Final report

"Process review and assessment of the Modified Conditional Cash Transfer for Homeless Street Families"

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Abbreviations and acronyms

4P	Pantawid Pamilyang Pilipino Programme
ALS	Alternative Learning Solutions
ADB	Asian Development Bank
COA	Commission on Audit
CCT	Conditional Cash Transfer
CHED	Commission on Higher Education
CFDS	Community and Family Development Session
CSO	Civil Society Organisation
DepEd	Department of Education
DOH	Department of Health
DBM	Department of Budget and Management
DILG	Department of Interior and Local Government
DRU	Disaster Risk Unit
DSWD	Department of Social Welfare and Development
ECR	Eligibility Check Routine
EPRI	Economic Policy Research Institute
FCA	Family Camp Activities
FDS	Family Development Session
FGD	Focus Group Discussion
FMS	Finance Management System
FO	Field Office
FNSP	Families in Need of Special Protection
GOA	Grassroots organizing activities
GDP	Gross Domestic Product
HSF	Homeless Street Families
IP-GIDA	Indigenous People in Geographically Disadvantaged Areas
KC-NCDDP	KALAHI-CIDSS National Community-Driven Development
KII	Key Informant Interview
KSA	Key Shelter Agencies
LGU	Local Government Unit
MCCT	Modified Conditional Cash Transfer
MIS	Management Information System
M&E	Monitoring and Evaluation
NAPA	Notice of Approved Payroll Action
NAPC	National Anti-Poverty Commission
NGO	Non-Governmental Organisation
NHTS-PR	National Household Targeting System for Poverty Reduction
NHTSO	National Household Targeting System Office
OM	Pantawid Pamilyang Pilipino Programme Operational Manual
PIDS	Philippine Institute of Development Studies
PHP	Philippine Peso
PLIA	Participatory Livelihoods Interventions Assessment

PMT	Proxy Means Test
PSM	Propensity Score Matching
PSU	Protective Services Unit
RCCT	Regular Conditional Cash Transfer
RCT	Randomised Control Trial
RPMO	Regional Programme Management Office
RS	Rental Subsidy
SLP	Sustainable Livelihood Programme
SNP	Supervised Neighbourhood Play
SSI	Support Service Interventions
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNOCHA	Office of the United Nations High Commissioner for Human Rights
WASH	Water, Sanitation and Hygiene

1. Introduction

In 2008, the Government of the Philippines introduced the conditional cash transfer programme *Pantawid Pamilyang Pilipino Programme* (4Ps). The 4Ps aims to build human capital by improving education and health outcomes for children and pregnant women. It further seeks to alleviate financial stress by means of conditional cash transfer grants and to encourage behavioural change among beneficiaries through so-called Family Development Sessions (FDS). 4Ps beneficiaries, poor households with children below the age of 18 years and/or pregnant women, are identified through the National Household Targeting System for Poverty Reduction (NHTS-PR), known as *Listahanan*, which is based on a proxy means test (PMT). The *Listahanan*, however, does not capture families without a permanent residence. To compensate for this exclusion, the government of the Philippines introduced the Modified Conditional Cash Transfer for Homeless Street Families (MCCT-HSF) in 2014.[1]

Since then, the MCCT-HSF is implemented as a bridging strategy pursuing the same core objectives as the regular 4Ps while simultaneously preparing beneficiary households for mainstreaming into the regular 4Ps. In order to facilitate this integration, and in consideration of the intensified support homeless street families (HSF) may require, the MCCT-HSF adds additional, time-bound benefits to the core package of the 4Ps. Beneficiaries of the MCCT-HSF receive a time-bound rental subsidy and can avail of so-called Support Service Interventions (SSI). These include livelihood assistance, cash for work or family camps. This additional support aims to empower homeless street families to fulfil the eligibility criteria of the regular 4Ps, enabling them to access regular social assistance programmes as a result of being captured in Listahanan.

Operational for five years now, there are no studies that capture the impact of the MCCT-HSF on programme objectives, nor investigate the programme's capacity to address the needs of its beneficiaries per its design and implementation. Hence, acknowledging this evidence gap, UNICEF and the Department of Social Welfare and Development (DSWD) commissioned the Economic Policy Research Institute (EPRI) to better understand how and under what conditions the MCCT-HSF is able to resolve the needs of homeless street families and to assess the extent to which the programme processes are adequate to improve the situation of HSF and extend the 4Ps benefits to HSF.

Informed by fieldwork in all seven implementation locations of the MCCT-HSF, this report presents the assessment's findings. For this purpose, adjacent to an introduction to the context within which the MCCT-HSF operates and evolved, the report explains the assessment purpose, objectives and scope, as well as the research methodology and its limitations. Then, the report

[1]There is a dedicated MCCT for the Homeless Street Families, the Indigenous Peoples in Geographically Isolated and Disadvantaged Areas, and the Families in Need of Special Protection. This review focuses on the MCCT-HSF alone and uses the term MCCT to refer to the MCCT-HSF only.

reflects on the findings and conclusions, which can be drawn from those. The report concludes with a set of recommendations addressing the findings of the assessment.

2. Background and context

Over the past decade, social protection interventions, especially cash transfer programmes, have gained substantial momentum as essential components of social policy interventions for children. Programmes which not only provide financial support but supplement this with information and additional complementary services for beneficiary families have shown to attain multi-sectoral benefits by increasing access, uptake and utilization of social services. As a result, social protection is increasingly and widely accepted as one of the most effective public policy instruments policymakers have available to reduce poverty and address other developmental challenges.

2.1. Social protection in the Philippines

In the Philippines, social protection interventions are relatively well established and operate in a formal framework, which was established in 2007. The framework seeks to promote and protect the populations' livelihood and employment, to protect them against hazards and sudden loss of income and improve their risk management capacities. And aims to achieve these objectives through labour market interventions, social insurance, social welfare and social safety nets, most of which are managed by DSWD. The main programmes are the conditional cash transfer *Pantawid Pamilyang Pilipino Programme* (4Ps), the *Sustainable Livelihood Programm*e (SLP) and the *Kapit-Bisig Laban sa Kahirapan-Comprehensive and Integrated Delivery of Social Services* (Kalahi-CIDSS) which seeks to improve community-driven development.

DSWD aims to integrate and harmonize the implementation of these main programmes to the largest extent possible through its internal convergence guidelines for the Core Social Protection Programmes.[2] The convergence strategy provides for three types of interventions. These are *protective measures* to provide basic social protection to beneficiaries and incentivise them to invest in human capital; *promotive measures* to support beneficiaries to develop their entrepreneurial potential by providing access to credit, enhancing their socio-economic skills and developing entrepreneurial values; and *transformative measures* to improve beneficiaries' access to financial resources through community-driven development. Convergence seeks to ensure that the systems and processes underlying the main social protection interventions are synchronized to enable beneficiaries to maximise outcomes for themselves using DSWD's and involved stakeholders' resources as effectively and efficiently as possible.

[2] (Philippine Institute for Development Studies, 2017)

2.2. 4Ps programme

The 4Ps was introduced to strengthen human capital among young children and to break the intergenerational cycle of poverty among poor households.[3] The 4Ps benefit package requires families to fulfil a set of conditions in health and education. In addition, families receive monthly family development sessions, a rice subsidy, and an unconditional cash transfer to cushion the negative effects of the Tax Reform for Acceleration and Inclusion (TRAIN) Law of 2018, and a sponsored membership of the National Health Insurance Scheme PhilHealth.

For the health grant (PHP 500 monthly per household), all children younger than five years and pregnant women must visit the health centre or rural health unit regularly, and all school-aged children (6 to 18 years old) must comply with a defined list of age-specific health care services. For the education grant (PHP 300 per elementary school child member and PHP 500 for children in high-school – provided per child, for a maximum of three children per household), children must be enrolled in school and attend at least 85 per cent of school days per month.

The 4Ps was institutionalised and benefit levels were adjusted upwards by Republic Act No. 11310 or the Pantawid Pamilyang Pilipino Program Act on 17 April 2019. The health and nutrition grant was increased to PHP 750 per month for a maximum of one year and the education grant was increased to PHP 500 for junior high school students and PHP 750 for children in secondary high school.[4] The programme's target group, the poor, are defined as those households who fall below the poverty threshold set by the National Economic Development Authority (NEDA) and are unable to cover their 'minimum basic needs of food, health, education, housing and their essential amenities of life'.[5] The 4Ps is currently implemented in 145 cities and 1,483 municipalities in the country.[6]

2.3. Modified conditional cash transfer

The number of beneficiaries of the 4Ps rose from 2.3 million to almost 4.4 million households between 2011 and 2016. Eligible households are identified using a unified targeting system called *Listahanan* since the programme's introduction.[7] The current beneficiary pool of the 4Ps is still based on the 2009round of *Listahanan,* which excluded a variety of particularly vulnerable and marginalised households because of its selection criteria. Therefore, Listahanan is being revised to resolve some exclusion and design flaws (Listahanan 3). However, at present, several vulnerable

[3] (Department of Social Welfare and Development, 2015)
[4] (Republic of the Philippines, 2018), Section 7
[5] (Republic of the Philippines, 2018), Section 3(i)
[6] Formerly known as the National Household Targeting System for Poverty Reduction (NHTS-PR) (World Bank, 2017)
[7] A proxy means test (PMT) is used to identify and locate poor and vulnerable households. The PMT allows to calculate household income based on household composition, education, socio-economic characteristics, housing conditions, access to basic services, assets, tenure status, and regional variables (Department of Social Welfare and Development, 2015)

groups are excluded from benefiting from the 4Ps. For instance, homeless street families are excluded because of their mobile lifestyle and indefinite residence. The Modified Conditional Cash Transfer (MCCT) was designed to facilitate the integration of the excluded groups in the 4Ps and to enable them to overcome their situation. Identified groups who may be excluded include indigenous people in geographically disadvantaged areas (IP-GIDA), families in need of special protection (FSNP) and homeless street families. Because they all have highly specialized requirements and priority areas for support, the MCCT has three dedicated, unique segments. These are the MCCT-IP-GIDA, MCCT-FSNP and MCCT-HSF. DSWD's programme tailored for the needs of the homeless street families is the Modified Conditional Cash Transfer-Homeless Street Families (MCCT-HSF).

After the initial pilot phase of two years, the MCCT-HSF was formally rolled out in 2014. The conditions and programme processes are based on the 4Ps but can be modified by implementors as required. The MCCT-HSF's additional, overarching objective is to empower beneficiaries to be eligible by the 4Ps targeting mechanism, known as 'mainstreaming'. The 4Ps Act explicitly makes provision for the automatic inclusion of all MCCT-beneficiaries in the 4Ps' standardized targeting system given they are identified as poor and meet a set of requirements.[8] To that objective and in addition to the core benefits of the 4Ps, MCCT-HSF beneficiaries are eligible for Support Service Interventions (SSI) which include cash for work (CFW), livelihood assistance (LA), grassroots organizing activities (GOA), family camp activities (FCA) and a rental subsidy (RS) of a 'prevailing' rate, currently PHP 4,000 for up to 12 months. These support services are allocated through caseworkers and are to be implemented in a concerted effort with other agencies.[9]

The case management activities, through which the SSI are allocated, depict the main difference between the regular 4Ps and the MCCT-HSF. Each beneficiary family is supported by a caseworker, who monitors their progress and has a therapeutic, individualised relationship with the family to help them identify and guide them in resolving their needs and prepare them to migrate to the regular 4Ps. The MCCT-HSF aims to familiarize the beneficiaries to the 4Ps by habituating them to comply consistently to programme conditions.[10] This process is referred to as 'mainstreaming' and should follow clear guidelines defined by DSWD and the MCCT Division (MCCTD) of the 4P. The readiness of beneficiaries is determined by their caseworkers who assess beneficiaries' progress towards fulfilment of the eligibility criteria for mainstreaming.[11] However, until now, no beneficiary families have formally undergone the mainstreaming procedure.

[8] (Republic of the Philippines, 2018), Section 6
[9] (Department of Social Welfare, 2017c)
[10] (Department of Social Welfare and Development, 2015)
[11] (Department of Social Welfare and Development, 2015)

2.4. Homelessness – a global phenomenon

Although housing is a human right and its role for human development is widely acknowledged as imperative, street dwelling is present and also increasing around the globe, in industrialised and developing countries alike. Homelessness is considered to result from a combination of adverse structural factors, such as negative labour market trends, weak access and coverage of social services, disasters, and lack of access to affordable housing and personal factors including character and behavioural issues. The underlying reasons for the increasing numbers of homeless persons include on the one hand globalisation and its economic effects such as increasing inequality, changing requirements on the labour market and a resulting inability to afford decent housing among an increasing number of households. On the other hand, climate change, the disasters and risks which come with it and the resulting displacement of poor and vulnerable communities are further contributing towards growing numbers of persons without adequate, safe and affordable housing.[12]

The international community and governments around the globe have hence included these aspects, as well as access to basic services as an objective within the Sustainable Development Agenda 2030. To this end, it has been identified as fundamental to develop holistic housing strategies which accomplish structural change through combining legislation, stakeholders, policies and programmes rather than relying on silo-based housing programmes which is often the case. Consequently, governmental failure to provide their population with safe, adequate and affordable housing is not a mere programmatic failure, but is a denial of human rights.[13] Since human rights are interdependent, indivisible and interrelated, denial or breach of the right to housing is likely to also affect the fulfilment of further human rights. This life in the streets, is associated with aggravated levels of poverty, intensified psycho-social, emotional, financial and security stresses.[14] While the effects of homelessness are grave for adult populations, children are affected even more substantially because their health, educational advancement and overall well-being depend strongly on having a safe home.[15] International experiences show that there is no one-size-fits-all solution to this highly complex challenge which is shown in the ensuing literature review.

2.4.1. *Housing as a devolved function of government in the Philippines*

In the Philippines, the state's responsibility to ensure and continue urban land and housing reforms to provide affordable, decent housing and basic services to underprivileged and homeless citizens in urban centres and resettlement areas are enshrined in the national constitution of

[12] (UNOCHA and UNHABITAT, 2018)
[13] (ibid.)
[14] (Sescon, 2015) (Mendoza, 2013)
[15] (UNOCHA and UNHABITAT, 2018; Mendoza, 2013)

1987.[16] The devolution of autonomy and financial resources to local government units in 1991 laid a strong basis for adequate service delivery. Local government units (LGUs) are mandated to provide "immediate basic relief assistance" such as "food, clothing, temporary shelter, emotional support" to families affected by major disasters and their consequences. The LGUs are further responsible to provide efficient and effective basic social welfare including interventions targeted at youth, women, family, and assuring community welfare; the welfare of the elderly and disabled persons. LGUs are also mandated to provide community-based rehabilitation interventions for drifters, beggars, street children, scavengers, juvenile delinquents, and persons who use drugs, among others.[17]

While decentralization is generally considered successful, governance mechanisms are perceived to be lacking strong coordination and planning, and the implementation of regional infrastructures and services is also considered to be falling short. LUG's capacity is perceived to vary in carrying out their mandate because of prevailing regional conflicts, as well as inadequate coordination and linkages between different tiers of government.[18] Not all LGUs operate housing offices and/or local housing boards who are mandated to resolve unmet housing needs of the poor and underprivileged persons in their constituencies. Key shelter agencies (KSA) tend to fulfil their functions based on their specific mandates, but responsibilities between the national and local government are not clearly defined.[19] National housing programmes include social housing, national housing production and small housing loans for urban poor families. The National Housing Authority (NHA) provides a demand-driven, project-based, and profit-oriented programme which is said to have limited relevance for poor and vulnerable households because of the financial requirements and responsibilities. Uptake of these housing interventions is also perceived to be inadequate at times, there were for instance 15,000 vacant houses in 26 resettlement sites in 2017. Direct housing assistance was provided to 730,181 households between 2011 and 2016.[20] For the period of the PDP 2017-2022, direct housing assistance shall be provided to 1,558,711 households, predominantly through the NHA Housing Production, Social Housing Finance Corporation's Community Driven Shelter Programmes, and Home Development Mutual Fund End-User Financing.[21]

2.5. Homelessness in the Philippines

While nearly half of the Philippines' surface is arable and developed land, access to decent, affordable, and secure shelter, especially in urban areas is a significant challenge for the country's

[16] (Republic of the Philippines, 2016)
[17] (Government of the Philippines, 1991)
[18] (Naik Singru, 2014)
[19] (Republic of the Philippines, 2016)
[20] (Republic of the Philippines, 2016)
[21] (Republic of the Philippines, 2016)

development. Land repurposing for urban and industrial usage, including the development of residential divisions and housing, are therefore important priorities. With an increased influx of rural dwellers to urban areas, especially the National Capital Region, and most Filipinos aspiring to homeownership, unplanned urban settlements develop, and urban planning efforts are under pressure to meet the increasing demand for adequate shelter.

The majority of Filipinos aspire to have a house and relatively few persons are identified and counted as homeless street families, for instance the PDP 2017 – 2022 states the number of homeless as 5,390.[22] The increasing urbanization, exponential population growth, weak reduction of poverty and little resilience to poverty, as well as increasing costs of housing facilities undermine government efforts to fulfil this mandate.[23] Consequently, for people and families living in the streets, safe and secure housing may be a dream of the distant future or may even appear unattainable throughout their entire lives.

Two studies, the *Rapid Appraisal of Homeless Street Families in the Cities of Manila, Quezon, Cebu, Tacloban, Zamboanga, and Davao (2015)* and *Including Homeless Families and Children in the Social Protection System: A Brief Review of International Experience and Data on a Philippine Pilot Programme (2013)* provide insights on livelihoods and characteristics of homeless persons and families in the Philippines.

Sescon's appraisal investigates pathways and characteristics of the homeless and is based on research among 2,000 homeless persons. Sescon settles on the categorization of three groups of homeless families the *transitionally homeless, episodically homeless, and chronically homeless* which are guided by the time spent on the street as this is considered a core determinant of their characteristics. As many as 43.8 per cent of his sample beneficiaries are chronically homeless (having lived in the streets for more than eight years), 28 per cent are episodic (living in the streets between three to seven years) and 28.6 per cent are transient homeless (lived in the streets for less than 2 years) homeless.

Sescon begins by identifying structural factors, namely 1) increasing urbanization, 2) exponential population growth, 3) weak reduction of poverty and little resilience to poverty, as well as 4) increasing costs of housing facilities which contribute towards homelessness. He acknowledges their importance for the overall pathway of ordinary members of society into homelessness, but underlines that personal circumstances, such as family feud, abuse, eviction, loss of job, illnesses, destructive behaviour such as illegal drugs are crucial too. He, as common in the literature, also is of the view that a combination of structural and personal factors cause homelessness and that with increased time spent on the street, the perceived benefit of living in the street outweighs the

[22] (Republic of the Philippines, 2016)
[23] (Sescon, 2015)

cost of it.[24] For many individuals, Sescon identifies that homelessness and its resulting insecurity become the most acceptable coping mechanism to resolve challenges in their lives.[25] He ascribes this to alternative cost-benefit analyses and choice behaviour theories which, in his view, differ between ordinary members of society and homeless persons.

He finds that with increasing periods of time spent on the street, HSF become increasingly socialised on the street resulting in them appreciating the streets as their home. This influences their household priorities which they rank as food, shelter, livelihoods and children's education. He further finds that with increased time spent on the street, food importance increases while livelihood decreases as a family priority, showing that their family priorities are focused on survival at the lowest cost possible. The advantages of life on the streets as perceived by HSF, include for instance the lack of traditional 'household obligations' such as maintenance cost of homes, and less pressure to fulfil normal responsibilities.[26] He identifies this as crucial for programming successful interventions for HSF and acknowledges that whether homeless families succeed to establish a life within regular society, is largely driven by individuals' reaction towards and acceptance of specific interventions. This, in turn, is primarily defined by personal circumstances, primarily the duration of their stay in the street, rather than structural factors. He found that the benefits of a regular life may still matter more for HSF in the early phases of homelessness, that is the transient and early stage of episodic homelessness.

Once families consistently fail to exit homelessness, they may ultimately give in and learn to accept and accommodate to the homeless lifestyle as permanent, with the benefits of regular life and its priorities becoming less tangible, which ultimately determines their cost-cutting strategy. As this determines family priorities, which defines housing as less important than food, livelihood and education, Sescon is of the opinion that the families' priorities should be resolved in their order of precedence but still be oriented towards the real psychosocial needs. As such, enrolment with the regular 4Ps was recommended as a priority action to satisfy education and food needs, while housing was left to be resolved at later stages of the programme.

2.5.1. *International responses to homelessness and housing challenges*

Mendoza (2013) analyses the societal issue of homelessness in a wider context, considering international experience to facilitate programmatic improvements in the Philippine's intervention. These shall apply to the targeting methodology and programme design features. The report focuses on the important role of social protection interventions to attaining inclusive growth and to this end, compares social protection interventions in lower and middle-income countries, namely Brazil, Chile, India and South Africa and shows that these offer conditional cash grants as

[24] (Sescon, 2015)
[25] (Republic of the Philippines, 2016)
[26] (Ibid.)

well as housing subsidies to their indigent population groups without permanent homes. Mendoza only distinguishes between transient and chronic homeless which is based on a UN-Habitat concept of 2000. He continues by emphasising the dire effects of growing up homeless for children, who will likely have poorer capacity and capability to successful labour market participation and may be more likely to fall into the infamous poverty trap. Having acknowledged this, he continues by discussing the approach of the MCCT and outlining beneficiary profiles based on the preliminary beneficiary data of 2012.[27] His comparison across the countries shows that support to homeless persons and families is primarily provided in-kind rather than in cash and that the provision of temporary shelter is more common than offering subsidized housing. He underlines the value of psychosocial support and treatment as these address households' and individuals' vulnerabilities and risks, primarily those of children. He further identifies strong information and monitoring systems of the more advanced interventions which facilitate the collection of data and inform and guide implementation of the interventions.

Mendoza analyses the four national solutions following the criteria of programme design, targeting, challenges and impact. For the Chilean *Solidario*, he highlights the benefit of cross-institutional cooperation and psycho-social support provided but also shows that the coordination of the multiple actors engaged in the implementation depicts a challenge for the implementation of the programme. However, the programme achieved to mainstream 2,700 homeless persons into the regular social protection system after only 12 months of implementation.

For South Africa's *Housing for the Poor* approach, Mendoza underlines that here, homeless persons and individuals do not receive a dedicated programme as such, but that the government, due to the country's past, pursues an objective to improve the housing situation of a wide segment of society through housing programmes. In addition, homeless persons qualify for the social safety net interventions, which are provided to a quarter of the country's population. However, the national housing programmes are faced with substantial challenges and 2.3 million families are considered to have inadequate housing. India's *Shelter and Sanitation Facilities for the Footpath Dwellers in Urban Areas* initially provided shelter and sanitation facilities (payable) which faced poor uptake among the target population, namely footpath dwellers. Mendoza identified legislative changes requiring state governments to adequately care for the homeless as insufficient and considers the situation of the homeless not appropriately resolved with the analysed approach. For Brazil's *Bolsa Familia,* Mendoza highlights the dedicated support provided for individuals in complex vulnerable situations which the Special Social Protection Unit provides for homeless persons and families. While institutional care is also designed to be available, it is unclear if and how this aspect actually benefits homeless persons. It remains further unclear if and how the unified database upon which the Bolsa Familia is based, succeeds in identifying homeless

[27] (Mendoza, 2013)

persons and to what extent the implementation of the programme, which is driven at the municipal level, actually serves the homeless beneficiaries.

Following this comparison, Mendoza encourages that targeting should be improved and become more cost-efficient while remaining fair and, primarily, be transparent for beneficiaries and applicants in the MCCT. Mendoza encourages that the case management component of the MCCT is strengthened and highlights that it is especially crucial for chronically homeless families. In learning from the Chilean experience, Mendoza suggests that the sequencing of financial support and case management may be reversed in the MCCT to reflect the approach chosen in Chile because of the success to bring 2,700 families off the street. Mendoza further encourages to strengthen interagency coordination between DSWD and stakeholder such as DOLE, strengthening regional development to curb economic migration as well as sustainably investing in education and employment trainings of vulnerable and poor communities. Mendoza further suggests considering Brazil's Social Service Reference Centre as a reference point to improve the use and management of beneficiary data.

In addition to these national approaches to the societal issue of homelessness, a trend in programming work can be observed over the past decades. In Europe and the United States (US), as well as Canada and Australia, over the past decades, a trend towards the so-called Housing First approach emerged. This approach sees the provision of housing as the first step to improving the lives of homeless individuals and families, rather than framing it as the final objective of an intervention.[28] Subsequent to the addressing the housing problem, the remaining issues a household faces may then be resolved. The approach is estimated to improve housing situations among 80 per cent of its beneficiaries.[29] The details of the approach differ between countries on the one hand, and the European concept is considered to follow a different paradigm than the one in the US. In the US, no conditions are attached to receiving support from the government to get into a housing scheme and beneficiaries can voluntarily decide to use services for an unlimited amount of time. Additional support is provided to enable beneficiaries to achieve other personal priorities and for families or individuals who are chronically homeless, more intensive support is provided through case management. Housing first interventions usually collaborate with a wide variety of service providers who are encouraged to provide "whatever it takes" to support a potential beneficiary to achieve a stable housing situation.

According to Pleace (n.d.), the European concept focuses on eight principles, namely 1) it recognizes housing as a human right, 2) it gives service users choice and control over which services they take up 3) it separates housing and treatment, 4) it focuses on recovery, 5) it reduces harm, 6) it encourages active engagement without coercion, 7) it focuses on person-centred

[28] (Pleace, n.d.) (United States Interagency Council on Homelessness, 2015)
[29] (The Housing First Hub Europe, 2019)

planning and 8) provides support for as long as needed. In the EU, trials and programmes following the Housing First approach have been carried out in France for instance and the approach has been considered as "the single most important innovation in homelessness service design".[30] Work of the Y-Foundation shows that Finland is a forerunner in terms of successfully resolving the housing challenge and is currently envisaging to eradicate homelessness within the next two government terms and has brought 12,000 individuals into a home since 1987.[31] According to the European initiative *Housing First EU*, evidence from Denmark suggests that the strong social protection systems in place here, as well as in Finland, facilitated the success of the Housing First approach for individuals with low support needs because of the holistic support available.[32] Similarly, a comparative case study across four Central European countries by Fehér et al. (2016) showed that the approach is not appropriate for their contexts (yet) due to a lack of housing options available, strategies which do not focus on the poorest segments of society but instead, prioritize homeownership as a solution to inadequate housing situations, bureaucratic requirements, inappropriate design, support and prioritization of homeless persons' needs.[33] While there is positive evidence on the impacts of the Housing First approach, there has also been critique, which shows that there is no one-size-fits-all solution to this challenge and that it is crucial to adequately contextualise any interventions to the individuals highly diverse needs as well as the national and community contexts which Kohan (2016) discusses.[34]

3. Assessment purpose, objectives and scope

3.1. Purpose

The purpose of this assessment is to better understand how and under what conditions the MCCT-HSF is able to resolve the needs of homeless street families and to assess the extent to which the programme processes are adequate to improve the situation of HSF and extend the 4Ps benefits to HSF. To this end, the assessment carried out a process review to understand

- the implementation of the MCCT-HSF and its components; comparing the implementation and design of the programme.
- aspects of adequacy, efficiency and effectiveness of composite processes along the programme cycle.
- the successes and challenges pertaining to the implementation of the programme and its components, and to identify lessons learned thus far.

[30] (Fehér, 2016)
[31] (Y-Foundation, 2017)
[32] (Housing First Guide, n.d.)
[33] (Fehér, 2016)
[34] (Kohan, 2016)

The assessment sought to

- identify sustainable, cost-effective solutions to help solve the problems of providing services for MCCT-HSF beneficiaries, using available resources effectively; which might further enable beneficiaries to improve their livelihood outcomes, taking into consideration the portfolio of services of relevant key stakeholders including, but not limited to, DOH, DepEd, NHA, DOLE, DILG.
- identify which services (beyond the capacity of DSWD) beneficiaries need to improve their current situation.
- generate an understanding of the role different LGUs play in implementing the MCCT-HSF across the regions, their capacity and potential for stronger involvement in the implementation of the programme.

In providing such insights and contributing to current discussions, the results of this assessment build evidence to inform policy discussion. The adequacy of the processes underlying the implementation was measured by considering improvements in the main programme outcomes and the MCCT-objectives. The guiding questions for the process review, as well as relevant sub-questions are listed in Annex B.

3.2. Objectives

The objective of this assessment was to

1. Generate an understanding of the factors that improve MCCT-HSF beneficiaries' access and usage of education and health services.
2. Understand which of the additionally provided support functions are most likely to prepare beneficiaries for enrolment in the regular 4Ps programme.

Therefore, the assessment

- separates and subsequently analyses demand- and supply-side factors.
- Identifies specific circumstances and conditions under which the programme has been able to change the behaviour, knowledge and practices of families without a permanent home.

3.3. Scope

The study employed mixed methods to understand how and under what conditions the MCCT was able to respond to the needs of homeless street families. The study carried out a desk-based, structured literature review of primary and secondary sources and a process review of the programme's implementation considering its design. These were supported by in-country, quantitative and qualitative data collection activities in the form of key informant interviews, focus group discussions and a household survey which was conducted with beneficiaries and a comparison group. The geographic scope of this study covers the seven regions in which the

MCCT-HSF is implemented. Primary data collection activities were carried out in all implementing regions.

Table 1. Implementing regions and number of beneficiary households

Region	Number of beneficiary households	Beneficiaries per region in %
Calabarzon (IV-A)	292	6%
Caraga (Region XIII)	258	5%
Central Luzon (Region III)	119	2%
Central Visayas (Region VII)	535	11%
National Capital Region (NCR)	3,360	69%
Northern Mindanao (Region X)	185	4%
Zamboanga Peninsula (Region IX)	179	4%
Total	4,980	100%

4. Methodology

This section elaborates on the methodology upon which the overall study is based, and the following sub-sections introduce the assessment framework for the study and elaborate upon the single methods, sampling, methodological limitations and ethical considerations for the assessment. The main component of this assessment is a review of the MCCT-HSF's processes. The process review was guided by the assessment framework shown in *Figure 1* and is based on the literature review, interviews with key informants and focus group discussions with programme beneficiaries.[35] Any outcomes which have been attained through the programme were captured through qualitative and quantitative research methods. The guiding questions for the process review, as well as relevant sub-questions, are listed in *Annex B*. In addition to this, the evidence obtained from key informant interviews and focus group discussions are verified and supported by an assessment of the quantitative data collected.

4.1. Assessment framework for the process review

The MCCT-HSF is a sub-component of the regular 4Ps and therefore, and in line with DSWD directives, the assessment framework is built on the 4Ps theory of change. The assessment framework in *Figure 1* presents the inputs, short- and medium-term outcomes of the 4Ps in three separate pillars. Inputs are coloured in green, short-term outcomes in blue, while medium-term outcomes are shown in orange. In each of these pillars, the 4Ps programme objectives are shown in the top boxes, shaded in a bold colour. Lighter shaded boxes at the bottom represent the additional support provided for homeless street families. The medium-term outcome 'Beneficiaries captured by regular 4Ps targeting method' is shown in the right bottom corner of the framework as it is the only dedicated MCCT-HSF objective.

[35] The list of documents under review can be viewed in Annex B.

The boxes depict static inputs and outcomes of the programme which are captured at a fixed point in time. Blue arrows connect the coloured boxes and represent the pathways through which the programme seeks to impact beneficiaries' lives and achieve the different outcomes. The blue arrows depict the programme processes, which are dynamic and visualise how the programme is intended to function.

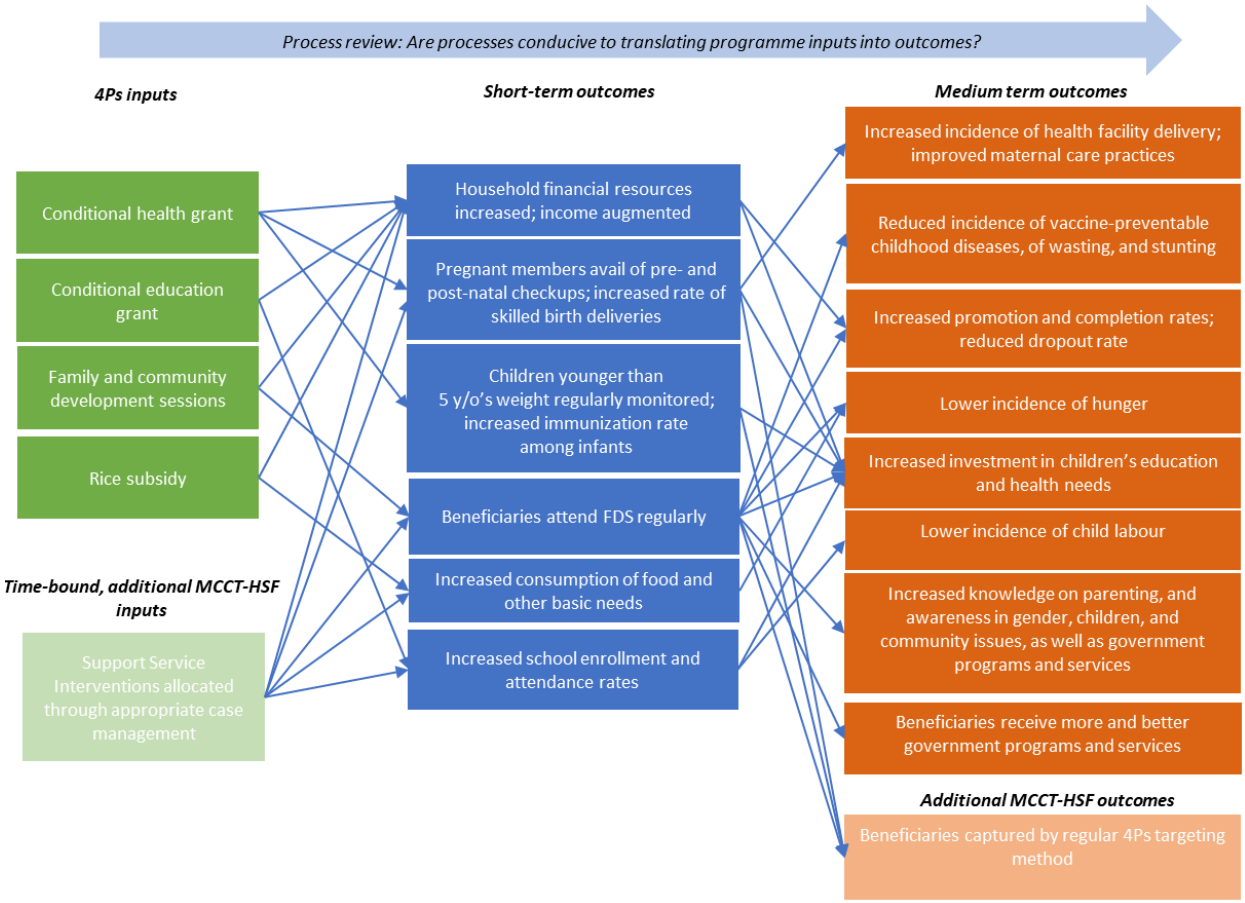


Figure 1. Assessment framework for the MCCT-HSF

4.2. Research questions

Available information was used to develop a theoretical mapping of impact pathways on a range of outcome indicators relevant for homeless street families. Based on the identified, yet hypothetical trajectories and outcomes, the research questions and research instruments for fieldwork were developed. In line with the assessment's objective to capture the suitability of the programme's design to mainstream beneficiaries into the regular 4Ps, the assessment sheds light onto adequacy, relevance, effectiveness and efficiency of the programme processes and in so doing addresses the main research questions:

Table 2. Research questions guiding the assessment.

Research questions
1. To what extent is the implementation of the programme following the processes prescribed as per the programme's design?
2. How are the programme's core inputs and dedicated MCCT-HSF inputs translating into outcomes, and in turn achieving the desired short-and medium-term outcomes? - Under which circumstances are the outcomes achieved? - What role do the implementation processes of programme components and regional variations thereof, household-level dynamics and support service interventions play in achieving these outcomes?
a) Do the processes for strengthening the usage of health and education services contribute toward improved use of health and education services, improved knowledge and attitude about these services among beneficiaries? - Does this ultimately lead to better school attainment, improved use of health services, improved parenting roles of beneficiaries? - Is there a difference between expenditures on health and education between beneficiaries?
b) Are the processes underlying the Support Service Interventions adequately designed and allow appropriate implementation by caseworkers to support MCCT-HSF beneficiaries?
c) Do the processes underlying the SSI and programme inputs contribute towards empowering HSF to be identified by the *Listahanan* eligibility criteria? - What are the main inhibitors for HSF to be mainstreamed into the regular 4Ps? - What is the role of design and implementation of programme components for HSF?
d) To what extent have the interventions been relevant to the needs of the MCCT-HSF beneficiaries? - Do the SSI provided reflect the needs of HSF beneficiaries? - What inputs and services may be dispensable? - What additional services/benefits do the HSF need? - How do the benefits of the regular CCT beneficiary and MCCT-HSF beneficiary differ? - What are the implications for an MCCT-HSF family once mainstreamed in the regular CCT?

4.3. Methods

The study employed mixed methods to inform the process review and answer all research questions. These included a structured desk review and analysis of existing secondary sources and data, as well as the collection of primary data through participatory research. Qualitative data was gathered through key informant interviews (KIIs) and focus group discussions (FGDs) with beneficiaries and a comparison group, and quantitative data was captured through a survey administered to beneficiaries and the comparison group.

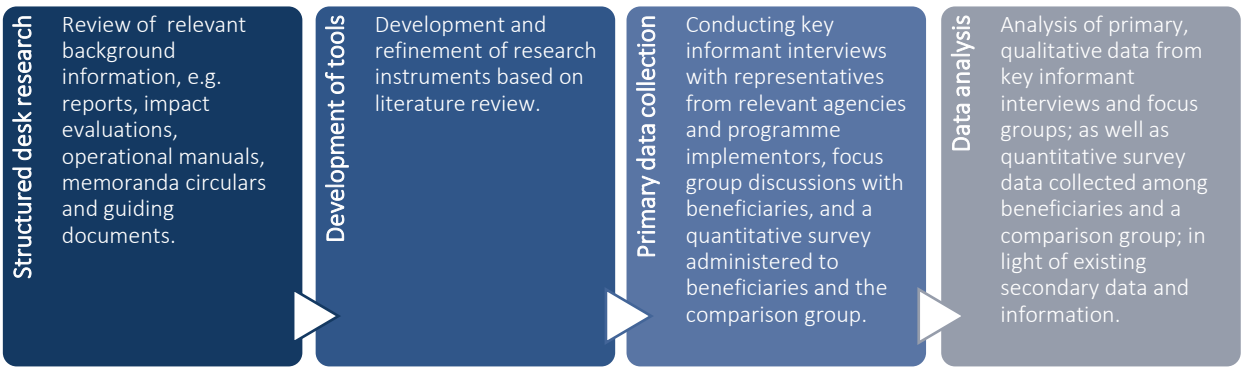


Figure 2. Overview of study methodology

The main component of this assessment is a review of the MCCT-HSF's processes, which serves to understand how effectively, efficiently and reliably the MCCT-HSF is implemented. The process review sheds light on the administrative and social environment in which the MCCT-HSF is implemented. The process review is based on the assessment framework shown above and results are based on findings from the literature review, interviews with key informants and focus group discussions with programme beneficiaries.[36] The guiding questions for the process review, as well as relevant sub-questions, are listed in *Annex B*. The described outcomes shed light onto the functioning of the processes and seeks to clarify which factors have been relevant to attain them, rather than capturing any representative impacts.

4.3.1. *Structured desk research*

Documents pertaining to homelessness and the role of social protection in curbing it were reviewed. In addition, among others, 4Ps and MCCT-HSF programme documents and guidelines, the current Philippine Development Plan, the Magna Carta for the Poor together with selected national legislation pertaining to housing and local government, were reviewed as they are imperative to understand the framework in which the MCCT-HSF is implemented. A complete list of documents reviewed as part of this process review is provided in *Annex A*.

4.3.2. *Primary data collection*

Primary data collection activities were conducted at the national- and sub-national level, comprising of KIIs, FGDs and household surveys with beneficiaries and a comparison group. As a result of limited historic data about the target group, the possibilities to robustly attribute the findings of the quantitative component directly to the programme are limited. To account for this, the study designed a comparison group. The research team's interactions with the comparison group served to develop a comprehensive, triangulated profile of the patterns that the MCCT-HSF beneficiaries would likely have followed, had they not had access to the programme. Together with qualitative research interactions, including FGDs and the literature review on the socio-economic performance and behaviour of homeless street families in the Philippines and abroad, the assessment presents a mixed qualitative-quantitative in-depth profile of the comparison group. Based on this, the assessment compared the findings among the MCCT-HSF beneficiaries with the comparison group to isolate and approximate the effect of the programme on homeless street families' education and health outcomes, as well as the objective to enable them to transition to the regular 4Ps. The findings shown in the outcome section, therefore, are merely indicative, not representative.

[36] The list of documents under review can be viewed in Annex B.

Qualitative data collection

Key informant interviews

Key informant interviews were conducted at the national level to gain information about the design processes, budget procedures and implementation of the MCCT-HSF. Informal discussions at the 4Ps NPMO, as well as the inception phase writeshop, contributed towards the development of the assessment framework and research questions and were used to select informants at the local levels. At the sub-national level, KIIs were carried out with the 4Ps regional programme coordinators (RPC) and provincial operations officers (POO), caseworkers, child psychologists and non-governmental organisations working with homeless street families. These KIIs served to inform the process review with information about the implementation of the MCCT-HSF, beneficiary well-being, and the desired programme outcomes. The KIIs served to understand the circumstances in which the outcomes are achieved, to identify successful patterns and best and poor practices.

Table 3. Interviews with DSWD staff

Level	Participant(s)	Planned KIIs	Conducted KIIs
National level		4	4
	Department of Social Welfare and Development MCCT-HSF Division	4	4
Sub-national level[37]		35	35
	Regional Programme Coordinator	7	7
	MCCT Focal and Provincial Operations Officer/Link	7	8
	Case or social worker Child psychologist CSO Support Services Interventions Focal Computer Maintenance Technician	7 - 14 2 - 7 2 - 7 0 0	10 3 6 1 1
Total KIIs		39	39

Focus group discussions

Focus group discussions were conducted with MCCT-HSF beneficiaries in each implementing region. Participants for the FGDs were invited by MCCT-HSF staff to collect first-hand information about the programme implementation and its adequacy to meet beneficiaries' needs. Beneficiaries were asked about challenges in their daily lives, how they relate to the programme, and if their living conditions improved after enrolment with the MCCT-HSF. FGDs were also conducted with the comparison group. Furthermore, in addition to FGDs led by EPRI's research team in 2019, access was provided to a summary document showing results of DSWD's own FGD which were carried out in 2015. This information was used to further triangulate findings.

[37] A maximum of three implementers per community level can be interviewed. To be decided upon discretion of research team and dependent on level of involvement of non-governmental actors.

Table 4. Overview of focus group discussions per region[38]

Region	# of beneficiaries	Beneficiaries per region in %	# of beneficiary FGDs	# of comparison group FGDs
Calabarzon (IV-A)	292	6%	1	1
Caraga (Region XIII)	258	5%	1	1
Central Luzon (Region III)	118	2%	1	1
Central Visayas (Region VII)	535	11%	3	1
National Capital Region (NCR)	3,414	69%	14	4
Northern Mindanao (Region X)	184	4%	1	1
Zamboanga Peninsula (Region IX)	179	4%	1	1
Total	4,980	100%	21	10

Quantitative data collection

The household survey sought to gather quantitative information from beneficiaries and the comparison group. The survey collected data among 500 beneficiary households to assess whether the pathways of the research framework can be observed in practice. Data analysis focused on identifying whether beneficiaries used education services and health facilities more and sought to identify which programme processes are operational. The survey also captured the attitudes and behaviour of beneficiaries with regards to parenting and care practices pre- and post-enrolment with the MCCT. In addition, the household survey raised questions regarding potential impacts of the programme on socio-economic variables such as income-generating activities, household expenditure and public service utilisation, among others. Additionally, 100 surveys were administered to non-beneficiary households. This group served as the comparison group whom the researchers identified using snowball sampling.

Sampling for data collection

As the number of beneficiaries varies substantially between the implementing regions, as seen in *Table 5. Total number of quantitative data collected per region* Respondents for the FGDs were sampled proportionately and purposively based on the MCCT-HSF roster. Firstly, the barangays with the highest numbers of beneficiaries per region were identified. Secondly, the selected barangays were shared with the MCCT-HSF focal person at the RPMOs to select beneficiaries from the MCCT-HSF roster to participate in the FGDs. Afterwards, caseworkers reached out to the identified beneficiaries and invited them to the FGDs.

[38] Composition is based on beneficiary data as of October 2018 and may be subject to change to reflect updates from the programme MIS.

Table 5. Total number of quantitative data collected per region

Region	Beneficiaries	Non-beneficiaries
Calabarzon	1	2
Caraga	29	6
Central Luzon	13	3
Central Visayas	59	11
National Capital Region	374	72
Northern Mindanao	22	4
Zamboanga Peninsula	2	1
Region not captured	0	1
Total	500	100

The comparison group was compiled through purposive snowball sampling. Snowball sampling is a non-probability-based and non-random sampling method. It is commonly used when targeted individuals belong to a group which is rare and/or difficult to find. It was decided to use snowball sampling because it enabled contact with homeless street families, it is flexible, cost-effective and made logistical sense due to the high degree of mobility among the population of interest and proximity of the identified barangays. The staff of the MCCT-HSF, as well as the research team, asked programme beneficiaries to identify respondents who were never enrolled in the MCCT-HSF programme and who lived in the street during the formal roll-out of the programme in 2014. Following identification of the families, a profiling questionnaire was used, intended to identify families that may have been able to qualify for the MCCT-HSF would they have been captured at the point of registration; ensuring that, at baseline, there is a high degree of similarity between the current beneficiaries and the comparison group. Below, **Fehler! Verweisquelle konnte nicht gefunden werden.** outlines the considerations underlying the identification and compilation of the comparison group.

***Box 1**. Finding a comparison group for the MCCT-beneficiaries*

The purpose of this assessment was to capture the extent to which the MCCT-HSF achieved its objectives in a relevant, efficient and effective manner. Various methods can be used to capture the effect of the programme that compare the changes in outcomes of beneficiaries – the treatment group – over time with the changes in outcomes of a group of individuals and households that were living in the same socio-economic circumstances at baseline but did not benefit from the programme – the control group.

The robustness of such methods depends on the ability to construct a robust control group. Programme assessors need to be certain that the control group was similar to the treatment group at baseline, and that the groups did not experience other external factors over time which may have led to the different development of outputs and outcomes; as otherwise, the assessment cannot be certain that the changes observed are the result of the programme. In theory, many methods exist to construct a robust control group for instance by randomly distributing treatment or control group participation to individuals in the target group at baseline. If the selection was not made at baseline already, or as often the case in practice, is not an option due to ethical concerns about randomly assigning treatment and control, a control group can still be selected retrospectively.

This often comes with several challenges, which also applies to this assessment. Firstly, available baseline data may be limited for the treatment group. This impacts the assessment as it does not offer assessors information on the profile of beneficiary households at baseline to which the control group should be matched. Meanwhile, methods to collect this baseline data retrospectively – for instance through recall methods – usually have significant measurement errors. This limits robustness and credibility. Secondly, the complexity and heterogeneity of drivers that lead families to live in the streets – complicated by the relatively small size of the total group of households that would meet the programme's eligibility criteria – further complicates the retrospective selection of a robust and credible control group. The experiences of people living on the streets differ significantly and as a result of only being able to select a relatively small sample of households, there is a high chance that a significant difference persists between the selected groups. Despite the limitations, constructing a control group and developing an in-depth triangulated profile of what would have happened to beneficiaries if they had not benefited from the programme can still be helpful. To this objective, the assessment made use of a comparison group. However, these challenges do imply that all data in the assessment from the 'comparison group' composed of non-beneficiaries are indicative of trends, and not representative. For this reason, the assessment uses the term 'comparison group' instead of "control group". To arrive at the most robust and credible comparison group possible under these challenges, the assessment relied on snowball and quota sampling for the composition of the comparison group.

4.3.3. *Quantitative data analysis*

In addition to the descriptive qualitative and quantitative analysis outlined in section 5.3, a quasi-experimental method was also applied to the data collected. This involved the use of both a difference-in-difference analysis along with propensity score matching in order to conclude whether significant differences in identified variables exist between the beneficiary and non-beneficiary households.

Difference-in-difference methods (DiD) are commonly used for evaluating the impacts of policies or programmes that were instituted at a specific point in time. In this case, the analysis aims to evaluate the impact of the MCCT-HSF that was formally rolled out in seven regions of the Philippines in 2014. The DiD thus compares changes over time in a comparison group (a group that

is unaffected by the intervention (MCCT_HSF)) to the changes in a treatment group (a group that is affected by the intervention (MCCT-HSF)). The difference that is found is attributed to the effects of the intervention. There are two types of bias that concern the DiD methodology: across groups and across time. The former occurs when the treatment and comparison groups differ, while the latter occurs when the two groups change in composition across time. Such changes in composition usually occur with repeated cross-sectional data rather than longitudinal data. As we have data that reflects the same households over time, the selection bias is limited by restricting the sample to households who have been enrolled in the MCCT-HSF – meaning they are present in both the pre- and post-years.[39]

In order to minimize the selection bias in DiD methods, a propensity score method can be used. This allows for the balancing of the treatment and comparison groups based on a set of baseline characteristics. In this case, these characteristics included age, sex, household size, whether the household was a single-parent household, as well as the region and province of residence. By applying such a method, the data is no longer sub-divided into two groups (treatment and comparison), but rather into four (treatment pre-intervention, treatment post-intervention, comparison pre-intervention and comparison post-intervention) based on the identified covariates. Commonly, a logit regression is used to estimate the propensity score, which is defined as the probability of receiving the intervention of interest as a function of the identified covariates. The three main benefits of using such a method are (i) more robust inferences, (ii) a more feasible balancing approach, and (iii) a reduction of potential biases.[40]

The current section is concerned with the effects of the MCCT-HSF intervention on household financial resources, health service usage, school attendance and a child's health status (the relevant dependent variables). As such, the methodology at hand estimates the propensity score of the treatment on the identified covariates using a logit model and stratifies households in blocks according to the propensity score, while ensuring that the balancing property is satisfied. The propensity score is then used to only keep matched households in the sample. Following this, a difference-in-difference methodology is applied in order to evaluate whether the intervention had an effect on the identified dependent variables.

[39] (Stuart, et al., 2014)
[40] (Stuart, et al., 2014)

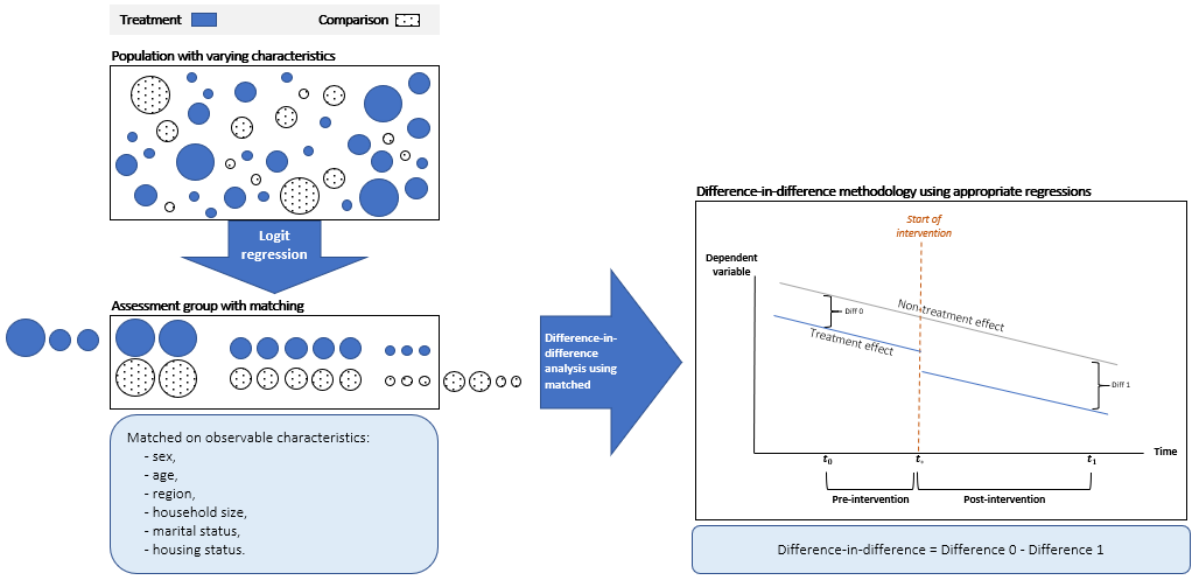


Figure 3. *Graphical representation of propensity score matching and the difference in difference methodology*

4.3.4. *Ethical considerations*

The research was guided by professional standards and ethical and moral principles in line with the *Norms and Standards for Evaluation* (2016), developed by the UN Evaluation Group (UNEG), as well as UNICEF's *Procedures for Ethical Standards in Research, Evaluation, Data Collection and Analysis*.[41] The data collection was carried out in accordance with DSWD's research protocol and was only initiated once formal research clearance was obtained. The participatory data collection method was designed to avoid stigmatisation, discrimination, and any form of harm to participants. Prior to interviews and FGDs, researchers gathered verbal informed consent of all potential participants and interviewees, and thoroughly explained to them the purpose of the assessment, their role in it, and what information would be asked from them. A consent script was read out prior to the start of research. In gathering informed consent, researchers assured all potential participants and interviewees of the confidentiality and voluntariness of their answers.

Researchers clearly communicated to potential participants and interviewees what they could reasonably expect from the assessment, as part of efforts to manage expectations. Responses and comments were summarised in this assessment report and on no occasion, respondents were identified by name or any other identifying characteristics. For the focus group discussions, the participants' real names were not recorded, instead, they were assigned numbers. At the outset of data collection, all participants were informed that their answers would be kept confidential. All interviews and group discussions were conducted in a quiet, private setting without

[41] (UNEG, 2016) & (UNICEF, 2015)

interruptions where possible. All information was recorded in audio on one device only which was kept strictly confidential and was not shared except through the verbal or written dissemination of the findings of the study. The notes of researchers were not shared outside the research team.

4.4. Methodological and other limitations

The process review and assessment underlying this report are neither able to, nor do they seek to, provide universally applicable findings and solutions. Instead, the report contextualises and seeks to explain how the processes underlying the MCCT-HSF may contribute to or hamper the attainment of programme outcomes ex-post. The main limitation of the assessment is the lack of clear baseline data, and the absence of a preassigned, robust counterfactual which are necessary to conduct reliable and generalisable inferential statistics. The lack of a counterfactual thus limits the methods available for the quantitative component. Nevertheless, by developing a mixed qualitative-quantitative profile of what the counterfactual likely would have looked like, the assessment narrowed down this limitation. While DSWD had conducted seven FGD with 168 beneficiaries in Manila, for instance in Tondo, Manila North Cemetery, Kanlungan Artist Park, Barangay 637 and Pasay City among 168, the data collected was not sufficient to serve as the comparison group.

To employ descriptive statistics and attempt the conduct of inferential statistics, a comparison group was sampled amongst non-beneficiaries of the MCCT. The assessment does not speak of attributability of impacts vis-à-vis the lack of a robust counterfactual. Instead, the assessment's findings are indicative and only generalisable subject to the above limitations. Furthermore, in the difference-in-difference analysis, it was not possible to ensure that the treatment groups were continuously enrolled in the MCCT-HSF throughout the five-year time period. As such, the model may be prone to selection bias.

Further limitations arise from the sampling approach used. Snowball sampling may underrepresent critical voices and individuals with smaller networks or who are not well integrated into communities. In the absence of a sampling frame, the individuals in the population of interest, who are the non-beneficiary households of the MCCT-HSF, do not have the same probability of being included in the final sample.[42] The research team collaborated with municipal links and caseworkers to ensure that the sample for the comparison group was sufficiently diverse and ensure that individuals who may not be well integrated into communities would also be invited for interviews.

[42] (Kirchherr, 2018)

5. Findings

This section presents the findings of the assessment. First, the findings of the 4Ps core package process review are presented, followed by the findings about the MCCT-specific aspects. Afterwards, the section continues by presenting the programme outcomes following the structure of the assessment framework shown in ***Figure 1.*** *Assessment framework for the MCCT-HSF*. The findings section concludes with a summary of the cross-cutting findings of all three components of the assessment.

5.1. Process review of the 4Ps programme cycle

This section elaborates on the programme objectives, components and thereby focuses on the aspects of the MCCT programme which are not implemented as per their design.

5.1.1. *Programme objectives and programme components*

Programme objectives

The MCCT objectives go beyond the 4Ps targets in health and education.[43] The Operational Manual for the 4Ps defines three specific objectives for the MCCT-HSF; namely firstly, to ***assist homeless street families to overcome barriers from enjoying the benefits of the government's social protection particularly the 4Ps programme***; secondly, ***to enable homeless street families to have a more stable and decent dwelling away from the streets*** and, thirdly, ***to prepare and mainstream the homeless street families into the regular 4Ps***. These objectives shall guide the overall implementation while they seek to provide beneficiaries with the relevant means and support to be included in the regular programme.

Generally, all three objectives are known and quoted consistently among beneficiaries and key informants. However, key informants expressed concern around the programme's ability to meet these objectives, which have a need to move into permanent housing at its foundation, and were not certain what the relation between or order of importance of the objectives was. They questioned whether, and if so how, the programme can achieve these objectives with its current design.

Firstly, the MCCT-HSF objective to *enable homeless street families to have a more stable and decent dwelling away from the streets* is known and was quoted by interviewees. Key informants and beneficiaries alike consistently identified beneficiaries' housing situation as a priority for the MCCT-HSF and consider it a prerequisite to improving beneficiaries' overall situation. While they acknowledged the similarity of vulnerabilities affecting beneficiaries of the MCCT and the 4Ps, they emphasised that these challenges, for instance, limited financial resources, poor health and educational status, are often more pronounced and graver among the MCCT-beneficiaries than

[43] A table of 4Ps objectives is shown in Annex C[43]

among the regular 4Ps beneficiaries. Key respondents identified beneficiaries' homelessness and the fact that their lives are centred on the street, as the root cause for this. As a consequence, to attain the second objective, key informants emphasised that beneficiaries' entire living environment and livelihood must change. Key informants highlighted that the provided inputs were not sufficient to achieve this. This is captured by the statement of one key informant who suggested: "[We must] go back to what our goal really is. If our goal is to really take them away from the streets, that they will be given a decent housing, so far, we are not providing it yet."

Secondly, key informants doubt that the third objective *to prepare and mainstream the homeless street families into the regular 4Ps* can be met with the bridging nature and limited duration of the MCCT-HSF programme' inputs. This aspect is directly linked to and confirms the previous issue. Interviewees emphasised that the majority of MCCT-beneficiaries needed to adjust to a more regular and normal lifestyle which they are unable to attain in a short time span. It was emphasised that this *normalisation* may need a more systemic and longer-term support than is envisioned by the current design. Key informants consistently pointed to the limited duration of interventions, for instance, the rental subsidy, and beneficiaries criticised that the cash for work component could substantially strengthen their livelihoods, well-being, and financial security if they received the intervention for longer than the 90 days which they are formally entitled to.

Moreover, there is uncertainty regarding the relationships between the different objectives, primarily whether the second objective on *housing* stands by itself, or whether it is *part of the third objective to mainstream* beneficiaries into the 4Ps programme. In other words, whether housing is an objective of its own, or only serves to mainstream them; and that if it only serves to mainstream, and if DSWD finds alternatives ways to mainstream beneficiaries into the 4Ps without them moving into more permanent housing, this objective would be dropped? There is a need to clarify this relationship, which means to define the role of housing in the mainstreaming procedure and within the context of the MCCT-HSF. Because if it were to mainstream them into the regular 4Ps, all DSWD needs to do is to modify the Listahanan Household Assessment form to enable capture of this vulnerable group.

Further, while the 4Ps provides for the graduation of beneficiaries from the programme, the MCCT-HSF aims to mainstream beneficiaries in the 4Ps programme prior to beneficiaries graduating from the 4Ps. Interviews have shown that no households have yet graduated from the 4Ps and that mainstreaming to the regular 4Ps is also not achieved as of now. As a result, there is no consistent understanding of mainstreaming among the implementers in the different regions because the process and implications are intangible. This further contributes towards implementers substantial freedom, or lack of information about the ultimate goal of the MCCT-HSF.

Programme components

The MCCT consists of the cash transfers also provided to the regular 4Ps and the additional support services interventions allocated through case management. The core programme components, the education and health grants – and their conditions, are well known among interviewees. Similarly, the automatic PhilHealth enrolment and FDS were frequently mentioned in KIIs and FGDs. This shows that there is clarity about the constitution of the core package of benefits among implementers and beneficiaries. However, at times, more limited knowledge was identified when considering the operationalization of the mentioned core components as well as the availability and conditions of more recently added secondary components (e.g. the rice subsidy and the unconditional cash transfer).

The limited understanding of the operationalization of the core components is largely a result of challenges related to the regularity of payments. Payments are often delayed and are infrequent. To compensate for these delays, often, several payments are combined into a single payment. This blurs the link between compliance to conditions and the higher benefits paid out to families during months where they comply. Consequently, any behavioural incentive that the conditions may achieve get blurred. Securing regularity of payments has the potential to more clearly distinguish between the different programme components and may direct larger shares of the transfer value to the intended expenditure category; in addition to having a range of other benefits to beneficiaries.

In addition, beneficiaries often had limited knowledge of the availability and conditions of more recently added secondary components of the MCCT. In fact, the rice subsidy was often only brought up after probing by the interviewer and the cash transfer to cushion effects of the tax reform (TRAIN) was rarely mentioned. This is unexpected as the majority of beneficiaries consistently emphasised their limited financial resources which suggests that any additional financial or in-kind support would be fully acknowledged and reported. The limited reference to these additional transfers could be for a variety of reasons including that information provided about the additional benefits may not be offered or be insufficient, or that the transfers may not reach beneficiaries widely yet.

Table 6. Overview of MCCT programme components

Component	Purpose	Detail	Conditions	Allocation
Education grant	Improve school attendance and reduce child labour.	PHP 300 for children in daycare, kindergarten, elementary. PHP 500 for high school.	Maximum of 3 children per HH Compliance with 85 per cent attendance in school per month. Non-compliance results in non-payment of the grant for the respective period.	Automatic after enrolment.
Health grant	Improve maternal and child health as well as nutrition outcomes by promoting preventive health care.	PHP 500 per family	Compliance with life-cycle specific requirements for mothers and all registered children according to vaccinations, weighing schedules.	Automatic after enrolment.
Family development sessions	To improve knowledge, behaviour, performance, and skills of caretakers to adequately provide for their children and families.	Parent education on a set catalogue of topics. These include Parenting, nutrition, etc.	Co-responsibility for HH grantee: - Attendance of grantee or primary caretaker once per month. - Both parents required during family planning, responsible parenthood and gender sensitivity sessions.	Automatic after enrolment.
Rice subsidy	To enable 4Ps beneficiaries to stand on their own feet.	PHP 600 per household per month. Maximum of PHP 7,200 per year.	Paid to registered, active, compliant households	As of 2017 to new and existing beneficiaries.
Unconditional cash transfer	To cushion the negative effects of the TRAIN Law of 2018	PHP 200 per month in 2018 and PHP 300 per month in 2019 and 2020.	Paid to registered, active, compliant households	Introduced in 2018.
PhilHealth membership	To provide access to health services.	Automatic enrolment with the programme upon registration with the MCCT.	Membership in the MCCT-programme	Automatic after enrolment.
Additional MCCT-HSF support				
Support service interventions	Uplift the socio-economic status of beneficiaries. Develop the capacities and expand the opportunities for the poor, vulnerable and disadvantaged sectors. Prepare beneficiaries for mainstreaming.	Cash for work: 90 days' work at 75% of the regional minimum wage, micro-enterprise/ livelihood assistance primarily through seed capital, income-generating projects, MCCT-feeding programme, family camp, rent subsidy for 12 months and others	FOs may refer beneficiaries to existing programmes available at DSWD or propose new, better-suited interventions tailored to the identified needs of beneficiaries. - SSI are not withdrawn once a beneficiary migrates to RCCT.	Through case management.

5.1.2. *Programme cycle*

The implementation of the MCCT and the core package of the 4Ps for MCCT beneficiaries is based on the 4Ps OM. To guide the implementation of the additional MCCT aspects, eight guidelines and memoranda circulars, which provide for the addition and clarification of the different support service interventions, exist. In addition, mainstreaming guidelines have been developed.[44]

The key informant interviews found that at higher levels of the administration, these eight guidelines are well known, while at the grassroots levels, the familiarity with the guidelines decreases. Consequently, the implementation of the guidelines differs substantially across the various levels of administration. As this determines how MCCT-staff implement the programme, the differences in familiarity and implementation also likely affect outcomes for and among beneficiaries and also the work of caseworkers. To counter this, and facilitate and harmonise the implementation of the MCCT, a draft version of the Operational Manual for the MCCT has been drafted. However, this manual was not yet approved as of 2019.[45]

This section, therefore, focuses first on the components of the 4Ps programme cycle which are applicable to the MCCT. The programme cycle of the 4Ps consists of eight steps, as illustrated in Fehler! Verweisquelle konnte nicht gefunden werden.. Steps one and two of the programme cycle – the selection of provinces and municipalities for implementation and supply-side assessment – were carried out prior to the initial rollout of the 4Ps, and not repeated for the MCCT. This is potentially problematic for two reasons; firstly, it cannot be ascertained that the most-in-need provinces are covered and secondly, facilities' actual capacity and resources endowment may not be sufficient to meet the existing needs of beneficiaries. This might create a mismatch of supply and demand, potentially putting a strain of existing services, and hampering the attainment of programme outcomes.

The following section first describes the components of the cycle in which the programme design is not entirely adhered to, and points to the identified challenges in the implementation. In doing so, the process review focuses on the clearly defined steps of the 4Ps core package while the support services interventions, the case management and the mainstreaming procedures are elucidated upon separately in section 5.1.3.

[44] (Department of Social Welfare and Development, 2015a)
[45] (Department of Social Welfare and Development, 2017a)

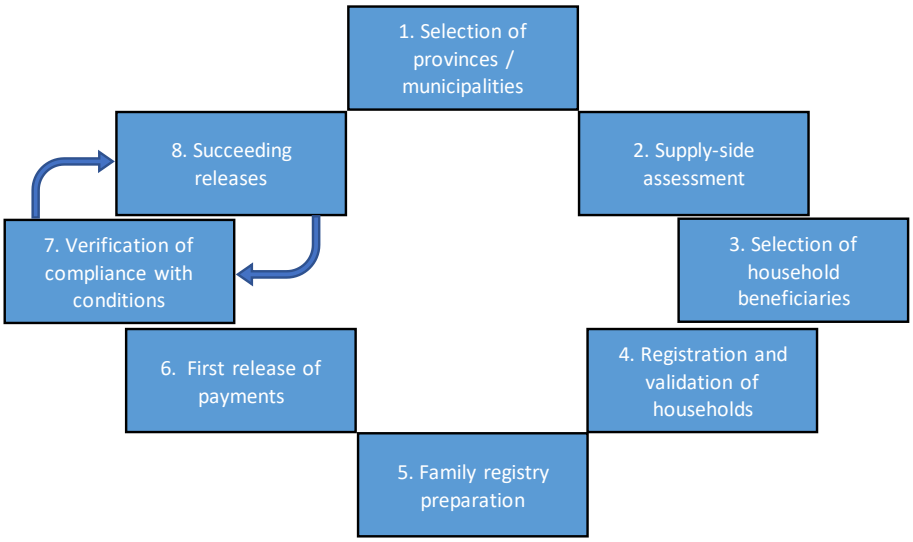


***Figure 4**. 4Ps programme cycle*

Step 3: Selection of household beneficiaries

The 4Ps Operational Manual stipulates clear eligibility criteria for the MCCT-HSF and defines HSF as:

> *"families who consider the street as their permanent abode. These are families who live on the street/occupy vacant areas not suitable for dwelling, spend most of their time on the street, living, working and playing. These families often create a sort of neighbourhood among fellow street families, and they occupy space as their shelter like wooden pushcarts, under the bridges, cemetery or any vacant space not for human habitation and moving from one place to another."*

The identification of potential beneficiaries for the MCCT-HSF was described by all respondents in a similar way. Interviewees explained that beneficiaries were identified by DSWD caseworkers who thoroughly searched the streets and known HSF-hotspots for eligible families. This search was largely informed by information from responsible LGUs. Beneficiaries and non-beneficiaries described an element of "luck" and "arbitrariness" during the identification process; as some respondents in the comparison group said they were initially interviewed but were not contacted again afterwards, without finding out why they were not eligible for the programme. While FGD participants mentioned that they accepted the outreach of the interviewers to be included in the programme, it was also frequently mentioned that some families and children ran away and sought cover during the search and were not interviewed as a result. It is likely that individuals, for instance, persons suffering from mental health challenges or those that have had bad experiences interacting with the government on previous occasions, are more likely to avoid contact with authorities and are thus likely amongst the most vulnerable families in most need of the MCCT. As such, the potential mistrust that has developed by these individuals may challenge the ability of programme implementers to reach some of the most vulnerable families. As a result, these

families are often still excluded from the programme. Overall, more careful sensitization and more transparent eligibility criteria and communication around these could help improve the selection of households in the future.

Step 4: Registration and validation of households

The registration and validation of beneficiaries were described relatively congruently with the design parameters. Key informants confirmed to follow the registration and documentation requirements to the largest extent possible, but they reported to make critical, inclusive adjustments such as waiving the requirement for specific documentation as homeless street families "usually have no ID or birth certificate". While this is crucial to include beneficiaries who are in need, a balance needs to be found to ensure that dual entries are avoided and that at least minimum standards for data management, accountability and transparency can be met. While some beneficiaries said to have undergone validation soon after the initial interview, others reported that a long time passed between the interview and validation without receiving a formal explanation for why this was the case.

Step 7. Verification of compliance

Key informants described the verification procedure in detail and said that they largely followed the design parameters of the 4Ps in so doing. However, key informants confirmed that they adjusted compliance monitoring for health and education conditions to be more lenient on MCCT-beneficiaries than the regular 4Ps beneficiaries, acknowledging the influence of individual circumstances on a household's ability to comply.

Based on the FGDs, beneficiaries were aware of the guidelines and consequences of failing to comply with the individual and household conditions. Most beneficiaries reported that it was not a problem for them to meet the conditions, but acknowledged that they sometimes missed FDS or check-ups, for instance when their children were ill. For those beneficiaries that did at times fail to comply, the follow up through their caseworkers is identified as decisive as it allows them to elaborate on the reasons for non-compliance. Following this, caseworkers can offer beneficiaries tailored solutions to get them back on track for education and health compliance. Furthermore, MCCT-HSF households can be temporarily deactivated upon request, disenrolling them from the programme for a flexible period of time and can later be activated again. This is a fundamental difference between the MCCT and the 4Ps, where a household cannot be activated again following deactivation. Although it was not elucidated upon who of the beneficiaries had made use of this possibility, key informants do think this is important to not harm the trust of the beneficiaries in government, their caseworkers and their ability to start complying again by cancelling their benefits early.

In addition, key informants said to carry out spot-checks and field visits to education and health facilities for compliance verification and follow up on cases individually in the field. Compliance verification remains a very staff intense process, subject to challenges threatening the accuracy of

the information used for benefit allocation. To counter this, MCCT-staff often travel to facilities to carry out spot checks and check-up manually as well; trying to ensure that the information used is correct. Despite the same challenges as experienced with compliance monitoring in the 4Ps, the programme seems to employ a successful and highly personal approach to stimulating compliance.

Step 8. Second payment and succeeding release of cash grants

Payments shall be made pending compliance with the programme conditions, following the regular 4Ps payment channels and cycle. In all regions, payments were reported to be done through cash cards, which was identified as an improvement by beneficiaries in the FGDs. However, two main challenges could still be observed in the payment stage.

Firstly, beneficiaries in all locations perceived their payment schedule as different from the regular 4Ps and said that it was delayed more frequently. Beneficiaries said to be aware of the correct payment schedule and hypothesized on reasons why there were delays, which sometimes are as long as a year. The delays in the payment cycle render it difficult for beneficiaries to track and link the exact transfer amounts to the compliance window and the time period the payment seeks to cover. Key informants and beneficiaries alike reported that beneficiaries already often lack a clear understanding of the exact amounts they are entitled to receive. This is aggravated by the irregularity of payments, as beneficiaries would be required to neatly document their compliance with the individual conditions per payment cycle to ensure that they understand which payments they are entitled to receive and later on, once payments are made, to compare if they received the correct amounts. Given that only 5 per cent of beneficiaries were able to show these records when they were interviewed, it is likely that households have a limited ability to ensure that they are paid the right amounts.

In addition, the role of programme staff during the payment procedure appeared unclear in several interviews. Whereas some MCCT coordinators said that DSWD staff must not be directly involved in payments, other interviewees reported being responsible for payments or to be directly involved in the payment and acknowledging receipts of payments to the cash unit at the FO. Clearer guidance on programme staff involvement in payment processes seems necessary, as it will not only protect beneficiaries from potential unjust processes but also protects the integrity and potentially independence of programme staff.

Step 9. Updating of beneficiary data

After the conclusion of the eight steps of the process cycle, it is of importance to update the data of beneficiaries in order to ensure the proper delivery of the programme and its components; yet, two implementation challenges are also faced here.

Firstly, the qualitative interviews found that the extent to which MCCT-staff are involved and have access to the MCCT-database varies and that there is no consistent approach towards beneficiary data management. One key informant from Northern Mindanao reported that the data

management, inputs and changes to beneficiary data cannot be carried out at provincial level because access rights for the MCCT-MIS are limited and data management activities are carried out at the RPMO. As a result, the MCCT-MIS was described as not suitable to support quick and effective data management.

Secondly, and relatedly, key informants mention that the current data management system was not suitable to respond promptly to changes in beneficiaries' situations, which include for instance requests for relocation or an (im)-permanent deactivation from the programme. Caseworkers identify beneficiaries' high mobility – resulting from their homelessness – as a reason for data often not reflecting the most up to date living situation of beneficiaries. As a further consequence, caseworkers reported to experience challenges to reach their individual beneficiary families often and emphasised that they, therefore, need to assure that data is up to date at all times. The current data management system was perceived as inadequate to fulfil this function.

Summary of process review – 4Ps programme cycle
The programme cycle is largely implemented as designed but several bottlenecks to attaining stronger outcomes were identified. Firstly, the selection of provinces and municipalities for implementation and supply-side assessment were not carried out for the MCCT. As a result, it cannot be ascertained that the most-in-need provinces are covered or that facilities have excess capacity to deliver services. Secondly, the selection of beneficiary households and the verification of eligible households faces challenges; namely inadequate sensitization, information sharing and lack of transparent communication about eligibility criteria. As a result, the selection process likely faces considerable exclusion errors, of potentially particularly vulnerable groups. Thirdly, compliance verification is highly staff intense and subject to challenges threatening the accuracy of the information used for benefit allocation. However, on the plus side, the MCCT does seem to employ a successful and highly personal approach to stimulating compliance among beneficiaries using the case management system; and caseworkers go above and beyond to try to get beneficiaries back into compliance. Fourthly, payments are often delayed and infrequent and result in beneficiaries' limited understanding of the payment amounts they receive. And, finally, a cross-cutting challenge affecting the programme's implementation is inadequate data management systems.

5.1.3. *Review of the MCCT-specific aspects*

Support services interventions

In addition to the 4Ps core package, the MCCT-beneficiaries shall receive support services interventions to be able to better address their needs in health, sanitation, education, livelihood, capability and capacity building and, through this, be enabled to enhance their quality of life. This objective is known among key informants and was also identified as a decisive difference between the regular 4Ps and the MCCT-HSF. A brief overview of the types of SSI received and their distribution across regions is provided in ***Table 7.*** *Types of SSI received, total and by region*. As can be seen, the most widespread SSI received by beneficiary households was cash for work, followed by the rental subsidy and skills training. Among the elderly beneficiaries, more beneficiaries

received the rental subsidy than cash for work or skills training, whilst youth disproportionally received skills training.

Table 7. Types of SSI received, total and by region

	Receiving beneficiaries (%)							
Types of SSI services received	Total	Calabarzon	Caraga	Central Luzon	Central Visayas	National Capital	Northern Mindanao	Zamboanga Peninsula
Employment facilitation	13%	23.9%	0.0%	0.0%	0.0%	70.1%	4.5%	1.5%
Job and livelihood opportunities	22%	0.0%	0.0%	1.9%	6.5%	86.1%	4.6%	0.9%
Family camp	23%	0.9%	0.0%	11.6%	47.3%	19.6%	19.6%	0.9%
Cash for work	62%	0.0%	3.3%	0.0%	6.9%	82.4%	7.2%	0.3%
Micro capital assistance	27%	0.0%	0.0%	0.7%	31.1%	63.0%	4.4%	0.7%
Rental subsidy	44%	0.5%	5.0%	0.0%	10.1%	75.2%	8.7%	0.5%
Skills training	32%	0.6%	0.0%	1.9%	20.5%	71.4%	5.0%	0.6%
Literacy training	10%	2.1%	0.0%	8.3%	16.7%	70.8%	0.0%	2.1%

Existing guidelines and memoranda provide for an implementation framework for the SSI and clearly reference the DSWD's internal convergence guidelines for the Core Social Protection Programmes.[46] The qualitative data and review of reference documents have shown three allocation channels for the SSI. These are 1) allocation of MCCT-HSF specific interventions through caseworkers, 2) linkage to existing interventions and 3) design of individual-and community-based activities.

The first allocation channel serves to allocate the MCCT-HSF-specific interventions, namely the cash for work, MCCT livelihood assistance, MCCT grassroots organizing activities, family camp and a rental subsidy. Through the second allocation channel, MCCT beneficiaries shall be linked to other existing interventions such as the Sustainable Livelihood Programme (SLP), the interventions designed by the Protective Services Unit (PSU) or the Disaster Risk Unit (DRU). The allocation procedures and eligibility requirements for these interventions shall be simplified to ensure they are responsive to the MCCT-beneficiaries' needs and that they can access them.[47] And, within the third channel, it is encouraged that following interactions and informal needs-assessments with beneficiaries, SSI are specifically designed for, and in coordination with, them. This shall be done by MCCT caseworkers, in coordination with project staff of the SLP or other partners, including the Local Government Units, the PSU, DRU, SLP and the KALAHI-CIDSS at the RPMOs.[48]

Each of these allocation channels was described to face different challenges. For the first channel, the main issue identified was the time-limitedness of interventions, for instance, the 12-months limit of the housing subsidy and the 90-days limit of the cash for work programme per year. In

[46] These require Provincial Action Teams and Municipal Action Teams to follow principles of sustainable, effective and efficient implementation. (Department of Social Welfare and Development, 2016)
[47] (Department of Social Welfare and Development, 2016)
[48] For effective coordination and partnership, MC 18 series of 2012 applies for the SSI.

relation to the second allocation channel, a lack of administrative alignment was found between the SSI for beneficiaries and existing interventions linked to the SLP, DRU and PSU. The latter often have additional requirements, such as the need to have formal bank accounts or memberships in associations, which beneficiaries often do not fulfil and hence lead to exclusion from accessing the interventions. This is primarily problematic as it prevents the uptake of service, but, as the key informant interviews showed, the fact that these hurdles only come out once a substantial amount of time and effort have been spent on linking the beneficiary to said intervention intensifies the problem.

For the third allocation channel, the challenge is that, though provisions are made for designing and implementing SSI specific to HSF, not all regions do provide these for beneficiaries, resulting in HSF not receiving the dedicated support they are eligible for by design. Instead, HSF receive the same SSI as FSNP and IP beneficiaries, which is often ascribed to the small number of HSF in the overall pool of MCCT-beneficiaries and suggests that HSF may only be given low priority among all MCCT-beneficiaries. Although the three beneficiary groups are similarly vulnerable, their needs are unlikely to be identical. As a consequence, the SSI available for HSF-beneficiaries may not be sensitive to their exact needs and might thus not be adequate to resolve their issues. A further, related issue is reflected in the fact that many caseworkers bring specialized expertise to the job, for instance in the agricultural sector. These caseworkers' better understanding of, in this example, rural communities' needs makes them well-positioned to develop highly sensitized and specialized interventions in that sector, which is often also where they will primarily focus on; but as a result, they may pay insufficient attention to other needs that beneficiaries may have.

In addition to these specific challenges, two cross-cutting issues were identified too. A lack of clarity pertaining to the implementation requirements was identified to result in a delay in the provision of support to beneficiaries. Key informants said to have to regularly contact the next higher level of administration or other programme units to clarify details about the day-to-day implementation of the SSI. This need for clarification raises the workload and delays the allocation of support to beneficiaries. An additional, cross-cutting issue was delayed funding disbursements. These hamper programme effectiveness because it renders effective and timely programming difficult. It delays implementation of projects which directly affects beneficiaries' livelihoods, thereby hampering programme outcomes and putting pressure on field offices to spend funds within the correct timeframes. This is further complicated by the strict financial regulations for disbursement of SSI-related project funding, further limiting the ability to respond in a timely manner to resolve the needs of beneficiaries on the ground.

In conclusion, the SSI are critical to attaining outcomes for beneficiaries and none of the inputs available under the SSI was identified as dispensable. Beneficiaries consider all SSI as helpful and relevant to improve their living conditions and emphasized that long-term interventions are more likely to sustainably improve beneficiaries' lives. The SSI shall be allocated through case

management, which the OM defines as an approach to providing services through the assessment of caseworkers. This approach is elaborated upon in the next section.

Case management

Case management is an important pillar within the MCCT-HSF. It seeks to identify beneficiaries' needs and link them to support services which shall enable them to resolve their needs. In addition, it seeks to provide beneficiaries with access to psycho-social support. Upon identifying beneficiaries' needs, the caseworker shall arrange, coordinate, monitor, evaluate, and advocate for a package of services to address the beneficiaries' needs through a "therapeutic" relationship with the beneficiaries to engage them as much and as proactively as possible in identifying their own needs and empower them to identify solutions to them.

Although MCCT-beneficiaries and regular 4Ps beneficiaries experience similar issues, many of these are identified as more pronounced among the MCCT-HSF because of their homelessness. Key informants identify beneficiaries' lives in the streets and their homelessness as the driver for their aggravated needs, as a result of which they believe beneficiaries have different perceptions of normality and, also different expectations towards life. Against this backdrop, case management is essential to understand the challenges and needs of the homeless street families holistically and to be able to resolve and address these. As the workload was anticipated to be higher for MCCT than for 4Ps beneficiaries, the ratio between caseworkers and MCCT was adjusted. The ratio of caseworkers to beneficiaries is, therefore, lower in the MCCT-HSF (roughly 1:50) than in the regular 4Ps (about 1:800). Despite this adjustment, key informants emphasized that the workload arising from the complex needs of HSF, and the additional work related to the SSI, may not have been considered adequately and therefore may still be resulting in unattainable workloads for caseworkers. In the absence of clear guiding documents for the expected case management, there is high pressure and responsibility on caseworkers to perform and provide well for their beneficiaries. This is exemplified in high workloads and expectations on them which go beyond what is officially required and can reasonably be expected.

Caseworkers have a wide portfolio of activities to cater to. While they are perceived and confirmed to be good at their main role, namely case and social work, they are also expected to develop project proposals, manage projects and coordinate activities. There was a perception among key informants that caseworkers lack capacity in these aspects and that beneficiaries need training in project management, proposal writing, networking and coordinating activities. The variety of differently capacitated and trained caseworkers contributes to the diversity of services available for HSF. However, at the same time, their thematic expertise and experience may render a holistic assessment and solution to beneficiary needs unlikely to be the starting point for the design of the support programme. In addition, caseworkers may not have sufficient resources and equipment to carry out their work, for instance, may be lacking computers or cell phones. In light of their spirit

to go above and beyond, this causes an intensification of their workload and may have contributed to a small share of the beneficiary population not getting adequate case management support too. The high workload and pressure which caseworkers perceive might also lead to the aforementioned lack of HSF-specific SSI.

Nevertheless, even though the workload is perceived as too heavy among staff, beneficiaries seem to be satisfied with the support they receive. Beneficiaries appreciate the case management and they consistently spoke about their caseworkers in an affectionate way, with over two-thirds mentioning them as trustworthy. Not only do most beneficiaries express a high degree of satisfaction with their caseworkers, they, and their caseworkers themselves, describe highly personalized and individualized relationships. Among most caseworkers, a programmatic spirit seems to prevail motivating them to "do whatever it takes" to support their beneficiaries. For instance, some caseworkers report giving beneficiary families money from their own pockets for their children's school allowance. However, these highly personalized and individual relationships between beneficiaries and caseworkers do cause inconsistent implementation because of the different levels of engagement that is inherent to human relationships. Providing better guidance documents and standardizing certain processes has the ability to reduce the human variance and strengthen outcomes across the board for all beneficiaries, also those with less personal relationships with their caseworkers.

The strong relationship between beneficiaries and their caseworkers is nevertheless an important and valuable component of the programme which contributes towards attaining the programme objectives. Case management is critical to understanding the real needs of beneficiaries adequately and is fundamental to linking them to available interventions out of the portfolio of DSWD and its partners. Case management is the crucial link between available interventions and positive outcomes, and should therefore also feature prominently, guided by adequate protocols and procedures, in a more systemic approach to providing the SSI. As caseworkers are the direct link to beneficiaries, it may be worth considering including them strongly in interest representation for MCCT at coordination meetings as this will further improve the outcomes for HSF, and ultimately mainstream them into the regular 4Ps. The following section outlines the implemented mainstreaming procedure and the bottlenecks encountered in mainstreaming beneficiaries.

Mainstreaming procedure

The SSI and the case management components, mentioned above, directly feed into the mainstreaming objective of the programme. Even though the objective is widely known to beneficiaries, key informants and programme staff, the mainstreaming procedure is characterised by the need for (i) clearer guidelines, (ii) a more adequate data management system, (iii) clarification on the implications of mainstreaming for beneficiaries as well as (iv) strengthened communication and information channels between the implementing bodies at the national and regional level.

Although guidelines for mainstreaming have formally existed and divided the process into three stages with clearly defined responsibilities for caseworkers, the national and the regional offices, this procedure has not been operational to date. However, the lack of communication about the status of the mainstreaming procedure, and whether it is operational or not, has led to confusion at all levels, though mostly in regional offices and amongst caseworkers. Stakeholders at these levels have characterised the status of the mainstreaming procedure in numerous different ways. While some believe the mainstreaming procedure to be operational and have criticized the lack of information received from the NPMO with respect to the mainstreaming status of individual families, others mentioned they are awaiting the revision of the MCCT-mainstreaming procedure before implementing it; indicating it is merely on hold. Others also assume the process in on hold, and that the MCCT mainstreaming procedure is interrupted due to a too high number of beneficiaries qualifying for mainstreaming. Nevertheless, although stakeholders have many different views on whether the procedure is operational, all of them did agree on one common theme as well; that the mainstreaming procedure suffers from a lack of communication on its status, leaving it largely up to the individual to make assumptions on what is happening.

The unclarity across regions on the status of the MCCT mainstreaming procedure has furthermore led to a lack of clear understanding of the purpose of mainstreaming by various regional offices. Some respondents have indicated that it was just a matter of terminology whether beneficiaries were mainstreamed or not, also emphasizing they had already mainstreamed beneficiaries; which is not evidenced in the MCCT-HSF roster. Meanwhile, others suggested that mainstreaming had limited implications beyond the mere transfer of data from one MIS to the other. The lack of clarity about the status and ensuing processes is worrying many key informants as they are unable to inform beneficiaries about the status of their mainstreaming request or provide clear answers to questions from beneficiaries regarding what would change would they get mainstreamed.

In addition to these findings, key informant interviews at the national level furthermore suggest that the formal transition cannot be carried out since there is no functional interface between the data management systems.

Summary of process review – SSIs, case management and mainstreaming

SSI, case management and mainstreaming are implemented to varying extends. First, the SSI are critical to attaining outcomes for beneficiaries and none of the inputs available under the SSI was identified as dispensable. The SSI would benefit from better guidelines though. The current absence of clear guidelines leads to delays in implementation and an unnecessary high workload for staff. Furthermore, delayed fund disbursements also threaten the timely implementation of SSI and reduce the effectiveness of interventions. Meanwhile, case management has been identified as being crucial to identify beneficiaries' real needs, and subsequently develop tailor-made treatment plans. Strong, positive and personal relationships between beneficiaries and their caseworkers exist. Caseworkers need to have a range of skills and seem to have a need for training in project management, proposal writing and networking and coordination activities. Furthermore, standardization of processes and more guidelines would also benefit them. Finally, with regards to mainstreaming, formal guidelines

exist but are considered not operational. However, this status of the mainstreaming procedure (not operational) is not known to many programme implementers, and beneficiaries continue to be suggested for mainstreaming. A lack of information-sharing between NPMO and regional, provincial offices leads to this poor understanding on the status of the procedure, which furthermore leads to confusion among implementers on the purpose of mainstreaming, with some mentioning it is merely a matter of terminology.

5.2. Cross-cutting process review findings

The information in the previous section draws a mixed image of the processes in place. In addition, several main, cross-cutting findings were identified which affect the programme's implementation and outcomes.

Inadequate MIS and IT systems: The data show that IT-support systems are not suitable to carry out the mainstreaming procedures or provide the necessary support for the programme. The inadequacies exist on the one hand because of inadequate targeting and selection mechanisms and criteria, which are based on *Listahanan I*. On the other hand, in the absence of an operational interface between the MCCT-MIS and 4P-PPIS, mainstreaming is effectively impossible. The programme's IT system was not updated since the programme's pilot phase, resulting in insufficient technical capacities and limited capacity to process and store data. There is limited staff and support available for IT and technical development, which is also exemplified by the fact that many MCCT-staff do not have access to computers or phones to carry out their jobs and have to rely on their private devices.

Insufficient information sharing with beneficiaries: Across the programme cycle and predominantly in payment and mainstreaming aspects, beneficiaries seem to have incomplete information about their rights and the benefits they are formally entitled to. It further appeared that beneficiaries are grateful to receive any type of support but that they were not fully aware of formal grievance mechanisms which they may use despite strong case management mechanisms in place. The lack of information and transparency provided for beneficiaries seems to be largely ascribable to a lack of clarity among programme implementers themselves, who often need to reach out directly to the next higher levels of administration to clarify details of their day-to-day work. This was exemplified for instance by the issues identified in the mainstreaming procedure.

Heavy workload of caseworkers: Although MCCT-staff, especially the caseworkers, have smaller caseloads than in the regular 4Ps, their cases are described as much more labour-intensive and time-consuming. For instance, one interviewee described it as "all-in-one" as staff are involved in the identification, registration, implementation, monitoring and evaluation steps of the programme cycle under the supervision of the MCCT-focal. Key informants reported that individual caseworkers were also affected on a personal and emotional level which is exemplified by a statement from a key informant who said that next to passion and motivation, stress management was an important characteristic for an MCCT-staff. Weaknesses in the

implementation of the SSI contribute towards the high workload and also depict cross-cutting issues which affect programme outcomes.

Box 2. Drivers of caseworkers' heavy workload

Challenges experienced by caseworkers

Unclear duties and lack of boundaries. Case management allows to cater to individual beneficiary families' needs and acknowledges that different types of support and interventions may be required to support them. Although guidelines for casework were quoted in some interviews, caseworkers and child psychologists miss sufficient, actionable guiding documentation in their day to day work. As a result, their daily activities often consist of ad-hoc decisions and activities to support their beneficiaries. This is exemplified by the frequency of meetings. While formally there are three meetings per month – one FDS, one livelihood meeting and one house visit – caseworkers and other key informants confirmed that there may be several more meetings based on the individual needs of a beneficiary. Caseworkers reported that beneficiaries contacted them on weekends and during night-time on their private phone numbers, and further said that the underlying reasons for beneficiaries varied. In the absence of a clear framework to regulate contact hours, caseworkers seek to accommodate their beneficiaries' needs fully, including requests for meetings, whenever possible. This suggests that there is a lack a professional distance between caseworkers and beneficiaries which is also exemplified by the fact that their relationships are described as close and caseworkers report to be "like a teacher, like a friend" for their beneficiaries. In the absence of clear boundaries, caseworkers are never really "off duty", causing a perception among them to "always be on call". This is further aggravated by the fact that job descriptions are often short, and not sufficiently specific. Caseworkers are expected to write daily activity reports for their individual performance contracts, showing that caseworkers are closely monitored. In contrast, many decisions about their beneficiary cases are left to caseworkers' professional judgement which suggests that they are expected to work in a highly independent context. This creates a mismatch between their reporting responsibilities and the extent of independence that is expected in other cases. As a result, job requirements and performance indicators are likely ambiguous and render it difficult for staff to objectively judge whether their performance is adequate. This likely contributes towards the programmatic spirit to "do whatever it takes" for their beneficiaries which was observed among caseworkers in the qualitative interviews. Although the motivation and willingness to serve the beneficiaries is fundamental to attain programme outcomes, this must be within reasonable and attainable boundaries for caseworkers to avoid stress and ensure their mental health is safeguarded.

Insufficient logistical and operational support. Although the designed caseload for beneficiaries is lower than in the regular 4Ps, duties which are not directly related to their core function add to their workload. This includes duties and tasks related to organizing and allocating the support services interventions, organizing venues for FDS as well as investigating low attendance rates during FDS and identifying absent beneficiaries. Although FDS, individual counselling sessions or skills trainings with beneficiaries should follow a regular schedule, the qualitative data suggest that coordination with barangays and LGUs is important to identify suitable venues for these activities. This raises the question if, and why the venues need to be reorganized for each session as this increases the overall workload of caseworkers. In addition, caseworkers spend a substantial amount of time on travel, follow-ups and spot checks for compliance. This is partially ascribable to the fact that vehicles are frequently not available, that the distance between individual beneficiary families may be large which increases travel time and thus intensifies their overall workload. Although it was acknowledged that HSF beneficiaries mostly lived in urban settings, their high mobility contributes towards this aspect and caseworkers also cater to IP and FSNP.

Inadequate training and skills. Caseworkers are primarily responsible to identify beneficiaries' needs and enable them to resolve these by linking them to available government interventions. The qualitative data showed that

caseworkers with expertise in a relevant field – for instance in agriculture or fisheries – are better able to support their beneficiaries because of their better understanding of the sector and how to link beneficiaries to it. In addition to these core functions, caseworkers do have additional administrative responsibilities which may not be directly related to their core function. These include for instance time-intense reporting requirements per individual beneficiary family, need for detailed data about beneficiaries and managing the data, project development and proposal writing, as well as networking and coordinating with relevant stakeholders. Key informants criticised that not all caseworkers have the adequate skills to perform these tasks. For instance, they observed shortcomings in project development and mentioned that caseworkers had difficulties in prioritising between important tasks and appeared to lack the ability or capacity to carry out administrative duties. A potential mismatch between job requirements and skills is a common driver of stress and is likely to contribute towards the perception of an overly high workload. Against the backdrop of high motivation and commitment to their jobs, staff in the MCCT will likely benefit immensely from needs-based trainings.

Inadequacy of coordination: The coordination mechanisms are clearly defined in the 4Ps OM and also seem to be followed in the regions; however, they seem to be not sufficiently responsive to addressing the specific needs of HSF in particular. Against the backdrop of high workloads, lack of clarity in certain aspects pertaining to the implementation of the MCCT overall and the HSF component in particular, the existing coordination mechanism for the 4Ps may not be capacitated to cover additional, and especially complex, aspects of HSF. It is likely that in such context, due to the small number of HSF-beneficiaries of only 5 per cent of the total beneficiary pool of 220,000, it is likely that the HSF are a second-order priority and hence may not be discussed in coordination meetings. In addition, housing stakeholders seem to be largely absent in many coordination efforts, leaving an important stakeholder's programmes for HSF excluded from better integration into and linkages with the programme.

5.3. Outcomes in beneficiary households

Following the review of programme processes, the subsequent section explores the functionality of the processes by investigating to what extent the desired programme outcomes were attained by beneficiaries, and under which circumstances. To assess this, the situation of beneficiaries was compared to that described by the comparison group. To this end, both groups of respondents were asked to recall their living situation in 2014, focusing on aspects such as health, school enrolment, knowledge on FDS-topics, their food security and housing. They were then asked to compare their situation from five years ago to today and were asked to elaborate on changes or improvements. These aspects are broadly aligned to the programme outcomes of the 4Ps, though the information is not captured on all outcomes. For instance, limited information was gathered on certain health outcomes in the 4Ps framework, including the number of pre-and post-natal check-ups, weight monitoring and immunisation rates.

To begin, a short demographic description will be provided on the characteristics of beneficiary and non-beneficiary households. Data collection was undertaken in seven regions. A total of 600 households were interviewed of which the majority were situated in the National Capital Region

(69 per cent), followed by Central Visayas (11 per cent), Calabarzon (6 per cent), Caraga (5 per cent), Northern Mindanao (4 per cent), Zamboanga Peninsula (4 per cent) and Central Luzon (2 per cent). These households consisted of MCCT beneficiaries (500 households) and non-beneficiaries (100 households) of which several descriptive characteristics can be found in ***Table 8.*** *Household characteristics of beneficiary and non-beneficiary families*.

Table 8. *Household characteristics of beneficiary and non-beneficiary families*

Household characteristics		Beneficiaries	Non-beneficiaries
Average size of the household		5.19	5.39
Average household members sharing space		2.77	N.A.
Average age of the respondent		38	37
Sex of respondent (shares)	*Female*	92%	83%
	Male	8%	17%
Per cent of respondents who were indigenous		15%	0%
Per cent of respondents having attained primary education		69%	81%
Per cent of households whose head attained primary education		84%	89%
Per cent of households having a single parent		29%	21%
Per cent of households that have a member with a disability		6%	7%
Average number of children in the household		3.08	3.24
Average number of household members registered with MCCT		2.24	N.A.
Per cent of households that are female-headed		46%	32%

5.3.1. *Short-term outcomes*

Household financial resources: Beneficiaries consistently mentioned the livelihoods support, the cash transfers, the rental subsidy and cash for work component as the most important aspects of the programme. As evidenced by the findings, the financial resources of households participating in the MCCT increased two times more when compared to non-beneficiary households. In fact, while beneficiary households had an average household income that was PHP 2,808 below that of non-beneficiary households before the start of the programme, the participation in the MCCT allowed the household income of the former to outweigh that of the latter by PHP 7,628.

Table 9. *Self-reported annual household income*

		Beneficiaries	Non-beneficiaries
Household income in PHP	2019	57,488	49,859

This significant difference[49] in financial resources between the beneficiary and non-beneficiary households across time can be ascribed to the MCCT-HSF as evidenced by the use of a quasi-experimental method consisting of both a difference-in-difference analysis along with propensity score matching. The quasi-experimental analysis also showed that beneficiaries whose reported

[49] The difference-in-difference analysis estimated a coefficient of 1.619 which was significant at the 1% significant level. The standard error was equal to 0.405, t-statistic equal to 4.00 and a p-value of 0.00. In addition, a 95% confidence interval between 0.824 and 2.413 was found.

monthly incomes were lower than those of the comparison group prior to the enrolment with the MCCT, had caught up with the comparison groups' monthly household budget due to the enrolment in the MCCT.

Nevertheless, despite this financial support, the main issue for homeless street families remained a lack of income-generating opportunities and limited financial resources. With regards to this, a frequent and consistent problem discussed by beneficiaries and key informants alike is the irregularity of payments of the cash transfer. This suggests that, though beneficiaries' overall financial situation has improved, it has not improved sufficiently for beneficiaries to meet their basic needs in absence of the programme; with any delay constituting a burden for beneficiaries, hindering them from meeting their basic needs in months when no payments are received. Many FGD participants reported having occasional work, for instance, washing clothes, tricycle driving or as caretakers of graves, before or in addition to the cash for work. However, work is often seasonal or infrequent, ultimately making beneficiaries at least partially dependent on the financial support of the programme to meet their needs.

Health: Overall, the health outcomes among beneficiary families seem to have improved over time, which beneficiaries ascribed to their enrolment in the MCCT and key informants link to the health condition of the programme. While 42 per cent of non-beneficiary households said that their child was sick in the two weeks prior to the interview, only 27 per cent of children in beneficiary households were sick. As evidenced by the quantitative data collected, the majority of MCCT beneficiaries' children were having flu-like symptoms, coughs or respiratory problems (81 per cent), diarrhoea (7 per cent), skin-related issues (4 per cent) and measles (2 per cent), among others. Non-beneficiary children experienced the same issues and the respondents from the comparison group described their own health-seeking behaviour and overall health on average as not having improved significantly over time. Some non-beneficiaries recalled getting free health services, for instance through health cards, PhilHealth membership or to avail of free vaccinations at the health centre. Others said that they 'cannot get help anywhere' and some reported they did not seek health services because of the cost. The FGDs carried out by DSWD in 2015, revealed that beneficiaries experienced stigma in health facilities and where not treated because of their appearance. This was confirmed by key informants and beneficiaries who recalled and recounted such to have experienced this.

FDS attendance: Almost all respondents report that they regularly attended the FDS and that it was usually not problematic for them to attend the sessions. Popular topics included for instance how to raise a child, violence against women and their children, women empowerment, disciplining children; some respondents even identified the FDS as their favourite component of the MCCT-HSF. Respondents claim that their knowledge on the topics of the FDS did not change over time, for instance, they emphasized that, despite their living situation, they care, and always

cared, strongly about their children's future and that they ascribed a high value to their education, overall wellbeing and health, even before their enrolment with the MCCT.

As similar attitudes were expressed in the comparison group, the impact of the MCCT-HSF on this may seem limited; but over 98 per cent of beneficiary households also admit that they are able to use the FDS information in their daily lives, and to have learnt to apply the knowledge from FDS in their life (***Table 10.*** *Beneficiaries that apply and do not apply specific FDS information in their daily lives*). It is especially knowledge pertaining to their own and their children's health that was frequently mentioned as being useful and new. And, of these households that mention having learned something new with regards to their and their children's health, 94 per cent believe that their children are healthier now than before their MCCT-HSF enrolment.

Table 10. *Beneficiaries that apply and do not apply specific FDS information in their daily lives*

	Apply information	Do not apply information
Care practices	63%	37%
Health practices	65%	35%
Food security	60%	40%
Mental health	47%	53%
Child education	68%	32%
Household budgeting	50%	50%
Water, sanitation and hygiene (?)	45%	55%

Moreover, further positive impacts of the FDS can be seen when looking at the extent to which beneficiaries and non-beneficiaries attach importance to certain aspects in the care for a child. ***Table 11.*** *Relevant aspects for childcare* shows that a higher share of beneficiaries report that love and care from parents, safety, a stable home, hygiene and play are important for children when they grow up. Overall, significant positive impacts are observed in beneficiaries knowledge pertaining to childcare.

Table 11. *Relevant aspects for childcare*[50]

Aspect for childcare	Beneficiaries	Non-beneficiaries
Education is important for childcare	95%	95%
Health is important for childcare	90%	92%
Love and care from parents are important for childcare	84%	55%
Safety is important for childcare	80%	53%
Food security is important for childcare	78%	68%
A stable home is important for childcare	72%	28%
Hygiene is important for childcare	68%	51%
Play is important for childcare	42%	31%

As a result, several key informants did notice a clear difference between those that benefit from the programme and those that do not, **reporting behavioural changes among the beneficiaries and how they care for their children that are not observed among the non-beneficiaries**.

[50] As perceived by beneficiaries and their comparison group

Compared to non-beneficiary families, key informants mentioned that "we see a big impact. […] For example, for mothers, they were awaken[ed] and saw the importance of having to take care of their children. We were able to fix the routine of beneficiaries and they value education more for the future of their children." Although some of these changes may be due to more resources being present in the household and beneficiaries facing less financial stress, in line with the findings that beneficiaries learned new lessons and observed improved outcomes in for instance health and childcare, even though beneficiaries may report themselves that their knowledge did not change, the FDS still likely has played an instrumental role in fostering improvements.

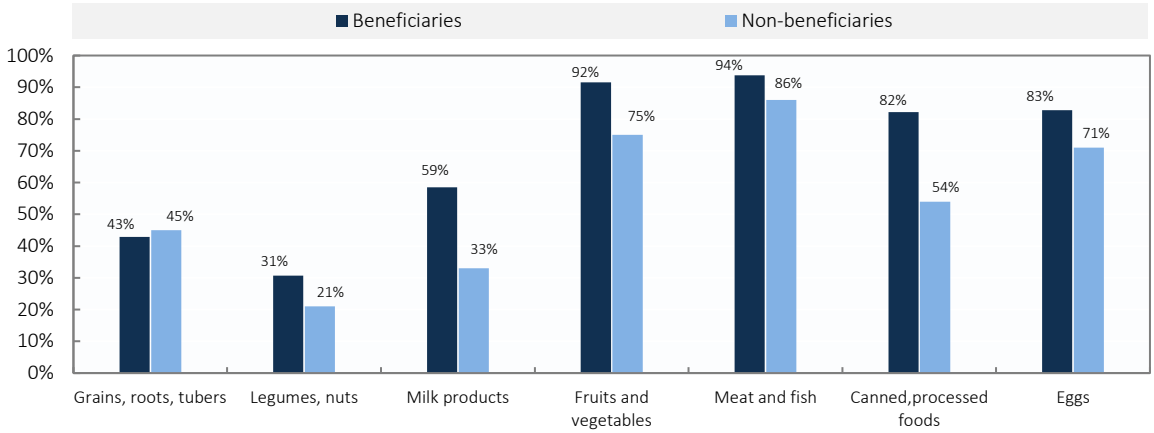
Finally, further benefits which the FDS may have, relate to creating a sense of connection with other families in the same situation. As a group that faces significant stigmatization in society, the FDS offer a place to connect with peers that find themselves in the same, at times isolated situation. This may help tackle feelings of loneliness and, as per the responses of beneficiaries, helps them deal with their living situations by providing them with a platform to talk and share their feelings. Generally, key informants emphasized the importance of behavioural changes and attitude among beneficiaries for attaining short-and medium-term outcomes. Therefore, the FDS were consistently identified as important for the overall programme.

Consumption of food and other basic needs: Beneficiaries report being better able to meet their dietary needs, expressing they experience hunger on significantly fewer instances than respondents in the comparison group. This is exemplified by the fact that 87 per cent of MCCT beneficiaries eat more regularly after receiving the MCCT than before, while among the non-beneficiaries only 52 per cent reported eating more frequently in 2019 than in 2014. Beneficiaries also reported to eat more meals now than prior to the programme, and in case payments are regular, also more regularly and consistently throughout the year. Whereas this is largely attributed to the financial support received, several beneficiaries mention the positive impact that other components have, referring for instance to the FDS and the encouragement received there to start vegetable gardens.

In general, beneficiaries have low expectations towards nutrition and access to food, which is shown in one FGD where respondents stated: "It is still ok, as long as we can eat anything in a day." Although more than two-thirds of MCCT beneficiaries are (extremely) satisfied with the amount they pay for food and despite their low expectations concerning the frequency of meals, beneficiaries complain that inflation negatively affects the food they can buy, with certain products such as fish or chicken only being available to them right after the receipt of the cash transfers. Of the food consumed, beneficiary households are more likely to consume legumes, nuts, milk products, fruits, vegetables, meat, fish, eggs and processed foods when compared to non-beneficiary households. However, the largest difference in consumption is shown amongst canned/processed food consumption, as shown in

Figure 5. *Types of food consumed by MCCT beneficiary status*. This seems to confirm that an increase in household income as a result of the programme may **not necessarily translate into increased consumption of healthy foods.** Two possible explanations come to mind; **firstly, the status associated with fast-food and the resulting impact that has on individuals preferences for these foods, as well as other canned and processed foods, leads households to shift from cheaper healthy foods to more expensive, less healthy alternatives. Alternatively, the increased consumption may be ascribable to the fact that beneficiaries prefer canned and processed foods due to their improved storage life in comparison to fresh produce**. As a result of higher household incomes, families may thus prefer to buy larger amounts of long-life products in bulk. In either case, the FDS, and its modules on nutrition, do not seem to have a sufficiently strong and positive impact on food choice and expenditure prioritization.

Figure 5. *Types of food consumed by MCCT beneficiary status*



School enrolment and attendance rates: School attendance rates of beneficiary households **increased by 14 percentage points between the period prior to the enrolment and 2019**. **At a rate of 95 per cent in 2019, the school attendance rate of beneficiary households now surpasses that of non-beneficiary households by 3 percentage points**. Relaxing the financial constraints is amongst the key driver of this improvements, as a number of beneficiary households stated that **without DSWD, their children would not be able to go to school either due to a lack of funds or a lack of opportunity of receiving a scholarship**, which many key informants reported were availed to some students.

However, at the same time, a number of key informants mentioned that schools, as well as household living conditions, are at times still not conducive for children from marginalized households, with experiences of discrimination by teachers reported as well as experiences of homeless children not having a possibility to do their homework as a result of a lack of lighting among other factors. **As such, it is of utmost importance to not only promote enrolment and attendance but to also ensure a conducive environment for inclusion, growth and graduation.**

5.3.2. *Medium-term outcomes*

The changes in medium-term outcomes are presented below. For several medium-term outcomes, only qualitative data was collected.

Health facility delivery; maternal care practices: Only qualitative data collection included responses on health facility delivery and improved maternal care practices. Within this, only in one FGD did respondents discuss maternal health issues and ante-natal care. One respondent reported that their daughter had accessed maternal care services at the health facilities prior to giving birth to her child. When the beneficiary's grandchild was born prematurely, it was cared for in an incubator and taken good care of at the facility. The beneficiary said that this service was covered and provided by PhilHealth and highlighted that without the MCCT, they would not have been able to access it because of a lack of financial resources.

Incidence of vaccine-preventable childhood diseases, of wasting, and stunting: Based on the information which beneficiaries shared in the FGD and how key informants described the families in the interviews, children were generally perceived to look healthier, and families were also described to have improved overall appearance. This was perceived as an indicator for improved health status. While some FGD respondents stated that their children were picky eaters and that their children still fall sick, some respondents also described their children as fat which they ascribed to the support received through the MCCT; and perhaps has a base in a diet increasingly being based on more unhealthy processed foods. Key informants reported that families did mostly comply with the conditions for the health grants and the quantitative data show that over three-quarter of beneficiaries regularly comply with the requirements. These include for instance age-appropriate vaccinations and regular weighing. Beneficiaries identify improved child health among their children which they ascribe to the monthly check-ups and provision of free vitamins in the health facilities among others. Most services that beneficiaries avail of at the facilities include using of medication and consultations when children have coughs or fever.

Promotion and completion rates: These were observed by key informants who often refer to the educational successes which beneficiary children attain in the long term when they are enrolled with the programme. **Many beneficiary families reported that their children studied eagerly and that they continued to study beyond primary school because of the MCCT.** In some interviews, key informants reported that beneficiary children had succeeded in securing scholarships and grants for tertiary education, also in acknowledgement of good educational performance. However, a persistent issue which affects many families was **the lack of financial resources to provide children with pocket money for school, which in some cases was reported to lead to absences because children were described to be unable to eat without the school money**. In other cases, caseworkers reported that they support families with their private money to assure children do get the necessary pocket money and are enabled to attend school.

Incidence of hunger: The **quantitative analysis showed that roughly 47 per cent of MCCT beneficiaries had a lower incidence of hunger.** Of the families that had no or only 1 meal a day before the introduction of the MCCT, 6 per cent found themselves in the same situation currently, while the remainder had improved their situation as 29 per cent now had 1 to 2 meals per day and 56 per cent had 2 to 3 meals per day which is shown in ***Table 12.*** *The frequency of meals per day per beneficiary before and after the MCCT*. An improvement was also seen for those families that survived on 1 to 2 meals per day with 88 per cent now living on two or more meals per day. Nevertheless, it also needs to be shown that a small percentage of beneficiary households that were food secure before the introduction of the MCCT were facing a worsening of their situation: 4 per cent of households that consumed 2 to 3 meals per day are now eating 1 to 2 meals per day. The same conclusion holds for 11 per cent of beneficiary households that previously had more than 3 meals per day and are now consuming only 2 to 3 meals.

Table 12. *The frequency of meals per day per beneficiary before and after the MCCT*

		Current				
		0-1 time per day	1-2 times per day	2-3 times per day	More than 3 times per day	Total
Before	0-1 time per day	6%	29%	56%	8%	100%
	1-2 times per day	0%	22%	59%	19%	100%
	2-3 times per day	0%	4%	56%	40%	100%
	More than 3 times per day	0%	0%	11%	89%	100%

Investment in children's (education and health) needs: Respondents described that they spend their cash grants on their children, including food, education, medicine, clothing and public transport. **On average, beneficiary households had an annual health expenditure[51] of PHP 955 PHP, an annual education expenditure[52] of PHP 14,442 and PHP 250 per day on food.** In comparison, non-beneficiary households annual education expenditure was more than twice that of beneficiaries, but less on food per day (PHP 204). As a result of the benefits obtained from the MCCT, many families reported that they were able to provide their children with additional money for transport – an important factor contributing to children going to school more safely. Key informants highlighted the importance of behavioural change and attitude among beneficiaries to ensure they reprioritise expenditures and adjust investment decisions. Although the beneficiaries are free to choose how they spend their grants, some key informants reported that initially, caseworkers had asked beneficiaries to prove that they spent their cash grants on their children's needs. Overall, beneficiaries did not report or discuss the use of vice goods and seemed to fully buy into the objectives of the programme and to be convinced of its objectives.

[51] Health expenditure includes spending on hospitals, local health facilities, medicine and other medical priorities.
[52] Education expenditure includes spending on school projects, supplies, transport, tuition and other related fees.

Incidence of child labour: In total, fewer children in beneficiary households work (13 per cent) than in non-beneficiary households (17 per cent). The non-beneficiary children that work are mostly employed as dishwashers, construction workers, drivers, errand boys, housemaids or vendors amongst others. While the majority of beneficiary children that work tend to be employed as dishwashers and construction workers as well, they also work in call centres and factories, including as caretakers, drivers, vendors, porters, salesclerk, restaurant staff or as town hall staff. Both MCCT beneficiaries and non-beneficiaries children that work, work more than five times per week. The reason that children need to work is related to the household's ability to afford food, housing and education supplies.

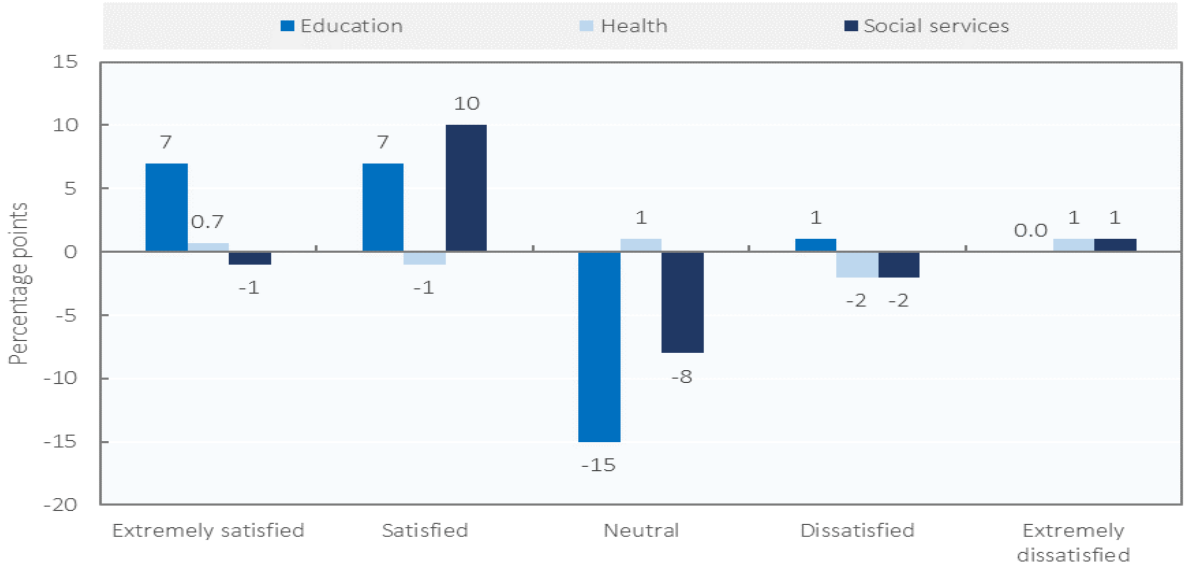
Knowledge of parenting, and awareness in gender, children, and community issues: Beneficiaries ascribe a high value to good parenting skills and a stable home, which is exemplified by one beneficiaries' reflection about their living situation prior to enrolment in the MCCT, recalling it as a painful experience. The beneficiary reported that there was a time when his children were mostly taking care of themselves because of a long commute between the family's abode and the place where s/he earned their livelihood. However, with the support of the FDS component of the MCCT, participants increasingly saw the importance of good parenting as evidenced by the differences in opinion on various aspects of childcare between the beneficiary and non-beneficiary households (see ***Table 11.*** *Relevant aspects for childcare*). In fact, the quantitative survey found that almost all beneficiary households report having been able to change their mindset towards themselves and to their children by attending FDS. As a result, participants in the FGDs consistently pointed to the importance of good parenting, while also highlighting education as crucial to preventing the transmission of poverty and poor living standards to their children. This suggests better parenting standards as well as a longer-term perspective on life, which was oftentimes perceived to be neglected by beneficiaries as suggested by literature or by key informants in earlier sections.

Beneficiaries receive more and better government programmes and services: Most beneficiaries reported to use health services more than before and also mentioned PhilHealth as an important factor for this. However, other respondents said to be unable to use health services, quoting a lack of financial means which prevented them from using the health services. In addition, it was mentioned that the health facilities were overcrowded and that sometimes, medication was not available. However, most importantly, beneficiaries in the FGD criticised that health staff behaved in a discriminatory way and that they had condescending attitudes. This was also reported by respondents from the comparison group, who reported to receive benefits from other governmental agencies or to have more knowledge on where to access services in 2019 than they had in 2014. This is supported by the quantitative data, which illustrates that the comparison group over the years 2014 to 2019 became more satisfied with the educational and social services

provided by the government, while minimal change can be witnessed for health services (***Figure 6***). The latter is primarily due to stigmatization and the quality of services provided.

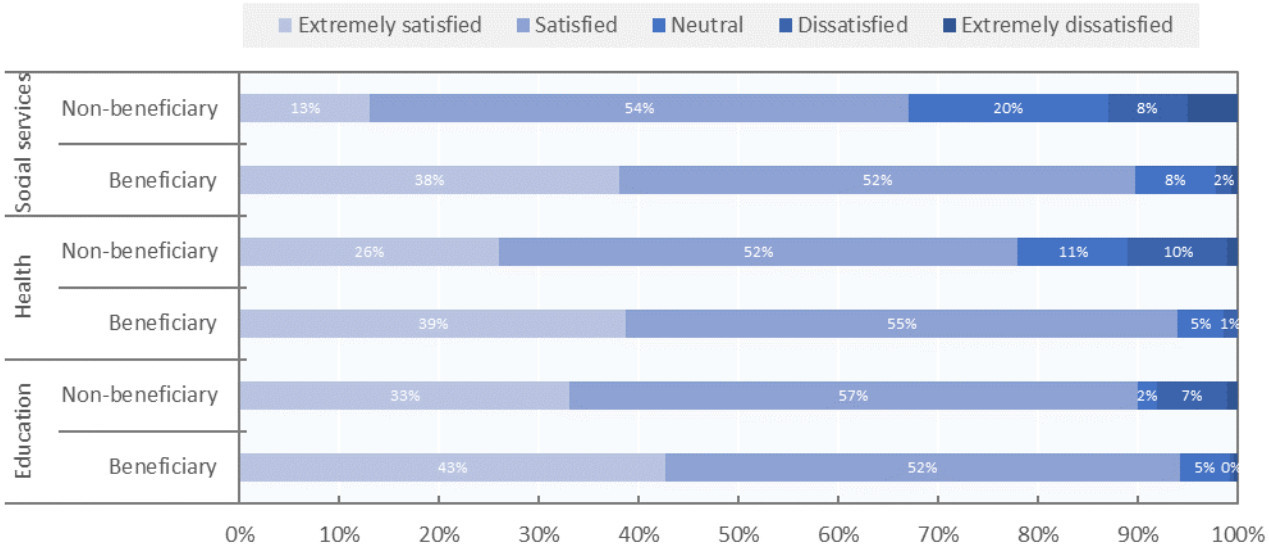
In addition, beneficiaries were more satisfied with the education and social services, increasing from three-quarters to nine in every ten for education, and from 58 per cent to 67 per cent for social services. Beneficiaries consistently mentioned that their children used education facilities but did not refer to other governmental services. Some key informants observed that at the enrolment in the programme, beneficiaries had very limited knowledge about government services; and that it did increase over time, though mostly referencing services they were referred to through case management, including the various SSIs.

Figure 6. *Differences in the levels of satisfaction between 2019 and 2014 the comparison group*



Furthermore, when comparing beneficiary to non-beneficiary degrees of satisfaction by service group, it can be concluded that MCCT beneficiaries seem more satisfied and less dissatisfied with the government services that are provided as shown in ***Figure 7***). In total, 90 per cent of beneficiary households are (extremely) satisfied with the social services provided; 94 per cent with the health services provided and 95 per cent with the educational services provided. This highlights that despite beneficiaries and non-beneficiaries likely trying to access the same social services, the feeling of support by the government that beneficiaries experience, also improves their general outlook on the quality of government social service programming in general.

Figure 7. *Degree of satisfaction by service group, beneficiary and non-beneficiary in 2019*



5.3.3. *MCCT-outcomes*

In addition to the aforementioned outcomes which the 4Ps core package seeks to attain, this section outlines the changes attained through the SSI and the role of case management to attaining these. The section also outlines the observed changes in households living situation and confirms the importance of the MCCT-HSF programme to attaining improvements for beneficiaries.

Beneficiaries captured by regular 4Ps targeting method: To be captured by the regular targeting method, households need to be housed safely for three consecutive months and be considered ready for mainstreaming. With 80 per cent of beneficiaries reporting to feel ready for mainstreaming and many beneficiaries reported an improved housing situation, important self-reported progress has been attained. 70 per cent of individuals indicating they felt ready for mainstreaming said they felt so because of their improved income-earning ability, which suggests they are more likely to be able to pay for their rent. The SSI as listed above in ***Table 7.*** *Types of SSI received, total and by region*, which are the dedicated MCCT-inputs are thus successful in uplifting beneficiaries' socio-economic status and also in preparing beneficiaries for mainstreaming to the regular 4Ps. When asked to identify the most helpful component of the MCCT, the majority of beneficiaries mentioned the financial support provided, followed by skills training, FDS information and lastly micro-capital assistance.

Of the individuals who saw an improvement in their housing, 82 per cent received a rental subsidy through the MCCT in the past and 37 per cent received it in 2019. For households in which no housing improvement was witnessed, 52 per cent did not receive a rental subsidy in the past and

19 per cent had received it in 2019. In addition to this, potentially surprisingly, key informants described the housing subsidy as not popular among beneficiaries because of the mismatch between the location of the houses provided and the livelihoods available in the immediate surroundings. This is an important observation since inappropriate locations of housing options will also hamper children's access to basic services including childcare, school and health facilities because transport may be too costly or the way may be unsafe.[53] This perception was confirmed by MCCT beneficiaries. Although many beneficiaries reported living in better circumstances than prior to their enrolment for an extended period of time, a number of MCCT beneficiaries also have doubts about their readiness for mainstreaming. 29 per cent have their doubts due to their poor housing conditions, 18 per cent have their doubts as they do not know the difference between MCCT and 4Ps, 6 per cent have their doubts due to still needing financial support, while 4 per cent have their doubts as they still require case management support. When asked about the main difference between themselves and the 4Ps beneficiaries, 40 per cent of MCCT-HSF beneficiaries identified income-generating activities while 54 per cent quoted the housing situation as the main difference.

Housing is frequently mentioned as the main challenge beneficiaries experience, and over half of beneficiaries believe that the main difference between themselves and the regular 4Ps beneficiaries was their lack of adequate housing. This underlines the complexity of attaining this outcome and shows that there is a group of beneficiaries who may theoretically be ready for mainstreaming, while a second group who is not ready exists too. This division suggests that the relevance of housing was not fully captured at programme conception, because the support may work for some beneficiaries and does not suffice for others. As a consequence, the processes underlying the MCCT may not be appropriate to meet this outcome reliably and consistently.

Appropriate case management for SSI: Beneficiaries express a high degree of satisfaction with their caseworkers, and over nine in every ten beneficiaries agree or strongly agree to the statement *I trust MCCT-staff.* This large majority of beneficiaries also shows better results in the programme outcomes, for instance, 85 per cent of beneficiaries who trust their caseworker feel ready for mainstreaming (those who do not trust 71 per cent) and the mean income among beneficiaries is higher among those who trust their caseworkers (PHP 59,107.6 compared to PHP 54,380.1). The importance of case management had already been emphasised and acknowledged by Sescon (2015) who underlined that for beneficiaries to escape homelessness, personal factors outweigh the importance of structural reasons as determinants of success of specific interventions. Consequently, the need to understand how behavioural dynamics of the different types of HFS differ between each other has to be met in individual case management and counselling sessions to ensure that their needs can be adequately resolved. While it is

[53] (UNOCHA and UNHABITAT, 2018)

acknowledged that there are more similarities among chronic homeless street families than as compared to the transient and episodic homeless, it would neither be practical nor equitable to design FDS targeted at different groups. Under the housing first approach, the support provided includes for instance monitoring of the housing situation, support with housing management and providing practical advice and assistance with the apartment and how to live independently, ensuring that relationships with neighbours are good, budgeting support and ad-hoc and flexible help where needed.[54]

The MCCT-HSF programme contributes towards an improved housing situation of beneficiaries. The quantitative data revealed that the housing situation for beneficiaries in fact improved post-MCCT-enrolment and many beneficiaries confirmed that their housing situation had improved: While 37 per cent of beneficiaries indicated to have no permanent space to live prior to the enrolment in the MCCT, this decreased to only 21 per cent in 2019. Prior to enrolment, 6 per cent of beneficiaries lived on the sidewalk but no beneficiaries reported to live there in 2019. The percentage of beneficiaries living in a single house increased from 16 per cent prior enrolment to 30 per cent post enrolment. This might show potential targeting errors because eligible households should be without a permanent abode at the time of or prior to enrolment. While the data captured does not yield information about the adequacy and quality of the houses and their surroundings, the types of housing mentioned confirm that beneficiaries' housing situation improved over the past five years. These changes are shown in the table below.

Table 13. Reported changes in beneficiaries' types of housing[55]

Type of residence	Prior to enrolment	In 2019
Cemetery/Mausoleum	4.2	0
Commercial/industrial/agricultural area	1	1.4
Critical area	1.6	0
Duplex	1	1.4
Institutional living quarter	0.6	1.2
Multi-unit residential	15.8	33.2
No permanent space	37	20.8
Other housing unit (boat, cave, and other)	15.8	12.4
Payag	0.8	0
Sidewalk	6	0
Single house	16	29.6
No answer	0	1
Total	99.8 %	101 %

[54] (Housing First Europe Hub, 2019)
[55] Numbers are rounded to the nearest decimal, totals may not add up to 100 per cent.

The quantitative data showed that beneficiaries are more likely to have an improved housing situation than non-beneficiaries as 73 per cent of beneficiaries improved their housing situation but only 26 per cent of the non-beneficiaries did. The difference in the housing situation between the beneficiary and non-beneficiary households is statistically significant[56] and could be ascribed to the MCCT-HSF through the use of quasi-experimental methods. Among the beneficiaries whose housing situation improved, 52 per cent received the MCCT-rental subsidy. Although the percentage of beneficiaries receiving a rental subsidy (on average worth PHP 27,098) declined from 79 per cent in 2014 to 32 per cent in 2019, this development can likely be ascribed to the fact that the majority of beneficiaries have been enrolled in the programme for several years already. As a consequence of the time limit of the rental subsidy, the majority of beneficiaries thus received the subsidy in the past.

An improved housing situation yielded further positive outcomes among beneficiaries as well: 80 per cent of households with improved housing agreed that their eating frequency had improved due to the MCCT and the quasi-experimental analysis confirmed a positive and significant effect of the MCCT-programme on household monthly income. Further, the quasi-experimental analysis confirmed that improved housing had a significant effect on the reported ability of households to care for their children and that it reduced the likelihood of children to be ill, while also contributing towards households' likelihood to seek medical advice. In addition, fewer children from households with improved housing have to work (4 per cent compared to 14 per cent among beneficiaries without improved housing and 9 per cent of the comparison group).

Table 14. Differences in child health status and labour rate by improved housing status

Child has been sick in the previous 14 days		Yes	No	Total
Housing improved	Beneficiaries	23.1%	76.9%	100%
	Non-beneficiaries	39.5%	60.5%	100%
Housing not improved	Beneficiaries	26.2%	73.8%	100%
	Non-beneficiaries	26.9%	73.1%	100%
Housing improved	Beneficiaries	4%	96%	100%
	Non-beneficiaries	9.3%	90.7%	100%
Housing not improved	Beneficiaries	13.9%	86.1%	100%
	Non-beneficiaries	79.2%	20.8%	100%

It can be concluded that outcomes are better among children in households with improved housing and that this aspect is crucial for attaining the 4Ps objectives among HSF. For children in households in the comparison group and without improved housing, poorer outcomes were observed which emphasises the need to extend the MCCT to achieve the 4Ps objectives.

[56] The difference-in-difference analysis estimated a coefficient of 1.987 which was significant at the 1% significant level. The standard error was equal to 0.718, t-statistic equal to 2.77 and a p-value of 0.006. In addition, a 95% confidence interval between 0.580 and 3.394 was found.

With regards to mainstreaming, the quantitative data showed that reported compliance varies for the different conditions between households with and without improved housing. For instance, compliance with the health condition is higher for households whose housing situation improved (92 compared to 78 per cent) and FDS-compliance (100 compared to 95 per cent) is also better among them. Due to the size of the sample and sampling methodology, these findings are indicative and only representative for the sample.

Table 15. Differences in programme compliance by improved housing status

Education grant compliance		Yes	No	Total
Beneficiaries	Housing improved	73.1%	26.9%	100%
	Housing not improved	93.3%	6.7%	100%
Health grant compliance				
Beneficiaries	Housing improved	92%	8%	100%
	Housing not improved	77.7	22.4%	100%
FDS compliance				
Beneficiaries	Housing improved	100%	0%	100%
	Housing not improved	95.1%	4.9%	100%
Ready for mainstreaming to 4Ps				
Beneficiaries	Housing improved	79%	21.1%	100%
	Housing not improved	82.6%	17.4%	100%

Summary of outcomes

The qualitative-quantitative profile of the programme indicates that the programme likely achieves several positive outcomes. To start, beneficiaries' financial resources improved as a result of the programme, providing them with more resources for a range of investments and expenditure. In addition, households report being healthier, attending the FDS regularly and many beneficiaries reported that they are more food secure. School attendance also improved, and beneficiaries are very aware of the value and need for education. These outcomes, in turn, contributed to increased investments in health, education and basic needs, including food. Beneficiary households experience less hunger, though impacts on nutrition may not be achieved in the face of a slight shift away from more healthy foods to less nutritious, unhealthy canned and processed alternatives now that households can afford these and may choose them for convenience. The programme may also contribute to positive improvements in terms of child labour, as child labour rates are lower for beneficiaries than non-beneficiaries. Furthermore, beneficiaries ascribe higher value to good parenting skills and a stable home than non-beneficiaries; and report higher satisfaction with government services after enrolment into the MCCT, and in comparison with non-beneficiaries. Only for health services, these findings are not confirmed, and beneficiaries report to have experienced stigmatization on occasion while taking up health services.

6. Conclusions

The MCCT-HSF aims to empower homeless street families to fulfil the eligibility criteria of the regular 4Ps to enable them to access regular social assistance programmes as a result of being captured in Listahanan by combining the regular 4Ps with the more individualized support through

the SSI and case management. This assessment sought to identify to what extent the processes underlying the MCCT-HSF were conducive to enable HSF to be mainstreamed to the regular 4Ps.

In the absence of formally mainstreamed MCCT-HSF beneficiaries and assessments to capture the impact of the MCCT-HSF on programme objectives, a need arose to investigate the programme's capacity to address the needs of its beneficiaries and clarify if the design and implementation are suitable to achieve its complex objectives. Through its mixed-methods approach, this assessment found that the programme does, in fact, achieve several important outcomes in the scope of the 4Ps core programme, as well as the MCCT-specific aspects. However, important factors inhibit the actual mainstreaming of beneficiaries.

The MCCT-HSF achieved several relevant outcomes for beneficiaries through the provision of the regular 4Ps core package and the provision of SSI and its proactive case management approach. Positive outcomes were captured for several short-and medium-term outcomes of the 4Ps. These include for instance that fewer beneficiary children than non-beneficiary children were reported as having been ill in the two weeks prior to the data collection and that 94 per cent of beneficiaries reported that their own and their children's health improved since enrolment in the MCCT. Although non-beneficiaries showed stronger improvements in self-reported attendance and enrolment rates than beneficiaries, beneficiaries reported higher overall school attendance rates.

A majority of beneficiaries reported that their food security improved as almost half of all beneficiaries report eating an additional meal now compared to prior their enrolment. While beneficiaries' diets are more diversified than those of the non-beneficiaries, beneficiaries also report consuming more canned or processed foods than the non-beneficiaries. This should be further investigated as it may indicate a negative development in the quality of foods consumed, following a tendency to choose processed and fast foods over fresh foods with improved levels of income which was also observed in the regular 4Ps programme.

It was further found that beneficiary households have a strong awareness of the value of health and education for their children and acknowledge their full responsibility for these important aspects of human development. This is exemplified in the fact that more beneficiaries reported spending their cash grants on their children's needs including food, education, medicine, clothing and public transport to school. Further, more beneficiary households than non-beneficiaries consider good parenting skills, hygiene, a stable home, safety and food security as important for childcare. With very limited support and information on the typical FDS-topics being available to non-beneficiaries, this finding emphasizes the importance of the FDS, which almost all of the beneficiaries consider important and report to apply in their daily lives. In addition, in beneficiary households, fewer children had to work (13 per cent) than in non-beneficiary households (17 per cent), indicative of potential positive impact on child labour.

Further positive outcomes were found in the areas addressed by the SSI, including beneficiaries' housing situation and livelihoods capacities, which were the most intensely discussed and frequently mentioned issues experienced by HSF. **The SSI were found to be decisive means to enable HSF to address these challenges, thus showing that the HSF-specific objectives of the MCCT can be met with the support provided**. On one hand, beneficiaries consistently mentioned the cash for work and financial support, for instance, the micro-capital assistance as important support they receive under the SSI because these enhanced their financial resources. The value attached to the SSI was further exemplified by the fact that beneficiaries who reported to have gained employment through the SSI were often still employed with their employer and that beneficiaries who founded businesses were more likely to operate their businesses more sustainably than non-beneficiaries who received no support. Both these aspects enable beneficiaries to generate incomes to alleviate the limitations of their financial resources in the long-term. On the other hand, it was shown that the SSI have the capacity to address the housing situation among beneficiaries, as more beneficiaries reported improved housing situations than non-beneficiaries. The rental subsidy is currently being received or has been received in the past by close to all beneficiaries and was found to have enabled 58 per cent of beneficiaries who did receive it to improve their housing situation.

In addition to finding that interventions provided are suitable to support beneficiaries, the assessment also found that the **case management methodology** employed is among the most decisive aspects to achieve the MCCT-specific outcomes. Due to its capacity to identify beneficiaries' real needs, case management and hence the individual caseworkers, are essential to identify ways to support beneficiaries adequately. Without a well-rounded and holistic understanding of the challenges experienced by beneficiaries, the likelihood of allocating inadequate or "quick fix"-solutions is high. This is not cost-efficient as change is unlikely to be sustained because beneficiaries' underlying problems are not addressed. The value and adequacy of the MCCT-HSF are also reflected in higher satisfaction with government services among MCCT beneficiaries than among non-beneficiaries (89 compared to 67 per cent).

Despite achieving these outcomes for beneficiaries, the programme is formally not attaining its primary objective to enable beneficiaries to be captured by the regularly 4Ps targeting method. The assessment found that this is not due to inadequate support provided but may rather be ascribed to the lack of clarity, adequate operational and administrative support and absence of coherently applied guidelines in the implementation.

The overarching challenge affecting the programme was identified to be that the housing and mainstreaming objectives and their relationship towards each other is not clear for implementers. This affects the entire implementation of the MCCT-specific components of the programme because of the absence of a clearly communicated and consistently understood objective renders it difficult to capture if it is effectively being fulfilled. However, the assessment found that

beneficiaries feel "ready" for mainstreaming, many have improved their housing situation since enrolment with the MCCT and implementers also submit beneficiary lists for mainstreaming to the NPMO. With the quantitative data confirming that the rental subsidy supports the improvement of beneficiaries' housing situation, the MCCT-HSF programme shows to be adequate to resolve the needs of HSF. As a result, the lack of mainstreamed households is not entirely due to the inadequacy of support provided. Instead, the qualitative interviews have shown that the data management systems underlying the MCCT-HSF and the 4Ps are not inter-operational and hence mainstreaming is not possible.

In addition to the lack of a clear objective which is the overarching programme weakness, the absence of mainstreamed households exemplifies four cross-cutting obstacles which affect the implementation, namely 1) lack of clarity pertaining to the types of support and access channels, 2) lack of information about the data management systems and their operational capacity, 3) inadequate coordination mechanisms and 4) unclear boundaries for case management.

Firstly, the 4Ps core package is largely implemented following its design, while the main difference to the regular 4Ps – the SSI – lack a clear design. This is exemplified for instance in the fact that several allocation pathways exist for the SSI or that the different regions and the NPMO have different interpretations of the need for, purpose and functioning of mainstreaming. This increases programme variation and as a result, it cannot clearly be identified which factors enable households to meet the mainstreaming criteria. While this flexibility has some benefits, it makes implementation inconsistent and difficult on the ground, largely affecting the mainstreaming of beneficiaries.

Secondly, currently used computer and data management systems for the MCCT-HSF hamper its implementation to an extent which affects the achievement of programme objectives. Even beneficiaries who are fully compliant and considered ready for mainstreaming cannot formally be mainstreamed because of inadequate IT-infrastructure and the absence of an active interface between the relevant databases. These issues are exemplified in the fact that key informants reported having mainstreamed beneficiaries, but no formal transitions from MCCT-HSF to 4Ps are confirmed at the national level or in the HSF-roster.

Thirdly, the formal coordination system of the 4Ps is adhered to but it seems inadequate for accommodating the multitude of relevant aspects for the regular 4Ps beneficiaries and the three distinctive target groups of the MCCT (IP, FSNP and HSF). As a result of the complexity of the issues pertaining to all these groups, the needs and interests of the homeless street families likely do not find sufficient attention in the regular 4Ps coordination meetings and structures. Moreover, housing stakeholders are largely absent from these coordination platforms as well.

Fourthly, there is a lack of clarity pertaining to the exact role of caseworkers and their mandates to support beneficiaries. The absence of clear guiding documents and reference frameworks in

combination with many caseworkers' having a high motivation for their work, support to beneficiaries may be inequitably distributed depending on the involvement of individual caseworkers' level of engagement. This further contributes to the programme's variation and challenges the development of a unique and systemic programme.

The assessment further found that the programme strengthens beneficiaries' financial resources and enables beneficiaries to improve their type of housing. The quantitative data showed that children in households whose housing situation improved are sick less often, engage less often in labour and all beneficiaries with improved housing reported that their children attend school. In addition, it was found that slightly fewer beneficiaries with improved housing reported that their meal frequency had improved than beneficiaries whose housing situation had not improved (80 compared to 87 per cent). This shows that despite financial improvements through the programme, households may still not be able to meet all their needs to a satisfactory extent and hence need further support.

This assessment shed light onto how and under what conditions the MCCT-HSF is able to respond to the needs and circumstances of homeless street families and assessed the extent to which the programme processes, designs and goals are adaptive and responsive to the situations of homeless street families and conducive to extend the 4Ps benefits to this, particularly vulnerable group. Based on this, a number of recommendations are formulated in the following section.

7. Recommendations

Based on the research findings and conclusions drawn, and in consideration of ***Figure 1.*** *Assessment framework for the MCCT-HSF*, a range of recommendations are proposed. These focus on solutions to serve the needs of the MCCT-HSF beneficiaries better in a more cost-effective and efficient way. Against the backdrop of the DSWD priorities for 2019, to improve the well-being of poor families, to promote and protect the rights of the poor and vulnerable sectors, to provide immediate relief and early recovery of disaster victims, to continue compliance of Social Welfare and Development Agencies (SWADAs) to standards in the delivery of social welfare services and improve the delivery of social welfare and development (SWD) programmes through LGUs, a refitting of the design of the MCCT-HSF could be beneficial.[57]

To this end, it is recommended to resolve the overarching lack of clarity pertaining to the design of the programme first. To this end, two different scenarios are worthy of consideration and will be presented. While the first scenario expands the scope of the programme, the second option to reshape the intervention depicts a reduction of its programmatic scope. Following this, a number of micro-level recommendations are provided which should be followed regardless of which direction the future MCCT-programme follows. While FDS should be tailored to the needs of HSF

[57] (Department of Social Welfare and Development, 2018c) (Republic of the Philippines, 2016)

in general, it is encouraged not to develop FDS which target HSF according to their duration of stay in the streets. Instead, these individual needs should be identified and resolved in individualised and intensive case management sessions as is practised under the Housing First approach. This also suggests that to sustainably resolve homelessness, the housing situation must be resolved first and then, the causes and effects of it must be addressed through tailored support.

Macro-level recommendation: clarify the programme objective

Scenario 1: Design the MCCT-HSF clearly as a housing intervention with the objective to bring families into homes first and integrate them fully into society, ensuring access to government services. To this end, the MCCT-HSF should be designed following a separate theory of change and be based on supportive programme documents, separate from the 4Ps. To operationalise this approach, *beneficiary profile*s of HSF should be developed to identify which support they need, depending on the severity of their homelessness. This could, for instance, be measured by the differencing between transient, episodic and chronic homeless and the influence this has on their behaviour. These should be aligned with the National Anti-Poverty Commission's (NAPC) concept of the *urban poor* and be further informed by the data collected for this assessment. To address the beneficiaries' prioritised needs adequately, case management and SSI should be further strengthened and refined. It is recommended to institutionalize interventions and establish case management as a systemic tool for the implementation of the programme. This approach should, among others, include the development of a service catalogue to be available at field offices, and possibly in electronic format. It should be assessed whether the Family Camps under the SSI can be reintroduced and if longer social preparation interventions for beneficiaries is feasible. These are likely to strengthen their understanding for the need to sustainably change their living environment and foster longer-term planning among beneficiaries, which will be necessary to enable them to sustainably change their lives for the better. In addition, the time limits on interventions should be removed and instead, interventions should be sequenced and timed according to beneficiaries' priorities. This would contribute towards the programme's overall capacity to meet the specific needs of homeless street families, but it still needs to be ascertained that the support is reasonably quantifiable.

Scenario 2: Phrase the MCCT as a real *sieve* intervention which focuses on extending the 4Ps core package to all groups referred to as the *basic sectors*, who are not included in the regular 4Ps but are legally entitled to receive public services. In this scenario, only the first objective of the current programme would remain, namely, to extend the 4Ps benefits to all vulnerable families. Housing would thus no longer be included in the objectives and this aspect will be left to other governmental authorities. As HSF, IP, FSNP seem to be treated nearly identically in the field which was largely identified to be ascribable to a lack of sufficient capacities in the field, this approach may be most practical. This scenario suggests tightening the links between the MCCT-HSF and the 4Ps and would strictly implement the MCCT as top-up support to the regular 4Ps. This option could

draw experience from past interventions and experience in the country with shock-responsive social protection, for instance where the 4Ps infrastructure was used to disburse payments to families affected by disasters, for instance after Typhoon Yolanda in 2013/14.[58] The approach however strongly depends on a reliable, up-to-date and functional data management system.

Micro-level recommendations: revise programme implementation

1. Consider case management procedures as solutions to broader social issues: Case-based support has the potential to address the vulnerabilities of the poorest and most vulnerable groups more sustainably and may be beneficial to strengthen outcomes within other core social protection programmes of the department. It should be considered to extend the case management approach beyond the MCCT. Within the programme, as case management is at the heart of its success, case management would benefit from better guidance and a clearer structure, improving overall effectiveness. The personal relationships between caseworkers and beneficiaries were identified to play the most decisive role in achieving outcomes for beneficiaries. However, their current workloads and responsibilities to help their beneficiaries are perceived as too high, especially because of the complexity of the SSI which they may design for and allocate to their beneficiaries. As the complexity of their duties hampers the attainment of sustainable and replicable outcomes, it will be beneficial to clarify caseworkers' job descriptions. Concrete points for action include:

A. Professionalize caseworkers and case management procedures: Caseworkers need clear job descriptions and adequate back-office structures. Therefore, case management tools need to be developed, become operational and be consistently implemented. This will enable caseworkers to carry out structured needs assessments, for instance through the Social Welfare Development Indicators; and will be conducive to creating formal referral pathways to additionally available support from other governmental and non-governmental organizations.

B. Build capacities of caseworkers: The professionalization of caseworkers should be supported through specific trainings for caseworkers. The training could include several thematic areas, but should at the minimum clarify the boundaries of *therapeutic relationship* for case management and train caseworkers on the clearer procedures developed as part of A. In addition, caseworkers need training in project management, budgeting, and proposal writing, in case these activities remain at the core of their jobs. Finally, caseworkers also need to be trained in holistic needs assessment and how to use standardized referral tools and pathways. As key informants and caseworkers alike criticised the heavy workload and stressful working environment, it is strongly encouraged to provide caseworkers with trainings on self-care to improve their stress-coping mechanisms and enable them to achieve a healthy work-life balance.

[58] (Aldaba, 2019)

2. Improve MIS and IT infrastructure: The functions and capacity of the MCCT-MIS are currently not adequate to support effective implementation. This affects the implementation in the field on the one hand. On the other hand, it also inhibits the attainment of the mainstreaming conditions because the current system has no interface with the 4Ps-MIS. Therefore, a revision and strengthening of the available IT-infrastructure and MCCT-database are necessary. To this end, the technical and functional system requirements to meet the programme objectives should be clarified across all administrative and implementation levels first. This should take into account the hard-and software resources available at the local level and funds should be allocated to invest in additionally required equipment, such as laptops to ensure convenient and needs-oriented data entry at the relevant levels.

3. Identify bottlenecks in beneficiary payment and financial disbursement procedures: Bottlenecks in the disbursement of payments to beneficiaries and in the release of funding for the SSI should be identified and addressed. Following this, clear expenditure guidelines which fulfil relevant legislative requirements should be enforced but it needs to be safeguarded that interventions can still be designed flexibly enough to the needs of beneficiaries. The development of clear expenditure procedures is anticipated to yield two positive outcomes. On one hand, these will contribute towards regular and reliable payments of the cash transfers for beneficiaries and will improve their understanding of the link between their compliance with programme conditions and the payments received. On the other hand, the timely and practice-oriented release of funding for the SSI will facilitate the implementation of the individual interventions for beneficiaries and will enable programme implementers on the ground to plan their activities better.

4. Improve coordination: There is a need to clarify the character of the MCCT-HSF and the resources dedicated to it to ensure all involved actors are informed and cognizant of the issues pertaining to HSF and priorities applicable to the programme implementation. While devolved social welfare programmes at LGU level are a priority for the DSWD, DSWD is mandated to relief deprivation among poor households but not to provide housing interventions. While LGUs are mandated to provide housing to beneficiaries, they are often not fully included in the programme implementation. In light of the lack of clarity pertaining to the current programme implementation, entry points for coordinated support to HSF may often remain unused.

5. Improve communication and information sharing channels: Improve and formalize information sharing between the national, regional and provincial offices to enable implementers and especially caseworkers, to adequately inform beneficiaries of programme requirements and available benefits, particularly for the SSI. While the beneficiaries are relatively well informed about the requirements for the core package where guidelines are clearly formulated, this does not hold for the mainstreaming and SSI components of the programme. By providing concrete information about available support, beneficiaries could be linked more effectively to available interventions and this is likely to strengthen programme outcomes. Concrete points for action

include strengthening knowledge management about relevant services, for instance through a service directory at the local level; and provide beneficiaries with clear information about available services which they may access beyond the regular 4Ps.

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Annex A. List of documents for process review

Author	Year of publication	Document title	Administrative reference
Republic of the Philippines	1991	Local Government Code of 1991	RA 7160
DSWD	*2012*	*Concept Paper on the Expanded Conditional Cash Transfer Project for Homeless Street Families.*	
DSWD	*2012*	*Implementing Procedures for the Conduct of Family Camp as Part of Pilot Implementation of Modified Conditional Cash Transfer Programme.*	*MC 26 s2012*
End of MCCT-pilot phase			
DSWD	2014	Revised Guidelines on the Implementation of the Modified Conditional Cash Transfer for Homeless Street Families.	MC 09 2014
DSWD	2014 (a)	Amendment to NAC Resolution 2016. Additional Guidelines on the Implementation of the Modified Conditional Cash Transfer for Homeless Street Families.	NAC Resolution 19 of 2014
DSWD	2015	Pantawid Pamilyang Pilipino Program Operations Manual.	
DSWD	2015 (a)	OPLAN BALIK BAHAY SAGIP BUHAY (OBBSB) TOR. Modified Programs and Services for Families, Unattached Adults and Children at Risk on the Streets.	
DSWD	2016	Amending the Programme Duration and Conditionalities of the Beneficiaries in the Modified Conditional Cash Transfer Programme.	NAC Resolution 31 s2016
DSWD	2016	Strengthening Implementation of MCCT-Support Services Intervention Programme.	
DSWD	2016	Guidelines on Strengthening Support Services Interventions Implementation for Modified Conditional Cash Transfer Beneficiaries.	MC 07 2016
DSWD	2016	Mainstreaming Guidelines of the Modified Conditional Cash Transfer (MCCT) Beneficiaries to the Regular Conditional Cash Transfer (RCCT) Programme.	MC 08 2016
Republic of the Philippines	2016	Philippine Development Plan 2017 – 2022	
DSWD	2017	Operational Manual MCCT (Draft). Quezon City: Department of Social Welfare and Development.	
DSWD	2017	Power Point Presentation: Pantawid Pamilyang Pilipino Program Theory of Change.	
DSWD	2018a	Revised Mainstreaming Guidelines of the Modified Conditional Cash Transfer (MCCT) Beneficiaries to the regular Cash Transfer (RCCT) Programme.	MC 02 s2018
DSWD	2018b	Implementing Guidelines for the Unconditional Cash Transfer Programme	MC 03 2018:
DSWD	2018c	Thrust and Priorities 2019	AO 24 2018
DSWD	2018	Pantawid Grievance and Redress System	
Republic of the Philippines	2018	Institutionalizing the Pantawid Pamilyang Pilipino Programme	Act No. 11310
Republic of the Philippines	2019	Magna Carta for the Poor	Act No. 11291

Annex B. Guiding questions for process review

Process review
1. What is the MCCT-HSF? • What are the components of the programme? • What processes are the different steps of the programme cycle based on? • What role do the Supply Side Interventions play? • How do the Supply Side Interventions work?
2. How is the programme implemented? • What steps of the programme cycle can clearly be identified? (identification, assessment, enrolment, payment, grievance and redress, mainstreaming).
3. Is the programme serving its beneficiaries? • Are inputs reflected in desired outcomes? • Are mechanisms in place to sustain desired outcomes, especially to ensure beneficiaries remain in the regular 4Ps once they are mainstreamed?
4. Have changes to the programme been made? • What changes have been made to the programme, and why? • What design changes may be necessary to replicate the strong programme outcomes?
5. What are the programme costs? • Has funding changed in the past? • Is funding anticipated to change in the future?
6. What are the conditions for future funding? (DSWD priorities) • What is the role of human resources/staff with regards to implementation? • What are the roles and responsibilities of members of staff etc.?
7. How is MCCT-HSF integrated into the wider network of government and non-governmental actors?

Annex C. Objectives of Pantawid Pamilyang Pilipino Programme

Health objectives	Education objectives
1. To improve the health of young children and mothers by promoting preventive health care.	1. To increase enrolment and attendance rates of children in Day Care, Kindergarten, elementary, and secondary schools.
2. To increase growth and nutrition monitoring visits of infants and children under five years old.	2. To contribute to the reduction of the incidence of child labour.
3. To promote complete immunization of infants and children under three years old.	3. To raise the average consumption rate in food expenditure of poor households.
4. To ensure regular visit to health centres of pregnant women and young children	4. To encourage parents to invest in their children's health, nutrition and education.
5. To increase child growth and lower stunting among children 5 years old below.	5. To enhance the performance of parenting roles of beneficiaries and their participation in community development activities.
6. To lower the incidence of complications in pregnancy and maternal deaths.	

Annex D. Mainstreaming procedure

Activity	Responsible office
Cross matching of MCCT beneficiaries with Listahanan	Listahanhan
Endorsement of cross matching result to PMED IMB	NPMO MCCT
Endorsement of data result of PMED to IMB	NPMO MCCT
Submit dump data of MCCT to IMB for *Tugmaan*	NPMO MCCT
Migration of cross-matching result to ECR database	IMB
Eligibility check routine and duplicity checking	IMB
Migration of ECR and duplicity checking result and family information from MCCT Database (MCCT dump data) in Tugmaan table	IMB
Data quality checks in *Tugmaan* table	IMB, NMPO-RMQAD, PMED, MCCT
Generation of list eligible beneficiaries for mainstreaming and downloading of *Tugmaan* Validation Form	NPMO BDMD
Printing of the identified list of beneficiaries and forms for *Tugmaan* validation to the city/municipal links	4Ps RPMO
Distribution of the printed list of identified beneficiaries and forms for the *Tugmaan* validation to the city/municipal links	4PS RPMO/POO
Conduct of *Tugmaan* (field validation)	City/municipal links
Processing of output and consolidate result of *Tugmaan* validation	Municipal operations office
Encoding and submission of reports	4Ps RPMO
Updating of family status of beneficiaries in MCCT-IS and 4Ps-IS using MCCT Mainstreaming Validation Form for the verified matches	RPMO
Encoding verified updates	RPMO/POO/MOO
Regional Director's Approval	RPMO
Tagging of successful mainstreamed MCCT beneficiaries in the MCCT database (Status code 20 or 21)	RPMO

Annex E. List of activities and participants by region

Research method	Participant group	Level	# of activities	# of participants	Total
National-level inception mission					
Key informant interview	Division head	National	1	1	1
Key informant interview		National	1	1	1
Writeshop	Department of Social Welfare and Development Social Technology Bureau and 4Ps NPMO	National	2	8	16
TOTAL					18
National-level data collection					
Key informant interview	Division head	National	2	1	2
Key informant interview	Programme Development Officer 3	National	3	1	3
TOTAL					5

Quezon, Calabarzon

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Focal	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	1	1	1
Key informant interview	MCCT-Social welfare officer	Regional	1	1	1
Key informant interview	Child psychologist	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Market view	1	8	8
Focus group discussion 2	Comparison group	Market view	1	6	6
Household survey	Beneficiaries		1		1
Household survey	Comparison group		2		2

Butuan, Caraga

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Focal	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	1	1	1
Key informant interview	Support Service Intervention-Focal	Regional	1	1	1
Key informant interview	CSO: Red Cross	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Langihan	1	6	6
Focus group discussion 2	Comparison group	Langihan	1	7	7
Household survey	Beneficiaries		29		29
Household survey	Comparison group		6		6

Zambales, Olongapo City and Pampanga, City of San Fernando, Central Luzon

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Focal	Regional	1	1	1
Key informant interview	Provincial link	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	1	1	1
Key informant interview	CSO: Jesus our Home International	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Upper Kalaklan	1	7	7
Focus group discussion 2	Comparison group	Upper Kalaklan	1	8	8
Household survey	Beneficiaries		13		13
Household survey	Comparison group		3		3

Cebu, Cebu City, Central Visayas

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Focal	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	2	1	2
Key informant interview	CSO: Pagtambayayong	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Careta and Taboan (1)	1	8	8
Focus group discussion 2	Beneficiaries	Careta and Taboan (2)	1	6	6
Focus group discussion 3	Beneficiaries	Imus Avenue	1	6	6
Focus group discussion 4	Comparison group	Imus Avenue	1	6	6
Household survey	Beneficiaries		59		59
Household survey	Comparison group		11		11

Manila, National Capital Region

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Focal	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	2	1	2
Key informant interview	Child psychologist	Regional	1	1	1
Key informant interview	CSO: Onesimo Bililit	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Alabang (1)	1	7	7
Focus group discussion 2	Beneficiaries	Alabang (2)	1	7	7
Focus group discussion 3	Beneficiaries	Almanza Las Pinas	1	7	7
Focus group discussion 4	Beneficiaries	Baclaran	1	7	7
Focus group discussion 5	Beneficiaries	Bambang	1	6	6
Focus group discussion 6	Beneficiaries	Bankgal (1)	1	6	6
Focus group discussion 7	Beneficiaries	Bankgal (2)	1	6	6
Focus group discussion 8	Beneficiaries	Divisoria (1)	1	6	6
Focus group discussion 9	Beneficiaries	Divisoria (2)	1	6	6
Focus group discussion 10	Beneficiaries	Divisoria (3)	1	6	6
Focus group discussion 11	Beneficiaries	San Dionisio	1	6	6
Focus group discussion 12	Beneficiaries	Sta Cruz	1	8	8
Focus group discussion 13	Beneficiaries	Tejeros	1	7	7
Focus group discussion 14	Comparison group	Bambang	1	6	6
Focus group discussion 15	Comparison group	Sta Cruz	1	6	6
Focus group discussion 16	Comparison group	Sucat	1	6	6
Focus group discussion 17	Comparison group	Tejeros	1	6	6
Household survey	Beneficiaries		374		374
Household survey	Comparison group		72		72

Misamis Oriental, Northern Mindanao

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	MCCT-Caseworker	Regional	1	1	1
Key informant interview	MCCT-Social welfare officer	Regional	1	1	1
Key informant interview	MCCT-Computer maintenance technician	Regional	1	1	1
Key informant interview	CSO: CLIMBS	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Barangay 1	1	6	6
Focus group discussion 2	Comparison group	Barangay 1	1	6	6
Household survey	Beneficiaries		22		22
Household survey	Comparison group		4		4

Zamboanga del Sur, Zamboanga

Research method	Participant group	Level	# of activities	# of participants	Total
Key informant interview	Regional programme coordinator	Regional	1	1	1
Key informant interview	Provincial operations officer	Regional	1	1	1
Key informant interview	MCCT-Social worker	Regional	1	1	1
Key informant interview	Caseworker	Regional	1		1
Key informant interview	Child psychologist	Regional	1	1	1
Focus group discussion 1	Beneficiaries	Sta Catalina	1	6	6
Focus group discussion 2	Comparison group	Sta Catalina	1	7	7
Household survey	Beneficiaries		2		2
Household survey	Comparison group		1		1