
LUZON									
ZAMBALES	Iba	■				■		■	
PAMPANGA	Lubao		■	■					■
VISAYAS									
CEBU	Balamban		■						■
	Danao City		■					■	
W. SAMAR	San Sebastian	■		■					■
MINDANAO									
SOUTH COTABATO	Pantukan		■					■	
COMPOSTELA VALLEY	Polomolok	■				■		■	

Table 2. Sampling Design

STAGE	SAMPLING METHOD	SAMPLING FRAME	SAMPLE SIZE
Stage 0	Stratification	3 Island groups (Luzon, Visayas, Mindanao)	All 3 zones
Stage 1	Semi-structured	82 provinces	Provinces that are vulnerable to disasters, that have IP communities, have high maternal mortality ratios, or have low maternal mortality ratios
Stage 3	Simple Random	Municipalities of the selected 6 provinces	1-2 municipalities per province, chosen based on vulnerability to disasters, presence of IP communities, or having either high or low maternal mortality ratios
Stage 4	Purposive sampling to reach women grantees and randomly available spouses and teenage children	All households of 4Ps MHC grantees who are 15-49 years of age	390 women grantee interviews, with at least 65 households interviewed per locality
		Municipal/City Health Offices, Rural Health units, or Barangay Health Stations	1 facility per municipality

4.4 Scopes of Inquiry

As indicated in the sampling plan above, the study went through multiple stages to reach the primary level of analysis, the household. It went through the DSWD Regional offices down to the field workers to reach the cluster of families where the interviews were conducted. The subject matter and scopes of inquiry are in the box below (Figure 2).



Challenges and Opportunities Of Pantawid Program	Understanding and appreciation of roles, Intersectoral collaboration, Challenges and Opportunities	Supply-side: Health facility ocular Assessment of facilities (SARA); engagement of Health sector with 4Ps clients, program planning, coordination and FDS FDS observation: fit, dissemination, interactions with clients and linkage to M&E	Utilization of Maternal Health and FP services, Barriers and Unmet Needs, KAP, Demand

Figure 2. Stages and Scopes of Inquiry

Key informant interviews (KIIs) were made from the regional levels through to municipal, health centre/facility levels. Key Informant Interviews (KIIs) were conducted on regional program coordinators, assistant regional directors, provincial operations office staff, provincial health officers, RHUs and health center heads. KIIs explored how the staff see Pantawid families, how often they use and if they have special needs, as well as their views on the challenges and opportunities presented particularly for maternal and FP services to

Pantawid families.

Focus Group Discussions were also conducted with municipal cluster coordinators and FDS facilitators, with a maximum of 20 participants per session, with one session conducted per province. Health sector staff were invited, although only in region (Luzon) was an FGD held with health representatives from the region and provinces (Pampanga and Zambales). The KIIs and FGDs examined administrators' and staff understanding of their clientele, their roles and the challenges and opportunities they encountered to gain insights into how the Pantawid Pamilya was implemented. Supply-side considerations were explored using KIIs with key health staff in the facility and ocular inspection of facility providing maternal and reproductive health care to Pantawid families in the localities selected.

The ocular inspection adapted a WHO tool known as SARA, or Service Availability and Readiness Assessment Tool (2013). The SARA tool is a systematic survey that generates tracer indicators for general service availability and readiness, and service-specific readiness (e.g., maternal and child health). This survey was conducted with the following target facilities: Municipal/City Health Offices, Rural Health Units, and Barangay Health Station.

At the municipal level, the conduct of the FDS was also observed, at least for one conducted while the research team were on field visit. No special arrangements were made to align the scheduled FDS with the study team's' visit (except possibly to extend their time). This may explain why we did not sit on any FDS related to family planning, which are noted by the team as calendared for the year. Observations on the FDS were jotted in the Field Notes of team observers.

The household survey covered the Pantawid Pamilya families—demographic and household composition, socioeconomic condition, health service utilization, including recent experience of childbirth for those with children 0-5 years of age, KAP on fertility and family planning, including use of contraception, modern and traditional. Unmet need was assessed following DHS-type questions. The main respondent was the mother-grantee. If a spouse or teen-age children were available at the time of interview, they were also interviewed with KAP questions. Teen-age interviews also sought information on sources of information and knowledge on sex, fertility and contraception. The questionnaires were coded every night and interviewers were given one opportunity to go back to the families in case some responses were unclear. There were 66 husbands and 106 teenagers who were interviewed from the sample of 390 household interviews.

4.5 Data Processing and Analysis

Qualitative Data

Summative qualitative content analysis was conducted with the existing study variables as the initial themes. A coding and categorization tool was developed on MS Excel. Two cycles of coding was conducted to analyze the notes and transcripts, with the first using structural coding and the second using pattern coding. Analytic memos were developed throughout the coding process and then subjected to coding. Two independent coders conducted the coding and thematizing process. Coding sorts were developed and organized into themes.

Statistical Analyses

Several statistical tests were used to analyze data collected. Univariate analysis was used to describe data and to show frequencies. Bivariate analysis using the t-test, chi-square test, and relative risk were used to show association between the exposure and the outcome variables. Multivariate analysis through logistic regression was used to measure the

magnitudes of the association. Logistic regression will also control for confounding variables, which may affect the study results by masking or amplifying the apparent relationship between independent and dependent variables. Only p-values of 0.05 or lower were considered significant. Stata 12.0 was used for data analysis.

5. BACKGROUND INFORMATION ON THE STUDY SITES

The study covered the following provinces within the Philippines: Zambales, Pampanga, Cebu, Western Samar, South Cotabato, and Compostela Valley. The economic status of these provinces can be gleaned from its classification in the Local Government Code (Table 3).

Table 3. Site Municipal Class

	Municipal Class (PSA)	
Balamban, Cebu	1	
Danao, Cebu	3	City class
Iba, Zambales	2	
Lubao, Pampanga	1	
Pantukan, Compostela Valley	1	
Polomolok, South Cotabato	1	
San Sebastian, Western Samar	6	

A class 1 municipality is viewed as relatively well off than one with a lower classification. Table 4 and 5 shows more secondary data material on the provinces. Overall, only infant mortality rates vary as expected with municipality classification; the poorer the province the higher the infant mortality rates. Mindanao's provinces showed mixed trends; while both were Class 1 municipalities, maternal mortality rates (MMR) in South Cotabato reflected the profile of Luzon, which had below national average MMR. Compostela Valley reflected Visayas' MMR profile. The economic conditions in Compostela Valley have mining sectors which are income earning but are health and safety hazards. All provinces showed poorer nutritional status than the national average (Table 5).

Table 4. Site Fertility Rate

	*Fertility rates (NDHS 2013)		IMR (PHS 2013; per 1000 live births)	MMR (PHS 2013; per 1000 live births)
	Total Fertility rate	Percentage of women age 15-49 currently pregnant		
National	2.6	-	12.5	0.9
Luzon				
Pampanga (Reg 3)	2.8	4.1	6.2	0.2
Zambales (Reg 3)	2.8	4.1	14.6	0.6
Visayas				
Cebu (Reg 7)	3.2	3.9	11.2	1.2
Western Samar (Reg 8)	3.5	5.9	5.0	1.4
Mindanao				
Compostela Valley (Reg 11)	2.9	5.0	9.7	1.1
South Cotabato (Reg 12)	3.2	3.8	8.7	0.8

PHS - Philippine Health Statistics

Table 5. Site Stunting and Wasting Prevalence

	**Stunting (NNS 2008; prevalence of malnourished children 0-5 years old)					**Wasting (NNS 2008; prevalence of malnourished children 0-5 years old)				
	National Average	Poorest Quintile		Middle Quintile		National Average	Poorest Quintile		Middle Quintile	
		Urban	Rural	Urban	Rural		Urban	Rural	Urban	Rural
National	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
Luzon										
Pampanga (Reg 3)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
Zambales (Reg 3)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
Visayas										
Cebu (Reg 7)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
Western Samar (Reg 8)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
Mindanao										
Compostela Valley (Reg 11)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8
South Cotabato (Reg 12)	30.3	44.2	45	29	27.9	7.9	9.3	9.6	9.6	6.8

6. HOUSEHOLD CHARACTERISTICS

6.1 Profile of Women Grantee or Main Respondents

This chapter is divided into three parts: the first part provides a profile of the women respondents, overall and by low-high MMR status of province and provincial distribution. The second part presents a profile of the socio-economic situation of their spouses and households. The last part examines their Pantawid Pamilya experience. A profile of teen-agers in the study is shown in Appendix 1. The household survey covered 390 Pantawid Pamilya households. A household is defined as inclusive of those living under the same roof and sharing the same meals.

6.1.1 Respondents' Profile by MMR Category of Province

Maternal Mortality status of the province was determined in consultation with the DSWD Planning, Monitoring, and Evaluation Division, which provided the study provinces.

Respondents in Low MMR (Table 6) areas are on average a year older, have on average been married for one fewer year, and have on average one fewer household members than High MMR areas. There are fewer respondents in Low MMR areas with a child below 5 years of age than in High MMR areas, with 46.74% in Low MMR and 53.26% in High MMR. Fewer respondents in low MMR areas also have children between 6 and 18 years of age, with 45.17% in Low MMR areas and 54.83% in High MMR areas. There are far more Service workers (33 in Low MMR, 3 in High MMR) and Laborers (28 in Low MMR, 12 in High MMR) in Low MMR areas. Average income is higher in Rural areas, with average income at greater than Php 4000 at 85.13% for Low MMR areas and 67.29% for High MMR areas.

Table 6. Profile of Respondents by Low-High MMR Status of Province

	Low MMR (n=195)	High MMR (n=195)
Mean Age of Women Respondents:	36.58 ± 8.04	35.65 ± 6.34
Years married or cohabiting	13 (1 to 48)	14 (2 to 32)
Mean Age when first Married (in years)		
Spouse	25.50 ± 6.35	24.70 ± 6.02
Respondent	22.01 ± 5.19	21.14 ± 4.98
Household size	6 (2 to 11)	7 (3 to 12)
Children per household (18 y/o and below)	4 (0 to 10)	4 (1 to 9)
No. and % of Women with Children below 5 years of age	122 (46.74)	139 (53.26)
No. and % of Women with children between 6-18 years of age	131 (45.17)	159 (54.83)
Educational attainment		
No formal education	266 (31.22)	266 (27.94)
Elementary completed	24 (2.82)	168 (17.65)
Elementary not completed	316 (37.09)	282 (29.62)
High school completed	64 (7.51)	80 (8.4)
High school not completed	147 (17.21)	123 (12.92)
Vocational completed	4 (0.47)	2 (0.21)
College completed	5 (0.59)	10 (1.05)
College not completed	26 (3.05)	21 (2.21)
Post graduate completed	0	0
Occupation of the women respondents (n= 106)		
Technicians and associate professionals	0	1 (1.2)
Clerks	1 (1.37)	2 (2.41)
Service workers and shop and market sales owners	33 (45.21)	3 (3.61)
Farmers, forestry workers and fishermen	2 (2.74)	4 (4.82)
Trades and related workers	2 (2.74)	0
Plant and machine operators and assemblers	0	0
Laborers and unskilled workers	28 (38.36)	12 (14.46)
Special occupations	7 (9.59)	8 (9.64)
Income of Woman from Occupation (mean overall and SD)-Earning for 2015	4 (0 to 4)	3 (0 to 4)
< 1,000	62 (31.79)	60 (30.77)
1,000-2,000	0	0
2,001-3,000	0	0
3,01-4,000	6 (3.08)	3 (1.54)
> 4,000	166 (85.13)	132 (67.69)

6.1.2 Urban- Rural Profile

Table 7 shows the distribution of the 390 women respondents by urban-rural settings.

In both urban and rural settings, the average age is 36 years, and the length of marriage is equally around 13 years. There are more service workers (26 Urban, 10 Rural) and laborers (23 Urban, 17 Rural) in urban areas. There are more respondents in urban areas who have children below 5 years of age, as well as between 6 to 18 years of age.

Table 7. Profile of Women Grantee Respondents, Urban-Rural

	Urban (n= 215)	Rural (n=175)
Mean Age (Standard deviation) of Women Respondents:	36.08 ± 6.88	36.16 ± 7.69
Years married (or cohabiting)	13 (1 to 35)	13 (1 to 48)
Mean Age when first Married: Years		
Spouse	25.98 ± 6.28	24.39 ± 6.04
Respondents	21.97 ± 5.25	21.26 ± 4.96
Household size	6 (2 to 11)	6 (2 to 12)
Children per household (18 y/o and below)	4 (0 to 10)	4 (0 to 9)
Educational attainment		
No formal education	266 (27.2)	266 (32.2)
Elementary completed	38 (3.89)	154 (18.64)
Elementary not completed	438 (44.79)	160 (19.37)
High school completed	45 (4.6)	99 (11.99)
High school not completed	163 (16.67)	107 (12.95)
Vocational completed	6 (0.61)	0
College completed	1 (0.1)	14 (1.69)
College not completed	21 (2.15)	26 (3.15)
Occupation of the women respondents (n=)		
Other occupations (clerksm farmers, machine operators)	7 (6.09)	5 (12.2)
Service workers and shop and market sales owners	26 (22.61)	10 (24.39)
Laborers and unskilled workers	23 (20)	17 (41.46)
Special occupations	6 (5.22)	9 (21.95)
No. and % of Women with Children below 5 years of age	142 (54.41)	119 (45.59)
No. and % of Women with children between 6-18 years of age	154 (53.10)	136 (46.90)
Income of Woman from occupation		
< 1,000	100 (57.14)	22 (10.23)
1,000-2,000	0	0
2,01-3,000	0	0
3,01-4,000	6 (3.43)	3 (1.40)
> 4000	67 (38.29)	189 (87.91)

Of the respondents in both settings, majority were not able to reach or to complete High School, with more respondents from Urban areas reaching but failing to complete High School (16.67% Urban, 12.95% Rural) but more respondents from Rural areas completing High School (4.6% Urban, 11.99% Rural)

That few women are not gainfully employed may be partly attributed to the ages of their children. Those with younger children, without adequate daycare facilities may not be at work. 46.74% of women in Urban areas and 53.26% of women in Rural areas reported having children below 5 years old, while 45.17% of women in Urban areas and 54.83% of women in Rural areas reported having school-aged (6-18 years of age) children. Average household size reported is 6.

6.1.3 Provincial Profile

A glimpse of the provincial profile of the respondents shows the following (Table 8):

Cebu has the most reporting 10 years of marriage while Western Samar respondents reported being married longest at 16 years. Western Samar had the largest number of respondents who reported having completed college education, with 9 respondents or 2.39%. Service Workers and Unskilled laborers constitute the largest groups of occupations reported by respondents, with South Cotabato having 19 of the service workers whereas of the 41 laborers, the largest single group is from Pampanga with 16, followed closely by

South Cotabato with 12.

Each household, including the respondent and spouse, had an average size of 6 persons, with the largest average sizes in both Western Samar and Compostela Valley, with 7, and smallest from Cebu, with 5. All households equally had on average one child below 5 years of age. Save for South Cotabato, more than half of the respondents from each province reported having monthly income of greater than 4000, with Western Samar having the most, where all respondents saying so.

Table 8. Women Respondents' Profile by Provincial Distribution

	Pampanga	Zambales	Cebu	W Samar	South Cotabato	Compostela Valley
Age of women interviewed (mean and SD)	35.17 ± 5.96	32.67 ± 5.89	38.31 ± 11.52	37.54 ± 5.82	36.28 ± 4.81	36.66 ± 6.3
Years married	13 (1 to 27)	12 (2 to 24)	10 (2 to 48)	16 (4 to 32)	14 (1 to 30)	15 (2 to 31)
Distribution of Women, by Years Married/ with Partner						
Mean Years	13.4	12.2	14.7	10.2	15.0	14.4
Standard Deviation	5.9	5.2	10.2	5.8	6.4	6.2
Min	1	2	2	4	2	1
Max	27	24	48	32	31	30
Ave Household Size: Overall 6.31	6.1	5.9	5.4	7.6	6.4	6.4
Ave. (SD) No. of children aged 5 years and below	1 (0 to 3)	1 (0 to 2)	1 (0 to 3)	1 (0 to 3)	1 (0 to 3)	1 (0 to 3)
Ave. No. of children aged 6-18 years old	4 (1 to 9)	4 (1 to 8)	3 (0 to 7)	5 (1 to9)	4 (1 to 10)	4 (1 to 8)
Education, by Province (Number & Percent of Provincial Total)	n=276	n=259	n=261	n=377	n=315	n=316
No formal education	96 (34.78)	85 (32.82)	76 (29.12)	106 (28.12)	94 (29.84)	75 (23.73)
Elementary completed	8 (2.9)	18 (6.95)	10 (3.83)	141 (37.4)	6 (1.9)	9 (2.85)
Elementary not completed	100 (36.23)	136 (52.51)	79 (30.27)	10 (2.65)	137 (43.49)	136 (43.04)
High school completed	11 (3.99)	5 (1.93)	44 (16.86)	72 (19.1)	9 (2.86)	3 (0.95)
High school not completed	57 (20.65)	13 (5.02)	28 (10.73)	31 (8.22)	62 (19.68)	79 (25)
Vocational completed	0	0	2 (0.77)	0	2 (0.63)	2 (0.63)
College completed	2 (0.72)	0	3 (1.15)	9 (2.39)	0	1 (0.32)
College not completed	2 (0.72)	2 (0.77)	19 (7.29)	8 (2.12)	5 (1.59)	11 (3.48)
Post graduate completed	0	0	0	0	0	0
Occupational Status: Reporting working in occupation earning income						
Service Workers						
Laborer, unskilled	6 (26.09)	0	8 (50)	0	19 (55.88)	3 (4.84)
Other Occupations	16 (69.57)	8 (57.14)	0	1 (14.29)	12 (35.29) 1	3 (4.84)
(clerks,farmers)	1 (4.35)	4 (28.57)	3 (18.75)	1 (14.29)	(2.94)	2 (3.22)
Unspecified Occupations	0	2 (14.29)	5 (32.25)	5 (71.43)	2 (5.88)	1 (1.61)
Household income (PhP)						
< 1,000	0	0	0	0	0	0
1,001-2,000	2 (3.08)	1 (1.54)	2 (3.08)	0	12 (18.46)	1 (1.54)
2,001-3,000	22 (33.85)	7 (10.77)	7 (10.77)	0	22 (33.85)	3 (4.62)
3,001-4000	6 (9.23)	11 (16.92)	19 (29.23)	0	7 (10.77)	12 (18.46)
> 4,000	35 (53.85)	46 (70.77)	37 (56.92)	65 (100)	24 (36.92)	49 (75.38)

On the overall, *Pantawid respondents in the study sites, compared to NDHS 2013 can be considered older, married longer, have much less education, have bigger household size having on average two more children, and are less gainfully employed*.

6.2 Profile of Husbands/Partners of Pantawid Grantees and Socio-economic Characteristics of Households

6.2.1 Profile of Women Grantees Husbands/Partners

Referring to Table 9, spouses of respondents are much older in Low MMR areas (36.5 years Low MMR, 31 years High), and were also at least a year older at marriage.

Like the respondents, majority of the spouses did not reach or complete high school, but a good number of spouses completed high school in low MMR areas (32% Low MMR, 23% High MMR). Also similar to the respondents, the largest groups of reported occupation were service workers and unskilled laborers, with almost half of spouses in both Low and High MMR areas reporting to be Laborers.

Table 9. Background Information on Husbands/Partners of Women Grantees

	Low MMR (n=195) Provinces:	High MMR (n=195) Provinces:
Mean Age of Women Grantees' Husband/Partner	36.5 ± 6.36	31±
Mean Age when Married: Years		
Spouse	25.50 ± 6.35	24.70 ± 6.02
Respondent	22.01 ± 5.19	21.14 ± 4.98
Educational attainment (n= 386)		
No formal education 4(1.0)	1 (0.52)	3 (1.55)
Elementary completed 95 (24.6)	37 (19.17)	43 (22.28)
Elementary not completed 105 (27.2)	25 (12.95)	27 (13.99)
High school completed 75 (19.3)	62 (32.12)	44 (22.8)
High school not completed 72 (18.7)	54 (27.98)	65 (33.68)
Vocational completed 11 (2.9)	2 (1.04)	2 (1.04)
College completed 4 (1.0)	3 (1.55)	0
College not completed 19 (4.9)	9 (4.66)	9 (4.66)
Post graduate completed	0	0
Occupation of respondents husbands (n= 379)		
Service workers and shop and market sales owners	44 (23.78)	12 (6.9)
Laborers and unskilled workers	91 (49.19)	76 (38.18)
Other occupations	32 (17.30)	94 (48.45)
Special occupations	18 (9.73)	12 (6.19)

6.2.2 Some Background on the Household Socio-Economic Conditions

Less than half of the households reported having 2 adult earners (41%) but 65.64% still report having an income greater than 4000 per month.

Majority report to having monthly food expenditures of less than 2000, and nearly all (99.49%) report to having expenses for cigarettes, alcohol, and games to be less than 1000 per month. For school expenses, 62% report expenses between 1000 and 2000.

A good number (70.77%) report to having a television, while only 11.79% report to having a refrigerator. Most use either a wood or coal stove, at 87.69%.

Majority source their water from faucets, with water from a spring a distant second, at

17.95%. More than half, at 59% have had home renovations since becoming a member of the 4Ps program.

Majority, at 82.31%, report to having roofs of iron sheet or “yero”.

Table 10. Background Information on Household Socio-Economic Conditions of Women Grantees

	No. Reporting
No. of households reporting 2 adult earners	161 (41.28)
Household income (PhP) excluding from PPPP	
< 1,000	0
1,001-2,000	18 (4.62)
2,001-3,000	61 (15.64)
3,001-4,000	55 (14.10)
> 4,000	256 (65.64)
No. reporting expenditures	
Food Expenses:	
< 1,000	169 (43.33)
1,001-2,000	191 (48.97)
2,001-3,000	22 (5.64)
3,001-4,000	5 (1.28)
> 4,000	3 (0.77)
Cigarettes, Alcohol, Games	
< 1,000	388 (99.49)
1,001-2,000	2 (0.51)
2,001-3,000	0
3,001-4,000	0
> 4,000	0
School Expenses (tuition, books, uniforms)	
< 1,000	0
1,001-2,000	242 (62.05)
2,001-3,000	72 (18.46)
3,001-4,000	38 (9.74)
> 4,000	38 (9.74)
Households with:	
TV	276 (70.77)
Refrigerator	46 (11.79)
Electric Stove	37 (9.49)
Wood/coal stove	342 (87.69)
Source of Drinking water:	
Piped/communal	68 (17.44)
Faucet	246 (63.08)
Spring	29 (7.44)
Deep well	11 (2.82)
Other sources	74 (18.97)
With House Renovation since 4 Ps	230 (58.97)
Roof	
Native/Cogon/Nipa	68 (17.44)
Iron Sheet	321 (82.31)
Others reported	55(14.1)

6.3 Profile of Pantawid Membership

Table 11 shows that the average grant received per month were Php 1400, which is roughly the same in both Low and High MMR areas. The values differ per province, with a low value of 1100 in both Pampanga and Zambales and a significantly larger high value of 2800 from Western Samar.

Respondents have been member of the 4Ps program on average at 4 years, but those living in High MMR areas have been members for longer, at 5 years, as well as the respondents in Western Samar, who have been members for 6 years.

The single most prevalent mode of grant transfer is the On-site over the counter transaction (41.54%), which is still the method most used in High MMR areas (65%). Provinces differ, with CASH Cards being most prevalent in Zambales, Cebu, South Cotabato, and the

Landbank Prepaid card in Pampanga.

Urban settings have been members of the program for 4 years and more than a quarter (28.37%) in Urban settings have been members of the program for 5 years. Those in Rural settings are more dispersed, with 32.57% having been members for 6 years, and 29.14% having been a member for only a year. The settings are roughly identical in other respects.

Table 11. Profile of Pantawid Membership

Ave. Pantawid Grant Amounts Received per households	
Overall	1400 (250 to 4000)
Low MMR Provinces	1400 (250 to 3600)
High MMR Provinces	1400 (500 to 4000)
By Province	
Luzon:	
Pampanga	1100 (500 to 1800)
Zambales	1100 (500 to 1800)
Visayas:	
Cebu	1600 (500 to 3600)
Western Samar	2800 (1000 to 4000)
Mindanao:	
South Cotabato	1400 (250 to 3200)
Compostela Valley	1300 (500 to 3200)
Average Years of Membership	
Overall	4
Low MMR	3
High MMR	5
Urban	4
Rural	6
By Province	
Luzon:	
Pampanga	3
Zambales	4
Visayas:	
Cebu	2
Western Samar	6
Mindanao:	
South Cotabato	4
Compostela Valley	4
Most prevalent mode of mode of cash transfer:	On-site over the counter transaction (162, 41.54%)
Low MMR	CASH Cards (98 (50.26%)
High MMR	On-site over the counter transaction (127, 65.13%)
By Province	
Luzon:	
Pampanga	Landbank Prepaid card (62, 95.38%)
Zambales	CASH Cards (51, 78.46%)
Visayas:	
Cebu	CASH Cards (39, 60%)
Western Samar	On site over the counter transaction (65, 100%)
Mindanao:	
South Cotabato	CASH Cards (59, 90.77%)
Compostela Valley	On site over the counter transaction (61, 93.85%)

7. UTILIZATION and UNMET NEED

7.1 Profile of Utilization of Antenatal Care and Family Planning services

This chapter is divided into three parts: the first part describes the number of antenatal care visits done for the latest pregnancy, the ANC services utilized, such as taking of blood pressure and blood tests, the place of delivery, and whether the respondents visited or was

visited by a health professional after giving birth to their latest child. The second part shows describes whether and how many of the respondents consulted at the health facility for family planning advice. The third and last part will profile the use of and the desire to use modern contraception. All of these will be profiled at both national and provincial levels.

7.1.1 Respondents 4 or more ANC visits

Majority of the respondents were able to get 4 or more ANC visits, and this was reflected in each province save for Cebu, which saw only 75% of the respondents getting 4 or more ANC visits. Low MMR areas also saw lower numbers for 4 or more ANC visits (88% Low MMR, 96% High MMR), and the same trend applies to rural areas compared to urban areas (88% Rural, 95% Urban). Overall, these show much better numbers compared to the national statistics from NDHS 2013, which report 84% having four or more ANC visits.

Table 12. ANC Visits by Province, Low-High MMR, and Urban-Rural

	Less than 4 ANC	4 or more ANC
National	30 (7.78%)	356 (92.23%)
Pampanga (65)	2 (3)	63 (96.92)
Zambales (63)	2 (3.2)	61 (96.83)
Cebu (64)	16 (25)	48 (75)
Western Samar (65)	2 (3.1)	63 (96.92)
South Cotabato (64)	5 (7.81)	59 (92.19)
Compostela Valley (65)	3 (4.62)	62 (95.38)
Low MMR (193)	23 (11.92)	170 (88.08)
High MMR (193)	7 (3.63)	186 (96.37)
Urban (212)	10 (4.72)	202 (95.28)
Rural (174)	20 (11.49)	154 (88.51)

7.1.2 Respondents utilization of ANC services

Five different ANC services saw mixed utilization, with Urinalysis and Blood tests showing markedly lower percentages. The giving of ferrous sulfate tablets, nutritional counseling, and the taking of blood pressure saw uniformly high utilization of greater than 90% with the Urinalysis and Blood tests at 65% and 59% respectively.

Similar trends are seen per province, with the exception of Zambales and Cebu, which saw high utilization even in the latter two services. No marked difference is seen between High and Low MMR, save for a slight difference in Urinalysis (72% Low, 58% High) and Blood testing (63% Urban, 55% Rural). No marked difference is seen too between Urban and Rural save for a slight difference in Ferrous Sulfate (54% Urban, 46% Rural), Urinalysis (68% Low, 60% High), and Blood testing (66% Urban, 52% Rural).

Table 13. Utilization of ANC Services by Province

	Ferrous sulfate Tablets (207)	Nutritional Counseling (208)	Blood pressure taken (210)	Urinalysis (211)	Blood test (212)
National	384 (98.46%)	356 (92.23%)	377 (97.67)	250 (64.77)	229 (59.33)
Pampanga	65 (100)	65 (100.00)	63 (98.44)	23 (35.94)	20 (31.25)
Zambales	65 (100)	63 (100.00)	63 (96.92)	63 (96.92)	63 (96.92)
Cebu	65 (100)	63 (98.44)	60 (92.31)	63 (96.92)	54 (83.08)
Western Samar	65 (100)	65 (100.00)	63 (98.44)	52 (81.25)	48 (75)
South Cotabato	60 (93.75)	60 (93.75)	65 (100)	23 (35.38)	20 (30.77)
Compostela Valley	64 ((96.97)	63 (96.92)	63 (100)	26 (41.27)	24 (38.1)
Low MMR	191 (49.74)	188 (97.41)	186 (96.37)	138 (71.5)	122 (63.21)
High MMR	193 (50.26)	191 (98.96)	191 (98.96)	112 (58.03)	107 (55.44)
Urban	209 (54.43)	206 (97.17)	209 (98.58)	145 (68.4)	139 (65.57)
Rural	176 (45.57)	173 (99.43)	168 (96.55)	105 (60.34)	90 (51.72)

7.2 Delivery in Facility

There are significant numbers of respondents who did not deliver in a facility in their latest pregnancy at 27%. Of those who did deliver in a facility, 166 or 43% delivered in a public hospital and 95 or 24% delivered in either a health center or a birthing center. Trends vary per region, with Western Samar notably having an opposite trend, with almost half of deliveries being done in health centers or birthing centers but at the same time also having the highest number of non-facility deliveries, along with Zambales.

Expectedly, there are far greater numbers of non-facility deliveries in High MMR areas than in Low MMR areas (34% High MMR, 22% Low MMR). Urban and Rural areas are nearly identical save for greater use of private facilities in urban areas.

Table 14. Delivery by Province, Low-High MMR, and Urban-Rural

	Health Center and birthing center	Public hospital	Private facilities	Non facility
National	95 (24.36)	166 (42.56)	21 (5.38)	108 (27.69)
Pampanga	1 (1.54)	49 (75.38)	0 (0)	15 (23.08)
Zambales	9 (13.85)	30 (46.15)	1 (1.54)	25 (38.46)
Cebu	17 (26.15)	24 (36.92)	2 (3.08)	22 (33.85)
Western Samar	32 (49.23)	7 (10.77)	1 (1.54)	25 (38.46)
Compostela Valley	10 (15.15)	33 (50)	7 (10.61)	16 (24.24)
South Cotabato	26 (40.63)	23 (35.94)	10 (15.63)	5 (7.81)
Low MMR	44 (22.56)	96 (49.23)	13 (6.67)	42 (21.54)
High MMR	51 (26.15)	70 (35.90)	8 (4.10)	66 (33.85)
Urban	45 (20.93)	94 (43.72)	18 (8.37)	58 (26.98)
Rural	50 (28.57)	72 (41.14)	3 (1.71)	50 (28.57)

7.3 Postnatal care visits

Majority of the respondents were able to get postnatal check ups, and 70% received these through a health professional that visited them in their residence. The trends vary widely per province, with Zambales notably with almost half getting postnatal visits at the health facility instead of at home. Notably too, Low MMR areas had much more postnatal visits that were done through a health professional visiting the household. The profiles for Urban and Rural areas are nearly identical. Overall and again, this compares favorably to the national numbers, which shows 72% receiving postnatal check ups, a lower value than the more than 90% value reported in this study's sample.

Table 15. Postnatal Care Visits by Province, Low-High MMR, and Urban-Rural

	No visit	Went to Health facility	Visited by health professional
National	8 (2.07)	79(20.47)	273(70.73)
Pampanga	1 (1.56)	4 (6.25)	56 (87.5)
Zambales	4 (6.15)	36 (55.38)	20 (30.77)
Cebu	1 (1.54)	21 (32.31)	34 (52.31)
Western Samar	1 (1.56)	2 (3.13)	54 (84.38)
South Cotabato	0	13 (20)	52 (80)
Compostela Valley	1 (.159)	3 (4.76)	57 (90.48)
Low MMR	3 (1.55)	27 (13.99)	144 (74.61)
High MMR	5 (2.59)	52 (26.94)	129 (66.84)
Urban	6 (2.83)	41 (19.34)	151 (71.23)
Rural	2 (1.15)	38 (21.84)	122 (70.11)

7.4 Family Planning and Contraception

7.4.1 Consulted at the health facility for family planning services

Respondents consulting the health facility for family planning services are uniformly high, with exception of Pampanga which showed only 80% consulting a health facility for FP services. Compared to urban areas, consultation in rural areas was nine percentage points less.

Table 16. Consultation at the Health Facility by Province, Low-High MMR, and Urban-Rural

	Consulted at the health facility
National	357 (91.54)
Pampanga	52 (80)
Zambales	60 (92.31)
Cebu	60 (92.31)
Western Samar	60 (92.31)
South Cotabato	60 (92.31)
Compostela Valley	65 (100)
Low MMR	172 (88.21)
High MMR	185 (94.87)
Urban	205 (95.35)
Rural	152 (86.85)

7.4.2 Modern Contraceptive Method Used

On the national level, Hormonal contraceptive or pills, were reported by 67% of the respondents, the highest among modern methods. This national trend is consistent and reflected in all the provinces, with the lowest share of use at 58% in South Cotabato and the highest at 84% in Zambales. This national trend is also reflected in the NDHS 2013, which shows the pill, a hormonal contraceptive method, having the highest utilization among other contraceptive methods.

High MMR areas also see much higher use of hormonal methods by respondents (75% High MMR, 60% Low MMR), but are otherwise identical.

Table 17. Modern Contraceptives Used by Province, Low-High MMR, and Urban-Rural

	Barrier	Hormonal	Intrauterine	Sterilization
National	28 (6.06)	309 (66.88)	33 (7.14)	26 (5.63)
Pampanga	3 (3.75)	54 (67.5)	0	7 (8.75)
Zambales	0	65 (84.42)	0	7 (9.09)
Cebu	8 (12.5)	34 (53.13)	6 (9.38)	3 (4.69)
Western Samar	4 (5.56)	52 (72.22)	3 (4.17)	1 (1.39)
South Cotabato	8 (7.92)	59 (58.42)	18 (17.82)	7 (6.93)
Compostela Valley	5 (7.35)	45 (66.18)	6 (8.82)	1 (1.47)
Low MMR	19 (7.76)	147 (60)	24 (9.80)	17 (6.94)
High MMR	9 (4.15)	162 (74.65)	9 (4.15)	9 (4.15)
Urban	14 (5.3)	181 (68.56)	25 (9.47)	15 (5.68)
Rural	14 (7.07)	128 (64.65)	8 (4.04)	11 (5.56)

7.4.3 Reasons for Stopping Use of Modern Contraceptives

Various reasons were provided for why the use of modern contraceptives was dropped, with Health reasons, which refers to fear of use, side effects, and bleeding associated with its use, with 53% of women citing this as reason. The same pattern is seen consistently throughout the provinces, although it was highest in Cebu (70%) and Western Samar (68%). A greater percentage of the rural sample reported discontinuation than urban samples. 9.4% reported dissatisfaction (e.g., experienced physical discomfort).

Table 18. Reasons for Stopping Use of Modern Contraceptives by Province, Low-High MMR, and Urban-Rural

	Health reasons	Method failure	Got pregnant/Started breastfeeding	Shifted methods	Dissatisfied
Overall sample	90 (52.94)	9 (5.29)	23 (13.53)	14 (8.24)	16 (9.41)
Pampanga	13 (41.94)	4 (12.9)	5 (16.13)	2 (6.45)	3 (9.68)
Zambales	14 (46.67)	2 (6.67)	3 (10)	1 (3.33)	5 (16.67)
Cebu	16 (69.57)	0	3 (13.04)	2 (8.7)	2 (8.7)
Western Samar	15 (68.18)	0	2 (9.09)	1 (4.55)	1 (4.55)
South Cotabato	24 (53.33)	1 (2.22)	9 (20)	4 (8.89)	4 (8.89)
Compostela Valley	8 (42.11)	2 (10.53)	1 (5.26)	4 (21.05)	1 (5.26)
Low MMR (99)	53 (53.54)	5 (5.05)	7 (7.07)	17 (17.17)	8 (8.08)
High MMR (71)	37 (52.11)	4 (5.63)	11 (15.49)	6 (8.45)	6 (8.45)
Urban	51 (50.50)	5 (4.95)	11 (10.89)	13 (12.87)	10 (9.90)
Rural	39 (56.52)	4 (5.80)	10 (14.49)	4 (5.80)	5 (7.25)

7.4.4 Willingness to Use Modern Contraception

For those who don't currently use, the methods that they reported they were most willing to use were Sterilization, both female and male, and the male condom. The pattern again holds throughout the provinces with some notable exceptions, such as the much higher willingness for female sterilization in Pampanga and Zambales, which reached 97% and 95% respectively, compared to 79% at the overall sample level.

Table 19. Willingness to Use of Modern Contraceptives by Province, Low-High MMR, and Urban-Rural

	Sterilization (female; male)	Pill	IUD	Injectable	Male condom
Overall sample	200 (79.05) 250 (98.91)	127 (50.20)	210 (83)	160 (63.24)	237 (93.68)
Pampanga	38 (97.44) 39 (100)	17 (43.59)	32 (82.05)	29 (74.36)	33 (84.62)
Zambales	38 (95) 40 (100)	24 (60)	39 (97.5)	27 (67.5)	35 (87.5)
Cebu	24 (58.54) 39 (95.12)	22 (53.66)	22 (53.66)	16 (39.02)	40 (97.56)
Western Samar	16 (47.06) 33 (97.06)	20 (58.82)	21 (61.76)	21 (61.76)	33 (97.06)
South Cotabato	38 (86.36) 44 (100)	19 (43.18)	42 (95.45)	33 (75)	44 (100)
Compostela Valley	46 (83.64) 55 (100)	25 (45.45)	54 (98.18)	34 (61.82)	52 (94.55)
Low MMR	100 (80.65) 122 (98.39)	58 (46.77)	96 (77.42)	78 (62.90)	117 (94.35)
High MMR	100 (77.52) 128 (99.22)	69 (53.49)	114 (88.37)	82 (63.57)	120 (93.02)
Urban	132 (86.84) 151 (99.34)	76 (50)	143 (94.08)	60 (59.41)	94 (93.07)
Rural	68 (67.33) 99 (98.02)	51 (50.50)	67 (66.34)	60 (59.41)	94 (93.07)

7.4.5 Unmet Need for Family Planning

There are still women who are not using any contraceptive and do not desire children, though less than 10% (or 6%) of the respondents both do not use contraceptive methods and do not desire children, which is a trend reflected in the provinces. There are larger numbers of women who do not use contraceptive methods in High MMR areas, which is almost double that of those in Low MMR areas. These compare favorably with NDHS numbers, which shows non-use of contraception at 45%.

Table 20. Unmet Need for Family Planning

	Overall Sample	Low MMR	High MMR
	Frequency (%)		
Women aged 15-49 who are not using any contraceptive	60 (16.30)	22 (12.29)	38 (20.11)
Women aged 15-49 who are not using any contraceptive and is not desiring to have children	30 (8.15)	9 (5.03)	21 (11.11)

8. KNOWLEDGE, ATTITUDES, AND PRACTICES

8.1 Results

8.1.1 On Pregnancy and Sex

Per Provincial disaggregation

Table 21. Knowledge of the Respondents towards Maternal Health Care and Family Planning per Province: Pregnancy and Sex

	Pampanga (n=65)	Zambales (n=65)	Cebu (n=65)	Western Samar (n=65)	South Cotabato (n=65)	Compostela Valley (n=65)
	Frequency (%)					
MATERNAL HEALTH CARE						
315: Alam ba ninyo kung kailan ang panahon na hindi mainam makipagtalik dahil maaaring mabuntis?						
Oo	43 (66.15)	29 (44.62)	53 (81.54)	64 (98.46)	58 (89.23)	29 (44.62)
Hindi	15 (23.08)	16 (24.62)	8 (12.31)	1 (1.54)	3 (4.62)	15 (23.08)
Hindi alam	7 (10.77)	20 (30.77)	4 (6.15)	0	4 (6.15)	21 (32.31)
314: Mayroon bang mga araw sa loob ng menstrual cycle kung saan mas mataas ang tsansang mabuntis ang isang babae?						
Oo	4 (6.15)	6 (9.23)	10 (15.38)	46 (70.77)	28 (43.08)	7 (10.77)
Hindi	4 (6.15)	1 (1.54)	0	0	2 (3.08)	2 (3.08)
Hindi alam	57 (87.69)	58 (89.23)	55 (84.62)	19 (29.23)	35 (53.85)	56 (86.15)

A high percentage of respondents across all regions know that there are days where there is greater risk of pregnancy upon sexual intercourse, with Western Samar having the highest rate at 98.46%, followed by Cebu at 81.54%.

Per Setting disaggregation

Table 22. Knowledge of the Respondents towards Maternal Health Care and Family Planning per Setting: Pregnancy and Sex

	Urban (n=215)	Rural (n=175)
	Frequency (%)	
MATERNAL HEALTH CARE		
315: Alam ba ninyo kung kailan ang panahon na hindi mainam makipagtalik dahil maaaring mabuntis?		
Oo	132 (61.4)	144 (82.29)
Hindi	36 (16.74)	22 (12.57)
Hindi alam	47 (21.86)	9 (5.14)
314: Mayroon bang mga araw sa loob ng menstrual cycle kung saan mas mataas ang tsansang mabuntis ang isang babae?		
Oo	41 (19.07)	60 (34.29)
Hindi	5 (2.33)	4 (2.29)
Hindi alam	169 (78.6)	111 (63.43)

Respondents in rural areas report knowing when it is likely that sexual intercourse may lead to pregnancy.

Per MMR disaggregation

Table 23. Knowledge of the Respondents towards Maternal Health Care and Family Planning per MMR Status: Pregnancy and Sex

	Low MMR (n=195)	**High MMR (n=195)**
	Frequency (%)	
MATERNAL HEALTH CARE		
315: Alam ba ninyo kung kailan ang panahon na hindi mainam makipagtalik dahil maaaring mabuntis?		
Oo	154 (78.97)	122 (62.56)
Hindi	26 (13.33)	32 (16.41)
Hindi alam	15 (7.69)	41 (21.03)
314: Mayroon bang mga araw sa loob ng menstrual cycle kung saan mas mataas ang tsansang mabuntis ang isang babae?		
Oo	42 (21.54)	59 (30.26)
Hindi	6 (3.08)	3 (1.54)
Hindi alam	147 (75.38)	133 (68.21)

More respondents in low MMR regions report knowledge of when the chances are higher of getting pregnant following sexual intercourse.

8.1.2 On Health Facility Utilization

Per Provincial disaggregation

Table 24. Knowledge of the Respondents towards Family Planning per Province: Health Facility Utilization

	Pampanga (n=65)	**Zambales (n=65)**	**Cebu (n=65)**	**Western Samar (n=65)**	**South Cotabato (n=65)**	**Compostela Valley (n=65)**
	Frequency (%)					
FAMILY PLANNING						
218: Kinailangan mo bang alalahanin ang pag-iwan sa inyong sambahayan (bahay)?						
Oo	33 (50.77)	20 (30.77)	22 (33.85)	36 (55.38)	13 (20)	45 (69.23)
Hindi	17 (26.15)	20 (30.77)	21 (32.31)	4 (6.15)	47 (72.31)	4 (6.15)
Hind alam	15 (23.08)	25 (38.46)	22 (33.85)	25 (38.46)	5 (7.69)	16 (24.62)
239: Kapag pumupunta kayo sa health center, kailangan ba ninyong magpasama sa inyong asawa/partner?						
Oo						
Hindi	13 (20)	11 (17.19)	21 (32.31)	7 (10.77)	20 (30.77)	18 (27.69)
Hindi alam	52 (80)	53 (82. 81)	43 (66.15)	58 (89.23)	45 (69.23)	47 (72.31)
	0	0	1 (1.54)	0	0	0
240: Kailangan ba niya kayong pahintulutan?						
Oo	33 (46.88)	43 (66.15)	11 (16.92)	58 (90.63)	40 (61.54)	40 (63.49)
Hindi	40 (51.56)	22 (33.85)	54 (83.08)	6 (9.38)	25 (38.46)	23 (36.51)
Hindi alam	1 (1.56)	0	0	0	0	0

All provinces report feeling worry when leaving the household for the health facility, with Compostela Valley having the highest proportion (69.23%) followed by those from Western Samar (55.38%). Those from South Cotabato feel no need to worry, with 72.31% of respondents saying so.

When going to the facility, some respondents report that they still need to be accompanied by their partners, with almost a third (30.77%) of respondents from South Cotabato reporting so. Majority of the respondents mention that they still need to be given permission by their spouse to go to facility, where 90% of the respondents from Western Samar feeling the need to do so.

Per Setting disaggregation

Table 25. Attitude of the Respondents towards Family Planning per Setting: Health Facility Utilization

	Urban (n=215)	**Rural (n=175)**
	Frequency (%)	
FAMILY PLANNING		
218: Kinailangan mo bang alalahanin ang pag-iwan sa inyong sambahayan (bahay)?		
Oo	82 (38.14)	87 (49.71)
Hindi	75 (34.88)	38 (21.71)
Hindi alam	58 (26.98)	50 (28.57)
239: Kapag pumupunta kayo sa health center, kailangan ba ninyong magpasama sa inyong asawa/partner?		
Oo	57 (26.51)	33 (18.86)
Hindi	157 (73.02)	141 (80.57)
Hindi alam	0	1 (0.57)
240: Kailangan ba niya kayong pahintulutan?		
Oo	148 (69.81)	77 (44.25)
Hindi	64 (30.19)	96 (55.17)
Hindi alam	0	1 (0.57)

More respondents from Rural areas feel worry about having to leave their households to visit the facility. However, majority of women reported that there is no need for them to be accompanied by their spouse (73% and 81% for urban and rural, respectively).

Per MMR disaggregation

Table 26. Attitude of the Respondents towards Family Planning per MMR Status

	Low MMR (n=195)	**High MMR (n=195)**
	Frequency (%)	
FAMILY PLANNING		
218: Kinailangan mo bang alalahanin ang pag-iwan sa inyong sambahayan (bahay)?		
Oo	68 (34.87)	101 (51.79)
Hindi	85 (43.59)	28 (14.36)
Hind alam	42 (21.54)	66 (33.85)
239: Kapag pumupunta kayo sa health center, kailangan ba ninyong magpasama sa inyong asawa/partner?		
Oo	54 (27.69)	36 (18.46)
Hindi	140 (71.79)	158 (81.03)
Hindi alam	1 (0.51)	1 (0.51)
240: Kailangan ba niya kayong pahintulutan?		
Oo	102 (52.85)	123 (63.73)
Hindi	90 (46.63)	70 (36.27)
Hindi alam	1 (0.52)	0

More respondents in High MMR areas feel the need to worry about their household to go to the health center (52% in high MMR areas against 35% saying 'yes, they do worry' in low MMR areas). A higher percentage of respondents, though, in both areas, do not feel need for husbands to accompany them to the facility. High MMR area respondents do not worry

as much as low MMR respondents, and lesser proportion reported need to be accompanied by spouse to health center. In both areas, a higher percentage reported having to get their spouse's permission to go to health centre (53% saying 'yes permission needed' against 47% saying 'no permission needed' in low MMR areas). In high MMR areas, those saying yes on needing permission (64%) is nearly double the 36% who said 'no permission is needed' to visit health facility.

8.3 On Family Planning with Spouse

Per Provincial disaggregation

Table 27. Knowledge of the Respondents towards Maternal Health Care and Family Planning per Province: Family Planning with Spouse

	Pampanga (n=65)	Zambales (n=65)	Cebu (n=65)	Western Samar (n=65)	South Cotabato (n=65)	Compostela Valley (n=65)
	Frequency (%)					
MATERNAL HEALTH CARE						
324: Pamilyar sa HIV	3 (4.62)	7 (9.23)	5 (7.69)	2 (3.08)	4 (6.15)	5 (7.69)
302: Noong ikinasal/nagsama kayo, pinag-isipan o pinag-usapan ba ninyo kung ilan ang magiging anak ninyo?						
Oo	15 (23.08)	36 (55.38)	15 (23.08)	50 (76.92)	23 (35.38)	31 (47.69)
Hindi	50 (76.92)	29 (44.62)	50 (76.92)	15 (23.08)	42 (64.62)	34 (52.31)
330: Pakiramdam ba ninyo ay makakausap ninyo ang inyong asawa, nang walang takot, tungkol sa gusto ninyong laki ng pamilya at paggamit ng contraception?						
Oo	58 (89.23)	61 (93.85)	63 (96.92)	64 (98.46)	58 (89.23)	62 (95.38)
Hindi	5 (7.69)	4 (6.15)	1 (1.54)	1 (.54)	7 (10.77)	3 (4.62)
Hindi alam	2 (3.08)	0	1 (1.54)	0	0	0

Very few report knowing of HIV, with Zambales already having the most, at 9.23%. Only respondents from Zambales and Western Samar had a majority who said that they discussed family size with their partner. All respondents reported feeling confident that they can talk to their partner without fear about family size.

Per Setting disaggregation

Table 28. Knowledge of the Respondents towards Maternal Health Care and Family Planning per Setting: Family Planning with Spouse

	Urban (n=215)	Rural (n=175)
	Frequency (%)	
MATERNAL HEALTH CARE		
324: Pamilyar sa HIV	16 (7.44)	9 (5.14)
302: Noong ikinasal/nagsama kayo, pinag-isipan o pinag-usapan ba ninyo kung ilan ang magiging anak ninyo?		
Oo	95 (44.19)	75 (42.86)
Hindi	120 (55.81)	100 (57.14)
330: Pakiramdam ba ninyo ay makakausap ninyo ang inyong asawa, nang walang takot, tungkol sa gusto ninyong laki ng pamilya at paggamit ng contraception?		
Oo	207 (96.28)	159 (90.86)
Hindi	8 (3.72)	13 (7.43)
Hindi alam	0	3 (1.71)

Both urban and rural settings have equallly low reported knowledge of HIV, with rural settings reporting slighly lower. The same trend is seen on whether the respondents thought of or planned famimly size prior to marriage or becoming partners.

Per MMR disaggregation

Table 29. Knowledge of the Respondents towards Maternal Health Care and Family Planning per MMR Status: Family Planning with Spouse

	Low MMR (n=195)	High MMR (n=195)
	Frequency (%)	
MATERNAL HEALTH CARE		
324: Pamilyar sa HIV	12 (6.15)	13 (6.67)
302: Noong ikinasal/nagsama kayo, pinag-isipan o pinag-usapan ba ninyo kung ilan ang magiging anak ninyo?		
Oo	53 (27.18)	117 (60)
Hindi	142 (72.82)	78 (40)
330: Pakiramdam ba ninyo ay makakausap ninyo ang inyong asawa, nang walang takot, tungkol sa gusto ninyong laki ng pamilya at paggamit ng contraception?		
Oo	185 (94.87)	181 (92.82)
Hindi	7 (3.59)	14 (7.18)
Hindi alam	3 (1.54)	0

Familiarity with HIV is again equally low. The respondents from High MMR had a much larger proportion of not having planned or thought of family size, with 60% as compared to 27.18% for those in low MMR areas. Respondents from both areas are equally comfortable talking to their spouses now.

8.2 Discussion

The KAP survey result highlights limited knowledge on sex and pregnancy, where knowledge is relatively low. More than a third of respondents incorrectly know about when is one's highly fertile period when sex should be avoided. This knowledge is disseminated via the FDS and by health professionals at the facility, and the relatively low proportion seem to indicate communication failures either through the FDS, the health staff, or both. Considering the church encourages the 'calendar' method, this has not been imbibed very well either in terms of knowledge of highly fertile period.

Some attitudes are strongly coming out, particularly with discomfort nor agreeing to talking about sex and pregnancy with teenage children; only slightly over half of women saying they should have control over their own income and can persuade their husbands to use condom.

A high percentage, 43%, reported having been influenced by others on their pregnancy decisions. Only 44% reported utilizing a public hospital for childbirth. Reading the graph downwards, it appears that attitude influences practice, rather than knowledge per se. *If FDS imparts knowledge alone, cultivation of right attitudes to promote better practice can be an area needing attention.*

9. HEALTH SYSTEM/DELIVERY SIDE PERSPECTIVE

9.1 Results

Eight facilities were selected for the ocular survey (Table 30), five barangay health stations and three rural health units. These facilities were selected in consultation with the local DSWD links. The target sites are health facilities that serve the barangay that was selected for the household survey. Given that health conditionalities of Pantawid are tied to services provided by frontline health workers and facilities, the team visited barangay health stations and rural health units.

Key informant interviews were gathered along with the ocular survey. There were two doctor respondents who happened to be municipal health officers. The rest of the respondents were midwives, 5 from barangay health stations and 3 from rural health units.

Table 30. Health Facilities Surveyed and Staff Respondents

Respondent	Barangay health station	Rural health units	LGU level (municipal health officers)
Medical Doctor	-	-	2
Midwife	5	3	-

Table 31. Health Facilities Surveyed per Province

	LGU level	Rural health units	Barangay health station
Zambales		1	1
Pampanga		1	1
Cebu	1	1	1
WSamar		1	
South Cotabato	1		1
Compostela Valley	1		1

Staffing

a. Health facility staff

Barangay health units have an average of 3.6 staff that provides maternal health care services. This is composed of an average of 3 midwives as well as nurses, and 0.6 medical doctors (Table 32). Rural health units on the other hand have an average of 2 maternal and health care staff: 0.7 medical doctors and 1.3 midwives and nurses.

Table 32. Maternal Health Care Providers Reported at Barangay Health Stations and Rural Health Units

Staff	Barangay health station	Rural health unit
Medical Doctor	3 (0.6)	2 (0.7)
Midwives and nurses	15 (3)	4 (1.3)
Total (Ave)	18 (3.6)	6 (2)

b. Health facility staff training

A larger percentage of responses at the barangay health station (40 percent, 10 out of 25) perceived that the trainings on adolescent sexual and reproductive health, antenatal care, integrated management of pregnancy and childbirth, and child immunization are not

applicable to them compared to those at the rural health units (27 percent, 4 out of 15) (Table 33). This corresponds to an average of 2 barangay health stations and 1 rural health unit. At the barangay health station, only 33 percent of the total training counts (5 out of 15) have these trainings in the past two years. At the rural health unit, it is 82% (9 out of 12 training counts). This averages to 1 barangay health station and 1.8 rural health units with the training complement.

Table 33. Training Profile of Maternal Health Care Staff in the Past Two Years Reported at the Barangay Health Stations and Rural Health Units

Training in the past two years on:	Barangay health station			Rural health unit		
	Yes	No	N/A**	Yes	No	N/A**
Adolescent sexual and reproductive health	1	2	2	2	1	-
ANC-related	1	3	1	1	1	1
** National ANC guideline ANC check-lists and/or job-aids	1	2	2	2	-	1
Integrated Management of Pregnancy and Childbirth (IMPAC)	-	2	3	2	-	1
Child immunization services	2	1	2	2	-	1
Total number of maternal health care staff with training * (Ave)	5 (1)	10 (2)	10 (2)	9 (1.8)	2 (0.7)	4 (1.3)

* Each staff may have more than one type of training
** N/A means that the respondents believe that the training is not applicable to them

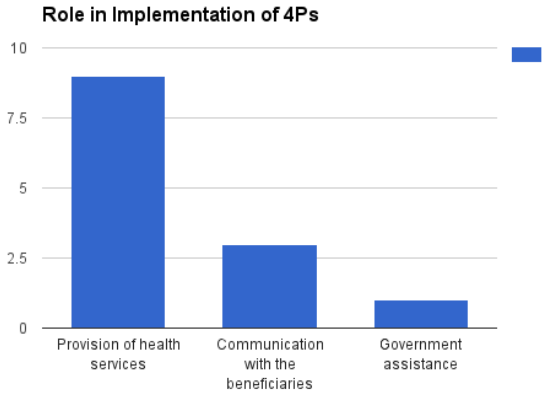
c. Staff perspective on capacity and role in Pantawid program

The key informants reported that they consider most staff as capable and trained in the provision of maternal health care services. They regard themselves as provider of health services. There is no positive claim that they are part of the Pantawid program providers (Figure 5). They are not heavily engaged in the planning and coordination of the program (Figure 6).

"As the midwife, I did commissions for 4Ps such as prenatal, immunization, monitor weight."

"DSWD coordinates the meetings and the DOH midwives and nurses attend."

MHO Physician on role in implementation: “Provision of health services.”



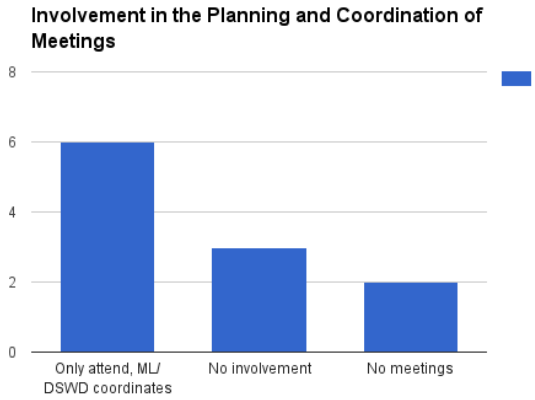


Figure 5. Provider's Perceived Role in the Pantawid Program
Figure 6. Provider's Involvement in the Planning and Coordination of Pantawid Meetings

Supplies

d. Family planning commodities

The numbers are suggestive that family planning commodities are more expected to be available at the rural health unit than at the barangay health station (Table 34). Of the responses at barangay health station that acknowledged that they should have the commodities, 74 percent of responses (20 out of 27) are positive. All of the rural health units acknowledged that they should have family planning commodities. 79.2 percent of responses (19 out of 24) are affirmative.

Table 34. Profile of Family Planning Commodities Reported at Barangay Health Stations and Rural Health Units

Family planning commodity	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
Combined estrogen progesterone oral contraceptive pills	4	-	1	3	-	-
Progestin-only contraceptive pills	3	-	2	3	-	-
Progestin-only injectable contraceptives	4	-	1	3	-	-
Emergency contraceptive pills	1	2	2	3	-	-
Implants	1	2	2	1	2	-
Intrauterine contraceptive device (IUD)	1	2	2	1	2	-
Male condoms	4	-	1	3	-	-
Cyclebeads for standard days method	2	1	2	2	1	-
Total (Average)	20 (2.5)	7 (0.9)	13 (1.6)	19 (2.4)	5 (0.6)	-

* Each facility may provide multiple answers
** N/A means that the respondents believe that they are not expected to carry the commodity

e. Prenatal medicine

All rural health units mentioned that they are expected to have prenatal medicine. However, only an average of 2 of the 3 rural health units have the medicine at the time of the visit (Table 35). An average of 2 out 5 barangay health stations believe that they don't have the mandate to ensure that prenatal medicines are available. Of the 3 barangay health stations that said they are expected to have prenatal medicine, these are available at the health facility.

Table 35. Prenatal Medicine Reported Barangay Health Stations and Rural Health Units

Prenatal medicine	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
Iron	3	-	2	2	1	-
Folic acid	3	-	2	2	1	-
Total (Ave)	6 (3)	-	4 (2)	4 (2)	2 (1)	-

* Each facility may provide multiple answers
** N/A means that the respondents believe that they are not expected to carry the medicine

f. Laboratory

An average of 2 barangay health units mentioned that they are not expected to have facilities to conduct HIV rapid testing and urine rapid test for pregnancy (Table 36). Of the remaining three (3) barangay health stations, all of these do not have these facilities. All of the rural health units are expected to have these tests but only an average of 1 out 3 perform these tests.

Table 36. Availability of Laboratory Tests Reported at the Barangay Health Stations and Rural Health Units

Laboratory test	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
HIV Rapid testing	-	3	2	1	2	-
Urine rapid tests for pregnancy	-	3	2	1	2	-
Total (Ave)	-	6 (3)	4 (2)	2 (1)	4 (2)	-

* Each facility may provide multiple answers
** N/A means that the respondents believe that they are not expected to have these tests

g. Infrastructure and equipment

Majority of the barangay health stations, an average of 4.2 agreed that they should have the minimum infrastructure and equipment listed under Table 37; Out of the 4.2 averages, all have the said facilities. All of the rural health units have these infrastructure and equipment.

Table 37. Infrastructure and Equipment Reported at the Barangay Health Stations and Rural Health Units

	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
Private room for consultation	5	-	-	3	-	-
Clean running water	4	-	1	3	-	-
Latex gloves	3	-	2	3	-	-
Toilet	5	-	-	3	-	-
Total (Ave)	17 (4.2)	-	3 (0.8)	12 (3)	-	-
** N/A means that the respondents believe that they are not expected to have these tests						

h. Lifelines

All of the health facilities are expected to have communication implements (Table 38). All barangay health stations have either a landline phone or a cellular phone. All of the rural health units have both types of communication.

Table 38. Communication Equipment Reported at the Barangay Health Stations and Rural Health Units

Communication implements	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
Landline phone	1	4	-	3	-	-
Cellular phone	4	1	-	3	-	-
Total (Ave)	5 (2.5)	5 (2.5)		6 (3)	-	-
** N/A means that the respondents believe that they are not expected to have these tests						

Electricity is also important in health facility operation. Four of the barangay health stations have electricity all the time, while one reported that it is often available. Two of the rural health units have electricity all the time while 1 said it is often available.

i. Information material

All of the rural health units have information, education and communication materials relevant to maternal health care. For the barangay health stations, four of these have information, education and communication materials while one mentioned that it is not expected of them to have these.

j. Health services

An average of two barangay health stations reported to have no mandate to provide family planning and HIV counseling. Of those that are expected to provide these services, only one

out of three do so (Table 39). All rural health units are expected to provide these services and two out of three deliver family planning and HIV counseling.

All rural health units are expected to provide emergency services for pregnant mothers. However, only an average of 0.8 rural health units claim that they provide all these. An average of three barangay health units are expected to provide emergency services and 1.3 of these do so

Table 39. Maternal Health Care Services Reported at the Barangay Health Stations and Rural Health Units

Maternal health care services	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
Family planning counselling	1	2	2	2	1	-
HIV counselling	1	2	2	2	1	-
Total (Ave)	2 (1)	4 (2)	4 (2)	4 (2)	2 (1)	-
Emergency services						
Parenteral administration of antibiotics (IV or IM)	1	2	2	-	3	-
Parenteral administration of oxytoxic for treatment of postpartum haemorrhage (IV or IM)	2	1	2	1	2	-
Parenteral administration of magnesium sulphate for management of preeclampsia and eclampsia (IV or IM)	-	3	2	1	2	-
Assisted vaginal delivery	2	1	2	1	2	-
Manual removal of placenta	2	1	2	1	2	-
Neonatal resuscitation	2	1	2	1	2	-
Total (Ave)	8 (1.3)	9 (1.5)	12 (2)	5 (0.8)	13 (2.2)	
** N/A means that the respondents believe that they are not expected to provide these services						

All of the rural health units provide immunization services (Table 40). An average of 3 out of 5 barangay health stations have immunization services while the remaining two are not expected to provide these.

Table 40. Immunization Services Reported at the Barangay Health Stations and Rural Health Units

Immunization services	Barangay health station			Rural health unit		
	Yes	No	N/A	Yes	No	N/A
BCG immunization	3	-	2	3	-	-
Routine polio immunization	3	-	2	3	-	-
Routine measles immunization	3	-	2	3	-	-
Routine DPT-Hib+HepB immunization (pentavalent)	3	-	2	3	-	-
Total (Ave)	12 (3)		8 (2)	12 (3)		
** N/A means that the respondents believe that they are not expected to provide these services						

k. Resources

The key informants believe that there are good to fair supplies and stocks at the frontline health facilities. Services are provided adequately both for members of the Pantawid program and those that are not. They also believe that the health needs of Pantawid members are not different from the rest of their patients (Figure 7, Figure 8).

"... all services are provided equally and in the same manner to both 4Ps and non-4Ps members."

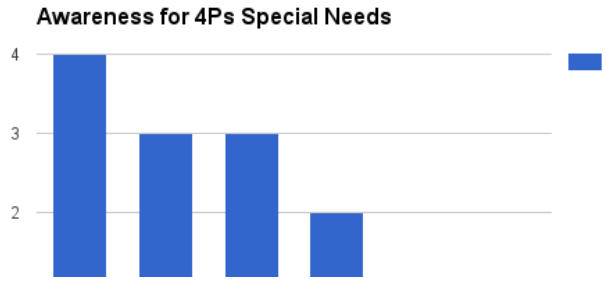


Figure 7. What Pantawid Members will Need Differently in Health Care

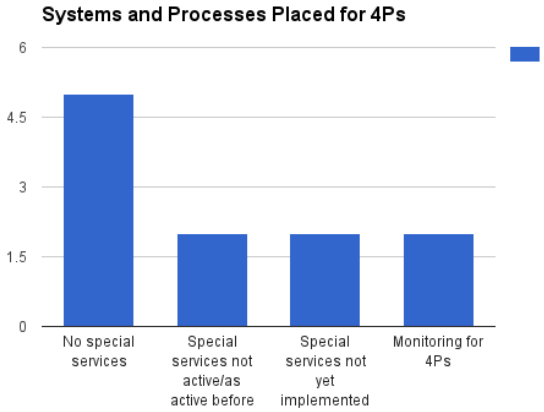


Figure 8. Whether there are Services just for Pantawid Members

In the household survey, respondents reported that they paid an average of Php 0 to health facilities. However, there were still some out of pocket spending for 17.2 percent of respondents (50 out of 293). In a related question, 96.6% of respondents (281 out of 291) received drug prescriptions and this translated to an average of PhP 200 out of pocket payment.

Twenty four percent of household survey respondents also reported that they were referred to municipal hospital at some point. Of these, 71.3 percent cited that this is a referral that require higher facility care, but there were 14.9 percent that said referral was due to lack of supply or equipment.

There were 6.7 percent that reported being refused of services. Of these, 38.5 percent was due to the lack of doctors and 26.9 percent due to lack of supplies and facilities.

Perspective on cross-cutting health service delivery issues

The respondents said that for their facilities, there is no special system set-up specific for families under the Pantawid program (Figure 9). Monitoring of attendance of Pantawid beneficiaries is done by DSWD, and not by the health workers.

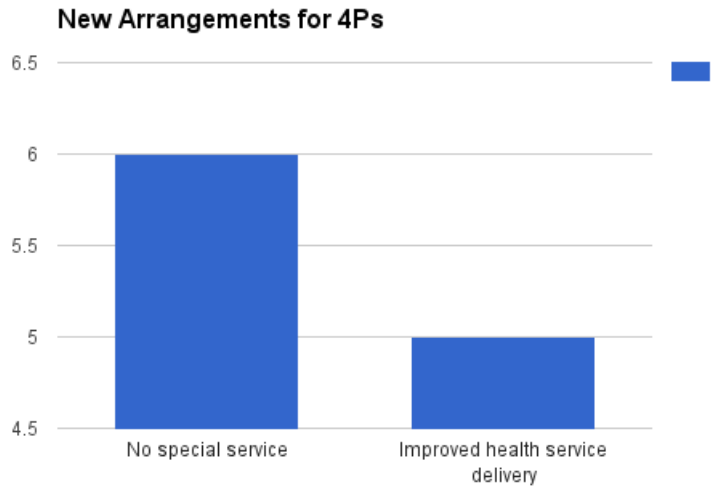


Figure 9. Whether there are Special Arrangements for Pantawid Members

Perspective of service utilization

Although health providers claim that Pantawid members utilize members either at an equal and even higher rate than their non-Pantawid clients (Figure 10), health facility staff believe that poor health-seeking behavior, difference in culture, and lack of accessibility (Figure 11) inhibits utilization for some beneficiaries. This access issue is limited to those who are really far from the health facility, which does not constitute the majority. Health facilities compensate by conducting outreach / missions.

"Still need better health-seeking behavior from beneficiaries; even when they have programs for vaccinations in school, they still don't avail." (DOH DMO, Pampanga FGD)

"Beneficiaries would rather pray than go to health center". (Municipal Link, Davao FGD

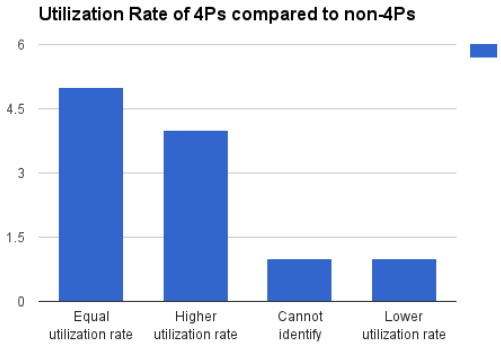
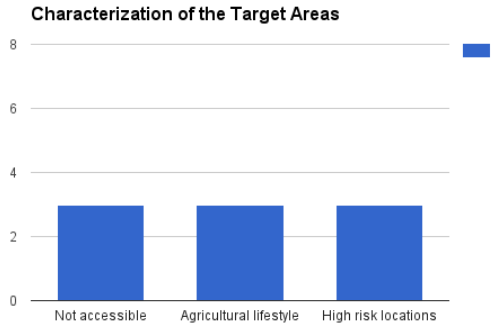


Figure 10. Perceived Health Service Utilization of Pantawid Members



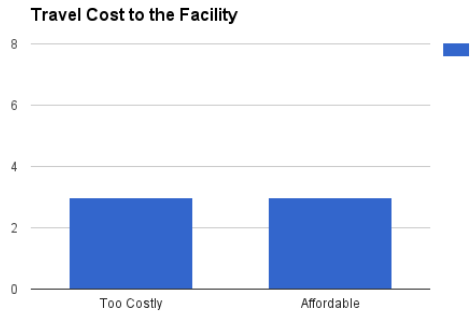


Figure 11. Health Facility Access Determinants

In the qualitative data above, barangays that are larger considered that travel to health facilities is costly. This is contrasted in smaller barangays when they consider travel cost to be affordable.

When household survey respondents get sick, they would prioritize going to health centers (79.8%) (Table 41). It is however notable that even this is so, the same set of respondents would have more regular visits to private clinics (Table 42). *There is also strong preference to bring their ailing family members to private clinics and hospitals* (Table 43).

Table 41. First Priority Facility to Visit by Household Survey Respondents when Sick

Botika ng barangay	6 (1.55)
Health center	308 (79.79)
Pharmacy	39 (10.10)
Hospital	31 (8.03)
Others	2 (0.52

Table 42. Health Facility Regularly Visited by Household Survey Respondents

Health center (n=8)	8 (100.00)
Public hospital (n=29)	22 (75.86)
Private clinic (n=176)	111 (63.07)
Private hospital (n=78)	51 (65.38)
Birthing center (n=0)	0

Table 43. Health Facility where Sick Household Members are Brought (n-291)

Health center	8 (2.75)
Public hospital	29 (9.97)
Private clinic	176 (60.48)
Private hospital	78 (26.80)
Birthing center	0

97.4 percent of household survey respondents are confident that they will get healthcare from the health facility that they visited. During visits, 97.7% felt that they were respected by health workers during consult. Only 67.9 percent deemed their workers to be courteous.

Only 7.3 percent of household survey respondents feel that health facilities are far from where they live. For those that take a transportation to go to health facilities, majority preferred tricycles (Table 44). On average, tricycle rides cost PhP 40 (Table 45). This cost does not differ much relative to the health facility type being visited (Table 46).

Table 44. Preference for Mode of Transportation Going to Health Facilities

Transportation used to the facility before delivery*	Frequency (%); Median (Range)
Walked	30 (7.77)
Car	7 (1.81)
Jeep	6 (1.55)
Tricycle	208 (53.89)
Karitela	6 (1.55)
Motor boat	5 (1.30)
Rowing boat	3 (0.78)
Bicycle	1 (0.26)
LGU vehicle	24 (6.22)
Others	31 (8.03)

Table 45. Cost of Different Modes of Transportation Going to Health Facilities

Cost of transportation (PhP)	
Walked	0
Car	1000
Jeep	28 (10 to 40)
Tricycle	**40 (5 to 1000)**
Karitela	45 (24 to 600)
Motor boat	200 (180 to 200)
Rowing boat	-
Bicycle	-
LGU vehicle	300 (0 to 800)
Others	78 (20 to 600)

Table 46. Transportation Cost of Going to Different Types of Facilities

Transportation cost	
Health center (n=8)	5 (5 to 40)
Public hospital (n=29)	**30 (0 to 1000)**
Private clinic (n=176)	**50 (0 to 1500)**
Private hospital (n=78)	**20 (0 to 1000)**
Birthing center (n=0)	0

Perspective of Pantawid program implementation

Health care workers provided mixed answers whether the Pantawid program implementation should be continued (Figure 12). It is generally good, but there are areas that should be improved. The program should needs to improve its monitoring and evaluation system. The family development session also needs to be improved in terms of content. Finally, the program should consider how it is to be expanded. The validation system is becoming an issue, with reports that non-qualified families are enrolled. Respondents from Luzon provided better assessment; those from Mindanao said it is fair, while the poor assessment came from Visayas respondents.

"Yes, but there should be better screening to identify those who really need to be part of the 4Ps program from those who don't."

"Continue 4Ps, but re-evaluate the validation system."

"Implementation is good. Non-cooperative members are the only issue

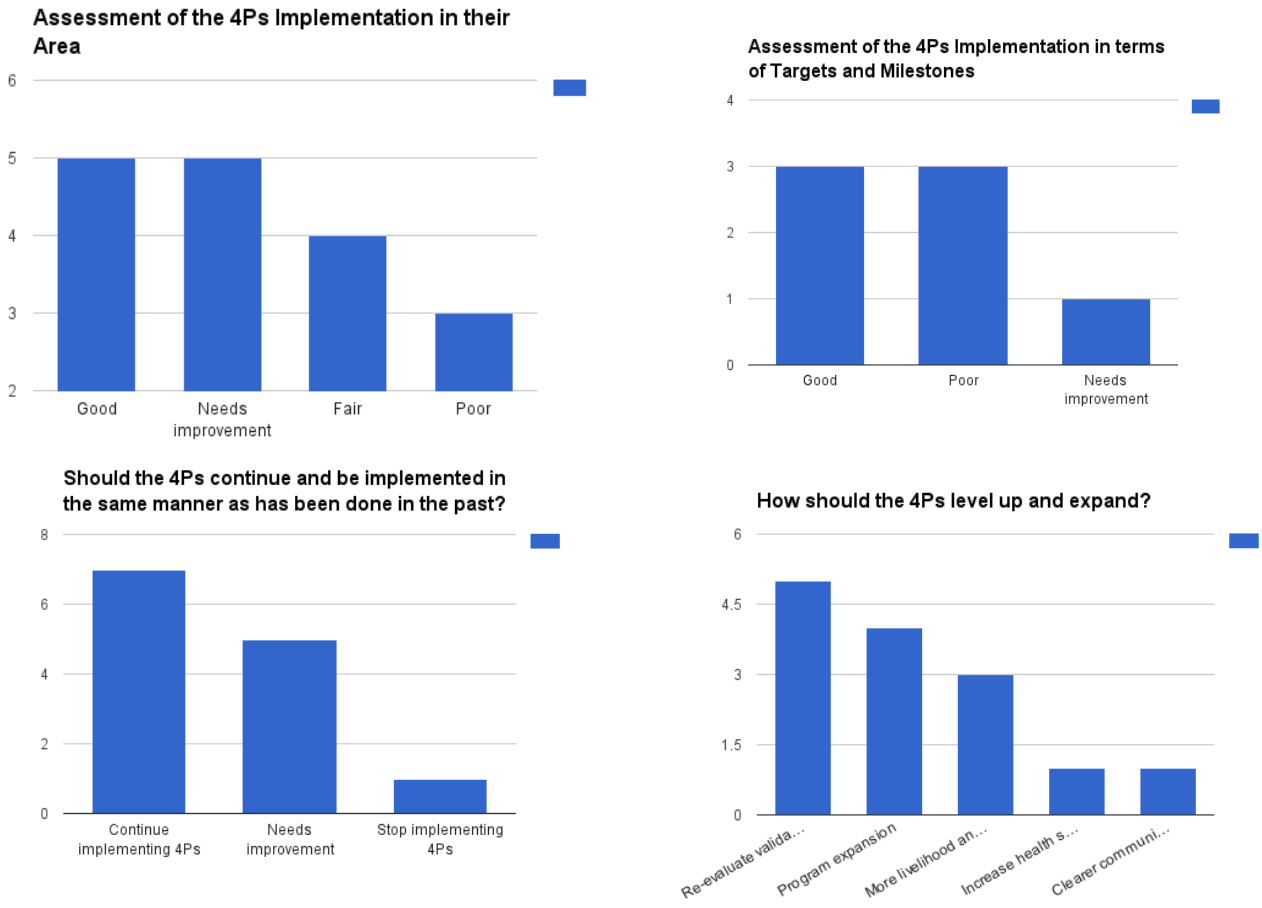


Figure 12. Whether the Pantawid Pamilya Implementation should be continued

9.2 Discussion

There is in general a fair staffing in barangay health stations and rural health units. An issue though is the frequency of training upgrades, particularly for those manning the barangay health stations. It is a concern that the frequency of 'no' training exceeds the completion of

'some training' that is important for maternal health delivery.

Staff at the frontline health facilities consider themselves primarily as health care providers, with almost no appreciation of contributing and being key stakeholders to the Pantawid program. The inter-sectoral coordination across DOH, LGU and DSWD is weak. The lack of synergy in the effort between these sectors undermines the effect of their activities. There is limited opportunity for the health professionals to contribute their technical expertise specific for Pantawid activities. At the same time, the opportunities for DSWD municipal links to utilize health care provision platforms for the objective of case management is not maximized.

The fairness of Pantawid member selection appears to be an issue to the providers interviewed. This may affect the way they regard their patients.

At the government facilities visited, the supplies, infrastructure and equipment are reasonably available. A number of health services are also reportedly provided. Staff report that whatever health service available is provided equally to both Pantawid and non-Pantawid members can be generally considered acceptable. This means that the providers regard their entire client base fairly. They give their services according to health needs assessed. There is a drawback to this treatment however. Members of the Pantawid program are in different life situations compared to their non-member counterparts. Poverty impacts the lives of people in many aspects. Equity considerations may suggest that Pantawid families should be monitored and accounted closely.

Looking into household responses about out of pocket expenses makes the point about regarding Pantawid members with more care. While some members of the community can accommodate some level of out of pocket expenditure, those who are poor may be driven to further poverty. Worse, they will no longer utilize services. Even when all Pantawid members are expected to be part of PhilHealth, the low support value of the social health insurance can still result to out of pocket payments. If this occurrence is not monitored, Pantawid families may opt to drop out of health service access.

Another case arguing for closer monitoring of Pantawid families are reports of being referred to other facilities due to lack of supply or equipment. There were also accounts of being refused of services. When these happen to Pantawid members, the referral may be prohibitive to access. It may require extra support from DSWD to make these referrals happen. Yet, this support may not happen if there is no monitoring and there is weak coordination between the health workers and DSWD caseworkers. Ultimately, the role for referral may be better delineated with better coordination of the DSWD and the health facilities.

There is good confidence of the health service providers from the perspective of patients. Yet, there is an apparent shift towards private sector service utilization as suggested by survey responses. This is counter to the perspectives of healthcare workers interviewed, but is consistent with the ocular visit findings that there are gaps still in supply availability. This trend can be regarded by the healthcare system with caution and should warrant close monitoring. The weak governance over the private sector can result to poorer outcome for these patients. There is no additional security under the current program that will ensure that patients are protected from financial catastrophe and provided with quality care.

The number and geographic location of health facilities are not much of a problem for most respondents. Although there are still inaccessible areas, majority are near health facilities. *The cost of transport is also not high.*

9.3 Conclusion

Based on established standards, health service delivery by the public sector is fair to good in the areas surveyed. Health providers though do not see themselves as active participants in the Pantawid program. The intersectoral collaboration is not yet maximized and this leaves patients unable to enjoy the synergy of efforts across LGU, DOH and DSWD. Patients have good confidence in the health system but the shift towards private sector health service utilization should be monitored. This calls for the necessity of the government sector to focus on monitoring how Pantawid patients are in the care of its facilities and providers. It makes the case for encouraging better utilization of government facilities and better protection from financial catastrophe. While government providers are urged to have special focus for Pantawid members, the issue of membership validity echoes the need to ensure that qualifications are enforced. This is so that true benefits of targeting intervention to the poorest of the poor bears fruit in terms of health outcomes.

10. DEMAND

10.1 Introduction

The demand for family planning and maternal health services is viewed as part of a decision-making nexus that values health intrinsically. Human capital theory posits that maximization of health is the ultimate objective of seeking health care (Grossman, 1972). Medical care services are inputs in the overall production of health. Consumption of medical care and other goods is determined by the amount of resources available or income and the prices of these goods and the amount of these goods. The individual maximizes welfare by choosing among a combination of goods and services that fits within the budget constraint.

Decision-making on sexual and reproductive health is influenced by education, by operating at the cognitive level of imparting information and/or through socialization that happens in these institutions. Bongaarts identified the pathway through proximate determinants like age at marriage, postnatal fecundity (via breastfeeding and postnatal abstinence practices) and contraceptive use (cf Darney, et al, 2013). A gender perspective would highlight access of women to prenatal care and the extent of how their heavy domestic household and farming activities are likely to affect their health, hence emphasizing the social and gender confines or strictures that influence a woman's fertility decisions and health seeking behavior over reproductive health (McCleary-Sills, McGonagle and Malhotra, 2012). This section on demand for FP and MCH services by 4Ps women works around the basic demand function as influenced by a vector of individual and demographic and socio-economic aspects of the women and their households which affect their demand.

10.2 Dependent Outcomes

Regression analyses examined several layers of women's decision making on reproductive health care demand: 1) the factors associated with being pregnant as a 4Ps beneficiary; 2) the demand for facility based delivery; 3) demand for ante-natal; and 4) demand for modern contraceptive methods. The first three, the likelihood of being pregnant as a 4Ps beneficiary, facility based deliveries, and demand for antenatal care came out to be statistically significant at 49, 8 percent, and 11%, respectively. Appendix 2 presents the initial runs on the demand models. The discussion will therefore focused on a reduced form of 3 demand models.

10.2 Independent Variables

All regression runs used the following variables related to:

Individual characteristics of the woman: current age, age when she got married, education, and if with own earnings;

Spouse/partner's characteristics: age and education;

Family characteristics: length of marriage (years), number of children before recent child (aged 0-5 years), if with teenage child and household monthly household income (over a range);

Locality or area characteristics: whether rural residence, whether a high MMR area;

Health service characteristics like perception whether health centre is far; transport cost to health centre (including companion costs); and,

4Ps inclusion: the amount received from Pantawid, per month.

The older or younger the woman is likely to affect reproductive decisions as she desires less children the older one gets (Sosa-Rubi, et al 2010). The earlier or younger the woman got married the more likely desire for children may have waned the longer one has gotten married and the greater number of children before the last child (aged 0-5). Having a teenager may influence either way: the presence of a teenager would ease having younger children, as babysitting is available. It could however also discourage having younger children, as costs of maintaining a teenager's wants and needs may be high. A higher income raises opportunity costs of having children (in the form of wages given up to care for them). Poorer families are associated to have higher number of children due to lower opportunity costs and perceived safety net function of children in their parents' old age.

Cash transfers can have unintended consequences—increasing fertility among beneficiary families, either through higher payments for larger families or reduction in male migration (cf Darney, et al 2013). However, Pantawid caps the child support to 3 children and this may correct for this unintended consequence. Sosa-Rubi (Ibid.) noted that locality factors indicate the availability of health centres, particularly as it makes midwives now accessible and can have an influence on the utilization, intensity of use, or simply selection of a facility (as opposed to home base) for childbirth.

10.3 Results (Reduced form)

(1) Model 1: Factors associated with pregnancy during 4Ps

Table 47. Likelihood of getting pregnant as Pantawid members

	Adjusted Odds Ratio	95% Confidence Interval	P-Value
Amount received from Pantawid, per month	0.9969	0.9962 to 0.9976	**0.000**
No. of children before birthed child	2.5962	1.8845 to 3.5762	**0.000**
High MMR	3.8283	1.8888 to 7.7624	**0.000**
With teenage child	4.9863	2.2552 to 11.0251	**0.000**
Age of women when first married	0.9157	0.8565 to 0.9790	**0.010**
Distance to Health centre (Far)	0.2247	0.0726 to 0.6952	**0.010**
Didn't finish HS (mother)	2.2308	1.1370 to 4.3766	**0.020**

P-Value < 0.001; R^2 = 49.14%

1. For every peso increase in PPP amount received, the odds of getting pregnant decreased by 0.31%.
2. For every increase in number of children prior to 4Ps, the odds of getting pregnant increased by 2.59 times.
3. Women who lived in a high MMR region were 3.83 times as likely to get pregnant during the 4Ps period.
4. Women with a teenage child were approximately 4.98 times as likely to be pregnant during 4Ps.
5. For every year increase in age when the mother first got married, the odds of becoming pregnant during 4Ps decreased by 8.43%.
6. Women who lived far from the health center had 0.2674 times the odds of being pregnant during 4Ps.
7. Women who were unable to attain at least a high school degree are 2.23 times more likely to have become pregnant during the 4Ps period.
8. The final model is significant, and explains 49.14% in the variability of the odds of pregnancy during the 4Ps period.

(2) Model 2: Demand for facility based deliveries

Table 48. Factors for delivery outside of health facility

	Adjusted Odds Ratio	95% Confidence Interval	P-Value
High MMR	3.3022	1.4753 to 10.1065	**0.006**
Distance to Health centre (Far)	3.8613	1.6893 to 6.4553	**0.000**

P-Value < 0.001; R^2 = 8.05%

1. The final model explains 8.05% of the variability in FBD delivery
2. Women in a high MMR, or lived far from a health center has 3 to 4 times the odds (or 3 to 4 times as likely) of delivering outside of a health facility.

(3) Model 3: risk factors for non-utilization of ANC (defined as having 3 or fewer ANC visits)

Table 49. Final model: Factors associated with absence of antenatal care

	Adjusted Odds Ratio	95% Confidence Interval	P-Value
Years married	1.1766	1.0468 to 1.3226	**0.006**
With teenage child	0.1578	0.0343 to 0.7267	**0.018**
Far distance to health center	3.4455	0.6443 to 18.4265	0.148

P-Value = 0.018; R^2 = 10.89%

1. For every increase in year married, the odds of not availing of antenatal care increases by approximately 17.66%
2. Women with a teenage child are 0.1578 times the odds (or 84% less likely) to not avail of antenatal care (i.e. those with a teenage child are more likely to seek antenatal care)
3. There was insufficient evidence to demonstrate an association between distance from the health center and absence of antenatal care.
4. The final model had an explanatory power of 10.89%, and was significant at p = 0.018.

11. Family Development Sessions

Regular attendance to the Family Development Sessions (FDS) is an important conditionality that the Pantawid beneficiaries must comply with in order to maintain their good membership standing in the program.

The FDS are envisioned to “build and strengthen family ties” and together with the education and health conditionalities are the vehicles by which the Program is able to help the beneficiaries be empowered for an improved quality of life.

Sessions are to be conducted once a month in the communities of the Pantawid members. A variety of facilitators conduct these sessions depending on the scheduled topic for the month. The City/Municipal Links, LGU Links, Social Welfare Officers, FDS Focal Persons, Civil Society Organizations (CSO) and local facilitators work together to conduct the FDS, guided by an FDS Manual provided by the DSWD.

The FDS Manual presents three (3) modules that are to be discussed to all Pantawid members. Responsible Parenthood and Family Planning is Sub-Module 2.2 within the Module 2: Preparing and Nurturing the Filipino Family.

Within this Sub-Module 2.2 are four (4) topics including Family Planning, Safe Motherhood Prenatal Care, Infant and Child Care and Early Childhood Care and Development.

The FDS Manual provides facilitators with a structure and references related to the various topics as well as guidelines on how to effectively deliver these topics so as to standardize all the processes related to the conduct of the FDS from social preparation, actual conduct and post-FDS monitoring.

Among the specific objectives of this study is to assess the role and effectiveness of the FDS and its contribution to increasing awareness on MHC and FP services among Pantawid beneficiaries.

Data related to this objective were obtained through (a) queries made to respondents in three (3) Focus Group Discussions (FGD) conducted in the three (3) main island groups of the country; (b) key informant interviews with Pantawid Program implementers and partners at the regional, provincial and municipal level; (c) actual on-site observations of FDS conducted during visits to the sites where household surveys were conducted; and (d) responses to selected questions in the household surveys.

Table 50. FGD Respondents’ Profile

Island group	Position	Average Years in 4Ps
Luzon	City Link (3), DMO IV - DOH (2), Monitoring and Evaluations Officer (1), Municipal Link (5), Provincial Link (2)	3
Visayas	City Link (1), GAD Focal (1), Monitoring and Evaluations Officer (1), Municipal Link (1), Provincial Link (2)	4
Mindanao	Monitoring and Evaluations Officer (2), Municipal Link (6), Provincial Link (1), SWO III (1)	4

Table 51. FDS Sessions Observed

Island groups	# Sessions attended	Topic discussed	Municipality
Luzon	1	Family roles and Gender and Development	Lubao
Visayas	1	Family Welfare Promotion	San Sebastian
Mindanao	2	Gender and Development	Pantukan, Polomolok

11.1 Results

It was quite unfortunate that at the time of the research team's data gathering, the FDS topics scheduled for the period were not about Responsible Parenthood and Family Planning. However, the observation of the FDS still generated many important insights and information.

In assessing the role and effectiveness of the FDS in bringing about behavioral and attitudinal change among the Pantawid members, the study team focused on two (2) important features – Fit and Dissemination.

Fit

Fit refers to the appropriateness of the topics discussed in the FDS and whether these have in fact created some impact in the lives of the Pantawid members. This characteristic also looks at the scope of topics discussed in FDS and whether these respond to the current and future needs of the Pantawid members.

As a whole, a number of KII respondents both from the DSWD and partner health facilities gleaned a greater awareness among the Pantawid members regarding the importance of education, family values and health which they attributed to the beneficiaries' attendance to the FDS. Some even noted that the members are more confident in participating in discussions during FDS, perhaps because of the additional information and knowledge gained through the sessions.

> *"The people in the community had a shift from not caring to being aware of the importance of education, etc through the FDS."* [KII respondent]

> *"They really love the FDS, since it has really impacted change through subjects like backyard gardening."* [KII and FGD respondent]

It was also noted that the conduct of the FDS was greatly facilitated by supportive staff both from the DSWD and the partner agencies.

From the FGD and KII, most respondents felt that the topics proffered in the FDS Manual and are discussed in the sessions regularly are appropriate and important. However, a significant number of program implementers and their partners also suggested additional topics to be discussed during FDS. These pertain to inputs on livelihood activities and other economic opportunities that can augment the income of the Pantawid members.

> *"It is hard to improve their economic status because even if they give them skills, employers don't take them* [sic] *because they don't finish high school…"* [FGD respondent, Visayas and Mindanao]

While not limited to the FDS, the recommendation made related to the inclusion of topics to generate livelihood was repeatedly mentioned by the DSWD and partner implementers of Pantawid.

Among the beneficiary-respondents of the household survey done for this study, 37 of the 390 family-respondents suggested additional topics that they hope will be taken up in future FDS. Of these, 19 topics were about income-generating and livelihood activities.

In relation to the possible contribution and role of the FDS in raising awareness on MHC and FP among Pantawid beneficiaries, 25.12% (98) respondents from the household survey cited health related topics particularly Family Planning and Child Care as sessions that they highly appreciated and found useful.

Of note, however, was a comment made by one of the KII respondents from the Health Facility regarding health-seeking behavior of Pantawid members:

> *"There is a need to develop the beneficiaries health-seeking behavior…"* [KII respondent]

Dissemination

Dissemination, on the other hand, looks into the methodologies used in carrying out the FDS. This also includes information on the appropriateness and conduciveness of the venue, the ability of the facilitator to connect to the listeners, among others.

The study team noted that in all of the FDS they observed, the attendees were usually the mothers. Some participants in the FGDs opined that:

> *"The family development sessions should be for the family, but it is always only the mothers who attend."*

Few spouses were observed to be involved in the sessions, except for those sessions where the topic related specifically to the roles of parents in the family. Only 7.47% (29) respondents from the household survey of Pantawid beneficiaries reported that their male partners accompanied them to an FDS at least once since the beginning of the year 2016.

In addition, the facilitators who ran the FDS that we observed demonstrated mastery of the topic discussed and was easily able to connect well with the participants or audience. More than 95% of respondents in the household survey perceived the FDS facilitators as both knowledgeable in the topics of the session as well as being easy to approach for questions. There is a palpable relationship of trust between the facilitators (usually these were the Municipal Links) and the Pantawid members.

The facilitators used participatory methods, generating responses and reflections from the Pantawid members who were at the FDS.

KII respondents from the health facilities observed that the FDS are well implemented. In particular, interagency coordination was good and thus it was easy for the Municipal Links to ask the RHU staff to conduct the sessions that had health related topics.

The venues where the FDS was conducted, albeit simple and sparse, were observed to be sufficient and accessible to the audience. The space though was limited and thus most FDS were done using a classroom type of seating arrangement, instead of a semi-circular arrangement which lends to greater interaction between facilitator and participant and among participants.

In some FGDs, respondents noted that the conduct of the FDS was sometimes compromised or cancelled due to the absence of facilitators. Municipal Links were also involved in the running of the FDS however, workload can be a hindrance in the conduct of the session.

> *"The workload of the case managers and staff conducting the FDS compromises the sessions."*

Table 52. Tabulation of Significant Statements from FGDs and KIIs

Feature of FDS	Sources of information	Themes	Frequency count	Quotes
Fit	KII-RPC, KII-Facility, FGD	Increased Awareness and Confidence of the beneficiary	9	"The people in the community had a shift from not caring to being aware of the importance of education, etc., through the FDS."
	KII-RPC, FGD	Supportive staff, partners and members	5	"They really love the FDS, since it has really impacted change through subjects like backyard gardening."
	KII-Facility, FDS Observation	Lack of economic earning opportunities	4	"It is hard to improve their economic status because even if they give them skills, employers still don't take them because they didn't finish high school."
	KII Facility	Perceived lack of Health-Seeking Behavior Development	3	"There is a need to develop the beneficiaries health-seeking behavior."
Dissemination	FGD, FDS Observation	GAD integration in the FDS	4	"The family development sessions should be for the family, but it's always only the mothers who attend."
	FDS Observation	Trusting relationship with the staff	2	"The facilitator knows to echo responses and to ask participants if she understood what the participants explained."
	FGD	Compromised FDS due to external issues	2	"The workload of the case managers and staff conducting the FDS compromises the sessions."

11.2 Discussion

Data gleaned from KII and FGD indicate that the Pantawid beneficiaries are receptive and responsive to the various topics discussed in the FDS. This was clearly shown by the consistently positive stance of many of the Pantawid implementers. Significantly, when queried about what to their minds is the single most important feature of the Pantawid that has impacted greatly on the lives of the beneficiaries, majority of the FGD participants immediately responded that it was the FDS.

Moreover, despite the limited number of sessions observed, the robust participation of the Pantawid beneficiaries was very palpable. It was also very apparent that the attendees to

the FDS were usually the women. This is not surprising since the Pantawid Program targeted the women to be the direct grantees.

However, suggested modules in the FDS manual delve on topics that require the involvement of other members of the Pantawid families, particularly the male partners, particularly for topics related to Family Planning and Gender. The teenage children are also included as target audience in many of the sessions as these are also heavily undergirded by values and life skills formation.

Youth Development Sessions (YDS) are also being conducted among Pantawid families. These are targeted for teenage children. Attendance to the YDS by Pantawid children, however, is not included in the conditionalities for Pantawid and is not conducted on a regular basis in the communities.

Enabling Features of FDS

Discounting the fact that attendance to the FDS is a conditionality that Pantawid beneficiaries must comply with in order for them to receive their cash grants, the FDS, has through the years, apparently evolved as an important community-based activity that has become an avenue for Pantawid members to obtain more information about themselves, their relationships and their families.

The attendees to the FDS may not recall or retain all of the information provided them at each session but the likelihood that they will have retained some important pieces of information is possible. The beneficiaries are provided notebooks where they are able to write down key learnings which they can then review some other time. However, as to whether in fact the Pantawid beneficiaries are faithful in taking down notes and reviewing these at home cannot be determined. The highest percentage of respondents in the household survey both from an urban and rural setting were either not able to go through formal education or were, at best, only able to attend elementary school but not able to complete this. In addition, during sessions where some members share their stories or opinions about the topic, listeners who resonate with these inputs tend to remember these and refer to these learnings even after the FDS.

Based on the household survey conducted among Pantawid members, the average duration of membership to the Program is 4 years. This means that it is very likely that the 3 modules presented in the FDS Manual have been repeatedly discussed in the sessions through the years. Thus, it is also highly possible that repeated listening to the same topics has also brought about more information to the members and, hopefully, also led to some behavioral change.

The FDS topics also appear to be relevant and important to the Pantawid families as these encompass overarching themes of family and values which appeal very much to the Filipino psyche particularly in terms of its being family-oriented and God-fearing.

Another feature of the FDS that is enabling is the trust relationship that is built between the Pantawid implementers (particularly the Municipal/City Links) and the beneficiaries. These relationships also serve as motivations for attending the FDS and participating robustly particularly if a bond of community spirit has already been fostered among the Pantawid families within the same catchment area.

This good relationship is also extended to Pantawid partners from both government agencies and CSO's. This enables the participation of other facilitators in the conduct of the FDS. Absent this, it is very likely that the Program implementers will find it challenging to engage other partners in conducting FDS and this then becomes additional burden on their workload.

11.3 Conclusion

The FDS, despite limitations in human and physical resources in many settings, has contributed towards raising awareness about MHC and FP among Pantawid families. Although the study methods related to questions about FDS did not zero in particularly on the sessions related to Responsible Parenthood and Family Planning, utilization data on use of modern contraceptives and utilization of Maternal Health Care facilities show comparable numbers to the national averages as shown in the DHS 2013.

The FDS also provides a concrete avenue for Pantawid members to participate and are opportunities for various social mobilization activities that can further enhance the development and transformation of the Pantawid families.

Learning sessions such as the FDS must always ensure that there is alignment in both applicability and appropriateness of the topics discussed in the sessions (Fit) as well as the methodologies and activities used to carry out the sessions (Dissemination).

In all of these, the expertise and skills of appropriate facilitators in a non-formal setting must be harnessed particularly those that can ensure full engagement and participation of the Pantawid members.

Post-FDS monitoring is also an important focus area which has not been well addressed in the past. In this way, the Program implementers are better able to assess the application of learning by the beneficiaries in their lives.

12. PROGRAM ASSESSMENT

Among the topics discussed during the FGD were the respondents' take on how the Pantawid Program has fared through the years. As shown on Table 49 above the respondents' profile of the participants in the three (3) FGDs conducted for the study were mixed. During the FGD, participants were queried about whether the Program should continue and whether these should be implemented as usual in the manner that it has been done in the past.

Additional questions were asked about how the Program can be expanded and leveled up as well as what, in their opinion, should be done to the current members and beneficiaries.

A simple tool of STOP-MAINTAIN-GO was used to obtain the FGD participants' responses to the above questions.

12.1 Results

Table 53 below is a summary of the responses indicated in the metacards of the participants and the corresponding number of similar responses are indicated in parentheses.

Table 53. Summary of FGD Responses on Pantawid Program Assessment

STOP	MAINTAIN	GO
Overload (8)	Family Development Sessions (FDS) (11)	Expansion (16)
Non-compliance (4)	Conditionality (7)	Case Management (6)
Individual approach (6)	Services (4)	Supplies/HR (4)
"Palakasan system" (2)	Social Welfare and Development Indicators (SWDI) Assessment (3)	Improve Partnerships (3)
Youth Development Session (YDS)	Youth Development Sessions (YDS) (2)	Data Management (3)
Prepaid/Cash Card	Case Management (2)	Grievance (3)
Bias against workers	Partnerships	Services (2)
	Expanded Student Grant for Poverty Alleviation	Improve Monitoring (2)
		Skills building FDS
		More Trainings
		Welfare Benefits

12.2 Discussion

The top most responses related to what in the Pantawid Program must continue and must be enhanced have to do with Program expansion as well as the maintenance of the traditional domain of Social Work – case management. Further discussions to probe these responses revealed that to the significant majority of FGD participants, the Pantawid Program has benefited and impacted the lives of poor Filipino families and must therefore be made available to more beneficiaries. In addition, getting to know and understand the unique circumstances of each family, which is the primary task in case management, is considered by many DSWD respondents to be a fundamental tool in the smooth and successful implementation of the various DSWD programs, including Pantawid.

Other Pantawid Program features that need to level up and expand are operational concerns such as staff augmentation and additional logistical supplies and resources. The need for capacity building sessions and training for Pantawid beneficiaries was also mentioned. Again, the Program implementers recognize that there is need to capacitate the beneficiaries in terms of economic activities that can help to augment the cash grants and their family income. These are necessary so that the desired goal of graduating these families from the Program when they become sustainable may be achieved.

In relation to what in the Pantawid Program needs to stop, a significant number of responses had to do with the overwhelming workload of the frontline staff, particularly the Municipal/City Links. Some of these respondents opined that the family caseload assigned to them is in the hundreds and work on the Pantawid is considered additional responsibility for the staff. Thus, the frontliners are expected to continue carrying out their work of managing family cases and also overseeing the implementation of the different features of the Pantawid Program.

There are additional aggravating factors that the Program implementers want to stop. These have to do with the problematic behavior of some beneficiaries who do not comply with the requirements of the Program. An example of wrong behavior among beneficiaries that was mentioned was the mortgage or "sale" of the Pantawid Cash Card by beneficiaries to non-

members in exchange for a monetary loan. Also, the practice of patronage politics, referred to as “palakasan” creates problems for the Program. Some of the FGD respondents observed that there are Pantawid beneficiaries that do not fit into the criteria used for selecting them and feel that there are worse-off members in the community who would benefit more from the Pantawid Program.

A unique and seemingly contradictory input given by one FGD participant had to do with the Youth Development Session (YDS). This component was placed under the STOP section by one FGD participant. When probed about why the YDS needs to be stopped, the respondent clarified that he/she did not mean that the YDS should be discontinued but that sessions for the youth should be overseen and implemented by the Department of Education and not the Pantawid Program of the DSWD. Furthermore, this respondent agreed that the YDS had an important role to play in shaping and forming the values of the youth.

Among the Pantawid Program components that the FGD participants want to keep or maintain, the FDS was the top most response given. As mentioned in other parts of this report, the FDS is recognized by the Program implementers as contributory to the behavioral change observed in some Pantawid members.

Expectedly, the other conditionalities related to education and health are deemed important and must thus be maintained. The other benefits extended to the Pantawid families (but not a component of Pantawid program) such as the Expanded Student Grant for Poverty Alleviation is also important to ensure that the Pantawid students are able to complete their education up to the tertiary or collegiate level.

Respondents also recognize the need to monitor program performance and thus express the importance of maintaining a monitoring tool like the SWDI.

13. RECOMMENDATIONS

The favourable outcomes with respect to the utilization of maternal health care and family planning services point to the following enabling factors among Pantawid families. At the same time, maximizing opportunities, if not maintaining these factors as regular program implementation features, present key challenges. The discussion below is structured in such a way that the enabling factors, challenges and opportunities are taken up in the context of each other. Areas outside of program implementation are discussed in the last section.

(1) Family Development Sessions

The FDS served as the main platform for reaching poor families. Across the years of Pantawid implementation, the subjects of self/community/program, responsible parenthood, child protection, family life, gender and family planning, including modern methods, were identified by families as topics they learned the most from. One could not imagine a non-religious based structure in present-day Philippines that can reach extremely poor families with health promoting and values formation messages, on a monthly basis.

Strengthening this structure, beyond just being a conditionality of receiving the cash grant, is the challenge. While the Manual has been guiding its implementation, Municipal Links, the main facilitator of these sessions, need to be continually refreshed on topics and delivery methods, particularly in low educational-level settings. Identifying activities that can be undertaken by these groups of families can strengthen community engagement and the families’ identity as prime movers of change and not just recipients. To do so, the Pantawid system has to open up to other groups that can help deliver these sessions and widen the network of information and support for Pantawid families. These partner groups can be specialists in certain areas, e.g., life skills on being proactive (identity, culture and

communication), financial literacy, including basic entrepreneurial training, and have national and local presence and can train trainers at regional levels for cascade learning. These groups and topics can be incorporated into the FDS learning system and require collaboration within the DSWD system, such that livelihood, youth and other training services are incorporated into the monthly FDS with different family-member engagement and not just women grantees. This will require more staff collaboration within DSWD, and possibly more field staff, as the case management of at-risk and vulnerable (in high mortality areas, older families with more children particularly of teen age years, and living far from health centre) Pantawid families should be foremost.

(2) Health services and sector engagement

The health conditionality has put the health sector in the co-driver seat of the Pantawid program. The organization of maternal and child care services needed to be accessed by the Pantawid families as part of their cash conditions were facilitated by the following: a) the LGUs put up and renovated some barangay health stations that were manned by volunteers and midwives as point of first contact for Pantawid families; b) PhilHealth's automatic enrolment of Pantawid families and their coverage with outpatient services, such as the annual checkup for grantees, and maternal and child care, on capitation basis, prompting the LGUs, as de facto 'owners' of local health systems, to stock facilities with basic equipment and supplies, including family planning supplies, and some, to renovate the health centres that served as the next referral point for families from the villages; equipping, stocking and renovations come as part of PhilHealth's certification for facilities to receive capitation; and c) within the last two years, the national DOH hired Nationally Deployed Personnel (NDP), comprised of nurses which have undertaken some of the health sessions of the FDS in some of the study areas, among their other responsibilities. These investments have loosened the supply and financing constraints and built the health services capable of serving Pantawid members and thus contributing to improved performance in maternal care services and family planning, with unmet needs now lower and modern contraceptive uptake and facility based deliveries much higher than those reported by the DHS).

Shortcomings in antenatal visits (with antenatal care visit rates among Pantawid being much lower than the last DHS, 92 vs. 95 percent respectively) pointed to a divided attention with those in high mortality areas and living far from health centres having more visits than those living nearby and in low mortality areas. The quality of antenatal care was mixed, with standard procedures not completely followed, for lack of laboratory facilities. More needs to be done by frontline health personnel to engage with Pantawid families as a client group with special needs, particularly in articulating their needs, by taking time and nurturing with appropriate health messages and family planning advice. This lack of a sense of co-responsibility of Pantawid program implementation stymies the fulfilment of Pantawid's goal of empowering families out of poverty as the health information and care needed by families, particularly better maternal and reproductive health choices, are not as adequately felt and addressed as important as other needs like, for example, education.

While PhilHealth is a financing source, improving the health facility investments made by LGUs to comply with PhilHealth requirements, it has not been fully maximized in terms of impacting on quality of service provision. In one area, after years of implementation, there has been no LGU legislation approving the distribution of PhilHealth funds to health personnel. It could be one reason health staff may not have valued having or engaged with Pantawid members, their regular source of capitation payments, whether these members used services or not.

(3) Enhancing Demand for Maternal Care and Family Planning Services

The health conditionality, a compulsion provided by the cash grant, is anchored on a human capital perspective that a child's early years, right from conception, must be appropriately nurtured by a trained health worker or professional; and the proper care and nutrition of neonates and mothers (antenatal care) and young children (immunization and deworming) must be ensured. Standard theory posits that having more children is linked to poverty not only in terms of direct costs of having children but also in terms of women trading off employment and income to care for children. Our study confirms that for every peso of Pantawid income, the likelihood of being pregnant decreases significantly by .31 percent. Pantawid therefore facilitates fertility control. Facilitating factors that lower chances of being pregnant during Pantawid membership, include having been married longer and being far (self-perceived) from health centres.

That having an adolescent child or children increases the chances of pregnancy may point to an unsystematic approach towards family planning despite low unmet needs for family planning, and the low understanding or knowledge of days of high fertility among married couples. The challenge therefore is inculcating a greater sense of deliberation over fertility control for both couples. The low male attendance in FDS points to the need to bring in the husbands into the learning loop, if not through lectures, possibly to alternative modes of delivery, through cooperatives, workplaces, and the like. The challenge of modern contraceptive uptake remains within the medical establishment to 'prescribe' such and for health workers to continue with advisories and anticipating and being proactive with women's queries on side effects of some methods. That being in high MMR areas will increase the odds of delivery outside of health facility shows that more needs to be done to encourage women to deliver in non-home based facilities. LGUs have been known to send their ambulance service to pick up women about to give birth in farther areas.

There is an unanticipated significant presence in the study, the presence of a teenager or adolescent child in the family. That having an adolescent child in the family can increase chances of pregnancy and improve the likelihood of mothers seeking antenatal care may indicate the relatively long reproductive span of Pantawid members and that there should be no slacking in informing women that they remain fecund well into the years they may expect to be menopausing. The study affirms the need not to slack on Pantawid's intended outcomes of delaying the age of marriage and completing high school as a way to break the cycle of poverty for many families. There is a need to be relentless in the pursuit of increasing awareness and utilization of family planning and maternal health care services, sustained by family development sessions as platform for family and community transformations.

Snapshot of Recommendations

Items	Proposed Actions to be Taken	Responsible Party/ies
Family Development Sessions	Continually train municipal links on FDS topics and delivery methods. **Identify activities that can be done by families for their communities.** Identify and engage other groups that can deliver sessions in the FDS. Incorporate identified topics, activities, and groups into the FDS learning system. Improve gender balance, with greater male participation and responsibilities for engaging in communities.	DSWD central and field offices and staff
Health Services and Sector Engagement	Continually engage with Pantawid families, particularly on articulating their needs, nurturing with appropriate health messages and family planning advice Encourage use of PhilHealth funds among health facilities, leading ideallly to local legislation	Local health facilities, particularly frontline health personnel Local Government Units and local health facilities
Enhancing Demand for Maternal Care and Family Planning Services	Continue increasing awareness of family planning and maternal health care services, with the Family Development Sessions as the main vehicle Explore alternative learning delivery mechanisms for adolescents Encourage husband or spouse participation in the Family Development Sessions.	Local Government units DSWD field staff DSWD field staff

14. CONCLUDING REMARKS

Overall, from the vantage point of Pantawid Program implementers and its partners, the Conditional Cash Transfer program that has been carried out by the DSWD is a beneficial and important program that has contributed to the work of uplifting the lives of Filipino families. Poverty alleviation efforts will be for nought if fertility and reproductive health

decisions are not systematically addressed. The Program has provided beneficiaries with the wherewithal to access key social and developmental services such as access to health care and education so as to ensure that the benefits and impact of the Program are sustained. Of course, the Program is far from perfect.

There are still many existing processes and systems that need to be re-visited and polished. DSWD personnel tasked with Program implementation confront serious challenges in terms of overwhelmingly heavy workload amidst limited resources and financial support. This situation is not unique to the Pantawid Program and is also true for any other programs in the DSWD and other government agencies. Partnerships among and across agencies need to be harnessed and new paradigms need to be brought in to respond to various external and internal drivers that influence the Pantawid Program and its implementers. This is true in particular with increased health sector engagement and with the health sector co-owning the outcomes needed to move Pantawid families out of poverty.

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APPENDIX ONE

TEENAGE PROFILE

The household survey yielded 106 teenager interviews. The interviews were largely focused on sources of information on sex and modern contraception. We are not confident on the outcomes of the survey on teen-agers as there were missing data and the general difficulty of getting responses from the teen-agers.

Table A1: Sources of information on sex ---

	Frequency (%)
INFORMATION ON SEX	
Obtains sex information from: (n=31)	
Teachers	11 (35.48)
Counselors	0
Friends	12 (38.71)
Social media	5 (16.13)
Others	3 (9.68)
Knows a friend or a classmate who is currently sexually active	23 (34.85)
Is in a relationship (has a boyfriend/girlfriend)	23 (34.85)
Feels comfortable to talk about sex with any family member	
Older sibling	6 (9.09)
Younger sibling	2 (3.03)
Mother	29 (43.94)
Father	6 (9.09)
Others (identify)	
Friends	1 (1.52)
Cousins	1 (1.52)

Nearly half of teenager respondents said they were comfortable talking about sex with their mother, but none mentioned their mother as a source of information for sex and reproductive health. A sizable proportion of the respondents also already report to being in a relationship, as well as knowing someone who is sexually active.

Table A2: Knowledge on Getting Pregnant and HIV/AIDS

	Frequency (%)
INFORMATION ON SEX & REPRODUCTIVE HEALTH	
Knows that there is a window in between periods with a higher chance of getting pregnant	35 (53.03)
Knows that there are days that must be avoided to avoid getting pregnant	25 (37.88)
Heard about HIV/AIDS	52 (78.79)

Of those who responded to knowing about how a woman gets pregnant, slightly more than half (53%) of the teenage respondents know that there are periods during the menstrual cycle where there is a higher chance of getting pregnant. A lesser (38%) percentage knows specifically about the days that must be avoided inorder to get pregnant. More than 70% also report having heard of HIV/AIDS.

Since the teen-agers of today are likely to be the parents of tomorrow, getting a pulse of the teen-agers views on the health sector is needed. The survey tried to capture awareness of their human rights with respect to health and health services. Table A3 shows that a third of respondents felt adequate attention (32%), felt respected when consulting a health center(33%). There is general acknowledgment that they have the right to be treated with respect (67%), with privacy (67%) and quite confident they have the right to privacy. Only 38% acknowledged seeing the patient rights posted in the health center.

Table A3: Health Centre Characteristics According to a Teenager

	Frequency (%)
Been to a Health Centre in the Past Year for being sick n=18	
Accompanied a friend to the health center (n=48)	7 (14.58)
Felt adequate attention when consulting at the health center	21 (31.82)
Felt respected when consulting at the health center	22 (33.33)
Found the health workers to be friendly (n=16)	14 (87.5)
Knows rights related to health and availment of health services	44 (66.67)
Knows that he/she has the right to be treated with respect, consideration and without judgment by the health workers	48 (72.73)
Felt respected when last visited the health center	50 (75.76)
Knows that he/she has the right to privacy while consulting	44 (66.67)
Knows that his/her medical information must be kept confidential	45 (68.18)
Feels that his/her information will remain confidential	43 (65.15)
Aware of the other rights	14 (21.21)
Saw that the list of patient rights was posted in the health center	21 (31.82)

*multiple answers provided.

Only 40 respondents expressed familiarity with modern contraceptive methods. When shown checklist of the different methods, and therefore allowing for multiple answers, the Pill was the top known method to the respondents, followed by male condom.

Table A4: Knowledge and Sources of Information on Modern Contraception

	Frequency (%)
Familiar with contraceptive methods* (n=40)	(37.3)
Female sterilization	1 (2.50)
Male sterilization	3 (7.50)
Pill	26 (65.00)
IUD	5 (12.50)
Injectables	8 (20.00)
Male condom	24 (60.00)
LAM	1 (2.50)
Rhythm	3 (7.50)
Withdrawal	4 (10.00)
Folk	1 (2.50)
Female condom	0
Implants	0
Patch	0
Learned these methods through:	

Health center	1 (2.50)
Knows a friend who uses modern contraceptive method	24 (36.36)
Has experience in using any contraceptive method	4 (6.06)
Knows that teenagers must learn how to use modern contraceptive methods	49 (74.24)
Assessed that modern contraceptive methods must be made available to teenagers	35 (53.03)
Thinks that their friends will not befriend them anymore if they learned that they are using contraceptives	14 (21.21)

*multiple answers provided

Knowledge was not known through the health centre at all. Only 6% has experience using any contraceptive method and that 36% know of a friend using a contraceptive method. It would be interesting to know how this second hand knowledge can compare with other countries. There is general awareness that teen agers must learn how to use modern methods (74%), however only 53% agreed that contraceptive methods must be made available to teenagers. There a fifth (21%) who feel stigma from using contraceptives, with their friends not befriending them if they are known to be using contraceptives.

This survey has shown that: a) teenagers appear to have more information on sex and reproductive health and HIV/AIDS than their parents; b) there is some knowledge of modern contraception and that this could be more expanded, working among peers than with health facilities; c) however, there is quite a good number (18) seeking a health centre for other reasons. With materials scattered in health facilities, this good serve as a good opportunity to learn more about reproductive health and family planning.

APPENDIX TWO

FULL VARIABLES USED IN THE DEMAND MODELS

The following tables show the initial models used in developing the demand model for the likelihood of pregnancy, facility based delivery, and the utilization of antenatal care.

Likelihood of pregnancy

A total of fifteen (15) indicators were included in the initial model in the regression model for the likelihood of pregnancy, with seven (7) being significant factors, and therefore included in the final demand model. While some indicators here seem to be significant given the p-value of less than 0.5, the adjusted odds ratio with a low value of less than one and a high value of greater than one indicates that the effect of the indicator may or may not be a risk or a protective factor. These indicators were omitted from the final model.

Table A5. Initial model: Factors associated with pregnancy during 4P's

	Pregnant during 4P's (n=278)	**Not Pregnant during 4P's (n=112)**	**Adjusted Odds Ratio (95% CI)**	**P-Value**
	Frequency (%); Mean ± SD; Median (Range)			
Age of Woman (years)	35.67 ± 5.90	37.22 ± 9.70	0.92 (0.85-1.002)	0.057
Age of Partner (years)	39.58 ± 7.13	39.79 ± 10.04	1.06 (0.98-1.14)	0.143
Did not at least finish high school (mother)	194 (69.78)	63 (56.25)	2.20 (1.05-4.61)	0.037
Did not at least finish high school (father)	139 (50.55)	49 (43.75)	1.28 (0.63-2.60)	0.499
Years married	13.96 ± 6.04	15.19 ± 8.65	0.95 (0.89-1.01)	0.151
Rural residence	105 (37.77)	70 (62.50)	0.57 (0.27-1.17)	0.125
Number of children before birthed child	4 (0 to 9)	3 (0 to 9)	2.59 (1.82-3.70)	0.000
Far distance to health center	17 (6.12)	12 (10.71)	0.13 (0.03-0.51)	0.003
Transportation cost to health center, including companions	212 (80 to 1200) (n=13)	40 (40 to 60) (n=3)	Omitted from model	-
Total Household Income				
<1000	52 (18.71)	9 (8.04)	(reference)	-
1001-2000	26 (9.35)	22 (19.64)	0.07 (0.02-0.34)	0.001
2001-3000	36 (12.95)	11 (9.82)	0.27 (0.09-1.18)	0.081
3001-4000	48 (17.27)	22 (19.64)	0.24 (0.06-0.99)	0.049
> 4000	116 (41.73)	48 (42.86)	0.27 (0.08-0.93)	0.038
Amount received from Pantawid, per month (Peso)	1,300 (250 to 3,800)	2,200 (500 to 4,000)	0.997 (0.996-0.998)	0.000
Woman without earnings	159 (57.19)	73 (65.18)	1.45 (0.65-3.23)	0.362
Age of mother when she first got married	21.15 ± 4.96	22.63 ± 5.31	0.87 (0.80-0.95)	0.001
With teenage child	156 (56.12)	53 (47.32)	7.73 (2.77-21.63)	0.000
High MMR	171 (61.51)	24 (21.43)	4.22 (1.89-9.40)	0.000

P-Value < 0.001; R^2 = 54.77%

Facility based delivery

A total of fifteen (15) indicators were included in the initial model in the regression model for facility based delivery, with only two (2) being significant factors, and therefore included in the final demand model.

Table A6. Initial model: risk factors for delivering outside of a health facility

	Non-FBD (n=71)	**FBD (n=207)**	**Adjusted Odds Ratio (95% CI)**	**P-Value**
	Frequency (%); Mean ± SD; Median (Range)			
Age of Woman (years)	36.37 ± 5.44	35.43 ± 6.05	1.004 (0.89-1.14)	0.947
Age of Partner (years)	40.62 ± 8.24	39.22 ± 6.68	1.02 (0.96-1.08)	0.535
Didn't finish HS (mother)	56 (78.87)	138 (66.67)	1.90 (0.91-3.95)	0.085
Didn't finish HS (father)	29 (41.43)	102 (49.76)	0.67 (0.36-1.24)	0.200
Years Married	15.48 ± 6.13	13.84 ± 6	0.998 (0.88-1.13)	0.986
Rural resident	32 (45.07)	73 (35.27)	1.03 (0.45-2.36)	0.941
No. of Children before birthed child	4 (2 to 8)	4 (0 to 9)	0.72 (0.56-0.93)	0.013
Distance to Health centre (Far)	12 (16.90)	8 (3.86)	4.11 (1.38-12.26)	0.011
Transport costs to health centre, incl. companion	0	200 (60 to 1,200)	Omitted	-
Total Household Income				
<1000	5 (7.04)	38 (18.36)	(reference)	-
1001-2000	5 (7.04)	16 (7.73)	1.25 (0.27-5.67)	0.775
2001-3000	12 (16.90)	25 (12.08)	1.21 (0.28-5.12)	0.799
3001-4000	16 (22.54)	36 (17.39	1.27 (0.33-4.95)	0.730
> 4000	33 (46.48)	92 (44.44)	0.93 (0.24-3.55)	0.918
Amount received from Pantawid, per month (Peso)	1,450 (800 to 3,800)	1,400 (250 to 4,000)	1.0004 (0.99991-1.0009)	0.105
Woman without earning	54 (76.06)	124 (59.90)	1.41 (0.68-2.95)	0.355
Age of women when first married	20.70 ± 4.59	21.44 ± 5.12	0.97 (0.85-1.09)	0.589
With teenage child	48 (67.61)	120 (57.97)	1.31 (0.56-3.04)	0.530
High MMR	58 (81.69)	113 (54.59)	2.68 (1.08-6.61)	0.033

P-Value = 0.006; R^2 = 13.62%

Antenatal care

A total of sixteen (16) indicators were included in the initial model in the regression model for facility based delivery, with only three (3) being significant factors, and therefore included in the final demand model.

Table A7. Initial model: Factors associated with absence of Antenatal care

	Without Antenatal care (n=11)	**With Antenatal care (n=267)**	**Adjusted Odds Ratio (95% CI)**	**P-Value**
	Frequency (%); Mean ± SD; Median (Range)			
Age of Woman (years)	37.64 ± 5.07	35.58 ± 5.93	1.06 (0.82-1.37)	0.669
Age of Partner (years)	39.73 ± 5	39.58 ± 7.21	0.89 (0.73-1.10)	0.275
Did not at least finish high school (mother)	8 (72.73)	186 (69.66)	1.58 (0.26-9.7)	0.622
Did not at least finish high school (father)	5 (45.45)	126 (47.73)	1.06 (0.24-4.60)	0.939
Years married	17.36 ± 5.61	14.13 ± 6.06	1.32 (1.02-1.72)	0.037
Rural residence	3 (27.27)	102 (38.20)	0.27 (0.04-1.88)	0.186
Number of children before birthed child	4 (1 to 7)	4 (0 to 9)	1.16 (0.64-2.11)	0.625
Far distance to health center	2 (18.18)	18 (6.74)	18.91 (2.15-166)	0.008
Transportation cost to health center, including companions	N/A	200 (60 to1,200) (n=13)	Omitted from model	-
Total Household Income				-
<1000	2 (18.18)	41 (15.36)	(reference)	
1001-2000	2 (18.18)	19 (7.12)	14.41 (0.77-269)	0.074
2001-3000	1 (9.09)	36 (13.48)	4.14 (0.14-125)	0.414
3001-4000	0	52 (19.48)	Omitted	-
> 4000	6 (54.55)	119 (44.57)	12.55 (0.59-125)	0.104
Amount received from Pantawid, per month (Peso)	1,300 (800 to 3,200)	1,400 (250 to 4,000)	1.0005 (0.9992-1.002)	0.471
Woman without earnings	7 (63.64)	171 (64.04)	0.5 (0.09-2.78)	0.428
Age of mother when she first got married	20.55 ± 4.06	21.28 ± 5.03	1.04 (0.79-1.38)	0.779
With teenage child	5 (45.45)	163 (61.05)	0.05 (0.004-0.56)	0.016
High MMR	5 (45.45)	166 (62.17)	0.28 (0.04-1.98)	0.202
Years as Pantawid members	4 (2 to 6)	4 (1 to 6)	0.83 (0.34-1.98)	0.669

P-Value = 0.229; R^2 = 23.83%